Hearing on Enhancing the Employer-Based Health Care System: Why Providing Parity Between Employers is Necessary to Universal Coverage

"How significant is uncompensated care due to free rider employers in the health care system in the rising cost of health care; particularly, insurance premiums, deductibles, co-pays and other cost-sharing arrangements?"

Good morning. Thank you, Chairman Andrews, for your introduction. I would like to thank the Chairman and his fellow esteemed members of this Committee for the opportunity to address you on this important topic.

Cooper University Hospital, based in Camden, New Jersey, is a major teaching hospital and regional tertiary-level referral center serving the southern New Jersey region. Cooper University Hospital is the flagship of The Cooper Health System. It is the premier university hospital serving South Jersey and the Delaware Valley. As the core clinical campus for the Robert Wood Johnson Medical School in Camden, Cooper is a national leader in medical education and research. With its comprehensive services and cutting-edge technology, the hospital is renowned for its prestigious Centers of Excellence in cardiology, cancer, critical care, trauma, orthopedics and neurology. Cooper has embarked on a $500 million expansion of its Camden Health Care Campus including the new $220 million patient Pavilion which opened in December 2008. Cooper and its community partners earned a 2008 Smart Growth Award from New Jersey Future for the vision of the Health Sciences Campus in Camden.

As many of you are aware, Camden city is one of the poorest cities in the United State, with approximately 40% of its households living below the federal poverty level. Cooper is the city's main health care provider, serving as its community hospital and provider of primary and sub-specialty medical care. As a consequence, Cooper is the largest provider of charity care services in South Jersey and is recognized as a "safety-net" hospital--one of the largest providers of charity care services in New Jersey.

While the national recession has taken a serious toll on Cooper's finances in the course of the past year, the Camden environment and its poor economy has presented difficult financial challenges for Cooper for decades. We have managed to grow over the past eight years by recruiting some of the top doctors in the country and developing clinical centers of

excellence with national reputation. This has enabled Cooper to increase its patient utilization and attract New Jersey residents who in the past have depended on the major academic medical centers in Philadelphia.

Cooper's payer mix presents a microcosm of the healthcare finance dynamics at work in New Jersey and the country at large. Fundamentally, healthcare providers such as Cooper with a great volume of patients that are uninsured or under-insured, must shift their costs to their paying patients. Those without healthcare insurance, and patients qualifying for charity care and Medicaid, totaled over 38% of Cooper's patient base in 2006, and this number has grown over the past three years to nearly 41% in 2008. While Cooper receives State funding for its charity care services, it only covers approximately 50% of the costs of these services; Medicaid funding typically covers only 60-70% of costs. Thus, for Cooper, this uninsured and underinsured population combined represents approximately 30% of our costs over the past three years, but only 15% of our revenue.

The reason why 40% of Cooper's patients only account for 30% of Cooper's costs is explained by the fact that the uninsured typically use hospitals for less acute, primary-care related services. Thus, their hospital cost-per-person is lower than the average. However, this represents a misallocation of resources in our health care economy in that expensive hospital resources are being utilized in place of less expensive physician-based primary care.

So Cooper is a safety-net health care provider, and we are there for our patients without regard for the patients' ability to pay for care—a mission Cooper has maintained for 120 years. But what are the economic consequences of this pattern of hospital utilization? Hospitals such as Cooper must shift expenses to those with health insurance.

Patients covered under Medicare insurance represent 30% of our patient base and Medicare rates pay close to actual cost of care, though in recent years, Medicare has not kept up with the increased cost of providing care.

Patients with employer-sponsored health insurance constitute just over 30% of our patient base over the past three years, and approximately 30% of our cost structure. However, this

segment of our business over the past three years represents approximately 40% of our revenue. One might say that this premium of ten percent over the cost of care for this segment of business represents part of the price of the social contract to care for those unable to pay for themselves.

Unfortunately, the underlying dynamics of our healthcare economy are not sustainable. As costs are shifted to the paying patients, premiums rise, and individuals and business are unable (or unwilling) to pay for health insurance coverage. This increases the number of uninsured and underinsured, which leads to further cost shifting, and the precarious healthcare economy we all face today.

Increasing health care insurance coverage will help to stabilize the inflation of health care expenses. While this is a necessary component of health care reform, it will be insufficient to reduce health care costs, unless greater resources are allocated to primary care and the proper clinical management of chronic diseases. There are numerous primary care initiatives and interventions being tested around the county, and at Cooper as well, which demonstrate that we can substantially reduce health care expenses by "case management" and patient education which facilitates better disease management and reduction in the use of expensive emergency departments and hospitalization.

The picture I have drawn of Cooper and the healthcare economy in Camden can be replicated for the State of New Jersey. Over the last six years, the percentage of uninsured, Charity Care, and Medicaid hospital cases have grown from 14.8% to 18.5%, while non-governmental health insurance payers including commercial, HMO, and point of service health insurance coverage has declined from 47.6% in 2002 to 41.9%. Approximately 90% of this category is employer-sponsored, according to O'Conco Healthcare, a prominent health care consultancy.

During the same time period, provision of hospital charity care services—priced at Medicaid rates, which are approximately 60%-70% of actual costs—grew from $624MM to $945MM—a 51% increase over six years. This represents an annual growth of demand for charity care services in New Jersey of 8.6% per year. New Jersey State payments for hospital

charity care services have grown from $381MM in 2002—covering 60% of hospitals' charity care services priced at Medicaid rates—to $715MM in 2008—covering 75% of charity care at Medicaid rates. The cumulative impact on the hospital industry of the shortfall in hospital payments for New Jersey charity care represents $2.32 billion over the past six years!

These trends regarding the decline in health care coverage and increase in the uninsured and underinsured in New Jersey, along with the continued deficit in hospital charity care funding, have take a serious toll on the hospital industry. More than half of New Jersey hospitals are operating in the red and eight hospitals have closed their doors since 2002.

It is useful to put these trends in perspective of the business community in New Jersey, and the pressure it faces in response to the continued increase in health care costs and the cost of health insurance coverage.

In 2008 the New Jersey Business and Industry Association's annual "Health Benefits Survey" found that health insurance costs rose by an average of 9.4 percent in 2007. Employers spent an average of $7,139 per employee. More startling, it found that costs have doubled in the past six years, given the effects of compounding. In spite of this, the vast majority of employers in New Jersey are continuing to provide health insurance coverage for their employees (98% of companies with 51+ employees and 95% of companies with 20-50 employees), though the beneficiaries have faced increased out-of-pocket expenses. Very small companies, however, seem to be reaching the breaking point. Some 75% of companies with 2-19 employees provided coverage last year, but 92% provided coverage just four years ago. Many small employers continued to provide coverage by cutting costs in other areas. Sixteen percent of small employers limited salary increases and another 10 percent scaled back hiring.

[Skip this next section from spoken testimony, but retain for written submitted testimony- go to ** paragraph reporting national data from the AHA]

The latest New Jersey Business & Industry Association's Health Benefits Survey was conducted in January 2008, and included over 1,000 New Jersey businesses, 88 percent of whom were small companies with 2-50 employees, representing all major industry sectors and all 21 New Jersey counties. Among their findings:

- The average cost of $7,139 per covered employee in 2007 included coverage of both full-time employees with no covered dependents and full-time employees with covered spouses and/or dependents. This was the amount paid by the employer. It did not include the share of premium costs paid by employees.

- The average increase of 9.4 percent for all companies in 2007 followed increases of 11.3 percent in 2006, 12 percent increase in 2005, and 11.2 percent in 2004. Factoring in increases of 13.2 percent and 15 percent recorded by the NJBIA survey in 2002 and 2003, and given the effects of compounding, employers paying these average cost increases would have seen their costs double over the past six years.

- The cost of health insurance, as a percentage of wages and salaries, also rose for many companies last year. The average cost of $7,139 per employee represented 15 percent of reported average wages of $47,414. This is up from 2006, when employer health insurance costs represented 13.5 percent of average wages.

- As a group, employers do not expect their health plan costs to moderate anytime soon. Survey participants anticipate that their costs will increase by an average of 9.7 percent in 2008.

- The proportion of the smallest companies, those with 2-19 employees, sponsoring coverage has fallen as costs have risen. Seventy-five percent of this group reported providing coverage in the current survey, down from 92 percent four years ago. The average size company in this group has six employees.

- When companies that no longer provide coverage were asked why, 76 percent said they could no longer afford it. Another 10 percent said they were unable to satisfy the State's requirement that at least 75 percent of their workforce participate in the plan.

**Nationally, the American Hospital Association is a useful source for data on uncompensated care nationwide. Among its findings:

- *In the aggregate, both Medicare and Medicaid payments fall below costs and the shortfall has been growing.*
- *Combined underpayments rose from $3.8 billion in 2000 to nearly $32 billion in 2007*
- *For Medicare, hospitals received payment of only 91 cents for every dollar spent by hospitals caring for Medicare patients in 2007*
- *For Medicaid, hospitals received payment of only 88 cents for every dollar spent by hospitals caring for Medicaid patients in 2007*
- *In 2007, 58 percent of hospitals received Medicare payments less than cost, while 67 percent of hospitals received Medicaid payments less than cost*

I have attached some relevant data on these trends provided by the AHA below in Table #x.

The AHA's policy position on the uninsured echo's the Institute of Medicine's report which focuses on the "cost of health care, particularly the cost and access to health care insurance, as well as the decline in employer sponsored health care as the key contributing factors to the recent rise in the uninsured. Solving the problems of health care coverage will be a critical step in solving the burden of hospital uncompensated care."

In conclusion, it would seem clear that employer-sponsored healthcare insurance has been and will continue to be crucial to the financial health of hospitals such as Cooper and New Jersey's healthcare economy. However, employer-sponsored healthcare insurance is endangered. Businesses have a right to be seriously concerned about the cost of their coverage and the increasing cost of health care. The trends are not sustainable. The cornerstone of health care reform will be to expand insurance coverage to all Americans, and employer-sponsored plans will necessarily play a key role. It is likely that business will need substantial incentives to increase their participation, particularly small businesses that are unable to afford coverage for their employees. Secondly, it will be important for there to be stability in health insurance premiums so that businesses and individuals are able to adequately plan for meeting their obligations. This, in turn, will require a decline in the rate

of healthcare cost inflation. Health care providers stand ready to do their part to better manage care and reduce unnecessary hospitalizations, and improve the quality and cost-efficiency of health care services.

I would be pleased to take any questions that members of the committee may have.

References and Sources of Data:

(1) O'Conco Healthcare Consultants, *Hospital Utilization by Payer Mix, 2002-2008*. NJ MIDS Data.
(2) New Jersey Hospital Association, *Trends in Charity Care Funding in NJ*, 2009.
(3) New Jersey Business and Industry, *Changes in Employer-Sponsored Health Insurance* Coverage.2008.http://www.njbia.org/news_newsr_080429.asp;http://www.njbia.org/hbs08.ppt.
(4) American Hospital Association, *Underpayment by Medicare And Medicaid: Fact Sheet*, November 2008
(5) American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet*, November 2008

APPENDIX- SUPPORTING DATA

Hospital Utilization- Cases By Health Insurance Payer - All NJ Hospitals by Data Year- Table #1

	Total Cases						
	2002	2003	2004	2005	2006	2007	2008**
Govt Payer (minus Medicaid)	460,773	496,937	518,724	521,679	525,041	527,230	514,077
Total - Medicaid & Uninsured	162,860	188,170	205,866	207,355	207,225	211,623	199,313
Total- Commercial & POS	523,863	505,368	490,179	485,862	488,121	487,168	452,791
Total	1,101,090	1,129,873	1,139,664	1,136,066	1,141,030	1,142,576	1,079,908

**2008 data incomplete

	Percentage of Cases By Payer Type						
	2002	2003	2004	2005	2006	2007	2008**
Govt Payer (minus Medicaid)	41.8%	44.0%	45.5%	45.9%	46.0%	46.1%	47.6%
Total - Medicaid & Uninsured	14.8%	16.7%	18.1%	18.3%	18.2%	18.5%	18.5%
Total- Commercial & POS	47.6%	44.7%	43.0%	42.8%	42.8%	42.6%	41.9%

	Percentage of Total Charges By Payer Type						
	2002	2003	2004	2005	2006	2007	2008**
Non Medicaid Govt Payer	56.1%	58.0%	58.4%	58.0%	57.5%	56.7%	57.9%
Total - Medicaid & Uninsured	12.7%	14.2%	15.1%	15.0%	15.3%	15.8%	15.7%
Total- Commercial & POS	34.8%	32.4%	31.7%	32.2%	32.7%	33.4%	32.7%

NJ State Charity Care Shortfall Trend- Table #2

State Fiscal Year	Charity Care Documentation (Services @ Medicaid Rates) *($ in millions)*	Charity Care Funding (Payments to Hospitals) *($ in millions)*	Charity Care Shortfall (Payments vs. Services) *($ in millions)*
1994	$327.3	$383	**$56**
1995	$327.3	$400	**$73**
1996	$402.7	$310	**($93)**
1997	$407.2	$300	**($107)**
1998	$463.2	$320	**($143)**
1999	$483.0	$320	**($163)**
2000	$518.1	$320	**($198)**
2001	$601.1	$356	**($245)**
2002	$624.4	$381	**($243)**
2003	$577.7	$381	**($197)**
2004	$778.1	$381	**($397)**
2005	$812.0	$583	**($229)**
2006	$910.0	$583	**($327)**
2007	$941.8	$583	**($359)**
2008	$945.7	$715	**($231)**
2009	$945.3	$605	**($340)**

TABLE #3

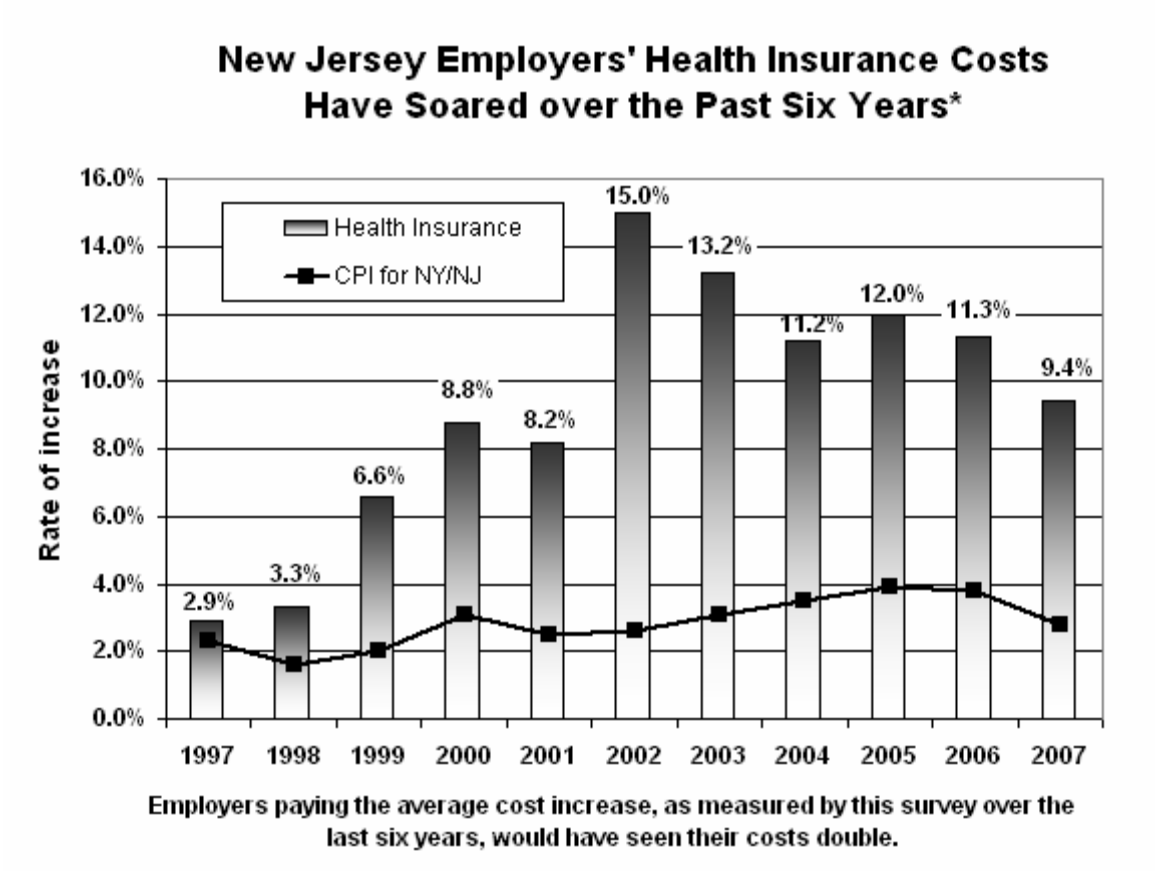

TABLE #4

National Government Underpayment for Hospital Services for Medicare and Medicaid 2000-2007 (in Billions)

Year	Hospitals	Medicare	Medicaid	Total
2000	4915	$1.3	$2.5	$3.8
2001	4908	$2.3	$2.0	$4.3
2002	4927	$3.3	$2.3	$5.5
2003	4895	$8.1	$4.9	$13.0
2004	4919	$15.0	$7.1	$22.1
2005	4936	$15.5	$9.8	$25.3
2006	4927	$18.6	$11.3	$29.9
2007	4897	$21.5	$10.4	$31.9

Source: Health Forum, AHA Annual Survey Data, 2000-2007
Note: Medicare and Medicaid payments include all applicable payment adjustments-Disproportionate Share, Indirect Medical Education, etc.; payments include both fee-for service and managed care payments.

TABLE #5

National Uncompensated Care Based on Cost*: 1980-2007 (in Billions), Registered Community Hospitals & Uncompensated % of Total

Year	Hospitals	Care Cost	Expenses
1980	5828	$3.9	5.1%
1981	5812	$4.7	5.2%
1982	5796	$5.3	5.1%
1983	5782	$6.1	5.3%
1984	5757	$7.4	6.0%
1985	5729	$7.6	5.8%
1986	5676	$8.9	6.4%
1987	5597	$9.5	6.2%
1988	5499	$10.4	6.2%
1989	5448	$11.1	6.0%
1990	5370	$12.1	6.0%
1991	5329	$13.4	6.0%
1992	5287	$14.7	5.9%
1993	5252	$16.0	6.0%
1994	5206	$16.8	6.1%
1995	5166	$17.5	6.1%
1996	5134	$18.0	6.1%
1997	5057	$18.5	6.0%
1998	5015	$19.0	6.0%
1999	4956	$20.7	6.2%
2000	4915	$21.6	6.0%
2001	4908	$21.5	5.6%
2002	4927	$22.3	5.4%
2003	4895	$24.9	5.5%
2004	4919	$26.9	5.6%
2005	4936	$28.8	5.6%
2006	4927	$31.2	5.7%
2007	4897	$34.0	5.8%

Source: Health Forum, AHA Annual Survey Data, 1980-2007

*The above uncompensated care figures represent the estimated ***cost*** of bad debt and charity care to the hospital. This figure is calculated for each hospital by multiplying uncompensated care charge data by the ratio of total expenses to gross patient and other operating revenues. The total uncompensated care cost is arrived at by adding together all individual hospital values. The uncompensated care figure does not include Medicaid or Medicare underpayment costs, or other contractual allowances. Moreover, the figure does not take into account the small number of hospitals that derive the majority of their income from tax appropriations, grants and contributions.