HPAE
Putting care first

WEDNESDAY, DECEMBER 13, 2017

PRIORITIES FOR A NEW ADMINISTRATION

HPAE represents 13,000 healthcare workers in NJ and PA, including nurses, therapists, pharmacists, ancillary staff, medical researchers, social workers and technicians at hospitals, home care, and other healthcare facilities including: Bergen Regional Medical Center, Englewood Hospital and Medical Center, VNA groups in Englewood and Essex County, Meadowlands Hospital, Christ Hospital and Bayonne Medical Center (CarePoint), Wanaque and Llanfair House, Cornerstone Behavioral Health, Rutgers University Professionals and RNs, Rowan University, University Hospital in Newark, Palisades Medical Center, Harborage House, Jersey Shore University Medical Center and Southern Ocean Medical Center (Hackensack Meridian Health), Virtua Memorial Hospital, Inspira Health Network, Cooper University Medical Center, Memorial Hospital of Salem County, American Addiction Centers at Sunrise House, American Red Cross/ PA Region and Temple Episcopal Hospital in Pennsylvania.

HPAE is affiliated with the American Federation of Teachers, AFL-CIO.

Transition

As Governor-Elect Phil Murphy and Lieutenant Governor-Elect have started the transition into a new Administration, HPAE is putting forward the following set of recommendations for policy initiatives and departmental changes for consideration. Through the last eight years of the Christie administration HPAE has witnessed the erosion of our government which has created a lack of transparency and accountability within NJ Departments. Those changes have an impact on the day to day work of HPAE members in the healthcare and behavioral health sector.

Safe Patient Care

Safe staffing

Acute Care Hospitals

At a time of shortened hospital stays, increased acuity levels and more technological interventions, patients need more nursing care, not less. Patients deserve the right number of qualified nurses at their bedsides, and that includes having the continuity of care that comes with proper scheduling of regular staff. Healthcare workers all feel the difficulty of treating patients when the unit is understaffed – and will feel the improvement when there are more RNs on the floor as well. According to numerous studies, nurses are overburdened with current low staffing, and patients are at greater risk for complications and even death. Lower staffing levels create an environment that does not allow nurses to perform all the functions of their job adequately. HPAE supports passage of legislation (S.1280) requiring safe nurse staffing levels in all NJ hospitals.

Addiction Treatment

Staffing regulations for addiction treatment facilities – inpatient, outpatient, acute care settings – fail to provide adequate guidance to operators or require adequate staffing in any setting for any staff position. For example, an inpatient short-term treatment center under the current regulations only requires one staff member to supervise every 24 adults during waking hours – this means only 4 staff members are required to be on staff during waking hours to supervise 96 clients, leaving plenty of room for staffing abuses. For halfway houses, the staffing requirement is even more reckless: one overnight staff member for up to 24 beds.

There is a dearth of studies regarding addiction treatment staffing, but the problems that arise from a lack of staff in the acute care setting are easily transferrable to addiction treatment care facilities. A Substance Abuse and Mental Health Services Administration (SAMHSA) 2003 facility survey found that low patient-to-staff ratios were associated with better, more accessible aftercare treatment and relapse prevention services, including more service availability while in treatment. More staffing is also responsible for keeping patients engaged for longer periods in their treatment, lowering client attrition rates.

Workplace Health and Safety

Protecting Patients and Workers

The healthcare and social assistance sector accounted for 52% of all reported workplace violence events causing injuries resulting in days away from work in 2014 according to the Bureau of Labor Statistics (BLS). Additionally, BLS data indicates the problem is worsening significantly: rates of workplace violence increased by 64% between 2005 and 2014 in private sector facilities, with rates for private sector hospitals climbing by 110%.

The federal agency responsible for workplace safety – the Occupational Safety and Health Administration (OSHA) – has yet to set a standard for workplace violence. Though NJ passed laws in 2010 that required hospitals to adopt policies to minimize workplace injuries due to unsafe lifting and workplace violence, little has been done to assess or enforce compliance. As a result, unionized workers are the main voice for enforcement, while struggling to gain hospital compliance.

HPAE recommends:

- OSHA should establish a standard for minimizing workplace violence that would allow for comprehensive enforcement.
- NJDOH should survey and inspect hospitals for compliance with workplace violence regulations, including that hospitals implement:
    - Written workplace violence prevention programs that also address bullying and harassment specific to the risk factors and characteristics of the healthcare setting; and
    - Healthcare facility analysis to identify hazards and conditions, including the tracking of violent incidents and threats; and
    - Implementation and evaluation of engineering and administrative controls specific to the existing hazards; and
    - Training appropriate to all workers' specific occupational needs; and
    - Evaluation and recordkeeping to improve the effectiveness of the program on an on-going basis. Security cameras, safety glass, automatic locked entrances, and panic buttons should all be required in hospitals and addiction treatment centers.

Living Wages for all Healthcare Workers

Unionized healthcare workers are setting standards for fair wages, yet not all healthcare workers are paid a living wage. In 2015, Home Health Aides and Nursing Assistants made the list of 100 lowest paid jobs in NJ. Studies confirm that NJ healthcare employees work in the industry that will benefit the most from a $15 Minimum Wage, which includes hundreds of HPAE members who make less than $15/hour.

Low wages and the high cost of living in New Jersey make it unaffordable for many families to live comfortably across the state. NJ ranked as one of the seven most expensive states to live in. In NJ, the living wage for a single parent with one child is $25.38.

HPAE recommends:

- NJ legislature passes legislation to increase the minimum wage in New Jersey to $15 per hour that would include every worker in healthcare institution; and
- State regulators work with the federal government and healthcare institutions to secure additional funding to support institutions to absorb the costs of raising wages to $15 per hour,

either through the form of higher Medicaid payments or other Centers for Medicaid/Medicare Services (CMS) program initiatives.

Access to Care

Access to Affordable Health Care Services

HPAE members are on the frontlines of caregiving, advocating for patients inside hospitals for access to affordable, safe, and effective care; for services based on need, not profit; and for the safety and well-being of both workers and patients. HPAE members care deeply about their patients and the future of their hospitals.

The policies of the Trump administration threaten our healthcare and essential social services, including the Affordable Care Act , Medicaid and Medicare. Access to health coverage has improved through these key programs across the country, including a 39 percent increase in the number of insured in New Jersey since 2013.[1] These improvements must not be undone by the U.S. Congress, yet if that is the case New Jersey elected officials must take steps to protect those impacted by the unraveling of health coverage, while continuing to improve upon the 39 percent reduction in the number of uninsured to ensure all New Jerseyans have access to adequate health care coverage.

HPAE has witnessed the impact of rising medical costs and debt on healthcare workers and our patients, and have joined with community organizations to examine the impact of medical debt on residents and workers. The changing landscape of health insurance coverage includes plans with high deductibles, high co-pays, and smaller provider networks that can lead to unexpected or higher costs.

A 2016 survey report from the Kaiser Family Foundation/New York Times found that 53% of those surveyed that were uninsured had trouble paying medical bills and 20% of those surveyed who had some form of insurance (employer plan, Medicaid, or private purchase) had difficulty paying medical bills.[2] More alarmingly, 62% of all those that had medical bill problems said the debt occurred with a family member who had health insurance.[3] Of those with

[1] Health Insurance Coverage in the United States: 2016, United States Census Bureau; https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf

[2] Liz Hamel, et al. *"The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey."* Kaiser Family Foundation/New York Times, January 2016, p. 1, http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/ .

[3] *Supra.*

difficulty paying medical bills, two-thirds identified a one-time medical crisis for the debt rather than chronic illness.[4]

From the time consumers enter the healthcare system, they have only inadequate or poorly enforced laws to protect them from mandatory upfront payments, high cost health plans and narrow provider networks, uneven and opaque hospital billing practices and abusive debt collection practices. Debt collectors buy millions of dollars of debt for pennies then collect the original amount owed, making huge profits at great cost to people just getting by. When medical debt goes to collection agencies and/or court, it increases the costs of other loans, like mortgages or car loans. And it places hard-working New Jerseyans in a spiral of debt that is hard to escape.

We can begin to address the debt crisis with public policy measures that promote economic justice and protect consumers through the following recommendations:

Policy Recommendations and Implications

- Expand existing health coverage programs, State Health Benefits Program and Medicaid/FamilyCare, by applying for waivers if necessary or through legislation to allow employers and individuals to opt-in to these programs.
- Enact New Jersey Bill A1952/S1285, the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act, which will:
    - Require providers and insurance companies to give advanced notice if they are no longer in an insurance network.
    - Protect consumers from balance billing when they inadvertently use out-of-network providers.
    - Require the posting of hospitals' standard charges for the services they provide, and a list of doctors and their contact information that are employed by or have a contract with the hospital and are in insurance networks.

- Establish an All Payer Claims Database (APCD) would increase the accountability and transparency of providers and payers by requiring full disclosure of pricing and payment information at all levels of the health care system. It would provide objective and reliable information needed to better inform decision making for health care consumers, providers, carriers, and policy makers to improve health care access, cost, quality, and outcomes. Unlike in 17 other states, New Jersey does not have a place where a consumer or policy maker may find comprehensive information on the cost of health services in New Jersey, compromising our ability to make informed decisions about the value and cost of health care services.

[4] *Supra,* p. 3.

- Enact legislation that would provide at least the five basic standards recommended by NCLC: [5]
    - Prevent debt collectors from seizing so much of the debtor's wages that the debtor is pushed below a living wage;
    - Allow a debtor to keep a used car of at least average value;
    - Preserve the family's home – at least a median-value home
    - Prevent seizure and sale of the debtor's necessary household goods; and Preserve at least $1000 in a bank account so that the debtor has minimal funds to pay such essential costs as rent, utilities, and commuting expenses.
- Codify, through state legislation, the National Consumer Assistance Plan (NCAP) 180-day waiting period before medical debt may be posted in a credit report.
- Require hospitals to meet 'best practices' for consumer education and protection, including:
    - Increased consumer education on eligibility for financial assistance and payment plans;
    - Mediation prior to any reporting of debt to credit bureaus;
    - Consumer protections and transparency standards for use of outside debt collection agencies, including minimal levels for selling of debt and a ban on use of foreclosure for medical debt.
- Regulate debt collection codes of conduct and business practices.
- Set limits on selling debt older than seven years; require debt collectors to provide consumers a notice of the debt; require itemized records, charges, and fees; and require admissible evidence of the debt.

Create and pass legislation on the state level that will prevent a consumer reporting agency from posting data on fully paid or settled medical debt after 45 days, taking it off a credit report once it is paid or settled.

Medical Debt

Since the enactment of the ACA, and with the growing awareness of the burden of high out-of-pocket costs for those with insurance, a significant amount of advocacy work is happening at the state and federal level to address high out-of-pocket costs and the burden of medical debt.

Limits on Debt Collectors

In its report, No Fresh Start: How States Let Debt Collectors Push Families into Poverty, the National Consumer Law Center (NCLC) explains that every state has a set of exemption laws, intended to prevent creditors from pushing debtors into destitution. Such exemption laws protect at least subsistence wages and essential property from seizure by creditors. However, all state exemption laws fail to meet basic standards of consumer protection, including:

[5] National Consumer Law Center. *No Fresh Start: How States Let Debt Collectors Push Families Into Poverty."* 2013, p. 1, http://www.nclc.org/images/pdf/pr-reports/report-no-fresh-start-bw.pdf .

- Preventing debt collectors from seizing so much of the debtor's wages that the debtor is pushed below a living wage;
- Allowing the debtor to keep a used car of at least average value;
- Preserving the family's home—at least a median-value home;
- Preventing seizure and sale of the debtor's necessary household goods; and
- Preserving at least $1200 in a bank account so that the debtor has minimal funds to pay such essential costs as rent, utilities, and commuting expenses.

HPAE urges NJ lawmakers to introduce legislation that will:

- Preserve the debtor's ability to work, by protecting a working car, work tools and equipment, and money for commuting and other daily work expenses.
- Protect the family's housing, necessary household goods, and means of transportation.
- Protect a living wage for working debtors—a wage that can meet basic needs and maintain a safe, decent standard of living within the community.
- Protect a reasonable amount of money on deposit so that debtors can pay commuting costs and upcoming bills such as rent and utility bills.
- Protect retirees from destitution by restricting creditors' ability to seize retirement funds.
- Close loopholes that enable some lenders to evade exemption laws.

States that allow lenders to take household goods as collateral enable these lenders to avoid state household good exemptions.

- Be self-enforcing to the extent possible, so that the debtor does not have to file complicated papers or attend court hearings.

Some best practices are regulatory in nature. In its report outlining the abuses of the debt buying industry, Human Rights Watch (HRW) points to New York as a model for reform. New York's attorney general has publicly condemned debt buyers who "abuse" the power of the courts at the expense of "hardworking families." Maryland has also been a "particularly active regulator" in this area. The chief judge of the state's district court has dismissed more than 20,000 debt buyer lawsuits since 2010.

At a minimum, before issuing a default judgment in favor of a debt buyer, courts should require plaintiffs to submit supporting documentation that tends to reliably indicate that:

- The plaintiff owns the debt at issue;
- The defendant owes the debt at issue;
- The lawsuit is not time-barred;
- The amount of the alleged debt along with any post-sale interest has been correctly calculated;
- The contracts governing the initial sale as well as any subsequent sales of the debt contain all the warranties of accuracy and legality described under DBA International's certification standard for debt buyers; and that

- The defendant in the case was properly served with notice of the suit against them.

In 2014 the New York state court system adopted rules that impose enhanced filing requirements on debt buyer plaintiffs. New York's rules require evidence of all the points highlighted above. California and North Carolina have adopted similar rules through court action or legislation.

Transparency and Oversight

Inadequate Laws and the Failure of New Jersey's Regulatory System

Health care professionals' working conditions and the quality of patient care are significantly determined by laws and regulations. Unfortunately, in New Jersey, Governor Christie has blocked every attempt to pass laws which set strong standards for safe staffing, workers' safety, and financial transparency in the healthcare industry. At the same time, the government agency charged with enforcing existing laws – the New Jersey Department of Health (NJDOH) – has been lax in enforcing compliance with existing laws and has failed to adapt to the changes in the hospital industry.

- The NJDOH has eliminated regular inspections, and relied instead on complaint inspections and 'regulatory' compliance statements from hospitals to monitor compliance with safeguards meant to protect patients and workers.

- The Certificate of Need (CN) process has been streamlined, reducing the need to gain state approval for many service closures.

- The DOH provides little oversight of mergers between large not-for-profit hospital systems.

With the move of the Division of Mental Health and Addiction Services (DMHAS) from the Department of Human Services to the Department of Health, it should be noted that it is even more critical that DOH is held accountable for inspections, licensing, and oversight. The role DMHAS plays in the health and well-being of individuals, especially in the current climate of opioid use and addiction, must be held to impeccable standards of care, coordination, accessibility, and safety.

Hospital Mergers and Conversions

More than 2/3 of hospitals in New Jersey are part of a healthcare system and just 10 systems operate 50% of all hospital beds. Mergers of hospital systems will leave New Jersey with 4 or 5 mega health systems, diminishing the strength and voice of unionized healthcare workers and

local communities. Eight of the 71 acute care hospitals in New Jersey are now run by for-profits; more are reportedly in discussions to purchase or partner with non-profit hospitals.

Not-for-profit hospital systems are now partnered with or own for-profit subsidiaries, physician practices and ambulatory centers, making financial transparency and taxpayer-accountability more difficult.

Currently, the DOH provides minimal oversight when two non-profits merge. However, national studies seem to indicate that contrary to the efficacy of mergers, costs for consumers continue to climb after mergers. In addition, transparency and accountability diminish.

HPAE has established a 'Merger Monitor' website to track pending mergers and conversions, and supports additional legislation to require a Certificate of Need process for all non-profit mergers.

In addition, enforcement of standards set during a for-profit conversion has also been lax, and HPAE supports additional standards and enforcement mechanisms be in place for 5 years following hospital conversions.

Lastly, in some for-profit conversions or pending sales, it should be DOH policy to review hospital projections that best meet the needs of community, whether for an acute-care hospital or other services.

Hold Tax-Exempt Hospitals Accountable to Their Charitable Missions

The total cost of U.S. nonprofit hospitals' tax exemption is estimated at $25 billion. This includes federal and state corporate taxes as well as state and local sales and property taxes. Of this amount, foregone property taxes account for 16 percent ($4 billion). In New Jersey, the average nonprofit hospital receives a $1.6-million benefit annually as a result of exemption from property taxes. While much of tax benefit supports charitable activities, profit-making entities and activities benefit from loopholes in existing law.

Nonprofit hospitals' property, operations, and finances are often entangled with profit-making entities and activities. It's not uncommon for for-profit entities to operate on tax-exempt property; for nonprofit hospitals to own and provide financing to for-profit subsidiaries; and for nonprofit hospitals to provide executives with excessive compensation. In these cases, the profit-making entities and activities benefit from the tax exemptions intended for *non*profits.

In return for exemption, the government requires nonprofit hospitals to provide community benefits. Originally, community benefits referred to charity care provided to patients without the ability to pay, but over time it has encompassed activities like research, training, and costs to offset losses related to participation in public insurance programs. Only eight percent of spending on community benefits goes toward community health improvement.

Recommendations:

- **Update standards to qualify for tax exemption.** Profit-making activities and entities functioning on tax-exempt property should disqualify that portion of property from exemption. Tax-exempt hospitals should be prohibited from commingling finances with for-profit entities, and from paying executives excessive compensation. Reasonable exceptions should be made for certain private physicians. An updated set of standards should take into consideration that healthcare services are increasingly delivered outside the hospital in the outpatient ambulatory setting.
- **Enhance transparency.** Holding tax-exempt hospitals to a higher standard requires more transparency. Tax-exempt hospitals should be required to submit regular reports describing how the tax-exempt property is used, whether and to what extent their finances are entangled with for-profit related entities, and the methodology by which they set compensation for officers and directors.
- **Ensure "community benefits" benefit the community.** Municipalities should have a right to charge community contribution fees if any portion of a hospitals' property is exempt from property taxes. The revenue raised from these fees should be used to fund community health improvement partnerships (CHIPs) with broad representation from the hospital, community groups, public health officials, and unions representing healthcare workers. The partnerships should be tasked with developing and implementing hospitals' community health needs assessments (CHNAs) required under the Affordable Care Act.

Over the last several years, New Jersey's healthcare systems have rapidly consolidated. The financial stability of hospitals has improved in NJ giving communities ease that healthcare services will be maintained. Yet this stability in the market has brought challenges to understand the complexities of hospital operations and finances. It is essential for communities, patients, and workers to have easy access to the audited and un-audited financial statements, so they can better understand how their hospital is investing in care and services. Hospitals in NJ serve the public, rely on financial support from the government, and these rules will help improve accountability of hospitals, something some hospitals have attempted to sidestep.

HPAE does have a concern over the proposed new provision [N.J.A.C. 8:96-2.2(d)] that will allow hospitals to apply for a waiver to permit not posting the unaudited quarterly statements. While we understand the reasoning of unfair advantage, and the fluidity in unaudited financials, we do not agree with the conclusions made by the hospital stakeholders. Therefore, we would like the Department to reconsider this provision, or at the very least provide a stringent list of acceptable reasons for the waiver request in the regulations so that the public may be better informed about this potential process.

The provision in new Subchapter 4 requiring the accurate disclosure of hospitals' participation in insurance networks prominently and conspicuously displayed on the hospital website, as well

as providing the list to anyone who asks for it, is a good step in helping patients become educated consumers. It may help to prevent unnecessary out of network charges.

It is unfortunate the Department did not include the recommendation from the 2014 "Hospital Transparency Report" for requiring reportage of contracts with related parties, self-dealing, or conflicts of interest. As the initial report states, "Self-dealing and conflicts of interest can lead to losses that endanger the health care system, compromise access to hospital care, and bring into question the stewardship of public funds." It continues with stating that related party transactions could be entered into for fraudulent purposes. Given that the Department is aware of this conflict responsible action would dictate the necessity for including this issue in the proposed regulations.

Additionally, HPAE would have liked to see a more definitive approach to the reportage of sale-leaseback agreements that would strengthen what was recommended in the 2014 Department report (p. 19-20). Reporting such a transaction only to the Department and at its annual public meeting hardly holds the hospital accountable to the public. The proposed regulations would serve the public better if it codified steps requiring the healthcare entity to make public the sale-leaseback process.

It is important that the new proposed regulations come with enforcement remedies such as provided but HPAE also would like to recommend that the fine schedule have more stringent penalties. Fining a hospital or system $50 or $100 dollars a day for not posting its audited financial statements only becomes a cost of doing business rather than a deterrent. If the fines were calculated in relation to the annual profit or revenue, that may be more effective than the fine schedule contained in the proposed regulations.

Overall, HPAE believes the proposed rules are a step towards greater transparency, accountability, and enforcement. The proposed regulations will help level the playing field for the citizens of New Jersey as they try to make educated decisions in the critical moments of their healthcare.