
Public Hearing

before

SENATE HEALTH COMMITTEE

SENATE BILL Nos. 1033 and 1098

*(Testimony regarding the joint negotiations
by physicians with health benefits plans)*

LOCATION: Atlantic City Convention Center
Atlantic City, New Jersey

DATE: May 5, 2000
3:30 p.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Jack Sinagra, Chairman
Senator John J. Matheussen, Vice-Chairman
Senator Robert W. Singer
Senator John H. Adler
Senator Richard J. Codey
Senator Joseph F. Vitale



ALSO PRESENT:

Eleanor H. Seel
*Office of Legislative Services
Committee Aide*

Caroline Joyce
*Senate Majority
Committee Aide*

Freida Phillips
*Senate Democratic
Committee Aide*

Hearing Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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SENATOR JACK SINAGRA (Chairman): Good afternoon. The Senate Health Committee is now in session.

Could I have a roll call, please.

MS. SEEL (Committee Aide): Senator Sinagra.

SENATOR SINAGRA: Here.

MS. SEEL: Senator Matheussen.

SENATOR MATHEUSSEN: Here.

MS. SEEL: Senator Bassano. (no response)

Senator Singer.

SENATOR SINGER: Here.

MS. SEEL: Senator Adler. (no response)

Senator Codey.

SENATOR CODEY: Here.

MS. SEEL: Senator Vitale. (no response)

A quorum is present.

SENATOR SINAGRA: Good afternoon. My name is Jack Sinagra. I'm the Senator for Middlesex County, and I'm also the Chairman of the Health Committee.

A few months ago, the Senate President, DiFrancesco, charged this Committee with reviewing four critical areas of health care for the State of New Jersey. One being health insurance; two, the financial conditions of our hospitals; three, provider issues; and four, quality of care.

We've had two hearings. This is, today, provider issues. We're here to listen to you, although one can easily argue that it's very difficult to talk about provider issues without talking about quality of care.

We have an agenda set. There are many speakers. I would ask each speaker to limit themselves to five minutes if they can. We have a time restraint. We must be out of here by a certain time.

With that, Irving Ratner.

IRVING RATNER, M.D.: Good afternoon, Mr. Chairman, and good afternoon to members of the Committee.

My name is Irving Ratner. I am an orthopedic surgeon. I practice in Burlington County, New Jersey. I am currently the president of the Medical Society of New Jersey, and tomorrow afternoon, when our meeting ends, I will turn the reins of the Medical Society over to this young gentleman sitting next to me.

We are very pleased to act as a welcoming committee for this monumental hearing, which is the first ever held during a meeting of physicians, especially tied to the Physicians Conference 2000. This particular conference has been in the planning stages for several years. Physicians have seen the need to come together. The Medical Society of New Jersey, in conjunction with the Academy of Medicine, and over 35 speciality societies, have come together to discuss public policy, educational advances, and of course, the many issues facing our changing health-care environment.

We are pleased to welcome a hearing of the Senate Health Committee on an issue that is critically important to the physician community in New Jersey. We have been working with the American Medical Association; the Texas Medical Association, who recently worked to help enact a similar bill into law; and with many other organizations to help to craft a bill which will help physicians and their patients and our patients.

Our nation is based on a representative government, but I think that your Committee's willingness to hold a hearing, here in Atlantic City, further exemplifies good government and constitutional representation. It is wonderful to see our State government taking such an active role in reaching out to the constituents, whom you serve, to discuss such an important issue.

In particular, we want to thank Senator Martha Bark and Senate President Don DiFrancesco for putting the names on the bill being discussed today, S-1033. Unfortunately, neither Senator DiFrancesco nor Senator Bark were able to join us today. We recognize that. But we did want to express our sincere thanks and a debt of gratitude to both of them.

I would like now to turn the podium over to my successor, Dr. Walter Kahn, for further remarks, with your approval.

WALTER J. KAHN, M.D.: Thank you, Irv.

My name is Walter Kahn.

Good afternoon, Mr. Chairman and members of the Committee.

I'm pleased to appear before this august body as my first official role as newly elected President of the Medical Society of New Jersey. I have been involved with the legislative and regulatory issues facing the physician community and the ophthalmologists in the state for many years. I understand the importance of working closely with the State Legislature and am pleased to participate in this important discussion.

I'm a practicing ophthalmologist from Red Bank, New Jersey, and have been in the state over 59 years, 35 of which are as an ophthalmologist. Before that, I was a farmer on my family farm in Toms River, New Jersey.

We have developed a simple seven-point paper which clearly highlights the benefits of enacting this bill, “The Seven Steps to Better Medical Care.” Step one: Individual physicians want help negotiating with large, powerful managed care plans that have presented each of us with a take it or leave it contract containing provisions the physicians fear could harm their patients.

Step two: The doctors decide who should be included in their group and they either hire professional help -- a health-care attorney, former managed care executive, a business manager, for example -- to decide to represent themselves in the negotiation.

Step three: The physicians apply to the Attorney General for permission to meet, communicate, and negotiate with the health plan. The Attorney General may deny the request if the physicians constitute too large a share of the total physician market or dominate any one specialty area.

Step four: If permission is granted by the Attorney General, the physicians approach the health plan and ask to negotiate contract provisions. These can only be discussed -- can be discussed only when the Attorney General determines the health plan controls a substantial portion of the local health-care market, leading to possible access problems for the patients. In no case can Medicaid fees be discussed.

Step five: The health plan may or may not choose to come to the table. Negotiations are voluntary and nonbinding and may be ended at any time by either party. Even during negotiations, the plan is free to approach individual members of the physician group.

Step six: If an agreement is reached, the Attorney General must review it to make sure the agreement is reasonable, will not hurt competition, and will serve the best interest of consumers. The agreement cannot go into effect without the approval of the Attorney General.

Step seven: Boycotts or any other cessation of patient care are strictly prohibited in this legislation. Also prohibited are negotiations to remove a requirement that physicians participate in all products offered by the health plan.

The bill prohibits union tactics and does not even include the words collective bargaining. It simply allows physicians to sit down with big insurance companies on a voluntary basis to negotiate the best care for their patients.

We applaud the members of the health-care committee for your leadership in advancing the discussion of this important issue.

And on a personal note, I very much look forward to working with all of you over the next 12 months of my term. I'm available to discuss issues with you or your staff. And working together, we can achieve good things for New Jersey consumers on health care.

As Governor Whitman said this morning, we have enough trouble fighting disease without fighting HMO problems.

Thank you.

SENATOR SINAGRA: Any questions? (no response)

Thank you.

Dr. John Sensakovic.

JOHN W. SENS AKOVIC, M.D., Ph.D.: Good afternoon, Senator Sinagra, distinguished members of the subcommittee (*sic*).

I'm John Sensakovic, President of the Academy of Medicine of New Jersey and Director of Medical Education at St. Michael's Medical Center in Newark, New Jersey. I'm also a practicing infectious disease physician who has been practicing in New Jersey for the past 18 years.

The Academy of Medicine of New Jersey is the oldest accredited continuing medical education organization in the State of New Jersey, founded back in 1911. The Academy is not a political organization, but we wanted to add our support to the concepts found in Senate Bill 1033.

Many of our members have been feeling the squeeze and the frustrations of dealing with managed care companies, especially those with dominant market shares in their own town. And they see this type of legislation as sound public policy for them and for their patients.

In many markets, health plans control such a large percentage of patients that physicians must contract with the HMO to have a viable practice. There are simply not enough patients outside of the managed care arena to provide most physicians in the marketplace with patient volumes necessary to maintain a financially viable practice.

When only a few health plans control most of the patients in a market, and all use similar contracts, failure to comply with contract terms means putting all of the contracts at risk, and thus, the practice and patients seen at that practice.

The result of these efforts has been devastating to physicians and patients alike, particularly in communities where just a few physicians'

practices take care of most of the patients in that particular community. Not only has medical decision making power become concentrated in fewer hands, and indeed the wrong hands, but physicians whose contracts are terminated for refusing to agree to a plan's terms have been forced to close their practices, and their patients have been forced to find new physicians.

Senate Bill 1033 simply allows groups of physicians to sit down with insurance companies and discuss issues associated with patient care and their health plan contracts. It's a voluntary process. The insurance companies can choose not to participate. There's nothing for the health-care plans to fear.

Again, we thank the members of the Senate Health Committee for its leadership on this issue and, on behalf of the Academy of Medicine in New Jersey, support its intent.

I thank you very much.

SENATOR SINAGRA: Excuse me, Doctor, one second. We have a question.

SENATOR CODEY: By the way, I'm glad to see--

Jack, for one thing, I was glad to see my fellow democrats show up. For a while, it was myself, Freida, and Jim McGreevey, and that was it in the whole room, I think.

Okay. Doctor, I wanted to bring out the basis of why we're here -- why we have these two bills here.

Correct me if I'm wrong, sir. It's because physicians feel that the insurance companies, regardless of which one it is or which ones, that you have no leverage anymore, in terms of decision making power, in terms of treating

your patients. You have no ability to leverage and negotiate a fair and equitable fee for your services. Essentially, that is why we're here?

DR. SENSAKOVIC: I think that's the essence of it, but I would even go further than that. I think it's come to a point, in some instances, of utter frustration in dealing with the bureaucracy, with the paperwork, with the impediments of getting things done. And the feeling by the physicians that they're out there alone, dealing with this-- I think it goes to the points that you made and beyond.

SENATOR CODEY: Has the decision making process, in terms of referral -- people at those particular companies who are telling you yes or no - Has that changed, recently, at all?

DR. SENSAKOVIC: In my experience, and I think in the experience of most physicians, not to a significant degree.

SENATOR CODEY: But to some degree, although that may be minute.

DR. SENSAKOVIC: Minute.

SENATOR CODEY: Okay. Thank you, Doctor.

DR. SENSAKOVIC: You're welcome.

SENATOR SINAGRA: Any other questions? (no response)

Thank you, Doctor.

Doctor Mary Campagnolo.

MARY CAMPAGNOLO, M.D.: Good afternoon, Senator Sinagra and members of the Committee.

My name is Mary Campagnolo. I'm a family physician practicing in Mount Holly, New Jersey, with a group practice of eight family physicians.

I'm Board certified in family practice, with a certificate of added qualifications in geriatrics. Yesterday, I was also elected President of the New Jersey Academy of Family Physicians.

In that role, I'm proud to come before you today, on behalf of our membership, the more than 1700 physicians, physicians in training, medical students, who have chosen to specialize in the practice of family medicine and serve as the main portal of health-care services to the citizens of New Jersey.

I also serve as Vice Chair of the Council on Legislation for the Medical Society of New Jersey and Chief, Department of Family Practice at Virtua Memorial Hospital of Burlington County.

I wish to accomplish three things today with my testimony: First, to illustrate the frustration of family physicians, their patients, and their employees in the policies of many managed care organizations; second, to voice the interests of the New Jersey Academy of Family Physicians in development of legislation to assist us in improving care of our patients; and third, to offer assistance to your Committee in crafting this legislation.

In my practice, and in my work as a volunteer leader within the New Jersey Academy of Family Physicians and the Medical Society of New Jersey, it has become clear to me that there is an absolute need for physicians within the state to find help in negotiating with the large, powerful managed care plans that control so much of the health care of the people of this state.

Well, we realize that the principles of managed care offer many patients access to health care who might not otherwise be able to obtain the services they need. We are also aware that far too frequently the managed care industry has put physicians in contractual handcuffs, which we fear reduces the

amount of health-care dollars spent on actual patient care and prevention and increases the administrative burden on physicians and their office staff.

For example, what previously was a simple process of referring a patient for a specialist consultation, a procedure, or a follow-up with an introductory note, pertinent clinical data, and perhaps assisting the patient in making an appointment, now also requires my office site of four physicians' practices to employ two full-time referral specialists. These clerical workers spend their day completing forms for managed care companies, computer data for the ones who happen to have automated referrals, and hundreds of phone calls weekly between insurers, specialists, offices, and patients inquiring if their referrals are ready -- for certain types of MRI studies, inpatient and outpatient surgeries, home health services, oxygen therapy, and durable medical goods. These employees also complete more forms, make phone calls for preauthorization, and then police requests which are still awaiting approval, or else they may never be approved.

One other frustration of the current system lies in the formulary systems of pharmacy benefits. Nurses and medical assistants working for our practice, in addition to direct patient care activities for routine and emergent problems, now spend a large portion of each day speaking with pharmacies and patients regarding prescriptions not covered by a health plan's formulary.

We contract with approximately six HMOs and an equal number of PPO plans, all with different formularies, often containing various subplans that dictate different formulary options and different drug copays. These formularies often contradict each other, mostly restricting drugs for ulcer treatment and reflux, arthritis and pain control, lowering of cholesterol,

hypertension, and treatment of infections. Unfortunately, these are some of the most common conditions also seen in our family practice.

An increasing number of patients are unable to afford the copays or the medications which help them the most, so we are treating them solely with office samples provided by the pharmaceutical companies until they run out or the medication is then finally added to the formulary, which may take months or years.

Of course, there are also forms to complete an appeals process, plus follow-up phone calls, if we want to plead with the health plan to grant an exception for a certain patient's medication.

I believe that groups of physicians negotiating with health plans would be able to improve these processes, based on sound medicine and science, for the benefit of all parties -- when we'd rather see these resources of time, energy, and money aimed towards enhancing electronic communication in linking patients, physicians, health plans and vendors, as well as collection of data and study of methods, which truly provide the optimum health outcomes.

Senate Bill 1033 offers the first attempt at a solution to this critical issue. While we feel that there is still a need for discussion of the details of this solution, we support the concept of allowing groups of physicians to voluntarily sit down with the large insurance plans and negotiate the best health care for their patients.

It is important to note that we are interested and indeed look forward to working with the Legislature, and other physician and consumer

groups, to ensure that, ultimately, we construct policy that protects patients and increases access to health care.

We believe that a policy which helps level the field in negotiations between the insurers and the physicians and allows us to truly advocate for the best care for our patients, will do just that.

As family physicians, we are generalists, trained to care for the whole person, and therefore we tend to view the world in the big picture. We realize that these types of discussions alarm people who worry about antitrust issues and union activity. For this reason, the sponsors have been careful to include provisions such as active oversight of the process by the Attorney General, the strict prohibition of boycotts of cessation of patient care, and completely nonbinding negotiations from which each party may withdraw at any time. We believe that these provisions address the major concerns that might be raised against this legislation.

Finally, we realize that this is just the beginning of the dialogue and that your task is formidable. We are grateful to the members of the Senate Health Committee and to the sponsors of S-1033 for opening the discussion.

On behalf of the New Jersey Academy of Family Physicians, I thank you for the opportunity to share our thoughts with you. Please feel free to call me, the other officers of our Academy, or the Executive Director of our Academy at any time.

I look forward to working with this Committee, and the entire Legislature, to bring quality, affordable health care to every citizen in New Jersey.

Thank you.

SENATOR SINAGRA: Thank you.

Any questions? (no response)

Jim McGreevey -- Mayor McGreevey.

MAYOR JAMES E. MCGREEVEY: Good afternoon, Senator. Thank you for the opportunity to be here.

My name is James McGreevey, the Mayor of the Township of Woodbridge. I also have the pleasure of serving as Vice Chairman of the New Jersey Conference of Mayors, and as a member of the President's National Cancer Advisory Board.

On the outset, I'd like to congratulate Dr. Ratner for his service, Dr. Kahn, and the grossermacher (phonetic spelling) Dr. Formica.

Especially today, when we focus on this legislation, which was generally modeled after Pennsylvania Senate Bill 1052, we recognize how hopeful we are that this legislation will pass. There's many features which will enable physicians to actively negotiate, on behalf of their patients, to obtain the quality of care.

As long as the present system allows the carriers to determine access to care, there will continue to be an irresistible force compelling carriers to withhold access to care for the sake of their profit margin. Once the playing field is leveled, physicians can act as the patient advocate in determining and defining not only the access to care, but the timeliness of care, which is crucial to the process.

In addition, while we recognize the need, ultimately, to pass the patients' bill of rights on the Federal level, for all of these reasons, to preserve

access to medically necessary care and provide for standing referrals, I believe there's also a greater problem. That greater problem, unfortunately, is the inability of the physician community and providers to effectively negotiate with the present HMO arrangements. Most particularly, when we evaluate the Aetna U.S. Healthcare, following its acquisition of Prudential HealthCare Plan, we see, from the data of the New Jersey Department of Banking and Insurance, that Aetna, in fact, continues to dominate the market -- the market share in a number of New Jersey counties.

Aetna's market share of HMO-POS market in Burlington, Camden, Mercer, and Hunterdon counties exceeds, according to Dr. Terrill, 60 percent in each of these counties. Terrill further notes that the market share in Essex County exceeds 50 percent, and the market share in my own County of Middlesex exceeds 42 percent.

Unfortunately, allowing such an entity to have such a dominant presence in the market says there exists the potential, and I believe the inevitability, for anticompetitive behavior.

Terrill notes, as are my convictions, that, unfortunately, there's a necessity for the State Legislature to provide for necessary oversight.

In addition, the present model has created a monopoly in certain areas. Unfortunately, it was this Governor's Office who approved the very same merger which was denied by Governor Bush in Texas.

But lastly, what I believe we should move forward to is to summon the innovations that were set forth by Governor Gray Davis in California. Fundamentally, Governor Davis understood and noted that all decisions, with respect to medical treatment, ought to be based upon the independent

judgement of the physician, the health-care provider, and not the insurance company or the physicians hired by the insurance company.

Governor Davis also noted that medical protocols -- fundamentally be based upon standard practices recognized by physicians licensed in that particular state and approved by professional licensing boards, and that medical treatment rendered by physicians ought not be restricted by certain HMO or standard care packages, but should be based upon the physician's independent judgement as to the best treatment for the patient.

And lastly, we also believe that it's long past due that this legislation that's before you today, by Senator DiFrancesco, ought to be the beginning and not the end for a full and larger discussion.

Governor Davis not only was able to establish minimum standards, but he adequately investigated for-profit managed care systems. He also ensured that managed care companies be responsive to providers and consumers, and lastly, provide a disaster relief prior to bankruptcy.

I'd like to thank you for the opportunity to address you here today. And I would urge this Committee to seriously examine the incremental reforms that were undertaken by Governor Gray Davis that fundamentally returned the power of decision making back to physicians and preserved the quality of access to care for the patients of the state of California, as must be done here in New Jersey.

Thank you.

SENATOR SINAGRA: Thank you, Mayor.

Timothy Clark.

TIMOTHY CLARK: Good afternoon. Thank you.

Thank you, Chairman Sinagra and Vice Chairman Matheussen, for convening this hearing. I think it's very important, certainly, to take a look at health care here in New Jersey. It's a very difficult situation.

I guess-- I'm going to be brief because I don't think I'm going to bring anything to the table that you won't hear from some of the medical communities.

My name is Tim Clark. I'm the Director of Governmental Affairs for the New Jersey Dental Association. I'd like to take a moment to thank Senator Matheussen and Senator Singer for their bill S-1098, which includes dentistry as part of some of the medical professions that can jointly negotiate. We have spoken with Senator Bark's office, and we're hopeful that we'll be included in her legislation, as well, if it is to continue.

I think-- You have my written testimony. I'm not going to sit here and read it line for line. I can only say this. I think that it's very important, as we look -- as fewer and fewer companies insure more and more lives here in New Jersey, that there has to be an ability for the medical community to negotiate with these companies.

There is going to be, soon, a situation where one company will write the 60, 70, 80 percent of the lives in a county. And I think it's going to be a situation where a dentist, a doctor, is going to have to accept what the company says. And I don't think that's good for New Jersey. I don't think it's good for its residents.

So I really appreciate the opportunity to come here today. I hope that you will consider adding dentistry to whatever piece of legislation eventually comes out of the Senate Health Committee.

We look forward to working with you.

I've met with Senator Matheussen, who was very helpful to us.

We hope that, you know, we can be included in this bill when it receives--

SENATOR SINAGRA: Thank you.

Dr. Pepe.

S A L P E P E, M.D.: Good afternoon. I want to thank you, Senator Sinagra and members of the Senate Health Committee, for your attention to this matter. I want to thank the Committee for participating in Physicians Conference 2000. I want to thank Senator Bark for S-1033 and Senators Matheussen and Singer for 1098.

My name is Sal Pepe. I'm an emergency physician. I'm the Director of the Emergency Department of Shore Memorial Hospital in Somers Point, approximately eight miles south of here. I'm the President of the New Jersey Chapter of the American College of Emergency Physicians, which represents 564 emergency physicians in the state.

Doctors are no longer in control of treating their patients. The health plans now control the terms of patient care.

As an emergency physician, I'm seeing more patients who were made direct admits to the hospital; however, the health plans either delayed giving authorization for admission or give a qualified approval impending concurrent review. Thus, the patients are sent to the emergency department to be made emergency admissions. This overuses our resources, and it causes unnecessary overcrowding and delays, especially in the treatment of those patients who come to the emergency department for treatment of emergencies.

Health plans are telling physicians when a patient can be referred to a specialist, what kind of medication can be prescribed for sick patients, and punitive terms that withhold compensation from physicians who see sick patients too many times. There are even contract terms, called all products clauses or tied product clauses, that force physicians to participate in all of the insurance company's present and future plans, even those plans that physicians find ethically or financially unacceptable. This is the result of the take it or leave it contract negotiation. This practice must stop.

In our life in the emergency department, many managed care companies will not even sit down with the physicians, leaving all negotiations up to the hospitals and leaving our physicians out of the loop.

The American College of Emergency Physicians in New Jersey strongly supports this type of legislation and looks forward to working with the Committee towards its enactment.

I'd like to introduce Mike Gerardi, President-Elect of our College.

MICHAEL GERARDI, M.D.: Thank you, Sal.

Thank you very much, Senator Sinagra, for allowing us to come speak today.

Please don't misinterpret my passion for disrespect, but I think the time has come to put the issues on the line. We are being bullied in the health-care system. The health-care system is a safety net -- is eroding.

To introduce myself again, I'm Michael Gerardi. I'm an emergency physician with expertise in pediatric emergency medicine. I practice at Morristown Memorial Hospital in the Atlantic Health System. I'm a resident of Morris County, New Jersey, considered by some to be an affluent

county, but believe me, the safety net is eroding there, as well as anywhere in the state.

Never before has there been a need for places to have advocates such as this august body sitting in front of me today. Physicians have their hands tied, and we're shackled. We cannot address the issues of our patients.

I'm going to share a case with you. It just happened to me three weeks ago. A 32-year-old woman with three children came in with headaches for three months. Her managed care company denied her access to MRIs and CAT scans. So where do people go when they're denied access? They go to the emergency department.

If any of you have visited an emergency department in the last several years, you've noticed that it's crowded. You're going to be sitting on a stretcher in a hallway. The reason being is that patients don't have access to physicians' offices or the hospitals. Or, as we've just heard about, their admissions are being denied and are being forced to go through the emergency department.

It's unconscionable. This woman had a brain tumor that was diagnosed by me in the emergency department. She had to have emergency surgery the next day and had no time to get her affairs in order to take care of her three children. And the blame of that is on the managed care organizations who were trying to dictate care and what patients are going to get it. That's why we're busy. That's why your emergency departments are overcrowded. People cannot get the care they need.

We need laws. We need some kind of protection so we can be advocates for our patients. The emergency physicians in this room see patients

24 hours a day, seven days a week, and we sense the frustration not only of our patients, but of our physician colleagues. We are ground zero (indiscernible) that's occurring right now in this state and this country.

Part of the reason of these antitrust laws that have been interpreted to allow health plans such a high degree of leverage that an appropriate balance of interest does not exist--

As a result, the power of the health plans to determine the kind of health care the patients received is unchecked. I repeat, unchecked. In fact, the health care plans use the threat of Federal antitrust laws to bully physicians. And that works in accepting contracts that we know adversely affect patient care.

And my personal advocacy as a physician makes this very difficult for me to do my job and to actually even be able to carry on a conversation with managed care organizations because I know they're trying to do one thing, save their shareholders money and make profits.

Therefore, while health plans have no antitrust fears, physicians do. It's an incredible paradox.

We've been forced, as emergency physicians, as Sal just mentioned, to accept negotiated rates from managed care organizations because emergency physicians have not been allowed to be at the table because we have an unique relationship with hospitals and contracts that we -- just don't have the power to negotiate these rates.

Under current Federal law, two or more independent practicing physicians cannot come together to discuss the terms of a health-care plan, how best to provide care in a cost-effective way. And I think that this Senate

Bill 1033 really addresses some of those issues and really has some great ideas on how to implement change in the health-care system -- taking off the shackles of antitrust threats.

Just to remind people in this room, these lawsuits, brought on by Department of Justice for antitrust, can result in doctors having three-year prison terms, \$350,000 fines, and legal bills in the six figures.

I'm pleased to join with my emergency physician colleagues, and also all the physicians in this room, to support these important bills that you're putting forth.

I invite anybody on this panel to come spend time in the emergency department to see firsthand the issues that I've put forth today.

Thank you again for your time.

SENATOR SINAGRA: Thank you.

Any questions? (no response)

Dr. Patricia Klein.

PATRICIA G. KLEIN, M.D.: Good afternoon.

My name is Patricia Klein. I'm a physician in private practice in Bergen County, in neurology, with my partner and myself. And I'm here as the Chair of the Council on Legislation of the Medical Society of New Jersey.

I would like to thank you, Senator Sinagra, Senator Matheussen, and the rest of the Committee, for being here with us today and to thank you for all that you've done in the past to protect the health care of the citizens of New Jersey.

The Council on Legislation in the Medical Society consists of 30 physicians, and we meet on a regular basis to review legislation and hopefully initiate legislation that impacts on our practice and on our patients.

This Committee knows firsthand the proliferation of legislation and regulations dealing with health care in New Jersey. The assault on the managed care community began right here, before your Committee, as you debated the legislation concerning drive through deliveries. And I was very honored to be present when Governor Whitman signed that bill into law at Holy Name Hospital in Teaneck several years ago.

Next, you considered banning same-day mastectomies and went on to craft one of the strongest patient rights bills in the whole nation. And we only hope that our Federal legislators can follow in your lead and pass a Federal patients' bill of rights that follows along with New Jersey's.

The New Jersey Legislature, and specifically this Senate Health Committee, under the leadership of Senator Jack Sinagra, has done more than any other entity to help the patients in the Garden State.

We came to you when physicians and hospitals weren't being paid promptly for the services we rendered, and you responded with support for the prompt-pay legislation, which took effect last December. And you followed through on your commitment to reimburse the physicians like me and my partner, who continued to care for the patients in the HIP program without knowing whether we'd ever get reimbursed for those services when that HMO went bankrupt. MSNJ was proud to watch as the Governor signed that important legislation into law recently.

Also, your leadership in the area of tobacco control, especially its effects on our children, is nationally recognized. We were proud to join Senator Sinagra as he accepted the AMA's most prestigious award, the Nathan Davis Award, in Washington, D.C., for your leadership on the tobacco front and on the managed care arena.

But today we are here before you discussing another important issue. The severe imbalance of power between health plans and physicians has reached critical levels around the nation. This imbalance has given health plans the power to determine what kind of medical care a doctor may provide.

For instance, recently I heard about a physician who saw a gentleman with an elevated PSA, prostatic specific antigen level, did a prostate biopsy, and because that patient was in a certain managed care plan, that biopsy had to go to a certain laboratory. The biopsy came back positive. The patient went to the hospital and had a radical prostatectomy, only to find out that the prostate was free of cancer.

I believe that if the physician had the right to send that specimen to the doctor -- the pathologist that they felt would be the best at interpreting it, perhaps that gentleman would have avoided that surgery.

These insurances also have the right, now, to tell our patients where to go for care. Recently, I had a woman, who's been my patient for several years, who had her insurance changed by her employer. She called the insurer to see if I was in the plan, and she was told I was not. And she was clearly told by her insurer that she should find a different doctor in the plan, even though she had out-of-network benefits, because the plan preferred that she stayed within the network.

So, in many communities around the country, these health plans have virtually dominated what's going on. In addition to how they dictate the way we care for patients, they're also trying to dictate -- they already do -- dictate what our contracts look like. And this affects our contracts -- certainly affect the way we can care for our patients. And we know that those contracts are certainly directed at controlling the costs of care.

So the Medical Society of New Jersey, and our Council on Legislation, welcomes the opportunity to participate in the dialogue concerning bills S-1033, by Senator Bark, and S-1098, by Senators Matheussen and Singer, that address this imbalance appropriately.

I'm pleased that you're here with us this afternoon to listen to the overwhelming support this concept enjoys.

Thank you for your years of listening to us and for protecting our patients.

SENATOR SINAGRA: Thank you.

Dr. Klein, we're all-- All of us up here -- all the members who've been here for a while are very proud to have sponsored and pushed all the legislation that you outlined.

Personally, I find it incredible that we have to do that. We have to pass legislation to tell you how to treat your patients when you know how to treat your patients. Hopefully, this set of legislation that we're going to pass, hopefully this legislative session, will do something about it permanently.

So, thank you, Dr. Klein.

Dr. Formica.

PALMA E. FORMICA, M.D.: Senator Sinagra, Senators who are on this Committee, my name is Pam Formica. I want to thank you for holding this Committee hearing and for listening to the stories that we have to tell you. And I'd like to represent the American Medical Association.

I am a practicing family physician in Old Bridge, the Professor of Family Medicine at the Robert Wood Johnson Medical School, and Chair of the Department of Family Practice at St. Peter's University Hospitals. And from 1990 to 1999, I had the privilege of serving as an elected member of the Board of Trustees of the American Medical Association.

I am pleased to have the opportunity to testify on behalf of both S-1098 and S-1033. I testify on behalf of my patients, my colleagues, and the American Medical Association.

Before I talk about the AMA, let me tell you about the story of a patient of mine -- and one of your constituents, Senator Sinagra -- who is 84 years old, lives in Old Bridge, and has been my patient for 40 years. Until six months ago, she was in good health. But she joined a Medicare HMO so that she could get the drug -- so she could get her drugs paid for. She was not on any medication, but she wanted the safety net. And ironically, when she did need medication, her HMO had raised the rates and eliminated the drug plan.

About six months ago, she began losing weight, and it was obvious she was in serious, serious trouble. We tried to do all of the testing on the outside so she wouldn't have to be sent into the hospital. She had repeated bouts of pneumonia. We thought she had a cancer. We were looking. She was so frail and debilitated, and lived alone with her 50-year-old son, that many times I took her to other people so that she would have her tests done.

The HMO refused to pay for any of these. She became so upset, she asked me to intercede for her. It was always the same answer. The referral was wrong. There was no preauthorization. When I finally got through to them that I wrote out the referral -- I hand carried it to the provider -- they suddenly found her name in the computer and that she was covered.

In January, she had a severe episode where she had to be admitted to the hospital. She has no memory of the first 10 days of her hospitalization. The HMO said because she had, as one of her diagnoses, pneumonia, she was entitled to two days of intravenous therapy in the hospital, and they said they would send a nurse out to give her treatments at home. I said, "How could she open the door for the nurse when she can't even get out of bed?" But they said that it was not necessary for this 84-year-old, frail lady to be in the hospital.

A month later, she was admitted to the hospital. Before that, she showed me her explanation of benefits, the EOB. Her hospital bill for her first hospitalization of 21 days was \$48,784. Her HMO paid \$4500.

Now, they tell me -- the HMO -- that she isn't going to have to pay for that. But being of her generation, her words were, "If I were treated, the people who treated me should be paid."

She was again taken to the hospital. The second time, she had congestive heart failure with a heart erythremia. For that, they allowed three days.

The third time she was admitted, she had a massive heart attack and had to be in the coronary care unit and the telemetry unit. They allowed four days. Two days for pneumonia, three days for congestive failure, and four days for the heart attack.

This is not unusual. In our hospital, in 1998, 4000 days were carved out of the reimbursement by the HMOs. That was in 1998. In 1999, it's risen to 6500 days that are excluded.

Now, at the AMA, we have heard of these horror stories from individuals all around the country. They all ask us for a level playing field. And as managed care, we come stronger and more consolidated. Doctors and patients are really getting the short end. Medical decisions should be made by treating doctors for the good of their patients and not for a surgeon who sits in Newark deciding how much care my patient needs.

The AMA has passed much legislation that first started here in New Jersey. One of the things that's been high on our agenda is antitrust relief and patient protection. And it's too bad that every one of these things -- we have to go back to the State and beg to have them changed.

Now, you know that, under the antitrust, two independent doctors cannot sit down and talk together about fees or contracts without being accused of antitrust. And officers from the Department of Justice and the Federal Trade Commission have come to the AMA and have told us that they will vigorously investigate and prosecute any doctors who are guilty of this antitrust. This is why it is so necessary that we go to the states.

Last year, the AMA had its Department of State Legislative Affairs look into the State's action doctrine. This has been used before in other states where workers could join together and have the Federal antitrust law amended. This kind of exempts those individuals in a limited group. If the State passes it and the State's Attorney General agrees to the terms--

This is the judicially created doctrine that allows states to do this. This is the similar legislation that Texas passed and was signed into law in June of 1999. Sixteen states and the District of Columbia -- and in those 16 states is New Jersey -- have brought forward these bills. It's not a perfect solution.

We also are encouraging the Campbell bill, which would rehaul the antitrust law. The Campbell bill would take away the onerous restrictions that physicians and patients have.

And it's interesting, Representative Campbell was a member of the Federal Trade Commission and a lawyer. And he thinks what the Federal government is doing is absolutely wrong.

Our patients, your constituents-- We need your help. And we can't wait too much longer.

Thank you very much.

SENATOR SINAGRA: Thank you.

George Wilson. (no response)

Dr. Dowling.

W I L L I A M J. D O W L I N G, M.D.: Senator Sinagra and distinguished members of the Senate Health Committee, thank you for giving me the opportunity to speak with you this afternoon.

I am Dr. William Dowling. I'm a practicing orthopedic surgeon. I'm from Basking Ridge, New Jersey, County of Somerset. I also serve as the Chairman of the Department of Orthopedics at Morristown Memorial Hospital in Morristown, New Jersey. I also serve as the President of the New Jersey Orthopedic Society and Chairman of the Board of the Orthopedic

Surgeons of New Jersey. I represent more than 600 orthopedic surgeons in this state speaking with you here today.

Allow me to express my appreciation, as well, for your participation in the Physicians Conference 2000 and for being here to hear us out today.

Twenty-nine years ago, I made a promise that into whatsoever house you shall enter, it shall be for the good of the sick, to the utmost of your power. When Hippocrates composed this oath 2400 years ago, I'm certain that managed care and HMOs were not on his mind. What was reflected in those ancient phrases was this: The physician has one, and only one, primary responsibility, the welfare of his patient. The ability to provide that care is being compromised by those entrusted to finance that care.

Let me tell you a brief story. A 60-year-old man came into my office 10 months ago. He had a complaint of low backache, a not so uncommon problem, as you're all aware, I'm sure. He had not responded to the simple, and normally effective, remedies provided and suggested by his family doctor. He had a past history of a kidney tumor, which had subsequently been operated on 18 years previously. He had been monitored over the years, with no evidence of any further recurrence of this problem. And in general, he was in very good health. As a matter of fact, his main emphasis for wanting to relieve himself of this backache was that he was an avid golfer and wanted to get back to enjoying his retirement.

I recommended, after my examination, not finding anything much in the way of physical findings, that he proceed with the appropriate X rays. According to his plan -- the health plan, under these circumstances, unless

there's a doctor -- a clear emergency, I'm not permitted to obtain those X rays in my office, in spite of the fact that I have the capacity to do so.

He was provided the appropriate prescription and referred back to his family physician who was then compelled -- not compelled, but was under the obligation to go ahead and forward this on to the appropriate X-ray facility.

The patient became frustrated with the delays associated with this and the bureaucratic hurdles that he had to go through to get the permission, etc. He decided the backache wasn't that bad and went to see someone else to have his back manipulated and proceeded to endure his symptoms for approximately two months. When they became much worse, he finally did become sufficiently ill, so he sought the care of his family doctor, again, who authorized the X rays. He then proceeded to the facility and finally dropped the films off at my office. Unfortunately, that evening I had to call him to tell him he had a tumor the size of a softball on his pelvis.

Now, clearly there is a responsibility of the patient to follow through with the instructions. As a matter of fact, I made an additional effort on my own part to follow up with him to find out why he hadn't come back, etc. And I got the explanation that, basically, he couldn't be bothered with all the bureaucracy.

So clearly there is the need and the necessity on his part to participate in his own care. Rarely in medicine, as in most aspects of life, is it any singular event that leads to a disaster. It's usually a series of events like a series of dominos, with one falling on top of the other, that leads to an adverse outcome.

I'm an orthopedist. I treat problems predominately related to bones and joints.

Senators, I cannot see bones with my eyes. My professional eyes are my X rays, and prohibiting me from directly obtaining the information blinds me.

Senate Bill S-1033 proposes to allow physicians in New Jersey to collectively negotiate with health plans over the terms of contracts. The concept is a voluntary negotiation with the oversight of the Attorney General. The process may be indicated -- initiated only with permission of the government and with the agreement of the health plan.

We understand that there may be concerns that giving us the authority to negotiate collectively may result in higher fees that would be adverse to consumers. Nonetheless, what this bill specifically does-- It's a demand for State oversight throughout the process and for final review and approval of the final outcome.

Furthermore, this bill does not allow union-like activities. There could be no strikes, no holdouts, no work slowdowns, or anything along those lines. We are physicians, and when a patient comes into our emergency room, we will take care of them no matter what agreement we reach, or don't reach, with any given health plan.

Thank you for your leadership in addressing this problem.

Further, I want to let you know of my willingness and availability to discuss this further with you or your staff so that working together, we may develop a better system for the citizens of this state.

SENATOR SINAGRA: Thank you.

Dr. Charles Blackinton.

C H A R L E S H. B L A C K I N T O N, M.D.: Chairman Sinagra, distinguished members of the Committee, thank you very much for giving up your Friday afternoon to hear my testimony. I sincerely appreciate this.

The mental health part of the story is much more complicated than the rest. The health insurance industry has made a tangled web -- a very tangled web involving what are called mental health carveouts. What you see when you see Aetna take over Prudential is the tip of the iceberg. Underneath that, for the mental health patient and the mental health provider, is a group of companies to which these major players subcontract the mental health administration. And instead of seeing 60 percent of county's patients being covered by one insurer, you may see a significantly larger percentage of the mental health benefits being managed by one subcontractor.

The group most likely to be discriminated against, to be disenfranchised in any health scheme, are the mentally ill. This is due to the prevalent stigma against mental illness and due to the fear of the results of that stigma.

Specifically in this bill, very importantly, clauses can be negotiated to limit access to the private notes of a psychiatrist for their psychotherapy sessions. Now, the individual physician is virtually powerless to protect his or her patient's privacy. They shouldn't have to agree to allow you insurance clerks to review these very private psychotherapy notes to allow a claim to be considered. This is inappropriate. A clinical summary by the treating psychiatrist should suffice. This can't be done under the present scheme. We are prevented from negotiating those clauses.

It is vital to the interest of patients that the providers be protected from requirements to participate in all products sold by a carrier. In my own practice, Aetna required that I participate in all products when they merged with other companies. I refused to do this. I was then dropped from their panel. Seven of my patients were then no longer covered for my services. Several of them sought services from doctors who still were in the panel. Some dropped out of treatment all together, and some continued as my patient. This dislocated their psychiatric care and prevented some of them from getting treatment.

By the way, these patients were either fully employed or family members of fully employed persons. They are the walking wounded who are most at risk to be disenfranchised and undertreated.

Several other psychiatrists who were likely to participate in all the products remained on the Aetna, but then some of them stopped accepting new patients.

Recently, one of my patients' spouse changed employers and went under a new insurance plan. This insurance plan provided one psychiatrist in Bergen County for that patient to choose from. And that one psychiatrist was employed by Mental Health Center. This is in one of the most populous counties in the state.

I'm the President-Elect of the New Jersey Psychiatric Association. I'm speaking on behalf of my patients and the patients of the over 800 psychiatrists who are members of the society.

I'm very strongly encouraging you to add two specific proposals, or two specific parts, to this bill: One, that the procedures for providing

clinical summaries of psychotherapeutic treatment in lieu of complete records be one of the specific items which can be negotiated; and also, that the health benefit plan sold or administered by the carrier, in which the health-care providers are required to participate, be a specific point to be discussed.

I'd be happy to answer any questions.

SENATOR SINAGRA: Anyone have any questions? (no response)

Thank you.

Excuse me, Doctor, wait. Doctor, there is one question. I'm sorry.

SENATOR SINGER: Just one comment. I have to tell you that insurance companies in general, not just HMOs, have truly made mental health dollars unavailable. Unfortunately, your patients are silent about it from both the State level and the insurance level. And the amount of care available, the options available-- Many patients are seeking help out of state because of what is happening. And I think we have to take more than just negotiations. We've got to make a proactive move in letting people understand that if they have a mental illness in this state, many insurance companies are giving them, virtually, no help at all.

DR. BLACKINTON: That's very true.

Thank you.

SENATOR SINAGRA: Dr. William Santa Ryan, please.

Thank you.

WILLIAM E. RYAN, M.D.: That's in reference to my Santa Claus days.

SENATOR SINAGRA: I had the pleasure of being at a party where Dr. Ryan played Santa, and it was a great role.

DR. RYAN: Great. And I wasn't indicted either.

Thank you very much, Senator Sinagra and members of this distinguished panel. I want to thank you for taking the time to be here -- to be at the Physicians Conference 2000 and for holding this hearing.

I'm Dr. William Ryan, who, this time last year, was a practicing physician in Mercer County up in Pennington. I retired June 30, and I went to Washington to work as a legislative aide for Congressman Chris Smith, New Jersey.

I'm here representing my own personal point of view and reflecting on my years as a practicing physician and rheumatologist up in Pennington. I am here to support the State action doctrine.

My leaving practice was somewhat unfortunate since my patients strongly preferred that I remain to serve their needs. I would have loved to stay and continue to be an advocate for them as a treating physician, but I found the task too daunting. I found there was no way for a practitioner, solo or group, to relate to the monolithic HMOs and obtain any meaningful feedback or obtain any reasonable dialogue on diagnosis or treatment.

Look what's happening to patient care without physician advocacy. You're hearing a lot about contracts and, perhaps, economic issues. I want to give you some practical examples from my practice as to what happened to patients who were forced to work in this system. You need to try to give them care. And I think that could be very substantially changed by a good law like this.

I had a patient with advanced arthritis who developed severe abdominal pain a couple of years ago. The patient's symptoms continued over several days. My request for outpatient X rays were not allowed, and a request for hospitalization was initially denied. I spoke to the plan's utilization nurse who was out in San Diego, California. I was turned down.

The patient had increasing symptoms with vomiting and shock-like symptoms. At my request, she met me in the emergency room at my hospital. We took X rays. They showed free air. She had a perforated bowel. She was very ill. A surgeon was summoned. The patient died on a stretcher on the way to the operating room.

I called the utilization folks back, and they said, "Oh, Doctor, you didn't make it clear to us that the patient was so ill." I certainly had. I think, at the very minimum, I should have been talking to a physician with a Jersey license. And if a number of us -- a number of physicians could have been organized, we could probably have stopped this kind of nonsense before it occurred.

In another instance, I had a patient with numbness and weakness in the extremities and some spinal pain. And I requested an MRI of the cervical spine, which was denied. I had the patient seen by a neurologist who felt the same study was indicated. This took a couple of months. And finally, when the study was done, it showed a neurological lesion in the mid-cervical spine, which, by this time, was inaccessible, and there was no chance for surgery.

Again, the plan had denied any responsibility, and the patient had no recourse.

Dozens of patients are being denied appropriate hospital care, in my judgement. Some elderly patients are being forced out of hospitals early because they have allegedly met some distant criteria such as Milliman and Robertson, which allows, in the judgement of the plan, the patient to be discharged.

One of my largest frustrations recently, that has been to the detriment of the patients, is the fact that new drugs are being denied by the plan who does not want to pay for them, apparently.

As a case in point, I'm a rheumatologist and prescribe many arthritis medications. Some of the newer drugs that have come on the market, apparently, pose a problem in coverage. In several instances, I have been required to fill out forms certifying that the previous drug treatment had been a failure. This often involved drugs prescribed by other practitioners going back years. That is extremely difficult to research. However, without this information on the form, the plan refuses to allow the prescription to be filled, and so the patient is in the middle.

We are therefore without the prescribed-- They are therefore without the prescribed medication because the documentation is not obtainable. And the physician is spending huge amounts of time trying to comply with this unnecessary and burdensome task. The plan is using subterfuge to deny the drug and adequate treatment.

So I called several of these plans, one of them in particular, and I said to them, "Why isn't this drug covered?" And they said, "Well, it doesn't meet our plan's criteria." And so I said to them, "Fax me the criteria." And they declined, saying it was proprietary information.

Allowing physicians to organize into a negotiating unit under the egis of this state would permit physicians to work on behalf of their patients in patient care, and certainly would allow us a much more favorable and equitable position at the bargaining table.

The bill in Congress, which has just been voted out of the House Judiciary Committee -- I was there when it happened -- passed by a vote of 26-2. And it accomplishes very similar goals. It does allow a level playing field, and the physicians can negotiate on the patients' behalf.

Physicians, as well as their patients, would like to see justice in the system. We feel that the physicians should have the ability to negotiate on an even footing with the HMOs. And it is in the best interest of patients and physicians alike.

Thank you very much.

SENATOR SINAGRA: Thank you.

Dr. Kukreja.

MEENAKSHI KUKREJA, M.D.: Mr. Chairman and members of the Committee, my name is Meena Kukreja. I'm a solo physician in Middlesex County. I'm speaking to you as a physician. They're my private thoughts, but I know that I represent many physicians all across the United States, as we discuss our frustrations.

I'd like to point out one thing. It is the fundamental right of a citizen of this country to be able to use any specialist, any hospital, and any pharmacy that he wishes. We allow this right to our citizens. Under Medicare, the citizen can go to any hospital, any pharmacy. Why do I have to be 65 in order to get my rights?

For an HMO to form exclusive contracts with hospitals, pharmacies, is an infringement against the citizens' freedom and a denial of his basic rights.

Honorable Senators, I wish to bring your attention to terrible things that are bringing down the morale of physicians in the country that was known to have the best medicine in the world. This is because organizations, run by laymen and ruled by greed, are dictating medicine today. If I say a patient is ill, the first response from an HMO is, prove it. "Prove it to me by letters, by tests, by reports, and I will decide if the patient is ill." So all of my education and experience is of no use.

I appeal to you today to ban all letters of necessity, all requests of notes before a patient is allowed treatment. Value my education and experience. If I say a patient is sick, a patient is sick.

Do you know that a nurse sitting on the other side of the telephone, who has never once seen the patient -- never once seen the patient, dictates to me what tests I can order, how long I can keep the patient in the hospital, what medicine I can give, what therapy the patient can have, without once seeing the patient?

Now, if I did that, I would be charged with malpractice. If this is not malpractice, then all of us physicians can go home, and we can treat patients over the telephone. And yet a nurse, sitting thousands of miles away, will dictate to me what treatment I can give to the patient.

And I urge you to consider this malpractice and to state that HMOs cannot employ nurses or physicians who can give judgements without examining the patients.

Honorable Senators, I want to give you an example of a third thing that bothers medicine today. If you tell a plumber to come to your house any time, day or night, and do as much plumbing as he wants, and at the end of the month, you will pay him \$9, do you think you're going to get good work? Of course not. But that's what a capitation plan is. A capitation plan means that I have to see a patient, day or night, 30 times if the patient comes, and at the end of the month, I'm going to get \$9. Do you think that patient-- Do you think that citizen is going to get good medical care?

And therefore, I'm requesting you to ban all capitation plans. Do not say that the physician does not have to join them. A physician has to survive. We have our bills, just like you. If people could do things voluntarily, you wouldn't have to pass laws saying that you cannot drive while you're drunk. Capitation plans are really a slap in the face of good medicine for your constituents.

I am requesting today that that health organization that keeps a doctor fighting so hard for months to be paid for services that he has little time to work, is immoral and leads to bad medicine. An HMO that refuses to pay the doctor, despite all care rendered, on the grounds that he did not put the fifth code, or his codes did not match the other codes, is immoral and leads to bad medicine.

An HMO that yearly lowers its bids so that the patient runs around, changing doctors frequently, leads to bad medicine because the patient loses continuity of care. An HMO that dictates to the patients, dictates to the doctors, dictates to the hospitals how long a patient can stay is immoral and leads to bad medicine.

We have meetings at hospitals where an HMO will come and say, “In New Jersey, you’re keeping a patient for appendicitis for five days. Do you know that in California, they keep them for four days?” So everybody in New Jersey runs around and keeps them for four days. Then they go to California and say, “Do you know New Jersey keeps them for four days? How come you don’t keep them for three days?” Then they come back to us and say, “How come you don’t keep them for two days?” Who do you think gets shortchanged? The patient.

It is not their business to tell us how long a patient should stay; it is the doctor’s business. And I’m requesting for you to say that this is a judgement that I have to make.

A good leader is one who feels the pulse of the public.

I’m requesting you to appoint a committee of doctors to advise you as to what is happening with us to help you to make rules that help the constituents.

A physician is supposed to be a powerful leader. Today, a physician is a powerless man -- Why is that so? -- because there is a law called antitrust law. Remove it, and see how we will fight for our patients. Remove it, and see the good medical care that will come forward. But I need your assistance in removing it.

Thank you.

SENATOR SINAGRA: Thank you.

Dr. Laumbach.

Your time’s up. (laughter)

ROBERT LAUMBACH, M.D.: Good afternoon. Thank you for giving us the opportunity to speak with you this afternoon.

My name is Robert Laumbach. I'm a third-year resident. And I have with me here today several other residents from our residency programs throughout New Jersey.

We believe that any legislation to improve patient care must also address resident physician working conditions. Resident physicians often work in excess of 36 hours and commonly work 80 to 100 hours per week. While on hospital floors, during these long hours, residents are often required to perform tasks such as drawing blood, inserting IV lines, and even transporting patients. This so-called scum work has no educational value for residents. The combination of long hours and inappropriate work fatigues and demoralizes residents, leading to compromised patient care.

A recent report by the National Academy of Sciences estimated that the medical errors in hospitals kill between 44,000 and 98,000 patients per year. The report made it clear that most medical errors result not from individual recklessness or negligence, but from basic flaws in the way hospitals operate.

While we do not know how many errors are caused by resident fatigue, common sense would dictate that physicians who have not slept in more than 24 hours would be more likely to make errors that might compromise patient care.

As Lucian Leape, one of the authors of the NAS study, points out, we don't allow pilots to fly more than eight hours. Few would question the wisdom of this limitation on pilot hours.

The issue of resident work hours is complex, involving not only patient care, but economics, culture of medicine, and medical education. Residents who, in New Jersey, earn about \$40,000 a year, on average, and work 80 to 120 hours a week represent cheap labor. For hospitals, it's like getting two or more residents for the price of one employee. In a climate-- For hospitals, it's like getting two or more highly skilled and motivated employees for the price of one. In a climate of falling reimbursements and cuts in other funding sources, it makes economic sense to have residents drawing blood and inserting IV rather than hire nurses and phlebotomists.

Residents are easily exploited. We spend an average of three or four years in a residency program. Our advancement is within-- Our advancement within our residency programs is crucial to the progression of our careers, for which we have already invested a great deal of time, effort, and money.

Many physicians have defended long work hours for residents on the grounds that they're both beneficial to residents and patients. For example, there is a belief that since residents learn by doing rather than studying, the more time a resident works, the more he or she can see and do and the more the resident will learn.

Certainly, many physicians look back on their residencies as rewarding and valuable experiences. Long resident hours has traditionally been seen as a right of passage for physicians. But the question remains, how much is too much? At what point does fatigue compromise resident education and patient care? Some have argued that resident work conditions are improving, since we work less on hospital duty than our forbearers.

While resident hours may not be as onerous as they once were, the problems with residency working conditions go beyond hours. As lengths of hospital stay have fallen dramatically, residents are caring for patients who are sicker and require more intensive care. There has been a proliferation of sophisticated, new technologies that residents must master. Requirements for documentation and other paperwork are constantly expanding. For residents, these changes have meant busier days and nights, less time to read and sleep, greater tension, stress, and fatigue.

In recent years, attempts have been made to address the problem of resident work conditions, both within the medical profession and through public regulation. For example, the Accreditation Council for Graduate Medical Education, the ACGME, has required accredited internal residencies to comply with guidelines that included an average of -- an average of an 80-hour work week with overnights no more frequently than every third night. Most of the other specialities have some type of guidelines on hours. In New York state, regulations have restricted resident hours to 80 hours per week with no more than 24 consecutive hours. Surveys have shown that both the ACGME and Bell limitations are routinely exceeded. Recently, New York state has stepped up efforts to enforce the Bell regulations.

As resident physicians, we urge you to take action to protect patients by improving resident working conditions. Our first step toward that goal would be regulations similar to New York, which provide modest, reasonable limits to resident work hours. We support Senate Bill S-120, sponsored by Senator Vitale and Senator Bennett. We also ask you to support

funding for graduate medical education at teaching hospitals so they can provide patients with adequate nursing and ancillary care staff.

Again, thank you very much for the opportunity to speak with you today.

SENATOR SINAGRA: Thank you.

Dr. Talone.

ALBERT TALONE, D.O.: Good afternoon, Senator Sinagra and Senator Matheussen and members of the Senate Health Committee.

I am Dr. Albert Talone, an osteopathic physician, and Vice President of the New Jersey Association of Osteopathic Physicians and Surgeons. The State Osteopathic Association represents more than 2400 osteopathic physicians, the majority of whom are primary care physicians.

The issue of whether physicians should be permitted to engage in collective negotiations with managed care entities is the State Osteopathic Association's top priority for the legislative session. We reviewed the bills pending in other states, as well as the Federal legislation. Based upon our research, we determined that legislation pending in Pennsylvania was the most comprehensive bill, and we requested Senator Matheussen and Assemblyman Asselta to introduce S-1098 and A-2241, respectively. The State Osteopathic Association thanks them for their sponsorship of these bills and commends Senator Bark for her interest in this issue.

I have been in private practice for more than 25 years, served on the Board of Medical Examiners and on the University of Medicine and Dentistry of New Jersey Board of Executive Directors, as well as numerous

other health care commissions and panels. During this time, I have witnessed the erosion of a physician's ability to practice medicine.

When I began my practice, managed care was not prevalent, and today, more than 70 percent of my patients are in some form of managed care.

As a practitioner in a small group practice, I know firsthand that we cannot negotiate with managed care entities concerning the terms and conditions of the contracts I must sign in order to be credentialed to treat patients with the respective insurance coverage.

The State Osteopathic Association urges the Senate Health Committee to adopt collective bargaining legislation for the following reasons.

1. Under Federal antitrust law, physicians are prohibited from engaging in collective negotiations. Current limited antitrust safe harbors have proven ineffective.

2. State legislation is needed to create State action immunity for collective bargaining to be permitted.

3. Physicians want to negotiate over fee- and non-fee based matters. The impetus behind this bill is not economic, as some have charged. We need to negotiate on fee-related matters so that physicians can limit restrictions on the patient's ability to receive medically necessary care.

4. All health-care providers should be included in the bill.

5. Health insurance carriers should be defined to include ERISA plans, as well as self-funded plans, so that the maximum number of covered lives are subject to the bill.

6. The definition of a carrier's substantial market power must reflect the fact that a few giant companies dominate the market. In New

Jersey, Aetna U.S. Healthcare-Prudential controls 59 percent of the market in Bergen County, 55 percent of the market in Camden County, 59 percent of the market in Hunterdon County, and 48 percent of the market in Mercer County.

7. The legislation must specify that the Attorney General approve the physician's petition if the procompetitive requirements are met.

8. Physicians do not want to strike or boycott. We want to sit at the table with carriers on an equal footing and basis.

9. Charges that the ability of physicians to engage in collective negotiations will lead to higher premiums are scare tactics. Premiums have steadily increased in recent years without physicians seeing that increase in their capitation rates.

10. Carriers should be required to negotiate in good faith and in an environment of binding arbitration.

I have included with my testimony -- and attached to this is a sheet for your review.

The State Osteopathic Association is ready to work with you on this important issue to our patients in the State of New Jersey and the physicians.

I thank you for your time and appreciate you having this hearing.

SENATOR SINAGRA: Thank you, Doctor.

Dr. Michael Graff.

MICHAEL A. GRAFF, M.D.: Thank you, Senator and members of the Health Committee. I will be brief, as I promised.

My name is Michael Graff. I am President of the New Jersey Chapter of the American Academy of Pediatrics. We represent over 1700 pediatricians in the State of New Jersey.

We're going to change focus a little bit. Our issue, right now, is Medicaid reimbursement. The State of New Jersey, we feel, must address this. And Senator Sinagra mentioned this at the beginning -- that reimbursement issues were going to be -- and Medicaid was one of the issues that your Committee is going to be taking up.

Currently, we are the second lowest reimbursed state in the United States, and we feel that is inappropriate. Because of the low reimbursements, physicians are dropping Medicaid as their panel. And because of that, we are seeing more and more children that are not receiving good health care.

We are currently one of the lowest vaccine rates in the United States, which, I believe, is appalling. With more managed care plans, physicians are no longer making what they used to and can't write off the cost of Medicaid and say, "Well, we'll see these patients for free." Many of my colleagues don't even bill Medicaid because the reimbursement rates are less than the paperwork required to fill out the bill.

We have supported KidCare. In fact, we were one of the leading people behind the Governor's push for KidCare. We supported it, and then the reimbursement rates dropped right in front of us. And I got quite a bit of egg on my face as being a strong supporter. I will support family care. But we ask that we address these issues prior to our engaging in them.

Lastly, the managed care companies asked the State to give them more money because they couldn't supply the care that they had promised the

State that they would supply for the money that they were receiving. The State agreed and gave them more money, and none of that money was passed on to physicians.

So, I'll close by saying that this is an issue that affects family practitioners, obstetricians, and pediatricians among -- and emergency medicine physicians among the most, as we care for the women and children of our state. We cannot ignore the reimbursement issue. It needs to be addressed sooner than later.

Thank you, all, for your attention.

SENATOR SINAGRA: Thank you.

Doctor, there's one question, maybe two.

SENATOR VITALE: In your testimony, you had mentioned that the KidCare rates were lower than you hoped they would be for reimbursement. I think that testimony was before our Committee a few months ago. You also just said in your testimony that you had similar concerns about the rate of reimbursement for treating those, potentially in the new FamilyCare program.

DR. GRAFF: We have the same rates for them. That's just a new plan that we haven't yet even seen. But the model that the State has used for all of these is a Medicaid HMO model, and therefore, I will be surprised if the FamilyCare program is much different than the Medicaid HMO programs have been.

SENATOR VITALE: It's my understanding that the model is similar to the KidCare program, as the legislation has now, recently, evolved.

I'm also concerned, and I hear that there's some hesitancy on the part of the society to support the FamilyCare program because the level of reimbursement is similar to KidCare. Don't you think it would be important to move that legislation forward now and address the issues of reimbursement along the way instead of waiting until we address the issues of reimbursement first before we move along to try to cover more of the uninsured in the state?

DR. GRAFF: We'd love to, but-- We have always felt that children come first. No pediatrician has ever denied the care to a child. So we'd rather have the children have some kind of insurance. But we are rapidly losing more and more of our members that support these programs, as they can't even cover the cost of their office staff. So yes, I think your statement is very good, and we'd support that move.

SENATOR VITALE: But do you support the FamilyCare initiative as it moves forward, before we address the issues of reimbursement?

DR. GRAFF: The Governor stated today that she is very anxious to get the FamilyCare program moving quickly. Having worked with the Governor before, when she makes that kind of a statement, it generally moves so fast, it's hard to slow it down. If your Committee is able to slow it down such that we can address these issues, I'd be very in favor of that.

SENATOR VITALE: Well, I don't know if I'm going to commit to slowing down the process of implementing FamilyCare so we can address the needs of the uninsured.

DR. GRAFF: I applaud you.

Thank you.

SENATOR SINAGRA: Thank you, Doctor.

And the final speaker is Michael DiDonato.

You realize, going last carries a lot of weight.

MICHAEL DiDONATO, M.D.: The best is always last.

SENATOR SINAGRA: Leave them all on a high note.

DR. DiDONATO: I'll take a different tact.

Senator Sinagra, Senator Matheussen, thank you. Members of the board, I appreciate your time.

My name is Mike DiDonato. I am a physician practice administrator for a urology practice in South Jersey, and I'm also the current President of the New Jersey MGMA, which represents approximately 250 physician practices across the state.

My tact here is to tell you not the stories, but basically to discuss those issues that are the operational issues in a practice. We represent the people who physically do the billing in an attempt to collect the money for the physicians. And even though there has been a prompt payment bill passed in this state, we have seen the insurance companies find ways to get around it. And also, they have attempted to minimize our ability to bill efficiently and effectively, via billing electronically, for example.

I discussed with a medical director of a large insurer, just a couple of days ago, the issue of down coding Level 4s and Level 5s to Level 3s. I mentioned to him that one of the charges in the State is to move efficiently to electronic billing for all procedures. I've said this was by down coding, and having to push those procedures to paper with documentation precludes our ability to do that. He said, "You're exactly right." He said, "You are required to bill electronically for the Level 4s or 5s. We will downgrade it to a Level 3.

If you want to fight that declination, you will have to push the paper and provide backup documentation.” I again reminded him that it didn’t make sense. He said he didn’t care.

This particular insurance company has contracted with a third-party administrator to make the payments for them. This third-party administrator, that is currently in the state and is now the same third-party administrator that has service under a new name, has been problematic in the way in which we have -- our ability to process our claims.

As part of their protocols, we have continuing with particular carrier-- There have been complaints of lost claims. They have complaints of slow billing -- slow collections -- and also, this continued process of down coding.

We would ask that the -- this -- the Senate -- the Legislature bring about some change in simplifying this -- the process of billing for physician practices.

I met with Horizon Blue Cross Blue Shield at the Medical Society about a week and a half ago. And at that meeting, they asked us, “What can we do to help you bill more efficiently?” Our comment back to them was, “Medicare in the state-- Medicare has it down pat. We bill efficiently. The information that comes back to us regarding declinations of payments are clear and concise, and it’s easy to make changes and get declinations handled and paid.” That is not the case with the HMOs. With the HMOs -- particularly insidious because what ends up happening for us is we are now getting, from a clean claims perspective-- If I bill 30 procedures-- From a clean claims perspective, I’ll get paid three and the rest would be put into review. Once it

goes into review, we have to provide documentation, and it then takes the payer an inordinate amount of time to reimburse us for those declinations. We are looking for simplification in the way in which we are required to bill and document claims.

Finally, we would like to have the prompt payment bill that was recently passed in the Legislature. We are asking that there is a clear and distinctive way in which we can file complaints to the Legislature regarding HMO billing policies.

I'm losing my train of thought here. And I'm currently nervous. And I apologize for that.

I think No. 1, what we're looking for as billing managers is simplification, reduction in the HMO's ability to force down coding of our E and M codes, and also, strict enforcement of the current prompt payment law.

Thank you for your time.

I'm a little dry right now.

Thank you.

SENATOR SINAGRA: Thank you.

That concludes the testimony. If any Committee member -- want to say anything.

The only comment I will have is that I urge all of you to really follow what's going on right now. We really do intend to put a package of bills together that, hopefully, addresses many of the concerns that you have. If something wasn't addressed today, because a lot of the concentration was on two bills-- If there's something else, you think, needs to be done, or something

that makes common sense, or some aspect of your relationship between your patient and your practice that needs to change, please write the Committee.

We'll be going into -- doing this for the next six weeks, and we intend to put some in and have more hearings. I urge all of you to write this Committee about something that may be in particular that you want to add to this legislation.

I want to thank you all for your attention today. And have a great convention.

Thank you.

(HEARING CONCLUDED)