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# *Public Hearing*

before

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE  
and  
ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

*“Testimony on issues relating to health care expenditures  
and insurance coverage for health care services”*

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**LOCATION:** Johnson Auditorium  
St. Joseph’s Regional Medical Center  
Paterson, New Jersey

**DATE:** January 19, 2005  
10:00 a.m.

**MEMBERS OF COMMITTEES PRESENT:**

Assemblyman Neil M. Cohen, Co-Chair  
Assemblyman Jack Conners, Co-Vice Chair  
Assemblywoman Nellie Pou  
Assemblyman Alfred E. Steele

Assemblywoman Loretta Weinberg, Co-Chair  
Assemblyman Herb Conaway Jr., Co-Vice Chair  
Assemblyman Robert M. Gordon  
Assemblyman Jerry Green  
Assemblyman Gordon M. Johnson  
Assemblyman Louis M. Manzo  
Assemblywoman Joan M. Quigley  
Assemblyman Eric Munoz  
Assemblyman Samuel D. Thompson  
Assemblywoman Charlotte Vandervalk



**ALSO PRESENT:**

Richard T. Corbett  
David Price  
*Office of Legislative Services  
Committee Aides*

Wali Abdul-Salaam  
*Assembly Majority  
Committee Aide*

Christine Pastore  
Tasha M. Kersey  
*Assembly Republican  
Committee Aides*

***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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**ASSEMBLYWOMAN LORETTA WEINBERG (Co-Chair):**

Good morning, everyone. Thank you for joining us today.

And before we get into the more official part of our meeting, I would like to ask our OLS staff to take the roll, please, for the Health Committee first?

MR. PRICE: For attendance, Assemblywoman Vandervalk?

ASSEMBLYWOMAN VANDERVALK: Here.

MR. PRICE: Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: Here.

MR. PRICE: Assemblyman Munoz?

ASSEMBLYMAN MUNOZ: Here.

MR. PRICE: Assemblywoman Quigley?

ASSEMBLYWOMAN QUIGLEY: Here.

MR. PRICE: Assemblyman Johnson?

ASSEMBLYMAN JOHNSON: Here.

MR. PRICE: Assemblyman Manzo?

ASSEMBLYMAN MANZO: Here.

MR. PRICE: Assemblyman Green?

ASSEMBLYMAN GREEN: Here.

MR. PRICE: Assemblyman Gordon?

ASSEMBLYMAN GORDON: Here.

MR. PRICE: Assemblyman Conaway?

ASSEMBLYMAN CONAWAY: Here.

MR. PRICE: Assemblywoman Weinberg?

ASSEMBLYWOMAN WEINBERG: Here.

MR. PRICE: Quorum is present.

ASSEMBLYWOMAN WEINBERG: And for the Financial Institutions and Insurance Committee?

MR. CORBETT: Assemblyman Russo? (no response)

Assemblyman Bateman? (no response)

Assemblyman Steele?

ASSEMBLYMAN STEELE: Here.

MR. CORBETT: Assemblyman Smith? (no response)

Assemblyman Panter? (no response)

Assemblyman McKeon? (no response)

Assemblyman Conners?

ASSEMBLYMAN CONNERS: Here.

MR. CORBETT: Assemblyman Cohen?

**ASSEMBLYMAN NEIL M. COHEN (Co-Chair):** Here.

And Assemblywoman Pou is substituting for Assemblyman Smith.

MR. CORBETT: Assemblywoman Pou is substituting for Assemblyman Smith.

ASSEMBLYMAN COHEN: Assemblyman Eagler will be substituting for Assemblyman Panter or Assemblyman McKeon.

MR. CORBETT: Assemblyman Eagler will be substituting for Assemblyman Panter or Assemblyman McKeon.

ASSEMBLYWOMAN WEINBERG: Okay. Thank you very much.

First of all, I would like to thank both Assemblyman Steele and Assemblywoman Pou, who are here sitting in and substituting for Committee

members, but also are the two Assembly members who represent the district in which we are guests today. So thank you for joining us and for your interest in this important subject.

And we would like to ask Mr. Bill McDonald, who is the Interim CEO here at St. Joseph's Hospital -- has asked to say a few words. But before you do, thank you very much for your hospitality and for arranging this meeting of one of the most important safety net hospitals in the State of New Jersey. And having spoken to somebody who is here to testify, as a former Health Commissioner, she informed me how terrific this hospital was and is in terms of reaching out and getting kids covered by FamilyCare.

**WILLIAM McDONALD:** Thank you very much.

And I'm Bill McDonald, the Interim CEO of St. Joe's Regional Healthcare System here and, as well as, Wayne. I want to extend my thanks to Assemblywoman Weinberg and Assemblyman Cohen, members of the Committee, and the audience for letting us host this very, very important event today. Paterson and this organization has been around for 137 years. I hope this is not the first of such events for the next 137 years. We are very, very pleased to have the members here dealing with a very significant issue that you'll hear about from many people today.

Once again, thank you all for picking us, and we're glad to host this. If there's anything we can do, please don't hesitate to ask one of our staff to assist in this process today.

Welcome.

**ASSEMBLYMAN COHEN:** Will you be hosting at the end of the 137 years, or-- (laughter)

MR. McDONALD: Absolutely, sir. If you'll be there, I'll be there.  
(laughter) We have good medical care, so we'll make it.

ASSEMBLYWOMAN WEINBERG: And I'd also like to take a moment to introduce, in the audience, a very good friend of ours -- both Assemblyman Cohen's and myself -- Father Joe Kakora (phonetic spelling), who is the one who originally extended this invitation about a year ago, I guess. So it didn't take us 137 years, but it did take us close to a year. So, Father Joe, thank you for all the work you've done here and on behalf of the people all over the State of New Jersey.

We, obviously, along with you, feel this is an extremely important issue that we are about to address this morning. And because it involves both health care, the access to health care, and the cost of health care, and the very vast health-care insurance market, the Speaker saw fit, as he has done in the past, to join together our two Committees to address this issue.

We have tried to divide this hearing into groups. We are asking people to please limit your testimony to five minutes. Most of you will have written testimony, which we promise we'll get into the record in its entirety, as well as being given to each member of the Committee. And housekeeping: if you want your testimony to be in the official transcript, you must come to that table and speak into those microphones or it will not be recorded. So, if you want to make sure your words are here for all of us to read in the future, you must use those microphones at the table.

The growing issue of the uninsured is a national problem. And probably not one that we're going to be able to solve all by ourselves here in New Jersey. But I believe that there is much we can do to get the more than

one million, or close to 1,250,000 residents in the State of New Jersey back into appropriate health care, both access and quality, as well as coverage.

And with that, I am going to turn the microphone over to my Co-Chair, Neil Cohen, Assemblyman Neil Cohen, to see if there are any other issues that he would like to add to this, and then we will move immediately to testimony, unless there's somebody up here who feels an absolute urge to say a few opening remarks.

ASSEMBLYMAN COHEN: Having no absolute urge, I just want to welcome everyone coming together today -- the entire health-care industry, and those related parts. In the best of worlds, legislators will investigate before they legislate. That isn't always the case. In many instances, the system is reactive as opposed to proactive. What we want today is to learn almost all aspects of the health-care industry, whether it's hospitals, nursing, managed care, physicians, health insurance companies; and to address issues of what we have in the uninsured area, address issues concerning costs, payment, reimbursement. And basically, I think the approach that Chairwoman Weinberg and I are going to take, in going forward with the Committee and other members in our House, is to really look outside the box, in terms of coming up with creative ideas to try to capture more uninsured and placing them into the insured category, as well as trying to stabilize health-care costs and make sure hospitals get paid in a timely fashion, make sure that doctors are going to be paid in a timely fashion and at the appropriate reimbursement, given their costs, and also to make sure that the industry survives so that costs can be stabilized to everyone in the system.

So I want to welcome you and thank you for coming out today.

And Chairwoman Weinberg will call the first witness.

ASSEMBLYWOMAN WEINBERG: Yes. I would like to ask the representatives of the Insurance and Banking Department, Assistant Commissioner Doug Wheeler and Assistant Commissioner Gale Simon, to join us.

And then the categories that we will be covering: The first will be health-care spending, reimbursement, loss ratios, and legislative mandates. The second category -- and we have people who signed up divided into those categories -- the second will be market reform leading to improved access. And the third will be recommendations for government-subsidized health care. So I will read your names in the groups in which we divided you, as soon as we get to that.

Thank you.

I do not want to hear one complaint from anybody who had to drive here from Trenton or further south. Those of us from North Jersey deserve a break once in a while. (laughter)

So, go ahead, Commissioner.

**ASSIST. COMMISSIONER DOUGLAS WHEELER:** Okay. Good morning, Chairwoman Weinberg, Chairman Cohen, members of the Assembly Health and Human Services Committee, and the Financial Institutions and Insurance Committee. My name is Doug Wheeler. I'm Assistant Commissioner at the Department of Banking and Insurance. With me is Gale Simon, who is our Assistant Commissioner for Life and Health. She is the expert, I'm not. So your questions will be directed to Gale. Put her on the spot.

ASSEMBLYMAN COHEN: You didn't tell me that yesterday.  
(laughter) You said you were the expert, Doug.

ASSISTANT COMMISSIONER WHEELER: Anyway, the Department is pleased to testify this morning. It is our understanding that the focus of the hearing will be on costs associated with health-care coverage; and understand, as you mentioned before, the list of witnesses is very long. We will keep our remarks to five minutes. I'm going to talk about -- more about -- ours is more about informational, our testimony this morning. I'm going to talk about, sort of, like the marketplace, what the Department has regulatory oversight over, and then Gale will get more into the nitty-gritty about loss ratios and some of the financial issues that you may have some interest in.

At the outset, it is important for the members of the Committees to understand the Department only regulates a portion of the health-care market. More specifically, the Department regulates contracts for medical coverage issued by carriers, which includes HMOs, insurance companies, and service corporations, which is Blue Cross Blue Shield.

Of the 8.5 million New Jerseyans, less than a third, or about 2.4 million, receive coverage from insured contracts issued to employers, other groups, and individuals. The remaining covered residents have self-funding coverage, mostly provided by large employers. That includes the State Health Benefits Plan, or a cover by government programs such as Medicare or Medicaid and FamilyCare. Those programs -- the Department has no jurisdiction, no oversight over them.

A handout in front of you -- it's called Source of Coverage. I hope it was distributed. And that sort of spells out all the various, different

categories of coverage, both what the Department regulates, what we don't regulate. It also has an estimated number for uninsured. These are Department estimates. It's our best guess.

Insurance coverage is divided, in terms of what the Department has oversight over, into three markets: You have the individual market, you have the small group market, and you have the large group market. The individual market covers approximately 75,000, 76,000 people not covered by group coverage. The small group market is about 900,000 or so people, and that's employers with two to 50 employees. And then the large group market, which has anyone over 50 employees, is the remaining 1.5 million or so.

All carriers must be licensed by the Department and meet minimum financial standards. The policies or contracts which carriers issue are subject to review by the Department or either the individual or small employer boards, which are boards that are in, but not of, the Department. Carriers must make informational rate filings to the individual board for the individual market, and to the Department for the small group market. Only HMOs, but not insurers or service corporations, are required to make informational filings of the large group rates to the Department.

So that's just sort of an overview of what the Department has oversight over. With that said, I'm going to turn it over to Gale Simon, who will talk more about loss ratios and more of, like, the nitty-gritty financial issues.

**ASSISTANT COMMISSIONER GALE SIMON:**  
Good morning.

One measure for appropriate rate levels is the so called *medical loss ratio*, or *loss ratio* for short. The loss ratio is the amount paid to medical providers divided by premium. Thus, it is the percent of premium that actually goes to medical benefits. In the reform markets, individual and small employer, as Doug mentioned, there is a minimum loss ratio requirement, set by statute, of 75 percent. Thus, at least 75 percent of each premium must go for benefits, and the remainder -- 25 percent or less -- is available to the carrier for expenses or profits. If the carrier's loss ratio falls below 75 percent in any given year, the carrier is required to pay refunds to policyholders to bring that percentage up to 75 percent. In the large group market, there is no such statutory or minimum loss ratio requirement. That market is unregulated with respect to rates.

I'm going to apologize for the numbers, but I have to give you the numbers. In 2003, the comprehensive insurance market -- that's large group, small group, and individual -- had total premiums of \$7.6 billion. It paid \$6.1 billion in claims, resulting in a loss ratio of 80 percent. If you divide the loss ratios by the three markets, the loss ratio was 82 percent in the large group market, 79.4 percent in the small group market, and 77.7 percent in the individual market.

The minimum loss ratio such as we have in the small employer and the individual market assumes that the acceptable level of expenses and profits as a percentage of premium, 25 percent, remains constant over time. Some expenses are reasonably sent as a percentage of premium, such as broker commissions, the provisions for profit, and premium taxes, or other taxes. Other administrative costs, such as the cost of maintaining policy records, all

the costs of administering each claim, vary by other factors, including inflation for goods and services and the number of claims per policy. A loss ratio standard assumes that medical inflation and inflation for general goods and services are roughly the same. Recently, however, medical inflation has been much higher than other inflation.

Providers, such as doctors and hospitals, incur expenses to receive reimbursements from carriers. There are expenses for submitting and monitoring claims, for verifying coverage, for providing referrals, and for seeking necessary authorizations. Providers who are a part of a network need to enter into and monitor contracts with carriers as well. Those expenses are not reimbursed separately by carriers. They are paid for by payments to the providers for medical services. Therefore, a component of the 80 percent of premium that goes to providers does not really pay for the provision of medical care. It reimburses the provider for the administrative costs of working with carriers.

The identification of that portion of medical costs to providers that is, in fact, administrative is very difficult to identify. A rough estimate is perhaps that 10 percent of payments to providers is, in fact, reimbursement for these billing and other functions.

ASSISTANT COMMISSIONER WHEELER: If anyone has any questions, if you don't have any today, or if, obviously, you have any follow-up afterwards, we will be a resource for you in terms of providing you any information. I know today is going to be a lengthy hearing, and you probably will have follow-up questions for us afterwards. Please, my line of

communication is always open, as well as Sheila Kenny's, who is here. So, anyway, any questions?

ASSEMBLYMAN COHEN: He has a question.

ASSEMBLYMAN CONAWAY: Just a clarification -- it may be the acoustics in the room -- you mentioned that some portion of that 20 percent, roughly, in one case, and maybe 25 percent, I guess by law in another case, goes to pay the administrative expenses of providers -- I guess that's hospitals and doctors -- for dealing with the insurance companies. What did you say that was?

ASSISTANT COMMISSIONER SIMON: We were saying that the 80 percent of premium that goes to pay medical costs really includes a 10 percent payment which goes to the provider for the administrative expenses of submitting the claim, getting the referral.

ASSEMBLYWOMAN WEINBERG: Excuse me. If you pull that center microphone a little closer to you -- make sure it's on.

ASSISTANT COMMISSIONER SIMON: Okay. That 10 percent came out of the 80 percent that went to the provider.

ASSEMBLYMAN CONAWAY: And that is, through the Chair, that number is an estimated number. That is, that number is not subject to any kind of a contract between the hospital and the providers. That is your estimate--

ASSISTANT COMMISSIONER SIMON: It's a guess.

ASSEMBLYMAN CONAWAY: --of what those costs are that come out of that 80 percent? Is that right?

ASSISTANT COMMISSIONER SIMON: That's correct.

ASSEMBLYMAN CONAWAY: So those administrative costs that are involved in the entire health-care system -- that's really being born by providers of care, would you agree with that statement?

ASSISTANT COMMISSIONER SIMON: That's correct.

ASSEMBLYMAN CONAWAY: All right. Thank you.

ASSEMBLYMAN MUNOZ: Thank you, Madam Chair.

(coughs) Excuse me, I have a cold.

ASSEMBLYWOMAN WEINBERG: Well, you're in a good place if you have a sore throat.

ASSEMBLYMAN COHEN: Do you need a doctor? (laughter)

ASSEMBLYMAN MUNOZ: I need to see a doctor.

A question -- this is an interesting chart. It looks like -- and it's a complicated problem -- it looks like about only 28 percent of residents in New Jersey are "in regulated markets." So that means 72 percent aren't?

ASSISTANT COMMISSIONER WHEELER: That's correct.

ASSEMBLYMAN MUNOZ: Okay. That's one of the factors. Maybe a little later I'll talk about the multiple factors which makes this a very complicated problem. So we as the government -- so I guess if we're the government, we're looking at a minority of the citizens. Okay.

ASSEMBLYWOMAN WEINBERG: Any other questions down here?

Assemblyman Manzo.

ASSEMBLYMAN MANZO: I wanted to address -- I know we're going to hear from the hospital associations. But one of the factors that has come before our Committee is the reimbursement issues. And I just wanted

to get your insight on, I guess, the focus of-- Do you look at that? Do you look at the problems?

ASSISTANT COMMISSIONER SIMON: No. We don't have any regulatory authority over reimbursement rates. We don't even see the reimbursement schedules that the carriers use to compensate hospitals and other providers.

ASSEMBLYMAN MANZO: Could your Department handle it?

ASSISTANT COMMISSIONER SIMON: Not as we're presently staffed, because that's a huge undertaking. Even if we were provided with the data, we don't have the expertise to determine whether those payments rates would be adequate. So at this point, I would have to say, no, we couldn't handle it.

ASSEMBLYMAN MANZO: Because from my looking at it, that seems to be where the most problems are, and there's got to be some agency or some oversight in the State somewhere to oversee that.

ASSISTANT COMMISSIONER WHEELER: Assemblyman, obviously it is a problem, but there may be-- There's obviously always some times -- there may be more, additional ways to address the issue. That may be one of the ways. There may be others as well. Obviously, it's something that should be considered and it's something that should be on the table as well as other ideas. And we're obviously welcome to consider anything.

ASSEMBLYMAN MANZO: When you're looking at profits from insurance companies, do you look at investments or do you just zero in on policies versus loss runs?

ASSISTANT COMMISSIONER SIMON: No. We look at both. We look at the underwriting profits, which would just be the profits from the insurance business, but we also consider investments and taxes.

ASSEMBLYMAN MANZO: You do consider that?

ASSISTANT COMMISSIONER SIMON: Yes.

ASSEMBLYMAN MANZO: And does that enter into premium setting? Does that enter into your evaluation of their premium setting?

ASSISTANT COMMISSIONER SIMON: Well, I have to step back. We don't have prior approval authority over any premiums. So when they file rates with us for the small group of policies that they do, it's for information only. And the only thing we can test it against is whether their actuary certifies that they will meet the loss ratio standard that's applicable in the small group market.

ASSEMBLYMAN MANZO: So is there anybody in the Department that says, if someone was soliciting a premium that they felt was outrageous, what they would do about it?

ASSISTANT COMMISSIONER SIMON: The only thing we can do is go back and say if you are subject to a minimum loss ratio requirement, are those premiums -- will you meet that? Even if we slip and they do use a rate and the rate doesn't produce the 75 percent, at the end of the year they would have to make refunds.

ASSEMBLYMAN MANZO: And the data for that evaluation is provided strictly by the insurance company?

ASSISTANT COMMISSIONER SIMON: Yes. It's provided to us. They make annual filings.

ASSEMBLYMAN MANZO: Is there any check or balance on that, or do you just take their word for it?

ASSISTANT COMMISSIONER SIMON: I have to ask my actuary. Those reports aren't audited.

ASSEMBLYMAN MANZO: So they're not audited?

ASSISTANT COMMISSIONER SIMON: No.

ASSEMBLYMAN MANZO: They're not?

ASSISTANT COMMISSIONER SIMON: They are not.

ASSEMBLYMAN MANZO: Does looking at reserves enter into this -- insurance company reserves?

ASSISTANT COMMISSIONER SIMON: I have to go back again.

Neil. Come on up.

ASSEMBLYWOMAN WEINBERG: I think, by the way--

ASSISTANT COMMISSIONER SIMON: This is our Chief Actuary, not some guy from the street.

ASSEMBLYWOMAN WEINBERG: While you come forward, the issue of reserves, I think, were addressed somewhat when we made the trek down to Camden at Cooper Hospital. And it was announced there that the Department of Banking and Insurance sets minimum standards for reserves, but not maximum. And correct me if I'm wrong, please.

**NEIL VANCE:** You're correct, Assemblywoman.

I think, to answer the spectrum of questions you're asking, the minimum loss ratio requirement doesn't take--

ASSEMBLYWOMAN WEINBERG: Excuse me a moment, but please state your name again for the record, so it won't be an unidentified voice from the--

MR. VANCE: I'm Neil Vance. I'm the Chief Actuary for Life and Health, in the Department of Banking and Insurance. I'm here today to answer any really technical questions that might arise.

The extra reserve funds of a carrier aren't taken into account in determining whether or not the 75 percent loss ratio is met. So in evaluating a carrier's rates, whether that carrier has a very high level of reserve funds or very low level of reserve funds would not be a consideration.

ASSEMBLYMAN MANZO: Concerning reserves, just two quick points, and I'd like your comments on them. Number one, money put in reserve, okay, for a patient or for an insured is based on a given figure on what the company anticipates might be needed to treat the person. However, if the treatment isn't over, the company is setting a premium based upon what they allocated or thought they might have in reserve, not the actual amount used to treat the patient. Does the Department keep any statistics on when the treatment doesn't add up to what was put aside in reserves, how much refunds went back to insureds?

MR. VANCE: Well, I think your question is based upon an idea about how rates are set -- that somehow the rate is matched up to a particular estimate of the cost for that patient. That the sort of analysis you're talking about does take place overall. In other words, in evaluating whether a carrier has paid out 75 percent of its premiums, at least 75 percent of its premiums in claims -- which is the only thing the Department is authorized to look at

now in terms of reviewing rates, because we don't have prior approval of rates -- the Department does consider whether carriers have correctly estimated the amounts they've set aside to pay for future claims. So--

ASSEMBLYWOMAN WEINBERG: Assemblyman Manzo, I'm going to interrupt you, because we have a lot of people who want to testify. And before we get hung up in too much of the technicalities-- We will have access to members of our own Department of Banking and Insurance to get at some of these, as we get on to some of the testimonies. So please keep your questions at a minimum, and remember there's a big audience out there with a lot of people who would like to testify.

ASSEMBLYMAN MANZO: I'll just ask for the information that I would request.

ASSEMBLYWOMAN WEINBERG: So if you could sum up. I know how strongly you feel about this issue and have been one of the prime movers in getting us to do this, but don't make sure that everybody's eyes glaze over. (laughter)

ASSEMBLYMAN MANZO: The information I'd like is, to look at to see what, in fact, was set aside for reserves for payment and what actually got paid, and whether or not the premium was based on what was set aside or actually paid. And the second thing concerning that is that insurance companies use what's put aside in reserve as a tax write-off. Okay? Technically, that money sitting in reserve, if it's not expended, in my point of view, shouldn't be used as a tax write-off, and I want to know the viewpoint of DOBI as for the -- of what a reserve should be accounted for in a holding for an insurance company.

ASSISTANT COMMISSIONER WHEELER: We'll be happy to provide that information.

ASSEMBLYMAN MANZO: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway, and then Assemblywoman Vandervalk.

ASSEMBLYMAN CONAWAY: Just to put -- a point of clarification. Could you tell me, because I know there's legislation floating around on this issue -- and that is, what audits of health insurers does the Department perform to verify the financial information that is submitted to them, if any?

ASSISTANT COMMISSIONER SIMON: We do financial examinations of insurance companies every three to five years. Those are done by our Financial Solvency Unit. We also do market conduct examinations, which focus on payment of claims to make sure claims are processed accurately. I believe those are more like once every five years. The financial exams follow the standards of the NAIC. There's a strict format. There's a handbook that the examiners have to follow, and the exam reports are all made public.

ASSEMBLYMAN CONAWAY: On the market exam portion of it, there's rules set for that?

ASSISTANT COMMISSIONER SIMON: Yes. The market conduct also follows the handbook. I don't think they're as -- they're not as frequent as the financial examinations, but at the conclusion of that exam the report is also made public. And the Department might take certain actions if

the report shows the company is not paying claims properly. There might be a fine or a remediation plan.

ASSEMBLYMAN CONAWAY: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Vandervalk, and then Assemblywoman Quigley.

ASSEMBLYWOMAN VANDERVALK: My question was just answered.

Thank you.

ASSEMBLYWOMAN QUIGLEY: I have two quick, non-technical questions. When you mentioned that the administrative costs are involved in this loss ratio, the administrative costs will include all costs including bonuses and salaries for the heads of the plans?

ASSISTANT COMMISSIONER SIMON: That's correct.

ASSEMBLYWOMAN QUIGLEY: So they can be adjusted, if necessary? I'm then curious as to, in your experience, or you can tell us over the last five or 10 years, how many health insurance companies have actually given refunds to their premium payers?

MR. VANCE: We don't have-- I don't have that information at my fingertips. In recent years, the number of carriers giving refunds has been relatively low. Last year, two major carriers, and three smaller carriers in the approximately 20- or 25-carrier, small employer market paid refunds. And I believe one or two carriers in the individual market paid refunds. The Department, and the SEH and IHC boards, do have this information. They can get it to you.

ASSEMBLYWOMAN QUIGLEY: Thank you.

ASSEMBLYWOMAN WEINBERG: Okay. Let me clarify one number, then give Commissioner Simon two numbers. You said the year 2003 -- it was \$7.6 billion paid in claims -- I mean, paid to the insurance market -- and that covered all insurance?

ASSISTANT COMMISSIONER SIMON: No. It was 7.6 in premium, 6.1 billion in claims.

ASSEMBLYWOMAN WEINBERG: Okay. The 7.6 in premiums covers the entire insurance market?

ASSISTANT COMMISSIONER SIMON: Large group, small group, and individual -- the 28 percent.

ASSEMBLYWOMAN WEINBERG: And that's for the year 2003?

ASSISTANT COMMISSIONER SIMON: Correct.

ASSEMBLYWOMAN WEINBERG: Thank you.

ASSEMBLYMAN COHEN: Thank you.

I had to step out for a second, but how do you calculate the number of uninsured, unless that's been asked and answered already?

MR. VANCE: The estimate of the number of uninsured comes from the Federal Government. It comes from the current population survey. So we use that number directly.

ASSEMBLYMAN COHEN: The numbers come from the Feds?

MR. VANCE: That's correct.

ASSEMBLYMAN COHEN: And what is their survey? Is it part of the census survey, or is it census data?

MR. VANCE: The current population survey, if I remember correctly, is a separate function of the Census Bureau that gets information annually. So it's not part of the every 10-year census. But it is a survey of a portion of the population, to get a number of different economic statistics and--

ASSEMBLYMAN COHEN: So this is polling?

MR. VANCE: Well, they would probably say *sampling*.

ASSEMBLYMAN COHEN: It's polling. So my question is, so we don't have the survey that -- other than is an estimate, correct?

MR. VANCE: That's correct.

ASSEMBLYMAN COHEN: So if you don't have a phone or you have a cell phone, you're not going to be contacted, correct?

MR. VANCE: I think the survey is done in person. I, in fact -- just as a personal note, I, in fact, was -- when I was much younger, my household was interviewed as part of the survey.

ASSEMBLYMAN COHEN: Could you find out for us how many people were sampled in New Jersey, number one?

MR. VANCE: We can make the entire survey available to you.

ASSEMBLYMAN COHEN: And also, what is the breakout in terms of the uninsured? I mean, does the uninsured include people who are here not legally? Does it include -- I'm not sure exactly what it may or may not include. I'm trying to get some kind of breakout of what the uninsured categories are between women, children, those who are over 18. Does that include people who are on COBRA for 18 months? I don't need the answer now, but I'm looking for some kind of breakout whether that's-- How does 1.2

million of uninsured -- has been calculated, and who it represents in the categories or subcategories?

MR. VANCE: Okay. In addition to getting you more information about the Federal survey, I think some additional studies have been done, and we'll get those for you, too.

ASSEMBLYMAN COHEN: Sure.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway, for the last questions.

ASSEMBLYMAN CONAWAY: Thank you, Madam Chair.

As I understand it, the Department of Banking and Insurance had formed some three task forces looking at the uninsured insurance reforms. I'm not aware of the, I guess, work product of those task forces. Have they completed their work? If they have, have they made their reports public? And certainly, if they have and their report's available, I'd like to formally request that those be submitted to the Committee.

ASSISTANT COMMISSIONER WHEELER: Yes, Assemblyman. We actually have -- each of the three working groups prepared a statement of deliberations. They made no recommendations. There are no -- it's just a statement of the deliberations, of the issues they discussed. All three are public, and we'll provide them to the members of both Committees.

ASSEMBLYMAN CONAWAY: Well, that just led to a follow-up question. A statement of -- I'm sorry?

ASSISTANT COMMISSIONER WHEELER: Deliberations.

ASSEMBLYMAN CONAWAY: Of deliberations. Are they going to produce a report or not?

ASSISTANT COMMISSIONER WHEELER: Well, that is the report.

ASSEMBLYMAN CONAWAY: With recommendations or not?

ASSISTANT COMMISSIONER WHEELER: The report is essentially a list of the issues that were discussed and, sort of, all the different viewpoints in those issues.

ASSEMBLYMAN CONAWAY: Thank you.

ASSEMBLYWOMAN POU: Madam Chair?

ASSEMBLYMAN COHEN: Any questions from the Financial Institutions side?

Assemblywoman Pou.

ASSEMBLYWOMAN POU: Thank you, Mr. Chairman.

I just had a real quick question. I wanted to know, in terms of the calculation, how is the calculation based upon any changes in the clinical delivery of medical care? For example, as we are now moving into some new technological changes in terms of medical care, how does that take into effect -- in the calculation. And is it, in fact, being provided or equated, in terms of what that actual cost is to the provider?

MR. VANCE: Is your question about the payment made by carriers to providers, or about how carriers calculate their premiums?

ASSEMBLYWOMAN POU: The question really comes -- is, I'd be interested to see -- as we are now moving, in terms of changing and advancing with new clinical standards, in trying to provide better and more advanced medical care -- how is it calculated from a financial point of view, to

ensure that those providers are being provided the type of benefit or cost to them -- the reimbursement end of that?

MR. VANCE: I hate to duck a question, but I think the carriers themselves might be in a better position to describe how they calculate their rates and how they take those kinds of advances into account.

ASSEMBLYWOMAN POU: Is it, however, taken into account-- Is there a part or a place where the insurance -- where you as the regulators looked to see, to make sure that those kind of care are being provided for, or benefits are, in fact, being adequately provided to those providers?

I see people in the audience shaking their heads no. And perhaps I'll differ to your statement that perhaps someone in the audience came better prepared, and answer that. But I just think it's-- Obviously, this is--

Madam Chair, Mr. Chairman, I know, as we're moving-- And many of the hospitals -- certainly St. Joseph's Hospital, being one of the leading hospitals, certainly, in this area that is constantly looking to change it, and improve its clinical standards and improve its delivery of care. How do we ensure that they continue to do that, but at a cost that is, indeed, calculated as part of a coverage within our insurance provider? So I'm just interested to see, how does that fall into play? So I don't know who has the answer to my question, but if anybody out there does, perhaps at that time someone can respond to it.

Thank you.

ASSEMBLYMAN COHEN: Any other questions from either Committee? (no response)

Seeing none, thank you very much, and I'm sure we'll be in touch.

ASSEMBLYWOMAN WEINBERG: Thank you.

ASSISTANT COMMISSIONER SIMON: Thank you.

ASSEMBLYMAN COHEN: And now that we have, technically, three chairs -- the representative of the AFL-CIO, Mental Health Association, and Physicians for a National Health Plan, come to the microphones?

ASSEMBLYWOMAN WEINBERG: We're calling you up in groups of three. So we just called the first three groups. You're looking kind of quizzical here.

UNIDENTIFIED SPEAKERS FROM AUDIENCE: We can't hear.

ASSEMBLYWOMAN WEINBERG: Oh, that's a good reason to look quizzical.

Okay, Neil.

ASSEMBLYMAN COHEN: Now that we have three chairs, one could be returned back.

The representative from the AFL-CIO, the Mental Health Association, and Physicians for a National Health Plan, if you could come forward.

ASSEMBLYWOMAN WEINBERG: What we would like is, if three of you could come up at once -- the other two groups that Assemblyman Cohen called.

ASSEMBLYMAN COHEN: Are the two groups here? The other two groups, are they here?

ASSEMBLYMAN STEELE: Madam Chair, maybe they didn't hear their name. Could you just state it again?

ASSEMBLYMAN COHEN: The representative of the AFL-CIO, Jim Wrich; the Mental Health Association, Kathy Chin; and Physicians for a National Health Plan, Dr. Richard Pierson.

Thank you.

Who would like to go first? State your name?

**JAMES T. WRICH:** I guess I've been elected.

My name is Jim Wrich, and I represent the Office and Professional Employees International Union of the AFL-CIO. And I'm here to testify with regard to loss ratio legislation in the mental health/chemical dependency treatment arena.

I think the earlier definition that was given of loss ratio was excellent. It's really an insurance industry term that denotes the portion of premium that an insurance company pays out in claims. And in the health care arena, loss ratio represents the percentage of premium that is spent on direct patient care. That needs to be distinguished from expense ratio, which includes all of the expenses -- claims, plus administration, and other expenses such as marketing and debt reduction.

When the expense ratio is less than 100 percent, an insurer makes a profit. When it's more than 100 percent, an insurer loses money. The loss ratios that were cited earlier -- I made note for the groups -- the various groups here in New Jersey are consistent with what we have found in providing consultation to our customers. I should say that, in addition to representing the AFL-CIO, I have my own consulting firm. It's J. Wrich & Associates. It's a health systems performance company where we do evaluations of health systems. And in the course of that work, we have been asked to do

performance audits of managed behavioral health-care companies. Managed behavioral health-care companies function in much the same way as a medical HMO does, except they focus on mental health and substance abuse services.

And what we have found in conducting those audits is that instead of the 75 to 83 percent loss ratio percentage that you normally find with a medical HMO, what we have found have been much, much lower. And we believe that legislation is appropriate to cause managed behavioral health-care companies to disclose their loss ratios. Organizations that purport to assume risk when they're providing health services, we believe, have a public trust -- that they will, in fact, provide care and not simply pocket the money or spend it inappropriately. And this trust requires accountability, and that, in turn, requires crucial information. But having the information is one thing; making it accessible to the public is where you create transparency. We have a saying that transparency lights the pathway to accountability.

Just very briefly, the first performance audit we did was in 1992. A major state asked us to come in and review the managed behavioral health-care services that were provided by one of the big managed care companies for the employees of this state. And in 1995, the *Wall Street Journal* did an article in which they quoted this study under the Freedom of Information Act. The findings were really a shocker to us and to everyone else. First of all, utilization was overstated by 45 percent. Delays in care delivery in excess of the providers own standards were, like, 300 percent higher. It took -- instead of 4.2 days, which was their bonded average, it took about 19 days before anyone got the care that they needed.

Failure to evaluate and treat substance use disorders: in not only that audit, but in subsequent audits in which we have been enlisted by employers, primarily -- and the audits have been done of managed behavioral health-care companies representing about 70 million people across this country -- we have found that in the best case, 55 percent failed to evaluate, diagnose, and treat substance use disorders. In the worst case, it was 78 percent. Failure to evaluate and treat psychiatric disorders ranged from 4 to 9 percent. Instances in which the patient had not received care within three months of initial contact, due to authorization or administrative delays, clinical delays sometimes, 4 to 26 percent. And failure to refer a patient to a provider with a specialty in the diagnosed disorder, 4 percent to 13 percent. Failure to follow up, 6 percent to 79 percent -- a huge, huge problem there. Failure to follow up with patients who were at risk -- those who were on medications, those who were suicidal, those who may have been homicidal -- up to 19 percent.

The treatment, in many instances, was limited to what's referred to as an Axis I diagnosis, which means that various personality disorders were excluded -- obsessive-compulsive disorder, mental retardation. But probably the most serious problem in the placement criteria was a prerequisite treatment failure at a lower level of care. In other words, you had to be treated at an outpatient level before you could get anything above that, and you had to have failed. Nowhere else in medicine is that done. I mean, that's like saying, out here on Main Street, if somebody has a terrible car accident and one of the passengers is hanging halfway out the door with their head split open and their leg broken, the paramedics come and they ask, "Have you been treated on an outpatient basis for this? We can't take you to the Emergency Room until

some lower level of care fails.” When you’re dealing with chemically dependent people, people who are depressed, who are suffering from an anxiety disorder, a lot of times you don’t get that second chance. You have to get it right the first time.

Attempts to harm self within the previous 24 hours -- in other words, an attempt at suicide -- if it had happened 36 hours ago, it didn’t qualify. Attempt to harm another person within 24 hours. Significant action to damage property with high lethality. So if a kid who is having serious emotional problems sets a bomb off in his school on a weekend, if nobody is in the school, there’s no chance of high lethality. Conduct disorders are not included.

ASSEMBLYWOMAN WEINBERG: Mr. Wrich, your reaching, yes, your time limit.

MR. WRICH: Am I going-- Okay.

ASSEMBLYWOMAN WEINBERG: And I know that this is a particular area of this whole issue, and an area in which we in the Health Committee have heard. So if you would wrap up--

MR. WRICH: I’ll wrap up in 30 minutes -- or 30 seconds, excuse me. (laughter) It was a slip.

We thought maybe they weren’t being paid enough. We thought maybe the premiums had to be higher. But what we found was that typically the loss ratio was between 36 percent -- that was the worst -- and 55 percent of premium. And when we look at the manner in which the mergers and acquisitions were carried off, the amount of money that’s left after debt and debt service, and administration and profit computes to about 38 cents on the

dollar. So we believe that it's in the public interest to know what the loss ratio is. We think if you're an employer or a union, or even an individual, you have a right to know which company is doing a good job in this area and which is not.

ASSEMBLYWOMAN WEINBERG: Thank you.

Assemblyman Manzo.

ASSEMBLYMAN MANZO: Mr. Wrich, thank you.

At the Health Committee, we had asked you if you could do some statistics on the -- not the mental behavioral side, but on the regular health side. Are you still in the process of doing that?

MR. WRICH: I'm sorry. I didn't quite get the question.

ASSEMBLYMAN MANZO: At the Health Committee hearing, I had asked if you would put some statistics together on the health side, exclusive of what you've done for the mental health behavioral side, as far as loss ratios. Have you been able to--

MR. WRICH: Yes. There's actually quite a bit of information in the loss ratios for typical HMOs -- are around 83 percent. For Medicare, Medicaid, the loss ratios are above 90 percent. In large groups, such as General Motors, the loss ratios are around 90 percent. They have some economies of scale. For small groups, it's lower. It's around 75 to 80 percent. And in large measure, that's because small employers sometimes use the insurance company to perform functions that would normally be done by a human resource's department.

ASSEMBLYMAN MANZO: One final question. The experiences which you've described as the patient not being able to get to another level of

care, are these decisions being made by doctors or people with an understanding of the condition, or are these being made by managed care gatekeepers with no medical background?

MR. WRICH: They're being made by managed care gatekeepers, and frankly, the medical background or the background in mental health and substance abuse is mixed. Some states, like Minnesota, have passed what is euphemistically referred to as privilege and criteria, where the people who are making those decisions for the insurance company have to meet the same -- they have to have the same credentials equal or better than those who are actually delivering the care.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: You mentioned that in your examination of behavioral health and the way that works, that there seems to be a problem with the way mental health services and behavioral health services are delivered. Now, in your review of this area, is it true or not that the large insurers hire Magellans -- I hate to use that word, but behavioral health-care companies, to use a more general term -- to do this work for them?

MR. WRICH: Yes.

ASSEMBLYMAN CONAWAY: And in your opinion, if you hire somebody to do a job, don't you have some responsibility over the way that they are doing that job? Where do you think the responsibility lies, if you will, for making sure that the quality of work being done by behavioral health providers is to a standard that we in society would expect?

MR. WRICH: Well, I think the responsibility lies essentially in two areas. It certainly lies with large insurance companies who employ

managed behavioral health-care companies on a subcontract basis. And one of the interesting things about loss ratio is, sometimes they include the whole price of the contract -- the large insurance company does. It includes the whole price of the subcontract to the managed behavioral health-care company as a part of their loss ratio, when maybe 60 percent of it is administration and not clinical. So things get skewed here. But there really isn't much in the way of outcome evaluations, and there really isn't much in the way of rigorous performance audits that are being done either by the employers or by the major insurance firms that employ managed behavioral health-care companies.

ASSEMBLYMAN CONAWAY: Madam Chair, if I may. You have mentioned loss ratio and expense ratio at the outset, and then talked a lot about loss ratio. Which of those numbers -- should we be using both of them, should we focus on one more than the other, what's your view of thinking about possible legislation coming forward? Which of those numbers should we focus on?

MR. WRICH: You should focus on loss ratio, because that's the percentage of premium that's actually paid out in direct care. And the legislation that is in the House right now, 2976, does a good job of defining what loss ratio is. There is a tendency on the part of the managed behavioral health-care companies to include the cost of utilization review and of their other staff in with the claims, simply because the review is being done by a clinician. Well, that's really an administrative function. The patient isn't benefitting directly from that. So loss ratio should be the amount of money that is paid to the direct providers of care for substance abuse and mental disorders.

ASSEMBLYMAN CONAWAY: Two more questions, if I may? Two quickies, I think they're quick. I'm pretty sure they're quick. One is, how do you suppose that this overutilization number is produced? What is being done wrongly? Because utilization is an important number. It affects our regulatory activity here. There's a great deal of concern that if we do some kind of a mandate on mental health, that because utilization is some X large number that, therefore, the costs will be enormous and therefore we shouldn't entertain any helpful regulation in this area. So I was wondering how -- why this number is inflated; how we got to that. And two -- I'll ask it now, so I don't ask again. (laughter)

ASSEMBLYWOMAN WEINBERG: You ask it now, because you won't get a chance otherwise. (laughter)

ASSEMBLYMAN CONAWAY: You mentioned, and I'm going to ask other people when they come up, that when you look at-- There's a difference clearly, according to your own paperwork here, your own testimony, between the loss ratios of Medicare and the loss ratios of commercial insurers. And this is a subject -- I've asked people this before and I'd be interested in your view of why there's such a large difference between how Medicare is able to operate with its large group and large insurance that have millions, many of them millions of beneficiaries in them, why their loss ratio is, why their administrative costs are so much higher?

MR. WRICH: Okay. The answer to the first question: They double count in a number of ways. One company issued a new case number every time a therapist would call in for authorization to deliver additional care. And what they do, of course, is they parceled out the care. So if I was the

patient and my therapist called and said, "I'd like to provide five sessions," they'd say, "Well, start with three." And then the second time they called in to get authorization for an additional two sessions, a new case number would be assigned to me. That was one way.

A second is that people who re-enter the program, who come in later for a second condition, or who are just coming in for follow-up, they get a new case number. So the only real way of doing this, I think, is to issue one case number to one person and they have that case number for as long as they're part of the plan. And if they come in for subsequent services, you differentiate those who come in as re-entries from those who are initial patients.

With regard to why is the loss ratio lower for Medicare, Medicaid, it's a single-payer, uniform benefit. And in doing an analysis of our situation in Wisconsin, three years ago I did a study for Wisconsin Citizen Action. We were spending 29 billion a year overall. And you're probably spending 40 billion a year overall with the regulated and the unregulated here in New Jersey. We found that with a single-payer plan or maybe a double-payer plan -- one for private, one for publicly funded health-care beneficiaries -- we could save a billion dollars a year just by eliminating-- And what that means is that you'd have the higher loss ratio.

ASSEMBLYWOMAN WEINBERG: And that is the perfect segue to our next speaker--

MR. WRICH: I thought he might appreciate that.

ASSEMBLYWOMAN WEINBERG: --but if I have to sum up some of the things that Mr. Wrich pointed to us, that perhaps performance

audits are extremely important in this area in terms of finding out what's really going on.

Mr. Wrich, thank you. I know you traveled far--

MR. WRICH: My pleasure.

ASSEMBLYWOMAN WEINBERG: --farther than from Trenton, to come and speak.

Dr. Richard Pierson, who is a Professor of Clinical Medicine at Columbia University, and is going to speak on the single payer.

**RICHARD N. PIERSON JR., M.D.:** The concept of the single payer is, indeed, best understood by saying how does Medicare work.

ASSEMBLYWOMAN WEINBERG: Dr. Pierson, excuse me. It's the largest microphone in the middle that's the amplifying one. So if you'd use that, thank you. (referring to PA microphone)

DR. PIERSON: The concept of single payer is my basic point. One should say that, well, why am I not in Washington rather than in Trenton or in Paterson to make this point. However, that's the way I have to make it. Because until we change the structure of how health care is financed on a broad basis, we don't accomplish the benefits which could be accomplished. And the simplest way to describe them is the benefits of Medicare.

A little over 15 percent of the gross domestic product in this country is being spent on health care. The highest anywhere else in the world is about 11 percent. Our story is briefly that until we can -- and I represent about 12,000 physicians who have put this argument together -- until we can make a national health insurance, which is very like Medicare in its structure,

we are going to be wasting about a third of the money which is being spent on health care.

Of my medical school class, which will have its 50th anniversary in a couple of months, all of the people -- 78 survivors -- 72 of them were in practice and eight of us are academics. The 72 that are in practice, only one is still in practice at age 75. Of the academics, all but one are still in practice. Why is that? It is deeply related to the health-care storm, the perfect storm in health-care payments, which have been described in some detail by my colleague, and indeed, those points are exactly relevant.

The single-payer system does the following: It adopts the existing Medicare logic, continued private ownership of hospitals, physician practices, and ancillary health facilities -- dental, mental health, prescriptions, etc. It requires free access for all patients to all providers. The 45-plus million uninsured in this country, on the day when single payer is passed for everybody, go away. There are no longer 45 million people who don't have access to care. And of course, they do have access to care. They come to St. Joseph's Hospital and Columbia Presbyterian Hospital without insurance, and they come much later than they should, much sicker than they should, because they have not had access to the preventive medical care and are coming with the first symptoms, rather than with the fatal symptoms -- which so frequently increase the death rates -- to where we are losing, by some analyses, around 100,000 deaths per year in this country of people who didn't need to die, had they been cared for in a timely manner.

The cost of national health insurance would expand from about 25 percent of the population, Medicare, to 100 percent, and the cost would

increase very substantially. However, predictions of the net actual cost, according to both the General Accounting Office and the Congressional Budget Office, are budget neutral, because of offsets and savings from reduction of costs, which are accomplished because the insurance company profits and overhead disappear. Private health insurance is eliminated. The billing systems in hospitals and in physicians' offices diminish by a factor of two-thirds, and this makes for a lot of unemployed people in the insurance industry. However, many of these people who are unemployed are nurses who could be back taking care of patients, instead of being gatekeepers, often ineffective gatekeepers, as my colleague has described.

The net savings were projected in 10 states by Lewin Associates and objective analysis. These have not been done for New Jersey, and I don't know whether New Jersey has asked for this analysis. But it seems to me that this is relevant to our current discussion. Fundamentally, the fiscal argument is that of offsets, which are accomplished by savings on insurance company profits, on HMO profits. Making health care go for-profit has turned out to be disastrous in terms of the costs of providing health care. And the best way to say that is the difference between 15-plus percent of the gross domestic product and about 10 or 11 percent, which we could accomplish simply by switching systems.

How we get from where we are to there is a very complicated question. And I think it's not going to be done at statehouses. But I think if the facts are heard and understood by people who are in government, I think that that is the first step to get where we need to be. And I will simply close

by saying that universal access, universal comprehensive coverage is a system for which the time has come.

ASSEMBLYWOMAN WEINBERG: Thank you, doctor.

Assemblywoman Vandervalk.

ASSEMBLYWOMAN VANDERVALK: Thank you.

It's very interesting testimony, but the testimony is really directed to the Federal Government at the Federal levels. We are State officials. And so, as was pointed out earlier, only about 25 percent, or 28 percent I believe, was the number of people are covered by the laws that we make in the health field in our state. Are you suggesting there's anything a state can do absent the Federal action?

DR. PIERSON: I am politically naive. I think, as I heard my colleague say what he did, this is exactly correct, that the points that I'm making have to be made on a national level. However, the principle of where the for-profit has taken health-care payments must apply in the states as well. And if we can find a mechanism for saying that for-profit health care is a failing system, it has resulted in a failing system -- whether that can be operated on the state level, I don't know.

ASSEMBLYWOMAN VANDERVALK: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Munoz.

ASSEMBLYMAN MUNOZ: Thank you.

Without knocking over the water, I actually agree with some of the things you're saying, Dr. Pierson, but I will give you a few caveats. The first is, I was part of the failed plan in the '90s, that I'll call a circus, but got into some of the things you're talking about -- universal coverage. And that was a

good lesson for the United States of what actually happened if you really do try substantial change. And I would also mention, when you use the word *for-profit*, okay, the president of our Senate in the United States happens to come out of “for-profit.” So you have to be real careful. I’m a surgeon. Do I work for profit? I work. I do operations. I get money for it. So you have to be extremely careful what the word for-profit means. Because when you say you’re politically naive, I agree 100 percent.

The single greatest problem we face in the United States is the fact we’re New Jersey.

ASSEMBLYMAN COHEN: You agree that he’s politically naive, or do you agree on for-profit? (laughter)

ASSEMBLYMAN MUNOZ: Well, he’s a doctor. He’s got to be somewhat--

ASSEMBLYMAN COHEN: Be very careful, Dr. Munoz.

ASSEMBLYMAN MUNOZ: Is 16 percent-- Right now, the different figures -- 60 percent of our economy is going into health care, and the figures are 20 to 25 percent. Now, the bad news is, for the economist, everything else has to get smaller. It means if we spent 22 percent of our GNP on health -- that means education, roads -- all the rest get less. It is a national or (indiscernible) problem. How do we stop that? Is there any way to stop it? Years back, I actually got a graduate degree from your institution, and I’m not so sure-- When I was younger, I thought that it could be stopped. Now that I’m older, I’m not sure it could be stopped.

So, thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gordon.

ASSEMBLYMAN GORDON: Thank you, Madam Chair.

A question for Mr. Wrich. As you know, we are considering legislation in the Assembly to make public the loss ratios for these behavioral firms. That assumes that somehow public knowledge will lead to accountability and mitigation of the problem. Do you think we need to go beyond that? Do you have any recommendations on how we can deal with some of the problems you cite -- of lack of care, delay of care, and so on?

MR. WRICH: Yes. I think standards are very important. You can't really control outcomes unless you're looking very carefully at the process. There are some types of treatment that have been characterized as sacred cows that are outdated and so on, one of which is the 28-day chemical dependency treatment model, which, by the way, was not developed by the treatment industry. It was mandated by insurance companies. Back in 1974, I was involved in that. I think just making those who are receiving the money disclose what it is, exactly, they're doing. I think placement criteria are extremely important. I think that that's something that you could, in fact, have a hand in legislating.

I do think that a lot of what we try to do, whether it's looking at loss ratio-- I mean, you're only seeing the tip of the iceberg here. You're seeing what the insurance company pays to the providers. It doesn't take into account the administrative costs that the providers incur in trying to comply with the mandates of the managed behavioral health-care firms. If that was factored in all across the board, you'd probably find that except in the case of Medicare/Medicaid, again, you'd probably find that the real loss ratio, the real amount of money that's being expended on direct care might be down to

around 50 or 60 percent for medical-surgical HMOs and down to around 20 or 30 percent for managed behavioral health-care companies. But it's a start. It's a start. It does differentiate those companies that have higher loss ratios from those that don't. That indicates that they're putting more money into treatment, less money into administration.

If you make a comparison of HMOs to self-funded indemnity plans and you compare like enrollees, as we did for the state of Vermont, you may find that the self-funded indemnity plans actually cost less and deliver more care. So there's a lot that can be done. It can only be done, however, if somebody is motivated to look at it.

ASSEMBLYMAN GORDON: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: To the good doctor, you mentioned moving to this, sort of, national system. How many in your study of this -- what kind of number do you need to have, in terms of beneficiaries, to have, let's say, an experiment that might go forward? I say this because, and I view states as being the -- what do you call it -- the test tubes of democracy and trying things at experimentation -- laboratories, there you go -- of democracy and various ideas. And why can't a state that has -- if it can bring, say, a million persons into a single-payer program -- state governments are large, a lot of employees, a number of uninsured working people out there -- what kind of number would you need to get an experiment like that off the ground? You've got a lot of data sitting in the Medicare Department, for instance, that could be transferred to the state. You don't have to recapitulate everything. We know there's a computer system that manages the payments

on the Medicare, as an example. So what are your thoughts about what kind of number you need to get an experiment started at the state level?

DR. PIERSON: A very interesting analogy can be made. Saskatchewan, one of those states up to the north, was the first one in Canada to start with a generalized health insurance system, and they preceded by seven years the next province of Canada to go in that direction. And then it took about five years for all of the other provinces to join. Saskatchewan, because their provincial system -- and it's conceivable that the state system is an analogy -- really did control-- Each of the provinces controlled its own insurance, controlled it's own health care. And they managed with quite a socialist governor -- they don't call them governors -- to put in a system which is very successful. And very quickly, other Canadians were jealous of what Saskatchewan had accomplished. And in the course of about 12 years, the rest of the country became nationalized. That was 1962.

So there is a precedent for trying it in a smaller area and then expanding it to a larger area. The state of Maine probably comes closest to having a national health insurance right now. The answer would take far more time than we have. But the state of Maine is interestingly different from other states in many ways. One of them, it's a very poor state. And the poorer you are, the more you benefit from efficiently using your resources.

MR. WRICH: If I could just make a brief comment? The state of Maine has only about 700,000 people. Saskatchewan, I think, has less than a million. The economies of scale on this are not 290 million people. Physicians for a National Healthcare Plan obviously favor a national health-care plan. But the State of New Jersey could have a uniform health-care

plan and eliminate the 1.2 million who are uninsured, just as we could have eliminated the 500,000 in Wisconsin, and actually spend less money.

ASSEMBLYWOMAN WEINBERG: We do have information that we've been given on the state of Maine plan.

Assemblyman Manzo.

And then that's the last question. I'd like to move on.

ASSEMBLYMAN MANZO: Picking up on that point, and what Assemblyman Conaway was talking about for the uninsured in our state, look at what we expend in charity care money and what we expend in our portion of Medicare supplemental. At one point -- what was it -- 8 million uninsured that our figure was about -- an estimate-- No, in New Jersey.

ASSEMBLYWOMAN WEINBERG: Our figure in New Jersey -- 3 million.

ASSEMBLYMAN CONAWAY: One-point-two million.

ASSEMBLYMAN MANZO: One-point-two million. If we were to configure or mandate that companies provide a policy that utilizes hospitals as the caregiver in regions, would there be a substantial savings in the amount of money that we expend, and can we insure more people?

DR. PIERSON: You have to establish a global budget for hospitals and for physicians. And in the countries where this has been done -- and there are many -- this is something which is done between physicians and the insurance industry, etc. I don't know whether a single state could establish a global budget to take care of the hospital needs, but I'll bet that the man who introduced -- from St. Joseph's -- would say that his hospital is on the verge of being in the red. In Manhattan, New York County, 26 of 28 hospitals are in

the red. The system, as it's working, is not paying -- take away the charitable donations that make up the difference -- is not paying for the care we're providing even now. And in our view, this is strongly due to the inefficiencies of the current for-profit system. And I think my colleague has more background in that area.

MR. WRICH: Well, not only charitable care, but bad debt. If you combine what hospitals and other providers are unable to collect, it's a very large amount of money. But once again, I don't know how many different plans there are in the State of New Jersey. In Wisconsin, there's about 400 different health-care plans. I mean, the administrative cost of that is enormous. You could fashion it after Medicaid or Medicare. Maybe you'd want to have some kind of cost sharing, of course, between the beneficiaries and the employers. But when you look at the whole picture, there's an awful lot you can do on a state level. And utilizing the resources in a manner that best suits the State of New Jersey is where you would have to start. And that's one advantage that you would have doing it as a state -- that maybe you have, maybe you wouldn't have -- if there was a universal national health plan. That's not to speak against a national health-care plan, but I do think that you'd have a better shot at it.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

We're going to hear from some of the stakeholders now.

Gentlemen -- Doctor, Mr. Wrich -- thank you very much.

DR. PIERSON: Thank you.

MR. WRICH: Thank you very much.

ASSEMBLYWOMAN WEINBERG: The New Jersey Medical Society, the New Jersey Hospital Association, and Horizon Blue Cross Blue Shield.

Remember, the smaller microphone is for the transcript; the bigger one is to amplify in the room.

Start, please, by stating your name and who you represent.

**MICHAEL KORNETT:** Thank you very much, Chairman Cohen and Chairwoman Weinberg, for allowing us to testify today. We'll keep our comments brief, and hopefully we'll get appropriate questions and supply answers. We have not coordinated our comments with--

ASSEMBLYWOMAN WEINBERG: Your name and--

MR. KORNETT: My name is Michael Kornett. I am the Executive Director and CEO of the Medical Society of New Jersey. I represent thousands of doctors in the state and millions of patients that they treat. And by way of background, I have 30 years experience in the State of New Jersey -- half the time spent as CEO of two major hospitals in the State of New Jersey, and I was a founder and CEO of two managed care companies that were multi-state but did business in the State of New Jersey. So I have a distinctive view on how the system works, and I know where the money is and I know where it isn't.

ASSEMBLYWOMAN WEINBERG: Well, good. If you just give us that in short notes--

ASSEMBLYMAN CONAWAY: We're done. (laughter)

MR. KORNETT: I'll get to that. Admittedly, years ago when managed care started, there were a lot of efficiencies and the public benefitted

from the early years of the implementation of managed care. Policy premiums were relatively affordable. More patients gained reasonable access to health care. And physicians and providers received reasonable compensation, which is no longer the case. The only efficiencies that managed care companies are concerned with involves market share, monopolistic power, and profits. The goal is to dictate -- no, make that *restrict* -- health care for business purposes. Shareholder value reigns supreme over patient value.

Patients are now referred to as members, physicians are now called providers, and the true customer, even though they are intermediaries, is the Wall Street analyst that follows and reports on the value of the stock on a regular basis. In managed care, we live from quarter to quarter, and the conversation always focused around hitting the numbers.

Twenty-odd years ago, there were over two dozen health-care plans in the State of New Jersey. Some were privately held or sponsored by hospitals and doctors, or combinations thereof, but those days are gone. The health-care insurance market continues to consolidate at a rapid pace. If you follow the trend, more than 300 mergers have occurred in health-care insurers and managed care organizations just between 1995 and the year 2001. Several months ago, here in the State of New Jersey, we allowed United Healthcare and Oxford to merge. More than half of all the commercially insured Americans are now covered by the 10 largest health insurers, and it will be worsened as the business model of gaining market share by merger, or what we call a *roll-up philosophy*, will continue to be unabated.

In New Jersey's northern counties, the combined merger of Oxford and United now represents 40 percent of the commercially written insurance

policies. And incidentally, United is a Minneapolis-based holding company that has had 47 acquisitions in the last five years and has a net worth double that of the budget of the State of New Jersey. So you're really dealing here with powerful forces.

Consider the opposite tactic taken by Aetna, which slashed membership and revenue as a way to boost profits and margins to record levels. In 1999, Aetna cut its enrollment from 21 million members to 13.3 million. In other words, they got rid of their unprofitable book of business. Those 8 million members who lost their coverage likely ended up with higher-priced plans with other insurers, or probably joined the ranks of the uninsured. When Aetna's revenue dropped 33 percent between Fiscal Year 2000 and 2003 because of that maneuver, its profit rose 603 percent, from 127 million to 938 million. And its profit margins went up tenfold.

The question should be asked: What has this meant to the health-care consumer? Dominant health-care insurers use market power to increase premiums, decrease payments for medical services, and to generate higher profit levels. The health-care insurance industry, dominated by large firms, increased health-care insurance premiums at double-digit rates in the years 2001 to 2004 -- 11, 13, 15, and last year, another 11 percent increase. And there's no end in sight to these increases, which were greater than the level of general inflation and medical inflation combined, and greatly outstripped employee compensation. Administrative costs and profits have risen even faster.

We all know the cost increases are a tremendous burden for our employers, forcing them to shift more of the burden onto the employees or to

drop coverage completely. The end result is that the number of uninsured has increased significantly with no remedy in sight. And insurance rates don't have to be so high. As publicly traded entities, managed care companies strive to make higher profits, not to provide affordable or equitable health insurance. Given the relative saturation of covered lives in this country, the only way to increase profits is to merge, to deny payments to providers, and to deny covered services to patients.

The 2002 pre-profit margins of the 10 largest companies publicly traded in this country average \$4.9 billion. In 2002 alone, the profits grew 50 percent, compared to the previous year. And the first quarter of 2003, profits were increased 42 percent over the first quarter of the previous year. And we have every reason to believe that this trend will continue. Further, extraordinary amounts of money are being diverted to CEO compensation. Managed care CEOs are now some of the highest paid executives in this nation. By example, a very relatively small regional player -- the CEO of Oxford Health Plans -- in 2002, received a total compensation package of \$76 million. The money was paid to one man, and not to say what was paid to other senior members, board of directors, and other insider investors.

The CEO of United Health Plans is one of the most highly paid, if not the highest CEO in the country. In 1998, he earned 23 million; in the year 2002, 54 million; 2003, 63 million. And at the end of Fiscal Year 2003, his unexercised stock options had the value of \$557 million.

ASSEMBLYWOMAN WEINBERG: We obviously found where we can go to balance our budget this year. (laughter)

MR. KORNETT: I'm going to skip ahead. Let me tell you where the money is not going. It's not going to the physicians. It's not going to the persons who provide patient care, and it's not going for preventive care. And it's not going to make insurance affordable, and it's not going to help the uninsured. And in the end, managed care, as I see it -- and I've worked in it and I know it -- is running out of road. It's an end-sum game. It probably has a life of three-to-five years before it frustrates all employers, health-care providers, and the public at large.

And now I'd like Dr. Patricia Klein, who is a practicing neurologist, to give the physicians' point of view.

**PATRICIA KLEIN, M.D.:** Thank you, Mr. Kornett. Thanks to all the members that are here today. From a physician's perspective, we know that managed care companies certainly have not helped us to manage care at all. All they've done is managed the money.

I'd like to address the issue, briefly, about Medicaid rates in New Jersey, and tie this in with Dr. Pierson's testimony. At the recent AMA meetings, a physician who I believe is in Dr. Pierson's group from Harvard also spoke on a national health-care system. And she admitted that in the United States we need Canada "heavy" -- that the Canadian system, as it stands, would not work in the United States.

So, in New Jersey, we have New Jersey "light." We have Medicaid reimbursement for physicians in New Jersey, which is the 50th in the country, with being only -- New York is the only state behind physician reimbursement with the Medicaid system. So, if you're going to look at a single-payer system in New Jersey, you could look at the Medicaid system, which is hardly in

trouble as far as reimbursement for care given to Medicaid patients and for access to care of the Medicaid population in this state. So please consider New Jersey light and Canada heavy when you think about a single-payer system in New Jersey.

The medical practices in New Jersey are a significant small employer business, and most of us are in that group of the small employers, of up to 15 employees, who are covered by some of the regulations that involve our health care that we purchase for our employees. We've moved away from single practitioners to small groups. We have many employees, including nurses and administrative personnel and technical staff. However, because of our unique position, we face more challenges in trying to run our small businesses. This includes a complexity of delivering health care, the cost of delivering that, and restrictions on our revenues from all payers, not only managed care.

Over the past 15 years, the relative amount that we've received from the managed care reimbursement has decreased as inflation has increased, because our reimbursement has not increased at all. At the same time, there's been more and more administrative burden that we've heard about that we, as a result of being -- if we are contracting with managed care companies, have to hire extra personnel in the office for the administrative costs of billing and getting precertifications. The precertification process is obviously an onerous one. We spend time on the phone with low-level employees, then have to go to physician employees to try to get the needed services for our patients. And this discourages many physicians we even find to do that, because of the time constraints that it imposes.

The managed care companies promised us, when they came out, that the way they were going to compensate us, because we took less reimbursement, was by increasing our volume of patients. But that is a two-way sword. Certainly we cannot give our patients the care they need if we have to put 10 or 15 patients in the slots that we should be putting four patients. This greatly interferes with the quality of care that we can deliver and interferes with our doctor-patient relationships.

We've already heard about the profits that the insurers make and what their CEOs are paid. During the 1990s, the median income of physicians remained basically stagnant. And basically, if you looked at the cost of inflation, it has dropped by probably 5 percent total in the past 10 years. As you know, our expenses skyrocket -- the cost of heating our offices, paying our employees, and as you well know, the cost of our medical liability insurance greatly interferes with how we can balance our budgets. Ironically, it has come to the point, also, where we, as small businesses, are having difficulty insuring our own employees. And I can tell you, each year the cost of insuring my employees goes up and up. But we have chosen not to ask our employees to contribute. We still cover them completely.

We've long recognized and fulfilled our responsibility to provide charity care and reduced compensation care to the citizens of New Jersey. When managed care increased from about 61 percent to 91 percent at the end of the 1990s, two-thirds of physicians continued to provide such care. And we estimate that approximately 14 to 15 percent of total patient care is uncompensated or at reduced compensation in New Jersey. However, as time goes on, fewer and fewer of us can continue to provide this uncompensated

care. Managed care, as I said, reduced our reimbursement and increased our power of cost of doing business, and this has caused the number of our uninsured and people that cannot access our care to increase.

When you think about forging a solution for the uninsured, as I mentioned, please don't use the Medicaid model in New Jersey. We rank 50th of 55 -- 51 in the country. We cannot afford to really participate in Medicaid. We basically prefer to see these patients and not really even bother trying to get Medicaid reimbursement.

The Medical Society of New Jersey wishes to work with you in addressing the issue of uninsured, because I believe if we can address the issue of uninsured, the issue of charity care will not be such a great one. And we look forward to working with the Committees, in the future, on these issues.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Thank you, Dr. Klein.

Mr. Kornett, if you get an opportunity -- since we heard about the money that is going to providers, but there was no breakdown on what their administrative costs are in order to get paid, for want of a better term -- if you have any information on that from the Medical Society, we'd be happy to hear that.

MR. KORNETT: Actually, we do, and we would be more than glad to forward them to you.

ASSEMBLYWOMAN WEINBERG: Thank you.

Assemblywoman.

I'm sorry. I thought that was you who raised your hand.

Assemblyman Manzo -- Munoz.

ASSEMBLYMAN MUNOZ: I'd like to ask a question. I want to thank both of you for testifying. I work most of the week at the hospital. I've noticed that there are a lot more women in medicine. Most of our students -- at least half of the students at the New Jersey Medical School are women. And in surgery even, we find a fair number of women. If you coupled that with the data where incomes are declining, there is certainly no question that over the years income is declining. I guess I'll ask Dr. Klein, is there anyway to stop-- As a workforce gets feminized -- this is now a national data--

ASSEMBLYWOMAN WEINBERG: I am going to interrupt before Dr. Klein answers that.

ASSEMBLYMAN MUNOZ: Yes.

ASSEMBLYWOMAN WEINBERG: And you hit on something that I've been very well aware of, particularly when it comes to OB/GYNs--

ASSEMBLYMAN MUNOZ: Yes.

ASSEMBLYWOMAN WEINBERG: -- women's health-care practitioners, who are now, because there are more and more women -- OB/GYNs -- because women prefer women physicians. So therefore, their reimbursement levels have gone down. And now, as more women go into medicine, reimbursement levels will continue to go downhill, and you can all draw your own conclusions.

ASSEMBLYMAN MUNOZ: Well, let me just jump in, and I agree with the Chair. As workforces get feminized-- I guarantee the CEO of United is not a women. I don't know who it is, but I guarantee it's not. But as workforces gets feminized, incomes tend to decline.

Dr. Klein, any way we can stop that? I mean, I'd like to, but back to the Chair.

DR. KLEIN: We know statistically that women physicians make less money than men physicians -- that's a given. And we know that women physicians tend more to look at part-time practice because of family issues, etc. And I think that probably -- I don't think that it's strictly the feminization of medicine, but it's going to be in the future that doctors are not going to do what doctors 30 years ago did. Doctors are not going to be around 24/7. Doctors are looking for a more managed care lifestyle, a more nine-to-five kind of lifestyle; not only women physicians, but men physicians as well.

This is a major issue that the AMA is obviously working on. Physicians are graduating from medical school over \$100,000 in debt. No one can afford to open a practice. There is no way that anybody coming out of medical school today can open a practice. So you're going to see a major change. New Jersey is one of the last states where these changes occur. But if you look at the California model, everybody is an employee. And I think you're not going to have family -- little doctor's offices any more. Those are a thing of the past. Everything is going to be large groups -- going to be physicians employed, come in at nine, go home at five. And the whole tenor of how health care is delivered in this country will be changed.

ASSEMBLYWOMAN WEINBERG: Dr. Conaway.

ASSEMBLYMAN CONAWAY: You touch on some issues on this administrative costs which really-- I guess there are a lot of things that bother me, but this is right at the top of the list. We passed a bill some two years ago in joint negotiations, and people always talk about, "Well, let's let the market

work, let's let the market work." And I want to put it on the record that with a bill that has been passed -- it's over two years-- We still don't have regulations to manage these joint negotiations process so that the market could work to deal with some of these administrative costs, so that physicians can get together and say, "Okay, you're taking this administrative cost out of our piece of it. Put it in the administrative section, which is the payer's piece of it." We still don't have those regulations. It's not like they're inventing an egg. We have had these regulations in Ohio. We have them in Texas, and we don't have them here in New Jersey after two years of a bill, now, of having a bill out there and ready to go.

And I want to commend the Committee. There are several pieces of legislation directly speaking to this issue on dealing with the referrals; on dealing with all the callbacks over getting meds to patients; over Web sites, that are supposed to be available to us to help our administrative costs, that don't work, where you have to work two or three days to get a password renewed. Over and over again, the patients who've been with your practice for years, who come in with the same insurance, and every time they bounce it back and don't pay it -- as if nobody has learned what the insurance of these people are so they can pay these claims in a timely way -- over and over again.

Now, if we're not going to let the market manage these administrative costs that are forced upon us, through a joint negotiations program -- which we still don't have in New Jersey after two years of having this bill done -- it seems to me that this Legislature is going to have to take this problem in hand and start to move the legislation through to deal with these administrative costs. I want that problem on the record for these Committees

to address and to begin to deal with. No one has ever answered the question, and I asked several-- One person gave me an honest answer -- why we still need referrals? The one person said, who manages these things, says, "Because we don't want people to get care." But other people have -- I ask that question and they dance around it every single time.

So this Committee, I would request, begin to look at this issue; and we need to do something about it. Now, a question. You didn't think one was coming, I know. (laughter) What is your opinion of what will happen in the marketplace if we have continued consolidation of these for-profit companies? People wanted to try a single-payer system. We're moving to that in the commercial market, right now, it seems to me. And I think one man is responsible for half a billion dollars of administrative costs in a system; and I keep thinking how many people would have health insurance if some percentage of that were directed actually to patient care. But what is your view of the continued consolidation of the commercial market and our practice on patients' access to care -- on actual costs within the system? And is this trend, which our government seems powerless to do anything about, is this a trend that's going to be good for health care, or bad?

MR. KORNETT: Well, I can answer that question. And I'll just use United Health Plan as a model. I mentioned to you that United had 47 acquisitions in the last five years. In order for a company to do that -- a roll-up company, a holding company -- they have to have a pipeline that they're knocking out five acquisitions, on an average, a year. There's got to be 15, 20 in the pipeline right now. And that pipeline will not stop in New Jersey. Because while they have 40 percent of the commercial insurance in the

northern counties, statewide they have 20 percent. If I was the CEO of United Health Plan, my game plan wouldn't be for 20 percent. It would be for the majority of the commercial marketplace. So you can rest assured that the other writers of insurance in the State of New Jersey are in that pipeline. And United has very deep pockets and have been very successful with their strategic plan.

And I once had an economic professor tell me, when I was in graduate school, "Some day you're going to see 12 large banks in this country." Well, that was in 1981 -- very hard to fathom. But if you look at the consolidations among banks -- and I don't know if that's good or bad -- but you're going to see the consolidation just the way it's going, very rapidly, with the health-care insurers. And frankly, all due respect to my friends at the Department of Banking and Insurance and at the Department of Health, whom I'm very friendly with, they are so outgunned there's no way in the world they can deal with them.

ASSEMBLYMAN CONAWAY: Just to put some fine points to what you said. Now, this consolidation -- we have a company that uses its business plan, dropping members from its -- putting people in the ranks of the uninsured -- we don't know they went uninsured, but they went elsewhere -- but anyway, they drain the ranks of membership in order to drive up their costs. Now, is it inconceivable that a larger entity, consolidated as it is, gobbling up other companies, might use the same strategy and actually exacerbate the problem of insurance in this country if that kind of consolidation is allowed to continue unabated?

And I remind everybody on this Committee, we as physicians have no way to negotiate with this entity at all. We don't have any legislation to prevent some of the administrative costs on the books now, and we don't have any negotiating. So they're going to do whatever they want with us in our practice. Isn't that right?

MR. KORNETT: That's correct. Now, Aetna was under a lot of fire from their shareholders. They had their profit margin pretaxed -- actually it went down to 0.5 percent. So they did the logical thing. They got rid of the unprofitable book of business, could care less what happened to the 8 million people. And you do that so you don't draw a recognition to yourself or attention to yourself by-- When you go in for a renewal, you price it so high that its -- you just know that they're not going to renew the policy. So you get rid of that book of business, you keep the good book of business. And obviously, the underwriters at the other companies that pick it up, if they do pick it up, know it's a bad book of business because Aetna dropped it.

ASSEMBLYMAN CONAWAY: One last point -- and I'm going to go to the other witness. But I would like to ask a request on behalf of this Committee -- ask the Chairmen to request, if they would, some accounting of this government for what's going on with the joint negotiations regulations in the State of New Jersey, some two years or more after that bill has been passed. That somebody needs to write to us and tell us why that's not done.

ASSEMBLYMAN COHEN: Thank you, Assemblyman.

Any other questions from either Committee? (no response)

ASSEMBLYMAN STEELE: Mr. Chairman, I don't think they've all testified. I don't think now, but maybe they have.

ASSEMBLYMAN COHEN: Oh, I'm sorry.

Who's willing to be next?

**S E A N J. H O P K I N S:** I'm Sean Hopkins. I'm the Senior Vice President of Health Economics with the New Jersey Hospital Association. We're representing 109 member hospitals. Thank you all for the opportunity to testify today.

I am here today to speak, frankly, about the financial stress that our hospitals are under. And joining us today is Jonathan Metsch, our Chairman Elect of the New Jersey Hospital Association and CEO of Liberty Health System. For the last five years, hospitals in New Jersey have barely broken even from operations. For the year ended 2003, audited financial statements showed that hospitals in New Jersey posted a one-half of 1 percent operating margin, with 40 percent of all hospitals operating in the red. Unaudited data through nine months of 2004 shows that hospitals are doing slightly better, with a margin of eight-tenths of 1 percent.

This up-tick in performance is directly attributed to the dynamic and visionary efforts of the Legislature and their actions related to the \$202 million increase in charity care funding to hospitals in Fiscal Year 2005. The Hospital Association and our member hospitals are grateful for your efforts in this area.

Still, even with the additional charity care funding, our hospitals are nowhere near the 4 to 6 percent bottom line recommended for a not-for-profit hospital by rating agencies such as Standard & Poor's and Moody's. As not-for-profit hospitals, any funds generated in excess of operating expenses are funneled back into the community in the form of new

services, added technology, or the refurbishing of a hospital's physical plant, not into the pockets of shareholders.

Conversely, the most recent financial data for the three largest HMOs operating in New Jersey show operating margins of between 4 and 7.5 percent. Some will say that hospitals in New Jersey are wasteful. These comments are unfounded. A recent study produced by the Hospital Association titled, "Leveling the Playing Field: An Analysis of Hospital Cost Efficiency," that was validated by both the Lewin Group and an economics professor from the University of Pennsylvania, shows that New Jersey is the eighth most efficient provider of hospital care in the country.

Hospitals are founded on a mission to provide the best, most comprehensive care to the members of their community. That mission extends beyond those patients covered by insurance. Hospitals in New Jersey are required by law to treat any patient that presents at their facility regardless of that patient's ability to pay. With 1.2 million, or 15 percent, of New Jersey's residents lacking insurance coverage, we are proud of our commitment to compassionate care. Last year, hospitals provided almost one billion in services to this vulnerable population.

On average, 75 percent of staffed hospital beds are occupied. Many hospitals have some beds that are not staffed. This is done specifically as a cost-control mechanism. However, these unstaffed beds, as well as any other unused beds, provide the state with critical surge capacity that will be valuable in the event of a natural disaster or terrorist event.

We recognize that the cost of health care is increasing. Costs associated with labor increases, emergency preparedness, new technology,

systems upgrades, and modifying physical plants to accommodate the changes in which care is delivered all add cost to the system. But without adequate payments from insurers, hospitals will be ill equipped to meet their mission of care. Both Medicare and Medicaid pay hospitals well below their costs, and managed care companies often attempt to pay at or below costs as well.

Hospitals are committed to provide appropriate, compassionate care to every patient that walks through their door. The payers should be accountable as well, and should be required to pay appropriately for those services.

My colleague, Valerie Sellers, is going to talk about managed care cost issues.

**VALERIE SELLERS:** Thank you.

Good morning. My name is Valerie Sellers, and I'm Senior Vice President for Health Planning and Research at NJHA. And thank you for the opportunity to comment this morning.

As you may recall, the objective of managed care was to introduce a more efficient system of health-care delivery, and to do so in a cost-effective way, where insurers and providers worked collaboratively to ensure an appropriate level of care. That objective has not been achieved. Eight years later, a system that should have become more efficient, streamlined, and less costly has instead become more complex, inefficient, has decreased access to necessary services, and has shifted much of the cost of health care to the provider community.

This observation is by no means limited to a hospital trade association. A study published in the *New England Journal of Medicine* in 2003

found that administrative costs represent 31 percent of total health-care spending in the United States, and that clerical and administrative staff make up approximately one-third of the health-care labor force.

Study co-author Dr. David Himmelstein, a nationally recognized faculty member at Harvard, told *The New York Times* last month that the culprits behind the high administrative costs are all the middlemen -- chiefly insurers -- tussling with doctors, hospitals, and nursing homes over bills and reimbursement.

The health-care delivery system of today is not working, and significant changes must occur if we are truly committed to having insurers and providers working in the best interest of the consumer. Toward that end, the Department of Health and Senior Services promulgated HMO regulations in 1996, and the Department of Banking and Insurance developed Prompt Pay regulations in 2001, with the objective of ensuring good business practices and protection of the consumer. Unfortunately, loopholes and ambiguities in existing statute and regulations, and inconsistent regulatory oversight have contributed to an inefficient, unresponsive system.

Hospitals' cost of delivering and administering health care continues to rise due to the hurdles providers face at every step of the way in caring for a patient, from admission to discharge. Claims denials continue to rise, payments are made incorrectly, they are delayed or they are not made at all. These issues contribute to the industry-wide problem of cost shifting, with other payers and patients confronted with higher costs because some payers fail to meet their financial obligations. And the burden of administering this complex system of hundreds of insurance products -- all with unique co-pays,

unique deductibles, and authorization requirements -- has shifted from the health insurers to the provider community.

In my written testimony, which you have before you, I've referenced some examples of these inappropriate administrative responsibilities that insurers have shifted to providers. In addition, you will also have an opportunity to hear from a managed care executive from St. Joseph's, who will provide a thumbnail sketch of what hospitals experience on a day-to-day basis. Through these examples, you can draw your own conclusions as to the cost born by providers and the inefficiency in the system, both resulting in increased costs associated with health-care delivery as a whole.

It is critical to raise these issues, as there's been an assertion that New Jersey's hospitals are inefficient and wasteful and contributing to the excessive cost of health care. In fact, NJHA has spearheaded legislation, in the last four sessions, of the Health Care Claims Payment Responsibility Act. And with the support of Assemblyman Cohen, and ongoing support of Assemblywoman Weinberg, we hope to see that legislation passed. It would have gone a long way toward reducing inefficiencies and waste. But the legislation was vigorously opposed by health plans. It has been reintroduced again this year as A-3496, but we anticipate the same battle ahead of us.

In addition, NJHA has suggested several changes to both the HMO and Prompt Pay regulations that would have tightened many of the loopholes and ambiguities that exist, but our recommendations were not implemented by these agencies with regulatory oversight of these plans.

If there were strict regulatory enforcement of existing regulations, with the insurers working collectively toward a standardized, streamlined

system, then the waste in the system overall would be reduced dramatically, and more money could be devoted to patient safety and quality of care, a priority for providers, insurers, and most important, consumers.

If we want to remove waste, then we need to move toward standardization across plans and simplification of processes, including utilization management and the payment of claims. In addition, insurers must assume responsibility for the administrative functions that clearly should not rest with the hospital or physicians, leaving the provider community with the time and resources -- both administrative and financial -- to treat patients. As important, we must tighten existing regulations, promulgate new regulations where necessary, and ensure strict regulatory oversight of managed care plans doing business in this state.

You're going to have an opportunity to hear about the life of a claim from Colleen Matthews, from St. Joseph's. And before I end my testimony, I wanted to share with you some examples of what hospitals go through on a day-to-day basis. And I'm just sharing two scenarios -- one where the hospital, trying to go through the process of getting a claim paid, and the other with -- well, I guess it is trying to get a claim paid -- but you'll see two distinct practices that are occurring. This happens with thousands of claims. And if there's a point to be made, that's the point.

What we have up here (indicating chart), and you actually have it in your packet -- if you can't see that far, because I can't -- is the time line of a hospital claim. If you'll see here -- I guess the point that I want to make is that a bill was submitted on May 10, 2004. It was for a 25-day stay. If you'll see there, on January 19, 2005, the claim has still not been paid, seven

months later. It goes through a series of phone call after phone call after phone call. And when you look at the responses, I don't know how anybody can justify doing business in this manner. In fact, they already -- once they pay the claim inappropriately, they no longer were subject to the Prompt Pay regulations. Therein lies one of the loopholes in those regulations. The minute they paid the claim, but yet incorrectly, they're no longer subject to that regulation and oversight.

ASSEMBLYMAN COHEN: Could you repeat that again?

ASSEMBLYMAN CONAWAY: That's an important point.

MS. SELLERS: Once a claim -- if they have paid a claim, it's recorded in their system as having paid that claim. So they could demonstrate that they have complied with the payment time frames and the existing Prompt Pay regulations. It doesn't matter if the claim was paid incorrectly. That is now no longer subject. They can demonstrate that they paid. And when they submit their reports, it will show that a claim was paid. But you see, through this example, what the hospital has to go through for months to try to ensure the correct payment.

Randy, if you could put the other one up. (indicating)

ASSEMBLYWOMAN POU: Mr. Chairman?

Could you just define *incorrectly*? When you say incorrectly, what does--

MS. SELLERS: It could be that the hospital submitted a claim for a particular rate. The claim was processed by a health plan. But let's say the health plan didn't load that rate into their system, they thought that they weren't responsible for a payment of five days, even though those five days had

been authorized. So then the hospital has to go back and demonstrate that they received the authorization for five days, and that they're entitled to the money. There can be a host of reasons why that claim isn't paid, and correctly.

ASSEMBLYWOMAN POU: Thank you.

MS. SELLERS: The other example that we have here are what we call *recaps*. And this happens on an ongoing basis, and I'm sure Colleen will speak to this. You'll see here that with this particular example there are recaps after recaps. Payments are made and they're taken back, and payments are made and they're taken back. There were six payments made for recaps. And when you look at the scenario, it begs a question of: how do you possibly reconcile an account? And this is for one patient.

I happened to visit a hospital, and they wanted to show me the claims they were trying to deal with. And they went back to their office and there were four file boxes. And I said, "I don't know how you are going to resolve these." And they said, "Oh, we're not worried about these;" and they took me into a back office, and there was a wall full of these claims. And they said, "We've given up on these." Because they had to hire staff to come in and try to reconcile these claims. These are examples. And I can't imagine what physicians go through in their offices, because you don't have the staffs--

And I guess one of the last points that I would make is that when you talk about appeals and having the right of appeals, and we've given these rights to providers-- They, more than likely, are appealing such a small percentage of their denials and inappropriate payments, because they have to make that tradeoff -- do I go for the high-end claims and deny all the small ones and get nicked and dined, or do I try to hire additional staff to come

in and appeal everything? And that's the challenge that you see hospitals facing today.

I'd be happy to answer any questions you may have.

ASSEMBLYWOMAN POU: Mr. Chairman?

ASSEMBLYMAN COHEN: A question from Assemblywoman Pou.

ASSEMBLYWOMAN POU: Thank you.

I'd like to address my question to-- Valerie, I know you spoke about it, but-- is it Mr. Hopkins?

MR. HOPKINS: Yes, that's correct.

ASSEMBLYWOMAN POU: I'm sorry. Thank you.

Mr. Hopkins, in your testimony, you made reference to the Medicaid and reimbursement in terms of the coverage. You also talked about, in that discussion, technology and some of the services that are (indiscernible). I'd like to kind of go back to my earlier question, but I'm going to change it a little bit. At what level are hospitals currently being reimbursed for Medicaid, Medicare, or even FamilyCare? And maybe we can start there to, hopefully, try to get to the point that I was trying to get to earlier.

ASSEMBLYWOMAN WEINBERG: Excuse me. But just before you answer, just general housekeeping. After this panel, we're going to call one more panel -- Cooper Hospital, Health Professional and Allied Employees, and the Association of Health Plans -- and then we're going to take a half-hour break for those of you in the audience who might need to go get something to eat or whatever, and then reconvene. So I just wanted to lay out the timing.

Go ahead.

MR. HOPKINS: I can speak specifically to the data that we have that looks at Medicare and Medicaid reimbursement to hospitals. Based on our most recent data, Medicare in New Jersey pays hospitals at about 90 percent of their cost. MedPAC recently released data that showed, nationally, that the Medicare margins for hospitals are a negative 1.7 percent. But in New Jersey, hospitals are being paid about 90 percent of their cost. For Medicaid, it is much more severe. In New Jersey, the fee-for-service, Medicaid rates that hospitals are paid -- they're being paid at a rate equal to about 70 percent of their cost.

On the FamilyCare side, I don't have specific data. You had brought that up as well, because those patients are ultimately enrolled into managed care programs. But I can tell you that the hospitals are dealing with issues such as what Valerie just brought up on those patients as well.

ASSEMBLYWOMAN POU: Through the Chair, how often are those rates adjusted when new technology is applied to the patient?

MR. HOPKINS: Are you talking about the Federal rates or the managed care rates?

ASSEMBLYWOMAN POU: Well, let's separate the two, both for Medicaid and Medicare.

MR. HOPKINS: The Medicaid rates, actually, have been updated annually for inflationary purposes, but the rates themselves have not been rebased. The basis for which those rates were established -- the cost base for which those rates were established has not been changed since 1988. Medicare updates its rates annually as well. But again, as we've said before, the

inadequacy of those rates has been consistent since the Balanced Budget Act was passed in 1997.

ASSEMBLYWOMAN POU: What about for equipment? Is that the same situation?

MR. HOPKINS: Technology and equipment, there again--

ASSEMBLYWOMAN POU: Both the same?

MR. HOPKINS: --on the Federal side, there would be components of what they referred to as the *market basket* increase, that would be designed to try and increase payments to hospitals to reflect those additional costs. But as I can tell you, in the last 10 years, hospitals have received full market basket only once, and that was last year. And just recently, MedPAC again, within the last week, has recommended to Congress that they give hospitals market basket minus four-tenths of a percent. I can tell you that we look at these numbers over five-year spans. If the market basket were reduced by four-tenths of a percent in each of the next five years for Medicare, it would cost New Jersey hospitals \$200 million in lost reimbursement for Medicare over that five-year period.

MS. SELLERS: Let me just speak to the managed care side, because Sean's talking about the fee-for-service. It depends on the term of your contract. And if you've signed a three-year or five-year contract with the plans-- I don't know many hospitals that are signing five-year contracts any more. But if you sign those contracts and new technologies are introduced, and you have to implement new systems and processes that have a higher cost associated with them, you do not necessarily have an opportunity to go back in and renegotiate rates. It's all driven, in large part, by the leverage you may

hold, but you're just going to have to bear the cost and hope that the next time you negotiate that contract that you're able to recoup some of those costs.

ASSEMBLYWOMAN POU: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Vandervalk, and then Assemblyman Manzo.

ASSEMBLYWOMAN VANDERVALK: Thank you.

Is there any hospital in the State of New Jersey that lets the public know what they charge?

MR. HOPKINS: All the hospitals in New Jersey have charge masters, which are documents that are quite excessive. As I say to people when you want to talk about the hospital's charge master, which identifies the charges that they have on the books for services, you would not measure it with one ruler -- you would measure it with several rulers. And they are documents that are extremely high and--

ASSEMBLYWOMAN VANDERVALK: Do they let the public know?

MR. HOPKINS: I believe if someone from the public were to approach a hospital and ask them what the charge would be for a certain service, I don't know why a hospital would not provide them with that information. However, I will tell you as well that hospitals operate differently in some capacities. So there is not the consistency, if you will, from charge master to charge master. They are not static documents that are uniform across all hospitals. They are unique to each facility. If you've seen one charge master, you've seen one charge master.

ASSEMBLYWOMAN VANDERVALK: Exactly, that's my point. I mean, the public has no way of knowing what they're going to be billed when they go into a hospital.

MR. HOPKINS: Ultimately, I would say that, again, based on our statistical data, there's probably about 90-plus percent of the patients that go into the hospital are covered by either Medicare, Medicaid, FamilyCare, or commercial insurance company. And as we had stated earlier -- as Valerie had said on the managed care side -- on the commercial side, you've got contractual rates that the payer will pay for those services. Medicare mandates what it will pay for those services. Medicaid mandates what it will pay for those services. So I think, when we're talking about 90-plus percent of the population, the amount that the hospital will be paid for the services provided are already either mandated or agreed to by contract.

ASSEMBLYWOMAN VANDERVALK: But the fact, through the chair--

ASSEMBLYMAN COHEN: I'm assuming the answer to Assemblywoman Vandervalk's question is "no."

MR. HOPKINS: The question--

ASSEMBLYMAN COHEN: About the public knowing what the charges are?

MR. HOPKINS: Again, the charge masters that the hospital have, I don't think there's any prohibition from patients ultimately contacting the hospitals and inquiring about the charge for a specific service.

ASSEMBLYMAN COHEN: So that responsibility, in accordance with Assemblywoman Vandervalk's question, is the patient then has to go

through all this information and all these books and all these documents to find out what's the cost of a hernia operation?

MR. HOPKINS: Actually, I don't know that they need to go to that extent, because, as I said, probably about, again, anywhere from about 92 to 94 percent of the patients that walk into a hospital are covered by Medicare, Medicaid, managed care, FamilyCare, or commercial insurance, and so--

ASSEMBLYMAN COHEN: So they'll pay for it, so there's really no need for the patient to know, because it's covered, right?

MR. HOPKINS: You're talking about a-- What we ultimately have in this country is a trinomial health-care system, where you ultimately have the patient, the payer, and the hospital as a provider. Yes, the hospital ultimately enters into a contractual agreement with a managed care company, or by mandate pays rates that have been established by Medicare or Medicaid. The hospital's goal is, ultimately, to provide the appropriate services to the patient.

ASSEMBLYMAN COHEN: Back to Assemblywoman Vandervalk, who had the floor.

ASSEMBLYWOMAN VANDERVALK: Right.

I know that there is a huge discrepancy in charges between one hospital and another. And I think the public is entitled to that information. And that surfaces very often when they go to the emergency room, and they're shocked with the bill that-- I mean, nobody should go to an emergency room if they can get care elsewhere. But we know that people do, for various reasons, go to an emergency room, because in their mind it's an emergency. There's just a huge difference in what hospitals charge, not only for the

emergency room, but for everything. I have seen examples that this is contributory to what drives up premiums. And unless we shed light on this, the hospitals that do a very conscientious job are going to suffer for those hospitals that have exorbitant, unimaginable rates.

ASSEMBLYWOMAN WEINBERG: Okay. I am going to ask the members of the Hospital Association, who are here, to provide us with information on how your charges are compiled and how a patient, even a patient covered by insurance, would go about finding out what the hospital bill is. In other words, if I'm covered by Horizon Blue Cross and Blue Shield, even though they negotiate the rate with you, I might, as a patient, want to know what that is you're being paid for. If you can get us that information, so that we have it as backup, we'd appreciate that.

MR. HOPKINS: Well, we can certainly do that. The only thing I'd like to add is that -- nobody is disputing the fact that we're operating at a broken payment system, with 45 million uninsured citizens in this country -- 1.2 million uninsured in New Jersey. I don't think that anyone is saying that there's -- a broken payment system where we have many of our major payers, some of our largest payers, meaning Medicare, Medicaid, and managed care, all looking to pay below cost. And hospitals are ultimately looking -- we're dual-mission institutions. Our primary mission is to provide the best, most comprehensive care we can to the members of our community. But hospitals can't do that without ensuring that they've got a reasonable bottom line, which I've mentioned in some of my comments, in order to try and reinvest in new technology, add services on an as-needed basis, and look into ultimately expanding or refurbishing the plant to meet the needs of the community.

It's a very complex system, and it's -- inherently the payment system is somewhat broken. So I'm not going to dispute that.

ASSEMBLYWOMAN WEINBERG: Okay.

It's 12:30, gentlemen with your hands up. We have a third member of this panel and one more panel to hear before we take a break, right? So keep your questions brief.

Assemblyman Manzo, direct question.

ASSEMBLYMAN MANZO: Yes. Just to dovetail with what Assemblyman Cohen was saying, I believe that insurance companies negotiate different rates with the same hospital. So you might have a provider saying you've got to charge  $X$  amount of dollars for this procedure, another provider says you've got to charge  $X$  amount of dollars for a certain procedure that you've negotiated. So that's why some rates could vary in the very same hospital, not only from hospital to hospital. But I'd hate--

ASSEMBLYWOMAN WEINBERG: Direct question.

ASSEMBLYMAN MANZO: Yes. Now, my question is, and I hate to sound like a cynic, when you were describing the trouble with billings and getting payment, it almost sounds like there's an incentive for insurance companies just to deny claim after claim after claim, knowing you have the inability to have the wherewithal to go after the money. Do you find this is a common practice, and do you find that more and more claims are being denied?

MS. SELLERS: Well, I can't speak to the motives of the insurance companies. Well, let me say, I will not speak to the motives of the insurance company. Do we see increasing denials?

ASSEMBLYMAN COHEN: I was just waiting for an objection of the leading nature of the question. (laughter)

MS. SELLERS: I won't object.

We have been seeing increase in denials. I think Colleen Matthews, when she speaks, and other representatives from Cooper Hospital-- The challenge is-- Even the denials alone, when you have to deal with incorrect payments, trying to track payments. So it's not one issue. But when you take them all together and the steps that you have to go through for an appeal, a three-stage appeal process, and you have to try to find the individual to sign off to let you appeal, even though they have no financial obligation, it's all of those factors together that I think are bleeding the hospital system. And those have to be addressed. Because the reality is that if we can't always address it on the revenue side -- that we're going to continue to see funding going to the hospitals -- then you have to fix it where there's a loss leader, and managed care is doing that now.

ASSEMBLYMAN COHEN: Request for information from your group -- a proportion, or if you give me a percentage of request for payments made and the percentages of denials, over maybe, on the tracking basis, from year to year. Let me just ask this question without leading. Are these denials of payment leading to costs for procedures going up?

MS. SELLERS: Well, I'm not sure -- I can't say definitively. But the reality is that if your administrative costs -- that the hospitals have to compensate for those administrative costs, then certainly you have to pass that on in the form of what you're charging and what you're able to negotiate in terms of rates. And I think that speaks to Assemblyman Conaway's point.

That if you don't have any leverage, you may not be getting cost. And so the problem is that -- where do you shift that? Is it? I would assume that if you have these administrative costs, they have to go somewhere. And I think that also speaks to Sean's point about the complexity of charges. So when the public sees a charge, they don't understand that what is built in there is processing the claim, paying for the nurse, cleaning the floor-- And therein lies some of the confusion as well.

ASSEMBLYWOMAN WEINBERG: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: Thank you, Madam Chair.

In your testimony, as is commonly done, you've indicated the percentage of your cost that you're reimbursed by Medicare or Medicaid -- the percentage of your cost that you're reimbursed by HMOs, and the percentage of your costs, etc., related to reimbursement. Now, of course, there's a difference between cost and charges, and the charges for uninsured is different from the charges that go with various health plans, etc. But the cost that you're relating everything else to, is this the real cost or is this some charge that you're making for certain types of patients, or what?

MR. HOPKINS: No. The cost that I'm referring to is the cost of providing care, the institutional cost of providing the care.

ASSEMBLYMAN THOMPSON: It's not the charge that you make in any case? It's the actual true cost?

MR. HOPKINS: That is correct.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Just a quick reference to that question about charges, so that -- for the benefit of the Committee. If the hospital knew what it was going to get paid, perhaps there might be some better connection between the charges that you had to put on a particular procedure and the cost of that procedure. And I know, and asked my accountant what charges to put on. My advice was, you need to make it 140 percent of Medicare, because every year the insurance company looks, "What are we paying? We're going to cut down below that." So you have to inflate that charge in order to try to even come close to meeting your costs. So the charges, as has been mentioned, are just absolutely out of whack, because the system is broken.

You seem to make a point, Ms. Sellers, that one of the things that drive complexity for you in terms of payment is that you have all these different rules coming in. And again, by way of thinking about solutions, can you envision a system where we can standardize that administrative burden, so that everybody coming in, and all of your inputs coming in have to follow a certain catechism, a certain set of rules, that will make it easy for your folks, who have to manage getting these payments done, easier to do? And then, let the people who have to do the paying compete elsewhere -- compete on how much they're paying. Their people who administer systems, CEOs, whatever else -- let them compete on those kinds of things, rather than competing in ways that raise your administrative costs and go to their bottom line. Can we do something, do you think, to standardize some of this payment process?

MS. SELLERS: Oh, I think you can. I think it requires the insurers working hand in hand with the providers. Several years ago, when, I

think, claims denial legislation was first introduced, several years ago, rather than moving that piece of legislation, we sat down with the providers and the HMOs and tried to come to some agreement as to where we could have some consistent practices. And they were small steps. But in the eleventh hour, when we thought we had agreement on some of these very small steps -- it gave us encouragement that we could deal with the more complex ones -- you found one plan after another saying, "I'm not comfortable with that." And so we stepped back. And ever since, we've been trying to, through the claims denial legislation that Assemblyman Cohen introduced and Assemblywoman Weinberg has supported, we've been trying to introduce some of those efficiencies and standardization. Whether you're dealing with a Prompt Pay claim or a utilization management claim, why do we have two completely different arbitration or dispute resolution processes? It doesn't make sense. And in the end, as you know as a provider, you simply don't take the time, because you either have to try to chase your money, or do you sit down and file appeals?

ASSEMBLYMAN CONAWAY: That point needs to be made over and over again. One last question--

ASSEMBLYWOMAN WEINBERG: We really have to move along.

ASSEMBLYMAN CONAWAY: Just one -- I almost forgot it. Oh, this question, again, of cost and payments, and I just want to throw this at you because I think it might get to some concerns. I know other members on this Committee have had, over -- and dealing with, for instance, the OB/GYNs and their actual real reductions in payments and reimbursements over time.

Hospitals, I'm sure, have seen the same thing. Medicare has -- and I know it's been criticized; maybe we can do it better -- has relative value units, where we try to look and access these costs and make sure that the reimbursements are in line with the costs, so that you don't have people being unable to afford to stay in practice, OB/GYNs, others. Do you think that we can set up some kind of a system -- and this is for everybody -- where we can have some panel of the government start to look broadly at these charges? Maybe we piggyback on what Medicare is doing here and apply them to our marketplace in New Jersey, with our increased cost for health insurance, property tax, and everything else, and come up with some way of making sure that the reimbursements are in line with the actual costs, so then people will actually come here to practice and think they can make a decent living doing what they want to do.

MR. HOPKINS: I think it's obviously on the right track. The question and the comment is on the right track. It's a very ambitious undertaking. I think underscoring exactly what you just said is that -- trying to find a method to make sure that the providers -- doctors, hospitals, other health-care facilities -- are paid appropriately for the services that they are providing. And I think that I would be surprised if everyone wasn't in agreement here that appropriate reimbursement for doctors and hospitals would be certainly something that we would be supportive of.

ASSEMBLYMAN COHEN: Let me just say one thing, quickly, in terms of the denial bill, because I've spent about 100 hours on it: We're going to wrap that up. In fact, the time that we had concluded our discussions with the help of Ms. Ryan, Ms. Stearns, and a number of other people, we were about 95 to 96 percent concluded; because I held round tables, from

everyone who didn't like each other at the same table, so that everybody could either lie to each other or tell me the truth. So we're going to go back to that. We were just a little interrupted by medical malpractice, predatory lending, car insurance, a few other things that have taken my time and the Chairwoman's time in terms of trying to get that concluded. But I've put too much time into that, and not only while I've been Chair, but when I worked with Assemblyman Bateman, when he was Chair; and Assemblyman Asselta, when he was working on the same thing. So we're going to get the bill wrapped up relatively soon and try to come to the compromises that we discussed in hours and hours and hours of meetings.

I just wanted one quick issue. There's probably not a quick answer. But nonprofit hospitals have for-profit organization spinoffs, correct?

MR. HOPKINS: In some instances.

ASSEMBLYMAN COHEN: Okay. What happens with that service that has now been spun off as a for-profit? Two things: Is that a service that was previously provided by a nonprofit hospital?

MR. HOPKINS: Without looking at the uniqueness of the spinoffs that you're referring to, it would be hard for me to make a blanket statement.

ASSEMBLYMAN COHEN: Well, let's just take a look at it generally. At some point in time in history, nonprofit hospitals -- I'm assuming to generate revenue, which is not illegal in New Jersey or in the country -- in order to generate revenue, they created certain for-profit spinoffs of the nonprofit hospital. Is that correct?

MR. HOPKINS: Yes.

ASSEMBLYMAN COHEN: Okay. Let's just say, generally, what are the types of things a nonprofit hospital will spin off as a for-profit mechanism? Is it surgery? Is it surgi-centers? What kind of for-profits, that you've heard about, exist with a nonprofit hospital?

MS. SELLERS: We've been looking very closely at this issue, and it could be, in fact, all of those. It could be radiology. It could be ambulatory surgery. It could be sleep clinics. It's not to the exclusion of continuing to offer those services at the hospital. In some cases, where you see hospitals joint venturing with physicians, it can be; not always. But one of the reasons may be that you don't want to see your book of business at the hospital going to an outpatient setting wholesale, and you could lose all sources of revenue that you typically use to fund non-profitable services.

ASSEMBLYMAN COHEN: All right. So part of my question is, things that were traditionally for the nonprofit hospitals, that brought the nonprofit hospital revenue, are now not being done. And that revenue is not coming into the hospital, because it's being done by a for-profit spinoff. Let's say radiology. Let's say you used to come into the hospital to get that done. That money then went into the nonprofit as a revenue. Now it's being done by a for-profit wing of the nonprofit, thus taking some revenue, that was traditionally there, away. What I'm asking on top of it is, that revenue that goes to the for-profit spun off by the hospital, where does that revenue go? Does that stay in that for-profit, or does it come back to the hospital?

MS. SELLERS: I don't know if you can speak to that? I think it varies.

MR. HOPKINS: It would vary. It would depend on whether or not the facility was under the umbrella of the hospital organization or whether it was under a larger corporate umbrella, and therefore, there were multiple entities, one being for-profit, one being not-for-profit.

ASSEMBLYMAN COHEN: Which means that billing is as complicated as the billing of Horizon Blue Cross? It's a joke. (laughter)

What I'm saying is, I want to look at -- and I think both Committees should look at -- is the nonprofit saying, "We don't have the money, therefore we had to do X." Or is the nonprofit hospital saying -- and this is just a small piece -- or is the nonprofit saying, "Look, we have less revenue, but you've been spinning off that revenue into for-profits," -- for which the public, and I imagine most of these Committees, have no idea how it works, don't know where the money goes, whether that money stays in the for-profit or whether it ever gets back to St. Joe's Hospital, or whether it stays in a St. Joe's radiological spinoff or surgi-center spinoff. All I'm saying is that that is an area that, at least for me, we're going to make some inquiries about, at least so that we understand it better.

(fire alarm sounds, and continues until Recess)

ASSEMBLYMAN CONAWAY: That was too good a question, Neil.

ASSEMBLYMAN COHEN: The speech was fire driven. (laughter) And on Sunday, you can all rest.

MS. SELLERS: Assemblyman, can I just add one point to what I was saying?

ASSEMBLYMAN COHEN: Go ahead.

MS. SELLERS: Many of the managed care plans today are shifting their members to outpatient services, and hospitals contracted with these plans, with the expectation that they would have steorage for certain number of individuals. And what they have found -- and those of you that have some of these plans-- I certainly got a letter saying that, "We want you to utilize these services in an outpatient setting," meaning ambulatory surgery or radiology. So the hospitals were seeing that they're losing revenue because they're shifting all these managed care members to the outpatient setting. So part of it is a strategy to maintain some of the revenue that would have been lost because of the practices of some of these health plans. It's not the sole reason, but I think what we're seeing now is a shift from the inpatient side, and that shift is being driven, partly perhaps, by consumer desire, but in large part by managed care directives.

ASSEMBLYMAN COHEN: But it's something that we're going to look at, because there's a source of revenue there that I don't know whether it's being accounted for, for purposes of rate hikes and everything else. Because technically, if you have somebody going out on a surgi-center, then you should be saving the health insurance provider, who is not paying for an in-house, inpatient stay, which is more expensive than in outpatient. So that's the savings that will be going to Aetna, Cigna, Oxford, and Horizon, correct?

MS. SELLERS: It should be. But you're also seeing what's left in the hospital are the charity care, the underinsured, or the-- I don't want to say the uninsured, because some of these plans are taking self-pays. But what you're seeing is, the hospitals are left with the unprofitable cases and more complicated cases.

ASSEMBLYMAN COHEN: In any event, I just wanted to raise it, because it's an area that I'm interested in looking at. Because there seems to be this cloud of mystery that surrounds for-profit spinoffs of not-for-profits; which is also an issue that Horizon will be dealing with, because Horizon is a not-for-profit, but they have for-profit managed care HMO spinoffs that make money. But it's an area that I'm curious about. So thank you.

ASSEMBLYMAN MUNOZ: Mr. Chair?

ASSEMBLYWOMAN WEINBERG: Dr. Munoz.

ASSEMBLYMAN MUNOZ: Wow. I've got a wicked headache. I don't know if I can ask above the fire drill--

For the hospital people, a question? You know, in the good old days, it was like an expense account. You submitted a bill and the bill got paid.

ASSEMBLYWOMAN WEINBERG: Remember, a direct question.

ASSEMBLYMAN MUNOZ: Pardon?

ASSEMBLYWOMAN WEINBERG: A direct question, now.

ASSEMBLYMAN MUNOZ: Absolutely. Okay, it's coming, and it's coming quickly. Okay. So that was 25 years ago.

New Jersey actually was the model where we introduced the diagnostic related group system, the DRG system. So the question is, given all this has happened to put pressure on hospitals, why do costs keep skyrocketing? Why hasn't it worked the way it's supposed to work?

If you can answer above the fire drill. You have to yell into the mike. (referring to PA microphone)

MR. HOPKINS: I think costs are going up for a variety of reasons. And again, some of it has to do with increasing technology and the cost of that technology, advances in pharmaceutical drugs and the cost of those pharmaceutical drugs, and, obviously, a greater reliance on health care.

I was just reading the other day, in a health-care periodical, that, actually, hospital costs went up in the last year, but it was a slower rate of increase than the previous three years. So, in totality, are costs still increasing? Yes. Is the increase in hospital costs slowing? This data from CMS seems to say that is, in fact, the case. That is, in fact, the case.

ASSEMBLYMAN MUNOZ: Remember, it's cycling. I mean, it goes on and on, if you look at the last 20 years. So next year, it will be slightly different, but you're right.

MR. HOPKINS: Yes. So, ultimately, I think there are a lot of factors that are driving the cost of health care. As I said, in New Jersey, I'd like to go back to the study that I referenced earlier identifying New Jersey hospitals as the eighth most efficient providers of hospital care in the country. We're pretty proud of that.

ASSEMBLYWOMAN WEINBERG: I would like to ask the representatives of Horizon Blue Cross Blue Shield -- we did not arrange this to interfere with your testimony. Maybe you could all shift down a little bit, just so that they can have some table space. Then we're going to ask the last panel -- before we take a half-hour break, and we'll only be a half an hour -- the last panel before that break will be Chuck Sessa, CEO of Cooper Hospital; Jeanne Otersen, from Health Professional and Allied Employees; the Association of

Health Plans, Paul Anzano; and Emergency Room Physicians -- if they can figure out how to get the fire alarm turned off.

Go ahead.

**DONNA CELESTINI:** Okay, you are right. We did not arrange for this fire drill, but I'm wondering if somebody else here did. (laughter)

ASSEMBLYWOMAN WEINBERG: Does anybody have any idea about the fire alarm and when that will-- Otherwise, we might take the break now, but I know we have the Emergency Room Physicians.

MS. CELESTINI: Can you hear me?

ASSEMBLYWOMAN WEINBERG: Is there anybody here from St. Joseph's Hospital who can give us the time or ETA on this? Yes.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Yes. The fire company has to respond and do an *all-clear* first, and then they're the ones who will turn it off.

ASSEMBLYWOMAN WEINBERG: I know that I asked for those folks who we were going to try to get in before the break. But with your indulgence, I think we'll take the break now, so we don't have to talk over this.

It is 12:55. We will be back here at 1:25. And anybody who wants to -- be here by then, please. Thanks.

**(RECESS)**

**AFTER RECESS:**

ASSEMBLYWOMAN WEINBERG: Can we resume?

I think there are some water and refreshments in the back. Thank you to the Hospital for treating everybody so grandly.

And would you introduce yourselves as we resume the hearing?

MS. CELESTINI: Okay. Good afternoon.

My name is Donna Celestini, and I am Vice President of Horizon Healthcare Services at Horizon Blue Cross Blue Shield of New Jersey. With me is Bob Meehan, a co-vice president.

Horizon Blue Cross Blue Shield of New Jersey wants to thank the Committee for allowing us to participate in this hearing regarding what we believe is one of our nation's greatest challenges today -- the rising cost of health care. While the cost of health care in New Jersey is a pressing problem, no serious discussion about improving our overall health care system can be undertaken without consideration of quality as well.

As President and CEO of the New Jersey Health Quality Institute, David Knowlton, recently wrote, "The bottom line is that while New Jersey ranks near the top in costs, it is near the bottom in quality." I think we all agree that the families of this great state deserve better.

There are neither easy answers nor one scapegoat for the complex problems that face our health-care system. And any attempt to find one would be wrong and simplistic. Therefore, we are here not to assign blame, but to look for solutions.

As we begin to consider solutions, let us acknowledge the inherent tensions built into the current health-care system. Consumers want access to the latest technology, best services, and breakthrough medications without paying any more. Health-care providers are seeking increased compensation

for the enhanced services that they provide. Health insurers are looking to keep premiums down for their customers, and government officials want a system where all parties are happy and costs are not eating up precious tax dollars. Any solution must involve all stakeholders.

The problems we confront are complex and did not develop overnight, nor will intelligent and viable solutions. So what are the problems we currently face? We've talked about many of them earlier today. Health-care spending represents over 15 percent of our nation's gross domestic product. In New Jersey, health-care spending is outpacing the rest of the nation. In New Jersey, hospital costs are the highest in the nation. Over 1.2 million people in New Jersey are uninsured.

Unfortunately, there is a general lack of understanding about what is really driving health-care costs. For the purpose of illustration, every premium dollar Horizon Blue Cross Blue Shield of New Jersey members pay, approximately 86 cents goes directly for paying medical claims. The remaining amount goes to administrative costs. But it is the medical claims portion of the premium dollar that is escalating.

In order to truly address these escalating health-care costs, we must acknowledge the real factors driving these costs. Some of those factors include the increasing consumer demand and the resulting utilization of health-care services and prescription drugs. Advances in medical technology and new prescriptions -- all great stuff, very costly. Only half of the recommended best practices in medicine are followed by health-care providers. Medical errors and quality issues cost New Jersey health payers more than \$18 billion in direct costs. Defensive medicine costs an estimated \$60 billion annually, nationwide.

Fraud is an issue. A lack of health literacy adds an additional 73 billion to annual health-care expenditures. And finally, poor lifestyle choices lead to poor health, adding significant costs to our system.

Given all of these facts, we believe that now is the time to act. We offer the following recommendations for consideration: Horizon believes there is nothing that is more important than increasing the quality of health care New Jersey residents receive. And numerous studies indicate that the quality of health care directly impacts its costs. Therefore, we believe State government can help reduce costs to the system by focusing on improving quality. Horizon believes the best way to begin improving quality is by ensuring that more information on quality is available to the consumer. Therefore, we believe the State should look at ways to improve the collection and reporting of hospital and physician quality data and make this information readily available to consumers.

We applaud the State's development of the Hospital Report Card. The Report Card is a great start, but so much more really needs to be done. The State must play a significant role in developing a unified system for quality data reporting, increased dissemination of this information, and education to consumers about how to use this quality data. We believe that this information is so important that Horizon is willing to voluntarily share its own quality data in order to accelerate the process and better inform consumers.

The State should also consider further encouraging methods to reward best practices, quality, and efficient health-care providers. By giving incentives for the practice of evidenced-based medicine, we can begin to

improve quality at the same time we reduce costs. Another area to consider is the use of prescription drugs in this state. The number of formulary restrictions continues to drive up costs for New Jersey consumers. Currently, New Jersey has one of the lowest generic drug usage rates in the nation. Increasing that rate will reduce costs.

Additionally, we need to reform the individual market in a way that will reduce costs and increase the number of insureds. Reforms that would eliminate pure community rating in the individual market -- and adopt in its place a modified community rating system whereby health insurers would be permitted to rate on the basis of age, gender, and geographic location -- would significantly reduce premiums.

Additionally, Horizon supports Assemblyman Neil Cohen's initiative, as part of his market reform legislation, to provide tax credits to small employers. We also support the efforts of Senator Joe Vitale and Assemblyman Bob Morgan to restructure the State's FamilyCare Program to increase enrollment and reduce the number of uninsured.

Another area where the State can make an impact on health-care costs would be in the area of education of the general public. As mentioned, poor lifestyle choices have a dramatic effect on the cost of health care. Horizon has teamed up with the Rutgers School of Pharmacy to create Shape It Up, a program teaching children healthy eating habits and the importance of exercise and the dangers of obesity. Over 400 New Jersey schools have requested the presentation of this program, and this year we will only be able to accommodate 150 schools.

In addition, Horizon has begun an effort to improve health literacy by working with Boys and Girls Clubs in Newark and Atlantic City. This program has won recognition from the Harvard Medical School, as well as an award for excellence from the New Jersey Business and Industry Association. This program provides teenage mentors to help younger children improve their reading skills by focusing on health-related reading materials.

These are examples of the type of educational programs that the government could develop to make an impact on this state's long-term health-care costs. Horizon believes a focus on quality, prescription drugs, individual market reform, and public education provides this state with ample opportunities to improve New Jersey's health-care system.

We look forward to working with the members of this Committee to come up with innovative solutions.

Thank you for your time.

ASSEMBLYWOMAN WEINBERG: Questions?

Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Thank you very much for the information. I support such programs as the Boys and Girls Clubs, but I don't see how that helps get my claims paid, and that's kind of what I'm worried about. We heard a lot of information just before we broke for lunch about the denials, about the length of time that it takes to pay claims. And I'm going to suggest to both the Chairs that perhaps we ought to look at legislation that would provide a report card for consumers on managed care companies and insurance companies, so that they are able to make wise consumer choices there. And they can look at how efficiently the managed care companies

process their claims. Because I don't think they have any way of knowing. In fact, I don't know if they have any way of choosing. Because in most cases, it's the employers who choose, and the employers' interests may not be identical to the employees' interests in coverage.

So I'd like to know what would be the reaction of Horizon and all the other companies that are here to having a report card on managed care efficiency and quality.

MS. CELESTINI: A report card already does exist that is produced by the State, and most of the insurance companies who have significant membership in this state are part of that report card. My recollection is that it has existed for a number of years, at this point.

ASSEMBLYWOMAN QUIGLEY: No. I'm not talking about the one that the Department of Health already produces that shows the kind of statistics on certain tests, such as preventive tests and what have you, but more on the kind of complaints that we heard about earlier.

MS. CELESTINI: There is a satisfaction component to that survey that does measure a lot of the items that you're talking about.

ASSEMBLYWOMAN QUIGLEY: Could you get us a copy of that one?

MS. CELESTINI: Sure.

ASSEMBLYWOMAN QUIGLEY: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Manzo.

ASSEMBLYMAN MANZO: The current system -- how it evolved in network managed care -- was supposed to bring down costs, when the concept came in. I think we're at a point where, realistically, if you look at it,

one would have to say it's failed. How can you explain to me why, if this state didn't have a policy where any insured could go to any doctor they want, to go to any hospital they want, and procedural costs were averaged out for the same expenses across the state, why would it be that the insurance companies, now competing for business, would have to bring down rates?

**ROBERT E. MEEHAN:** Assemblyman, the reaction I would give you is--

ASSEMBLYWOMAN WEINBERG: Would you just state your name for the record?

MR. MEEHAN: My name is Bob Meehan. Donna introduced me earlier. I'm a Vice President at Horizon.

We offer a multitude of products across the complete spectrum. In fact, we're fairly proud of that. We think we offer more products than any other competitor. And I will tell you that the cost basis for indemnity programs, of the type you speak, are at least 25 percentage points higher than most of other average programs. We clearly have consumers who want to buy them, and we intend to continue to deliver those programs. But in answer to your question, they are much, much more expensive.

ASSEMBLYMAN MANZO: Is that because the volume isn't there now for them?

MR. MEEHAN: No. It's because the prices and the costs are just much higher.

ASSEMBLYMAN MANZO: And you're telling me that even with average costs for procedures across the state -- meaning that every hospital charging, almost within the realm of a few dollars, the same price for a

procedure -- that the insurance industry, faced with not having to put in-network, out-of-network components together, and simply can face with who wants to go to them based on a rate, wouldn't have to compete to bring down the cost of insurance?

MR. MEEHAN: You're asking a hypothetical, I think, Assemblyman.

ASSEMBLYMAN MANZO: I'm asking how a business runs.

MR. MEEHAN: We offer that product already. And I can tell you, first of all, we don't pay one rate. And the rate we pay for indemnity care is typically higher. This is the rate we pay to providers.

ASSEMBLYMAN MANZO: How can you justify for me two people sitting in a doctor's office -- one in network, one out of network -- and one paying maybe three to four times more for a procedure than the other person? And tell me how this isn't impacting upon the overall rate structure in the state, and why wouldn't it be better doing it the way I just proposed?

MS. CELESTINI: I don't believe it would be better the way that you just proposed, for the reasons that I mentioned in my testimony. I think part of the problem that we have with health-care costs today is the fact that there are excess costs in the system. There are experts that indicate that 25 to 30 percent of health-care costs, not just in New Jersey, but nationwide, are excessive and unnecessary. And what we have to start doing is looking at evidence-based medicine, determining what is the appropriate practice, what is the appropriate treatment, and making sure that we are addressing that issue in whatever structure we develop, moving forward.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Vandervalk.

ASSEMBLYWOMAN VANDERVALK: Thank you.

I have here the individual health benefits plan -- the Horizon monthly rates. And the monthly rate -- the cheapest, the very cheapest -- is the Horizon HMO plan. A \$30 copayment for a family is \$1,244. If you extrapolate that for a year, that's \$15,933, almost \$16,000 for a family plan, the cheapest available. If you don't get health insurance in this state from your employer, I don't know how anyone can afford it.

MR. MEEHAN: We can't agree with you more. And we support reform in this market because of that.

ASSEMBLYWOMAN VANDERVALK: One of the reforms that we started years ago was the medical savings accounts, known as MSAs, and the Federal Government has pushed that as well. And you hear a lot of talk about that all over. They call them HSAs, it's the same thing. But to my knowledge, you cannot get the high deductible plan -- it's just not available. And that's part of -- that's integral to the MSA or the HSA. You have to have the coverage there in the event of a very high -- a catastrophic plan, if you will. Help me out with this? What can be done?

MR. MEEHAN: Sure. The Internal Revenue Service actually defines what the plan has to look like. We actually, and some of our competitors do as well, have HSA-compatible plans now in the small employer and large group market. We're working with the individual health coverage board to introduce an HSA-compatible plan in the individual market as well. I will tell you, though, that for the near-poor -- who are the growing uninsured

population, the largest cohort -- these are people that are just above the charity support programs, high deductible plans are not the answer for them. They can't afford the deductible. In individual insurance, by definition, there's nobody putting money into that account, that HSA account, for them.

For an employer-based plan, some employers are generous or have the means to put money into those accounts for the employees. But in the individual market, again, by definition, there is no such subsidy. So we're not optimistic that HSAs and that kind of plan, in and of themselves, can make a real significant dent in the uninsured problem.

ASSEMBLYWOMAN VANDERVALK: Through the Chair, if I may ask a follow-up question. Putting aside the MSAs for the time being, what can we do to get coverage for people in this state who can't get it through their employer? Nobody can afford 15, almost \$16,000 a year, as the cheapest plan. And I'm quoting -- I want to make it clear -- I'm quoting from Horizon's rates, but I think all the others are very close to that as well.

MR. MEEHAN: Actually, some of them are much higher. I think it has to be a multi-faceted approach. Assemblyman Cohen has a proposed bill that has the roots of what we think are positive reform for individual. I think Senator Vitale is also trying to attack it by increasing coverage through FamilyCare. There have been studies that suggest that -- and I've shared this with some of the members of the Committee -- that once you pass about 5 percent of gross income, people start dropping out of the system. Five percent of gross income at \$35,000 a year is not a big number. And unless that premium is subsidized, as it typically is in group insurance through employers, people clearly just don't have the wherewithal to do it. What we're doing is

really attacking this at the margins, in an incremental way, by reducing the subsidy that's currently inherent in the individual market, because everybody pays the same price. The problem with that is the younger subsidizing the old. And as a societal problem, we're going to have to deal with that.

And in the small employer market, I think the tax subsidy program that people like Assemblyman Cohen have put forward, both on a local level and a Federal level, are important to continue to encourage American and New Jersey employers to provide this valuable coverage. It's that employer subsidy that really makes the American system work. When you pull out government payers in this country -- Medicare and Medicaid -- it's American employers who really pick up the lion's share of health-care costs. And we have to be sensitive to their needs as well. And employers -- and I'm sure you listen to them -- a lot of these people are your constituents. This is a tremendous issue for us.

ASSEMBLYWOMAN VANDERVALK: One final point.

It's, again, the individuals that don't get it through their employer. They don't get coverage through their employer. What can we say to them? What can they do? What options do they have? They don't-- I can't see any.

MR. MEEHAN: Well, there are bills around, Assemblywoman. And I think we'd love to work with the Joint Committee to put the best of those bills forward. There are ideas. Changing the rating methodology is one of them. Allowing carriers to be more flexible in the plan designs that they deliver is another, just as examples. The tax credit for small employers--

ASSEMBLYWOMAN WEINBERG: Herb.

ASSEMBLYMAN CONAWAY: Just staying with this point about the individual market for just a moment-- And I -- thinking about possible solutions. Is there a large difference between the average person who is in the individual market and, say, someone who is working at Acme, or for State government, or for GM? Are there significant differences in the profiles of those persons, vis-a-vis someone who is employed-- I mean, I understand that you've got disabled people out there that might have other issues. But are those folks, somehow, outliers -- and they have cancer, they have terrible heart disease they got when they were 30. Are they very much different than the average person who just happens to have a job, and their insurance through their employer?

MR. MEEHAN: The short answer is yes. Now, when you say much different, I don't want to overcharacterize these people as walking basket cases. But if you think about the economic dynamics of the group insurance market, where the employer is typically picking up 75 percent of the premium-- So, for most people, making a value judgement, that's a less expensive opportunity, versus the person who has to pick up 100 percent of the premium. And they look at that and say they have to make choices. "Do I make the car payment, do I put the kids in private school, do I pay for the health insurance?" And if they haven't had significant health expenditures in the past several years, a significant number then start dropping out, leaving people who are sicker.

ASSEMBLYMAN CONAWAY: I understand that folks are going to make economic decisions based on their individual circumstances. I'm

trying to think, however, about a proposition such as this -- and I'll just throw it out there.

The State government could -- has its own insurance plan that folks administer, as an example. Now, if you were to look across the broad number of people who are working-class people, if you want to use that term, who are not working for people who are insuring them -- and we have a whole freerider problem that some people talked about addressing.

What if the government were to say, "Rather than paying \$15,000 a year to Horizon, or some other entity that's going to charge you that amount of money based on an individual rating, why don't we allow that person to purchase themselves into the State Health Benefits Plan," as an example? If they are not outliers, in terms of their health-care costs -- you may not want to open this up to everybody. But in terms of getting a big debt -- getting at the problem of uninsured -- that is employers not providing it because it's too expensive. They can't take advantage of a group rating and drive their costs down. These self-insured plans do very well, apparently, doing it themselves.

The State is like a big self-insured plan. Why should-- Is the-- Are you aware of any barrier in law that would prevent the government from taking some large percentage of individuals, enrolling them into the State Health Benefits Plan, relieving the individual of the burden of having to pay \$15,000-plus, rather than whatever the premium is for the -- under the State Health Benefits Plan, and doing it that way -- and making them pay for it? At least they're paying less.

MR. MEEHAN: Assemblyman, I can give you a very simple answer to that. You have a very good program already in place. It's called New Jersey FamilyCare, where you do exactly that already.

ASSEMBLYMAN CONAWAY: And so your point would be that people aren't paying for that now.

MR. MEEHAN: No, what I'm saying is, enrollment was closed because the State ran out of money. Several years ago, the State was allowing in childless couples. That enrollment was closed. Senator Vitale's idea on the table is to open up that enrollment, again, to childless couples.

ASSEMBLYWOMAN WEINBERG: But that is not the point, I don't think, in--

ASSEMBLYMAN CONAWAY: Well, I mean -- but it's--

ASSEMBLYWOMAN WEINBERG: You're talking about those people who don't qualify for FamilyCare.

ASSEMBLYMAN CONAWAY: Well that's right -- people who don't qualify for FamilyCare. There are people out there who don't qualify for FamilyCare who, otherwise, you look at them -- they're a good risk. They're pretty healthy, they're not going to keel over tomorrow.

MR. MEEHAN: I think I understand your point, Assemblyman. It's a very good point. My point is, the model exists. The Chairperson is correct. The current eligibility criteria would not allow the near-poor to join. But to your point, could they join? There's no obstacle. The problem is money.

Even the State Health Benefits premium-- If you open that up to the general public and said, "You can buy it--" What we're suggesting -- back

to the statistic I gave you -- 5 percent of gross income would still be beyond the means of the target population we're talking about, the near-poor. The people who don't qualify for these public programs could not afford the State Health Benefit premium, unless the State were to subsidize the premium.

ASSEMBLYMAN CONAWAY: Thank you.

Moving on to a different topic -- another question. You mentioned that New Jersey has the lowest generic drug usage rates in the nation. Do you have any--

MR. MEEHAN: One of the lowest.

ASSEMBLYMAN CONAWAY: One of the lowest. Thank you for the correction.

Do you know why that would be? Are we using more drugs that just happen not to go off a patent? Is there something about the way-- I mean, I know that I rarely put on a prescription that someone has to buy -- I almost never do it unless somebody specifically asks -- that they have to have -- that they are not allowed to use the generic form of the medication. I just think that-- I won't say why. That's the way I operate, anyway.

MS. CELESTINI: I think we probably need the technical experts back home to give you the real good answer to that question. My understanding of the issue is that we have restrictions on formularies that other states don't have, and that in some of our product designs that are mandated for the small-group market -- that the tiering process causes us to be less competitive, in terms of pricing, and costs, and incentives towards using generic drugs than other types of programs offered in other states.

ASSEMBLYMAN COHEN: Any questions from the Committee?

ASSEMBLYMAN STEELE: No, Mr. Chairman. I would just actually, kind of, weigh on the working poor, which would come to uninsured -- and I would just listen to that aspect of it, because that seems to be a major issue.

ASSEMBLYWOMAN WEINBERG: Have you put in any proposals on reforming the small and individual market?

ASSEMBLYMAN COHEN: You want counsel with you, Bob, on this?

MR. MEEHAN: We prefer to work with the Legislature. We have-- The Association of Health Plans -- and Michele Guhl, you know, will be behind us.

ASSEMBLYWOMAN WEINBERG: And I will put that question to Michele, too.

MR. MEEHAN: We have a model for the Legislature that represents the thinking of all of the health plans, not just Horizon. And we've begun the process of speaking to some of you about what we think the merits of that proposal are.

ASSEMBLYMAN COHEN: I'm saving my questions for private meetings.

ASSEMBLYWOMAN WEINBERG: That's very unusual.

ASSEMBLYMAN COHEN: It's the weather outside.

ASSEMBLYWOMAN WEINBERG: Okay, second time around. Charlotte and then Lou Manzo.

ASSEMBLYWOMAN VANDERVALK: Thank you.

What is the time line on that proposal you're working on jointly?

MR. MEEHAN: We were ready last year. Seriously, any time -- and I think some of the key members here know this -- we'd like to see this passed this session.

ASSEMBLYWOMAN VANDERVALK: What would that do? Could you plug in a percentage of reduction on the premium? I mean, what are you anticipating to happen there?

MR. MEEHAN: We think-- We're talking about moving from pure community rating to adjusted community rating.

ASSEMBLYWOMAN VANDERVALK: Right.

MR. MEEHAN: Some of the premiums could be reduced by over 40 percent. For example, in some states -- and we think we can replicate this here, under the model we're talking about -- we think we can, and we need to, to get to a premium of under \$200 for a single person. The premium, as you saw, is about \$410, right now. We need to get down to at least the \$200 level. Some states have a \$100 premium.

ASSEMBLYWOMAN VANDERVALK: Thank you.

ASSEMBLYMAN COHEN: Let me just, if I may, interject. I guess, beginning about 10 months ago, I started working on an individual reform. I met with Horizon, I met with Cigna, Aetna, Oxford; plus my own ideas, in terms of the view on them. And without getting into a lot of detail now, there is a big difference between what the industry would like and what I think is a more balanced approach, in terms of legislation. Because as part of the industry -- and I won't name any particular company or companies -- but under their change in rating, you would have a lower rate, obviously, for 25-and 30-year-olds. But that rate would go up dramatically for those who are

age 50 and older. And I wasn't going to sacrifice senior citizens, and those 50 and older, to get the kind of rating to attract 25- and 30-year-olds who do not care about health insurance but care about going to Cancun. Their priority is not health insurance. Their priority is, "I'm never going to get sick." And there are very few claims and very few administrative costs for the area of 24 to, let's say, 30 or 32. That's really just pure revenue to a health insurance company.

So there are a lot of discussions going on. There's been some difference of opinion and difference of modalities that should be used. But it's complex, because if you lower something here, you've got to raise it on those who have the least money, or the most vulnerable, and are susceptible to illnesses that can disable them, cripple them, or cause death.

There's a way to do this where you can make -- have a good approach. You're not going to get a home run. But you're going to make an incremental difference in: one, stabilizing those rates that are with seniors, at the same time trying to attract the younger, healthier people into the marketplace.

So there is work being done. I didn't want it to, maybe, linger out there that there's things out there and nobody's doing anything. I'll gladly talk to my friend from Bergen County. The bill has been introduced, so it's online.

ASSEMBLYWOMAN VANDERVALK: It has?

ASSEMBLYMAN COHEN: Yes, I've introduced the bill. And we're trying to work around some other pieces to improve it or to make sure that we're not hurting one -- hurting any of the consumers -- making sure that there are-- I want more competition. We only have, really, four major carriers.

And we need to also attract other companies to come in and write health-care policies. But there is a discussion. Work is being done. And if anybody wants to take a look, or go on -- or ask questions about the bill, it's already been introduced. I'd be more than willing to give you my time.

ASSEMBLYMAN STEELE: What's the bill number?

ASSEMBLYMAN COHEN: I don't know the bill number. I'm not good with bill numbers. (laughter)

ASSEMBLYMAN STEELE: That's okay. That's not really important.

ASSEMBLYWOMAN WEINBERG: Do you have another question?

ASSEMBLYMAN MANZO: On that subject, I was interested in a concept of providing small insurance business shifts, where-- I know when you insure municipalities, for example, you clump the public works director in with the guy who actually goes out in the streets and repairs the streets, up to the business administrator. When you look at small businesses, they're not allowed to mingle apples and oranges. And I think an approach where the industry begins to provide and allow businesses to join in, despite what different types of workers they have, to pool to buy insurance -- and use regional hospitals and regional doctors -- would drastically bring down rates.

MR. MEEHAN: Assemblyman, there is a regulation that allows associations to approach a carrier. It's called the -- I forget which legislator sponsored the bill -- we call it the alliance bill.

ASSEMBLYWOMAN WEINBERG: They can, but the problem is, they can't find anybody to sell them the insurance.

ASSEMBLYMAN MANZO: Yes, but the problem with that is that they're all clumped. An association has, like, the bus drivers. I'm talking about the butcher and the hardware store.

ASSEMBLYWOMAN WEINBERG: No, the chamber of commerce can do it, the small business.

ASSEMBLYMAN MANZO: They can?

ASSEMBLYWOMAN WEINBERG: Yes, but they can't find--

MR. MEEHAN: The Chair is correct. The thing I would just add to that, though-- It goes back to a comment that Assemblyman Cohen made. We're very sensitive that if you start allowing groups to come out of -- think of the small employer as a large pool -- to create a special deal with a carrier, or two, or three -- that you've done violence to the lame in the hall to remain in the existing pool.

Studies have been done, including the Congressional Budget Office, over the last three or four years, that would suggest that association health type plan allowances -- that kind of plan would increase the uninsurance rate in the United States by a good -- I think it's at least by another 2 million. Because what it does is, it attracts more people into -- initially into those association-type arrangements, but, over time, erodes the safety net for the really sick who are currently in the pool, because those people are not allowed into those arrangements. That's the way most of those pools work in other states. Pennsylvania is a good example, our neighbor to the west.

ASSEMBLYMAN MANZO: If they restructure like you do a municipality, where you have to insure everyone who's a worker in the municipality, you can't exclude them.

MR. MEEHAN: But remember we're talking about small employers. And the average small employer in most states, including New Jersey, is two employees. You don't have to take them. And that's the way the Federal plan is set up.

ASSEMBLYWOMAN WEINBERG: And we'll move on. But just by way of notation, I know, in my community -- in Teaneck, the chamber of commerce formed such a group for the small, downtown merchants. But they cannot find anybody who is willing to sell them the insurance. So the regulation does absolutely no good if-- And the reason they're giving is, they don't have a rating history, so they don't know about the people who are joining this. Are they sick, are they well, are they whatever? That's the public reason they're giving.

ASSEMBLYMAN MANZO: So why wouldn't Horizon (indiscernible) for a policy then?

MR. MEEHAN: The other thing I'll tell you -- that associations, under the best of times, are difficult to underwrite. Most of the HIFs in New Jersey have disappeared for that reason. They're no longer viable entities. Property and casualty insurance is a very different ball game, with very different drivers and different dynamics. They're working, and they're doing fabulously. Those are the JIFs. The HIFs are not doing well in New Jersey.

ASSEMBLYWOMAN WEINBERG: Last question, and then the next panel.

ASSEMBLYMAN MANZO: Deductibles-- Have you ever looked at a study on the correlation of a deductible based upon income, where within a group you have a group deductible, and then, maybe within that deductible,

you could then have the guy at the higher end of the ladder winds up paying more of a deductible -- than the guy at the lower end -- who can afford more?

MR. MEEHAN: There are some self-insured, very big, national companies that have that approach -- had it years ago. There's a movement back towards that on the self-insured side, because it makes sense -- people who can afford to pay it. It's kind of a progressive tax type thing.

I don't think it's legal, in most states, on an insured plan. And it would probably be difficult to administer. I wouldn't say that we wouldn't support it as a company. I would throw that back to you and say, "If you think that's a great public policy idea, we'll find a way to administer it." I don't think we'll take a stand on that one, frankly, right now, Assemblyman.

ASSEMBLYWOMAN WEINBERG: Thank you, and thank you for your patience.

The next panel included Chuck Sessa, from Cooper Hospital; Jeanne Otersen, from the Health Professional Allied Employees; Michele Guhl, from the Association of Health Plans; and two representatives of the emergency room physicians.

Mr. Sessa, you came the farthest, I think, other than Mr. Wrich, who came from out-of-state. You returned the favor since we traveled to Camden for a hearing.

**CHARLES E. SESSA JR.:** Correct.

Thank you, Chairwoman Weinberg, and Chairman Cohen, and the other Committee members, for the opportunity to address you today.

I want to-- You have my testimony in front of you. As you can see, it is quite long. And I certainly, with five to seven minutes, won't go through this whole thing.

But I do want to tell you that there are definitely new ideas that are out there with regards to addressing the issue of the uninsured and the underinsured, both with regards -- new ideas, as well as existing programs. And I would encourage you to look for sources of funding other than just the State subsidies. And I would encourage you to look at those that can afford, in order to subsidize these programs. I think it's very clear, with regards to who are the organizations that have the ability to fund and address this very serious problem. And I don't think that you will find that there are any objections from any of the health-care providers, with regards to being held to standards regarding quality, or with regards to their efficiencies at any point in time. And I also think that you will find that the health-care providers are more than willing to put all their cards on the table with regards to the costs associated with running their respective organizations, whether they be inner-city teaching hospitals like Cooper University Hospital, or any other community hospital in this state. I would strongly encourage that you do push for that.

I'd like to present to you today a perspective of the challenges of running such a hospital as Cooper, and the key factors that contribute to the growing expenses of health care, and provide some other observations and practical suggestions that may warrant legislative follow-up.

I would begin by reinforcing Sean Hopkin's observations, with regards to New Jersey hospitals -- as a whole, are financially fragile. But New Jersey's hospitals are overwhelmingly successful in meeting their societal

obligations and caring missions, from caring for the uninsured and underinsured, providing charity care services, stressing emergency preparedness, to training our nations doctors and keeping up with new technologies that serve to improve health and provide an enhanced quality of life.

I'd like to focus on -- since we refer to it, but we don't get into the specifics -- with regards to what are the factors that are driving the increase in expenses with regards to health care -- and just walk through them with you and let you see what they look like from our perspective, and where there are opportunities, other than just focusing on the administrative backlog, with regards to billing.

These are sources, as again you can tell from my testimony, that have come from PricewaterhouseCoopers on a national basis, as well as cost factors specific to health-care organizations operating here in the state, including Cooper University Hospital.

First, increasing patient volume and labor cost remain the most important driver of increases in spending on hospital care. Number two, expensive, new medical technologies; number three -- what all health systems in this state are facing at this point in time -- the replacement of capital and, specifically, the required investment in facilities and the debt service associated with that, and the required investment in information technology where we have lagged for so many years; number four, rising medical malpractice liability insurance; number five, which we've talked about -- increasing bad debt and charity care due to the increasing number of uninsured and underinsured; and

finally, number six, the administrative overhead in claims processing and managed care.

Let's go to the increase in volume and labor costs. For the third consecutive year, the payroll of hospital workers rose more than 8 percent. This is consistent with Cooper's experience. Cooper, despite the fact that it's trending an average of approximately 6 percent annual increase in utilization, in a market that's growing 1.5 percent -- evidence of our growing market share. However, Cooper's labor expense increased by an average of 8.3 percent per year during the same period. And, unfortunately, our labor expense, as a percentage of our overall expenses, remained relatively flat, indicating an overall increase in expenses.

Why are hospital labor costs rising faster than the general inflation rate? The clear answer is, a significant labor shortage in critically important medical professions: nursing and a wide range of medical technicians. Nursing labor expenses have grown significantly over the last five years, on average twice the level of inflation -- medical professional positions, such as respiratory therapists, radiology technicians, medical record recorders, so on and so forth.

Part of the solution of rising health-care labor costs would seem to involve opening up the educational pipeline for the expansion of specialized health-care professions in short supply. New Jersey needs to invest in expanding access to nursing and medical technology educational programs. The combination of State funding to directly support increasing the number of faculty members in these programs, along with incentives, and stipends, and grants to incentivize students to pursue these careers and work in New Jersey's health-care delivery system -- this is another idea which could have a material

positive impact on reducing the labor shortages that is one of the key factors that is driving health-care costs.

Let's look at the next two factors: expensive, new medical technology and the replacement of capital. Now, I will comment on the fact that these two factors are viewed from a different perspective than the remaining three, in that these expenses, while higher expenses in the short run, they represent forms of investment in health-care services that are associated with better quality outcomes and an improved standard of living that everyone in this state demands, deserves, and requests; in addition to future operational efficiencies and cost avoidance of future hospitalizations.

It's the final three factors where there would seem to be opportunities for constructive policy initiatives that can positively reduce those costs. Medical technology is a major driver of health-care costs. Why? Because the latest technologies mean the difference between life and death. A significant portion of the money that this State invested in Cooper University Hospital, through the Camden Revitalization Bill, has been dedicated towards increasing the need to expand and modernize our critical care facilities. And that type of investment is taking place across the state, by all health-care institutions.

Drug-eluted stents, automatic implant defibrulators-- These are examples of how changes in clinical standards of care results in increased costs. But improved clinical outcomes enhance the quality of life for their patients. To reiterate, increased health-care expenses associated with improved medical technology represent an investment associated with better quality outcomes, so important by all of the providers in this state -- improved quality of life and

cost avoidance of future hospitalization. This is really not an area, we believe, where the legislators need to focus their attention. A good board of trustees and a good management team should be focusing their attention in these areas.

The rising health-care cost associated with the replacement of capital-- Needless to say, everyone is aware of the need to invest in the health-care structure and providing the necessary health-care financing to take care of the 87 million baby boomers that will start reaching the retirement age in 2010.

The hospital industry had recently shifted from having surplus capacity in hospital beds and in-patient technology to the projected future needs of approximately 200,000 beds nationwide.

Cooper, again-- Cooper's \$135 million, recently announced capital facilities expansion was designed to increase our bed capacity. And you have health-care institutions throughout the state -- including everyone in the southern New Jersey region -- that is going through a similar type of expansion.

Capital investment in information technology is critical to ensure operational efficiencies and to continue to improve the quality of patient care. The health-care industry has generally lagged behind for-profit industries, and this is clearly an industry that has had -- this is clearly an area that has had a negative impact on operating efficiencies in the hospital industry. These are investments that we are in the process of making.

What can the State of New Jersey do, with respect to the need for this new capital investment in New Jersey's health-care infrastructure? Well, you have one recent example that has worked quite well. And that was the investment in capital that took place into the city of Camden and the Camden

Revitalization Bill. A simple investment of \$12 million to \$13 million in Cooper University Hospital has been leveraged into a \$175 million expansion of our services. We have to look for opportunities in order to provide low-cost capital financing to enable the health-care providers in this state -- to increase their capacity in order to address the future demands, as well as to improve upon information technology. Again, items that are focused on quality and meeting the demands of today.

A second, is with regards to medical education. I spoke about the future need with regards to rising demand for health-care services. There's also a future demand with regards to the need of a shortage of physicians. One perfect example is to continue to fund the University of Medicine and Dentistry's budget, and they're focused on providing medical education. You have a perfect opportunity for that with regards to the expansion of their medical school programs -- including the one that's based in Camden -- throughout the state.

This pays dividends. There's an immediate return on investments. You heard me speak at the last Committee meeting with regards to the number of southern New Jersey residents that were leaving the region, going over to Philadelphia and taking their health-care dollars, because they perceived that they could obtain something better and because of the lack of the resources that were invested in the southern part of the state. That is changing, and the results that you can see at Cooper University Hospital, and any of the folks that you talk to in that area-- You can see where investment and the improvements, with regards to the hospital, have stopped that outflow and

have begun to keep those health-care dollars here in that state. It would encourage more programs along those lines.

Let me move to the next item here, with regards to increased medical malpractice liability insurance. At Cooper University Hospital and other health-care providers across the state, since the year 2000, we've seen a five times increase in the cost of medical malpractice insurance. The leadership of this Assembly is to be publicly recognized for their path-breaking medical malpractice liability reform at the last legislation session.

I just would make one point here. And that is that we trust that the Legislature will continue to monitor the progress and address any changes that need to be made. It would be unfortunate if the cost of such coverage continues to parallel with the increases in medical malpractice settlements. So that, again, is an area that we have to remain focused on.

Let me move, now, to the rising health-care costs with regards to increasing bad debt and charity care, caused by the increasing number of insured (*sic*), which we have talked about. The path-breaking charity care legislation, adopted in 2004, provided significant relief in charity care payments for Cooper University Hospital, and the other hospitals throughout the state, particularly in light of the formal designation of Cooper University Hospital as a safety-net hospital. This legislation is crucial to all health systems' financial stability and ability to meet their mission as the major -- as teaching hospital and safety-net providers.

But there are other opportunities. Medicaid and Medicaid HMO, as you've heard, pays approximately 70 to 80 percent of the hospital stay.

Charity care is priced at Medicaid rates. And, therefore, health systems receive even a lower percentage with regards to the cost of the hospital stay.

There are those that do not qualify, as we've heard talked about, with regards to Medicaid or charity care. But there are initiatives that can take place. One is from the perspective of how to avoid some of the Medicaid, and managed Medicaid, and charity care expenses by increasing access to the quality primary care providers. Many primary care physicians have withdrawn from the Medicaid program due to low reimbursement for services rendered to Medicaid patients. For numerous reasons, managed Medicare HMOs are generally unsuccessful in managing the health-care services of a Medicaid patient. Many charity care patients go without primary health-care services. Physicians, as you are aware, that do not receive charity care funding are reluctant in order to treat these primary care patients.

There is a perfect opportunity. There was a recent study, in 2002 and 2003, in the city of Camden, that indicated that 16 percent of hospitalizations, per year, were preventable, ambulatory care sensitive conditions. This equates to approximately \$28 million worth of charity care hospitalization that could have been prevented with a focus from the primary care physician perspective.

Cooper University Hospital and other inner city hospitals have indicated their willingness to participate in a Medicaid demonstration project that focuses on providing the primary health-care services, in order to keep these patients out of the hospitals when their situations become much more serious.

The next rising health-care cost -- due to the administrative overhead. I don't want to repeat, and in my testimony you've got five specific problems and the proposed solutions. I would just emphasize that if you look at those proposed solutions, you will see that the payer should be required to, or to explain why not -- a reasonable solution. There's ample opportunity for us to sit down, as an industry overall, and work out these solutions for purposes of accelerating the payment cycle, all of which we have talked about here in great length.

I'd like to just wrap up. And as Sean Hopkins also pointed out -- and to emphasize that the growth in spending in hospital services is moderated. Having spent considerable time on the factors that are contributing to this rising health-care cost, you should note that, right now, there is success, that the rate of growth is -- with regards to spending -- is declining. And, specifically, you can see that as evidenced at Cooper, as well, where the average cost, per case, has declined for three straight years over the last three years.

So, with that, I'd like to conclude. I know there was a lot here to cover, and I went through it very quickly. And I'd be glad to answer any questions that you have.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Is Ann Kohler still here? (affirmative response)

If you would take note of what Mr. Sessa just spoke about, in terms of an inner city hospital Medicaid demonstration. Perhaps you have to get Medicaid patients into primary care -- or under primary care physicians. We'd be happy to get some input from you, in terms of the development.

Thank you very much, Ann.

Thank you.

I was also supposed to call up, with you -- which I didn't do -- Colleen Matthews, right there, from Saint Joe's -- very rude of me -- and the New Jersey Counsel of Teaching Hospitals.

But as they are gathering, Michele, if you would--

I'm sorry. Were there any questions?

ASSEMBLYMAN GORDON: Yes.

ASSEMBLYWOMAN WEINBERG: Bob.

ASSEMBLYMAN GORDON: Thank you, Madam Chair.

I'd like to follow up on this issue of labor costs as a driver of hospital cost structure.

I've been led to believe that there is a pool of qualified ancillary medical staff -- respiratory therapists, and so on -- who are foreign medical graduates, and that there are some regulatory obstacles to tapping that pool of talent.

Has that been your experience? Are there some things that we can do, in a regulatory way, to try to remove some of the obstacles to getting access to either technicians or nurses? Could you comment on that?

MR. SESSA: Yes, I can. At this point in time, it's not an issue with regards to just hurdles that we're facing, but the pool of talent is there. It's an absolute shortage, with regards to the talent that is necessary, from both the nursing perspective, as well as the medical technician perspective.

And the problem is not-- There are those that want to be educated, there are those that want to be trained in each of these areas. From a funding perspective area, however, the class sizes are limited. And so

whether you're talking about the University -- UMDNJ's nursing school, whether you're talking about Rutgers' nursing school, there's a limit, with regards to the number of students that they can accept because of the funding that they receive and the available faculty that's there to teach them. And it's not that there's not qualified faculty members that can do so. And so it's just a question of being able, in terms of -- we only have limited amount of capital everywhere. And so it's a question of making the best use of that capital, in terms of being able to fund those programs that educate the very individuals that we are looking to hire and that need -- whether you're talking about a physician, whether you're talking about a nursing executive, or whether you're talking about a medical technician -- is only going to get worse.

ASSEMBLYMAN GORDON: Okay. Thank you.

ASSEMBLYWOMAN WEINBERG: Michele.

**MICHELE GUHL:** Well, good afternoon, ladies and gentlemen, distinguished members.

I'm Michele Guhl, President of the New Jersey Association of Health Plans. The carriers that I'm proud to represent -- just so you can put the Association in context -- cover more than 97 percent of the covered lives in this state.

So newsflash, "The nation's spending on health care grew more slowly than it had in several years. But for consumers, out-of-pocket spending accelerated to a 7.6 percent pace in '03, as employers shifted more costs to employees, and more people went without insurance." So we've been hearing about this all day today. This quote, by the way, is an excerpt from the *Wall*

*Street Journal*. It ran a story just last week on the 11th of this month. And here we all sit.

Health care and, by extension, health insurance are just too damned expensive, and we're not going to take it anymore. We're frustrated, befuddled, and angry. There must be someone, or rather, some group to blame.

ASSEMBLYWOMAN WEINBERG: You're stepping up to the forefront, is that right, Michele? (laughter)

MS. GUHL: Apparently.

Well, like it or not, it's always amazing to me that there are people who just don't seem to accept this truth. Premium increases are merely a symptom of the underlying increases in health costs in general. There are a number of factors -- many of them have been delineated already -- that contributed to this in health-care costs. People like me, in my age category -- the infamous baby boomers -- we're aging to the point where, like my sorry knees, we're needing more and more chronic care. So that's, clearly, adding to the cost.

Increases in in- and outpatient hospital services, increases in the cost of and utilization of physicians, prescription drugs, new technologies -- all of this is adding. But, mostly, we are just using, consuming, in a voracious sense -- and I say that without any value judgement -- a lot more medical services.

Now, someone did mentioned earlier about the failure of managed care. Let me just point out -- again, without any value ascribed to it -- a key short-term cost driver is the retreat from tightly managed care that

characterized the health insurance market in the '90s. Managed care was developed to contain costs -- and managed care, a lot of-- There was a lot of reaction to how tightly managed care was -- a lot of consumer backlash, a lot of regulatory, legislative, other kinds of backlash. So it has loosened. And with that loosening, you do see premiums going up. As it loosens its grip, consumer demand was unleashed, manifesting itself in higher health-care costs, and concomitantly, higher premiums.

There was also corresponding provider consolidation and pushback, and a demand for higher reimbursement from the industry. Hospitals passed along the wage increases that they had granted to address labor shortages -- you've heard about that -- especially in the area of nursing.

One of the things we haven't talked about, and I'll simply state it briefly, is that-- One of the issues is that government programs -- Medicare, Medicaid -- have very -- have fixed rates. So the pressure, when one is negotiating -- a hospital, a doctor, any type of provider group -- for increased reimbursement, there's more pressure put on the commercial insurance industry simply because there's flexibility there. You can't negotiate with Medicare to increase the rates. You can with a policy -- an Aetna, or United, or Horizon policy.

As noted, new medical technology is thought to contribute to increasing costs. There are hosts of new procedures, new applications of old procedures, and many technological innovations that, while they may decrease unit costs, generate increased demand and increased volume in services. These advances do not exist in a vacuum. The public expects new technologies, new procedures, new drugs, and new cures. Direct-to-consumer advertising has

enhanced this demand. Physicians and hospitals that do not offer the newest services will be avoided, as patients search for advanced treatments.

Understanding, as we do, that wanting access to the best possible care, and the newest treatments, is, frankly, natural. After all, we're talking about our health here, and the health of those we love. So we search for ways to fix the system to make it more affordable without sacrificing access or quality.

There must be somewhere to cut. Perhaps it's in the arena of administrative costs, particularly that of the insurance industry. After all, no one really wants to cut costs by reducing covered services or retightening the managed care belt.

So let's discuss administrative costs. My testimony is here-- The Department of Banking and Insurance did a wonderful job detailing for you. You know about the medical loss -- or minimum loss ratios, and New Jersey's standard of 75 percent, and that. Let me not go into that. But let me just say -- because I don't think this point was made, and I did research it.

Few states have an MLR requirement greater than New Jersey's. There are some at 75. There may be one at 80 -- I think New York. But the vast majority of states across this country are either less restrictive or silent on a minimum loss ratio, just so you know -- in context.

So how are we doing in this regard? I think -- I hope you were pleasantly surprised to learn that the carriers in this state are at an 84.7 percent -- in 2003. So they're about 10 points higher paying out in medical claims than the law requires them to be.

So what are these non-claims? We keep talking about administrative costs. What are the kinds of categories that constitute administrative expenses? Let me just tick off a few: claims administration, sales and commissions, billing and enrollment, detection and prevention of fraud -- I don't think any of us want to see that get cut -- customer services, regulatory compliance, wellness and health programs, marketing, and State and Federal taxes. That's what we're talking about when we're talking about the aggregate term *administrative costs*. Churning in the health-care industry is also -- adds a lot of administrative costs. Every time an individual disenrolls or reenrolls, whatever, that adds to the cost.

In an '03 report, Milliman USA analyzed health plan administrative cost nationwide and found that while premiums were going up an annual rate of 7.4 percent -- this is an average over five years -- administrative expenses were increasing, but at a lower rate.

That's not to suggest that there aren't efficiencies here in administration that can be achieved. For example, we already have, in New Jersey, a Prompt Pay law system that rewards for electronic submission of claims by providers. There's a long way to go here, however. And there's still lots of pockets, resistant, of providers, particularly -- frankly, in the physician arena -- resistant to some of the systemic improvements that computerization affords.

Doctors, hospitals, and employers can benefit significantly from plugging into health plans' real-time systems that provide instant information on eligibility, enrollment, disenrollment. Wholesale utilization of these systems would substantially reduce the number of rejected claims and allow

employees to have virtually instant coverage. Plus, providers would be paid more rapidly. The take-away point here is simply that these types of technology save money.

Respectfully, I'd also remind this body that every new regulation promulgated by our regulators, though well-intentioned I'm sure, adds to the cost of administration for health insurance. Like most everything else in life, temperance in regulation should be considered for regs cost, in the very real sense of the word.

So, what's the deal here? If overall administrative costs are within reasonable limits, where do we go? Again, I'm not going to speak on topics that have already been spoken. But let me just make a couple of broad points. I would submit that, collectively, there's a long way we can go. However, to succeed, we must be willing to acknowledge that the blame, as it were, does not fall on any one segment of our complicated health-care system and that, surely, the solutions will necessitate change in all components: hospitals, doctors, insurance companies and other payers, government leaders, employers, and even consumers.

What are the key things that we think would work? Frankly, we have to address the uninsured. It's the right thing to do, morally, and it's the right thing to do, economically. The fewer people there are, as you well know, uninsured-- Just one of the examples is less pressure on the uncompensated care system in this state on our hospitals. That's just one point.

So, to that end, I certainly applaud -- and the Association does -- Senators Vitale, and Buono, and Assemblywoman Weinberg, and-- I'm sorry.

ASSEMBLYWOMAN WEINBERG: Morgan.

MS. GUHL: Morgan, thank you -- and the FamilyCare bill that was recently introduced.

Some of you may know, in an earlier life I oversaw that program. I think it's a wonderful one. New Jersey is not unique in having to, sort of, curtail it. A lot of states are suffering from economic troubles that have necessitated that. However, I would argue -- and I sat on the committee with Senator Vitale and Assemblyman Morgan -- that that bill, and the priority of expanding FamilyCare, is -- should go to the top of any list in your consideration for the upcoming budget, not withstanding the fiscal pressures that I'm very aware you face.

Again, you've heard about the need to reform the individual and small market. And though it looks like he's left, Assemblyman Cohen's bill -- though it's not exactly what my industry would like to see happen -- if that got passed, it would go a heck of a long way toward reforming the market. And we understand that improvement is incremental. So I want to be on the record saying that that's critically important. We've got to move quickly.

I watched Assemblywoman Vandervalk -- and almost the shock in many people's eyes when they looked at the premium costs. We've got to pull out -- particularly the individual market -- out of its current debt spiral and allow it to operate on the principles ensuring a viable market affordable to a large cross-section of citizens, not just those who are too sick not to pay its brutally high premiums.

Quality is an area that--

ASSEMBLYWOMAN WEINBERG: Michele, could you sum up?

MS. GUHL: I will.

I want to talk real quickly about quality, because you've heard it saves money. There's a great serendipity between improving quality in our whole system and saving money. We should be panicked about some of the reports. We should channel the passion that -- a lot of our reactions about fighting against the validity of the reports about needless death, or how inaccurate those reports are -- rechannel it into working together to address quality, ancillary impact. We're going to save on costs.

Payers -- people like I represent need to do more. We need to find ways to incent top-quality providers. We need to provide more data to our members. We have to stop paying for poor quality. Every time-- This, of course, is exactly what we do every time we pay for a physician, or hospital visit, or additional drugs resulting from preventably poor care.

Employers can do a lot to incent their employees.

Transparency, I think, you've heard about. Until we get more information, we don't know what's good. We don't know what's good quality, mediocre or, in fact, poor quality. We've got to get more report cards out there, we've got to get more Web sites out there, we've got to let consumers start to shop for quality and value.

And the consumer will, in fact, over time, help to drive improvements, I'm convinced, in the whole system.

I'm skipping here, very quickly.

And I guess I'll just end by saying this -- reiterating what I learned when I had the privilege of overseeing the Department of Human Services. I learned very quickly there that an easy solution to a complex problem was guaranteed to be flawed. I'm sure each one of you, as legislators, has had that

same truth hammered home to you many times. So, too, with this issue. Cost and quality of health care -- a clearly complex issue, if ever there were one -- and it's important that we guard against easy answers, against affixing blame, or finding the scapegoats. Fixes will be incremental, and varied, and involve all parts of the system. They will take a sustained effort on all our parts.

My members, the members of the Association of Health Plans, stand ready to be a part of the solution. And I would hope that you would view us in that regard.

Thanks.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Michele.

Any questions here? (no response)

Jeanne Otersen, from Health Professional Allied Employees (*sic*).

**J E A N N E O T E R S E N:** Now that we are just all worn out.

I'm Jeanne Otersen. I'm the Policy Director for the Health Professionals and Allied Employees.

And I'm knocking everything over.

We represent 11,000 nurses and health professionals -- those that might be driving up the labor costs, as mentioned. We represent nurses at Cooper Hospital, so we'll talk later.

And normally, when we come before this body -- particularly the Health Committee, that we've worked with a lot -- we're here as frontline caregivers, which we are. We see, I think in every hospital, good, bad, indifferent -- the kinds of problems in our health-care system. And we focus

mostly on quality issues, because that's what we do. And the financial end -- we monitor, we look at.

But here, today, I think we're here for a little bit different reason. And I brought Jeff Peck with us, who is the President of our local union at Bergen Regional Medical Center -- somewhat the poster child, I think, for everything going wrong in our health-care system today.

**J E F F P E C K:** Not me.

MS. OTERSEN: But he's here in a unique role, compared to everyone else, including myself, that's speaking today. He's here because he's one of those folks who has an insurance policy that does him very little good. And that's what I think we're talking about, more than anything. We're talking about all these big systemic problems with, in my view, everyone talking about who else is to blame, as opposed to how do we fix this.

But I wanted Jeff just to give you a couple of examples of what's going on with one health insurance company in New Jersey. And then I want to talk about what that costs us, in terms of taxpayer dollars, Medicare dollars, health-care dollars that are being, literally, sucked out of the system not providing care. And we will be, if nothing else, brief.

And Jeff has to go off to work at the hospital. So I just wanted to give you a couple of examples of what's going on in the real life of individuals.

MR. PECK: Okay.

The reason that my hospital is unique is the same three gentlemen -- Robert Salazar, Ari Krausz, and David Sebbag -- who manage the hospital at a profit of millions of dollars per month, also manage the medical plan. So

they're not only experts at receiving money, they're experts at withholding money that should be paid out.

We have dozens of our members in collections, because their health plan -- the same three guys manage the health plan. And it's interesting to sit here today to hear different people, in various ways, point fingers at other organizations. This is the same three gentlemen who are responsible for receiving money from plans -- also are responsible for paying out. They are very good at receiving money. And, in fact, the State is magnificent in making those payments.

ASSEMBLYWOMAN WEINBERG: And the name of that company is?

MR. PECK: Solomon Health Services. But they also have other--

ASSEMBLYWOMAN WEINBERG: No, the name of the--

MR. PECK: They have Global health care.

ASSEMBLYWOMAN WEINBERG: The name of the insurance company.

MR. PECK: It's Global Administrators. But they had a-- They had an IDA that they used to manage it to cover for Global. When we made too many complaints, they said, "Well, cut out the middleman and you deal directly with Global." When payments still weren't made, doctors were fleeing the plan, they said, "Well, we'll get another administrator." And now we have IBA, which is an administrator for Global insurance, which is still the same three owners that manage the hospital.

MS. OTERSEN: And I'll go through the Global financial statement in a second. I just wanted Jeff to talk for the individuals.

ASSEMBLYWOMAN WEINBERG: And do you have some statistics on their loss ratio?

MS. OTERSEN: Yes, I do.

MR. PECK: I, again, just have anecdotally -- have to anecdote-- A woman had a baby last month. The baby needed a medication that cost \$1,000 per injection, and the medication was withheld until the money men figured out whether or not it was going to be paid for.

We have a member whose husband was in Holy Name Hospital, which is supposed to be a 100 percent provider on our medical plan. But the-- He went for an x-ray while he was in Holy Name Hospital, and the x-ray department of Holy Name Hospital is not covered, but everything in Holy Name Hospital was supposed to be covered.

ASSEMBLYMAN CONAWAY: He's not speaking into the microphone.

MR. PECK: We have a--

ASSEMBLYWOMAN WEINBERG: You have to use both of those microphones.

ASSEMBLYMAN CONAWAY: It won't go on the tape.

ASSEMBLYWOMAN WEINBERG: See, that one is the recording microphone.

MR. PECK: We have a member whose daughter needed -- and I'm glad this was brought up earlier in the day -- needed mental and drug abuse help -- the daughter. And although we have uninsured who would have recidivated and made this literally over 100, our plan only covers one illness per lifetime, if it's a mental illness. Otherwise, we don't get payment.

It's not exclusive to the union. Our director of personnel, who has since left the hospital, was denied a claim for a year-and-a-half. It doesn't matter who works for them, they get treated similarly.

ASSEMBLYWOMAN WEINBERG: Didn't you have some statistics on the loss ratio of this company?

MS. OTERSEN: Yes, let me go through the company.

ASSEMBLYWOMAN WEINBERG: It seems to be exactly opposite of what the State regulation requires.

MS. OTERSEN: And Michele has asked me to point out that it's not a member of her Association.

Part of the problem is probably above and beyond this Committee, but it needs to be looked at. This is a company -- Global health insurance. It is a subsidiary of Solomon Healthcare, which manages Bergen Regional Medical Center. So as Jeff pointed out, they're paying themselves. They take in \$18 million, \$1.5 million a month, in fees to provide health insurance. They take in a little under a million a year from premium dollars. They pay out, in claims -- and this is based on two years that we had to fight lawsuits to get access to -- goes to your disclosure issue -- 2001-2002. In 2001, they had \$5.7 million in claims that they paid out, and another \$150,000 in administrative costs. So they don't have a big old group of people working for them. So in each year, to sum up, they had either \$6 million or \$7 million in claims that they paid, while they took in almost \$19 million each year. About 65, 66 percent, as I added up -- somebody else better with numbers -- is going to profits for that company.

Now, it's a self-insured company. It's what Assemblywoman Vandervalk was talking about before. How do we get at these companies that are escaping regulation? And maybe the way is, why would this company be allowed to exist in the first place? Why would a company, who runs a hospital, who is insuring 1,600 people, be allowed to pay themselves with public dollars? Remember, this was a public hospital for years. It's still considered a public hospital when it comes to funding.

So no matter what any of us here believe, when we're talking about where our health-care dollars are going, they're not going to this Association, they're not going for health care, and they're not going into the health insurance for people who are supposed to be getting it.

We surveyed our members. Fifty-five percent of them said they had denials and delays of payments in the last year. Some five months, some nine. As Jeff mentioned, one a year-and-a-half.

ASSEMBLYWOMAN WEINBERG: Do we still have -- members from the Department of Banking and Insurance are here, I think.

UNIDENTIFIED SPEAKER FROM AUDIENCE: I'm here.

ASSEMBLYWOMAN WEINBERG: Sheila, I hope you're taking note of this testimony. I would expect the DOBI to look into this and inform us the answers to some of the questions that Ms. Otersen is raising.

MS. OTERSEN: These are-- As one of the most -- quick -- and I'll finish up -- horrific examples Jeff was talking about is a woman whose daughter was -- and it was the second time -- admitted to a hospital after complications resulting from a, luckily, failed suicide attempt. She was denied coverage, because they don't cover self-inflicted injuries or illnesses.

The denials come, sometimes, after certification. They certify a procedure and say, "We still withhold -- hold on to the right to change our minds," essentially. We are going -- trying to go to the Federal Department of Labor with this. It's a travesty, and I'm sure it's worse than anything anyone else could describe. But it does say not only the kind of abuse that individuals are undergoing -- who have a union who's out there fighting for them. Jeff is out there fighting for his members every day. But, again, this is 1,600 people at this hospital.

I would ask-- As I mentioned earlier, we're also frontline caregivers. So we're not just part of this process because we have problems with this horrific insurance company. But as it's been said, the whole system needs to be transparent. We fought for two, three -- I think three years to get this information so we could figure out where the health-care premium dollars were going. And, again, these are payments coming out of tax dollars. This is a public hospital, for all intents and purposes.

We need our system to be transparent. We need some limit on profit taking, as opposed to just being efficient administrators. Twelve million dollars in profit a year-- And I should mention really quickly that what I also have seen from their financial statements-- You talked a lot about reserves. They spend that down at the end of every year. At the end of every year, you see a taking of those profits to give to these three men. And in that health plan, at the end of the year, is left about \$55,000.

ASSEMBLYMAN COHEN: How do they get a profit of \$12 million?

MS. OTERSEN: They are paid one-and-a-half-- They pay themselves \$1.5 million a month to manage a health insurance company -- self insure their own health insurance company. Those are from Medicare cost reports and documents we had to sue to get. So they make \$18 million a year, and they pay out somewhere between \$6 million and \$7 million a year in claims.

ASSEMBLYMAN COHEN: How are they regulated?

MS. OTERSEN: ERISA.

ASSEMBLYMAN COHEN: So they're subject to ERISA.

MS. OTERSEN: And we have gone that route. We're in the process of trying to go that route. They've not provided summary plan descriptions, exemptions. But it seems, from what I can see under ERISA, frankly, if you tell someone you're about to really do them an injustice, it's okay. It's when you don't tell them. So if you don't give them a list of exemptions, you're in violation. But if you give them this long list that says, "You're paying for health insurance, but you can't go here, you can't go there--" We have diminishing networks, doctors have left because they don't get paid, people are denied their exemptions. And there's nothing in ERISA that says this amount of money is excessive.

ASSEMBLYMAN COHEN: Are they a public authority, quasi-public, or just private?

MS. OTERSEN: It's this bizarre relationship. And, again, we could take all day. So cut me off at any point.

ASSEMBLYWOMAN WEINBERG: I'll explain that later.

MS. OTERSEN: It is, the county has leased the hospital to BCIA, an independent authority, who leases the hospital to Solomon Health Group, who set up a corporation called Bergen Regional Medical Center. They have all these subsidiaries to provide care. They have a hospice where a patient just committed suicide. It's their for-profit hospice. If you can imagine that -- a contradiction in terms. They have this Global health insurance company that doesn't provide health care to the people who are enrolled in it. And that's how they do it.

ASSEMBLYMAN COHEN: So the Improvement Authority leases it to them, therefore they are not a public authority.

MS. OTERSEN: Right. But they are a public hospital for psychiatric--

ASSEMBLYMAN COHEN: And, therefore, they're not subject to--

MS. OTERSEN: I'm sorry -- for psychiatric cost-sharing dollars. They get a higher reimbursement rate as a public hospital.

ASSEMBLYMAN CONAWAY: Higher reimbursement always perks my ears. I'm trying to figure out--

ASSEMBLYMAN COHEN: No, it's just wishful thinking, Herb. (laughter)

MS. OTERSEN: It's the whole point of health-care dollars that everybody is scrambling for. And here is this microcosm of--

MR. PECK: It's what they're expert at. They're expert at procuring dollars and holding onto it.

ASSEMBLYMAN COHEN: Do they do this anywhere else?

MR. PECK: Yes.

MS. OTERSEN: They have nursing homes in Colorado. That's it here in New Jersey. They have this one hospital.

And I think, again, the bigger picture is -- the smaller picture, the localized to us -- is can we do anything about this system in any way -- and its impact on individuals? Isn't it time to look at models like were talked about earlier today in Maine, Wisconsin, Hawaii, wherever they are, for some kind of state plan? Because you can fix this, you can fix that.

It's what you were saying a little earlier, Assemblyman Conaway, about expanding State health benefits beyond this. We're not going to fix it if we just close all these little problems and loopholes. It's not going to happen. And I just sat in, a couple weeks ago, on the mental health hearings that Assemblyman (*sic*) Codey has put together. And they were compelling and fascinating. If you talk about that as a system that is failing people, it's horrific. And, again, the dollars-- This is, again, related to Bergen Regional.

ASSEMBLYMAN COHEN: Let me just ask you quickly, and I'll move -- I'll just retreat for the moment.

What patients go to that hospital who would ordinarily go to, let's say, Hackensack, Atlantic, Moorestown?

MS. OTERSEN: It's a mix of three. It's the largest psychiatric institution in the state. And Jeff can -- he's a nurse in that mental health division. He can speak to that. It's in-patient, it's chemical in-patient treatment.

MR. PECK: And it's a nursing home.

MS. OTERSEN: And it's a nursing home. And it has a small acute care division that's mostly people from the hospital. Because when we get folks into the behavioral health section, they have multiple health problems. And so they might wind up in acute care. The same thing for the long-term nursing care beds. So it's three different divisions in one. But its biggest thing is, really, psychiatric care.

ASSEMBLYWOMAN WEINBERG: You asked a question earlier today, Neil, about not-for-profit hospitals spinning off to for-profit foundations, or whatever. This is the first for-profit hospital in the State of New Jersey. And if it is a model, I hope it's the very last for-profit hospital we ever see in New Jersey.

ASSEMBLYMAN COHEN: Thank you.

MS. GUHL: They would get money from the Division of Mental Health. As I listen to this, they're being funded by Mental Health in Human Services. If this is Bergen County Psych-- I mean, that's one of the places to try to--

ASSEMBLYWOMAN WEINBERG: I know. We have had a hearing on that and another planned in the near future.

Assemblywoman Vandervalk.

ASSEMBLYWOMAN VANDERVALK: Yes, thank you.

I suppose you've tried these routes, but I'm going to ask the question anyhow. The Bergen County Improvement Authority, which was set up to have oversight over the hospital-- Have you gone to them with these problems that you just presented to us?

MS. OTERSEN: Their basic response is that that is a labor-management issue. It's not-- The most horrific response we got, I have to say, was from the attorney for the BCIA, who said, "As long as they're providing care, who cares if they make a buck or two?"

ASSEMBLYWOMAN VANDERVALK: But there's also a community oversight board that's involved.

MS. OTERSEN: Say it's not anything-- They are only overseeing the care at the hospital, is what they respond. And they have nothing to do with this health insurance issue.

So we're here because we thought, "God, this is an example of what you're talking about." But also, everywhere we go--

MR. PECK: We're regular attendees at their meetings.

ASSEMBLYWOMAN VANDERVALK: I'm sure you are.

Just as another follow-up, has this ever been put on the table for union negotiations?

MS. OTERSEN: Oh, yes.

MR. PECK: Yes. And, in fact, we had to fight hard to maintain the poor plan that we currently have. And at that time, that was the first time we ever saw a summary plan description. None of our members had seen a summary plan description until this past summer. And it was one of the reasons why we went on strike, to maintain -- not even to advance, but to maintain the plan that we had.

There is a tiered system in the hospital. Other unions -- their plan isn't even as good as ours.

MS. OTERSEN: They wanted to increase premiums for this plan.

ASSEMBLYWOMAN VANDERVALK: I pass.

ASSEMBLYMAN COHEN: The \$12 million profit -- is that after they've already made their payments to the improvement authority?

MR. PECK: Yes.

ASSEMBLYMAN COHEN: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: It's a question I've had for a while. And given the panel, I'm going to ask it, with a segway about for-profit conversions of these institutions.

I don't know that it is necessarily a bad thing. As long as the services get delivered, I really don't care how they're organized. But I guess the question is, from a hospital CEO perspective, someone who has to pay entities providing health care, and someone who actually work them, in one of these institutions -- however they're organized. I am curious to hear from all three of you -- is a perspective on this question of hospital conversion, in general. Is it necessarily good or bad? Is it-- What things-- If you are aware of the, sort of, current statutory and regulatory framework in New Jersey -- and we have one down in South Jersey -- Salem Hospital, I think, that is for-profit-- I'd be interested in comments on that, because it's an issue that, certainly, we've had to deal with in my own district, when we had -- I guess it was Allegheny or Tenent -- Allegheny got bought by Tenent, who happened to own a hospital in Burlington County. So it's-- I'm curious to hear your comments on that.

MR. SESSA: Assemblyman, as far as the large, urban, inner city teaching hospitals, I can assure you that we don't have to worry about for-profit conversions in the future -- at least not anyone in their right mind.

I will also tell you that from the perspective of -- and this situation is an unfortunate situation-- Most of the for-profit subsidiaries of a not-for-profit that I have seen -- and the creation of those for-profit subsidiaries, and the utilization of those for-profit subsidiaries -- has been from a defensive perspective. And it's from a defensive perspective as -- and you commented on it earlier -- where you have different -- some of the different services that are provided. And it's the more profitable services that are provided, primarily, in a community-based facility. And what is happening is, the physicians that serve that profitable, particular area -- such as, for example, radiology, and there's many numerous examples -- because of reimbursement, because of low reimbursement, because of having to share the revenue of the health system -- are going on their own, purchasing the facilities, and providing those services outside of the hospital. And it puts the hospital in the position where they either lose 100 percent of their revenue, or they have an opportunity to joint venture to try to hold on to some portion of that revenue. And that's usually what I've seen as has been the -- what's been driving any of these for-profit subsidiaries being established under not-for-profits. There's no act of for-profit subsidiary at Cooper.

ASSEMBLYMAN CONAWAY: And it's defensive because of what's happening, in terms of reimbursements. Those folks are lucky enough to be in a position to be able to -- because of the nature of the way their

services are provided -- to defend themselves against these constant erosions in reimbursement.

ASSEMBLYWOMAN WEINBERG: Okay. Thank you.

I'd like to get to the gentleman -- doctor who is representing the Emergency Room Physicians. And as he's doing that -- call up -- because I'm very remiss -- particularly since you've been so hospitable here -- William McDonald, Colleen Matthews, from Saint Joe's; and the New Jersey Counsel of Teaching Hospitals, and the osteopaths.

**STEVEN A. KATZ, M.D.:** Thank you, all, very much.

I'm going to, truly, make my remarks brief. And, hopefully, we'll not be as controversial. That will remain to be seen.

Good afternoon.

I want to thank the Committees for allowing me to speak today.

My name is Dr. Steven Katz, and I'm an emergency physician in Trenton. I come here today as President of the New Jersey Chapter of the American College of Emergency Physicians. We represent nearly 600 emergency physicians across the state. Emergency physicians are the frontline of medicine, and we're its safety net, as well. We see all comers, 24 hours a day, 365 days a year, weekends, and holidays. We are the physicians patients turn to in times of crisis. We are certainly in a crisis when we speak about the uninsured.

According to a recent study, each emergency physician provides over \$125,000 in uncompensated care per year, far overshadowing any other physician group. In a busy, 12-hour shift, I may see upwards of 75 patients in my emergency department. We average about 33 percent uninsured, what we

call *self pay*. I frequently ask patients why they came in today for an illness that has been going on days to weeks, hoping to find out what symptoms worsened so as to make an accurate diagnosis. But more than half the time the response is, “I don’t have any insurance, so I didn’t see the doctor sooner.” The emergency department, a center for acute and unscheduled care and excellence, becomes the defacto primary provider of medical care to the uninsured. We take care of all of those people who have no other alternatives for access to medical care.

New Jersey-ACEP wants to be at the table to discuss these issues, and we want to be the organization that provides solutions to the problem. Because we are part of the largest national emergency medicine organization, we have the resources and manpower to find out what has worked elsewhere and bring the best ideas here to New Jersey.

Many states have grappled with the concept of some type of universal health care or a system where employers with a set number of employees are required to provide coverage. Other states have put in some type of premium assistance program.

Here in New Jersey, we can certainly explore these issues and, maybe, adapt some of them to our unique population. We feel, however, that the best solution is some type of public-private partnership with the creation of a series of clinics throughout the state that will serve as a low-cost or gradation-scaled alternative to provide for the primary care needs of the people of our state. This will give the uninsured a place to follow for their long-term care, once they have been seen for their acute illness in our state’s emergency

departments. We don't want to shunt people away from the emergency department, only provide them the access to care across the health continuum.

Emergency physicians want to remain the safety net for all the people of New Jersey. We want the public to turn to their local emergency department when they have an emergency. The Federal government, under EMTALA, will continue to mandate that we see all comers. We just want what you're providing us here today, the ability to sit at the table and air our views and potential solutions on the uninsured issue.

And for this, I thank you.

I hope I kept my remarks brief enough for you.

ASSEMBLYMAN COHEN: Thank you very much for that courtesy.

Dr. Goldstein.

**COLLEEN MATTHEWS:** Bill isn't coming. Bill, I think, had to be excused for a meeting.

Plus, he spoke already.

Hello, my name is--

ASSEMBLYMAN COHEN: Oh, go ahead.

MS. MATTHEWS: My name is Colleen Matthews. I'm the Administrative Director of Managed Care Services here at Saint Joe's, both Paterson and Wayne. And I have a PowerPoint presentation, but I won't even bother because of the later hour.

ASSEMBLYMAN COHEN: Then we'll increase your funding for the hospital.

MS. MATTHEWS: That's okay. I used a lot of black ink though, as you'll see on the screen shots. You are getting a copy of the presentation if you haven't already. And I'll just refer to slides so we can get through it pretty quickly.

What I'm trying to accomplish today is, really, give the Committee a real feel for what the hospitals go through, from "those administrative hassles," and what we need to do to comply with managed care requirements in order to get care and services for our patients, as well as get paid.

If you look at slide number two, it just goes over a brief agenda that I put together. And, basically, what I'm going to do is briefly go through our departments and staffing that's affected. And then I have four case studies. I won't belabor each case study. But I think, as Val Sellers from the Hospital Association said, and as I will reiterate here, when we look at these four case studies, just keep in mind that this kind of -- these kinds of scenarios, this back and forth to managed care companies, goes on here on a daily basis, and it goes on, probably, in every single hospital in this state. These are not unusual situations.

On Page 3, I have what I kind of put as a schematic, as a managed care encounter. I put a managed care encounter into three buckets. The pre-admission phase, which takes into consideration probably what you're most familiar with -- the precertification, the eligibility, the insurance ID, the referrals. At Saint Joe's, we've put in, about three years ago, a previsit services department of about nine FTEs, just to deal with those responsibilities. They do a great job. They do it for in-patient admissions, as well as all our out-patient services. They communicate with both the health plan, the doctor's

office, and the patient to make sure that everything is in -- all the ducks are in a row before that patient comes to get serviced at Saint Joe's.

The second phase, the in-patient phase, from a managed care perspective, really focuses on the case management department -- or care management department, as many of them are becoming called -- which includes the case managers, which are usually RNs, as well as social workers. I think you may be surprised to know that hospital case management departments speak to managed care companies on a daily basis about the patients that are in the hospital. At Saint Joe's, we actually fax reviews on all our patients to their care manager counterparts. What usually happens is, we get some type of log back that says whether or not the day was approved, denied, pended for additional information. But that is done on every single managed care patient, every single day, defined as Monday thru Friday, because most managed care companies aren't open or operating on Saturday and Sunday.

The post-discharge phase is what I would call the billing follow-up for the payments, that type of thing. But I wanted to keep in mind about that case management piece, because that's so critical, because the managed care companies already know the clinical aspects of the case. And when you see when we don't get paid properly, you have to ask yourself, "How could we not get paid correctly when they knew about it while the patient was here in the hospital?"

On slide four, I just mention provider manuals, because this really defines everything that you see in that whole managed care encounter: Pre-admission, in-patient, and post-discharge phase.

I don't know if you saw me dragging this (indicating) over here. This is pretty heavy. This is just a sampling of our provider manuals. Some of them are hard copy, some of them are in binders, some are soft, some are on CDs now, some are on-line. But every single company has a different administrative binder that we have to abide by.

They not only differ among the managed care companies, they differ within the managed care companies. For example, we could have a -- let me just show you. This (indicating) happens to be Cigna's. I'm not picking on Cigna. Physician coordinated plans and open access plans-- One requires precerts, one requires referrals, one doesn't require precertification, one only for hospital admissions. And this is repeated over and over again. Horizon -- this is the list of things we have to do -- the list of different products they have, and how many different people we have to call, or access this list to call. Part of it is because of the self-insured business nature of our state here, that a lot of these larger plans are able to write their own benefit design. And we have to go through them to get things precertified.

But that's the provider manuals. They're not consistent. They're often out of date. In fact, we just requested one recently. We got it this week. It was from April of 2004, and we just got it this week, because we requested it for another project that we're working on.

Again, I'm going to go through the case studies, starting on Page 5, real quickly. Just remember, there's no question about the eligibility of the patient. These patients are enrolled. There's no question about the services being covered. There's no question about the medical necessity. This is repeated over and over again every day in all of our hospitals.

The first patient -- again, I'll go real quickly. It was a 51-year-old -- very sick, in a major commercial plan. His date of discharge was 10/08/2003. We billed about one week later, which is quite timely. During the stay, this patient needed post-acute services. He needed to be transferred to another facility. This is a common problem, also, that hospitals face with managed care companies. We often-- Well, we almost always can never transfer a patient to an acute--

ASSEMBLYMAN COHEN: Was the person in-- Were they being discharged from acute?

MS. MATTHEWS: They were being discharged from acute.

ASSEMBLYMAN COHEN: And did you have a problem with the carrier regarding acute/subacute rates at the end?

MS. MATTHEWS: Yes.

ASSEMBLYMAN COHEN: Just to let you know, that's being addressed in the ongoing, four-year process on the Prompt Pay.

MS. MATTHEWS: And I don't think a lot of hospitals take issue with that, if we have some culpability in it. But when there's no place for us to move that patient, because there is a problem with the network, or the medical condition--

ASSEMBLYMAN COHEN: And that's exactly what we're trying to deal with.

MS. MATTHEWS: Good.

ASSEMBLYMAN COHEN: And we're trying to reach a compromise that, on the date where this patient becomes, technically, subacute, and the carrier wants to pay subacute, but you still have the patient

and the network hasn't found another place for them to go-- We're trying to work out a compromise where, at some point, it would be reduced from acute to subacute. And if the patient is not networked out, it will go back up to acute.

MS. MATTHEWS: Well, I think most hospitals will be appreciative of that.

What happened here was, we started appealing that, even while the patient was in-house, because, again, it was not our fault we couldn't find a subacute facility for this. We did have several days lowered, and we appealed it. They were overturned on 11/03/03. The last time I checked this week, we have yet to be paid for those overturned days. That's a year-and-a-half.

ASSEMBLYMAN COHEN: How much is owed on that patient?

MS. MATTHEWS: It is a couple of days. I don't have the exact amount. I didn't bring the screen shots with this one. But there were several days of lower-level care. So you're probably talking a couple thousand. Seven days we're talking about getting recouped that, again, were overturned in '03.

Case Number 2 is a Medicaid HMO. I tried to be fair and spread the shame here. A 66-year-old male intubated on a respirator, no question of medical necessity. He was here for 79 days. Every single day was reviewed by the managed care company and approved, concurrently, meaning the patient was in the house when we got approvals.

The patient went home. We billed a week later. That's very timely. We were paid six months later, and incorrectly. Six months later -- and this was a Medicaid HMO. We were paid on 05/13/04. We appealed the incorrect payment. And I say that appealed, because I don't think we should

ever have to appeal something that they didn't pay us correctly. But, unfortunately, that's what the managed care companies require, that's what the Prompt Pay regs require.

We had numerous follow-up calls to the plan. You can go through some of the screen shots. I'm not going to bore you with them. But you'll note on the upper right hand corner of each screen shot, I did put the date it was billed so you'll have an easy reference point as to the follow-up. But do look at them to see how often we get, "It's being processed. We'll return your call." They also admitted that it was probably being delayed because it was a high-dollar claim. That's what Medicaid HMO said.

It kept on going on for a few days. On January 5 -- remember it was billed in October -- they don't know why-- It's been processed, but the managed care company still doesn't know why we weren't paid. Again, we were told it was probably the high-dollar amount. We asked to speak to a supervisor who said they couldn't contact anybody in their claims department. Some of these claims shops are located out of state. Now, whether or not that had impact here, I'm not sure. But we had asked to speak to a supervisor. The person at the managed care company said they couldn't contact the claims department.

Again, requested a supervisor -- a claim process not yet released. This is what I particularly like about this. This is what the managed care company said to our people. This is on January 13. "Claim goes directly to the health plan for final processing payment; has no way to contact them by phone, only e-mail; and appears they haven't responded to previous requests either." That's what the managed care company is saying to us. So their own

people, internally, are not responding to people who are trying to follow up and get us -- get a response on our claims.

On Page 20 is the finalization of this claim. There was an additional 24 pages of notes like this -- screen shots -- on this claim, to follow up. And, probably, all these claims I'm talking about are probably similar in volume of-- I've seen over 50 pages of claims -- pages following up for claims.

It was paid correctly on 12/28/04, over one year after the initial billing and seven months after the incorrect payment.

The final one was another Medicaid HMO patient, very sick, lot of cardiac problems. We did have some lower and denied days, which we decided not to appeal. But 13 were approved at the acute level. We billed a week later. We billed on 01/17-- Again, this is another Medicaid HMO. We received a payment -- incorrect payment two months later, which, again, is a violation of the Prompt Pay regs.

We did get a whopping interest payment of \$10.06 on 08/06/03. And I think that's another concern of the hospitals -- that the interest payment that is built into the Prompt Pay regs really doesn't serve as a deterrent to managed care companies to pay us on time, especially-- Again, this is another high-dollar claim, and we feel that they really take their time paying us on high-dollar claims.

They were closed to bad weather. Eight months after the initial billing, and six months post incorrect payment, they acknowledged they paid incorrectly, sent for reprocessing. They also notice, on Page 25, that there was an overpayment, and they recouped money on this account.

What Val Sellers was talking about -- that recoupment on that claim-- When a company changes their payment -- they paid us one day. Say they pay us two days out of a five-day length of stay. And we say, "You owe us for all five days." So they already paid us for the two days. Rather than pay us for the three days, they will recoup the two days and pay all the five at once. What I'm talking about here-- If there was an overpayment-- If they believe there was an overpayment on another account, they'll take it back on a current account, which makes the accounting even 10 times more difficult. And I don't mind repaying anybody if they overpaid us. But I think they should request a refund, have us look at it, and then we would refund it if it's really reasonable. But they have that power to do that -- to what we call *offset* against current payments, because they write the check.

They have no idea what happened to it. They don't have any idea. I don't know how we can. They said it's not how we bill, it's how they approve it in the system. But our contract says it's how we bill, and that's what the problem was here.

We appealed it. They acknowledged the appeal. Two months afterwards, it was still in review. Remember, all these days were approved while the patient was in-house. Two weeks later, appeal in process, they acknowledged they were three months behind in July. They acknowledged they were three months behind on their appeals, the Medicaid HMO. And these are payment appeals. These aren't even clinical appeals.

August -- they sent for reprocessing. Then they told us to allow another 30 days for reprocessing.

Again, they can't figure out, in September of '04, what happened. It went to appeals supervisor, allow another 10 days.

Finally, reprocessed payment comes in 10/25/04. And guess what? It's still wrong. This is one year and nine months after the initial billing. And it's the Medicaid HMO.

Then I keep on talking about-- And after that -- even the initial payment -- the second payment -- they still owe us \$25,000. So this isn't chump change that we're talking about. A payment came in 12/13/04, almost two years from the date of the initial billing.

My last one I'll take to you real quickly. This is a huge insurance company, a huge national insurance company. It was twin baby boys born here on 08/21/02 -- '02, remember that. Baby A went home first -- had 13-day length of stay. That was billed timely. It was paid timely -- Baby A.

Baby B went home 34 days. So we billed Baby B. What they did was -- paid us on Baby A account, but they paid us from the date of discharge from Baby A to the date of discharge of Baby B. They didn't pay us from the admission date of Baby B to his discharge date. So there still were 13 days left unpaid on Baby B.

ASSEMBLYMAN COHEN: For how long?

MS. MATTHEWS: How long? It's still opened. We're still not paid.

ASSEMBLYMAN COHEN: Since 08/01/02 (*sic*).

MS. MATTHEWS: And this particular one-- What really bothers me about-- They finally have-- It took our people a while to figure out the problem, because it was so confusing, because they kept on paying us on Baby

A's account. And almost every insurance company has a problem paying multiple births. They all get it wrong. And multiple births are quite common now.

ASSEMBLYMAN COHEN: Do they get it wrong, or they do it intentionally wrong?

MS. MATTHEWS: They got it wrong. And they're still getting it wrong. They promised us payment. And guess what they said? It will still be on Baby A's account, though. And when I last checked, which was January 16, we still hadn't gotten the payment. And that's '05, and this was an '02 account.

ASSEMBLYMAN COHEN: You're going to work with issues that you brought up -- some of which we're dealing with in the claims denial bill. You're working through the New Jersey Hospital Association, with regard to your issues?

MS. MATTHEWS: Uh-huh.

ASSEMBLYMAN COHEN: Okay.

MS. MATTHEWS: And also, through-- There was-- I don't know if Ann Kohler is still here, but there's been a couple of Medicaid workgroups that have been established. But, again, it's not just limited to these managed care plans. It's a constant problem.

There was just one other little item I'd like to mention. The previous panel talked about that particular union -- that TPA that wasn't paying. We also see that. I'm glad they brought that up. There's a lot of locals in the area that have very, very limited benefits.

We had two NICU babies. One had a benefit -- in-patient hospital benefit of \$10,000. The other one, \$15,000. That covers the first one or two days. And these parents had no idea that was the benefit.

And I don't know if that's what this -- if it's a similar situation to what Bergen Regional was talking about. But we see that a lot. Unions have very, very limited benefits. And I have a feeling that maybe some of their members aren't aware of the limited nature of their benefits.

ASSEMBLYMAN COHEN: Thank you.

From the osteopaths, we have -- because they have to get back to their patients--

**HARRY E. MANSER JR., D.O.:** Assemblyman Cohen, thank you very much, and Assemblywoman--

ASSEMBLYWOMAN WEINBERG: Use the big microphone, please, too -- both microphones.

Thank you.

DR. MANSER: Thank you.

Assemblywoman Weinberg, Assemblyman Cohen, thank you for the opportunity to participate.

I am an osteopathic physician, and I have practiced in Burlington County for the past 35 years. I have an M.B.A. from Saint Joe's in medical management. And I am currently--

ASSEMBLYWOMAN WEINBERG: Your name?

DR. MANSER: I'm sorry. Harry Manser.

And I am currently serving as President of the New Jersey Osteopathic Association.

Throughout my years in practice, I have noted many changes imposed upon practitioners by the managed care system, which have produced additional bureaucratic burdens on the practice of medicine and have resulted in a decline of overall patient care. Therefore, speaking from my area of expertise, with respect to my family practice, I want to focus on several areas that I find to be most egregious.

First, I will describe what I refer to as the *hassle factor*, which is imposed upon physicians. This is an onerous time burden caused by the denial of medically necessary care, which is caused by the ridiculous requirements to obtain precertification for increasing numbers of routine procedures and tests. Even many prescriptions -- medications require preauthorization. This denial in care, which is increasing since managed care companies and their medical directors are now exempt in many instances by Federal statute for liability-- This results in an astronomical cost to the system. Because a procedure may be delayed while awaiting approval, life-threatening and catastrophic crises are occurring.

Allow me to explain a recent situation in my own practice. A managed care company refused to determine if a -- refused to give permission for a procedure to be done where a person who had previously had a stroke -- a young, 48-year-old male had a stroke, needed to go back and have an arteriogram done in six months. The procedure was denied by the managed care company. The patient was taken off his Coumadin in preparation for this procedure, because it was thought it was approved. The man remained off his Coumadin in anticipation that each day he would get approval. He went on to have a further stroke -- a very significant one, where it left his body half

paralyzed and he was unable to actually speak. Now this has gone from a \$1,500 procedure into a multi-million dollar care for this man who is now permanently disabled.

The medical director is off the hook. He is under the laws of the Federal government. And all the physicians that were previously trying to take care of this gentleman are now responsible for him. And we'll probably all be sued.

Just to show you that the above case is no exception, I also had another middle-aged man not too long ago who had a rare pneumonia. This required a specific antibiotic that was proven by culture to be effective. The managed care company, again, denied the medication because it was too expensive and it didn't fit into their formulary.

When I spoke to the medical director personally, he said, "Try using a similar one." I said, "You don't understand. This man is seriously ill." He said, "I'm not approving it." Fortunately, I knew the manufacturer of the antibiotic. I called the pharmaceutical company. Not only did they deliver the medication, but they delivered it that evening. And we got the gentleman started on the medicine. He has survived, but we have terminated our contract with that managed care company. We have lost some of our patients who, unfortunately, were not able to transfer out of that because of their employers having specific, long-term arrangements with that care.

It is no exaggeration to state that it takes the efforts of one full-time employee, in all practices, just to fulfill all the requirements, forms, faxes that are required to comply with managed care. This has increased the cost of all our practices by at least 25 to 30 percent. And yet, when it's all said and

done, it is the patient that suffers. To a great degree, medical care is now being managed by non-physician personnel, who are restricting a patient's (*sic*) ability to prescribe the best possible medications and the most appropriate courses and treatment for a particular patient.

Allow me, again, just to present one further example. A young man in his early 20s was stung by a bee numerous times. He arrived at our facility, to proceed to have an acute, anaphylactic reaction, and actually died on his way to our examining room.

A code was called and, fortunately, my associate and myself were able to cause this man to actually survive, after providing care for over two hours. We billed the managed care company only for the medicines in the crash cart. We never billed them for our services. There was no bill sent at all other than this. When we tried to collect, just to replace the drugs in our crash cart, we were told by underlings that we actually violated the rules of the managed care company, because we didn't follow their protocol. I asked them what their protocol was. They said, "You should have called an ambulance and sent the man to the emergency room. We pay for emergency room care, but we don't pay for that in your office."

I tried to get through to a medical director without satisfaction. Finally, thanks to one of the members on your Committee, we were able to get through to the managed care. And months later, we actually did receive the reimbursement to actually cover the cost.

ASSEMBLYMAN COHEN: What an amazing thing.

DR. MANSER: We actually did--

ASSEMBLYMAN COHEN: Legislative collection process.

DR. MANSER: We actually did get through, and we actually replaced the drugs.

Thank you.

In specifics, the amount of time and frustration that ensues in obtaining approval for appropriate medications is unconscionable. It is time that New Jersey considers, more closely, regulating the activities of managed care companies. The examples above show denial of care, failure to provide life-saving medications, and a complete disarray -- disregard for the lives of our patients.

Physicians must be responsible parties to determine their patients' care. Pharmaceutical products should not be substituted or denied based on the buying power or the drug rebate given to a managed care company. Quality medicine must stay in the hands of the physician. The cost of the health-care system, from the denial of care, results in greater harm to the patients and an exorbitant spending, down the road, to correct the errors.

What is happening out there is that-- What is projected over this coming year, according to the Outlook for the Managed Care publication for 2005, is that corporate research groupings -- findings published in November of 2004 indicate that managed care profits are expected to rise 20 percent this year, premiums are expected to go up by 10 percent this year across the board. And when managed care companies require more return on their income, they simply just retract past payments from physicians with the excuse that they were paid excessively for their services, the services were not covered, or the patient's insurance was not in effect. Payments are withdrawn years after the

services have been initially paid. And this requires patients to be billed later for services that they thought were paid by their managed care company.

I just gave Zoe -- that's Assemblywoman Weinberg's associate -- a packet of where, in our practice, one of the managed care companies retroactively has taken back payment for one person, for a year-and-a-half ago, that was paid. They took back the payments, and they deducted them from three other patients that were just being billed recently.

Now, this is a bookkeeping nightmare. Not only do you need to actually deduct -- credit the three patients with their payment, you must deduct, now, the payment from the other person that they took back. And then bill the patient, a year -- for services that were rendered a year-and-a-half ago, because this present insurance company is certainly not going to pay them now.

So many of these patients don't understand why they're being billed for a service they thought you were previously paid for. And, if you are lucky enough ever to collect the payment, you've now got to go back into the accounting procedures and credit the three patients who have been deducted.

Now, if I'm doing this as a solo, or-- We have a small practice. But imagine a solo practice, or even small practices like myself, doing all this administrative work. You can imagine what this is like on a hospital level, or whatever, and trying to make patients understand why they're getting billed a year-and-a-half later.

ASSEMBLYMAN CONAWAY: I just have to interrupt on that point, because I am one of those -- that small practice that's had that situation. It is an accounting nightmare. People are always asking us -- "You have to

understand what your cost-- You have to tell what your cost of service is so we can be able to reimburse.” How do you do that when you have a payment system that is as haphazard and just chaotic as that? You can’t do it.

And when you try to produce a bill for someone, how do you get the bill -- how do you get your program to do the bill? If you’re a one-stop shop, like me, you’ve got to do it -- I use Quicken and QuickBooks; other people using other programs. You can’t tuck that kind of stuff into these programs so that you can produce a bill that someone will understand. It is an absolute nightmare.

You talked about a possible legislative reform. That kind of gamestership, if you want to call that -- with reimbursing these claims -- must be stopped. It has to be stopped.

DR. MANSER: Thank you.

Now, one closing remark, if I may.

Leaving my role as family practice and going over to my MBA role-- I’ve taken the approach of Jack Walsh, as he has done with GE. I go through my managed care contracts each year, and I take the lowest 10 percent, on the basis of what my employees tell me are the most difficult to work with, give my patients the most grief. And I’m now eliminating them, one by one, every six months. We have now eliminated three companies, and we’re on our way to the fourth. And I think this is the approach, unfortunately, that many physicians must start to take, and sit down and say, “Is it going to cost me more in the long run on lost patient revenues? But am I going to be able to go home and sleep at night knowing I’ve given my

patients, that I presently have, the best satisfaction and care that I can give them?”

Thank you for listening.

ASSEMBLYMAN COHEN: Thank you, Doctor.

Dr. Goldstein.

Anyone who has testimony, it should be submitted to us so we have it for the record and so the members can get a copy.

**J. RICHARD GOLDSTEIN, M.D.:** Chairwoman Weinberg, Chairman Cohen, Assemblyman Munoz and Assemblyman Conaway, thanks for sticking around.

I’m Rick Goldstein, President and CEO of the New Jersey Council of Teaching Hospitals, the State’s premiere association of major teaching institutions. I have a 20-year career in New Jersey and was honored to serve as your commissioner of health under Tom Kean.

I’m going to address many of the issues. I’m going to cover a wide spectrum of--

ASSEMBLYMAN COHEN: Doctor, if you could just do us a favor, because we still have additional -- and we’ve been doing pretty good at getting everybody in -- if you could possibly summarize. It’s a four-page statement.

DR. GOLDSTEIN: I’ll get it summarized. There’s just about three points I’d like to make--

ASSEMBLYMAN COHEN: Sure.

DR. GOLDSTEIN: --that I think are important for you to understand.

First is, there are two separate aspects to charity care: paying for it and eliminating the need for it. Frankly, New Jersey has spent more energy and dollars on paying for it with mixed results. From our perspective -- and as was discussed earlier -- payer systems, the DRG system was, in fact, the fairest solution to pay for charity care, although we acknowledge DRGs did nothing to reduce the problem of charity care. In fact, DRGs, arguably, exacerbated the problem simply by existing. And, even today, employers can shirk their social responsibilities, knowing that their workforce, those that earn less than 200 percent of the Federal poverty level, will receive free hospital care in New Jersey, no matter what.

ASSEMBLYMAN COHEN: Are you talking about Wal-Mart?

DR. GOLDSTEIN: Wal-Mart insurers. No, I'm not talking about Wal-Mart.

ASSEMBLYMAN COHEN: Go ahead, it's a private joke.

DR. GOLDSTEIN: But we do have a list.

The DRG system self-destructed when the markup for charity care on the bills of the insured reached 24 percent. Bear in mind, the problem has gotten much worse. If DRGs were still in place, the charity care markup would be 34 percent.

Because Medicare, Medicaid, and charity care -- as you all heard -- recipients pay less than actual costs -- and because the balance of the reimbursement rates are negotiated today with the largest payers getting the largest discounts, the actual cost shifting reaches up to 84 percent for the smallest payers, individuals, small businesses, and unions.

Charity care, as you know, is paid for directly from Federal and State funds through the Uncompensated Care Pool; it's funded by general revenues, which is taxpayers; the UI fund, which is employers and employees; and indirectly by the insured, which are employers and employees, in the form of higher hospital bills, due to the cost shifting the shortfalls from charity care that which it doesn't pay. This sets in motion a vicious cycle, because higher premiums, as you well know, lead to more uninsured.

So I would posit that the key problem today is the high cost of health insurance. If it were affordable, everyone would have it. And if everyone had it, it would be affordable. And very few charity care dollars would ever be required.

Hospitals represent a \$15 billion industry in New Jersey. Charity care, last year, infused \$583 million, well below the true cost of charity care: over a billion. Nevertheless, to demonstrate how important that \$583 million is, the total hospital margin, statewide, was an anemic \$78 million, or half a percent. Hospitals need a real bottom line, such as 5 percent, to replace aging equipment, keep pace with technological advances, construct modern physical plants, make big investments in IT, and to introduce systems to eliminate patient safety errors.

Is it possible that the 47th ranking of the quality care of New Jersey's hospitals is attributable to the woeful financial state we're in? The right solution is to pay for both charity care and to introduce initiatives to reduce the need for charity care. Solutions cost money, and someone must pay.

But taxing the providers that provide the service is inappropriate, because the taxes cannot be shifted. And it is, frankly, inherently insensitive, if not offensive, to tax those that provide the care. It is akin to taxing teachers that take extra time with needy students. Furthermore, taxing insurance companies is problematic because they can and do shift the costs. So that only serves to increase the cost of premiums, which leads to more uninsured.

So what should we do? For the past 18 months, the Council has set up a committee, which is chaired by John Lloyd, of Meridian. And we have been deeply involved in studying the issues that you had this hearing on today. In addition, we also served on the--

ASSEMBLYWOMAN WEINBERG: Who's chairing the committee?

DR. GOLDSTEIN: John Lloyd chairs our committee -- did chair the committee that did this work.

In addition, we also served on the DOBI Task Force on the Uninsured and the Vitale/Morgan task force. From these efforts, we built a large library of research materials and wrote several white papers, which we're sharing with you today in your packets.

The most interesting finding in those packets is that we're not alone. We do not need to be pioneers. We learned that other states with equally large challenges have been quite innovative and have found ways to reduce costs and improve coverage. We also learned that some states like Tennessee, Texas, and Florida overreached and have had to retract. Hence, there is no shortage of lessons learned.

Comparing ourselves to these states is very instructive. We are the second wealthiest state in the nation, arguably should have the best health-care system. And as I mentioned earlier, we rank 47th in quality, according to CMS indicators.

The second wealthiest state in the nation has established a Medicaid eligibility cap at 42 percent of the Federal poverty level. And that's under \$8,000 for a family of four. This ranks us in the bottom 5 percent in the nation, along with Arkansas, Louisiana, and Mississippi. States around us put us to shame: New York at 150 percent, Pennsylvania at 200 percent, and Massachusetts at 200 percent of the Federal poverty level.

ASSEMBLYMAN COHEN: For us to move to those levels, what would it cost us?

DR. GOLDSTEIN: I don't know. I'll calculate a figure for you in a minute.

Ninety-six-- I can tell you almost exactly. Ninety-six percent of charity care recipients earn less than 200 percent of the Federal poverty level. Think about it. Ninety-six percent of the charity care tab is from individuals that are less than 200 percent of the Federal poverty level. And Pennsylvania's Medicaid eligibility is set at 200 percent of the Federal poverty level. No wonder they don't have the charity care problem that we've got.

ASSEMBLYMAN COHEN: Do they have charity care in Pennsylvania?

DR. GOLDSTEIN: No, they don't need it.

We could pick up the difference if 200 percent of Federal poverty level is paid for in Medicaid. And we would pick it up now, because the \$583 million is nowhere near of the billing that it costs us.

Our Medicaid managed care administrative cost is the highest in the nation, at 25 percent. The national average is 11.2 percent, based on 2000 data, with Pennsylvania being at 8.4 percent to 9.8 percent in 2005 data. In addition, Pennsylvania's managed care HMOs, Medicaid HMOs, provide a component of enrollment services, thus reducing the contractual costs of the administrative vendor.

So there's no question New Jersey can do better. To do it right, we need to borrow or modify the solutions that have worked. California has invested in IT solutions that enable Medicaid eligibles to enroll on-line and in the field via the PDAs. They are willing to make their IT system available to us.

As stated earlier, Pennsylvania -- the Medicaid managed care HMOs -- do portions of the enrollment process, reducing other vendor costs. This could mean a \$10 million to \$15 million savings for our State. Our State is held tightly to the county-administered Medicaid program infrastructure, while many other, more progressive states have moved to a state-administered structure. They've reduced the silos, integrated their IT and data systems, improved efficiencies, and reduced costs by over \$5 million a year.

We have documented all of these findings in the reports before you. The opportunities are vast, and the savings are significant. But it will take political steadfastness to alter the antiquated systems and policies.

There are some critical private and public insurance reforms which must be contemplated, however. First, what is required is the commitment that high health insurance premiums are, in fact, the real problem and that initiatives that raise the cost of the premiums are counter-productive. For example, we are not opposed, as an industry, to hiring more nurses or reducing the number of our medical residents' work. But there is a very high cost to these initiatives, and they will result in higher premiums. Regardless of their desirability, all mandated initiatives must be scored on their impact on health insurance premiums.

In that light, our annual conversation to eliminate the mandatory personal injury protection, embedded in auto insurance, should cease. To remove PIP would cost shift all of the trauma cost to health premiums, which, as I have said, inexorably increases the uninsured, which leads to further increases in premiums.

There are also hospital-based overhead costs in the premiums, as some states have managed to reduce. We can easily document that our hospital malpractice costs are still rising at an alarming rate. Someone is profiting, and it is not us, and it's not those that have been injured.

Hospital care is expensive, and we are taking steps to reduce costs. But most of the steps being suggested by outside parties are punitive. For example, Medicare will probably reduce reimbursements to cover the costs of an "efficient" hospital, but not the costs of an average hospital. The result of such belt-tightening policies will be a decrease in the quality, followed by hospital closures. Proponents argue that in the larger scheme of things, fewer hospitals is good news, but probably would feel differently if it's their local

hospital that closes. You must ask yourself how your constituents -- whether or not they want their local hospitals to close.

There are entire industries that make huge profits from hospitals. Equipment manufacturers like GE and Siemens, pharmaceutical companies, and suppliers of routine bandages and sterile supplies enjoy very profitable bottom lines. No one is suggesting that these businesses cut their profits to lower hospital costs.

Second, it is clearly prudent to use Federal dollars whenever possible. Raising New Jersey's abysmally low Medicaid eligibility level is not only the right thing to do, it also results in the Federal government picking up half the check. If New Jersey can afford it, making this move this year makes perfect sense, because if Medicaid goes to block grants next year to protect the Federal deficit, you will want the Federal contribution to be as high as possible.

Third, individual and small business insurance reforms are absolutely required. It is central to the problem. Also, changing the rules so that health savings accounts can be introduced is absolutely necessary. They're not for everyone, but they are part of the solution -- will probably pick up at least 200,000 business owners that will buy that product.

Fourth, support companies that have insured workforces by giving them an edge in getting State purchasing contracts. Our member hospitals are doing just that. Companies that do the right thing should be rewarded.

Fifth, work with the business community. They understand the business dilemma, the question of paying a little now or paying a lot later. They pay for the largest portion of charity care and bad debt through cost shifting. They also understand that when more employers insure their

workforces, the charity care bill will be reduced. It also levels the competitive playing field for businesses at large.

Sixth, improve New Jersey public program infrastructure and cost effectiveness by moving to a State-administered program, reducing the allowable administrative loss ratios to national norms; investing in our IT structures, including data warehousing, so we can get some quality indicators out there to accelerate data-driven decision making, on-line enrollment and integration of providers; invest in FQHCs; and improve Medicaid to optimize the enrollment and care processes.

I think you'll also enjoy reading these briefs that we've put together. They are very informative.

ASSEMBLYWOMAN WEINBERG: Thank you, Dr. Goldstein.

Did Ann-- Oh, there you are, Ann.

I'm sorry. I would like you to review -- on behalf of the Committee -- to review Dr. Goldstein's testimony, particularly the issues of our Medicaid eligibility, our comparison to Pennsylvania.

**A N N C L E M E N C Y K O H L E R:** Sure, we're happy to do that, Assemblywoman.

I think it's important, though, that I--

ASSEMBLYWOMAN WEINBERG: I think you have to come to the microphone if you want to say anything for the record.

MS. CLEMENCY KOHLER: One of the major issues for Medicaid is the fact that under the Federal rules, you cannot cover people who are not either in a family, or aged and disabled, or blind. And so you have a whole host of people that are over 18 but under 64 who do not qualify for

Medicaid today. So I wouldn't want the Committee to think that we could just automatically eliminate charity care because of that. Because, in fact, many of the people on charity care are in those age groups, or they're illegal aliens who don't qualify for Medicaid.

ASSEMBLYWOMAN WEINBERG: I think I understand that. But in terms of what our poverty level is -- to qualify for Medicaid.

MS. CLEMENCY KOHLER: Sure. We'll be happy to do a comparison of how we compare with other states.

ASSEMBLYWOMAN WEINBERG: Okay, thank you.

He had some interesting testimony. So I'm sure -- get a copy of that.

MS. CLEMENCY KOHLER: Sure.

ASSEMBLYWOMAN WEINBERG: Thank you very much, doctor.

We're going to call up business representatives from Business and Industry, who have been very patient, and with whom we have been working over a number of months -- along with Dr. Elizabeth Varas, from CarePlus; and Marilyn Dahl, Assistant (*sic*) Commissioner, from the Department of Health.

Doctor.

**RICHARD TANCER, D.O.:** Thank you, Assemblywoman.

I'd like to continue on this discussion, regarding the uninsured/underinsured, as it pertains to my state association.

My name is Dr. Richard Tancer. I'm the former president of the New Jersey Association of Osteopathic Physicians and Surgeons, as well as the

past president of the New Jersey Chapter of the American College of Family Physicians.

Being an osteopathic family physician, I feel it is my obligation to take care of, in part, in my practice, the uninsured and underinsured.

I have participated in one plan of Medicaid HMO until about four years ago, at which time I felt I could not continue to give adequate care to these patients for several reasons. Number one, the lack of specialists that I could refer to, in my area -- even though the panels were presented to us -- many of the physicians in all specialities started to drop out. And I was told that, given a certain radius of about 15 miles, there were physicians. When we tried calling them, a lot of them were in Paterson with a three-month wait. And I don't think that was appropriate for my patients to wait that long for urgent care.

The second part that -- reason I dropped was, the patients abuse the Medicaid system. I found that they were not choosing me as their primary doctor -- walking into my office, getting care -- and then I wasn't compensated. And the insurance company was very callus to that. They said, "Well, you were supposed to check on a Saturday morning, at 10:00, in a snowstorm, that they didn't have you as their primary doctor." Well, that was impossible.

Failure to provide me with vaccines, as well as my colleagues-- The VCP program has stated that they would give us vaccines, flu shots, meningitis shots, MMRs, etc. I was on this plan for seven years, I got vaccines -- zero. Every year I would apply for it. They would ask certain questions, I would answer. I never got a single vaccine.

I experienced many more problems. But I wish to outline the most important ones that we discussed. Administration: The cost, as we discussed-- The administration of these plans, in my office -- I'm a solo practitioner -- has increased at least four-fold. I'm in my office 70 hours a week. At least 20 of them is just administrative. The cost of seeing my patients in the office has been worked out to approximately \$63 per patient. That is before my salary is taken. And that's roughly having 5,000 patient contacts per year. The insurance companies -- commercial ones -- are paying roughly between \$41 and \$50 a visit. So, already, I'm at a loss.

Other problems with the panels-- This is an important concept. In the commercial aspect, a lot of the specialists had found that they were getting paid higher if they were out-of-network. So a lot of the surgeons, OBs, etc., have dropped their panels, thus having the patients come in as out-of-network and getting paid much higher, even with that deductible. The problem is, most of the patients are now coming in, as of 2005, with the HMO product, and they have no out-of-network benefits. And, again, they won't be able to be seen by specialists.

It ends up that my staff has to write three to six referrals for the same patient, for that same specialty before we hit on someone that's still in the plan. That's wasted time for me, my staff, as well as the patient when they're trying to find someone they can see.

It is my impression that we need a uniformity in billing. Each insurance company states that they follow the CPT and ICDM-9 codes, codes that we base all our billing on. Yet, they arbitrarily don't pay for many of the delivered services. And we only find out after we've delivered them. They

don't recognize specific modifiers, which enable us to be reimbursed for a complicated visit as well as a procedure on the same day. They will end up paying the cheapest cost, which is maybe one of the procedures, and thus knocking out the E/M code, which is the visit.

The CMS sets the standard with the AMA, which each insurance company should be made to adhere to, as far as following these codes. One example: I have five separate codes in my computer for a strep test, depending on the commercial carrier. I have four separate codes for flu shots. This makes no sense at all. This is duplicating the same thing and just a very, very difficult way of keeping our records.

ASSEMBLYWOMAN WEINBERG: Excuse me, Doctor.

Is the representative from the health plans still here? Is Michele Guhl still here? (no response)

Well, Christine, I might ask you to carry back one of these major problems to see what can be addressed here.

Okay, doctor.

DR. TANCER: Dr. Manser stated one very important issue. We are now getting retroactively denied care that was paid to us, and we're seeing the reductions in current patient visits.

Now, these insurance companies are going back several years as a way of recouping money. They're going through different credit agencies or collection agencies to do this. Meanwhile, our contracts say that if we make a mistake, or we don't bill on a claim on a patient, we only have 90 days to do that in most instances. Why shouldn't they have the same requirements -- that

if they don't find a mistake in 90 days, they shouldn't be able to retroactively punish us?

That is just a little nuts and bolts of my practice, and what's happening in the practice of private medicine in our state.

Thank you very much.

ASSEMBLYWOMAN WEINBERG: Thank you very much, doctor.

We did ask the New Jersey Medical Society if they could provide us with some figures on the administrative costs to providers of keeping up with the paperwork. And if the osteopath society has such figures, we'd be happy to hear from you, too.

DR. TANCER: Personally, I don't think we could put a number on that, because that's time that I take away from my family. On Sunday mornings, from 7:00 to 12:00, I'm doing appeals. I'm trying to do my patients' paperwork.

ASSEMBLYWOMAN WEINBERG: Well, I'm sure there would be some way that you could quantify the number of hours. I won't talk about quality of life issues, but--

DR. TANCER: Most of the time, this is not information and things that we can delegate to our staff members. These are things that we need to fill out for the benefit of our patients.

ASSEMBLYWOMAN WEINBERG: Whatever it is -- whatever information you could supply us in that area, we'd appreciate having.

Thank you.

DR. TANCER: Thank you.

ASSEMBLYWOMAN WEINBERG: Christine, thank you for your patience and willingness to turn the microphone over.

**ELIZABETH VARAS, M.D.:** I'm Dr. Elizabeth Varas.

I thought it important enough to be here that I gave up a day of seeing patients. I am here today as the Medical Director of a community mental health center and as a practicing psychiatrist in the mental health profession.

As you are all aware, five minutes -- because of the five-minute time rule, time is valuable, and time is money. My community mental health center, whose doors remain open to all, regardless of their ability to pay, is operating under increasing cost constraints as the State budget tightens. The requirements that Medicaid HMO providers require prior approval for certain classes of psychiatric medication is a cost that is now being shifted to the community mental health center.

As discussed in Governor Codey's Task Force on Mental Health, the lack of psychiatric resources for children in New Jersey is at a crisis level. Psychiatric medications for children, especially those for the treatment of attention deficit disorder, are the medications most strangled by the need for prior approval by gatekeepers.

To complicate the situation, Medicaid's HMOs have different New Jersey drug formularies. An approval for a medication this month does not guarantee an approval the next time the very same medication is needed. Each time a prior authorization is needed, an average of 60 minutes of our nurses' time is required, just to get through the gatekeepers.

Once our part of the process is completed, the HMO then has 48 to 72 hours to approve or deny that medication. This delays the time for the initiation of the prescribed medicine for up to three to four days from the time that the patient first sees the doctor. For attention deficit disorder, that translates into three to four days of family fights, fights at school, and lost learning time.

Our center has needed to shift nurses and nurse practitioners from direct care to medication access duties. We rely more and more on the use of pharmaceutical samples in order to treat those with no insurance and those whose insurance formularies limit access to drugs, and/or limit dosing, or can't afford the copays. While generous samplings of medications by the pharmaceutical companies provides for some, it creates anxieties for all involved. Samples are not limitless. We run out. Staff are left with priority lists, asking patients to come in frequently to pick up small supplies of samples to try to get everyone through the week. My nursing staff is talented and dedicated. Their effectiveness is diluted by this burdensome responsibility. Constant phone calls to pharmaceutical reps is part of their day.

Before access to a newer, non-stimulant attention deficit medication is granted, a child must fail two prior trials of an older stimulant medication. This increases further the opportunity for that child to fail.

My closing statement: Access to good medicine is never a bad investment.

Thank you very much for hearing me.

ASSEMBLYWOMAN WEINBERG: Thank you, doctor. And thank you for your patience and courtesy.

Are there any questions? (no response)

And, Christine, since the Association of Health Plans is not represented here anymore, if you hear the tenor of the frustration of dealing with different codes, different paperwork, different forms-- If you could, somehow, translate that back. We will have, of course, a complete record of the proceedings here. So we can get the verbatim comments. But I think you have the general gist.

And I will say that Christine Stearns represents Business and Industry, who has as large a stake in what we do here as any other group that we've heard from, because it is her members that are paying for a lot of this. So the more people we can get covered, the lower the cost we can provide, the healthier your members will be, too.

And I appreciate your cooperation. You've really attempted to work with us on a number of different issues, which has been very refreshing. **CHRISTINE STEARNS, ESQ.:** Well, thank you. I appreciate that.

Can everyone hear me?

You have my full comments. Well, everyone in the room has the full comments, so I won't try to go through and read them. What I actually just want to try to do is run through and pull out a few numbers and concepts to highlight for you, because I do appreciate your comments. The business community-- That's why we're here -- is that we are very concerned about the uninsured, but also about making sure that legislators remember that 66 percent of the people in New Jersey obtain their health insurance through their employer. And that, as much as dealing with the uninsured, should be a

priority for legislators. Trying to continue to make sure that businesses have access to affordable health insurance is really critical because that is, right now, where the majority of the people are.

As you hear me talk about frequently, the cost of health insurance has skyrocketed in recent years. Our NJBIA survey has found that in the past four years the cost of health insurance has gone up by 53 percent. And, of course, the overall inflation rate is nowhere near that. So businesses really are struggling to continue to provide health insurance. Our numbers in our survey isn't about the piece of the cost increases that get passed on to the employee -- because that certainly does happen -- but really are about the numbers of how much the employers are actually paying for their health insurance.

And, in fact, another survey has found -- the Towers Perrin employer survey -- that employees are paying about 19 percent of their individual coverage and 22 percent of their family coverage, just to give you an idea. And that number seems to be remaining stable, but, of course, that's a percentage. So as the cost -- the premium cost goes up, the percentage (*sic*) that the employee has to contribute is going up, also. It's just that the percentage is remaining stable.

Let's see what else I can skip over.

We've come up with an agenda that has a few basic points, some of which have already been touched on, so I won't go through it again. But, obviously, market reform is a priority for the Association and for our members. Assemblyman Cohen did a lot of good work on auto insurance. And I equate some of the reforms -- the market reforms for health insurance to be sort of a

similar thing -- is looking to take some of the administrative inefficiencies out of the system and try to provide some cost savings that way.

Second, we obviously are very interested in tax credits to help employers that are struggling with the cost of health insurance to manage that. Again, Assemblyman Cohen sponsored legislation that was released last year by the Assembly Health Committee, I think unanimously, with all members being supportive of that. And that's a key issue -- and particularly to remember that small employers, who are those who have the most difficult time providing health insurance to their employees, are the ones that are struggling. And they're in the market that you regulate. So they're, sort of, those that are within your power to help. But it is the case that about 60 -- only about 60 percent of employers with fewer than 50 employees are actually able to afford to provide health insurance benefits. And so that is something, in your discussions, that -- to understand that, overall, two-thirds of the people in this state may well be getting their health insurance through their employer. But when you start looking at the people that are working for smaller employers, the needs are much more critical. It takes a lot less to put people's health coverage in jeopardy. And that's a critical issue.

I also will point out that we were very disappointed, at BIA, last year with the Legislature, during the budget process, of adding the 1 percent tax onto the cost of purchasing HMO coverage in New Jersey. And we're hopeful that that will sunset this year and not be continued, because that is a direct additional cost on small employers who are purchasing HMO coverage in New Jersey.

I'm going to skip ahead.

Obviously, we're interested in quality. And I think both of you have heard me go on about the need for greater IT investment -- reducing medical errors, electronic medical records. These nationally-- The experts seem to look to these kinds of administrative efficiencies to both promote better quality care, as well as more efficient care. And we would hope that New Jersey would also lead the way in this area.

We support the efforts to expand the FamilyCare program to try to help address the issue of the uninsured in New Jersey. The business community recognizes that we bear the cost of the uninsured through the charity care costs that we pay, through UI diversions, through higher taxes, through increased hospital charges -- that we want to be there, very actively working with you on any solutions that you're developing.

Additionally, mandates-- We continue to be very focused on any legislative mandates. They can increase the cost of purchasing health insurance, therefore putting people's coverage in jeopardy. And the State, using the mandated Health Benefits Commission, were optimistic that that commission will be able to provide the Legislature with objective information about the impact of these mandates.

And I just, once again, want to remind you that it's only about 30 percent of the citizens in New Jersey who are in that market that you place those mandates, and that those tend to be the smaller employers. Federal definitions of small employers are usually those with fewer than 200 employees. So that's, certainly, the small employer market; but also the bulk of those that are actually in what we call the *large group market*. So that's, sort

of, a critical piece for you to remember as you're trying to juggle the multiple priorities that you have at any given moment.

And that concludes my testimony. You have a full copy of my written testimony in front of you. I appreciate the opportunity to testify today. I know it's been a long day, so I appreciate your being so patient and listening to me.

Thank you.

ASSEMBLYMAN COHEN: Thank you for being patient, Christine.

ASSEMBLYWOMAN WEINBERG: Assistant Commissioner Marilyn Dahl.

You've heard a lot today. We started off listening to the Department of Insurance and Banking telling us about what the marketplace is. Now, maybe you can, kind of, sum up the health-care aspect.

**DEPUTY COMMISSIONER MARILYN DAHL:** Well, I don't know that I'm prepared to discuss--

ASSEMBLYWOMAN WEINBERG: State your name for the record, please.

DEPUTY COMMISSIONER DAHL: It's Marilyn Dahl, Deputy Commissioner, Department of Health and Senior Services.

Actually, what I have prepared for today was an overview of the charity care population and some of the financial trends. I can certainly take back additional questions that you'd like the Department to respond to and make sure that we get back to you on them.

I'm focusing, now, on calendar year 2003 charity care. Our audited documented charity care, priced at the Medicaid rate for calendar year 2003, was \$814 million statewide. This was, since calendar 2000, a 35 percent increase in the cost of documented charity care in New Jersey. There is, however, within this period, a lot of volatility -- and, in fact, particularly on the individual hospital level, there tends to be annual volatility. But during the period from 2000 to 2003, we actually had one year where charity care declined. That was between 2000 and 2001. It declined 11 percent. There were some unusual things happening that year. But that also corresponded with the peak of enrollment in FamilyCare. And I think that may have played a role.

For the first 11 months of calendar year 2004, claims were running 6.7 percent over the same time period in calendar year 2003. But we do allow hospitals to submit 2004 claims through the end of February. So this data is not yet complete. It's not yet audited. We do not yet have a final charity care number for 2004.

In 2003, 230,000 people received charity care services. This represented a 17 percent increase over 2002. The cost per recipient of charity care in 2003 averaged \$3,413. This was an 11 percent increase over 2002. Ninety-seven percent of charity care recipients have incomes at or below 200 percent of the poverty level. This is an unchanged percentage from 2002. The remaining 3 percent have incomes ranging up to 300 percent of the poverty level. And, basically, between 200 and 300 percent -- people can qualify for what's called *partial charity care*. A portion of their hospital bill can be charged off to charity care.

The northeastern counties of Hudson, Essex, Bergen, Passaic, and Union account for 61 percent of charity care recipients in 2003. This is down slightly from 63 percent in 2002.

Fifty-six percent of the charity care recipients are female. This is unchanged from 2002.

Children and people age 65 or older account for only 12 percent of charity care in 2003. It was 13 percent in 2002. This finding is not surprising, because through Medicare, and through Medicaid, and the success of KidCare we have better insurance availability, and accessibility, in populations in those age groups.

Contrary to some popular beliefs, charity care patients are not predominantly the General Assistance clients with substance abuse problems. But this population is disproportionately expensive. And within that population, there are very large substance abuse problems and mental health problems.

We analyzed claims from the first seven months of 2004, and matched them to the General Assistance client file to match. Ten percent of the charity care recipients were General Assistance clients. These General Assistance clients accounted for 18.4 percent of in-patient claims, 13.4 percent of out-patient claims, and 17 percent of the total costs of the claims. But these are the claims as priced through the intermediary. It doesn't have all the final calculations added on.

Another popular belief about charity care is that the uninsured are using the emergency department visits for non-emergent care, and that charity care is all taking place in the emergency department. This is not true.

Emergency department visits that do not result in admission -- unfortunately my data doesn't allow me to get at the ones that do, at least not right now-- The visits to the emergency department that didn't end up in admission were only 5.9 percent of total charity care costs in calendar year 2003. It was \$46 million. And that was up 5.3 percent in calendar year 2002, which was \$32 million. Out-patient charity care costs, which include emergency department visits, but also clinic visits-- The out-patient visits in the emergency department that don't result in an admission, plus all clinic visits -- these costs are growing faster than the in-patient costs of charity care. In calendar year 2003, they increased 39 percent over calendar year 2002, and they, as a group, equaled, overall, in-patient costs of charity care.

There were, in 2003--

ASSEMBLYWOMAN WEINBERG: Excuse me, do you have a breakdown, demographically, who those people are?

DEPUTY COMMISSIONER DAHL: Other-- We're not-- I'd have to go back and talk with our systems people. We've been working with them for some time about trying to be able to pull more demographic data off the claims so that we can sort it in a variety of ways.

ASSEMBLYWOMAN WEINBERG: Do any of those increases correspond with the closing down of FamilyCare for parents and General Assistance--

DEPUTY COMMISSIONER DAHL: The subsequent increases, I believe, happened after most of the shrinkage of the FamilyCare program had taken place.

The out-patient charity-- Let me go back.

On the in-patient side, in 2003, there were 76,542 in-patient admissions. And they were priced out at \$392 million. Again, this is before we do some other calculations to add on some graduate medical education costs. The in-patient admissions increased 23 percent in cost and 17 percent in number of admissions over 2002.

We are able, automatically, to sort the in-patient services into major diagnostic categories. There are 25 of them. And just for illustration, the two major diagnostic categories, for mental illness and substance abuse, accounted for 28 percent of in-patient transactions, about \$86 million, or 22 percent of the in-patient costs.

The major diagnostic category for circulatory system disorders accounted for 14 percent of in-patient transactions, or \$70 million in costs. And that was roughly 18 percent of the in-patient costs.

There were 3.4 million out-patient charity care transactions in calendar year 2003, translating into 950,000 visits, again at a total cost of \$392 million, before any calculation of add-ons.

We don't have a methodology with groupers that allows us to automatically sort this data. But we did do a manual review of the diagnoses that represent 70 percent of transactions and 63 percent of the out-patient costs.

Interestingly, in terms of the largest volume transactions, pregnancy related visits -- again, we're talking all out-patient -- was the largest category, 11.8 percent; then circulatory system issues, 8.4 percent; mental illness/substance abuse, 8.1 percent; and cancer, 7.1 percent. The largest costs were for mental illness/substance abuse at 12.2 percent. And this was about

\$48 million. Next came cancer, 9.1 percent, \$36 million; circulatory system, 7.6 percent, or \$29 million -- actually \$30 million; and then skeletal system problems, 6 percent, or \$24 million.

So this is just a thumbnail sketch of what's going on within the charity care system. It is, obviously, I think as everybody would acknowledge, not the ideal way to provide care to a population. On the other hand, particularly when you look at the volume of out-patient visits that are taking place-- No one can deny that our hospitals are playing an extraordinary safety net role in providing care.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Commissioner Dahl.

Does my one colleague that's left here--

Bergen County wins the centerpiece for the two legislators that managed to stay throughout the entire proceeding.

Do you have any questions, Gordon?

ASSEMBLYMAN JOHNSON: No, Madam Chair.

ASSEMBLYWOMAN WEINBERG: Marilyn, thank you very much. Thanks for your patience.

And I assume that if you have any ideas or suggestions, based on anything that you have heard today, that you will forward those to us.

DEPUTY COMMISSIONER DAHL: Definitely.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Also, for the staff, on behalf of the Committee -- both Committees -- we would like to inquire of the Attorney General's Office the status of the joint negotiation bill. So I want to get that publicly on the record.

Okay. Is there anybody in the audience that wanted to speak and from whom we have not heard? (no response)

Well, first of all, let me thank the staff -- those of you who were responsible for the recording and for putting together the hearing, and getting in touch with the potential witnesses and developing the agenda. Thank you very much.

And I am going to ask the staff if, based upon--

Let's see. We began about 10:30, 11:00, 12:00, 1:00, 2:00, 3:00, 4:00 -- it's about six hours of testimony, give or take, which I know we will get, verbatim. But if, together -- particularly our staffers for the two Committees -- to put together an outline of some of the suggestions that we have heard today, that we can consider.

Ann, thank you very much.

MS. CLEMENCY KOHLER: Thank you.

ASSEMBLYWOMAN WEINBERG: I appreciate your attendance. I think it's snowing, so drive home safely.

MS. CLEMENCY KOHLER: Thank you, you also.

ASSEMBLYWOMAN WEINBERG: Kind of an overview or an outline of the suggestions that we have heard today. Many of them were good, some big, and some very small that, hopefully, we can address.

Thank you, all of those who stayed, and again to Saint Joseph's Hospital.

To you, Mr. Morris, it is? Thank you very much. You have been very hospitable. The food was delicious. And you enabled us to stay in fairly good humor because we were well fed.

Thank you.

**(HEARING CONCLUDED)**