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# *Public Hearing*

before

## SENATE HEALTH COMMITTEE

*“Testimony on the causes of insolvency of the HIP Health Plan of New Jersey”*

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**LOCATION:** Committee Room 1  
State House Annex  
Trenton, New Jersey

**DATE:** May 20, 1999  
9:00 a.m.

**MEMBERS OF COMMITTEE PRESENT:**

Senator Jack Sinagra, Chairman  
Senator John J. Matheussen, Vice-Chairman  
Senator John H. Adler  
Senator Joseph F. Vitale



**ALSO PRESENT:**

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

Freida J. Phillips  
*Senate Democratic  
Committee Aide*

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

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**SENATOR JACK SINAGRA (Chairman):** Good morning.

Now that Senator Adler has arrived--

I want to thank everyone for being here this morning. I know this has been -- we've read a lot about this upcoming hearing. It's taken a while for us to get here today. I want to say from the onset that it is not my intention that this hearing try to affix any kind of blame on any of the Departments of government.

The purpose of this hearing is to gather facts, understand exactly what the transactions were, and come up with some legislation and statutory changes that might help prevent a similar company or circumstance to happen in the future.

This morning hopefully we will get to all three Departments that were involved in this transaction. There will be presentations by each, and then there will be hopefully adequate time to ask questions. I can tell you from a personal experience reviewing all of these documents is quite a monumental task, and hopefully you will be able to run us through most of the background, Commissioner.

Please, Commissioner LaVecchia.

The red light has to be on. (referring to PA microphone)

**COMMISSIONER JAYNEE LaVECCHIA:** There is no red light on.

**SENATOR MATHEUSSEN:** There were no red lights coming into Trenton this morning either. (laughter)

**SENATOR SINAGRA:** Well, so much for the hearing. (laughter)

Well, we are just going to have to speak very loudly today, aren't we.

COMMISSIONER LaVECCHIA: I will certainly try to do that.

SENATOR SINAGRA: It was on a second ago and then Eleanor turned it off.

COMMISSIONER LaVECCHIA: Good morning, Chairman Sinagra and members of the Committee. I am here to testify on issues related to the role of the Department of Banking and Insurance in the regulation of the health maintenance organization known as HIP of New Jersey, as well as the approval of the business relationship between HIP and PHP, as you have requested. I thought to start, in order to assist the Committee to understand what I'm going to say later with regard to HIP, I would like to first set out the respective relationships of the three Departments.

Under the HMO Act, the Departments of Banking and Insurance, and Health and Senior Services share responsibility for supervision of HMOs. The Department of Banking and Insurance is responsible for ensuring that HMOs meet and maintain their statutory net-worth requirements and related financial requirements such as reserves. The Department's duty is to consult with the Department of Health and Senior Services on all matters, all of which relate to the financial solvency of an entity.

On the other hand, Health and Senior Services has the authority to grant certificates of authority, to amend them, and to supervise the quality of care that is delivered by the HMOs. So the review of delivery of care issues such as utilization management and quality control protocols all fall under the jurisdiction of Health and Senior Services.

The third agency here today is the Attorney General whose role is to render advice to all agencies of State government, as you know, including the Departments of Banking and Insurance, and Health and Senior Services. Also, in the event that a matter implicates the disposition of charitable assets, if the potential for diminution in the charitable estate were to be involved, then the Attorney General has the discretionary authority under the common law to act to protect the charitable trust.

This morning I am going to be addressing your questions, Chairman, from the perspective of the Department of Banking and Insurance and its responsibilities regarding HIP and the transaction I mentioned before. I am going to be telling a story today about HIP, and it's one that I think few appreciate because the facts -- the detailed facts -- of this HMO's performance have never really been completely set out. I intend to do that because this Committee I think needs to and I think wants to appreciate the company's development over this time period in order to appreciate the company's responsibility for what happened to it. And I am also going to tell you what the Department did every step along the way.

As I said, I think the Committee wants this kind of presentation because questions one through six in your letter to me, Chairman, are best answered in the context of a historical analysis of HIP, and it's one that I think needs to start in 1995. I picked 1995 because actually at the very -- toward the latter end of 1996, September to be specific, HIP received approval to expand into network delivery, in addition to direct care, through its clinic-based centers. Prior to that, most of its activity was center based. They did have some specialists out in network practice. They expanded their service

delivery at that time into three additional counties and expanded their network into five other counties. At that point then they had operations in 17 counties.

This network business impacted on HIP's position because it required HIP to process and pay claims and perform utilization management for providers outside of its health centers. By the time the third quarter of 1995 arrives, HIP's combined medical loss ratio and its administrative expense ratio exceeded 100 percent for the first time.

And I am providing, in addition with my written testimony, several charts to the Committee this morning, some of which I have blown up for the benefit of everyone to see. I prepared these charts as part of this presentation in order to illustrate its performance since 1995. Attachment *A*, which is probably the most complex chart in the group, focuses exclusively on HIP data. Whereas the other charts, *B* through *I*, actually examine specific parts of HIP's performance either alone or sets them against trends within the industry.

To appreciate the financial information that we are going to be going through and the other performance data, one has to first recognize a couple of events that had an impact on HIP during the period between 1995 and 1997 when it entered into its contract with PHP. During this time the company:

1. Created HIP Insurance Company, which was an indemnity provider, to provide point-of-service plans. That was before legislation was passed that put a service plan requirement in, so they were a little ahead of that.
2. It required approval to market Medicaid in 12 counties.

3. It received HCFA approval to offer Medicare on a risk-base contract in 17 counties, all of the ones in which they operated.

4. It developed HIP PRO, Inc, for worker's compensation business.

5. It expanded into four southeast counties of Pennsylvania.

I'd like to point the Committee's attention to about the middle of Chart A, where you see the line marked Medical Loss Ratio and then just above that the profit loss line. You will see that in the third quarter of 1995 HIP lost \$987,000. That was the first loss they had had in a quarter for many years. And the important thing to notice as you look to the right along that page on that line at no point in time after that did HIP ever make a profit.

During 1996 two significant events happened. First, HIP had been utilizing Garden State Medical Group for the management of its center operations and the delivery of the physician services. Garden State's 20-year contract was due to expire on December 31, 1996. HIP has tried during 1996 to get Garden State to reduce costs through changes in protocols and procedures that HIP wanted them to implement, and they said they would implement, but this turned out to be unsuccessful.

Because HIP had reached an impasse in its negotiations with Garden State, HIP began during 1996 to gear up for managing its center operations itself, as well as managing its expanded network operations. HIP was also engaged in some bitter and costly litigation with Garden State in the latter half of 1996 as the contract end neared. So, thus, in the latter half of 1996 and then carrying over into 1997, HIP had to prepare and implement its delivery system itself, which it had not been doing, and implement a utilization

management program, all of which entailed significant additional expenditure to their operations which they told the Department approximated \$20 million. This was occurring at the same time that their medical loss ratio -- that's the chart on the left -- continued to climb from an average of 84 percent. That means that 84 cents of every premium dollar was going to pay for medical expenses. That was their rate in 1995. By the middle of 1997 it had risen to 101 percent. And as you can see it, ultimately did get higher than that later.

SENATOR MATHEUSSEN: Is that the chart on the left, Commissioner?

COMMISSIONER LaVECCHIA: It's the far left, Senator.

And you also have it in your packet, Attachment *G*.

A second significant event for HIP, occurring also during 1996, was that on January 1, 1996, HIP reduced its large group, that's more than 100 lives, commercial rates by approximately 23 percent. Later in July of 1996, HIP filed with the Department to reduce the rates for the groups of 50 to 100. So they reduced those commercial rates by about 22 percent effective September 1, 1996. The company's goal was to increase their market share by becoming more competitive with their peers.

During 1995, HIP had had relatively flat enrollment and also had experienced a relatively declining market share. That's in Attachment *B*. The reduced rates did generate an increase in enrollment to approximately 208,000 members by the time it reached the fourth quarter of 1996. So during 1996 its medical loss ratios were going up, and you see an increase in their enrollment of approximately 30,000 members. It's quite a lot to absorb in a single year.

SENATOR SINAGRA: Can I just stop you for one moment and ask a question? (affirmative response)

In your Department's review of rates, when someone comes and wants to change rates, do you take into consideration when allowing them to either to raise them or reduce them that chart there?

COMMISSIONER LaVECCHIA: Yes, I was just about to get to that -- what they told us and what we looked at in allowing those rates to go forward. And I'll just get there in one moment, Senator.

The membership, unfortunately, did decline slowly from that high point of 208 at the end of 1996 as resources were diverted from active marketing to attending some of those other things that I told you about before, namely their delivery system and the litigation that was consuming an awful lot of their time and attention.

To justify the '96 rates, HIP represented to the Department -- this is before they even put in for the January 1, 1996 rates. But they were relying on a commitment from Garden State to implement cost reduction by bringing medical expenses in line with industry standards. They told us that they anticipated some erosion of their net worth to accomplish this, but they expected to stabilize their costs by the time we reached 1997 after the health center delivery system costs were reduced. At that time, looking at their projections and the premium and membership result in dollars that would come in, projected medical and administrative costs appeared to justify the premium levels.

Later, HIP eventually raised their rates by 5 percent in January 1, 1997 -- I'm sorry, July 1, 1997 and by another 5 percent on January 1, 1998.

But the failure to come to terms on renewal with the Garden State group and the result that there was no contract also resulted in Garden State not initiating during 1996 any of the cost-savings measures that they had agreed to and on which HIP had relied in anticipation of reducing their rates.

By the end of 1996 it was--

SENATOR SINAGRA: Again just to interrupt one more time.

Looking at the chart that you provided us that is not up there--

COMMISSIONER LaVECCHIA: Which one?

SENATOR SINAGRA: This one. (indicating)

COMMISSIONER LaVECCHIA: A.

SENATOR SINAGRA: And you talked about that they asked for and received a 5 percent increase as of July of '97.

COMMISSIONER LaVECCHIA: Yes.

SENATOR SINAGRA: According to this chart, as of July of '97 their losses had literally doubled. They went from the first quarter of '97 from \$5 million to the third quarter of '97 to over \$11 million, correct?

COMMISSIONER LaVECCHIA: Correct.

SENATOR SINAGRA: Did the Department at time feel that a 5 percent raise in-- I'm just trying to understand the thought process here. That a 5 percent increase in any way impact the incredible losses that this company was--

COMMISSIONER LaVECCHIA: By the time we get to July of 1997 not only were we looking at the medical loss ratio and the rate increase, we were looking at a lot of other things that we were telling them to do. In going through the-- (remainder of comment indiscernible) I do intend to also

advise the Committee on that as well. But the short answer to your question is yes, we did look at it.

SENATOR MATHEUSSEN: Can I just -- I'm sorry to interrupt because I know you want to get through your testimony. But in a chronological sense when-- It's important for me to understand something. When do you actually have the third quarter figures?

For instance, the Chairman just asked about third quarter figures of being losses of over \$11 million. When do you actually know -- when are those actually reported?

COMMISSIONER LaVECCHIA: We actually receive quarterly financials approximately 45 days after quarters end.

SENATOR MATHEUSSEN: So it's sometime in the middle of the next quarter.

COMMISSIONER LaVECCHIA: Yes.

SENATOR SINAGRA: Well, the second quarter was a loss of \$10 million, also.

COMMISSIONER LaVECCHIA: There is always a lag because they have to collect all the data and process it and make sure you're getting all the--

SENATOR SINAGRA: I understand that. I'm just trying to understand why the Department wouldn't have made HIP raise their rates significantly more than 5 percent.

COMMISSIONER LaVECCHIA: By the time the mid-1997.

SENATOR SINAGRA: Right.

COMMISSIONER LaVECCHIA: Well, as I said, there were a number of things the Department looked to HIP to do at the same time and the increase in rates was one of several things that fit into the package.

SENATOR SINAGRA: I just have a hard time understanding why it was only 5 percent.

COMMISSIONER LaVECCHIA: Because it was combined with reductions and expenses. It was combined with the money infusion that was coming in eventually a few months later with the PHP deal. But mostly it was because there was a judgment that they couldn't raise more upgrades much beyond that without further loss of membership.

The Department's Managed Care Bureau reviewed HIP's business plan at a meeting with senior officers each year. In September of 1996, in light of the negative operating results through the second quarter -- so the second quarter would have ended in June, we would have gotten those financials some time in mid-August -- a meeting was called to review HIP's revised business plan and their plan's action to reverse the trend. HIP blamed their financial problems at that time on essentially two things.

1. They said that membership and premium yield was below budget due to implementation of their new company.
2. Hospital referrals, pharmacy expenses, and plan administrative expenses were well over budget.

They advised us that they would be implementing numerous cost reduction activities including reductions in staff, reductions in advertising and other administrative expenses, changing their pharmacy program, implementing disease state management, which is a form of utilization

management. It's just a more specialized and intensive management program. Eliminating an increment for their nonphysician pension program that otherwise had been planned for, and changing their hospitalization pre-certification and review processes.

By the time June 3, 1997 approached, the Department again met with HIP. They met with HIP's CFO and their counsel to review their revised business plan of action because the first quarter financials showed that losses were continuing to mount. So after 1996 we see a medical loss ratio of 93 percent -- had risen even beyond the 84 percent we talked about before -- membership had gone up by \$30,000; rates had been cut by over 20 percent; they now had network, as well as center, delivery in 17 counties; and their net worth had continued with a steady decline.

HIP showed, as I said, in their first quarter of 1997 that their losses were mounting even further. They stated at that meeting that they saw a need for a partner for the management of their delivery system, similar to the Garden State arrangement. They didn't mention any specific partner at that time. They just indicated that they felt a need to return to having a partner as they had had one with Garden State.

When HIP filed its second quarter financials in mid-August of 1997, their net worth had dropped to \$16 million. That was \$6 million below the required \$22 million amount and their quarterly losses exceeded \$10 million. By the time those financials came in, the Department had already been presented with a signed contract between HIP and PHP. That was HIP's proposed solution to its worsening financial circumstances.

This all sets a stage of HIP's history and condition as of the time it presented that signed contract to the Department in the late summer of 1997 and presented it to, as I said, to our Department, as well as the Health and Senior Services, for approval. While I cannot say what was the thinking of the HIP management and its board of directors that led to this new contract, I can tell you, all the members of the Committee, what HIP told the Department was its rationale for (indiscernible) on this course of action.

HIP again referred to the terminated contract with Garden State, the entity that had staff and operated the health centers and had managed the HIP network specialty providers. HIP stated that because of this termination, it had assumed responsibility for hiring physicians and the support staff who wanted to go back to a relationship with the medical group to perform these functions. They advised that they retained the investment banking firm of Wasserstein Perella to locate a partner and that after a competitive bid process, PHP was selected to manage HIP's delivery system. Thus, HIP sought approval of this arrangement with PHP as a new provider agreement. That was how it was characterized.

With regard to questions 7 through 10, which is focusing on the actual transaction and its review, the Department reviewed the contents of the Health Services Agreement, which is what it was presented with. We asked for and received eventually all of the attachments to that health services agreement. We also asked for the Asset Purchase Agreement. It was not initially provided to us, and after some time we received it, and thereafter, again on our request, we received all of the attachments that went with it.

We requested and reviewed financial projections and actuarial submissions to see how the venture was supposed to perform. The agreement with PHP contemplated even more cost-cutting measures than the previous commitment HIP had received from Garden State. Those measures included recontracting with providers to reduce fees, that's both medical providers as well as the hospitals. They planned to consolidate the health centers and reduce the hours of the health centers. They were going to adjust staffing levels. They intended to subcontract for certain services like physical therapy, behavioral medicine, and vision care. They intended to close the in-house pharmacies. And they also intended to implement a utilization management system to determine medical necessity and referral appropriateness. Further, they intended to introduce information technology and to practice management provider scheduling and maintain electronic medical records. They also contemplated contracting on a fee for service basis with the OB-GYN physicians who were on salary at the time.

The Department concluded that with those initiatives being implemented in the time frames that they were allocating for those activities the medical cost portion of the capitation payment to PHP should have been sufficient to pay claims and health center costs as was intended by the transaction. From a rate perspective the rates appeared adequate. Additional rate increases were viewed as likely to result in losing membership when realistic cost reductions appeared obtainable. HIP's experience immediately prior to its transaction with PHP was regarded as atypical for this HMO because HIP has been forced by circumstances to develop its own claims utilization management system in '96 and carry it over into 1997 because they

were losing their relationship with their provider who had done all of those services for them for approximately 20 years. And they took it over at a time when the savings which they had anticipated from Garden State's revised protocols and procedures in fact never materialized because Garden State did not implement them.

With regard to PHP itself as an entity, the Department reviewed the parties' detailed terms of their contracts which set out how they plan to respectively perform their roles. As to PHP, the Department reviewed its 10-K filing for the year that ended April 30, 1997 and the booklet which PHP provided to the Department -- our Department, as well as Health and Senior Services, which described in general terms the history and operations of PHP, including its model for contracting with third-party payors.

As the Committee knows, a 10-K is an annual financial report that publicly traded companies are required to submit to the FCC. The 10-K that was delivered and that was reviewed, on Page 25, gave some brief biographical data on the officers of PHP. The 10-K also indicated that PHP's revenues has increased from \$118 million in 1992 to \$232.3 million in 1997. Although the company incurred a net loss of \$4.1 million, in 1997 it had had net income of \$9.1 million and \$952,000 in 1996 and '95 respectively. A copy of the 10-K filing is being provided to the Committee. You may have had it previously, but I wanted to make sure that you did.

In addition, the Department asked Blue Cross and Blue Shield of New Jersey, which had in March of 1994 contracted with PHP to operate 10 health centers for Blue Cross, to provide health-care services to certain Blue Cross members for a global capitation, for its assessment of PHP's

performance. As a matter of fact, Blue Cross sold those same 10 health centers to PHP in February of 1997.

Blue Cross indicated that PHP was fulfilling its contractual obligations in all respects. The Department was also aware that PHP was licensed as an HMO in other states and among its existing contracts was a long-standing contract with the Federal Department of Defense.

With regard to HIP's assets that were transferred to PHP, the Department's involvement was limited to a review of HIP's filed financial reports with the Department to examine how HIP had represented the value of various assets to the Department in the past in calculating its own net worth and other required filed financials. As you know, PHP paid \$73 million to HIP as part of this deal.

As an aside, I want the Committee to also be aware, if it wasn't already, that as part of this overall transaction, PHP also loaned \$40 million to HIP New York to cover a \$40 million surplus note that HIP of New York had given to HIP New Jersey that otherwise would have been the responsibility of HIP New Jersey. Those documents were not provided to us. They were not regarded at least by HIP and PHP as part of the transaction involving HIP of New Jersey. They regarded it as part of a separate side relief deal that they were doing with HIP of New York. And we were informed that that was, in fact, taking place at the same time.

The Department was also aware that representatives of the Attorney General's Office had received a fairness opinion that had been delivered to HIP's Board of Directors and had reviewed that same document with HIP's counsel and with its investment banker.

After reviewing all of the material that had been submitted to our Department and to the Department of Health and Senior Services, the two Departments concluded that the transaction was more than a simple new provider agreement and that it required an amendment to HIP certificate of authority. It was not how HIP had presented it nor what they asked us to do, but that was how the Departments chose to proceed.

You asked if the Department knows the financial reason for HIP's transfer of its interest in the real and personal property in those health centers. Again, as to this question, I can only answer by looking back to HIP's stated reason, which was that HIP wanted to return to a structure where a medical group operated the health centers as opposed to HIP operating them directly. They told us that the health centers were more value to the PHP than to HIP. Because if transferred to PHP, PHP could provide services at those centers to individuals who were covered by insurers or HMOs other than HIP. PHP was already employing the same strategy in the centers it purchased from Blue Cross.

With regard to the transfer of risk and the licensure of PHP, the Department did request PHP to become licensed as an HMO in view of the risk sharing that was involved between it and HIP. PHP refused. They stated that they preferred unlicensed status so that they could enter into service contract with multiple insurers. The risk sharing reflected in the PHP-HIP arrangement was permitted because the law did not prohibit subcontracting arrangements whereby subcontractors took on risk sharing with an HMO.

Since HIP was the licensed entity, the Department had HIP to rely on to ensure compliance with New Jersey legal standards, even through its

contractual ability to monitor and enforce the provision of its contract with PHP. And, in addition, we ask for and obtained in addition, new language in which PHP did covenant to abide by New Jersey law both statutory as well as regulatory.

Finally, with regard to the remainder of the questions I offer the following. As to question 11, which pertains to the Department's monitoring of HIP's and PHP's cash flow, two days after the transaction was approved the Department directed HIP to provide detailed financial information on a monthly basis. And the report was to include the following:

1. This had to be an actual budget report segregated by lines of business. The projections used had to be the projections that were submitted by HIP to the Department in support of the Health Services Agreement. Any item that was deviated from that projection by more than 10 percent had to be explained in writing.

They also had to provide a balance sheet, income statement, and statement of cash flow information with a special emphasis on claims reserves, which had to also incorporate PHP's performance.

The October report, which would have been the first one, was initially due on November 26, 1997. However, due to problems HIP encountered in collecting and coordinating data at the end of '97, HIP asked for, and was granted, an extension until December 15th of that year to submit that first report. All future monthly reports were due 45 days after month end and did come in timely. The Department received reports for the period from October of 1997 through April of 1998. The May report, which was due July

15, 1998, was delivered and discussed at a July 9th meeting, which I am going to address in just a moment.

Pursuant to the phase-in of the Health Services Agreement, as of May 1, 1998, PHP began to assume responsibility for payment of network member claims. Up to that point in time PHP had only been responsible for claims associated with health center members. HIP had continued to be responsible for payments to network members for claims incurred up to April 30.

Over the period from November 1, 1997 through April 30, 1998 the Department monitored HIP's financial situation under the new agreement with PHP. The submission of the first quarter 1998 report, coupled with the April 1998 monthly report, showed that HIP's net worth had reduced to 15 percent of the required amount. A series of meetings were held at this time during this time frame in which the Department directed HIP to pursue various options, including the setting up of a trust, a letter of credit, or a reinsurance arrangement to address the minimum net-worth requirement.

As I mentioned earlier, there was a conference held on July 9, 1998 in which HIP discussed their May monthly financial report and their deteriorating net-worth position. It was during this meeting that HIP representatives raised their suspicion that PHP was becoming delinquent in the payment of claims.

The Department had not been hearing of problematic claims payment problems with PHP through its complaint channels before July 1998. The Department of Health and Senior Services reports that during the period

from January 1 through August, they received only 10 reimbursement complaints associated with HIP.

The Department instructed HIP to get detailed information from PHP as to the processing of checks. Per their contract, HIP was supposed to receive weekly reports detailing all paid claims, specifically what checks were cut. This continued until the beginning of August when an apparent breach of this obligation PHP stopped providing these weekly reports. HIP itself could not monitor the bank account out of which those checks were being paid by PHP's third-party administrator, a TPA known as North American Health Administrators. It was located in Buffalo, New York. TPA only reported to PHP.

As a general matter, the Department's tools in this regard are derived from standard quarterly financial reports that the HMO provide us with and the report card that is prepared by the Department of Health and Senior Services that is based on consumer input. As you know, also, the Prompt Pay Agreement had been signed by most HMOs, including HIP, in September of 1997, and in February of 1998 the Health Care Quality Act became effective, and it gave the Department of Banking and Insurance the ability to conduct, at an HMO's expense, market conduct and financial examinations on HMOs for the first time.

By August 1998 it was apparent to HIP and to the Department to whom it had brought its concerns that although the responsibilities of the parties under the Health Services Agreement were detailed, HIP, in fact, had little success in getting PHP to provide requested information or to live up to its part of the Health Services Agreement. There were extensive standards of

performance, but there was no regulatory authority to enforce these obligations directly against PHP. The Department had to work through HIP. And HIP's ability to enforce was limited to declaring breach and seeking judicial enforcement of its rights under the Agreement.

By the close of August 1998, the Department and Health and Senior Services were involved in intensive meetings with the two parties. During this period, and I'm going to focus now between August 31 through September 8th, several important events happened in rapid succession. Following earlier meetings, another meeting took place on September 2nd at which PHP's CEO, Jack Mazur, told me that he had a claims payment backlog but represented that within two to two and a half weeks they would have claims being paid with 60 days of presentation of the claim.

Two days later, PHP advised me and others from the Department, as well as through Health and Senior Services who were with us, that they could not agree to the financial conditions I now said I wanted to require between the two parties to deal with the financial and reserve problems that existed at that time. Without advising the Departments of Banking and Insurance or Health and Senior Services, even though they were with us for hours that morning, later that day, which was the Friday before Labor Day, PHP laid off 400 employees at the health centers. The Departments independently learned of those layoffs not from PHP or HIP, but independently very late that afternoon which, as I said, was the Friday before Labor Day.

Tuesday when we all had the next business day, HIP was placed in administrative supervision and the Department of Health and Senior

Services notice of violation was issued as a result of those layoffs. Further, I directed that the administrator supervisor, whom I had appointed, the Honorable Richard Cohen -- that he take steps to ensure that the medical component of the capitation payments be released only for the payment of providers.

Immediately after placing HIP into administrative supervision, auditors were dispatched to the TPA in Buffalo to assess the claims backlog. It was quickly revealed that approximately \$25 million worth of cut checks to claims were sitting at the TPA unable to be released due to insufficient funds in PHP's account. Another five weeks worth of claims, approximately \$25 million, were in process.

As you know, later in September I made the fact of administrative supervision public. Following weeks of discussion and meetings with HIP and PHP, which failed to produce an acceptable business plan for timely restoration of the financial health and well-being of HIP and for payment of overdue claims, I and the Commissioner of Health and Senior Services asked the Attorney General's Office to file a complaint in Superior Court seeking a court order placing HIP into rehabilitation and also seeking some other emergent relief. Rehabilitation ultimately proved unsuccessful, and as a matter of record by order of Judge Lintner, an order of liquidation of HIP was entered on April 9, 1998.

We are in the process of identifying the full scope of debt of this insolvent estate and of marshaling all the assets that we can bring into the estate to cover that debt. Part of that analysis will be to determine whether PHP improperly diverted HIP premium payments to sources other than

providers. Forensic accounting is necessary to complete these tasks and special counsel is in the process of being secured for purposes of investigating and evaluating all possible causes of action, including a directors and officers action against HIP management and board members.

Finally--

SENATOR MATHEUSSEN: So that is taking place or is contemplated?

COMMISSIONER LaVECCHIA: It is taking place. Counsel is being brought on board.

Finally, you've asked for my views on legislative change to avoid circumstances as we faced with HIP from happening again. I do have some suggestions for the Committee to consider. First and foremost, risk sharing between licensed entities and subcontractors has to be understood as having become prevalent at this point in the industry and extremely varied in its structure.

I have a significant concern about arrangements which transfer risk to unlicensed entities. First, the unknown financial viability of the unlicensed entities exposes the public to risk of failure that may result in, among other things, a consumer losing access to health-care services or being responsible for large unpaid bills. Two, the quality of care is of concern when quality assurance and utilization review functions are subcontracted to a nonlicensed entity that is not subject to regulation. Three, the continuity of care for an individual is not guaranteed if the unlicensed entity fails or the contract is terminated.

I think the State's goal has to be to ensure that consumers receive the health coverage they have contracted for, and I think it's appropriate and timely for the State to consider requiring less licensure on such entities, and I urge the Committee to consider taking action in this regard.

I also recommend that the Legislature consider making HMOs subject to the Insurance Holding Company System Regulatory law. This law provides protection against detrimental takeovers of insurance companies by regulating merger with an acquisition of any domestic insurer. Presently HMOs are exempt from this act. Among other provisions, it requires prior approval of such transactions, it details specific information which must be disclosed by the acquiring party, and requires a public hearing on any proposed merger or acquisition. It also provides standards for denying such transactions. It imposes requirements on management agreements and transactions with affiliates. It's a very good law, and I think it's one that fits here.

These legislative suggestions would fill out the complement of reforms that I think are appropriate in the wake of the HIP and APPP insolvencies, when also added to the regulatory reforms put into place, as well as Senator Littell's health-care information networks and technologies bill, and the prompt pay bill sponsored by Assemblymen Talarico and Asselta.

I want to thank the Committee for soliciting my views this morning and for its patience in allowing me to present my prepared remarks. I hope to have addressed the questions that you pose, and I'm prepared to answer any other questions that I can that will facilitate the Committee's work.

SENATOR SINAGRA: Thank you.

John, do you have any questions you'd like to ask?

SENATOR MATHEUSSEN: Not just yet.

SENATOR SINAGRA: Senator Adler.

SENATOR ADLER: Commissioner, good morning. Welcome up here to sort of another branch of government. (laughter)

I guess my first question is sort of a general question, and maybe you will have to take some time to answer it, and maybe you can say yes right away. I suspect there are all sorts of internal memos within the Department and memos between the Department and the Attorney General's Office that led to a lot of the decision making by the Department. So I have sort of a general conceptual question as to whether or not, without in any way committing the executive branch of government towards a general waiver of whatever privileges it feels it can assert in the future with respect to any internal documents that you might otherwise think of as privileged under an attorney-client basis or under some deliberative process basis-- You might waive that privilege as the client in the capacity of the attorney-client relationship and as the Department in a deliberative process from context -- waive those privileges so that we could be privy to all the documentation that you, your predecessor in the Department, and staff members in the Department had so that we can help educate ourselves, review the chronology, and better understand whether this was a colossal bureaucratic screw up in part or whether this is something that just needs new legislation.

I would hate to leave here today and have us rush out and do new legislation if, in fact, we had a bureaucratic screw up of monumental proportions or something worse than that. And I think it would be very helpful to the members of the Committee and to the members of the

Legislature if we had the internal thinking to the extent it was memorialized in documents to help educate ourselves so that we can not repeat the errors of the past, but actually learn from them properly on their own rather than filtered through very productive conversation and testimony on your part.

COMMISSIONER LaVECCHIA: I'm going to answer all the questions that you just posed because there were actually quite a few.

As you know, the question of those documents was litigated, and they were found to be privileged. I respectfully decline to waive the privilege. There is going to be lots of continuing litigation associated with the transaction and I do not intend to-- If I waive the privilege, it's waived for all time. I do not intend to do that in the context of future litigation which could cause it to be necessary for the State to want to assert the privilege if it's necessary.

But let me tell you this, Senator, because I understand what it is you really want to get to. This transaction did cause there to be, within my Department, a tremendous amount of internal discussion, as it should. Any transaction like this should generate intense scrutiny and discussion. And if it weren't so, I would think that there is something wrong. Because that means people are afraid to speak up and say what it is they think about a transaction that took place here.

The concerns that were raised within the Department were generally understood and felt at all levels. There were concerns about the reserve obligation and whether or not HIP would be able to meet it. There were concerns about the fact that PHP was an unregulated entity. All of those concerns are voiced in the letters that were, in fact, released because they were the letters that were sent back to HIP asking for certain amendments to the

Health Services Agreement and raising concerns and looking for feedback to answer, and hopefully address, some of the worries that the Department had with regard to this transaction and how it would work.

So even without my ability to release more documents to you, I am telling you that you already know of the concerns that were the subject of discussion within my Department, and you also know how HIP responded to them and how PHP responded to them.

For example, one of the letters that was sent out to HIP summarized all the amendments to the Health Services Agreement that we wanted. We wanted changes in the language concerning coordination of benefits and independent contractors. We asked for, and got, language in the Health Services Agreement that said we wanted the ability to be able to go out and audit, if necessary, the claims payment processes of PHP in addition to HIP. And they did agree to that, and it ended up being put into the agreement.

As you know, PHP did decline to be licensed, and ultimately they were part of the transaction without being a licensed entity. HIP wanted us to look at reserves in a certain way. They wanted to take credit for their capitation payment to PHP and have that reduce their reserve obligation. The Department said no, that's not an appropriate way to handle the reserve obligation. The reserve obligation is on you HIP as the regulated entity unless, in the course of this transaction, somehow you agree to set up some trust or vehicle like that that gave us the assurance all your reserve obligations were being met in conjunction with PHP. But the two parties declined to submit to

any such arrangement, and it ended up with HIP having all of the reserve obligations on it, which had freely understood and agreed to.

So that's a long way of telling you that there was intense discussion. The concerns that were discussed within the Department were made known to HIP and are made known to you in the communications that have already been released. And, as you know, we've seen HIP's response, we've seen PHP's response, and I've tried today to tell you why the Department ultimately approved this deal in the context of HIP's terrible financial situation as it existed in the latter half of 1997.

SENATOR ADLER: You mentioned just now that you thought PHP had declined submitting itself to New Jersey law. On Page 15 of your testimony--

COMMISSIONER LaVECCHIA: Not law, licensure.

SENATOR ADLER: Licensure.

What do you mean in your sentence at the end of Page 15, PHP did covenant to abide by New Jersey law, both regulatory and statutory? They just said we'll agree with New Jersey law, but you can't do anything to enforce it. Isn't that the essence of the problem you had?

COMMISSIONER LaVECCHIA: Well, as regulators under law, we have the ability to reach only the regulated entities. The only regulated entity in this transaction was HIP. Separately through its contract, HIP got their contractor -- their subcontractor if you will -- PHP, to agree to satisfy all New Jersey lawful obligations. That was the point of that clause. But that clause, since it's a contract only between those two parties -- we were not a party to it -- it's not something that is enforceable by us.

SENATOR ADLER: So what enforcement mechanisms do you think the Department had on going forward after that acquisition?

COMMISSIONER LaVECCHIA: As I said in my testimony, our enforcement mechanism was limited to requiring HIP to enforce its contractual terms with PHP. All of our power was focused on making HIP do what it should do under law as a licensed entity. And the tools that HIP had available to it were forcing PHP to honor its contractual obligations. And, of course, those contractual obligations are enforceable only through declaration of breach and judicial enforcement.

SENATOR ADLER: Did the Department entertain any thoughts prior to approving this asset sale of acquiring PHP to set up some sort of fund or to maintain monies in New Jersey rather than have all the money swept out of New Jersey? Is there any sort of thought to restricting the deal in such a way that the State would have some real hammer, some real enforcement powers with respect to PHP?

COMMISSIONER LaVECCHIA: Nations Bank is a national bank. It had centers all over. It was the bank that handled all of the financial arrangements for PHP, including its letter of credit, as you know. So all of its banking was done through them. The TPA was also a national servicing entity that was one that was known to us. So the fact that those were out of state I don't think was the real problem here. The problem was that PHP was a non-regulated entity and it was paying the claims.

SENATOR ADLER: Did you think about putting in any sort of mechanism that required monies to stay, to be held in the fund, if PHP wasn't reimbursing providers on a regular basis?

COMMISSIONER LaVECCHIA: Thank you for asking me that. Because one of the other points that we asked for and did have added to the Health Services Agreement was that if PHP failed to make payments to providers -- and under the contractual terms they were obligated to turn the money over to HIP so that HIP could make the payments. Obviously they did not satisfy that contractual obligation either.

SENATOR ADLER: And what powers would the State of New Jersey have with respect to enforcing that and protecting the providers of New Jersey?

COMMISSIONER LaVECCHIA: Again this contract was between HIP and PHP. We were not parties to it, so the enforcement was typical contractual enforcement.

SENATOR ADLER: Well, you were sort of a party of it. You had the right to refuse to approve this asset sale. You did approve it.

COMMISSIONER LaVECCHIA: We did approve it, you're right. We could have not approved it, but we did.

SENATOR ADLER: Explain, if you can, to me this \$30 million payment to HIP New York. How did that benefit HIP New Jersey and its insurers?

COMMISSIONER LaVECCHIA: It benefited it in this way. In 1992 HIP had asked for, and gotten, a surplus guarantee of \$40 million from HIP of New York, which was its parent company. That allowed HIP of New Jersey to show that as an asset, and it improved its financial position at that time. Because it's a surplus guarantee, it doesn't show on HIP of New Jersey's financials as a liability unless, and until, the Commissioner authorizes the

repayment. So it's a very nice thing for a troubled HMO -- any HMO would need some financial assistance from its parent to receive.

HIP of New York, of course, didn't have the \$40 million because it was pledged to New Jersey. The result of this \$40 million loan that PHP paid to HIP of New York was that HIP of New York received an immediate \$40 million cash infusion.

SENATOR ADLER: That's good for New York. I'm not sure that's good for New Jersey. I guess you had the chance with HIP of New York at the table looking for its \$40 million and insisting on getting that \$40 million in exchange for signing off on this asset sale.

COMMISSIONER LaVECCHIA: No, my point in pointing it out was only that by them making that loan to HIP of New York, it had a collateral effect of relieving HIP of New Jersey of something that would otherwise have been its obligation.

SENATOR ADLER: At that point you've got a troubled HIP with eight consecutive losses and a loss ratio where payments are exceeding premiums dollars. It's losing money steadily month after month, quarter after quarter. I guess a clean balance sheet is not the highest priority. Cash flow to make sure that they stay in business is a little bit higher priority than giving \$40 million to a parent company that would, of course, like \$40 million.

COMMISSIONER LaVECCHIA: Senator, \$40 million was not anything that I think HIP of New Jersey or any State regulator here in New Jersey was looking for. It was a side arrangement made between PHP and HIP of New York. I raised it and put it in here in order to make sure that the Committee was aware of it.

SENATOR ADLER: I guess my question is, was the Department aware of it at the time the Department signed off on this asset sale?

COMMISSIONER LaVECCHIA: Yes, we were.

SENATOR ADLER: And I'm sort of stumped how that helped keep HIP of New Jersey going, to let \$40 million go north.

COMMISSIONER LaVECCHIA: It's not \$40 million out of HIP of New Jersey. It was an additional loan that PHP took out and paid to HIP New York. It really didn't--

SENATOR ADLER: In all fairness, PHP was willing to spend \$40 million more as part of its asset purchase, and arguably you could have insisted that that extra \$40 million go to HIP New Jersey, or some percentage of it, and have HIP New York concede some of the debt that was owed to it by HIP New Jersey. You let \$40 million go north that could have stayed somehow in the fund, maybe paying down the debt over time--

COMMISSIONER LaVECCHIA: Wait a minute, wait a minute. HIP of New York -- the surplus note would have been extinguished. It did relieve HIP of New Jersey of that \$40 million debt.

SENATOR ADLER: But that's \$40 million it didn't have and HIP of New York wasn't going to get it.

COMMISSIONER LaVECCHIA: But, Senator, you are asking me what happened. That's what happened.

SENATOR ADLER: So you're telling me that you didn't at the time or your predecessors didn't at the time say to HIP New York, "Listen, you are going to have to get this money over time. You're not going to get \$40 million from a dying HIP. You're going to have to take it a little bit at a time,

and we are going to put it in a fund, and maybe we will give you \$5 million a year over eight years.” And you chose not to -- not you, the Department, your predecessor -- chose not to be creative and say everybody is going to have to give a little bit so HIP New Jersey thrives.

COMMISSIONER LaVECCHIA: The deal as presented to us only involved approximately \$73 million coming into New Jersey. That side arrangement was not even discussed as part of the negotiation involving the HIP of New Jersey transaction, and that is the way in which the presentation and all discussion of it went.

SENATOR ADLER: But you were aware of it?

COMMISSIONER LaVECCHIA: We were aware of it.

SENATOR ADLER: So as part of the consideration for the transaction just wasn't part that you thought you could get at somehow.

COMMISSIONER LaVECCHIA: I can't call it consideration for the transaction. I raised it with the Committee so that you would be aware of it. It was not part of the consideration. The \$73 million was the consideration.

SENATOR ADLER: Which Department of the State looked at the Wasserstein Fairness Opinion? Was that your Department? Was it the Attorney General's Office? Was it--

COMMISSIONER LaVECCHIA: The Attorney General's Office.

SENATOR ADLER: Okay.

I see a memo from John Kohler to Gail Simon. Ms. Simon is in your Department or was in your Department?

COMMISSIONER LaVECCHIA: Yes.

SENATOR ADLER: Dated October 28th in which he says that essentially he is going to rely on various representations made by your Department to his Department because time constraints don't allow him to independently evaluate the various representations.

Can you tell me what sort of representations were made by your Department to Health and Senior Services on which Mr. Kohler on behalf of Commissioner Fishman relied in signing off?

COMMISSIONER LaVECCHIA: There were numerous conversations back and forth between the two Departments regarding the Health Services Agreement, and concerns and changes that both Departments were interested in seeing being made to that document. I don't recall there being detailed memorialized specifics other than the letters that were going back out to HIP that I referred to before. Before the memo that you are referring to, there was a separate letter to our Department from Commissioner Fishman indicating that he was satisfied and prepared to sign off on the Agreement.

I think John Kohler's memo was simply referencing the various telephone or other meeting discussions that took place between staff of the two Departments regarding the Health Services Agreement.

SENATOR ADLER: Can I ask you to provide the Committee with a copy of--

COMMISSIONER LaVECCHIA: Commissioner Fishman's letter.

SENATOR ADLER: That would be very helpful.

COMMISSIONER LaVECCHIA: Absolutely.

SENATOR ADLER: And can you give me a sense of what time constraints you believe Mr. Kohler is referring to in stating that he didn't have time on behalf of his Department independently to verify the various representations made by your Department?

COMMISSIONER LaVECCHIA: As part of the shared responsibilities between the two Departments often results in the regulated entities sometimes telling information that relates to one agency's area of responsibility to the other agency. And that information goes back and forth telephonically or meetings all the time. I think John was referring to that kind of interaction that was going on.

Most of the meetings that were taken place with HIP were being done with members of both Departments present; although, I can't say that all of them were. And I think the Departments wanted to be on record of making sure that ultimately all the information that was coming from HIP to one agency or another was being shared back and forth.

With regard to time constraints, I think everyone was aware of the financial situation of HIP New Jersey. The parties had an anticipated closing date I think of November 1, that they told us all along they were hoping to achieve, even when they presented the signed agreement to the Departments on July 24th. So that was, I believe, the short time frame that John makes reference to. It was a combination of, one, we were all aware of HIP's financial condition and, two, the anticipated closing date the parties hoped to meet.

SENATOR ADLER: What was the State's public policy interest in having it closed November 1st, rather than November 15th or November 30th? Any reason?

COMMISSIONER LaVECCHIA: At times the Departments had had to force agencies to push back closing dates if things were not complete.

SENATOR ADLER: Well, this one was okay--

COMMISSIONER LaVECCHIA: I think in this instance they felt they were.

SENATOR ADLER: Thanks.

SENATOR MATHEUSSEN: Commissioner, just as a point here. I see that-- We'll use the third quarter of 1997. At that point in time it seems to be a good reference point for a lot of things that began to occur here. There were losses of over \$11 million at that time, and that proceeded with a quarterly loss of \$10 million, and then after that another \$23 million loss.

COMMISSIONER LaVECCHIA: Right.

SENATOR MATHEUSSEN: I also see that the medical loss ratio continued to climb during that period. First, being what I would consider to be, I guess, profitable, or at least potentially profitable, when it was in the less than 100 percent ratio, but it exceeded 100 percent in the second quarter of '97, and then again in the third quarter of '97 it went up to 117 percent in the fourth quarter of '97. The same time it's losing market share. And you had indicated that some of the proposed plans that were put forth by HIP in order to stop this decline were to do some significant cost-cutting measures as well as perhaps a slight increase in their premiums.

Looking at this Attachment A that you have given to us, how many potential buyers would have been out there, if you know, of a company that is losing market share, losing literally tens of millions of dollars per quarter,

and has a medical loss ratio? Are there many buyers out there for that kind of a company?

COMMISSIONER LaVECCHIA: It's hard to speculate in who would have been interested at that point in time. I can tell you that when I was trying to find a partner during rehabilitation to come in and work with some portion of HIP if enough resources could be brought in to cover the debt, I had a tremendous amount of difficulty, precisely because of the medical loss ratios of HIP in its performance over the last couple of years.

Many HMOs came in and looked at the data and saw a company that had been exercising little, if any, control over their utilization management, over their medical expenses. And it was so weak a program that they told me they couldn't even venture a guess as to whether they were dealing with a population of patients that were just -- had more problems -- more health problems than the average subscriber in their programs or not, and they were unwilling to take the risk.

And I suspect similar problems would have existed right here because, as you point out, not only were the medical loss ratios more than the contract dollar being brought in, but the administrative expenses on top of it make it clear that this was a company that had no control over its expenses. And didn't have control well into going back into 1996. They couldn't do it.

SENATOR MATHEUSSEN: Having that in mind what -- and I know this is mere speculation on your part, but it's speculation that I certainly would like to hear about. What would have happened to HIP had it been left on its own without any partners? In other words, allow it to continue without forming a partnership with PHP.

COMMISSIONER LaVECCHIA: In '97?

SENATOR MATHEUSSEN: And so on and thereafter. If there had been no other mergers, what would have happened to HIP and its members?

COMMISSIONER LaVECCHIA: In 1997 there had not been this transaction. I am sure that they would have become insolvent well before the end of that calendar year.

SENATOR MATHEUSSEN: And what happens to its members when it becomes insolvent?

COMMISSIONER LaVECCHIA: Well, we just experienced that. The membership would have to be absorbed by other plans.

SENATOR MATHEUSSEN: And the providers who provided services under that would they have been paid?

COMMISSIONER LaVECCHIA: Probably not. We would be in the same situation as we found ourselves when I asked for a liquidation order. The Commissioner at the time would have had to ask for a liquidation order and would have been charged with marshaling the assets of this data at that point.

SENATOR MATHEUSSEN: I don't mean to put words in your mouth, but would this have been considered sort of like a last ditch effort to try to bail out HIP one last time before it went down the drain?

COMMISSIONER LaVECCHIA: These are such hard decisions. I think a regulator's heart tries to -- not heart -- a regulator's policy direction is always to try to save in a regulated entity. And here is an entity that looked like it had lived well past its nine lives and yet had another partner with

legitimate cost-cutting programs about to be put into place, which, if implemented, would have brought their expenses in line with their available premium dollars and brought in a significant infusion of money that immediately restored their reserve obligations and net-worth obligations. So this was their chance, their last chance I think, to try to make a go of it if the parties had behaved as they should have and as they said they would under this contract, but they didn't.

SENATOR MATHEUSSEN: Somewhere in the meeting it was said that they described HIP as being a very healthy company and suddenly formed this partnership with another company outside of the State of New Jersey who basically raped it of its profits and assets and took it out of state and left a perfectly healthy company to just dwindle away on the (indiscernible). That doesn't seem accurate from the figures that you presented us today.

COMMISSIONER LaVECCHIA: It was my point in presenting these figures to you so that you would know the true picture of HIP's health and performance in understanding the situation. I'm not here to defend PHP by any means. I have my own reasons with the estate liquidation to be looking at them as well. But this was not a healthy company by any means, and that characterization was not accurate.

SENATOR MATHEUSSEN: As a matter of fact, it started in the third quarter of '95 that they started losing at least a million dollars a quarter and considerably increased thereafter each quarter.

Thank you, Commissioner.

COMMISSIONER LaVECCHIA: Thank you.

SENATOR SINAGRA: Senator--

SENATOR ADLER: I have a few more.

SENATOR SINAGRA: Can I go?

SENATOR ADLER: Absolutely, you're the Chair. (laughter)

SENATOR SINAGRA: Thank you, Senator.

Can you, just for the Committee, to the best of your ability, explain what the \$73 million of infusion as capital was used for?

COMMISSIONER LaVECCHIA: Yes. At the time the \$73 million actually was made, I believe two capitation payments had already passed, so there was the bookkeeping back and forth between the two companies. But the remaining money and the capitation payment, as you know, was \$14 million twice a month. So that \$28 million was netted out of the amount and used to pay the health center expenses that PHP was responsible for. The money that actually moved to the HIP side of the ledger was paid over to HIP and was used to cover reserve obligations and payment of old claims.

SENATOR SINAGRA: And how much was that of the total?

COMMISSIONER LaVECCHIA: Roughly 73 million minus 28 million, \$40-some million.

SENATOR SINAGRA: And under the powers that you have existing and getting to some of the other questions about HIP's financial condition and your ability to force them to increase premiums, to do some of the things that obviously PHP presented and potentially doing even though we didn't have the authority to regulate them, did you have the power, going back in hindsight, to have taken steps to change the behavior of HIP as it pertains

to administration costs, their loss ratio, their management of utilization review? Is that-- Does the Department of Insurance and Banking have that power?

COMMISSIONER LaVECCHIA: The Health Quality Act amendment certainly give the Department the ability to go in and conduct the kind of exam with hands-on, on-site examinations that would allow the Department to look at those daily activities and direct how they could be better performed. We got that power in February of 1998. I think certainly at that point in time the Department was better positioned to be able to go in and give that kind of thorough examination and direction to a company.

Before that I don't think the Department really had the practical ability to provide that kind of micromanaging expertise and direction to a company. I think the members of the Department tried valiantly through the meetings and numerous conversations that took place through the years with HIP to try to help it come up with better practices and certainly told it to do certain things and to improve their practices.

But in terms of actually getting in there and telling them how to change it, the Department did not have the staff or the clear legal ability to do that.

SENATOR SINAGRA: Were there those either within your Department or yourself that did a review as it pertains to PHP having the financial ability to live up to what you wanted them to accomplish? In other words, they were paying \$73 million for approximately \$20 million worth of assets, correct? Twenty-two million dollars worth in assets.

COMMISSIONER LaVECCHIA: That's what the HIP is at.

SENATOR SINAGRA: In addition to that, they were paying \$40 million, for whatever reasons -- I still particularly don't understand why, but it is certainly coming out of their ability to raise money and operate. We're talking about PHP. They spend another \$40 million to HIP of New York, so together they are paying approximately \$117 million for \$20 million worth of assets that they can go to the bank and say this is what I have.

Was there any concern raised within your Department, and is this part of a thought process, as it pertains to PHP's ability to do the things that was necessary for them to continue to support HIP's operation?

COMMISSIONER LaVECCHIA: Well, as the 10-K review, PHP did have a lot of debt at the time.

SENATOR SINAGRA: That wasn't my question.

COMMISSIONER LaVECCHIA: Yes. The short answer is no. We looked at it from the perspective of was there adequate money, premium dollars, that would be transferred to the respective parties to cover their respective obligations going forward. And the analysis of the staff was that, yes, as everyone did what they were supposed to do including the cost-cutting measures and the changes that were supposed to be implemented immediately. A lot of them were supposed to be accomplished within the first -- well, within the first six months of operation. It would have been adequate to cover those responsibilities. That was the focus of the Department.

SENATOR SINAGRA: I'm just trying to understand whether there was a review by your Department of the ability of PHP after putting themselves -- spending an incredible amount of money, 73 plus 40 -- they have

the financial wherewithal to continue to live up to their obligations. Was a review done of their capabilities?

We all know what shape HIP was in. There is no question HIP, whether PHP would have purchased them or didn't, would have probably been ceased to do business anyhow. But I'm just curious about the review that your Department made or didn't do as it pertains to--

COMMISSIONER LaVECCHIA: Our review was limited to what I just described, Senator. We looked at HIP, we looked at the financial impact there would be on HIP. We looked at whether PHP, under these financial arrangements, be able to carry out the obligations that it was taking on as a result of this transaction. But if you're asking if we did an independent analysis of PHP's debt position and whether they (indiscernible) through all of their various revenue sources satisfy that that position, the answer is no. That's not what we would do.

SENATOR SINAGRA: Do you think in the future in the event that this -- we have a similar circumstance, where a for-profit, public, on the stock market company would buy a not for profit or substantial portion of the assets not for profit -- do you think that a further review would be necessary?

Because the problem with public companies-- In fact, I own many stocks that look like that over there, (indicating charts) (laughter) unfortunately, in my portfolio. But as we all know that many companies -- their market capitalization can change dramatically. Their ability to borrow money-- The first thing that happens when a company reports one quarter, especially a public company, they are all of a sudden out of their covenants with their banks, the banks withdraw the lines. Things can deteriorate

considerably faster with a public company, certainly one that is necessarily financially that stable and with a private or not for profit.

COMMISSIONER LaVECCHIA: I agree with your concern and that's why one of my recommendations was to consider making the holding company act applicable. Because one of the things that it would put in place as a requirement for approving mergers and acquisitions in the future is whether or not the acquisition debt of the acquiring party exceeds 50 percent of the purchase price of the insured. That would have prevented this deal if that had been in place.

SENATOR SINAGRA: And just one final question, which I'm not quite sure piggybacks on Senator Adler's question. But, to your knowledge, was there anyone within your Department that raised a red flag as it pertains to PHP's ability to perform and service their debt?

COMMISSIONER LaVECCHIA: The debt?

SENATOR SINAGRA: Their own obligations under some of their other contracts.

COMMISSIONER LaVECCHIA: No, to my knowledge, no. The concerns within the Department focused on the reserve issue and the fact that we would be dealing with so many activities being subcontracted to an unregulated entity.

SENATOR SINAGRA: Did you have another question, Senator?

SENATOR ADLER: Senator Vitale wants to cut in front of me again.

SENATOR SINAGRA: Okay.

SENATOR VITALE: Commissioner, I just want to go back for a moment to the Garden State Medical Group and their management. They manage the center operations for HIP.

COMMISSIONER LaVECCHIA: Yes.

SENATOR VITALE: At the end of -- their contract was due to expire as of December 31st of '96. That was a 20-year relationship that they had with HIP.

COMMISSIONER LaVECCHIA: Yes.

SENATOR VITALE: Does the Department know-- Clearly here you described that they tried to renegotiate with Garden State, specifically with the protocols and procedures and other issues within the center operations.

To your knowledge or your opinion, did Garden State -- or what level did Garden State have or role did they play in terms of the costs and effects that they had on HIP? I see they wanted to renegotiate some of those procedures, and at what level does Garden State have or what role do they play?

COMMISSIONER LaVECCHIA: Garden State has a role in a number of ways. One is that earlier in '96 they had promised their contracting partner, HIP, to implement those numerous procedural and protocol changes to effect the savings, and in fact, they breached that promise to their contracting party. I think it was a significant part of HIP's problem.

Two, the negotiations were unsuccessful for a variety of reasons, not the least of which they were demanding exclusivity, and HIP could not agree to that. As a result, you had Garden State which had been responsible for center operations walking out at a time where the membership was vastly

increasing, the provider network was vastly increasing and changing its nature, as I described before. And Garden State was frankly not really lifting a finger to help. And then, of course, the litigation started late in 1996. It was nasty, and I can tell you that it's ongoing. That's one of the litigations I have inherited as the liquidator of the estate.

SENATOR VITALE: One of the things that HIP was asking -- I think asking Garden State to provide for was to restructure their staffing levels. Do you know what they mean by that -- what they meant by that?

COMMISSIONER LaVECCHIA: HIP historically had a very high administrative two-member ratio higher than many of the other HMOs, and they, at various times, said that they were going to be reducing their administrative staff to bring it more in line with ratios that we saw with some of the other HMOs. But I don't think we ever achieved that -- not even up until the end.

SENATOR VITALE: You're talking about caregiver ratios or just administrators in general?

COMMISSIONER LaVECCHIA: Administrators in general.

SENATOR VITALE: So pencil pusher is not health-care providers.

COMMISSIONER LaVECCHIA: Yes, I'm not talking about the physicians.

SENATOR VITALE: Thank you.

SENATOR ADLER: Commissioner, you are in a sort of unique advantage point because you are now in the Department of Banking and Insurance and previously you were in the Attorney General's Office. So you

have been in two of the three executive Departments that played a role in this unhappy story.

In the context of 200,000 people whose medical continuity of care has been disrupted and the many thousands of medical providers, hospitals and doctors, etc., who are left unreimbursed for services already provided, can you take a few minutes to look back and share with us your thoughts on mistakes of judgment, errors or omissions, or lost opportunities on the part of your current Department, your prior Department, or the Department of Health and Senior Services to help us understand how we got to the position we are in now?

COMMISSIONER LaVECCHIA: Well, I've tried to do essentially that by telling you what recommendations I think we need to put in place to prevent this from happening again -- those specific legislative changes. I think it's unfair to ask anyone to sit here with the hindsight of the many months we've had since this took place and look back in September of 1997 and say, with this failing HMO and its dire financial situation and the partnership, the only partnership possibility coming with an entity, bring \$73 million into it, I would have made any other decision, frankly.

I think, from a public policy perspective, the most important thing that we can learn as a result of this entire transaction, and also what I've learned in the few months that I have been Commissioner of Banking and Insurance, is that we really have to regulate unlicensed entities that are widespread in usage in the HMO industry. Various levels of risk in the performance of activities that we've traditionally--

You have to remember, the HMO is a relatively young one that has evolved dramatically in a relatively short period of time. And when it started, we anticipated the HMO itself doing all of the activities that gather the services and provided it directly to members through their docs that originally they employed or contracted with directly. And what has happened is that slivers of the HMO's responsibilities have begun over the 10-, 15-, 20-year experience to be delegated out to entities that allegedly and generally have proven to be able to provide it at a lesser rate, a lesser cost. So you see utilization and you see quality standards sometimes going out to other people. You see all the provider -- various provider organizations that have developed over time being created and willing to take on certain aspects of risk not only with regard to their performance, but is expanding now into the performance of, or the control of, costs associated with pharmacy and hospitalization.

It's evolving. This is an industry that is still going to evolve. We haven't seen by far the last of how creative these various organizations can be. And right now the law is not equipped or ready to keep pace with the changes that are going to happen -- that are happening right now.

I have had asked of me several times, "What's going on with regard to an entity called Heritage?" Heritage is an entity that is operating in many states across the nation, and it's begun to try to operate here in New Jersey. There is nothing wrong with Heritage. They provide specialized risk-base services, generally in a Medicare setting. They take on all of the risk associated with providing services to a Medicare population, but they do so under the name as a subcontractor to a licensed HMO. They are not licensed themselves.

They are operating, as I said, all across the country. They wanted to operate here in New Jersey in a similar set up. And after having experienced HIP and APPP, I had not permitted that. I have allowed the companies to contract with Heritage but only in a traditional TPA setting, not with the kind of risk sharing that they are used to providing HMOs elsewhere in the country.

Now I think we have to take a look at that. I don't think it's good competitive position for New Jersey's health-care industry to be in -- to not be able to take advantage of new trends and new ways in which perhaps costs can be kept down, but we have to do it safely and have to do it in a way and make sure consumers are not going to be placed at risk for not getting the health-care services that they are supposed to get. And that's why I made the recommendations to you that I've made.

The law in New Jersey has to change because it certainly did permit what happened here with PHP. That was not an illegal transaction.

SENATOR ADLER: Respectfully, I don't understand your answer at all.

You knew -- someone knew -- maybe everybody knew, except the Legislature and the people in the audience that you had an HIP of New Jersey that was suffering loss after loss, quarter after quarter, and somehow you didn't structure a deal which mandated with some enforceability that the costs would be cut, the revenues would be raised in such a way that that ratio be corrected, and the profit would be there and the payouts would be below 100 percent rather than above 100 percent.

Respectfully you acknowledged to Senator Sinagra that the Department didn't even look at what PHP was all about and what its principle

is all about and what histories they had in terms of responsibility to former shareholders and whether they were the sort of responsible parties you would want to take over (indiscernible) HIP New Jersey.

You told us that you knew \$40 million was going north, but New Jersey couldn't do anything about it. And yet the problem -- after this approval occurred, the problem got so monumentally worse that we have many, many millions of dollars that providers are unlikely to get back absent some legislative assistance from the State of New Jersey.

So I guess I am going to ask you one more time and hope that you'll maybe reconsider your answer. What went wrong from the bureaucratic point of view with existing legislation that allowed this thing to go so far south on us?

COMMISSIONER LaVECCHIA: Well, respectfully, we did look at PHP. We did examine the 10-K. We sort of revealed their debt position and all the information that was set forth there and that was examined. We did examine the deal to make sure that the revenue and the projections on the cost and the cost-saving activities would, in fact, from an actuarial basis and from a complete financial review, generate a situation where the premium coming in would cover the respective financial obligations of both entities. We checked on the performance of PHP using with an entity right here in New Jersey that was using their services for a couple of years already and their performance was fine.

So, Senator, I don't want to be an apologist for PHP, and I don't intend to do that because we are going to be looking very hard at them as a potential action bringing additional assets into this estate. But from a

perspective of the agencies' responsibilities what I'm trying to say -- and maybe I didn't say it artfully enough -- is that I think the people in, at least my Department, try to and, in fact, did do the kind of review that was well intentioned. They attempted to be thorough. They were doing all of that in the context of an entity that was in severe financial trouble, which is an incredible pressure to be under. And they looked at a deal that when tested out seemed to look to them in good faith to be one that would work. And it was because it was viewed in that way that it was approved.

From the Attorney General's perspective, there was an examination done to make sure that value was being paid for assets that were sold. There was no diminution in value to the entity. So I really don't see any problem there. And I think Health and Senior Services certainly should speak for themselves--

SENATOR SINAGRA: They will.

COMMISSIONER LaVECCHIA: I'm sure they will -- with regard to what things they could do better.

I can tell you, Senator, that we are doing better, we will do better, we've looked hard at that Heritage situation as I told you before to make judgments as to whether or not that should be allowed here in New Jersey, and it hasn't yet. And I can also assure you that all of the required checks that need to be done whenever an entity comes to us with change that generates a need for an amendment to a certificate of authority -- I can assure you that we will-- A check list is necessary. A check list will be used to make sure we will be able to demonstrate that every single thing that needs to get looked at does get looked at and is explained as to why it satisfies regulatory and statutory

requirements. So I don't know what else I can say in response to your question.

SENATOR ADLER: In your capacity as Deputy Attorney General did you have any role in evaluating the fairness opinion?

COMMISSIONER LaVECCHIA: When I was a Director of Division of Law, I did see the fairness opinion, yes.

SENATOR ADLER: Were you one of those high senior attorneys that Attorney General Verniero referred to in a recent hearing who believed that the Wasserstein Fairness Opinion was the valid basis on which the Department could approve the asset sale?

COMMISSIONER LaVECCHIA: Yes, I was.

SENATOR ADLER: Did you have any concern about Wasserstein's bias in favor of having the transaction go forward?

COMMISSIONER LaVECCHIA: No, it's not uncommon at all for the same investment banker that's involved in working with an entity looking to partner to also be the one to provide a professional opinion to the board of directors in the exercise of their duties that, in fact, fair value is being provided for the assets that are being transferred.

SENATOR ADLER: Did the State consider doing an independent valuation of the transaction to determine whether or not the Wasserstein Fairness Opinion was in fact itself fair?

COMMISSIONER LaVECCHIA: We considered it and didn't think that it was necessary. There are times when an independent evaluation may be required. We didn't think it was required in this instance.

SENATOR ADLER: What was your thinking along those lines. Why did you think in this case it wasn't necessary?

COMMISSIONER LaVECCHIA: The assets were being transferred for value that so far exceeded the value on their financials that it was pretty apparent that more than fair value was being provided.

Let me also add that in hindsight that judgment was correct. Remember these facilities had been transferred to PHP. They became part of the bank of the state. When it came time for the bankruptcy trustee to accept or reject leases and other contracts, based upon whether there would be any value in them to the estate, they were rejected. HIP got more than fair value as a result of this transaction, and it's borne out with the independent subsequent action by the bankruptcy trustee.

SENATOR VITALE: One quick--

SENATOR SINAGRA: No, it's my turn.

SENATOR ADLER: Okay, go ahead, Mr. Chairman. (laughter)

SENATOR SINAGRA: Thank you.

I just want to ask one question that's kind of troubling me. And in your comments you approach PHP to become licensed by New Jersey. In this entire scenario that you've played out of transaction after transaction, what would have been different in the end if PHP was licensed? If the Department would have held its ground -- because you did have control-- You were playing a very big card here. Either it went through or didn't go through based on how forcefully, and there is no question I think there was a motivation on the Departments and the states to do something about HIP. What would have been different?

COMMISSIONER LaVECCHIA: If PHP had become licensed, then all of the collateral obligations with that status would also apply to them, including the obligation to reserve.

SENATOR SINAGRA: Okay.

COMMISSIONER LaVECCHIA: And that would have been a difference in what we had here because--

SENATOR SINAGRA: HIP had that same obligation, and it didn't appear to be adequate.

COMMISSIONER LaVECCHIA: That's correct, but we would have had HIP -- PHP's larger financial picture to look at in terms of coming up with the reserves.

SENATOR SINAGRA: The only other part of this that troubles me in your entire presentation this morning is that I think there was a lot of wishing prayers. In other words, I think the control over the Department was to indicate to force them to raise their rates more significantly because all of the rest of this is maybe it will happen, maybe it won't happen, maybe it will get more efficient, maybe we won't get more efficient. But the fact of the matter -- the only fact that we know for certain is their loss ratio is out of control as it pertains to their premiums.

And the only thing that I think that the Department failed to do, and maybe there is a whole bunch of consequences that may have happened and maybe they would have lost enrollment and maybe things would have changed a little-- The only thing that you definitely have control over that you can, at that time under the laws, force to happen is raising the rate. And I think that was in hindsight a big mistake not forcing that end.

Now you can ask your question.

SENATOR VITALE: Thank you, Senator.

COMMISSIONER LaVECCHIA: Can I just add to that, Senator?

SENATOR SINAGRA: Sure.

COMMISSIONER LaVECCHIA: I can understand you feeling that way. And I also understand why it sounds like we keep relying upon HIP and its various partners to carry out what it is, in fact, that you represent to us that they are going to deal--

SENATOR SINAGRA: Isn't it easier to have them raise their rate, and then if they do what they are supposed to do, lower it?

COMMISSIONER LaVECCHIA: It could have been done that way.

SENATOR SINAGRA: Because then they would certainly had the motivation to take those steps in order to get their rates back down to be competitive rather than the other way around, which also could end up in patient care in the areas where they want to cut from. This is the Department-- This is the Health Committee, and we deal with HMOs on a regular basis that do cost-saving measures that eventually end up affecting patient care.

So I just wonder why it wouldn't be more logical to have them raise their rates, and then they would have a certain strong motivation to curtail the costs.

COMMISSIONER LaVECCHIA: The policy direction when HMO's were deregulated from a rate perspective was, I thought, I understood to be more of a market driven rate-based approach, and maybe that needs to be rethought.

SENATOR SINAGRA: Do you have a question?

SENATOR VITALE: Yes, thank you.

I just want to go out to Wasserstein just for one moment and talk about this competitive bidding process. It said that HIP advised that they retained the investment banking firm of Wasserstein Perella to locate a partner and that after that process PHP was selected to manage HIP's delivery system. Do you know how many other organizations Wasserstein had sifted through and finally came up with PHP?

COMMISSIONER LaVECCHIA: There was a report that I believe was made available, and if you didn't get it I will certainly--

SENATOR VITALE: I got it this morning.

COMMISSIONER LaVECCHIA: Okay.

There were, I think, half a dozen of companies that were contacted. I don't believe all of them ultimately produced bids. I think ultimately there may have been two bids.

SENATOR VITALE: And PHP was the best out of the two.

COMMISSIONER LaVECCHIA: Yes, and ultimately during-- It was later represented to us that perhaps a second one backed out as well.

SENATOR VITALE: Can you tell me what Wasserstein was thinking? I know you can't but--

COMMISSIONER LaVECCHIA: No, I can't. (laughter)

SENATOR VITALE: If--

COMMISSIONER LaVECCHIA: I don't even want to venture a guess.

SENATOR VITALE: If PHP was in the kind of condition that everyone knows they were in and that second company was turned down, I wonder where they are today. And how is it that-- Did the Department just essentially take Wasserstein's word for the health and well-being of PHP?

COMMISSIONER LaVECCHIA: No, we also had the 10-K available to us which was examined by members of the Department. And we also asked, as I said, for some financial information and actuarial basis for how the companies were going to work together. That also was examined as well.

SENATOR VITALE: In spite of all of that PHP was still approved.

COMMISSIONER LaVECCHIA: Yes.

SENATOR VITALE: Given their condition still approved then.

COMMISSIONER LaVECCHIA: Yes, Senator, that is correct.

SENATOR VITALE: Thank you.

SENATOR SINAGRA: Senator Adler, do you have any other questions?

SENATOR ADLER: I wanted to follow up on your question, Chairman.

Is it your view that from a regulatory basis your Department, in conjunction with the Department of Health and Senior Services and the Attorney General's Office, couldn't have conditioned approval of this asset sale on your attention of some funds in a special account someplace to make sure that providers got paid or your attention of some of the HIP New York payment monies in a fund for a year or two to ensure that HIP New Jersey had some reserve someplace?

COMMISSIONER LaVECCHIA: The cash that came into HIP, the \$40 million plus, as I said, that was a part of the \$73 million, did go to their reserve. And, Senator, I have to disafuse you of your idea that we had any involvement or interaction with HIP New York and PHP with regard to that \$40 million that was loaned through PHP to HIP New York because we simply did not.

SENATOR ADLER: I'm still stumped on that. I can't imagine you couldn't say to HIP New Jersey we are not going to approve this transaction if you don't renegotiate with HIP New York and turn the note over in (indiscernible) years. You are in such desperate straits you can't afford to be giving \$40 million of your assets, which are essentially PHP consideration assets, to a third party. It doesn't benefit HIP New Jersey, its providers, or its insurers.

COMMISSIONER LaVECCHIA: Senator, I think we are just not connecting on this. Yes, we could have turned down the \$73 billion deal, but I think your approach to this New York loan that was taken out by PHP and given to HIP New York was separate and apart completely from the \$73 million that was presented as the consideration for this transaction.

SENATOR SINAGRA: I'd like to just cut to the chase. I know where you are going, and I think I'd like just to ask the question directly.

SENATOR ADLER: Go ahead.

SENATOR SINAGRA: Did HIP New York come out smelling like a rose? (laughter) I mean did HIP New York end up benefiting from this entire transaction, reducing their exposure, their loss, while HIP New Jersey went in the tank? I think that's the question if I can put that clearly.

COMMISSIONER LaVECCHIA: HIP New York got a cash sweetener out of this.

SENATOR SINAGRA: Okay, thank you.

SENATOR ADLER: And otherwise they would have been one of the creditors waiting to get satisfied in a HIP New Jersey bankruptcy.

COMMISSIONER LaVECCHIA: Yes, and a surplus guarantee note would be way down there on the list.

SENATOR ADLER: So at least--

SENATOR SINAGRA: I think that's where you were going.

SENATOR ADLER: Yes, but I guess I'm looking for the Department to tell me that the Department missed a chance to force this third party to forgo this immediate benefit in exchange for the long-term solvency of our interest, HIP New Jersey.

COMMISSIONER LaVECCHIA: Let me tell you a little bit about HIP New York. When HIP New Jersey was in--

SENATOR SINAGRA: We're still trying to figure out HIP New Jersey. (laughter)

COMMISSIONER LaVECCHIA: HIP New York felt pretty free to stop making appropriate payments to New Jersey that it owes us as a result of typical business transactions between the two entities. They have also shifted some of their legal fees over to our accounts and did it before we were able to stop it. And to the number of other things that we will be going after HIP New York on, HIP New York is not smelling like a rose to me at all.

SENATOR SINAGRA: I'm not saying that it came out smelling--

COMMISSIONER LaVECCHIA: Yes, but understand that HIP New York's Chairman was the Chairman of the Board for HIP New Jersey and signed the deal for HIP New Jersey with regard to PHP transaction.

SENATOR ADLER: That's exactly my point. You've got this party at the table, and whether or not you want to acknowledge the table or not, their Chairman is the one approving the HIP New Jersey transaction. You have a chance to squeeze HIP New York and say you don't get the money now and we're not going to approve this transaction. You missed a chance here. You missed a lot of chances, I think, with all due respect. And I know you weren't in charge of it, so this is not a knock on you personally. But you missed a lot of chances, but this is one, obvious one, a glaring one, to force HIP New York to forego this immediate cash infusion pending the survival of the endangered HIP New Jersey.

COMMISSIONER LaVECCHIA: I don't know if that's a question. But please do remember that as a result of this transaction and the money that was paid for the various contracts that were entered into, HIP New Jersey did restore itself to a positive net-worth situation, and it was only thereafter that its practices brought itself down again.

SENATOR SINAGRA: Thank you.

I want to thank you, Commissioner, for testifying today, and I hope in the event that we need another hearing because of documents that may be presented later that you will agree to come back.

I also want to say for the record -- I want to compliment your Department specifically for going through a period of uncharted waters. Part of-- Today we are pretty much talking about finances, but the fact of the

matter is there were 200,000 people that were left in the lurch as it pertains to their health care. And our laws and our regulations don't even contemplate this happening, and you were able, through your office, and through your caring in court to make sure that the residents of New Jersey, as it pertains to this fiasco, were taken care of medically. So I compliment you and your Department for that.

COMMISSIONER LaVECCHIA: On behalf of the many people that worked very hard to achieve that goal, I thank you for those kind words, Senator. And I would be pleased to come back before the Committee any time.

SENATOR SINAGRA: I don't know about pleased, but--  
(laughter)

COMMISSIONER LaVECCHIA: I will be here.

SENATOR SINAGRA: Thank you, Commissioner.

I think the mike is now working and--

Wait a minute, we are going to take a five-minute break, and then we will hear from the Commissioner of Health.

**(RECESS)**

**AFTER RECESS:**

SENATOR SINAGRA: Commissioner.

**COMMISSIONER CHRISTINE M. GRANT:** Good morning. Good morning, Mr. Chairman and members of the Committee.

I want to assure you that every member of the Department of Health and Senior Services has been greatly concerned about the unfortunate demise of HIP New Jersey, especially as to the impact on its members and the providers. The experience has been a trying and stressful one for everyone. My impression, which has been confirmed since becoming Acting Commissioner, is that our staff and the staff of Department of Banking and Insurance, have spent literally hundreds of hours on the phones and in the centers assisting HIP members and the providers who serve them to maintain access to health care.

I trust that during my presentation I will be able to answer your questions and give you a better understanding of the process that the Department of Health and Senior Services uses and follows in reviewing and assessing HMOs. Let me start by saying that I am prepared to answer the individual and specific questions, but before I do that, I want to address three basic issues. First, how does the process for approvals of HMO certificates of authority usually work in the Department of Health and Senior Services? Second, how did it work in regard to the HIP-PHP transaction? And finally, what measures can be taken to prevent a like situation from occurring again?

How does the process work? The Department of Health and Senior Services reviews transactions by health maintenance organizations under N.J.A.C. 8:38. In reviewing any transactions, the issues we are interested in include:

First, network adequacy, which means what the network of care will look like as to physicians, hospitals, and other providers on a county-by-county basis.

Second, quality assurance. That is how the HMO will monitor itself to see that nationally accepted health-care standards -- health-care quality standards -- are followed.

Third, utilization management. That is how the HMO applies nationally recognized standards of medical necessity to the health-care services which they provide.

Fourth, credentialing. And that's the process applied by the HMO to assure that their providers are adequately licensed.

And, finally, the content of the HMO's provider contracts.

The Department assures that these functions are carried out in a way that complies with the New Jersey HMO regulations. There is frequently further exchanges of questions and clarifying information between the HMO and both DHSS and DOBI during the review process.

Under the HMO regulations, an amendment to the HMO's certificate of authority is required when there is a change in the operational model used by the HMO to deliver medical care, a change in the service area, the addition of Medicare or Medicaid recipients, or a change in controlling ownership. The Department also reviews transactions that do not require a certificate of authority amendment, such as the initiation of new provider agreements.

How did the process work in this instance? HIP initially presented the PHP transaction to the Departments of Health and Senior Services and Banking and Insurance as a simple provider agreement. After review, both Departments determined that the transaction required an amendment to HIP's certificate of authority.

In reviewing the transaction, my Department reviewed documents such as the agreement between HIP New Jersey and PHP, amendments to this agreement, the Asset Purchase Agreement, and the transition plan. Our review focused on the access and quality considerations I mentioned previously. Initially, the Department had some concerns about the arrangement with PHP, primarily related to the broad scope of responsibility being delegated to PHP. We determined that these concerns could be addressed through HIP, if necessary, subsequent to the transaction and that we should proceed with the approval.

Finally, what policy changes are being, or could be, made to prevent a similar occurrence? On the advice of the Commissioner of Banking and Insurance, the Department has now signed regulations to strengthen the financial solvency requirements for HMOs. New Jersey already has the strongest net-worth and deposit requirements in the country. The new requirements for HMOs include quarterly, not annual, filings; a 60 percent minimum of admitted assets in cash or liquid assets; strengthened deposit requirements; and elimination of allowable offsets.

The Department also believes that further legislative changes strengthening the State's ability to oversee contractors who provide medial care or administrative services under contract to an HMO are warranted. Meanwhile, I can pledge to you that I will vigorously and aggressively enforce the existing regulatory requirements designed to protect HMO members and the providers who care for them. New Jersey has earned a national reputation for HMO consumer protection, and I intend to keep our role strong.

At this point, let me address the specific questions provided in the Chair's letter to me.

First, did the Department review the record of PHP and its executives in terms of its previous business ventures in the health-care industry, both within and outside the state?

Yes. The record of PHP and its executives, in terms of previous business ventures, was available to the staff through the SEC Report for PHP Healthcare Corporation for the fiscal year ending April 30, 1997. PHP also provided a flow chart of PHP's New Jersey entities received by the Department September 22, 1997. The Department was familiar with PHP because of its presence in the health-care industry since 1975, the existence of PHP U.S. government contracts, and PHP's operation of the New Jersey Blue Cross centers since 1994. Staff had no knowledge of any violations through the Blue Cross centers.

Staff also reviewed the following documents: The Rate Filing sent to DOBI December 9, 1996; Health Plan Response to the Department Request for Statewide Provider Network, January 1997, that's a binder listing all PHP's specialists, hospitals, ancillary providers; The Health Services Agreement by and between HIP New Jersey and Pinnacle Health Enterprises, July 24, 1997; there was a first amendment to that Health Services Agreement by and between HIP of New Jersey and Pinnacle Health Enterprises, July 24, 1997; the Asset Purchase Agreement by and between PHP Healthcare Corporation and HIP of New Jersey dated July 24, 1997; Performance Standards of Pinnacle Health Enterprises and HIP Health Plan of New Jersey received September 5, 1997; PHE's Anticipated Budget Under a Representative

Commercial Premium of \$135, which is the basis on which the medical loss ratio can be determined; a Transition Plan that is regarding transition from the current status to PHE's assumption of management responsibility under HIP's oversight and supervision, which was received September 12, 1997; Claims Processing Standards received September 12, 1997; Pinnacle Health Enterprises Quality Improvement Department Policies and Procedures received September 22, 1997; Pinnacle Health Enterprises Utilization Management Department Policies and Procedure received September 22, 1997.

The second question was what was HIP's performance record prior to the inception of the business relationship with PHP in providing quality medical care, and what was PHP's performance record in providing quality medical care and other operations in the state?

HIP's performance record was tracked in three ways by the Department: first, through tracking complaints; second, by the assessments consumer and assessments published in the HMO report card; and third, through ongoing monitoring of regulatory compliance.

First as to complaints. In 1997, prior to the November 1st inception of the business relationship with PHP, HIP members and providers complained to the Department 27 times, either via telephone or letter. The average rate of complaint per month per member in 1997 was .001 percent, or one per thousand, which gave HIP the lowest complaint rate of the five largest HMOs in New Jersey.

The Department received three complaints from HIP members or providers that progressed to the Independent Utilization Review Organization or External Review Process in 1997. And two of these three were ruled in favor

of the complainant by the IURO, and HIP agreed to comply and pay for the previously denied services. In the third, the IURO concurred with HIP's initial denial determination.

In the 1997 Annual Report to the Department, HIP self-reported 2304 general complaints that were resolved internally by HIP regarding timeliness of claim payments, benefit limits, pharmacy benefits, quality of care, and courtesy.

The second tracking of the performance record was done through the HMO report card. The Department's first HMO report card, released in November of 1997, included a patient satisfaction survey with data collected pre-PHP, June to August 1997. HIP performed below the state average in nine out of eleven measures. The report card also included preventive and screening health-care measures, such as breast cancer screening, immunizations, and prenatal care for pregnant women. HIP's 1997 performance data, compared to the 1996 performance data, showed a decrease in HIP's performance prior to the merger with PHP.

The third way to track was the monitoring of regulatory compliance. There were no documents or other indications on file regarding violations. Staff reports that the plan was responsive during routine complaint investigations. The Department was not aware of any problems with PHP's performance record in providing quality of care in its other operations in the State. PHP had run 10 Blue Cross health-care centers since 1994. The Department had kept no separate record for the 10 centers per se, but no problems were identified in the Department's tracking of Blue Cross overall.

The Department's tracking of complaints for Blue Cross in 1997 showed a rate consistent with the state average of .0002 percent.

Third, what were PHP's obligations under the business arrangement with HIP with respect to the credentialing of physicians and other providers who were on staff at the health centers and providers in the network outside the centers?

According to the Health Services Agreement by and between HIP of New Jersey and Pinnacle Health Enterprises, dated July 24, 1997, responsibility for credentialing of physicians and other providers was delegated to PHP with HIP maintaining oversight and final approval for any changes made to the credentialing program.

Fourth, what was the Department's understanding as to the necessity of HIP's ceding its direct responsibility to provide health-care services to its members?

The Department was not in a situation to presume HIP's motives. Prior to PHP assuming responsibility, HIP Health Plan had always contracted with a series of independent groups to deliver health-care services and run the health-care centers. The PHP and HIP arrangement was similar to HIP's established health-care delivery model, as evidenced in the agreement between Garden State Medical Group and HIP, effective January 1, 1993, which delegated medical management of enrollees and management of the health centers to Garden State Medical Group.

Fifth, how many of HIP's former medical staff members continued to serve the organization after PHP assumed responsibility for the center?

The Department has no specific information about the number of medical staff who continued to serve the organization after PHP assumed responsibility for the centers. But on the other hand the Department has no knowledge of any unusual medical staff turnover or change that may have occurred until the layoff of approximately 400 staff in September 1998.

Sixth, did the Department receive complaints about PHP's slow payments to providers, when did the complaints begin, and did the Department consult with DOBI with respect to these complaints?

After the November 1, 1997 PHP agreement, the Department did not receive any complaints regarding slow payment. In 1998, from January through August, 34 general complaints were received by the Department. Ten of the thirty-four complaints pertained to reimbursement which included slow payment as well as other issues regarding money such as the amount of payment to the physicians. The Department and DOBI had no particular discussions regarding slow payment complaints for HIP.

Seventh, did the Department detect the development of any administrative or other problems experienced by HIP when it expanded its reimbursements for health care provided to its members to nonstaff or nonnetwork providers?

No, the Department did not detect any problems.

Have HIP members been successfully relocated to other HMOs and have patient records been forwarded satisfactorily?

As to the HIP members finding new sources of care, the Department knows that all large group contracts have been successfully transitioned as have all eligible HIP members subsidized through the Health

Access of New Jersey, all Medicaid members and all Medicare members. The Department has required all New Jersey HMOs to submit information on new enrollments from HIP. This information has, in fact, proved very difficult to capture because the HMO data systems don't routinely track information on prior coverage.

During the last two weeks in March, DOBI did conduct a statistically valid sampling through telephone survey to determine the subsequent coverage of former HIP members. The survey indicated that in the individual market, 89 percent had already secured replacement coverage. In the small employer market, 85 percent had already secured coverage. This survey had just a 5 percent margin of error. And the Department continues to believe these figures probably understate the extent of replacement coverage because some people may have chosen to get coverage through their spouse or through other means.

As to patient records, all medical records and all unfilled requests for medical records have been transferred to Record Masters, a long-term medical record storage facility. Original records are being sent to physicians upon request by either the member or the physician at no cost. Stored records will be kept by Record Masters for 10 years for adults and for children until the age of 23 years is reached, or for 10 years, whichever is longer. There is no cost to members for one copy of their records.

Requests for original records are being given priority, as are requests from members who have scheduled physician appointments or have impending medical needs, but all requests will be and are being filled. Urgent requests are being filled in 24 hours. Every HIP member has received notices

advising them of the procedure for obtaining their medical records. Record Masters has added additional staff, copier equipment, telephone lines to handle this matter.

The Department realizes that the medical record situation has been a very difficult one due to the large number of requests received in a relatively short period of time. And the Department is aware that there is a backlog of unfilled requests. And while HIP coordinates daily with Record Masters, the Department coordinates weekly with DOBI and Record Masters to track the progress in filling these record requests. And I assure you that efforts are being made to provide these records as expediently as possible, while still maintaining sight of the fact that these are medical records and these are very important health documents requiring both quality control and protection of confidentiality.

Have most of the PHP medical staff been credentialed by other HMOs, and have support personnel who agreed to remain on the job until the end -- have they been provided for in terms of assistance in finding other employment?

The Department does know that several major HMOs, including Aetna, U.S. Healthcare, and the University Health Plan have fast-tracked credentialing of former HIP providers. We have heard that other plans are not moving as quickly.

The State also took many steps to assist HIP employees with finding new employment. The State Department of Labor sent rapid response teams to the centers to conduct unemployment briefings and provide information on training opportunities. Staff resumes were provide to Abel

Leasing for the creation of a resume data bank. Abel contacted more than 500 companies to look for openings for HIP staff. HIP Human Resources contacted local hospitals, group practices, other HMOs to seek additional openings and placements, and all available openings were posted in all of the HIP centers. Also, Horizon Blue Cross Blue Shield held job fairs at three of the centers. Employees were given the use of resume software, assistance with creating their resumes, and information regarding interviews, how to write resumes, cover letters, and were allowed four hours per week for interviews we understand.

Finally, was there adequate sharing of information between DHSS and DOBI?

Yes, the Department and Health and Senior Services and DOBI shared information as per a normal routine when reviewing a request for certificate of authority or a modification of a request for certificate of authority. And since HIP has been placed under supervision, really unparalleled efforts at coordination and cooperation have been required, and have been met, between DHSS and DOBI as well as several other State agencies.

Thank you.

SENATOR SINAGRA: Any questions?

SENATOR ADLER: Commissioner, good morning.

COMMISSIONER GRANT: Good morning.

SENATOR ADLER: Was there any thought to making any of the decision making, particularly regarding the transfer of the assets to PHP, a public process for public input?

COMMISSIONER GRANT: I can't speak to what may have-- To my knowledge, the Department did not formally address that issue or consider that issue, nor would it have it have normally done so.

SENATOR ADLER: I guess as we're looking for things to do better in the future or differently in the future and because you are a new Commissioner that there is none of the responsibility for any of the past of this, I'd be hopeful that you would try to incorporate a public participation process or input process or comment process to the extent possible if there are subsequent applications to the Department and the other Department for substantial asset transfer.

COMMISSIONER GRANT: We have just recently held a public hearing in the matter of a proposed merger of two large HMOs, and certainly it's within staff's prerogative and would be my intent when that would appear appropriate and useful to do that.

SENATOR ADLER: That's terrific. I thank you for that commitment.

Do you know if anybody in your Department recommended against approval of this asset sale?

COMMISSIONER GRANT: I have no knowledge of that.

SENATOR ADLER: Do you know who in the Department might know that we can talk to?

COMMISSIONER GRANT: I know only that Ms. Anne Weiss is our Assistant Commissioner of Health Systems Analysis -- whether she has knowledge of that. I would say that it's important to understand, if and when you go down that line of discussion that as the Commissioner of Banking and

Insurance explained, and certainly from prior regulatory experience I have experienced this consistently, that it is the role during any process, whether it be looking at HMO certificate of authority or any regulatory change, to ensure that there is a full discussion of all aspects of an issue. But as to the narrow point that you drew, no, I don't have knowledge of that.

SENATOR ADLER: How about do you have any knowledge whether anybody expressed reservations, not necessarily recommending against approval of an asset transaction, but just reservations about the way things are headed with PHP?

COMMISSIONER GRANT: It's my understanding, as I indicated in the testimony and whether reservation is the right word or concerns, it's in the nature of questions to make sure that the Department staff fully understood the nature of the delegation and wrestled with that. And as my testimony indicated, the ultimate decision of the Department was based on a judgment that to the extent that HIP would remain party to the transaction that any issues that did occur might occur after the transaction could be handled at that time.

SENATOR ADLER: I think you were in the room when Commissioner LaVecchia testified that even with hindsight she didn't see any mistakes were made in the bureaucratic process through the approval of the asset sale or the PHP. Do you have a sense as a new Commissioner who was not involved in any of this chronology whether from your perspective there were things that you would have done differently had you had information that's now available to us in hindsight that you would have done differently?

COMMISSIONER GRANT: I do not know of anything I would have done differently given the regulatory purview that the Department had and has now. I would agree with the Commissioner's assessment that clearly, since the market for managed care has evolved, will evolve, that we should look into relationships, have more directive regulatory authority over subcontractors. I would agree that legislation is clearly needed in that area.

SENATOR ADLER: In your testimony you itemized a list of documents that staff had reviewed I guess in preparation of your testimony and for your testimony. Did you look at internal memos that you might consider privileged? But did you look at internal memos or have staff look at internal memos regarding this transaction, this part of the preparation?

COMMISSIONER GRANT: For today's hearing?

SENATOR ADLER: Yes.

COMMISSIONER GRANT: No, I did not look at memos, nor do I represent that I have reviewed all of the listing. What I was listing there was so we had a clear understanding of what the Department staff, at the time of the transaction, reviewed that formed the basis of its judgment for the transaction. I can't speak to what any particular person may have been looking at in the last short period of time.

SENATOR ADLER: I guess what I'm hoping for is to find out whether or not there are memos within the Department that help illuminate the Department's thinking based on the documents it had before it and the conversations it had with folks at HIP or PHP prior to the approval of the assets of HIP.

COMMISSIONER GRANT: Right, I can't speak directly as to what the record looks like.

SENATOR ADLER: That's all I have for now.

SENATOR SINAGRA: Senator Vitale? (no response)

The one thing, Commissioner, that I think might help us understand what the Departments' knowledge they had is -- according to my staff, we don't have all of these documents that the Department had an opportunity to review, that you list in your testimony, starting on Page 4.

COMMISSIONER GRANT: Yes.

SENATOR SINAGRA: Would there be a way that you could provide all those--

COMMISSIONER GRANT: Yes.

SENATOR SINAGRA: --same documents to this Committee--

COMMISSIONER GRANT: Yes.

SENATOR SINAGRA: --before our next meeting? That would be very helpful.

COMMISSIONER GRANT: When is your next meeting?

SENATOR SINAGRA: Tomorrow. (laughter) In June.

COMMISSIONER GRANT: Yes, we will provide that.

SENATOR SINAGRA: That would be great.

And I am going to reserve the same thing that I said to Commissioner LaVecchia. I hope that you will come back as we review more of this. There are more different questions. I'm sure Commissioner LaVecchia thinks you are getting off easy, but I'm not quite sure we are done yet. (laughter)

COMMISSIONER GRANT: She did such a splendid job. She previously answered most of your concerns, but I will be happy to do that.

SENATOR SINAGRA: I understand the difference in your role verses the Department of Banking and Insurance as it pertains to this transaction. Now we are about to ask the third part of that decision-making process to testify.

COMMISSIONER GRANT: I'll be happy to come back anytime.

SENATOR SINAGRA: Thank you.

SENATOR ADLER: Chairman.

SENATOR SINAGRA: Yes.

SENATOR ADLER: Along the same lines with the Commissioner, I wonder if we could have either the Commissioner familiarize herself with any internal memos that existed and any interdepartment memos that existed or have someone else testify who is already familiar from the Department with the Department's thinking process leading up to its approval of the asset sale.

SENATOR SINAGRA: Okay, thank you.

I forgot who is testifying from-- Is Peter Verniero here? (laughter)  
I forgot, I'm sorry.

**ACTING ATTY. GENERAL PAUL H. ZOUBEK:** Mr. Chairman, Mr. Vice-Chairman, members of the Committee: Thank you for the opportunity to speak and appear before you today. As Acting Attorney General, I am prepared to testify as fully as I can about the role of the Attorney General's Office and the Department of Law and Public Safety in this matter.

I would like to focus my testimony before the Committee on the Attorney General's role in the oversight of charitable trusts. The

Commissioners of Banking and Insurance, and Health and Senior Services can and have best addressed the role of those Departments as to HIP.

The Attorney General does not regulate not-for-profit corporations, and there are no statutes that specifically define the Attorney General's role in the area of charitable trusts. Rather, the Attorney General's responsibility with regard to charitable trust relate back to the Attorney General's common law powers.

When such trust issues are brought to the attention of our Office, the Attorney General has the authority to intercede to be sure that the charitable trust operates to serve its original intended purpose. In other words, the Attorney General is charged with ensuring that the trust assets are not diverted from their original purpose or diminished in value by a use unconnected to that purpose. As a charitable organization, HIP fell within the common law authority of the Attorney General.

In late August of 1997, the Department was contacted by HIP's general counsel regarding HIP's proposed transaction with PHP. There were two questions that my Department needed to consider with regard to this transaction. One, whether the charitable trust purpose involved in the work if HIP would be continued, and, two, whether the value of the charitable trust interest in the HMO was being diminished.

The transaction we were presented with involved a service contract and an asset sale between HIP and PHP. The asset sale involved the sale of certain assets, including a health-care center and the assignment of leases in other health-care centers. The service contract provided that PHP manage the delivery of medical services and allow HIP to continue such functions as

marketing, maintaining contracts with employer groups, government entities and other subscribers. Under the terms of the transaction, HIP would continue to have ultimate responsibility for assuring the quality of care being provided.

The Department, therefore, looked at the transaction and determined that the not-for-profit health maintenance organization, HIP, would continue to operate as an HMO for purposes of seeing to the delivery of services to the members its original purpose. So, therefore, the charitable purpose of providing health care would continue.

Second, the Department looked to whether the value of the charitable trust was being diminished. Because this was a cash transaction-- I will leave that for others to follow up on that question there. (laughter) Because this was a cash transaction, the question was whether the amount of cash coming into the HMO for the assets being transferred would result in the diminution of the charitable interest. Given that this was a cash transaction, the financial viability of the purchaser was not at issue.

An investment banking and financial services firm, Wasserstein Perella and Company, have been engaged to provide HIP with financial advisory services, as well as to assist in the competitive process that concluded in the transaction being reached with PHP. In that capacity, Wasserstein prepared and issued a request for proposal and analyzed the responses to that request.

In reviewing the transaction, my office requested a fairness opinion from HIP. This was undertaken by the Wasserstein firm which, as is

customary, provided this fairness opinion to HIP's Board of Directors as a charitable organization.

Based on the fairness opinion, along with the marketing efforts undertaken by Wasserstein Perella and Company, the Department concluded that it was receiving adequate consideration for the value of assets being transferred. Thus, the charitable interest was not being diminished.

Accordingly, we concluded that there was no reason for further involvement by the Department from the perspective of the Attorney General's limited role and responsibility for charitable trusts. Given this, in a letter dated October 10, 1997, my Department advised HIP that if it obtained the necessary approvals from the Departments of Health and Senior Services, and Banking and Insurance, we would not object to the transaction on the basis of charitable trust issues. And that was the focus of the Department of Law and Public Safety limited to that particular issue.

In closing, this summarizes the Attorney General's primary role in this matter, and I will answer any questions that you may have.

SENATOR SINAGRA: John.

SENATOR MATHEUSSEN: General, if you could just explain for me, at least, what you mean by the fairness opinion that was delivered by the counsel for HIP. What does that do and what does it entail?

ACTING ATTORNEY GENERAL ZOUBEK: During the course of our evaluation of the submissions by HIP, a determination was made in the Department to seek a fairness opinion from Wasserstein to look at whether the consideration being paid for the service contract and the assets was fair, to determine as the issue of whether or not there would be a diminution in the

charitable assets. And that was the focus Wasserstein had participated in a process of putting a request for proposal out into the marketplace during a period of time of their significant financial difficulties and had received responses and had received ultimate bids.

The bid that was accepted and followed was a PHP bid, which provided in excess of \$70 million in cash. And so the consideration of the Department, and that's why an examination of Wasserstein's opinion was part of our analysis, was whether or not that was a fair value. And as Commissioner LaVecchia noted that was \$70 million in a cash transaction for what was valued at approximately \$22 million in assets at that time. And we believe that there is no question at this point in terms of the fairness of the money that was received by HIP at that time, which was the basis for the Department's decision that since the charitable purpose continue from its original incorporation documents was to provide medical services through the HMO, and since it was actually an enhancement of the financial position in terms of assets at that time that therefore there was no basis to object as related to charitable trusts issues with the notion, of course, that the other approval issues were issues for the Department of Health and the Department of Banking and Insurance.

SENATOR MATHEUSSEN: Does the Attorney General's Office do an independent review of the fairness opinion, or do they just rely on outside -- is that counsel or is it a financial firm that delivers that opinion? Who's qualified, I guess?

ACTING ATTORNEY GENERAL ZOUBEK: In this instance it was the investment banker financial advisory firm that was retained by the

charitable organization, by HIP, to advise HIP as the board of directors of that charitable organization as to whether or not the amount of money to be received in that transaction was fair value for the assets that were going to be distributed to PHP.

SENATOR MATHEUSSEN: In hindsight, which we do a lot of, particularly in hearings like this, do you still feel -- does the Attorney General's Office still feel that \$70 million was a fair amount of money to be transferred for the sale of assets?

ACTING ATTORNEY GENERAL ZOUBEK: Actually, in a number of the issues which are hindsight issues here today, one of the clearest hindsight issues, which I think can be resolved easily, is the notion that that \$72 million figure was fair at that time. The bankruptcy court has found it to be such, and there really has been no valid questioning as to whether or not an entity that was coming in to pay \$72 million for \$22 million of assets -- whether that was at that time a good transaction for the continuation of the charitable assets at that time.

SENATOR MATHEUSSEN: Does the Attorney General's Office do a follow-up in making sure that the money transferred for the assets is being put to the use that the charitable organization says it will?

ACTING ATTORNEY GENERAL ZOUBEK: In this instance there was an evaluation with respect to the charitable trust issue and then the issues in terms of financial follow-up, and regulation of that transaction fell under the purview of the Departments who have testified here today.

SENATOR MATHEUSSEN: So it's not the Attorney General's Office then to do follow-ups.

ACTING ATTORNEY GENERAL ZOUBEK: And as I stated in my testimony, the Attorney General's Office does not regulate not for profits per se. It examines the charitable trust issues that come before it in the context that I just brought up.

SENATOR MATHEUSSEN: Commissioner LaVecchia mentioned some indication that there was, I guess, an assumption or a payoff of a note between HIP New York and HIP New Jersey by PHP to the tune of about of \$40 million or \$30 million. I forget what--

That has some concern and it raised some concern, I think, this morning. Although Commissioner LaVecchia I think aptly explained that that was something that went on outside of the review process and we were not really a party to that transaction, it would seem to me, again in hindsight, that perhaps HIP of New York may have pulled one over on us, or PHP pulled one over on us. What, if any, steps would the Attorney General's Office of the State of New Jersey take to follow through to make sure that that either did or did not occur? And if it did occur, what we would do about it?

ACTING ATTORNEY GENERAL ZOUBEK: Well, in this instance we have been working with the Commissioner of Banking and Insurance, and we will continue to work with the Commissioner of Banking and Insurance in the role in terms of the follow-up and the liquidator and following up to see what potential recovery there may be or further investigation there may be to determine whether any actions that we may be able to take. As it relates to the question here in terms of the role that was played historically here, again it was solely limited to the charitable trust issue.

SENATOR MATHEUSSEN: Had there been discussions about a follow-up -- about follow-up litigation by the State of New Jersey against any of either the directors or any of the main players of either HIP New York, HIP New Jersey, or PHP?

ACTING ATTORNEY GENERAL ZOUBEK: I think Commissioner LaVecchia referred to that. The answer is yes. Those are under consideration because part of her role now is to preserve those assets, maximize those assets, look if there is any ability to go back and recover assets, if there was any improper transactions, and that's part of what is being looked at, and it's part of my understanding of what the counsel will be retained to examine that to see if there was any effort, anything that occurred that inappropriately affected the charitable assets of that HMO.

SENATOR MATHEUSSEN: Do you know whether or not the bankruptcy court has taken a look at those transactions and will look also to preserve those assets?

ACTING ATTORNEY GENERAL ZOUBEK: I imagine-- I'm not specifically familiar with the bankruptcy transactions and rulings at this point in time. There could be issues that could be raised in the bankruptcy context. I can provide the answer to that question through the Chair if you'd like.

SENATOR MATHEUSSEN: It would seem to me that the bankruptcy court would be interested in preserving assets so that the creditors of PHP, HIP be paid to the maximum that they could possibly have with whatever is leftover. And it would seem to me that that would certainly fall under the jurisdiction of the bankruptcy court and be something that the court would be interested in preserving. Does that reflect on the approach that the

State of New Jersey, through either the Commissioner's Office or through the Attorney General's Office, would direct outside counsel to take?

ACTING ATTORNEY GENERAL ZOUBEK: Well, I think it's a combination of coordinating the various recovery prospects and the various forms that we have. One would be the Commissioner's role in the liquidator of that HMO, also in terms of representing -- in terms of the bankruptcy court to ensure that the bankruptcy court mechanism is used to maximize potential recoveries. Because obviously the bankruptcy court is to marshal the resources and marshal the assets as well. So we will be working with the Commissioner of Banking and Insurance, through the Attorney General's Office, to ensure in the various forms that we have worked to maximize the recovery of assets in that case and take whatever steps and file whatever litigation needs to be filed in order to make sure that there is a protection of assets and, if any suits have to be filed against any individuals, to recover assets that may have been inappropriately devoted that will be investigated and followed through on.

SENATOR MATHEUSSEN: And I guess just one follow-up question. If, in fact, those diversion processes bordered on or exceeded what we would consider to be criminal, I assume the Attorney General's Office would then take those up separately?

ACTING ATTORNEY GENERAL ZOUBEK: Yes, that would be correct. We would work with the Department, and we will fully investigate the matter and pursue what other civil and other remedies might be available.

SENATOR MATHEUSSEN: Have those investigations begun?  
If you can answer.

ACTING ATTORNEY GENERAL ZOUBEK: I'm not in a position to answer that question.

SENATOR MATHEUSSEN: Thank you.

No further questions, Mr. Chairman.

SENATOR SINAGRA: Senator Vitale, do you have any questions?

SENATOR VITALE: Thank you, Mr. Chair.

I asked a question of Commissioner LaVecchia earlier regarding Wasserstein's role in all of this. And based on your testimony you say that along with the marketing efforts undertaken by Wasserstein and Company, the Department concluded that HIP was receiving adequate consideration for the value of the assets being transferred. Can you tell me how that process works?

ACTING ATTORNEY GENERAL ZOUBEK: It's my understanding that-- I believe that you should have access to records with respect to the request for proposals that were forwarded out into the marketplace. Keeping in mind the chronology that Commissioner LaVecchia outlined that since the HMO was in distress and since they had moved away from their Garden State arrangement, they wanted to find another provider. And, indeed, if you look back at their certificate of incorporation, it provides therein that they can enter into such agreements to provide for services.

So they issued a request for proposal. They put it out in the marketplace with the notion of maximizing, obviously, the bids that they could receive for that. And I noted, and Commissioner LaVecchia had noted, that there were six or seven entities that they communicated the request for proposal to. There were three or four preliminary responses that came in from

entities, and there were two or three actual bids. So it was not just-- And I think it's important to keep in mind that chronology that the Commissioner identified -- this is not just an instance in which there was a request to go out and do an appraisal/fairness opinion with respect to this particular transaction. This was as a result of going into the marketplace, which is the only real indicator of what value is at that time.

So you have the combination of going into the marketplace, seeing what entities were willing to come forward and make bids, and combining that process with the fairness opinion put in context provides the basis or, in particular, why the Department of Law and Public Safety concluded that it was a fair transaction in terms of the receipt of consideration by HIP at that stage of our analysis.

SENATOR VITALE: What role did your Department play in all of that?

ACTING ATTORNEY GENERAL ZOUBEK: As I outlined in my statement, in late of August 1997, the Department was contacted by counsel for HIP and also notified by the Department of Banking and Insurance with respect to the July 24, 1997 agreement. At that point in time, representatives of the Department met with representatives of HIP, requested a series of financial documents, documents with respect to the particular transaction, and received presentations from members of the Wasserstein Perella firm that outlined the request for proposal process that outlined the bids that had come in, outlined the transaction, and it was then, at that point in time and some time in late September, early October, that there was a request for the fairness opinion, which, as I said, was a follow-up to essentially the marketing process

of Wasserstein having gone into the marketplace to determine whether or not there could be a transaction at that point to find another provider group.

SENATOR VITALE: So your Department relied on Wasserstein's opinion.

ACTING ATTORNEY GENERAL ZOUBEK: Among a number of things. In terms of evaluating the issue of -- two issues: One, was the charitable purpose continuing? And in order to evaluate that you have to look at the nature of the transaction, and since they were simply going -- as part of the process, they were going to a provider group to provide medical services, and they were still continuing with their charitable purpose. That was one part of the evaluation.

The second part of the evaluation was the determination as to whether there was a diminution in the charitable estate assets. And because of the transaction being \$72 million of what was \$22 million worth of assets, the determination was that was a fair transaction. And in reaching that overall conclusion, one of the things that we also relied on was the Wasserstein Fairness Opinion.

SENATOR VITALE: Well, their opinion wasn't, I mean, what I consider to be impartial in that they are being paid by HIP to help do their work, to carry their water.

ACTING ATTORNEY GENERAL ZOUBEK: Well, what I was trying to point out before is the distinction here that what-- There was a process in terms of attempting to sell and arrange a service agreement that Wasserstein had been involved in. And they were providing information with respect to the transaction and an opinion back to the board of directors of the

charitable institution that it was fair. And in that context -- I'm just trying to highlight -- that this is not going into a phone book and calling someone to appraise the entity. This is as part of a process, a request for proposal process, going into the marketplace -- and my professors reminded me in college that the marketplace gives us our best indicators. And it was not just simply an appraisal, it was a result of a marketplace, a marketing effort, and the receipt of bids that had come in from the marketplace.

SENATOR VITALE: It just seems to me that it would be more appropriate to have an impartial source to do that analysis and not just only Wasserstein, and the Department relied solely on that information. They may have done something on their own even though there is--

ACTING ATTORNEY GENERAL ZOUBEK: Well, I--

SENATOR VITALE: Besides the focus of leaving your focus of particularity (indiscernible) charitable trust.

ACTING ATTORNEY GENERAL ZOUBEK: Well, I think if-- Since we are looking back in hindsight obviously today, but this appropriately so, so that we can move forward with respect to handling these transactions in the future. But I would submit, as it relates to hindsight issues, the receipt of \$72 million or \$22 million worth of assets, which was then essentially upheld by the bankruptcy court, was not an inappropriate decision at that time based upon the nature of the relationship of Wasserstein to the transaction to rely in part on the Wasserstein opinion to the board of directors or of a charitable institution.

SENATOR VITALE: Thank you.

SENATOR SINAGRA: Was your Department aware of the \$40 million, as characterized, side deal that was involved with HIP New York?

ACTING ATTORNEY GENERAL ZOUBEK: I have been advised by staff that our analysis focused primarily on the asset and service agreement and the \$72 million in terms of our making the determination with respect to charitable estate issues.

SENATOR SINAGRA: But that wasn't my question. My question was, was your Department aware of the side contracts idea of involving \$40 million to HIP New York?

ACTING ATTORNEY GENERAL ZOUBEK: It was not part of the charitable estate focus. In the course of our relationship with Health, and Banking and Insurance as our clients, at some point in time the Department may have been made aware of that.

SENATOR SINAGRA: Okay, as long as you were aware of it.

Now, in hindsight, or as a professional, do you think -- could you think that \$40 million can be construed as additional compensation involving this transaction? In other words, that \$40 million is not a gift. PHP didn't decide because they like HIP New York they were going to give him \$40 million as a loan. Would you consider that part of the compensation in this transaction?

ACTING ATTORNEY GENERAL ZOUBEK: As it related to--

SENATOR SINAGRA: In hindsight, of course.

ACTING ATTORNEY GENERAL ZOUBEK: In hindsight I would say that I am not familiar enough with the specifics of the transaction in terms of the \$40 million as it relates back to the service agreement. As it

relates to the charitable estate issue, it did not enter into our consideration as to the questions and the line of questions in terms of asking issues and whether there could have been different ways of negotiating. I'm not in a position here to answer that question.

SENATOR ADLER: General, you talked earlier about the Department's determination with the charitable trust was not endangered based on the documents you had reviewed of the proposed transaction. What process is triggered if the Department finds that the charitable trust in danger?

ACTING ATTORNEY GENERAL ZOUBEK: I think the phrase that you are using, Senator, you are using if the charitable trust is in danger. Our analysis is whether or not the intended purpose continues and whether there is a diminution in assets. And I think the distinction is important because you can not take some of the issues as it relates to continuing financial viability issues that were outlined by Commissioner LaVecchia. That isn't specifically the issue with terms of the charitable estate issue that we were looking at that time. We were looking at the exchange of the transaction, the exchange of assets, and whether fair assets were being received.

The other question that you may be focusing on is to whether or not the overall financial condition of the entity on the long-term basis. This was a view as it relates to the Department's role, as to just a charitable estate issues, as to whether there was fair value being received.

SENATOR ADLER: Let me ask you, in that way, if the Department determines there is not fair value being received, what process is triggered then?

ACTING ATTORNEY GENERAL ZOUBEK: If fair value is not being received, the Department could look and take further investigation in an effort to oppose parts of the transaction or to work further with respect to how that transaction goes forward.

SENATOR ADLER: Is there any legal requirement of a public hearing based on the determination of fair value for the Department?

ACTING ATTORNEY GENERAL ZOUBEK: One of the things I outlined in my remarks is that the Attorney General's role is one that is not set out by statute. It is not set out by regulation. It is based upon the Attorney General's common law authority. So when you ask whether or not there is a requirement for public hearings, the answer to that question under the current framework is no.

SENATOR ADLER: Okay. I was very encouraged to hear Commissioner Grant describe her willingness to have public hearings in the future whether there is a common law requirement, whether there is a statutory requirement, whether there is the discretion to do it. I was very encouraged that she suggested that the public hearings would be a valuable tool for her Department and for the State going forward.

And I guess one of the hopes I have coming out of this look back is that in the forward -- in going forward, we will have some public hearings that might air some of these issues out more generally in a way that we lacked in this process.

So I share that with you in the hope that you will recommend that to other departments the way the Commissioner of Health and Senior Services on herself has volunteered that.

ACTING ATTORNEY GENERAL ZOUBEK: Well, I know one of the things the Department will continue to work with this Committee on, continue to work with Senator Sinagra and others on, are issues with respect to pending legislation as it relates to the issue of codification of issues with respect to the (indiscernible) and the (indiscernible) doctrine and the analysis, and we'll be happy to continue to work with this Committee as they evaluate various alternatives.

SENATOR ADLER: Thank you, General.

I want to follow up on Senator Vitale's line of questioning about the Wasserstein Fairness Opinion. Do you know who in your Department evaluated that opinion?

ACTING ATTORNEY GENERAL ZOUBEK: It was part of the analysis of all individuals who were involved in that particular -- the evaluation of that transaction. It was part of the decision-making process as it relates to an evaluation of the contracts, the structure of the organization, the RFP marketing process, and the ultimate fairness opinion that was received by Wasserstein. It was part of the Department's analysis and the ultimate decision of the Attorney General's Office with respect to this transaction.

SENATOR ADLER: I understand. Do you know who in the Department looked at the opinion -- at the fairness opinion -- and decided that is good enough as part of our total evaluation that you just described? Which members of the Department looked at it?

ACTING ATTORNEY GENERAL ZOUBEK: It was an evaluation by the various members. There were a number of staffpeople at senior levels and lower levels that looked at the transaction. And I have said, and I will

continue to say, that it was part of the ultimate decision, that is, the Department's decision with respect to this transaction.

SENATOR ADLER: Former Attorney General Verniero indicated in recent testimony that "two very senior attorney's in my office looked at the opinion." Do you know who those two senior attorneys to whom he refers?

ACTING ATTORNEY GENERAL ZOUBEK: I believe that the General testified that it included former First Assistant Attorney General Mintz and Commissioner LaVecchia as a matter of public record.

SENATOR ADLER: Do you know who the other senior attorney-- Did you say one person or two? Commissioner LaVecchia--

ACTING ATTORNEY GENERAL ZOUBEK: I said Commissioner LaVecchia has already testified as to her role and First Assistant Attorney General Janice Mintz at the time. I believe that's based upon Attorney General Verniero's public record comments on this already.

SENATOR ADLER: I'm looking at a copy of the Wasserstein Opinion. And on Page 2 it indicates we have assumed with your consent -- you're referring to HIP New Jersey -- that the financial forecasts and projections provided to us by the company, the company being HIP New Jersey, were prepared in good faith and on bases reflecting the best currently available judgments and estimates of the company's management as to future competitive operating and regulatory environment.

Do you have available to you in the Department's files the forecasts and projections upon which Wasserstein reportedly relied in issuing its fairness opinion?

ACTING ATTORNEY GENERAL ZOUBEK: We will be able-- We have provided and I will confirm that we have provided the material that HIP, counsel, and Wasserstein provided to the Department. I believe those have already been provided. I will confirm that that has been the case and will provide those through the Chair.

You are noting language which is very typical language in a financial opinion letter with respect to the financial information they may have received from HIP. The extent to which the Department received that information and its public record we will ensure that it has been -- I believe most of it has been -- provided to the Committee.

SENATOR ADLER: And, General, you can understand why we want to hear and see those projections. As Senator Matheussen's questions earlier pointed out, we had some pretty negative actual data for a period of many quarters preceding the approval of this transaction. Things were headed south pretty quickly in a lot of ways. And particularly with the payout ratio, you are not going to make that up in volume, and you're losing on every insured.

ACTING ATTORNEY GENERAL ZOUBEK: No, I think the point of Commissioner LaVecchia's testimony, in substantial degree, was there was a downward line for a period of time. And so the issue in terms of what those financial projections were at the time -- it was an entity that was in financial distress which framed the whole process at that time.

SENATOR ADLER: So you can imagine why we would be curious to see what it was that Wasserstein reports to rely on in concluding that things

are going upward or somehow are going to go upward because it is going in the opposite direction.

ACTING ATTORNEY GENERAL ZOUBEK: But I would point out that the extent to which we are focusing on that particular language-- Again, as it relates to the charitable state issue was whether or not assets were being received sufficient to the charitable organization. And here \$73 million for \$22 million worth of assets was sufficient. So the issue with respect -- if I may, with respect to the financial projections may go to the more long-term issue of the performance of the HMO, not to the charitable estate issue that we are presented with at the time.

SENATOR ADLER: Well, let me ask the questions just from the opposite perspective. Why do you think PHP would be willing to spend \$73 million and give a third-party consideration to HIP New York of \$40 million for assets of \$22 million? What was in it for PHP if the math is as we look at it?

ACTING ATTORNEY GENERAL ZOUBEK: A provider agreement in an asset sale. I won't speculate any further with respect to that.

SENATOR SINAGRA: I'm not comfortable going down in this path, and I want to ask a couple of questions piggybacking on Senator Adler. Because obviously the marketplace, as you indicated, was a strong determination, but I'm more concerned with the process and how things -- you know, people's judgments are involved in the process. And I can tell you that-- Would it surprise you to know that the principals of PHP would question-- they were viable for a short period of time, and when professionals here ask them why they paid that much they actually felt that bought it cheap. Would

it surprise you know that HMOs -- forget HMOs-- In business, go to the stock market, look at the net worth, look at the assets of companies, and then see what they sell for. In many cases, what they sell for has no resemblance to what their assets are.

And, in fact, the way I understand it, in many cases between HMOs and purchases, it's really the number of people you insure, the lives, that determine the value of the company and has no relationship to how much assets are being transferred. Now, I'm not saying that it wasn't a fair transaction, but I am a little disturbed with your testimony that the asset is the only determination to-- This seems to be the game is \$100 million with \$22 million worth of assets. But the fact of the matter is in the marketplace, if you look the year before in transactions similar to this, there is a certain value paid per body insured. And this is far less than the average of the transaction that took place in the previous years. I'm not saying-- Unfortunately, I agree the marketplace didn't get a higher price. But the fact of the matter is PHP thought they got a bargain. Obviously they didn't.

That's all. I'm just saying I just don't like the process.

SENATOR ADLER: Chairman, I was going there, but I was trying to give little bits at a time to get him-- (laughter)

SENATOR SINAGRA: Unfortunately, we don't have that much time.

SENATOR ADLER: Well, we do. The people of New Jersey have the time.

But, Chairman, it's like the old story. If you throw a rabbit in a pot of boiling water, it jumps right out -- or frog -- but if you put the animal in the pot and then turn the heat up slowly.

I was trying to get you a little bit at a time, Paul, sorry.

ACTING ATTORNEY GENERAL ZOUBEK: But I think the point still must be made is that through this series of hypothetical questions of what may be going on with respect to the rest of the marketplace and what may have gone through the year before, the question is as it relates to the Attorney General's determination at that time as it relates to the charitable estate issue in terms of the fairness of that, in terms of the exchange I stand by that.

SENATOR SINAGRA: I just think from the process point of view I'm not comfortable with the Attorney General's Office not going out to look for another opinion.

SENATOR ADLER: And I think the Chairman's point is that there was more value in HIP than the \$22 million of hard assets.

ACTING ATTORNEY GENERAL ZOUBEK: I understand that, and that's also reflected in Wasserstein's analysis in terms of the value of the subscribers, and that's what they are buying in part. I'm just saying that as it relates to the charitable estate issue, in terms of the diminution, that is one of the analysis that you could do in terms of the assets that they were valued at the time and what was received. And so you are looking in essence at the balance sheet of HIP from a charitable perspective.

SENATOR ADLER: I also just want to know the Department's view of the second to last paragraph of the Wasserstein opinion in which they basically say, "Don't rely on this opinion."

ACTING ATTORNEY GENERAL ZOUBEK: Well, I would submit that many opinions of financial entities in the transaction are written in a way as it relates to alliance. That is not an atypical phrase. It is a phrase that is included and is customary, I think opinions of investment advisors and financial advisers in these transactions given the nature of the opinion that Wasserstein was giving.

SENATOR ADLER: I guess I'm struck by one sentence in this opinion which is not typical of the securities offering, which I think is the analogy you are drawing here. In the sentence it says, "This letter does not constitute a recommendation of 20 persons with respect to whether or not to approve the agreement and the health agreement and should not be relied upon by any person as such." It seems like a letter covering themselves with respect to your Department.

ACTING ATTORNEY GENERAL ZOUBEK: No, I would disagree with that. I think the approval of the agreement really goes into the regulatory issues, and that's really the regulatory issues of the other Departments. And I believe that the Wasserstein opinion was used, as I said and I must reemphasize -- it was one of a number of factors that we looked at at the time and not the exclusive factor.

SENATOR ADLER: Was there any question in your mind that Wasserstein was going to come back with a fairness opinion that said that the transaction was fair? When I say you, I am speaking of the Department

generally because I believe you are not personally involved in this transaction or this analysis.

ACTING ATTORNEY GENERAL ZOUBEK: Well, I think that's a hypothetical question. I think that-- I'm not in a position to answer that hypothetical question for you.

SENATOR ADLER: That's all I have.

SENATOR SINAGRA: John.

SENATOR MATHEUSSEN: Again an observation. Maybe I'm not the most astute businessman in the room, and I know that there are all kinds of deals that take place on Wall Street. But I have to go back to what I've learned here today at this hearing and in reviewing some of the documents. And maybe I'm off base. I don't know. But PHP seems to me to be the one who made a bad deal here. They bought a company -- if my numbers are correct, the Wasserstein report said that the net value of HIP in September of '97 was negative \$20 million. They were losing. And HIP for the previous 10 quarters up to the purchase had lost almost \$58 million. They were losing customers, and here we had a company coming along saying we would buy them, if you include the note from New York HIP, for about \$112 million. It seems to me that perhaps PHP should be talking to Wasserstein. That's not a question. It's just a-- I'm still scratching my head because I don't know who got fooled here.

SENATOR SINAGRA: Any other questions from the Committee?

(no response)

I want to again thank you for agreeing to testify today, as with the other Commissioners. General, I would hope you'll make yourself available.

ACTING ATTORNEY GENERAL ZOUBEK: I would be happy to do so and the information we said that we would provide for you as well.

SENATOR SINAGRA: Thank you very much.

That concludes today's hearing, and you'll be notified as it pertains to the next hearing.

Thank you.

**(HEARING CONCLUDED)**