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# ***Public Meeting***

of

## SENATE HEALTH COMMITTEE

*(Testimony from consumers and other interested parties concerning access and quality of health care coverage, particularly as it relates to managed care; testimony on issues related to minority health)*

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**LOCATION:** Hickman Hall  
Douglass College  
New Brunswick, New Jersey

**DATE:** June 12, 2000  
10:00 a.m.

### **MEMBERS OF COMMITTEE PRESENT:**

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



### **ALSO PRESENT:**

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

Caroline Joyce  
*Senate Majority  
Committee Aide*

Freida Phillips  
*Senate Democratic  
Committee Aide*

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

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

Thank you for attending today's health-care meeting. As you know, this the last in a series that we've had. We've traveled pretty extensively, and we've tried to concentrate on different subjects at different meetings.

Today we are going to hear about health-care access and coverage, and the status of minority health in New Jersey. With that, the first person to testify is Jerry Flanagan.

Did I catch you off balance this morning?

**JERRY FLANAGAN:** What's that?

A little bit, yes.

**SENATOR SINAGRA:** Would you like to go last?

**MR. FLANAGAN:** Whatever you'd like. (laughter)

Thank you very much.

Jerry Flanagan, from New Jersey PIRG, and we're actually waiting for two folks that have been working with us on these HMO issues.

**SENATOR SINAGRA:** Do you want to wait, Jerry?

It's okay.

**MR. FLANAGAN:** Is that okay?

**SENATOR SINAGRA:** It's a small group. We don't have to be that formal.

**MR. FLANAGAN:** Okay.

**SENATOR SINAGRA:** If you would like to pass and let me know when you want to go on--

**MR. FLANAGAN:** Yes, that would be great--

SENATOR SINAGRA: Okay, that would be super.

MR. FLANAGAN: --because I think that we have some delays this morning. I appreciate that.

SENATOR SINAGRA: Anthony Wright, are you ready, wherever you are?

Anthony is always ready. (laughter)

Now I'd like everybody -- we have a pretty long, extensive --

**ANTHONY E. WRIGHT:** I'll be brief.

SENATOR SINAGRA: How did you know I was going to say that? (laughter)

We have a very extensive list of people who want to testify. Some people have actually testified previously, and I would ask them to really reduce the amount of time they take because we've heard from them. And the rest, because I want to get to everybody and give them time, please limit your testimony to five minutes.

With that--

MR. WRIGHT: Got it.

I have submitted written testimony, and I'll be briefer in my spoken comments.

On behalf of New Jersey Citizen Action, the state's largest consumer watchdog organization, and our 60,000 family members and 85 affiliated organizations, we thank you for holding these hearings on the state of health care in New Jersey.

We hear from patients around the state with horror stories about problems about their managed care coverage, about the closing of community

health providers like HIP and local hospitals, and about services being scaled back, and the quality in a hospital or nursing home lacking, or about not having health insurance altogether.

You will hear some of these stories directly today, from some of the accompanying organizations that we've been working with, illustrating that our health-care system is in crisis.

It's a crisis of quality, cost, and access. Many New Jersey citizens are without access to affordable, quality health care, and even those with insurance are concerned about the quality of their coverage by their plan, and their care by their doctor, hospital, and/or nursing home.

The problem is precipitated by the corporatization of our state's health-care system, which was heralded as a solution to our health-care woes in the beginning of this decade but now seems to have exacerbated the situation. New Jersey has witnessed an upheaval in both the health delivery and financing that includes the dramatic rise of managed care, the consolidation of both hospitals and health plans, including the large behemoth Aetna/US Healthcare-NYLCare-PruCare combination. And with the high-profile bankruptcies we've had, New Jersey-- For example, the New Jersey HMO market has gone from 26 to 15 HMOs in a mere four years, with three having over two-thirds of the market. And none of this activity, unfortunately, has actually decreased the cost of health care, which is again going up beyond the rate of inflation, signaling the end of savings brought about by managed care.

And so, we need to reevaluate the direction of health care in New Jersey, and we believe that this Committee has responded appropriately to

many of these challenges, passing laws like the Health Care Quality Act. And we ask that this Committee ensure that some key proposals to improve access and accountability are part of any new legislative package that attempts to deal with this crisis. And that's what I want to talk about today.

In terms of access, the number of uninsured in the state are staggering. In 1989, it was 11.7 percent of New Jersey's population under the age of 65 was uninsured. Today -- in 1997, not even a full decade later, the figure was 18.4 percent or 1.3 million. With extrapolating from national figures, we believe that's higher than 1.5 million people uninsured in New Jersey. And this figure continues despite low unemployment. In fact, according to the Kaiser Family Foundation, 85 percent of the uninsured population comes from a family with a least one worker, 75 percent with at least one part-time worker. New Jersey's working families need help in getting and affording health insurance, and this needs to be central to any reform that this Committee proposes.

Fundamentally, we are strongly supporting the FamilyCare proposal and any other programs to expand health insurance in New Jersey, especially using the opportunity of the tobacco legislation and the tobacco funds that are coming up. New Jersey took a very good first step with New Jersey KidCare, but when it faltered with a too cautious start, it was this Committee that really expanded family -- KidCare to make sure that it was available to more children. We strongly support the FamilyCare proposal which builds upon the successful KidCare model and is similar to what New York and Rhode Island have already done. It expands insurance to low- and

moderate-income families with a package that maximizes Federal funds and offers a solid benefit package.

This offer has enormous grassroots enthusiasm, and we have been working with over 40 statewide organizations to ensure passage, including some in the audience today, Elected New Jersey Council of Churches, Legal Services of New Jersey, and many other organizations. We -- according to the Urban Institute, New Jersey would join 14 other states in expanding coverage to uninsured adults.

Fundamentally, we also need to encourage private health insurance. We're supportive of some of the proposals proposed by members of the Committee that provide incentives for employers who do right by their workers and provide significant health-care coverage. But the New Jersey policies with regard to employer-based insurance should use both the carrot and a stick. And we need to withhold certain tax or regulatory benefits to those employers who withhold health insurance. We need to help employers fulfill their responsibility not only to their workers, but to the community at large, which ultimately has to pay for health-care costs.

And to keep costs down, New Jersey needs to closely monitor where our health-care dollar goes to maximize the amount of money that goes to direct patient care, as opposed to administration and profit. We should look to tighten our safeguards regarding medical loss ratios, which indicate the percentage of premium dollar that actually goes to patient care rather than paper pushers. Pending proposals would actually create loopholes in existing ratepayer protections by reclassifying many administrative expenses as medical,

including, ironically, the cost of denying patient care. And so we certainly don't think we should go in that direction.

Like many medical professionals, the Committee should follow the creed, "First, do no harm." And so we certainly don't support certain reforms that we think are being pushed, including medical savings accounts and any attempts to back away from community rating, which may benefit some of us who are healthy and wealthy, but would further disadvantage the rest of us and shred our state's health-care insurance safety net.

So we need to expand access, but we also need to expand accountability in order to assure the quality of our health care. And that means, more information to monitor these developments, and -- more aggressive oversighting enforcement by regulators and the public to prevent abuses that drain our resources and harm patient care.

On the financing system we need to -- we have finally implemented the Health Care Quality Act of 1997. The regulations were finally implemented last month after three years. We hope that this Committee vigilantly works to enforce -- makes sure that that work is enforced, and we're talking with the medical society about a new independent effort to do that.

We need to improve our patient protections. This Committee started that by adopting and passing a binding appeals process, and should continue by allowing providers to actively advocate on behalf of patients as part of that independent appeals process.

Fundamentally, the loophole should be removed that exempts HMOs from being responsible from their decisions. This Committee should

pass a right for patients to hold managed care companies accountable under medical malpractice laws. We know that these insurers act differently when the right to sue is in place.

To prevent HIP and American Preferred type situations, we need strong financial oversight, that to prevent ineptitude and outward fraud. This means aggressive enforcement of existing laws, including public hearings and investigations into companies that want to be entrusted with the health of New Jersey patients. Some important reforms were passed last year, but there are other bills that need to be considered and approved.

And finally, we need more information, including additional and more frequent reporting of insurance companies, not only a financial status, but again of where the premium dollar is going. In the HIP and American Preferred cases, health-care dollars went for everything but health care: executive Jaguars and corporate jets, out-of-state business enterprises and buying back stock to inflate share price. Private greed should never again come before public health.

And finally, accountability for our health-care institutions. We need better reporting on health-care outcomes at both the doctor and the hospital level, especially in light of the recent Federal report on the significant health impact of medical mistakes. We need disclosure of quality indicators in hospitals and nursing homes, from frequent and unannounced spot-checks of institutions to the publication of staffing ratios, waiting times, and health results. And that then we support the Patients First legislative package that this Committee has been considering.

We need to preserve the certificate of need system that maintains local public hearings in a community voice in our area's health-care infrastructure, not to mention uphold the quality of care, keep unnecessary health-care spending in check, and protect our urban safety net institutions.

I'll also say that since corporatization, which is one of our -- the corporatization is something that's going on nationally. Something that is very important is the Community Health Care Assets Protection Act, which this Committee has passed before and we hope will pass again to make sure that we ensure community accountability in the preservation of the public's investment in that nonprofit hospital, if that hospital goes for-profit.

And finally, we support expanding the Office of Minority Health. You'll hear additional testimony about this later -- to make our health-care institutions accountable to communities of color. This includes efforts to ensure that health providers are multilingual to best care for all of New Jersey's families, and mindful of the cultural differences that create many of the troubling racial and ethnic health-care disparities.

These and other efforts are essential to reinstall trust in our health-care system. New Jersey families right now have many questions about their health care, whether they will even have coverage in the next year, whether that coverage will really protect them in a health-care emergency, and whether they will get quality treatment. This Committee can take a big step toward answering those questions.

Thank you for your consideration.

SENATOR SINAGRA: Thank you.

Any questions? (no response)

Maryellen Kluxen.

Whoever is next, just make paper airplanes and just -- (laughter)

**MARYELLEN KLUXEN, R.N.:** Good morning.

SENATOR SINAGRA: Good morning.

MS. KLUXEN: I'd like to thank you for the opportunity to speak here today to this Committee.

My name is Maryellen Kluxen. I'm a registered nurse, and I'm the coordinator of the Patients First Coalition, which is a coalition that represents over 30,000 health-care workers and their unions in New Jersey, as well as consumer advocates and senior activists.

I'm here today to talk on behalf of our health-care workers because we are very deeply concerned about the quality of care that our patients are receiving in hospitals and nursing homes in New Jersey. And we feel that as nurses, nurse's aides, health-care providers, that we are obligated to advocate for our patients, which is why we became health-care workers to begin with.

We've seen, and this Committee has heard, a lot of testimony around HMO crisis, around the crisis in hospitals in New Jersey, loss of money and reimbursement to facilities in New Jersey. And what we're here to talk about is the first response that always happens when these crunches come, and that is to reduce staffing in facilities.

In New Jersey hospitals, the only staffing ratios that are mandated by the Department of Health are in intensive care areas, which is a 3-to-1, 1 nurse to 3 patients. That is the only nurse ratio that is mandated by the State of New Jersey, and that's by regulation. But we've seen in our medical -- in our med-surg areas in hospitals the level of acuity, which is the level of illness. I

know you Senators understand that expression, but for the people here, acuity means, "How sick are your patients?" And, "How much care do they need?"

We've seen the level of acuity in medical-surgical units go up proportionally over the last 10 years. I know myself, when I first started nursing, there were many cases that would only be in an intensive care unit that are now being taken care of on the floor. And you see R.N.s with 8, 10, 12 patients in their care on a given day. Even on the day shift, to take care of those patients, how does this effect the care that we give our patients?

We've collected many studies, and some of the Senators -- some of the studies have been given to your Committee before. There are at least 13 studies in the past 10 years that directly correlate the level of staffing to the quality of patient care. And we'd be happy to furnish all 13 to the Committee. We have some examples here. Besides surveys of R.N.s, *RN Magazine* did a survey in 1999. Seventy-six percent of the R.N.s responding to that survey said that low staffing in their facilities was endangering their patients. Over a quarter of respondents to a Louis Harris poll who knew -- people who knew of -- firsthand of a medical error being committed by a family to a family member, one-quarter of those people said that they knew that that medical error was committed because of understaffing, rushed, hurried and stressed-out health-care givers.

In 1997, the Health Professionals and Allied Employees -- some of the nurses from that union will be testifying a little later on their personal experiences with understaffing -- 72 percent of the nurses responding said that their facilities had cut nursing, and 94 percent of them, including myself,

believe that those cuts have drastically affected our ability to care for our patients.

There was a study done in 1993, and repeated in 1994, that showed -- and I have this in the testimony, the references -- that if you cut staffing by 8 percent in a hospital, you are 400 percent more likely to see more morbidity and mortality in patients in that facility.

One study in 1998 showed that one extra hour of registered nursing care after surgery can reduce urinary tract infections by 10 percent, and pneumonia -- postoperative pneumonia, which is a common complication, especially in the elderly, by 8 percent -- just one extra hour of R.N. care per day for those patients.

Safe staffing is also a disastrous problem in our nursing homes. Nursing homes have seen, also, a higher level of acuity. People have opted to stay at home and receive home care. Seniors to go to assisted living facilities, which means the patients in our nursing homes in New Jersey, which is approximately 46,000 citizens in New Jersey, live in nursing homes. Those patients are sicker, they're older, they're frailer, they suffer from Alzheimer's, dementia. Some of them are young people with end-stage diseases like AIDS, who are not able to be cared for in the community due to lack of resources. Those patients need hydration, nutrition, mobilization. They need to be moved. They need to be turned. They need skin care, and they need good nutrition. Are they receiving it?

If a certified nurse's aide is caring for 15 or more patients per day, and that aide has to give that patient -- who, we remember, is very frail, may be demented -- one to two meals per shift, turn them every two hours, provide adequate hydration, toilet them, move them, how can one nurse's aide, with

over 15 patients per shift, possibly provide the kind of care that those patients need to prevent complications?

In a U.S. Subcommittee-- A Senate Subcommittee of the United States on Aging estimated that \$12 billion per year are spent treating preventable bedsores in nursing home patients. And \$3 billion per year are spent treating incontinent care because patients are not properly toileted. Think of what kind of nursing care and the kind of staff that could be hired and trained with that kind of money to provide better care to our patients.

In 1996, the Institute of Medicine did a report and said, "Inadequate nurse aide staffing leads to increased risk of medical complications and expense, intermittent discomfort from hunger and thirst, escalated need for even more nursing care, and sensory and psychological deprivation." Is this the way we want to treat our 46,000 citizens living in nursing homes? I don't think so.

Another study that was just published last year in *Gerontologist* magazine found the same thing, that low staffing produced high urinary catheter use, low rates of skin care, poor feeding of residents, malnutrition, dehydration, and a low resident participation in activities. Again, if you're thinking of early Alzheimer's and dementia patients, psychological and activity -- participation in activity is a very important part of their day. And those things are not happening with these gross understaffing problems.

Poor staffing in nursing homes also takes a toll on the workers. The injury rate among nursing home workers is the third highest in the country in industry rate. And that's from the U.S. Department of Labor -- 18.2 percent injury rate for nursing workers. Coal miners have a 6.2 percent

injury rate, construction workers have a 10.6 injury rate, but nursing home workers have an 18.2 percent injury rate, mostly from back injuries that can be very disabling from trying to lift patients alone. Even though the equipment exists and the training exists, the people are not there to help them lift those patients. The nursing home industry pays up to \$1 billion each year in workers' comp money that can also be used to train and adequately train nursing home workers and provide direct care to the patients.

I just heard a recent radio address by Jim Hightower, the former Secretary of Agriculture in Texas who is also a political commentator, and he said, "When your family feels an economic pinch, do you cut back on the basics, or do you cut back on the luxuries?"

Well, our facilities, our insurance companies, our HMOs are cutting back on the basics, and that's the staff to provide the direct patient care. While HMO CEOs are earning bloated salaries in the millions of dollars, while hospitals are making money on for-profit subsidiaries, like equipment companies, transport companies, while they are spending millions of dollars on marketing and advertising, our patients are receiving less care, and the people who provide that direct care are being cut.

So these are the recommendations that we as health-care workers would like to make to this Committee to advocate for our patients.

The first is to strengthen the existing regulations that exist by the Department of Health and other agencies to ensure safe staffing in New Jersey, to support the Patients First package of legislation. And we'd like to thank our sponsor, Senator Joseph Vitale, on the Committee, who is our prime sponsor for these bills, S-120, which gives the public the right to know the quality of

a nursing home or hospital by posting the staffing levels in those facilities, and also the negative patient incidents such as falls, bedsores, infections acquired within the facility, etc.

The second is legislation that will mandate and provide qualified caregivers at the bedside and mandates ratios -- caregiver-to-patient ratios for care. And the third is a bill that would prohibit forcing health-care workers to do mandatory overtime in facilities. Many facilities do their staffing by forcing their health-care workers, their nurses and nurse's aides, to work overtime. And we have a bill now, in our Patients First packet, that would make that -- that would prohibit that, except, of course, in an emergency situation.

And I can tell you, after 27 years of nursing, that when an emergency situation happens in a facility, everybody chips in and helps out. People come in on their days off. Whatever needs to be done, needs to be done. I'm talking about mandatory overtime when the staffing department in the hospital knows two weeks ahead of time that there is only two R.N.s to cover a floor that requires four R.N.s, and now it's Sunday morning and you have to stay the second shift because they haven't filled that staffing.

We also support the use of tobacco settlement funds for health-care use to expand access to health care, such as the FamilyCare program, and also to provide incentives to employers to provide health insurance, and that this money, this reimbursement to hospitals and nursing homes, go directly to staffing and not to extraneous costs like advertising, etc.

We also support increasing-- We ask this Committee to look and reevaluate the abysmal Medicaid rates that New Jersey receives, and to reevaluate that, and if there are any Medicaid windfalls, as we've heard there

may be, that that money be returned to nursing homes, where it belongs to provide direct care for patients.

I just want to finish by saying at least 26 states in the country are looking at the problem of unsafe staffing in facilities one way or another. The bill that was passed in California last year mandates the Department of Health in California to set up staffing ratios. Our bill does the same. We ask the Committee to evaluate that bill.

We thank you for your leadership in the past for progressive health-care legislation like the Whistle Blower Act, like the Safe Needle Bill. We ask for your support on this package and your leadership in this coming period.

Thank you very much.

SENATOR SINAGRA: Thank you.

Bryan Markowitz

Good morning.

**BRYAN MARKOWITZ:** Good morning.

It's wonderful to come back to this room, a room that I think I took my last final in maybe 10 years ago. But anyway--

SENATOR SINAGRA: I assume you passed? (laughter)

MR. MARKOWITZ: I did. I'm here. (laughter)

SENATOR SINAGRA: Well, it could also mean you failed. (laughter)

MR. MARKOWITZ: Right, or maybe staying after the Committee hearing to take the exam over again.

Good morning, Mr. Chairman and members of the Committee. I am Brian Markowitz, and I'm here representing the New Jersey Business and Industry Association. The association is a statewide trade organization that represents approximately 16,500 employers statewide. We represent everybody from the largest companies in the state to the smallest. Our average member size is seven employees. I think 84 percent of our members have fewer than 50 employees. So most of our members purchased health insurance in the small group marketplace.

We come here today with some various concerns regarding health insurance. Each year we do two surveys, a business outlook survey and a health benefit survey. And I know -- business outlook survey, we ask our members all of potential problems that they may have and ask them to rank them and don't even give them any choices, let them write in the answers. And every single year, without -- bar none, the No.1 problem according to our members is the cost of health insurance. Regardless of whether property taxes or auto insurance or overregulation or other issues that are out there -- the cost of health insurance is always No.1.

For many years, we saw that the cost of health insurance remained fairly stable, where the inflation rates range from anywhere between 0 percent to a 3.3 percent. In this past year's health benefit survey, though, we unfortunately saw the first large increase that we were hearing was going to be coming, and that was a 6.6 percent, and the expectation is that it will be even larger in the upcoming years ahead. With that average, we saw that 40 percent of our -- of the respondents saw that their inflation rate went up by more than 10 percent, so we had some that their inflation rate had remained at 0, and

that's what kept the average down to 6.6 percent. But a large amount saw their inflation rate go up by more than 10 percent. And this is really -- we've seen -- had a direct correlation on the employer's ability to offer health insurance to their employees in many cases. The number of employers that are offering coverage to employees had dropped for the first year, minimally, from 94 percent to 93 percent. However, we saw that there were several other changes. And we saw -- we began to see some chipping away. We saw a dramatic decrease in the number of employers offering coverage to the employees' dependents.

In a -- two years ago, a survey in 1997, 80 percent responded they are providing coverage to employees and their dependents and paying a portion of that, and that number dropped to just 74 percent this year and had dropped -- I think it was 78 percent the year before that. So we're seeing a steady decline in that number.

Also, another trend that we've been seeing is an increasing reliance on asking employees to pay for a portion of the share of health insurance. One -- at one point in time, employers used to simply just switch plans, and in most cases switch from a fee-for-service plan to some sort of managed care product in order to save money. Now that's not the case since most of them have switched already. And what they're doing is asking their employees to pay either a higher copay, a higher portion of the premium, or higher deductibles. And we again, expect this -- we've seen this trend over the past couple of years and expect it to continue to grow.

As an association, we're placed in a very precarious position, and we try to be an honest broker between balancing cost and quality of health

insurance. We don't negate that there are problems when it comes to quality of issues, and that's something that we have tried to deal with. And we try to be supportive of measures that will help quality without severely hindering costs at the same time. And we believe that we've been successful in doing so.

There's one bill out there-- And I'm here, really, just to talk about two of the proposals. There's one bill out there that we think would not achieve a balance in balancing cost and quality, and that's S-722, which is sponsored by Senator Bassano, which would give individuals a right to sue their health plan for medical malpractice and also for wrongful death. We fear that this is going to lead to a flood of litigation and that that would be very costly for the insurance companies, and inevitably, as one of my colleagues tells me, there is no free lunch, and that cost is going to be passed along to the consumers, and in this case the employers, who are paying for the health insurance in the form of higher premiums. Our fear, I guess, is that the insurance company would be named in every single medical malpractice suit regardless. Some would because they are the insurance company -- that they have deep pockets and that they can pay.

More importantly, we feel that dragging a case through the court system is not likely to bring forth a very quick verdict and give someone quality -- guaranteeing quality care immediately, but it's likely to drag on for years and years. I could think of many court cases that businesses have dealt with, have taken five, ten years to go through the court system, and we feel that at the end this is going to do little to impact health-care quality.

We believe that the much more fairer and balanced approach lies in the Senate bill S-640, which is sponsored by Senator Matheussen and

yourself, Senator Sinagra, and makes the appeals mechanism which was implemented through the Health Care Quality Act binding. In this scenario, an individual that requires an answer regarding medical necessity can receive one within a finite period of time and guarantee that a proper decision regarding medical necessity was made. And I've even been told -- we actually have put forth a pamphlet for our members and have gotten, I'd say, hundreds of calls on how to appeal a health-care decision, and have made that available. And I've been told that in cases of emergencies where someone has to know immediately, that this appeals mechanism goes through the three steps in a very quick period of time, sometimes within 24 hours. So it's something that we feel is working and can, if made binding, which would make a lot of sense, can work even better.

NJBIA realizes that the issue of health insurance is one that is crucial to everybody in this state, and that balancing cost and quality has to be a major factor in guaranteeing that the greatest number of people are covered by the best quality health insurance. And that's really our goal.

We also encourage the Committee to take a look at offering a greater choice of plans, specifically in the small group marketplace, where the plans that are offered are somewhat finite, and that perhaps having different plans out there can encourage more small employers to get involved. There have been a lot of other members that have called for -- always asking about association plans and other risk pools -- not necessarily saying that's the answer, but something that should definitely be taken a look into. And also, making good use of the independent appeals mechanism that's in place already is something that we do recommend.

And I thank you.

SENATOR SINAGRA: Thank you.

Any questions?

SENATOR MATHEUSSEN: Yes, I have one.

SENATOR SINAGRA: Sure, go ahead.

SENATOR MATHEUSSEN: Bryan, as Chairman of the Senate Oversight Committee, and as a spin-off to what this Committee was doing, I tried in the last two months to have a Committee hearing addressing the very issue that you just brought up, and that is the cost of small group policies. And to my amazement, not one person showed up with regard to representation from the small group board. Well there was, but he said he was not there as a member of the board, he was there as an individual broker, period.

What else are we suppose to do? I've been speaking before brokers. I've been speaking before consumers who both concerns -- have concerns about the cost of it. I hear your testimony today, and I'm sure I'll hear more testimony today, and yet, when we have a hearing, no one tells us. Do they want us to legislate on our own, without hearing from the public, and make our minds up as to what should be included in these small policies -- small group policies? Or are we not to expect any -- any advice whatsoever from these groups?

MR. MARKOWITZ: I think that -- and again, I'm only one member of the board, not necessarily representing the entire board, but I think that the board itself feels -- believes that the plans in place are working because there are several standard plans with riders attached to them, and that there is a fear of change leading to some sort of adverse selection.

Saying that, I, as a member, believe that we probably could do a lot more to have a lot more choices out there, maybe some investigation into some sort of bare-bones-plus policy where -- not just in a hospitalization plan with a high deductible, but some sort of policy that would cover a finite amount of physician visits and whatnot and things of that nature that really can be implemented.

SENATOR MATHEUSSEN: Why didn't anybody from the board show up? Why doesn't the board -- Why didn't the board participate?

MR. MARKOWITZ: I think their reluctance based upon -- was really based upon the Committee notice. I know the Committee notice focused on how -- focusing on how the plans were developed. Most of us -- I think there's only one of us on the board that sits there now that was there from the beginning and actually developed the plans. I can't speak for how the plans were developed, I can speak to more of what I think --

SENATOR MATHEUSSEN: I assure you that was not the design of the Committee hearing. I am absolutely dismayed at the testimony that has come forth from your association and from others today that clearly indicated that the number of people who have insurance is increased -- who don't have insurance is increasing dramatically. Small group policies are part of that mix that are sowing less and less coverage, and yet, no one wants to come up with an answer.

I thought it somewhat arrogant for them to sit there and tell us that they don't enough, and yet, they don't want to come to the Legislature to find answers. Having said that, thanks.

MR. MARKOWITZ: You're welcome.

Thank you.

SENATOR SINAGRA: Thank you.

Lisa Negron and Regina Sessoms.

**LISA NEGRON:** Good morning, Chairman Sinagra and members of the Senate Health Committee.

My name is Lisa Negron, and I am a mental health consumer employed by Collaborative Support Programs of New Jersey. It is a consumer-run agency for the State of New Jersey, dealing with the services rendered to and received by adults with severe mental illness. I am here with a fellow consumer, colleague, and friend to speak on the experiences of mental health consumers in regards to access and quality of mental health services.

**REGINA SESSOMS:** Hello, my name is Regina Sessoms, and I suffer with a mental illness. Unlike what you've been seeing displayed on television and in newspapers, I am schizo-effective. I take medication to keep everything intact, and as I said, what you see on television and what is being hyped up by the media is not realistic.

Although I sense I've had this illness for some time, it didn't really manifest until July of 1995. When it happened, I didn't understand what was going on. I spent three weeks in a hospital, and upon release, tried to kill myself again, and landed back in the hospital for another three-week period. During this time, I was working for a temporary agency and didn't have health insurance; however, due to some smart thinking of the Legislature, I was offered Charity Care, which paid for the expenses that I incurred in the hospital. I had to enter a day program, which was a condition of release. On my coming out of the hospital, again with no insurance, I was able to get

Medicaid, and they helped me to submit papers to get benefits from Social Security. As a result of the day program, I entered the hospital two times between 1996 and '97, which was down from the seven times I entered between '95 and '96.

In a survey, American people have said that they believe in equal care for mental illness and that every person needing care should have access to a psychiatrist of their choice. Unfortunately, many employees are opting for HMOs and PPOs to cut cost. These systems may limit your choice of doctors and even limit the amount of psychotherapy visits you may have. Don't assume that because you do not have a mental illness that you don't need good benefits. One in four adults will suffer from a mental illness or substance use disorder in any year. The best plans provide the same coverage for mental illness as they do for medical illness; however, many do not. They provide less care for mental illness and require you pay more out-of-pocket for the care you receive.

I presently am employed, and I have an HMO. The doctor that I am seeing now is a rare find. I was able to find him, and unlike what a lot of you may believe, psychiatrists no longer do psychotherapy. You have to go to a therapist. So you are paying \$85, \$100, \$110, for a 10 minute visit from a doctor who says, "Well, how are you doing? Oh, you're not doing well, do you think you need to go to the hospital?" Well, every problem that you have is not settled in a hospital, and it shouldn't have to be that way. However, the doctors are only concerned in getting as many people as they can within an hour, so you're allotted your 10 minutes, you say no, you don't want to go to the hospital, and you're sent -- and they go, "Okay, fine, here's your

prescription, see you in three months.” Well, after being hospitalized again and working with my company, as Lisa said, who provides services for people with mental health, I was able to find a psychiatrist who now listens to me.

Research shows that patients do better in treatment when they choose their own psychiatrist. However, economically, it’s impossible sometimes for them. I’m lucky, and I can afford to pay the \$110 a visit to see my psychiatrist and get subjected to a \$250 deductible for going out-of-network and get reimbursed the little \$80 that I might get. But I’m lucky and I’m a rare find, also. Many of my fellow consumers are not afforded this opportunity, and it’s something that needs to be done.

I guess the main thing that needs to be done is that there needs to be a continuum of care between the psychiatrist and the doctors that are giving benefits. There needs to be some kind of laws that legislate, that just because you have a mental illness that you’re not a citizen. You know, you’re a citizen first before you are a mental health consumer. And you should be afforded all the opportunities that other citizens within this great company have, you know. And that is affordable health insurance, freedom of choice for a practitioner, and a say in what you have to do with your own illness.

Thank you.

MS. NEGRON: To further elaborate on the quality, the ideal scenario -- when seeking health care, consumers have the right to gain access to quality services provided by quality providers. A quality health-care provider is one who: takes the time and makes the effort to understand the consumer’s needs holistically, mind, body, spirit, as well as impact of culture on health; provides a holistic assessment of a person’s problem and look to

strength to empower the person to assume control over their illness and/or condition; educates the consumer and does not assume that what is being said is understood; communicates effectively with the consumer and functions in the role of consultant, helping the person to develop a plan of action for dealing and overcoming the health problem.

In the present system there is a very narrow focus on the problem without regard to the holistic needs of the person, and there is very little time allocated to the therapeutic intervention and/or relationship provision of the service.

In accessing-- In an ideal system, consumers have access to appropriate, quality service. This means that they get the services, they do not have to wait a long time for the services, and to have access to services that are appropriate. Problems exist in terms of access to culturally competent providers -- language and understanding the culture, they're not the same; long waiting lists; access quality services are poor because payment rates for providers is low; access to dentists are very difficult to obtain with Medicaid and Medicare, very few of the good ones want to accept that form of payment.

Access and quality issues relating to HMOs and Medicaid: Provider selection is extremely limited, not all doctors will accept them; limited selections of physicians for both mental and/or physical health care -- often, when a mental health consumer presents a medical -- physical health problem, there is a poor coordination between the providers; a stigma issue, especially difficult to find a dentist who will accept Medicaid. When on Medicaid or Medicare, usually we're forced to clinic care because private doctors will not accept what we have. A problem with clinic care is that there

is often lack of continuity; the consumer is a number case rather than an individual with strengths, needs, and a unique life experience.

Very often physicians lack cultural competency. Consumers often do not have access to the provider that understands their condition, considering the unique aspects of their culture. Major problems exist when there are language barriers, leading to poor coordination and quality of care.

Personal scenario: I am of Hispanic decent, but I'm extremely proficient in English. I was born and raised here. I've recently returned from Washington, in March, from the National Congress on Latin Mental Health. Within the material that I have received, the statistics showed that the three minority groups by society standards, the Asian population, the Latin Americans, and the Afro-Americans, in a very short period of time, will be the largest groups that will be underserved by mental health. Those of us of Latin American decent, although we may have Spanish as a common bond, our cultures vary between the Islands, between South America, between -- and Central America. Same goes for the population of the Asians. Asians will include your persons from China, from Asia, from India, Southeast Asia, and also their dialects vary, their culture varies, so that it becomes very difficult. One cannot just pull in somebody in the hospital or clinic that may speak the language in general; they may not know the actual specific culture. I know it can become very difficult because there are so many various dialects, but to misdiagnosis us is even more detrimental.

I'm very lucky, I -- like I said, I speak proficient English, but when I was diagnosed and told that I had to have a psychiatrist, I fought the idea because I demanded a Hispanic. They didn't want to provide me with one

because of my English proficiency, but yet, there was something within myself that knew that part of my difficulties had to do with my culture. I happen to have a Hispanic psychiatrist who speaks both languages. And with his help -- I've only been diagnosed since '91, I'm only talking nine years. I've been employed by this agency since '93. I consider myself equally lucky as Gina does.

Not all consumers become ill at the same times of their lives. Some of us have been able to obtain educations, which allows for additional proficiency. So it's easier for us to advocate for ourselves. We're here to help advocate for our, like I say, my friends, my colleagues, and fellow consumers.

Thank you.

SENATOR SINAGRA: Thank you very much.

MS. SESSOMS: You're welcome.

SENATOR SINAGRA: Paula Hayes.

**PAULA HAYES:** Good morning, Chairman Sinagra and members of the Senate Health Committee. My name is Paula Hayes. I am Director of Public Policy for the Mental Health Association in New Jersey. I am here today to discuss concerns regarding quality and access for consumers receiving behavioral health treatment through managed care.

There are several issues relating to quality that I'd like to bring to your attention. They relate to experience, reimbursement rates, pressure to limit treatment authorizations, and difficulties experienced by those with chronic problems.

Many provider networks do not include the most experienced providers. Reimbursement rates paid by the state's dominant managed care

company are 60 percent of universal and customary charges. Top quality clinicians will not contract to provide services at these rates.

Managed care companies, particularly those at risk, are under great pressure to limit treatment authorizations, particularly for acute levels of care. Consumers can too often be discharged back to a living situation that is likely to lead to an exacerbation of their condition.

Managed care companies have a spotty record of providing services to consumers with chronic behavioral health conditions. Their approach was developed to serve working people and their families. It is not always applicable to those with lifelong illnesses.

The issues around access relate to convenience, ease, timeliness, and choice. Because of the low rates paid by many managed care companies, consumers who are covered under the lower-paying benefits will often not have their pick of treatment times during the day and may have to either wait weeks to see a provider of their choice, see a provider who is practicing in a location that is not convenient, or forgo the option of seeing a provider who has been recommended to them.

The Mental Health Association of New Jersey is concerned about these issues of quality and access. We thank you for the opportunity to bring them to your attention.

SENATOR SINAGRA: Thank you very much.

Les Hirsch.

Did you forget something last time? (laughter)

**LESLIE D. HIRSCH:** Good morning.

SENATOR SINAGRA: The middle mike. (referring to PA microphone)

MR. HIRSCH: The middle mike?

Okay.

Good morning, and thank you for having us back, Senator Sinagra and members of the Committee.

My name is Les Hirsch. I am the President and Chief Executive Officer of The Cooper Health System, and with me is Gary Young, who is our Vice President for Planning and Marketing. And I have a prepared statement that I'm going to provide for you.

Good morning. I'm pleased to have the opportunity to address the Committee today. You may recall from my previous testimony, when this Committee convened hearings in Washington Township earlier this year, I focused my remarks on statewide issues concerning the inadequacy of Charity Care revenue, the need for rebasing Medicaid rates, and the persistent problems with managed care payers characterized by slow pay, no pay, and wrong pay.

This morning I would like to focus your attention on serious issues facing the health-care delivery system in the City of Camden. The issues I will address are symptomatic of problems of health policy statewide, particularly for inner-city major teaching hospitals facing a reduction in Charity Care, and increased demand for care by the uninsured and underinsured, due to the closure of a nearby facility.

You are aware of the intention of The Virtua Health System to close its acute care facility in the City of Camden. This decision cannot be

criticized from the vantage point of the economics of an overbedded delivery system. On the other hand, the closure of the Virtua-Camden Division Facility will have a significant impact on the residents of Camden City, as well as local community hospitals, in particular, Cooper Hospital/University Medical Center.

For many individuals in Camden City, the Virtua-Camden Division Facility acted as both the primary and acute care provider. This is in evidence in the high percentage of self-pay and Medicaid patients, approximately 40 percent, utilizing this facility. These patients will now have to find another health-care provider and, considering the types of primary and tertiary care services provided at Cooper Hospital, Cooper will be the preferred choice. Cooper already provides care for 54 percent of the residents of the City of Camden, more than twice the market share of the sole remaining provider, Our Lady of Lourdes Medical Center, while a small minority of city residents seek care outside of the city.

To assess the impact on Cooper Hospital, we performed a zip code patient origin analysis, for all inpatients utilizing Virtua-Camden Division, to determine the number of Camden City residents, as well as other outlying zip codes, which are utilizing the facility. We then applied Cooper Hospital's respective market share percentage, by zip code, against Virtua's discharges to determine the number of potential patients who would utilize Cooper Hospital. The market shares were conservatively adjusted up, by 5 percent, to take into account the increase in market share due to proximity and preferred service offerings at Cooper, such as the children's regional hospital, open heart

surgery, trauma, and other tertiary care services. Inpatient market shares were used to project utilization for all other services.

Approximately 30 percent of Virtua's patient population, when considering charges, are self-pay or charity care. There is no reimbursement for these patients, only the potential for reimbursement a year later, when Cooper might receive 50 percent of the Medicaid rate through the Charity Care Subsidy Fund. Additionally, Cooper also experiences a marginal loss for treating Medicaid patients, even when paid at the full Medicaid rate. Cooper currently also experiences a marginal loss for Medicare, as well. Losses cannot be offset by other payers due to the fact that this market environment simply does not support better paying commercial payers.

The economic impact analysis conducted by Besler and Company, an outside consulting firm with excellent credentials, has quantified Cooper's loss attributable to the additional Virtua patients as approximately \$20 million over the next two years. In addition, the hospital will need to make certain facility modifications in order to properly treat the additional patients. These modifications include the relocation of our laboratory to accommodate an expansion of our emergency department, and increase in intensive care unit beds, and the reopening of a 30-bed unit. In total, approximately \$7.5 million in additional costs over a two-year period.

I should point out that the existing transitional funds available to facilitate closure of health-care facilities are woefully inadequate. It is my understanding that there is only \$8 million available, or proposed, and keep in mind that these funds flow to the health-care system closing the facility, not the institutions impacted by the closure.

While the management and entire staff at Cooper have worked tirelessly to bring financial stability to The Cooper Health System, the economic impact of the closure of Virtua-Camden will be a devastating blow.

With due respect to this Committee, and members of the Governor's staff, it seems tragic that the current bill deploying tobacco funds for various health-care initiatives does not appear to address the deterioration of the health-care delivery system in the City of Camden.

I will close my remarks by underscoring two issues that are at the heart of the inadequate revenue flowing to Cooper in the current economic environment.

First, Medicaid. Medicaid rates pay below cost. Medicaid desperately needs to be rebased and the rates improved.

Secondly, concerning Cooper's Charity Care payments, Cooper's Charity Care payments continue to drop under the current formula because of two factors. First, Cooper's market has, historically, a disproportionate amount of both managed Medicaid, and most importantly, managed Medicare. That is why Cooper appears to have more private pay revenue compared with other inner-city major teaching hospitals. They have more Medicare, that is, more nonprivate pay revenue than Cooper. Secondly, compounding this calculation in the formula, many institutions misrepresented their revenue on their share forms by counting managed Medicaid as simply Medicaid fee-for-service, in an inadvertent error. A recent study indicates that over \$300 million of managed Medicaid revenue was incorrectly listed as Medicaid fee-for-service. This has had a multimillion dollar impact on reducing Cooper's Charity Care payments this year.

Quite simply, I'm appealing to you to find the appropriate financial remedy, not in legislation that will help 18 to 24 months from now, but will materially assist Cooper and the health-care delivery system of the City of Camden this calendar year. There is simply too much at stake.

I appreciate the time and consideration you have given me and Cooper. I would be pleased to answer any questions, either today or later, as you complete your deliberations.

Thank you.

SENATOR SINAGRA: Thank you.

Do you by any chance know the Charity Care dollar figure that Virtua would receive -- has received or does receive?

MR. HIRSCH: Well, actually my understanding is--

SENATOR SINAGRA: If any?

MR. HIRSCH: -- that they have not received any funds and are scheduled to receive some funds under the \$30 million supplemental appropriation for hospitals to get them at least 50 cents on the dollar. But as far as we know, they have not received any funds, especially for those Charity Care patients that are in the City of Camden. They've received no funds, which admittedly, if I were my counterpart, Virtua, that's a problem for him, for sure.

Our concern is that while funds -- while no Charity Care has been provided, they lag in receiving any Charity Care funds, the fact that it's paid dramatically below cost, and then the fact that the other payer types patients with other payer types really are "less favorable," in terms of Medicaid, managed care, managed Medicaid, managed Medicare. Both pay below cost

when you look at the comparison of the payment source compared to others.

So in other words, “it’s not an attractive--” From a purely financial standpoint -- obviously, our mission is our mission and we’re committed to it, but from a financial standpoint, it’s not an attractive book of business, and it will have an impact as patients move down the street, so to speak.

SENATOR MATHEUSSEN: Les, what impact would it be if the C of N was denied for Virtua to leave? Would that help you?

MR. HIRSCH: If the C of N is denied?

SENATOR MATHEUSSEN: Yes.

MR. HIRSCH: Well, we’re not advocating for the C of N to be denied. It would be difficult to argue against the closure of a facility that’s operating at less than optimal occupancy levels. So they are having a negative financial impact. I guess in some respects what we’re saying is two wrongs don’t make a right. That facility on the inpatient side, again, we can’t argue against it’s closure. It should be done in an orderly fashion. It should be done with proper planning, and at the same time should be done in such a way so as to consider the negative financial impact that other institutions that remain, specifically in this case, Cooper, have. That’s what we’re advocating for. We’re not advocating that a C of N be denied to close the inpatient service.

SENATOR MATHEUSSEN: Could that facility be put to better use to serve the community and relieve some of the concerns that you have that are coming towards Cooper, if the closure, in fact, does occur?

For instance, an outpatient service of some kind that relieves emergency rooms of the burden that they have?

MR. HIRSCH: I think it's critical that they continue to maintain outpatient services. I know they're only proposing to close the inpatient services. Clearly, we are already seeing an impact. If you spend some time at Cooper Hospital these days, you will see that our emergency room is overrun with patients. If you look at our figures of the percentage of admissions in the hospital that originate from the emergency room now compared to two years ago, they're up dramatically. If you look over the last several months since the closure was announced, and really, in some respects the institution has been unofficially closed, because once you announce that you're going to close a facility, you go from -- they went from 70 or 80 beds, now, to 20 and 30. And so we're already seeing the impact on Cooper.

The EMS is not delivering very sick patients there, so we're already seeing the impact on Cooper. So other community uses could be beneficial. That would be for them to decide -- could be residential housing, could be drug treatment, detox, what have you. But as far as inpatient, acute care services and its relationship to emergency medical services and where patients are delivered, as far as the delivery system in Camden, is very likely that -- and we're already beginning to be overrun -- those patients will end up at Cooper predominately, and to a lesser degree at Our Lady of Lourdes. Even if they maintain a walk-in ury-care type center, still they are not in a position to take patients that would otherwise require admissions to the hospital once the inpatient facility closes. And even now, what we've observed is that the more acutely ill patients are now being diverted to Cooper and Lourdes, causing us to be overrun right now. We are overrun.

SENATOR MATHEUSSEN: What's the likelihood of some of those patients being transferred to one of their other facilities, as opposed--

MR. HIRSCH: For emergency patients? I think not likely, because really what we're talking about is the traffic in the City of Camden for the most part. So it's really -- it's a Camden health-care delivery system issue, in my opinion.

SENATOR SINAGRA: Thank you.

MR. HIRSCH: Thank you very much.

SENATOR SINAGRA: Jenna Sheinfeld.

**JENNA SHEINFELD:** Good morning. My name is Jenna Sheinfeld, and I'm here today representing the New Jersey chapter for the Society for Public Health Education.

New Jersey SOPHE represents hundreds of public health education professionals throughout the State of New Jersey. Part of our mission statement is to contribute to the health of all people through excellence in health education practice and the promotion of public health policies conducive to health. And we believe that S-1333 is such a policy.

Currently, we're working closely with NJ PIRG on this issue, and we strongly support S-1333, which, as you know, holds HMOs legally accountable for denying necessary medical care. As you can see from the handout that I gave you, this is one part of NJ SOPHE's recommendation.

All New Jersey citizens deserve confidence in, and access to, quality health care. S-1333 is the perfect opportunity to address this. We strongly urge that you adopt it and send a message to health insurers to act responsibly. It's time to make HMOs accountable.

And that's all I have.

And then I have -- Carol is here.

**CAROL R. CHERNACK:** I thought I had less.

MS. SHEINFELD: Yeah well -- I just -- I went brief.

MS. CHERNACK: Thank you for the opportunity of allowing me to speak a little bit on behalf of S-1333, as well.

I'm Carol Chernack, Director of Public Affairs for New Jersey State Nurses Association, and that's an association of registered nurses. We represent the interests of the state's 115,000 registered nurses.

Historically, nurses have been known to be strong advocates for patient care. One of our mottos, especially-- You've probably heard the physicians' Hippocratic oath. One of the mottos that I've seen, "Above all else, do no harm." So nurses have also, as part of a New Jersey Hospital Association poll in 1993, I believe, asked patients around the country, "What is the key indicator of quality care?" And that answer came up, the nurse.

When asked-- Just in a recent poll I saw in the American Nurses Association, the nurse is the one that patients look to as the educator, as the person who spends the most time. I like to think of the physician as the laser beam that treats what needs to be treated. The nurse is the one that the family goes to and asks for additional things and what's happening.

Another study, when there was a severe nursing shortage in the '80s, they said, "Well, what keeps good nurses in hospitals?" Because patients are the key that we need to -- that's why we're here, to help patients get better or get well -- to improve. Nationwide, there are 5000 acute care hospitals, and the American Nurses Association and the American Nursing Credentialing

Center did a study -- a magnet study called "The Magnet Study: What attracts excellent nurses to facilities?" They based their findings on 14 standards of care, which I won't discuss, but the main thing was nursing excellence and patient care outcomes.

Nationwide, of the 5000 hospitals just recently, only 17 have found to be magnet status based on a very -- volumes and volumes of studies that they had to show why they were excellent. Of those 17, 8 are in New Jersey. California is known for its wine, for its beaches. New York is known for its skyline, and New Jersey is known for its nurses. The nurses have always been these advocates, and we feel that for patient care we want to hold the HMOs and managed care accountable. If there's a treatment decision, we want that to be made by the health-care provider.

NJSNA has worked for the Whistle Blower legislation. We've worked to get advanced practice nurses, who are primary health-care providers, to have the ability in working with collaborative relationships with physicians, to have the ability to do what they do best and they can -- you can go to a primary care provider as a physician, or you can go to a nurse practitioner. And in that, the nurse practitioners must deal with insurance, as most nurses and hospital -- any kind of health-care provider at some point. You go into your physician's office or your nurse practitioner's office and there are insurance things to handle.

Therefore, above all else, do no harm. We would -- we strongly support this S-1333 to hold HMOs accountable.

And thank you.

SENATOR SINAGRA: Thank you.

Barbara Rosen and company. (laughter)

**BARBARA ROSEN, R.N.:** Good morning, Senator Sinagra and members of the Senate Health Committee. We'd like to thank you for the opportunity to speak today.

My name is Barbara Rosen, and I am a Critical Care nurse at Bergen Regional Medical Center, of where I have worked for the last 25 years. I am representing, along with the colleagues here today, the Health Professionals and Allied Employees, a union of 8000 health-care workers.

We're here today to collaborate, also, with the testimony that you already heard by Maryellen Kluxen, on behalf of the Patients First Coalition.

In my 25 years, I have witnessed public and private management, and then a total transfer from public to for-profit health care, in my own hospital. I have been in health care as we shifted from a health-care system focused on the patient to one focused on cost-cutting and profit-making. I have been witness to fiscal crisis and nursing shortages. This time, the crisis is deliberate, with far-reaching implications.

Within the last dozen years, we have allowed the managed care industry to deliberately ratchet down expectations of our health-care delivery system. The ratcheting down of costs, the primary motivator, had a domino effect on quality and access. As managed care came to dominate the market, it drove hospital admissions down, shortened lengths of stay, and reduced the number of hospital beds. Only the sickest of sick patients now make it into the hospital at all. And of those, even few spend the night. Access to care has been deliberately reduced for everyone, even including the well-insured.

The hallmark of how managed care companies save money is through their contracts with hospitals, with discounting rates that are often below the cost of care. The financial pinch felt by the hospital from this discounting has created a downward spiral of care.

Consumers or patients, or now they're called customers in our hospitals, now are expected to bring their family members along with them to ensure care, or they hire a private-duty nurse. That's because the hospitals have tried their own experiments with cost-cutting; cutting the number of nurses at the bedside; replacing registered nurses with unlicensed personnel; cutting ancillary staff.

These conditions have actually led to a severe nursing shortage, one with no easy solutions, and worsening conditions for the nurses that are left behind. This nursing shortage is a self-imposed shortage, created by the hospitals' responses to managed care. Hospitals literally drove nurses out of the profession through layoffs, attrition, and horrific working conditions. Nurses left their professions from stress, exhaustion, and the feeling that they were no longer providing quality care. Nurses are accountable under their license for patient outcomes, even though the conditions in the hospital make it near impossible to meet those conditions.

Now, hospitals seem surprised that they can't find nurses, the same nurses that they told a few years ago were a dime a dozen, or when the nurses complained about the increases in patient assignments that were unsafe, they were told, "If you don't like it, there's the door." Unfortunately, an overwhelming number of our nurses have taken that advice.

Now, this nursing shortage threatens any attempt to repair the damage done in the last 10 years. Hospitals are actually beginning to offer sign-on bonuses to attract nurses back. But they are not coming back. They left to go into real estate and other professions that don't have health-care sweatshop conditions. They are not coming back into the nursing schools, and many hospitals have closed their nursing schools. Applications to nursing schools are down, there are fewer graduates, and nurses are retiring early, or they are just plain tired.

Some of the changes taking place in health care are due to our increased medical technology. And just when we need most, the highly specialized nurses to care for these patients with more complex illnesses, they are no longer there.

Now the long-term question is, who will care for our patients? Who will speak up for patients when they are too ill to speak for themselves? I would urge this Committee to add the nursing shortage and real term -- long-term solutions to your list of concerns.

Thank you.

**C H E R Y L A . R O S S I , R.N.C.:** Good morning, and thank you for allowing me to speak here today.

My name is Cheryl Rossi. I am a registered nurse in the high-risk obstetrical area at Cooper Hospital in Camden, and I have worked at Cooper my entire nursing career.

Others have eloquently addressed the issues affecting the delivery of health care in this state. I'd like to take a moment to speak about the

impact that the changes brought about by managed care have had on a nurse's ability to provide quality patient care at the bedside.

Because of the discounted contract, hospitals like Cooper have been forced to negotiate with managed care companies. Many institutions in the State of New Jersey are suffering from historically low reimbursement rates and face significant financial hardship. Unfortunately, these cost-cutting measures are often manifested at the patient's bedside.

As a staff nurse with 16 years experience in an acute care setting, I have seen firsthand that, as managed care has come to dominate health care, patients' lengths of stay have dramatically been reduced. This has resulted in patients who are far more acutely ill, now making up the populations of most hospital nursing units. As a cost-saving measure, many hospitals have reduced staff, either of professional nurses or of ancillary and support staff. These staff cuts allow for much less time to be spent by the nurse at the bedside, as he or she now has to perform duties formerly handled by maintenance, transport, dietary, or bedside assistive staff.

As recently as five to ten years ago, staffing was not a major concern or issue for nurses at Cooper, as we had not yet seen the dramatic increase in patient acuity and decrease in length of stay that managed care has brought about. Now, a nurse may have to take responsibility for 10 to 12 patients, who are all profoundly ill. Many procedures are now being performed in an outpatient setting that would have necessitated a hospital stay a decade ago. Patients recovering from major surgery are discharged within a few days.

With a limited amount of time available to spend with our patients, we have had to revise the shape of our practice. We can no longer

spare the time to sit with our patients, offering them and their families the emotional support they often desperately need.

Direct patient education has also suffered, as bedside nurses are increasingly consumed with performing the necessary tasks to help our patient heal. Patient education is frequently reduced to a handout or a video, and the limited amount of time the discharge nurse can spare the day the patient goes home. There is often little time for such basic and essential patient education as wound care, well baby care, dietary, and medication instruction.

Floating, or the practice of moving a nurse from her area of expertise to another unit, often with little or no training or orientation, is another manifestation of the impact of managed care at the bedside. I have personally been reassigned on my shift from the high-risk obstetrical unit where I have practiced for the past 13 years, to the pulmonary care unit, which is a cardiac care unit. I had no previous cardiac experience, but was fortunate to have been floated there with a group of wonderful, professional nurses who gave me an appropriate assignment. I was also able to team up with another nurse for the first four hours of my shift. None of my patients suffered any detrimental effect from my having been pulled there that night, but I couldn't promise that would always be the case.

All of these issues have combined to create a working environment which is extremely stressful. Many nurses, often of the highest caliber, are leaving the profession in search of more satisfying, less frustrating positions. And as we watch many of our mentors leaving bedside nursing, we also face declining enrollments in many nursing programs. Nursing, though a respected

profession, has become so physically and emotionally demanding that many of the best and brightest now seek other fields.

As some of you may know, the professional nurses at our hospital recently organized a union and successfully negotiated our first contract. Of primary importance to us during the organizing and negotiating processes were many of the issues I have discussed today, staffing, floating, recruitment and retention of qualified registered nurses, and appropriate ancillary and support staff. All of these issues have at their core the goal of increasing our ability to spend time with our patients at the bedside and to provide the kind of high quality nursing care we all dreamed of while in nursing school.

We addressed these issues in our contract with Cooper by working with the hospital to establish clinical floating districts. This will ensure that a nurse will only be assigned to work in those areas most directly related to his or her specialty, and only following an appropriate orientation or training period. We have also created a joint staffing committee, which will contain representatives from the hospital, as well as the nursing staff. The purpose of this committee is to evaluate staffing levels on all the hospital's units and, armed with information about scheduling, current staffing levels, turnover, and overtime, to recommend appropriate staffing levels and skill mixes for the units, to establish patient acuity tools, which can be used to determine adequate staffing, and to improve patient satisfaction and unit and hospital functioning.

Our contract also addresses the issue of mandatory overtime which, although not yet a persistent problem at Cooper, is currently being practiced at many hospitals across the state. In light of the impending nursing

shortage, mandatory overtime is likely to become a much more common practice in coming years. Now, Cooper's professional nursing staff enjoys specific limits on mandatory overtime to help ensure that we can continue to practice our profession, with patient safety and quality patient care at the forefront.

We are proud that, as nurses and as a union, we were able to win contract provisions that we believe will enable Cooper to recruit and retain qualified nurses and maintain the highest quality of patient care.

Thank you very much for your time.

**MARY T. TIETJEN, R.N.:** Good morning.

Thank you for this opportunity. My name is Mary Tietjen. I have been a registered nurse for 22 years. I have worked for 19 years at Bergen Regional Medical Center. I can say that, in all this time, right now is the most dangerous point in my career, for myself and my patients.

I say this because as a registered nurse we seem to be the only ones left accountable in the system. We are at the bedside, and our license is on the line. Even when we are given a patient assignment that is humanly impossible to do, we must do it, and we are accountable. At the same time, we are answering the phones, picking up medications from the pharmacy, delivering specimens to the lab, searching for central supplies, arranging and completing housekeeping chores, transporting patients, performing clerical duties, passing out food trays, and filling out endless paperwork.

Since our hospital was privatized, we went from 435 R.N.s to 260. When we have more patients than is legally allowable, we are still responsible. When our employer mandates us to work 16 hours straight, with or without

a break, we are exhausted, but we are still responsible. If we leave our patient's side, we are abandoning our patients.

To the nurse, it seems that there is no one else accountable, and no one is minding the store. When you are in the intensive care unit and are short of staff, the Department of Health is nowhere to be found. But when they do show up, so does the extra help. The hospitals know how to pull people from other floors just during the time when the Department of Health is on the unit.

Though our hospital has been fined and cited repeatedly, there has been very little change. We are still the incredibly shrinking staff. And this is true in almost every hospital throughout the State of New Jersey.

At other hospitals, complaints of understaffing have also brought the Department of Health in for inspection. But it can take one full year to go from complaint to inspection to citations to the hospital's accepted plan of corrections. Patients don't have that time to wait.

In the meantime, nurses suffer, and so do the patients. In hospitals and nursing homes, patients' incidents, medication errors, preventable complications, injuries, and infection rates are increasing.

At our long-term care unit, an independent study demonstrated the impact of short-staffing in delayed meals, increased pressure sores, patients still in their bed at noontime without any stimulation or recreational activity.

Where is the accountability of the industry's CEOs and managed care? How are our elected officials holding them accountable for quality care for the funding that they receive?

While we have been firsthand witnesses to the shrinking nursing staff, we have not noticed any CEO salary shrink or advertising budgets or even profit margins. The dollars we spent on health care come primarily from tax dollars and the pockets of consumers and their employees. The public has a right to know where their funds are going. And the public has a right to demand that public funds go directly to patient care.

We also have a need to adequately fund health care. When you cut funding, you cut care. Right now, managed care has entirely too much power over our system, through their unfettered ability to demand discounted rates. That power is particularly harmful to the health of patients in urban areas, in public hospitals, and in areas where high-risk patients require more care and more funding. The State has a right and an obligation to limit this power.

In addition to supporting the recommendation of the Patients First coalition for safe staffing, HPAE would like to recommend State regulations and oversight to:

No 1, improve the oversight of the Department of Health on staffing as it applies to acuity systems in hospitals and nursing homes. We also suggest a report to the Committee, from the Department of Health, on the number of staffing complaints, and the results of the complaints and citations.

Require managed care organizations to increase their payments to hospitals, in order to contribute to funding for health care for the uninsured. Managed care practices have contributed to and made worse the problems of the uninsured. Managed cares should bear their fair share of the cost. Set

limits on discounting to ensure that all hospitals receive adequate funding to provide quality health care.

No. 3, require hospitals to report the degree of discounting given to managed care organizations and the proportions of expenses allowed to nondirect patient care items. The public has the right to know where the hospital revenues are going. This right to know should also include quality indicators and staffing levels, including direct-care givers.

On behalf of HPAE, we thank you for this opportunity, and we would be glad to answer any questions you may have.

SENATOR SINAGRA: Thank you.

Hal Garwin.

Is Hal here? (no response)

Jerry Flanagan, are you ready?

MR. FLANAGAN: Thank you, Chairman, and members of the Committee.

SENATOR SINAGRA: There is only one mike that actually--  
(referring to PA microphone)

MR. FLANAGAN: There is only one live one? These are fakes?  
(referring to recording microphone)

SENATOR SINAGRA: They're for recording.

MR. FLANAGAN: Great.

Thank you, Chairman, and members of the Committee. My name is Jerry Flanagan, New Jersey PIRG.

I'm joined today by Edward Ashanky, from Warren Township. He'll talk a bit about his dealings with some HMO issues, and then also Dr.

Drew Harris, of Public Health Association. Edward Ashanky is actually on your list. Drew is not, so I'm going to concede some of my time to him. He put a slip in this morning.

Just to be very brief -- and I put in some testimony -- a lengthy written testimony. As many of you know -- one, I want to say that I think this Committee hearing is particularly timely considering the events of the U.S. Senate last week. The vote against the right to sue, and HMO accountability issues at the national level, extends credence to the need for New Jersey to address these issues. And I thank you for addressing these and taking the time to deal with these issues, and again, calling on New Jersey to take the lead on health-care reform -- much like you did in 1997 with the Health Care Quality Act.

Some of these issues that we've been dealing with as a public interest group in members coming to us is that they purchase health-care insurance because it's a mandatory component of life, that we know that they need it, and there's a vague understanding that somewhere down the road, they may actually have to call on that health insurance, either for themselves or their family members. And for a growing number of us, I think the Hospital Association's testimony and their information about denials across the state -- for a growing number of those, we found that the trust we put in HMOs is growing, and it's been misappropriately placed. And not to say that all health insurers are denying care, and not providing care necessary -- there certainly are good actors among the group -- but it's certainly obvious that both, I'm sure, from your constituents and also from consumers around the State, you've heard HMOs at a growing rate denying or delaying medically necessary care.

And when that happens, patients' health, obviously, is put further in jeopardy, more than it would be by whatever ailment that person may have.

Just very simply, I think we're entering a dangerous period in health care where -- because HMOs have been exempted from very basic consumer protection principles, from product liability. We have lemon laws, and we have -- that protect us when we purchase a car that does not meet standards or hinders us. We have toy safety laws that hold basic principles and quality of product, and essentially a message in product liability law that says if you have a product that negatively impacts the care of a consumer, you should be held accountable.

The same thing is happening now with HMOs and health insurers that are denying care based on profit line and money that can be saved from not paying out premiums or limiting what a physician prescribes as necessary care or limiting hospital stays. And when you make decisions like that, you must be held accountable to the highest consumer and medical principles. And those checks and balances work. I think that one of the most important things right now is, when you send a message, which we have to managed care, that you're not going to be held accountable if you deny care, we find that many, many cases and one in which medically necessary care is denied, and ultimately, they do have to deliver that care. After the independent review board reviews that issue, there is no legal deterrents from denying care ad hoc. And that is obviously a concern both for, I'm sure, for the Committee and also for consumers and patients and also for my organization, as well.

Very simply, the HMO accountability legislation that we are focused on, and hope for your support, would send a powerful message to

health insurers to act responsibly by holding HMOs legally accountable for medically necessary care. And this is a side note, we want to thank Senator Sinagra and also Senator Matheussen for your legislation S-640 that would make the review, the HMO watchdog, so to speak, legally binding on the carrier.

We feel, though, in conjunction with that legislation, it's necessary to have the HMO accountability legislation, S-1333, simply to create the deterrence so that only real contested decisions are referred to the review board, and that those that would ultimately be granted by the HMO are allowed up front. That is critical.

Again, Bryan Markowitz testified on some of the cost issues. Like him, I've been in this room before. I took my graduate school entrance exams in this room, which were not as enjoyable as the final, because that was the beginning of something rather the end of something. (laughter) It was at the same time, about 10:00 in the morning, and I think it took about 3 hours as well.

The key thing here is cost. The Texas data that we have available to us has shown that, based on their law that passed in 1996, the employer consultant Watson Wyatt Worldwide has found that premiums had raised less than 1 percent because of this legislation. There's only been five cases that have come up as a result of that legislation, and the utilization review -- the independent review board numbers have dropped drastically. And what that shows is very simple, that with the threat of liability with the judicial hammer, HMOs are less likely to deny care up front. There aren't a lot of litigation, because there aren't needless denials happening, and the impact, therefore, on

premiums has been very slight, and I think the trade off-- And BIA would admit of -- having health care that's worth having is worth the small amount in premium increase.

In a state where, I think how far we were up last year -- Bryan's group did a study about health-care cost increases. They're not 7 percent. I think they're at least 7 percent or more. And that's not coming. This legislation should not be a gatekeeper to this sort of legislation, and I would urge the Committee to support -- and I will end at that. There is some lengthy comments that I have put into the Committee that's either answering questions today or in the future.

I want to turn briefly over to Edward Ashanky to speak about his issues.

**EDWARD ASHANKY:** Good morning.

Thank you for the opportunity of appearing here. My name is Edward Ashanky. I'm from Warren, New Jersey. And I'm a consumer of health insurance services.

Recently, I had a rotator cuff problem, and I was entitled to 12 additional physical therapy treatments; however, Aetna/US Healthcare chose to deny my claim for this treatment that I was entitled to, and in subsequent two or three months they lost the health records that I got from my doctor and sent to them on appeal.

The third time, after getting sick of this, I got the name of a representative at the health insurance operation, and I faxed to her the records, and I insisted that she fax back to me a memo acknowledging receipt, which she did. The same nonsense went on for almost a month. I still never heard

anything. And then the coup de grâce was that the medical review board claimed they never received my records. And of course, you all know, we don't have the right to sue health insurance carriers. However, in my particular case, I got a hold of the girl that I sent the records to, and I threatened to personally sue her for gross negligence for mishandling and losing my records. And surprisingly enough, a miracle happened. Within two days, I had a written approval for treatment and a guarantee of payment.

Now, I think that the job that this Committee has is very important at this time in history. And I think that we have to remember that, when we're dealing with people, you're dealing with three elements. You are dealing with a physical being, you're dealing with a mental being, and you're dealing with a spiritual being. And certain laws that you write can break that spirit, it can break that mental barrier in a person's mind. It can affect their health. It's very, very important. I think that in cases like mine, where I've had one open heart surgery and two carotid artery surgeries in the past, I don't need agitation. What I need is a clear, simple contract of coverage and accountability by a carrier.

And I think a few of the quick points that I would like to make in closing for suggested solutions are that, when you consider reform, don't consider just the one element of the insurance industry. Consider the insurance industry, consider the well-being of the patient, and consider the terms under which a medical practitioner has to work. Give them the tools to work with, and a clear conscience that they can go to bed at night and relax and not worry about what they didn't do with a patient because of the constraints of time. I think that's very important.

I think it's important that we have a Patients' Bill of Rights. I think it's important that we have the right to sue, to prick the conscience of unfair practitioners, and I think, above all, it's very, very important that we don't have elements of law that hold harmless industry to where they don't have to be afraid. They need something to keep them in line.

And I think medical decisions must be made by doctors. And I think another thing that we have to do is publicize something that I was ignorant of. With all the problems that I had for those two or three months trying to get treatment, I never realized, and no one ever bothered to inform me, that I could have simply gone to the New Jersey State Department of Health and filed a formal complaint, and I probably could have had this addressed within two weeks of my first request.

Thank you, gentlemen, for hearing me.

SENATOR SINAGRA: Thank you.

**DREW A. HARRIS, D.P.M.:** Good morning. I'm Drew Harris, President of the New Jersey Public Health Association, a 125-year-old public health advocacy organization. I'm also a podiatric physician in private practice, so I can speak about the current state of affairs from different perspectives.

Thank you for allowing me to speak first in favor of the Patients' Bill of Rights, and then for the FamilyCare program, A-49.

The people of New Jersey are frustrated, upset, and angry over the current state of affairs. The once simple process of a doctor's visit has become a nightmare of red tape and confusion. Similar to the situation with telephone companies, people do not understand why it has to be so complicated.

Increasingly, they have relied upon the assistance of their doctors to help them negotiate the complicated maze that separates them from appropriate health care. At the same time, an equally frustrating burden has been placed upon the shoulders of our state's physicians. They, too, are angry and frustrated. Instead of spending their time with patients, they now sit on hold and argue with clerks about what medication, test, or treatment is appropriate for the patient. I call it the death of 1000 paper cuts.

In this system, the doctor ceases to be the patient's advocate. People need to know that managed care is driving a wedge between themselves and their doctors. Sure, a doctor will make the occasional call to get the needed treatment for the patient. However, if every case is a battle, every decision is second-guessed, how many times will even the most resolute physician go to bat for his or her patients?

The managed care companies want to change physician behavior, and they have, for doctors are giving up fighting insurance companies for the patients except in the most egregious cases. This is what people are losing in our current system. If we make the managed care companies legally accountable for the decisions, then they will have to restrain themselves. Make no mistake about it, the power to deny payment is the power to deny care. And when that care is inappropriately denied, leading to harm, then the people who made the decision should be held accountable. Doctors, nurses, and hospitals are all accountable for the mistakes they make. Knowing you are responsible makes you sharper, it improves the care you give. So too will it be with managed care companies.

Current law allows people to sue for what care was inappropriately denied, not for damages. So if the safer medication that would not have hurt you cost an extra \$30 for the prescription, then that is what you would get in court. Thus there is every financial incentive to cut corners knowing that their liability is severely limited.

There is a group of people in our state for whom even bad care or frustrating treatment would be a blessing. These people have no health insurance. Many are working, or their family members are working people. They can't afford the thousands of dollars to buy real health insurance. So good, decent people are forced to find treatment in emergency rooms for illnesses far more advanced than they should have been and never receiving the basic preventive services that may have avoided the crisis altogether.

Untreated hypertension becomes stroke. Improperly managed diabetes becomes amputation. For society, there are no savings in having uninsured people. Ultimately, they will get care. The question is where, and at what cost?

Vulnerable inner-city hospitals in minority communities with a strong sense of compassion are bearing an unequal burden of the care of the uninsured. The doctors in these communities also have a large charity care responsibility that is driving many from where they need it to the better insured suburbs.

A vicious spiral is leading us to a two-tier health-care system based solely on insurance status. If current trends continue, you will see more of these vital institutions consolidate or go out of business, further worsening inner-city health care.

The low-income, uninsured need a health plan that:

1. Provides a comprehensive package that covers all appropriate services and office visits.

2. Pays more than the 20-year-old Medicaid rates. A plan that pays a physician one-quarter of his usual fee is asking the doctors to give away care. They won't. These people will have worthless insurance cards. They will be forced to seek out charity clinics to be seen by medical students and residents and;

3. Finally, this plan must recognize that prevention is the key to long-term health-care savings. This health plan must be put -- must put the formerly uninsured back into the system, where appropriate prevention services can be given.

New Jersey ranks at the bottom of the nation for adult immunization and breast cancer screening. This is a travesty. Only a comprehensive, systemic overhaul that brings together the insurance company, the provider, and the public health communities will put us back where we belong.

Now, before, the representative for the New Jersey BIA made some comments regarding increasing health-care cost. And we all know that the price of insurance is going up, but, you know, don't blame the patients. They are getting less care, their deductibles and their copays are going up. Don't blame the doctors or the hospitals because payments are decreasing and hassles are increasing as a result. We have to realize that managed care is really failing in this current form, and it's time to try something new.

Senators, thank you for the opportunity to speak before you today. I will be happy to answer any questions or share even a few juicy anecdotes, if you like.

SENATOR MATHEUSSEN: Jerry, I have a question for you -- it doesn't matter, but I thought maybe I'd direct it to you. Do you think there is a way of connecting-- You know, the theory of an exhaustion of remedies under the law requires you to exhaust all your remedies before you get to the ultimate lawsuit, so to speak. Do you think that there's an appropriate connection between, perhaps, the bill that Senator Sinagra and I have, with regard to binding arbitration as an exhaustion of remedies before a lawsuit should be enacted against an HMO?

MR. FLANAGAN: Well, I definitely think that the -- actually, litigation should be the last step, because anytime that we really reach a judicial review period and a litigation ensues, that means that care has been delayed for a long time, much too long, and I think that all of these judicial hammers are meant to be a deterrence from delays outright. And again, send a message that we spoke in length here today, about sending a message to HMOs and health insurers to act responsibly up front -- care delivered up front to ensure that patients and doctors don't have to battle for medical coverage.

I guess the key thing is that I think that the full process that you are speaking to that we are sure that would have binding -- one that we would use in the independent review process and we are -- as we start any kind of review process, that we are working within that system. But I think the need, in order to send the message, one, to HMOs accountable, we need the judicial hammer of potential litigation. I guess one way to think about this as well is

that, for whatever reason, or at least in practice, HMOs have been exempted from a very basic consumer tenant and they operate in a form all of their own, which is a place where they are not held fully accountable for denying care. And I think when we put them -- we have to ask ourselves why are they operating in that kind of special world.

SENATOR MATHEUSSEN: I agree with you, but what I'm saying is that I do have some concern -- this gentleman -- I'm sorry I forgot your name -- testified--

MR. ASHANKY: Edward Ashanky.

SENATOR MATHEUSSEN: --Mr. Ashansky had more than adequate care. He was supposed to be guaranteed at least 12 visits for what he was supposed to get; however, there could be someone living next door to him that bought a much lesser policy that didn't get any of those services for the money that they paid. They signed a contract and they paid \$2000. This gentleman paid \$6000 for his coverage, and all of a sudden his next-door neighbor turns around and wants to sue the insurance company to the fact that he didn't get the same benefits as this gentleman did, but he paid for it and the other one didn't want to pay for it.

MR. FLANAGAN: Right. Well, if we speak directly to the S-1333 HMO Accountability, that's a very specific, dealing only in the contractual terms that the consumer was -- so it's not like we're saying you should give -- well, it's basically the contractual law that we're talking about here; I bought a piece of paper that said I'm allowed ordinary care--

SENATOR MATHEUSSEN: Get these services back, right.

MR. FLANAGAN: Right, and we're not talking about mandates here, we're talking about -- I was granted, or supposedly, I bought coverage under ordinary care or this narrow definition, and then if you're denied within that contractual agreement, then there is a judicial hammer. But there isn't any -- we're not adding mandates here of, you know, I didn't get the same care that he had, but it's not in my contract then.

SENATOR MATHEUSSEN: I don't want to delay the hearing any longer, but I just have one more question, if I could, Mr. Chairman?

SENATOR SINAGRA: Go ahead.

SENATOR MATHEUSSEN: To the doctor, how do you grab that group of people who are just irresponsible and don't want to buy health-care coverage?

What about the person who doesn't want to spend the \$5000, or whatever it is, because the government will take care of me?

Are we -- what are we supposed to do about them?

DR. HARRIS: That is a dilemma.

SENATOR MATHEUSSEN: It's a big one, and I would imagine that there is a very significant number of people out there who are uninsured because of that very reason.

DR. HARRIS: Because they make their own personal decision not to have insurance-- Look, a lot of people make bad choices in our society and we make--

SENATOR MATHEUSSEN: It seems like a lot of them are making more and more of them, though.

DR. HARRIS: Well, that's possible. But unfortunately, you know, sometimes legislation also encourages bad choices, like, for instance, repealing the requirement to have a motorcycle helmet.

Now, if someone wants to make the choice not to wear one of those helmets, and they are injured, then we as a society have to take care of them. Same thing with many other public safety measures. We pass laws that require people to wear seat belts, and therefore, people can chose not to, but they are somewhat responsible when they make that particular choice.

I think, ultimately, we have to get to where there is a system that allows everyone to have some form of health insurance. I think we need to get to universal coverage because we are a compassionate people. We're going to provide the care, and unless you are willing to accept people dying on the sidewalk because they made the bad choice in not buying their health insurance, we're going to give it to them -- we're giving them that care anyway. But it's going to cost us a lot more. So the social -- societal cost of uninsured people are great even if those people made their own personal choice in that matter.

SENATOR MATHEUSSEN: So you want government to pay for it all?

DR. HARRIS: Do I want government to pay for it all?

I would be happy to have some sort of a private system, similar to other countries -- what they are offering in Germany, where it is handled through the employer, through constrained groups that provide the very set to find benefit packages. I don't think that we need to mandate that every employer offer insurance, I think there may be an alternative there. Before I

go to defining the solution, I think what we need to do is acknowledge that there is a problem, deal with that problem, and bring everyone together to the table to come up with a reasonable solution. That's why we're here today.

SENATOR MATHEUSSEN: Thank you, Doctor.

MR. FLANAGAN: Senator, if I may add one comment to that as well -- and I think that some of these issues that Dr. Harris was talking about are how we deal with universal health-care issues are important. But I think that our organization's focus right now is that, before we can even start addressing those concerns adequately, we first have to clean up the managed care house to make sure that having insurance is worth having, that when you need it, it's there for you.

And I think that, you know, as we address that issue that making them accountable for action and including them on a very basic -- basically, playing by the same rules that every other merchant in the state has to. And of course, when you have health insurance, it's a much more important and emotional and traumatic experience than if you bought a car, but it should play by the same rules.

Thank you very much.

SENATOR MATHEUSSEN: I would only disagree that we don't have to do it first, we have to do it all at the same time.

SENATOR SINAGRA: Thank you very much.

MR. FLANAGAN: Thank you.

SENATOR SINAGRA: Peter

**P E T E R G U Z Z O:** Well, it's either good morning or good afternoon, depending on who--

SENATOR SINAGRA: It's still good morning.

MR. GUZZO: It's still good morning, okay.

Good morning, Mr. Chairman and members of the Committee. I am Peter Guzzo, Director and Legislative Agent for Consumers for Civil Justice. As most of you know, Consumers for Civil Justice is a coalition of consumer victims, labor, and health-care advocates dedicated to promoting and preserving the rights of injured persons to seek remedies, either through the civil justice system or through government.

Members of CCJ include other organizations you've heard this morning, such as Citizen Action, the Health Professional and Allied Employees, New Jersey PIRG -- AARP is also a member -- The Breast Implant Victims Organization, the Brain Injury Association and many others, all with the common goal, and that is to protect the rights of victims to be compensated.

With me today is Myles O'Malley, who is a member of the CCJ board of directors, and also wears many victim advocate hats, including that of being Director of the Childhood Lead Poisoning Emergency Response Organization and the White Lung Association. Myles has a background in dealing with many consumer causes. I will yield the microphone to Myles for a presentation on behalf of CCJ.

**MYLES O'MALLEY:** Thank you, Peter. Good morning, Senator and Members of the Committee.

We've presented you with some testimony, and I'll just go on ahead and read it for the benefit of the audience.

CCJ joins with New Jersey PIRG, the New Jersey Hospital Association, AARP and many other advocacy groups in supporting S-1333. I want to thank, in particular, Jerry Flanagan and his New Jersey PIRG for assisting us in presenting and formulating the data that underlies this testimony.

These bills afford the consumer of health care at the time of his greatest vulnerability, when he is sick, an important tool in seeking what he most needs, appropriate treatment. By providing patients the right to sue the HMO for denial, reduction, or delay in the provision of treatment, a climate of accountability is created in which the HMO will be encouraged to attend more closely to the sanctity of the doctor-patient relationship than to the HMO's relationship to cost saving measures. Making the HMO share in potential malpractice liability with the physician should measurably relieve the pressure many physicians must feel in serving two masters: duty to the patient and duty to the paymaster. HMO accountability will surely serve to enhance the patient's confidence in the objectivity and professionalism of her physician's diagnosis and treatment.

Contrary to the fears of health-care carriers, these insurer accountability bills, based upon model Texas legislation, are crafted to rectify instances where health care is inappropriately allocated, and not to add grist to the mill of trial lawyers. The bills contain a number of provisions designed to facilitate corrective action, lessening actual injury to patients.

For example, upon filing suit challenging a carrier's health-care treatment decision, the patient must simultaneously file an appeal under the carrier's internal review process or with the Independent Health Care Appeals

Program, administered by the New Jersey Department of Health and Senior Services, under the auspices of the Health Care Quality Act. A mechanism is thereby created for resolution of the suit almost immediately upon it being filed, for the court hearing the action may take notice of the DOH's independent review recommendations. In addition, the court must employ alternative dispute resolution to hasten solutions that are fair and equitable. The right to sue should serve to provide muscle to appeals mechanisms already in place.

If the Texas model is any indication how HMO accountability will work in New Jersey, we will not see a deluge of lawsuits, nor will we see dramatic increases in health carrier premiums. As Mr. Flanagan noted earlier, since passage of the Texas legislation, a mere five lawsuits have been filed, and increases attributable to accountability are 1 percent, according to the Texas Medical Association.

S-1333 is eminently fair to health-care carriers. To bring a successful action, the bills require that the patient must prove that the carrier "controlled, influenced, or participated in the health-care treatment decision," and in so doing, cannot rely exclusively "on proof that the provider's name appears on a list of approved health-care providers made available to covered persons under a health benefits plan." Thus the law is a great incentive to health-care carriers to stay out of the business. They are not licensed to practice the practice of medicine. As stated above, the legitimate interests of cost containment and the ethical interests of noninterference in the medical treatment of individuals are more likely to be kept separate.

There is a great need for this legislation in the State of New Jersey. According to New Jersey PIRG, the member organizations of the New Jersey Association of Health Plans deny 4 percent, or 4 million health claims per year. Although the number of external appeals is increasing each year, it is hard to understand why only a mere 323 of these denied claims are filed with the Department of Health and Senior Services since the inception of the law in 1997. Those in immediate need of health care constitute a vulnerable population. A vulnerable population is less likely to be aware of and exercise its rights. I think Mr. Ashanky's testimony is anecdotal of that fact. Access to the courts can only serve to broaden the exercise of these rights and improve health care in the State of New Jersey.

Thank you very much.

SENATOR SINAGRA: Thank you very much.

Hal Garwin.

**HAROLD B. GARWIN:** Which one is the live one? (referring to PA microphone)

SENATOR SINAGRA: The big one.

MR. GARWIN: Last time I was in movies, I used to know where the microphone was, but since I've retired from the movies I missed that.

Good morning.

Thank you for giving me the opportunity to be here today. Thank you, Chairman Sinagra and members of the Committee.

The issues that are related to access and quality of health-care coverage may be the most important questions facing the Legislature, the State, and the public at this time. This is especially true in New Jersey as the State

initiates its second wave of mandated managed health care for thousands of elderly and disabled recipients of Supplemental Security Income and Medicaid.

As you all know, the TANF population was the first wave, and it was introduced a couple of years ago. The population now that is being moved into the managed care situation adds to the thousands of individuals and families covered through commercial managed Medicare and other managed care programs. I believe, and the Law Project and its Board of Trustees believes, that we must be extremely vigilant at this time, as to the access to health care and the quality of service given under these various health plans.

My name is Hal Garwin, and I am the President of the Community Health Law Project, which is a legal and advocacy organization that is dedicated to providing services to people with disabilities and the elderly throughout the State of New Jersey. We've done so for about 24 years, doing legal advocacy, training, education, and other activities.

I'm also the father of a severely disabled child, who has had a brain tumor removed five years ago, and as a result has a myriad of health problems. These past five years have clearly shown me what health care can do and what health-care services, when made available appropriately, can do to help an individual who has a disability in their family. It has also given me the impetus, with several other people at the Law Project, to try to set up programs and services that help families and disabled individuals deal with the maze of managed health care, in particular. I have lived through that for the last five years and know the difficulties in trying to get what is needed for my daughter without completely wiping out my family's income and assets, as well as allowing me to still continue to act as a professional and continue to do my job.

I understand very fully what it is to live through being an enrollee in a managed health-care plan. I have to say that my managed health care is an excellent plan, that for the most part we have been able to get the kinds of services needed. But the health care that is needed is so complicated for individuals who have health difficulties of a myriad type that even someone who is intelligent, someone who is educated, and someone who has worked in the system sees the faults and difficulties in doing that.

It is really a system where, if you do not know the referrals that must be gotten for a particular service, the kind of precertifications and preauthorizations that are needed knowing that you have to renew those at a certain time, and trying to work through the health provider and the insurance company to understand that many people, particularly those with chronic illnesses and disabilities, do not need merely acute health services, but they need maintenance of health care. And that is one of the things that is most important, that in any plan, in any system that's set up, it must be established. I fear, in particular, when we move the disabled and elderly who are on the SSI rolls into managed health care, that that will be one of the major problems.

I know, I've participated in the last couple of years in the State's effort to develop a contract that would guard against and protect people with disabilities and the elderly and the SSI population, protect them in the sense that they would get the health care that they needed. But I also know from being a participant in that, it's very difficult to transfer containment of costs from being containment of health care, particularly when you're talking about maintenance.

One prime example I will give you from my daughter is that she suffers from a situation where there is no lymphatic draining. Her lymph system does not work. Many women, in particular, who have mastectomies done have difficulties with their lymph system draining in one limb. And there has been a system developed called manual lymphatic draining, where they can manually drain the lymph systems in that particular limb to reduce the fluid and a variety of medical problems that occur. My daughter has full lymphedema. She needs to have herself drained, minimum once a week, usually twice a week. And when she is not in some kind of inpatient hospitalization, she is home. It is then under health care. There is extreme difficulty in getting any insurance situation to cover that maintenance lymphatic draining. We get periodic short-term draining if we go to a program. This kind of maintenance of effort is really going to be the hallmark for many of the people with disabilities and the elderly, who are pretty much homebound and who are not in patient facilities.

It also requires some intelligent dealings with case managers in the insurance companies because the customer reps really don't understand it. They look at the plans, it's not in black and white. They need to be able to deal with the nursing staff and the medical directors. That is just a small example of what we are facing in managed health care and particularly with this chronically disabled population.

There are a number of other points that I made in my written testimony, which you have before you, which you certainly can peruse, and I'd be glad to answer questions on it.

What I just want to emphasize that the State must do in its overseer and oversight role is to make sure that the system is set up so that it is not only convenient, but it is really user-friendly. And that there is a conversion from the philosophy of containment of costs and only acute care to the understanding when you deal with the chronically ill and the chronically disabled, long-term disabilities, it's maintenance of service and specialized care. Managed health-care programs and insurance companies are not good at those aspects. We must be very careful so that this population is cared for and provided with the services that are necessary.

SENATOR SINAGRA: Thank you.

MR. GARWIN: Thank you.

SENATOR SINAGRA: Theodore Carrington.

**THEODORE R. CARRINGTON:** Good afternoon.

I'm here on behalf of New Jersey Work Environment Council and also Metuchen-Edison NAACP. I want to talk particularly about the environmental injustice and possibly causes of some of the concerns that people have expressed here in regards to health care.

I think that, in the State of New Jersey and across the nation, there's been a large number of facilities -- toxic facilities that are located primarily in communities of color and poor, working-class people. And as a result, in these communities you have high, outrageous incidences of asthma, other respiratory problems, cancers, and other kinds of health issues. In the schools alone, on any given day, especially on a hot, humid day, you can see many of our children down at the nurse's office because of asthma and other kinds of respiratory problems.

In the United States, and certainly in New Jersey because we have a high preponderance of toxic facilities -- we have over 600 major polluters in the State of New Jersey. Asthma is off the charts in some areas. It's increased over 600, 800 percent in the State. It's -- we're in a situation where, with the TRI, toxic release information, there are facilities that put out over 10,000 pounds of various kinds of chemicals yearly, and in some facilities that's just one chemical. Those facilities that put out a large number of chemicals, the numbers are astronomical, and it doesn't seem to be very hard to make the link between air pollution, water pollution, and ground pollution to the development of our children to the health of the citizens of this state.

Just recently, the Greater Boston Physicians for Social Responsibility has done a major report, "In Harm's Way: Toxic Threats to Child Development," and many of the problems of our youth, including attention deficit hyperactive disorder, autism, IQ,, all is on a major increase across the country. And again, in communities of color and poor, working-class people where the Superfund sites -- three out of five are located in those communities. Facts are that usually when the EPA comes into a community to clean up that site, they usually take a little longer and spend a little bit less money.

So my concern is that, we know some of the reasons why there are problems -- health problems, so that we're not ignoring auto pollution, certainly, we're not ignoring some pollution from other states that come in here. But the fact is that it seems to me there's a lack of concern on the effects on -- in our communities where there is a concentration -- for instance, in Linden and Roselle and different areas with large concentrations of people of

color and poor, working-class people, where we have incinerators, where Linden is almost overwhelmed with garbage. Garbage coming in from New York, garbage -- looking for a new hospital waste facility to be erected there besides getting a transfer of garbage coming in from New York, besides right down the road there is a major incinerator in Rahway, besides the major incinerator in the Ironbound section of Newark.

It wasn't too long ago that science tried to make the link between smoking and cancer. And this took a while for the science to catch up, to actually provide a definitive response that smoking causes cancer. I think that we're in a position right now where we're looking at connecting the dots, but it's not officially there, in terms of air pollution, water pollution, and ground pollution causing the health problems that many have expressed -- causing health problems that many have already expressed.

My main concern is that, if you're looking at increases across the country, which there have been in terms of health problems, increases are across the country, my concern is that, in areas where there are concentrations of facilities, concentrations of highways, concentrations of water and ground pollution, they are in communities of color and poor, working-class people. And I'm hoping that this kind of Committee can look a little further beyond what happens with health care because that's after the fact.

I'm looking at -- maybe we can start to look at the very beginning to why there is such a need for various kinds of health-care programs, various kinds of insurance needs. Maybe I'm looking for some sort of response, and hopefully, at some given time, to show that there is a major concern about

what I see, especially in communities of color and poor, working-class people, an epidemic on our children that's happening.

And I think that you ask any school nurse at any school especially -- and they will tell you that the increases have been immeasurable.

SENATOR SINAGRA: Thank you very much.

Dr. Rodgers.

**DENISE V. RODGERS, M.D.:** I'm Denise Rodgers. I'm the Associate Dean for Community Health at the Robert Wood Johnson Medical School, and I'm here today to address the issue of minority health in New Jersey.

Mr. Chairman and members of the Senate Health Committee, thank you for giving me this opportunity to speak with you about minority health issues in New Jersey.

Recent demographic trends clearly document the increasing diversity of our state. It is estimated that in ten years, by the year 2010, minorities will make up nearly 40 percent of the state's population, with over 30 percent of the population being Hispanic and African-American. These demographic trends speak to the urgent need for us to ensure that all segments of New Jersey's population are healthy and able to contribute fully to the state's economic growth and prosperity.

The World Health Organization defines health as, "a state of complete physical, emotional, and social well-being, and not merely the absence of disease." Unfortunately, we in health care and public health do a poor job of measuring well-being, and therefore, must use data on life

expectancy, disease incidence, death rates, and years of potential life lost as proxy measures of health, or the lack thereof, in our state.

Using data from the national and state Centers for Health Statistics, it becomes clear that many members of our one family with many faces are not doing as well as others. For example, the life expectancy for African-Americans in New Jersey is approximately eight years less than the life expectancy for whites. Hispanics are nearly three times more likely to be uninsured than whites in New Jersey. In this State, blacks die in disproportionately high numbers from heart disease, cancer, diabetes, stroke, homicide, asthma, unintentional injuries, HIV/AIDS, and infant mortality. These poorer health statistics are borne out when asking people about their health status. In 1996, 88 percent of whites reported being in good to excellent health, compared to 83 percent of Hispanics and only 77 percent of blacks.

It should be noted that efforts are being made to address disparity at both the Federal and State levels. The Department of Health and Senior Services, under the direction of Commissioner Christine Grant, has cosponsored two health summits looking at disparity in health status among African-Americans and Hispanics in New Jersey. The formal recommendations of the African-American Summit are now available, and the recommendations from the Latino Health Summit, which was held earlier this month, will be available shortly. While these summits are extremely important steps in addressing this problem, they are not enough. The enormity of the problem of disparity in our state will require significant efforts on the part of government, health-care organizations, health profession schools, and

community-based organizations. In order to further demonstrate the need for these efforts, I would ask you to look at some of the data in more detail.

Looking in more detail, we see that African-Americans are 24 percent more likely to die from heart disease than their white counterparts. Furthermore, blacks are more likely to die at a relatively young age from heart disease. Forty-two and a half percent of heart disease deaths in African-American men occurred in men less than 65 years of age, compared to only 18 percent of heart disease deaths in white men.

African-Americans are 24 percent more likely to die from cancers than their white counterparts. The recently released report on “Cancer Among Hispanics in New Jersey, 1990 to 1996,” shows that while Hispanics have overall lower cancer incidence and mortality, they are more likely to die from cancers of the cervix, liver, gallbladder, stomach, and multiple myeloma.

Hispanic women have a cervical cancer incidence that is 86 percent higher than the cervical cancer incidence in white women, and the cervical cancer mortality rate is 78 percent higher than in white women. The cervical cancer incidence and death rates are 112 percent and 173 percent higher in African-American women in New Jersey when compared to rates for white women.

African-Americans are less likely to get breast cancer, and more likely to die from it, than are white women.

While African-Americans are no more likely to smoke than whites in this State, the lung cancer death rate is 24 percent higher in blacks compared to whites.

In 1997, the prostate cancer incidence in white men was 145 per 100,000, compared to 225 per 100,000 in black men.

The death rate from diabetes in African-Americans is almost two and a half times greater than the diabetes death rate in whites.

Blacks have a 75 percent higher age-adjusted death rate from strokes than whites.

The age-adjusted death rate from asthma is over three and a half times greater in blacks than whites. Hispanics and blacks account for approximately 59 percent of hospital admissions for asthma, even though they only make up approximately 26 percent of the State's population.

The age-adjusted death rate for unintentional injuries is 63 percent higher in blacks compared to whites, and black men are 10 times more likely to die from homicide than white men in the State of New Jersey.

As we know from the Black Infant Better Survival Initiative sponsored by the Department of Health and Senior Services, black babies are nearly three times more likely to die in the first year of life than are white infants. Hispanic infants are also more likely to die in the first year of life than are white infants.

Finally, as we look at causes of excess mortality in minorities in New Jersey, particular attention must be paid to HIV/AIDS. New Jersey ranks No. 4 in the nation in persons living with HIV and AIDS. We also rank No. 4 in the nation in the number of women with AIDS, and in the number of pediatric AIDS cases.

The death rate from AIDS is 10 times higher in African-Americans compared to whites in New Jersey. Approximately three people in New Jersey die every day from AIDS. Approximately two of those three people are black.

AIDS is the third leading cause of death for African-American men and women. It is the eighth leading cause of death for white men, and the fifteenth leading cause of death for white women.

Forty percent of AIDS cases are directly related to injection drug use, a number that doesn't include heterosexuals who get infected by drug-using sexual partners.

Eighty-seven percent of the children with AIDS in New Jersey are black and Hispanic.

Clearly, this epidemic is having a devastating impact on the African-American and Latino communities in our state.

I'd like to now offer six specific recommendations, I believe this State can use to help eliminate disparity.

The elimination of racial, ethnic disparities in health status in the State of New Jersey will require access to high-quality health care for all residents of the State. New Jersey's uninsured population must be provided with coverage, which allows them to receive preventive and primary care, as well as emergency services. Any program of coverage for the uninsured should include reimbursement for cancer screenings such as mammograms, sigmoidoscopy, and Pap smears. Furthermore, subsidization for the cost of medications should be included to facilitate the management of chronic diseases such as diabetes, hypertension, and asthma. This will help to

minimize adverse outcomes for people with these problems and may ultimately reduce overall health spending in the State.

No. 2, legislative actions should be taken to strengthen the Department of Health and Senior Services, Office of Minority Health. This office should serve as a central repository for all state-funded programs related to minority health. Working in collaboration with other divisions within the Department of Health and Senior Services, the Office of Minority Health should provide consultation for the development of culturally appropriate public health interventions. The Office should also have the resources to develop an evaluation unit that looks at all state-funded minority health programs to assess their effectiveness and efficiency. Additionally, grant dollars should be allocated to the Office for distribution to CBOs, faith-based organizations, and other community groups to develop and implement community-based interventions to help address health disparities. Finally, the Office of Minority Health should be the statewide clearinghouse for all health data related to minorities.

No. 3, it is virtually impossible to deliver high-quality health care if language barriers exist between patients and providers. For this reason, all health insurers, including Medicaid, should reimburse health-care providers for the cost of providing medical interpretation in settings in which 20 percent or more of the patients are monolingual in one specific language.

No. 4, accurate data collection by race and ethnicity should be required for all hospitals, federally qualified health centers, managed care organizations, and funeral homes. This should include data on diagnosis, outcome, access to tertiary care, and patient satisfaction survey data. Data

should be specific enough to capture information about all of the state's major racial and ethnic groups.

No. 5, Cultural competency training should be required for all health profession students and practicing health professionals in the state. Nationally recognized resources such as The Center for Healthy Families and Cultural Diversity at the Robert Wood Johnson Medical School and the Institute for Transcultural Nursing at Kean University should provide consultation in developing statewide standards in cultural competency for all health professionals.

And finally, No. 6, health policy research must be done to look at the potential benefits of drug treatment on demand and harm reduction strategies, including needle exchange, in reducing AIDS transmission in this State.

Thank you.

SENATOR SINAGRA: Thank you, Doctor.

Is Daniel Santo Pietro here?

**DANIEL SANTO PIETRO:** Chairman Sinagra and members of the Committee, we thank you for hearing us today.

I'm representing the Hispanic Directors Association, but I'm also-- My name is Daniel Santo Pietro, Executive Director -- but I'm also a member of the Latino Health Advisory Committee convened by Commissioner Christine Grant, and an organizer of the Latino Health Summit that the Department of Health and Senior Services carried out on June 2nd and 3rd at UMDNJ's Robert Wood Johnson Medical School.

And I have with me Valerie Esposito, a family worker, a frontline worker in one of our agencies, the Puerto Rican Action Board here in New Brunswick, and Maggie Kennelly that -- we would like to make a few comments in terms of her personal experiences with the -- dealing with health issues.

Our Association brings together 27 community-based organizations, organized by the Hispanic community throughout the state. We easily impact probably more than 1 million Hispanics in the sense that our agencies do bring together volunteers and boards and work throughout our communities. Nearly all of our agencies carry out health education. One member, Cura, is probably the premier agency in the area of substance abuse prevention. Two agencies in -- North Hudson's Community Action and FOCUS, who in collaboration with the New Jersey Medical School operate important community health centers. Another member, Proceed, recently expanded its contract with the Center for Disease Control to train community-based organizations throughout the entire country in HIV/AIDS prevention. It's this expertise that we bring to the table, and all of it is the initiative of the Hispanic community.

The Latino Health Summit, you heard Dr. Rodgers speaking to it, represented nearly a year's work of the volunteers in the Latino Health Advisory Committee. Our goal is simply to eliminate the health disparities that afflict our community. I've attached, here, some of the information prepared for the summit in regard to disparities. You heard a number of examples from Dr. Rodgers, but it will give you a good overview of what we're dealing with.

Four of our agency directors, key UMDNJ staff, two Latino medical doctors, the Hispanic Nurses Association, and several other Latino health leaders participate in the advisory committee. The Summit brought together about 300 key health providers, state and private sector health decision makers, and community leaders. And basically, I think we can say the Summit ratified a lot of our concerns, and basically that we -- the committee was already working with. The official report will be ready in September, but I'd like to share with you just a few of the recommendations that resonated most with me during the Summit.

Effective outreach was a constant theme of the Summit. The Latino community cannot eliminate disparities if we do not have the information and real communication with all parts of our community. Effective outreach means using culturally appropriate messages, vehicles to communicate and motivate Latinos to action. There are many facets to the solution to this problem, ranging from the inclusion of more Latinos in health policy bodies, including local health boards and State Health Commissions, and the forging of a real partnership between Latino community organizations, health providers, and State programs. We have to learn the lesson from KidCare and not take outreach for granted. There must be resources allocated that combines media messages and local community action to reach everyone in the community.

Secondly, the cultural competency in our health delivery system must be a given. UMDNJ and the Hospital Association need to take leadership and establish formal task forces, so that all health providers can gear

up their services to their fastest growing customer base. I think Dr. Rodgers's testimony, again, brought that point well.

There's a lot of discussion about how to increase bilingual health professionals and to at least make competent, trained translators available. UMDNJ, during a summit, agreed to set up a task force and study how to resolve this problem. Before the summit, our committee conducted 12 focus groups of Latinos throughout the state. Consistently, Latinos felt their access to health care was seriously impaired by the lack of staff who could communicate in their language and understand their health needs. Nowhere is this more evident than mental health services and substance abuse counseling.

Clearly, you can't do counseling unless you're speaking in the language the person is most comfortable in using. The lack of Spanish speaking counselors to meet the demand is leaving a substantial portion of New Jersey's Latinos without access to counseling services. The thousands of foreign trained health professionals who need assistance to get certified is an obvious pool that could alleviate the present crisis, and do not doubt that it is a crisis.

New Jersey, in essence, has to do more to enforce Title VI of the Civil Rights Act, because as we see it, what's happening today is a violation of the law.

The increase in the number of uninsured in New Jersey, even as we have approached full employment, should open our eyes to impossibility of universal coverage through private insurance. The State has to redouble its public insurance efforts. It has to pass family health care immediately. The program's target of 125,000 is unfortunately inadequate to deal with the

minimum of 300,000 to 400,000 eligible adults that the Urban Institute's recent study indicated needed insurance in New Jersey. Once again, without adequate outreach, Latinos will be the largest segment that will not benefit from this program. Other initiatives are needed, such as support for FQHCs and other community-based health centers to fill the gaps in health care, including all legal immigrants and the undocumented.

We need to restore, restructure actually, minority health within the Department of Health and Senior Services and give it real resources to support community-based health initiatives. The present Commission needs modification to achieve its goals. It must incorporate the success of the Latino Health Advisory Committee to its structure. And most important, the Senate Health Committee has to prepare legislation as soon as possible to assign real resources to the Office of Minority Health. At a minimum, this Office should have a fund of \$1 million to fund community-based initiatives to deal with the problems we've described. Until we activate our community to demonstrate change from below, I fear we'll see very little change at higher levels.

The Department of Health and Senior Services has been woefully inadequate in directing its resources to minority health needs. Even funding directed to Latino needs often goes to health institutions that have little track record and competency in working with our community. And it's time that we recognize that public health must include everyone, and it really starts at the grassroots efforts.

And at this point, I want to commend Commissioner Grant, incidentally, for the work that she has done because she has opened the doors

and taken some of the initiatives that we felt have been needed for a long time, and we are at least moving in the right direction.

But in closing, I want you to take a look, hopefully, carefully at the resources that we need to meet this crisis. I urge this Committee to dedicate all the tobacco -- to urge that -- ask that all the tobacco settlement fund be used to expand the quality and quantity of health care. It's logical and less cumbersome funding that would allow the State to take creative initiatives to resolve many of the challenges I have described. School reconstruction is an obligation this State must meet, but not at the cost of basic health needs of families.

I assure you the HDANJ and our committee will continue to work with Commissioner Grant to develop our ideas -- I believe we'll even arrive at specific ideas for legislation -- and we look forward to sharing them with you as we move ahead. And I hope we can all take heart in the Governor's words at the Health Summit when she said, "Reducing disparities is important because our family can't realize its full potential as long as some of us are left behind and families solve problems juntos," as she put it, meaning, together, "That way, we can all enjoy New Jersey's bounty."

I want to thank you for the time, and if you can bear with me and just take a few more minutes here, I'd like you to hear from Valerie and Maggie, in terms of giving you an even more concrete idea of what we're going through.

**VALERIE ESPOSITO:** Hello, my name is Valerie Esposito, and I work here in New Brunswick at the Puerto Rican Action Board. We provide social services to many other communities.

I work specifically at the preschool that we have, and since New Brunswick is an *Abbott* district, we service low-income families. And I have seen a variety of incidents where families do not have access to health care at all.

And one specific example I can think of is a little girl-- One of our students came to school and she had a rash on her body. And according to the regulations of the Board of Education, we had to call the mother and have her pick her up to make sure that she wasn't contagious to the other students.

The mother did not have health care and she had been to the clinics in the town and she still owed them money. And so she could not take her child back to the clinics because she owed them money, and she didn't have the money to pay for it and they wouldn't see her until she had settled her debts.

So the girl is still not able to be accepted back to school without a written note from the doctor explaining that she's okay to be in school, and thus she is being denied of her rights to education because of the lack of health care that her family has.

And that's just one of many examples. We also have a lot of problems -- the parents face a lot of barriers because of the language. And they can't have proper service because they can't communicate themselves -- communicate with the health-care providers.

I'll pass you over to Margaret. She will tell you her situation.

MR. SANTO PIETRO: And I would point out, Margaret is not a Latino, but I think she exemplifies many of the issues that immigrants are facing in this country. So we were delighted to have her come and talk.

**MARGARET KENNELLY:** Hi, my name is Maggie Kennelly.

I've been in the country for 31 years. I'm from Ireland. I am not a citizen and I don't have health care right now, and my problem started in April of this year.

I had a heart attack. I was hospitalized for seven days, and they found three blockages, which means I have to go in for open-heart surgery. And I've gone to social services to see if I can get Medicaid. It was denied, and actually, a girl from the Puerto Rican Action Board has been helping me with social services. But it's like, when you don't have health care, you fall through the cracks. And Saint Peter's was very good. They had given me the Charity Care when I was there. So now, when I get out of the hospital after I have the operation, I have to have certain medications, but I will need Medicaid for that. So that's still up in the air with social services. And they want you to become a citizen before they give you anything.

So I've gotten somebody to pay for my citizenship, and now I'm waiting to hear from them on that.

I don't know what else I can add.

**MR. SANTO PIETRO:** Just to finish the point, I think the level of confusion that exists in our immigrant community for her to be told this is basically the issue that we're dealing with. Imagine when you don't speak the language, and you don't have the ability to communicate what happens to you.

So we want to thank you very much for your time, and we're delighted to have had this opportunity to welcome you to New Brunswick. We hope to see you back again.

**SENATOR SINAGRA:** Thank you.

Dr. Riscalla.

**LOUISE RISCALLA, Ph.D.:** I've been in the health-care field for over 30 years, and I was on the staff of county and state facilities. However, I'm here because I'm the consumer as well as the provider.

I'm speaking only for myself, although I am involved with a number of organizations. I'm here because I care.

It appears that insurance companies control health care. So, as a consequence, clerical and other nonmedical personnel are apparently making decisions. It seems that insurance companies could be practicing medicine without a license, and it should be subject to legal action. Although insurance companies may employ physicians and other medical personnel, it appears that their role is to carry out company policies. When I am ill, I want my physician to make decisions with me regarding my health care. I don't want to have clerical personnel or physicians hired by the company to evaluate my condition on paper. I'm a human being, and I would like to be evaluated in the context of my uniqueness and my condition.

A physician may not have enough time to be with patients because of the need to have a high volume practice in order to make a living and to pay for clerical personnel to take care of billing or pay for a billing service, handle insurance issues, schedule appointments and make referrals, check the patients in and office nursing staff. Physicians also need time for patient care duties such as reviewing records, phone calls, documentation, reading diagnostic reports, correspondence, and family conferences which are often not compensated. Some physicians have told me that they are forced to practice assembly line medicine and fear making mistakes.

Diagnosis and treatment have been delayed because patients who had diagnostic tests done in a physician's office are referred elsewhere because of contractual restrictions. For example, I was told that I could no longer have X rays done in my doctor's office because the insurance company won't pay for them. I now have to go to another town, which is inconvenient, time consuming, and delays my report, and consequently, my treatment could be held up because of it.

Medicare does not cover the cost of hearing aids, and it seems that most insurance plans do not have hearing aid coverage. The National Academy on an Aging Society reported that four out of five people with hearing loss do not use a hearing aid and that "untreated hearing impairments cost the U.S. economy \$56 billion in lost productivity, special education, and medical care each year." There are other items in addition to hearing aids not covered by managed care which are necessary for health, safety, and quality of life, such as eyeglasses, diapers for incontinence, canes, crutches, orthotics, and other items ordered by a physician. Individuals on fixed incomes or low incomes may be forced to do without because they cannot afford things which are not covered by their insurance, yet are ordered by their physician.

I wear a hearing aid myself, and it's very costly to have a hearing -- not only a hearing evaluation, but to have the hearing aids replaced. A hearing aid is essential for the quality of my life, for my occupation, and for other things, and I can just picture how difficult it is for other individuals who need these hearing aids, but can't get them because they can't afford to pay for them. It's essential. And that's just one example. There are other items that should be covered but aren't.

Some managed care plans provide prescription drugs and have a rigid adherence to a limited formulary which can deprive a patient of medication necessary for effective treatment. A physician who is legally responsible for the patient should be able to prescribe whatever medication the physician believes is necessary.

Health Maintenance Organizations, Preferred Provider Organizations, and Point of Service are part of a health-care industry with the purpose of making a profit for shareholders. Managed care limits patient care with the intent of cost containment for the health-care industry. I really feel that an exploration of the feasibility of terminating managed care should be considered.

I don't have any answers. I don't have too many recommendations, but I do know that a doctor should tell me and should be able to decide what I need, and I don't want to have to deal with another bureaucracy, because health care has a tremendous bureaucracy. And I think that that jacks up the cost of health care.

I had another experience, not too long ago, when I got these forms back, telling me what the insurance covers and what it doesn't. Very often, I have spent hours on the phone trying to get through to someone to question what all these things mean. Or I would get a bill from a doctor and I would call up the insurance company to find out whether I'm covered or not covered. All this is time consuming and costly, and I think that one has to take a look at the overall picture and see that, perhaps, we're robotizing people, that we're treating them en masse, that we've lost our sense of individuality and that we've also lost the doctor-patient relationship. Medicine can no longer be

mechanized. And I think that's what has happened here. And I would hope that it can get back to some form of consideration, as the individual as a whole, and that the doctor as a whole, too, in the interaction.

And consider the fact that hospitals are being closed when people may need long-term care or may need longer hospitalization. That's all done by insurance companies who are determining the type of care that is being given.

I think that this type of practice needs to be stopped.

SENATOR SINAGRA: Thank you, Doctor.

Ed Ludwig.

I think, Ed, you were here once before?

**EDWARD LUDWIG:** Yes, briefly.

I just want to bring you a quick update.

Mr. Chairman, my name is Ed Ludwig. I'm the Practice Administration for a large medical practice here in New Brunswick, and past President of the New Jersey Medical Group Management Association.

I'd like to bring you up to date on some of the changes that have happened since we last appeared before the Committee.

In our particular office, we send claims electronically and on paper. We try to do as much electronically as possible; however, we're hindered by the fact that the insurance companies require that we have written authorizations and documentation. We're submitting claims now to insurance companies daily. Recently-- I live in Bergen County, and recently I sent a package to myself in a carrier up there, TPA, and the package took two days to get to my house and two weeks, supposedly, to get to their office.

We're still running into problems of the claims being held up, being sent around--

SENATOR MATHEUSSEN: Insurance companies -- they just don't get the good kind of mail service that we--

SENATOR SINAGRA: Well, because the mail carriers are covered by the HMOs. (laughter)

MR. LUDWIG: Yeah, I think so.

Carriers and TPAs that are using computer programs are now automatically downcoding the E and M procedural codes. This forces the provider then to send more documentation to justify the original code.

I was personally informed recently by a rep from one of the insurance companies that all the codes that go to their company are automatically downcoded one level. If the doctor wants it to be upgraded, submit documentation. We're forced again to submit constant documentation to these insurance companies. Since the carrier is now -- basically are notifying us in -- a lot of them are notifying us within 30 days of problems they're receiving with claims -- supposedly clean claims. They're doing this usually on the 26th, 29th day, so they get an additional 30 days to carry out the process. Usually, we'll provide information two to three times before a carrier will respond. Then, of course, after the 60 or 90 days, they notify us that it's too late to respond because we've passed the time limit.

Another problem we're having also are the carriers now are going back two to three years and saying that the payments they made -- they don't feel were right, and they want their money back. We've had this happen in a

number of cases, and they just take the money out of the next check. Then we're forced to go back and again try to get the money back.

The last issue I'd like to discuss is the release of patient records. When the physicians are discussing patient records and confidentially issues of marital problems, social problems, whatever the case may be, those records should be maintained between the patient and the physician. We're finding that the physicians are finding that when they submit the claims -- if they don't submit the documentation the insurance companies want, they are downcoded one level. So they're forced to look at an issue of whether they should be -- submit the records and get paid for the level they should be paid for, or just let it sit and eat the difference. Most of the physicians will not release the information, and therefore, get less pay.

I'm just going to give you an idea of some of the examples of the carriers that continue to manipulate the system and interfere with the running of the medical practices.

My office originally -- right now has four people in support just for the insurance aspect, and we're looking at a fifth person. This is primarily responsible from the insurance companies because of the amount of paperwork and phone calls that are needed. We are forced to send 1500 claims because of the paper process involved by certain carriers and the documentation issues. The carrier should be compelled to adhere to electronic reconciliation and claims processing, if at all possible.

Again, we'd like to thank you for appearing today, and if you have any questions, feel free.

SENATOR SINAGRA: The only question is, what could we possibly do in the form of -- what would be our job, legislatively, or part of this package that would stop an insurance company from having a pattern of downgrading?

That would be a very difficult thing for us to do, wouldn't it?

MR. LUDWIG: I think if they know that there's some teeth in the law, that will have to give justification for those downcodes, not just because of a computer program that just haphazardly reduces claims. That's wrong. It's ethically and morally wrong.

If a person provides the services they provide, I have no problem justifying that service, but not justified before we get paid, and that is what's happening. They're causing undue paperwork, and it's just becoming horrendous in a medical practice.

SENATOR SINAGRA: Okay, thank you.

MR. LUDWIG: Thank you.

SENATOR SINAGRA: According to my records, we are at the -- Elizabeth Shea, okay.

You're the last -- is there anybody who signed up that I have not called on? (no response)

Elizabeth, you have the incredible responsibility of being the last person to testify, which means the only thing that stands between me and lunch and the men's room is you. (laughter)

**ELIZABETH SHEA:** Don't worry--

SENATOR SINAGRA: I'm just teasing.

MS. SHEA: --I won't be long, if for no other reason than my mouth will freeze shut in this room.

SENATOR MATHEUSSEN: Nancy wants to testify?

SENATOR SINAGRA: She did not sign up.

SENATOR MATHEUSSEN: Nancy's out of here. (laughter)

SENATOR SINAGRA: Eleanor must have ripped it up. (laughter)

MS. SHEA: Good morning. My name is Elizabeth Shea. I'm here on behalf of Covenant House New Jersey, which is the state's largest nonprofit organization serving homeless youth between the ages of 16 and 21.

I am here, primarily, to urge your support of the FamilyCare Health Reform Initiative. And I want to bring a particular issue to your attention, which is addressed by the FamilyCare proposal but seems to be a little known provision of the initiative.

Under current State law, a childless youth aging out of the foster care system can only receive Medicaid coverage if they are disabled, pregnant or meet the low-income and resource test for what's called Medicaid Special. Under Medicaid Special, a single person cannot earn more than \$185 per month. Although there are some disregards available, \$185 per month is only 27 percent of the poverty level for a family of one. The FamilyCare Initiative takes advantage of the new Federal Foster Care and Independence Act, which was just recently passed, which would allow states to receive up to 50 percent Federal matching funds to provide Medicaid coverage to 18- to 21-year-olds, former foster children, without regard to their income or resources.

We believe that this is sound public policy because it encourages young people to work full time and establish themselves in the labor force.

The current conditions for coverages, pregnancy, disability, or meager earnings send the wrong signal to New Jersey's children about what we value. By encouraging former foster youth to work full time without penalty, the proposal affirms the innate dignity of labor.

Many of the homeless and runaway youth that we serve at Covenant House are aged-out foster care youth. For most of them, the State, through DYFS, has served as their parent for several years, if not all or most of their life. At 18, if they haven't been placed or adopted, their case is generally closed, and they're out on their own. Most of them then need at least two years, if not three to transition successfully into independent or adult living, whether that means getting their -- finish getting their GED, getting other educational or vocational skills, saving money for an apartment, whatever it is.

During that time under current law they usually have to choose between health coverage and working. Most, for obvious reasons, choose to work. It is particularly frustrating to have to tell a young person with a serious medical problem that they are better off if they don't work, even if they are perfectly capable of work, and want to work, but currently there is a disincentive to work for youth who need regular medical care. And I want to just give you an example of this. One of our clients was supposed to be here today to testify, however, couldn't get out of work, so I just want to read you an excerpt from his testimony.

Good afternoon, my name is Cornell Warren. I am a graduate of the foster care system, and I'm here to speak about my personal struggle for health insurance.

I was in foster care since I was five years old, in and out of group homes and different foster families. When I turned 18, my foster care case had been closed, and I was on my own. That same month it seemed like I started needing to use the restroom every three minutes and having to drink water every minute after that. I went to my personal doctor, who had treated me for years, to find out what was wrong, and I was diagnosed with diabetes.

Here I am, 18 years old. I have a security job that pays \$8.50 an hour. My foster care case has just been closed, and now I am diagnosed with diabetes. No more sweets or fried foods--

This particularly upset him, it really did.

--and I had to go on an immediate diet. But the bad thing was -- the worst thing was, at the end of my doctor visit I found out that my Medicaid was cut off and I had no more health insurance.

Since that time, I have applied twice for Medicaid, and each time I was denied because they believe I have a job that makes too much money at \$8.50 an hour. However, I never got health insurance with my job and have had to use the free clinic to treat my diabetes over the last couple of years.

There have been many specialists who I have not been able to see, and many testing machines I have not been able to purchase during that time because I've been without health insurance.

I just want to add that Cornell showed me -- he has to purchase a vial of insulin that's about this (indicating) big every four days, and it cost him \$35 every four days to purchase it, and obviously out of somebody's paycheck who, you know, makes \$8.50 an hour working full time. Every four days,

spending \$35 on insulin is a lot of money, and is enough to make or break his opportunity to save for an apartment or pursue education or whatever.

In conclusion, we vigorously support the FamilyCare Health Reform Initiative and urge your adoption of this or similar reform measures, as well as, we support the use of tobacco funds for this particular bill, and in particular, because many of the young people who will qualify for coverage were targeted initially by the cigarette industry.

If you have any questions, I'd be happy to answer them. Otherwise, thank you for the opportunity to speak.

SENATOR SINAGRA: Thank you very much.

Nancy, you're up -- now you have the responsibility. (laughter)

**NANCY PINKIN:** If I can warm myself up enough to speak.

SENATOR SINAGRA: You jumped up here before with testimony, didn't you? What happen then? (laughter)

MS. PINKIN: I'm going to be speaking on behalf of the New Jersey Primary Care Association, the Federally Qualified Health Centers, and actually, I think a number of people gave testimony on behalf of me today just through their comments.

The Health Centers, as I think all of you on the Committee know, are struggling to provide care and the fact that -- I'll try to just paraphrase my testimony -- the fact that the number of uninsured are growing are having a dramatic impact on their ability to keep up with that service.

For the second year in a row, the uninsured have outgrown the number of Medicaid being treated in the Health Centers. In 1997, they were

-- the number of uninsured was 61,000, and this is just New Jersey. And just going to the Health Centers, that number is now 78,000.

The Health Centers, I think, as most of you know, get funding -- partial funding from the .53, and that is not -- it was \$8.8 million when it was first put into place, which was 1991, and that number hasn't changed; it still remains the same even though the numbers of patients receiving care there are dramatically increasing.

And I have some data on these statistics. Nationwide, 43 million Americans, or 18 percent of the population, have no insurance. In New Jersey, 1.3 million are uninsured. Based on a Department of Health study in '97, 33 percent of those patients, 19 to 24, had no health insurance coverage followed by 25- to 34-year-olds, with 20 percent who had no insurance.

As far as the minority population, 36 percent were Hispanic with no health insurance, 22 percent of the black non-Hispanic population had no coverage compared to 14.1 percent of the whites.

In addition, the Health Centers are struggling with all of the health-care issues. You heard people mention today whether it's dealing with cultural competency, dealing with trying to provide interpreters under a tightening financial budget. The amount of AIDS is increasing dramatically, which is the cost -- I think most people know the cost for AIDS care is very, very expensive. Infant mortality is still a problem. Dental is another big issue. There is virtually no dental specialty care available to the Medicaid or the uninsured population. There were only two endodontists in the entire state that accepted Medicaid and three prosthodontists who accept Medicaid in the state.

Three counties currently have no dentists who will accept Medicaid and, you know, it's just a growing problem. So basically, the problem that the Health Centers are having are the problem of staying afloat. Dealing with that -- funding that has not been increased since 1991, the Medicaid rates are having a dramatic impact. When we had a meeting with Medicaid the other day, we said the last time that Medicaid was increased, it was 10 years ago, they themselves said that was a minor adjustment, that it really hadn't been increased in 30 years. Now, how we can deal with that Medicaid that hasn't been adjusted in 30 years is a real problem.

SENATOR SINAGRA: We're trying.

MS. PINKIN: So basically, we support the increase in the Medicaid rate. We'd like to see that cap get up from the 1991 \$8 million fund that we get from the Department of Health.

We do -- we would like to go back to your legislation on the tobacco funding that did provide some money for the Federally Qualified Health Centers.

SENATOR SINAGRA: So would I.

MS. PINKIN: Yes, that is really important to us. And we also support KidCare and FamilyCare.

Do you have any questions?

SENATOR SINAGRA: What are you wearing, Janice?

UNIDENTIFIED SPEAKER FROM AUDIENCE: I found a shawl in my car. I'm freezing.

SENATOR SINAGRA: Is it that cold out there? (laughter)

UNIDENTIFIED SPEAKER FROM AUDIENCE: Yes.

MS. PINKIN: I know. It's so cold I can barely talk.

SENATOR SINAGRA: Well, we have to wear our jackets. It's the rules. (laughter)

MS. PINKIN: But on that note we can go out and warm up.

SENATOR SINAGRA: I don't think it's that warm out today.

MS. PINKIN: Well, it's freezing in here.

SENATOR SINAGRA: I want to thank the Committee, especially the Committee Aides and staff, for traveling all over the State with me on these hearings. Certainly, to Senator Matheussen, who has come to every meeting all across this State. I thank all of you, and I'll see you all in Trenton, probably, next week.

Thanks.

**(MEETING CONCLUDED)**