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# ***Public Meeting***

of

## SENATE HEALTH COMMITTEE

*“Public meeting on the affordability and  
accessibility of health insurance for residents of the state”*

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

**DATE:** February 23, 2000  
2:00 p.m.

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

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



### **ALSO PRESENT:**

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

Laurine Purola  
*Senate Majority  
Committee Aide*

Freida J. Phillips  
*Senate Democratic  
Committee Aide*

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

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## TABLE OF CONTENTS

	<u>Page</u>
Senate President Donald T. DiFrancesco District 22	1
Hank Meisner Director Government Affairs Horizon Blue Cross Blue Shield	15
Dennis Marco Vice President External Affairs, and Corporate Communications Horizon Blue Cross Blue Shield	16
John J. Lynch Vice President, and Chief Actuary Horizon Blue Cross Blue Shield	19
David Norcross, Esq. Counsel Blank, Rome, Comisky, and McCauley Representing Aetna U.S. Healthcare New Jersey	29
Frank G. McCauley General Manager Aetna U.S. Healthcare	29
Jay A. Krakovitz, M.D. Mid-Atlantic Regional Medical Director Aetna U.S. Healthcare	35
Richard J. Gilfillan, M.D. Senior Vice President, and General Manager AmeriHealth HMO of New Jersey, Inc.	55

## **TABLE OF CONTENTS (continued)**

	<b><u>Page</u></b>
Wardell Sanders Executive Director New Jersey Individual Health Coverage Program	70

### **APPENDIX:**

Testimony submitted by Frank G. McCauley, and Jay A. Krakovitz, M.D.	1x
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**SENATOR JACK G. SINAGRA (Chairman):** Today is the first in a series of hearings we're going to have on health care. And we're very honored today to have the Senate President here to testify before the Committee.

With that, Mr. President.

**SENATE PRESIDENT DONALD T. DiFRANCESCO:**

Is that it?

SENATOR SINAGRA: That's it.

PRESIDENT DiFRANCESCO: Could you turn this on, Jack?  
(referring to PA microphone)

SENATOR SINAGRA: The red light means on.

PRESIDENT DiFRANCESCO: It's not on. They're not on. I think you control it. Don't you control it?

SENATOR SINAGRA: Go ahead. Is it on?

Never mind.

MS. SEEL (Committee Aide): Is it on?

PRESIDENT DiFRANCESCO: No.

SENATOR SINAGRA: Is it on now?

PRESIDENT DiFRANCESCO: No.

MS. SEEL: The other ones are all working.

SENATOR SINAGRA: They're trying to get an increase in the budget for equipment. (laughter)

PRESIDENT DiFRANCESCO: It's a beautiful room.

Well, you'll hear me anyway. They just won't hear me, right?

SENATOR SINAGRA: Wait one second.

Don, you're just going to have to try to speak loudly.

PRESIDENT DiFRANCESCO: As long as you guys hear me it's all right.

SENATOR SINAGRA: We've had this problem once before, Don. Don, the minority has offered a seat over here.

PRESIDENT DiFRANCESCO: Okay.

Now, what did you say before, just start?

SENATOR SINAGRA: Just start.

PRESIDENT DiFRANCESCO: Okay. Thank you.

I want to thank you, Senator Sinagra and, obviously, Senator Vitale and Senator Matheussen and Senator Singer and Bassano for being here on a day that -- well I won't say we normally aren't here, but a nonsession day and certainly not a committee day, because we felt, as you felt, that this is an important area of the law that we're addressing and important to everyone in this state. And so I wanted to do something that perhaps I don't usually do. From time to time I do testify, but I don't usually get in the way of the committee action. But in this case, because I had asked you really, in concert with discussions we had had about this -- about the health-care issue or situation, I thought I should make a statement, to some degree, charging the Committee in a way that I feel you should be charged, and then you can take it from there.

So I'd like you to consider this particular fact to begin with. And that is that the largest purchase the average American family will make in their lifetime isn't a home any longer. It's health care. So is it any wonder that a recent Eagleton poll -- 68 percent of New Jersey residents thought health care

was going to become less affordable in the future. So we all know the story. In fact, we've either lived the story or we've heard the stories of our constituents -- the thousands of our citizens who have shared with us their concerns, their complaints, and in many cases, their catastrophes in dealing with modern health care. So that's why we're here today.

New Jersey's health-care system, we believe, is in need of emergency treatment, and we think this Legislature, this Committee, should intervene.

I want to thank you again, Jack, and all the members of your Committee for sharing my sense of urgency and for being willing to undertake a series of hearings that will examine the state of health care in the Garden State.

Now, I think this is a huge undertaking complicated by the simple fact that public policy and health care are contradictory in their objectives. Practitioners seek to provide care that is in the best interest of the individual patient regardless of the cost, while managed care seeks to contain costs.

So at the intersection of these differing perspectives is perhaps where we will find, hopefully, the essence of health-care reform, a nexus where affordability and accessibility are achieved while delivering the best possible health-care system in the world.

Now, we've identified our goal there, and now we have to find a way to reach it. There are countless pieces that comprise this state's health-care system. So for the purposes of these hearings, I would ask you to examine the system in four broad topical areas: The first one being health insurance,

more precisely, keeping it affordable and accessible. How can we continue to promote the highest quality health care at prices New Jerseyans can afford?

The second issue is the condition of our hospitals. We need to give them the tools they need to be financially competitive while delivering the quality care that New Jerseyans have come to rely upon.

The third area concerns provider issues. We need to empower physicians and other providers to be the primary medical decision makers for patients.

And the fourth area involves ensuring quality health care for every segment of our diverse community, from seniors to children to the minority population.

Now, you're certain to hear from a number of experts and interested parties as to problems and solutions, and their input will be invaluable to our final analysis and response and, in fact, is required.

But I would, however, like to begin these hearings by offering a few suggested points of discussion as well. On health insurance, I would ask the Committee to examine how the State can encourage more private associations to self-insure, promote greater variety in health benefit plans, and expand the use of medical savings accounts. I think it's also critical that you give serious consideration to the law governing HMOs in New Jersey, which dates back to the early 1970s.

Now, some people might suggest shifting the decision of determining medical necessity from HMOs to patients and their physicians. Some people might want to put on the table the right to sue HMOs. You will need to consider the feasibility of both. But most important, I would ask you

to take another look at our Health Care Quality Act -- I know, Senator Sinagra, you're quite familiar with that -- this state's Patients' Bill of Rights, to see if it's truly providing the adequate protection that we had hoped. And in light of HMO insolvencies, the Committee should review the State's ability and authority in scrutinizing the operations and the financial position of HMOs.

No reform of our health-care system is possible without addressing fundamental problems in the hospital system. Now for example, in any given day, 30 percent of the State's 30,000 beds are empty, and our hospitals have the highest length of stay for Medicare patients. And while the financial performance of many hospitals has improved, New Jersey hospitals have a higher level of debt and lower level of cash than the national average.

So how do we promote better use of beds, space, and staff, and the development of cost accounting systems? How do we assist them in streamlining their accounting procedures and providing them with more flexibility in billing? You need to explore these ideas to help hospitals do their job better, such as increasing Medicaid reimbursement rates. And we have to help them be more efficient.

Now, of course, New Jersey physicians have a number of concerns that also need to be examined, with priority given to the question of Medicaid reimbursement. The reimbursement rate has been unchanged for a long time. A revision of Medicaid fees should be discussed for physicians, as well as hospitals.

Another issue is a measure to be introduced on February 28 by Senator Martha Bark. Senator Bark's bill would authorize our Attorney General to permit providers to join together to negotiate medical quality of

care issues and provider reimbursement rates with an insurer that has market dominance in a geographic area. I support this concept and will be assigning this bill to this Committee for your consideration of its merits.

Now, for our senior population, quality health care is often dependent on a daily regimen of prescription medications. Unfortunately, of course, the greatest annual increase in the cost of these medications, 22 percent this year alone, has been in the medications most often used by seniors, of course. It's an issue that the Federal government is looking at, but I would also ask this Committee to make helping seniors our priority concern this spring.

For the minority population -- for the minority community, evidence has shown that there is a significant disparity between the quality of their overall health care compared to the rest of our state's population. True health-care reform can't be achieved unless we begin to meet the needs of New Jersey's diverse communities.

Now, the key to this issue may be found within the State's Office of Minority Health, an office that I think you should consider expanding or funding at a higher level.

Finally, the future of health care, I think, is right here, right here in New Jersey. As the leading center of pharmaceutical and biomedical research, we're at the forefront of tomorrow's medical and technological breakthroughs. To the extent that we, the Legislature, can create opportunities or incentives to promote this research, we should, and we will. For all our efforts in the State House -- for all our efforts -- the answer to better health will ultimately be found in the lab.

New Jersey can be proud, I think, of its record on health care, including such landmark initiatives as hospital deregulation, guaranteed access to insurance coverage, KidCare, and the Health Care Quality Act.

But with lives literally hanging in the balance, we can't afford to say that our job is done. It is not done, nor will it be, until we begin to leverage the successes we have achieved and remedy the failings we know exist in our health-care system.

So I want to thank you in advance for your efforts and for your time and look forward to this Committee's recommendations.

Thank you very much, Senator.

SENATOR SINAGRA: Thank you, Mr. President.

Does anyone have any questions or comments?

SENATOR CODEY: I do.

PRESIDENT DiFRANCESCO: Senator Codey.

SENATOR CODEY: Good afternoon, Mr. President.

I was a little late. I was laying up at Saks Fifth Avenue. That's an inside joke.

Donnie, you mentioned, while I was here, prescription drugs, and I couldn't agree with you more. And of course, you or I and the rest of our colleagues here are -- live in a state where we enjoy the fact that most of the major pharmaceutical houses headquarter here. And there's literally tens and tens of thousands of their employees who live within our state, which is great, but at the same time, I look at the PAAD program-- What happens in another couple years with the inflation rate of drugs? Where are we going to get the money to continue the senior citizens in New Jersey who are on those

programs? And at the rate we're going, in about another five years, whether you're a governor or somebody else that may come to the Legislature and say, "What do we do here," we cannot sustain it any longer.

That's a major problem, and I think the pharmaceutical houses have to work with us and understand that this is a big, big problem. And I know, back in 1992, when Clinton was first elected, he was talking about this issue, and I think the houses got a little concerned, so they more or less put a freeze on their prices. And then once that threat went away, the inflationary rate has obviously crept back in.

And I'm concerned, and I see it in my own line of business. I think within the health system, we have done as much as we possibly can to cut prices. And years ago, it was a straight line, in terms of inflation. But I think, now that we've taken as much waste out of the system as we can, the old spiral of inflation is back to us where a 10 or a 15 percent increase for a large group is not so bad. And that's what happened back in the mid and late '80s and why we did so many things that we did, in terms of HMOs and negotiating contracts with hospitals and the like. So you're right on that.

I'm happy you mentioned the Office of Minority Health. I created it. So any more money you want to give there-- But I would also say, and I had a brief conversation with Freida, it's more than just minority. The difference and the disparity between what's available and the quality of health services for rich and poor is very, very -- the gap widens, I think, every day. And for those people who don't have access to doctors or don't have health plans, even though they might work, that gap, I think, continues to widen each

year here in the State of New Jersey. I hope that we certainly can do something about that.

So regardless of whether you're poor or whether you're rich, whether you have a health plan or not, some way, medical care can be equalized for all New Jerseyans, as well as, hopefully, for all Americans.

But I welcome your testimony because I agree with it.

SENATOR SINAGRA: Senator Singer.

SENATOR SINGER: Thank you, Jack.

Just briefly, Mr. President, just two things.

First of all, one issue I think we have to also -- is long-term care insurance as well as nursing home situations in general for the senior population.

We haven't moved forward enough with long-term care insurance. It's problematic. We truly have a problem with that, whether it's moving people to assisted living at our nursing homes -- a whole phenomenon of the senior aging process, better home health, more respite care. There's a whole issue of that of health. I think we have to address and look at that, too. It's very important.

And just one comment I'd just like to share with Senator Codey about minority quality of health. Some of it is simplistic. A person comes into one of our facilities and our clinics and needs to go to a specialist but doesn't have cab money to get there. There is nothing in the system that allows us to give that person the cab money to go, so you know what happens? They don't go.

So we've got to look at not just availability, but how that person gets there. And that may seem simplistic, but in our area of the state where there is no public transportation, there is physically no way for that person to get there many, many times. And they just--

SENATOR CODEY: Well, they use cabs, which are very expensive for them.

SENATOR SINGER: Well, if they don't have the money, they don't use anything. They just don't go. And that's problematic because there's nothing in the system that gives them that money to do that.

So there's a whole bunch of things you have to look at, not just the delivery of it, but how they access it and how it is accessible to them to get to, not just from the clinic aspect or the doctor's office, but how they get to the specialist and back and forth.

PRESIDENT DiFRANCESCO: Joe.

SENATOR VITALE: You had mentioned in your testimony that the hospital deregulation several years ago had an impact on the way in which we deliver health care in the state. I just wanted to ask if you could just expand on those comments in terms of how it relates to the issue of insurance and accessibility and affordability.

PRESIDENT DiFRANCESCO: Well you know, we've tried so many things, Senator. When I was first elected--

Help me out. (speaking to someone in audience) Who was the Commissioner? Joanne Finley, was it?

Commissioner Finley, Eleanor?

The DRG system came into play. And the DRG system-- She was very confident. I should say we. I don't want to just-- We were very confident it would be very helpful in controlling costs. It identified a length of stay, etc. And of course, there were a lot of complaints over the years from hospitals about that system. And eventually we abolished it, in fact.

And so there have been a number of ways that we've tried to address these issues. I think deregulation has been more positive than not. I think that it has allowed more flexibility with hospitals in terms of their ability to run their hospitals like a business, to treat patients the way they should, and to not have their hands tied by a very difficult, bureaucratic regulatory system.

On the other hand, as you know and I know, and I know you know better than I, there are a lot of problems right now with our hospitals. And it stems from a variety, I guess, of different symptoms, and managed care is only one of them. I think some of them are business related, some of them are population related -- what kind of population do they have, what kind of services do they offer, where they're located, what their infrastructure is, how old are their buildings, I mean, what kind of technology they have -- a lot of issues that go into the financial capabilities or feasibility of a particular hospital.

So I put it on the table, in looking at hospitals because I think deregulation has been good, but I think that, just like I think the Patients' Bill of Rights was good, we need to look at this now and say, "Okay, we have this system. Can we make it better? Can we find out from the people sitting behind us and the people you will be listening to how we can make it better? And you're going to have to weigh all this testimony." I'm hoping that Senator

Codey says, "You bring people from the pharmaceutical industry to the table. Ask them to help us. Ask them how we can help, with respect to prescriptions." He's right. You're right. Where is this program going? It's a fabulous program. When I was on the Committee -- an institutions committee in the Assembly was created out of, presumed -- Eleanor -- a very low cost. Now it's very high cost. And perhaps we were -- we did not, in any way, anticipate the success of the program or the need for the program, however you'd like to put it.

But we're certainly not going backwards with these issues. I think we need to move forward. And you have to decide just how we do that. I think all of you-- I'm really -- always felt that this particular Committee has so much expertise. You've all garnered so much knowledge in this area that you bring to this Committee. I'm really confident that you'll be able to listen to all of the players, all the special interests, all the people involved, providers, patients, hospitals, whoever -- and try to make recommendations that are far reaching.

This is hard because Dick's raised some issues very quickly, and certainly Bob has raised some issues off the top of his head, too, that play into this. These are difficult issues because they affect health care, lives, and the quality of life, and therefore, these are decisions that become very difficult. But I think we have to make them. I think we have to move forward. I think we have to take action. I think we have to be progressive. I think we just can't sit back and let it move forward without us. I think we have to be a player. The extent of how far we go is what I'm asking you all to find out because I don't know. I don't know.

SENATOR VITALE: Just in terms of affordability and accessibility-- I mean, it's clear that affordability has a great deal to do with accessibility to individuals, whether in the group market or in the individual market.

But in terms of accessibility -- physical accessibility-- We had the issue of a hospital that closed, at least, hopefully, temporarily in some fashion in the district that I represent. But whether it's the hospital report that was issued this fall or any other number of professionals that recognize that there are, at least in their opinion, any number of hospitals that ought to close in the state or should close or merge or whatever--

I just think that we have a responsibility beyond what the letter of the law says. And I'm just hoping that you'd be willing to entertain those ideas, in terms of how we, at least, try to attempt to solve them.

When they say that there are anywhere from 8 to 10 to 12 to -- some folks say 20 hospitals that should or may close -- and we don't take the responsibility, in terms of a proactive manner, to say how it is that we could -- how is it that we can make this transition more smooth-- The report doesn't say who ought to close, they just say that they ought to close.

PRESIDENT DiFRANCESCO: Well, I mean, I think you're right in that we can suggest that -- not our fault. we weren't here, so to speak. But we are here, and we're part of a system that has created the present system that we have of providing accessible health care or presumably providing universal health care. So if we're part of a system that has promoted that, let's be part of a system that continues to promote it and fix it and really, what you're saying, make sure it really happens for everybody. And when there are difficult

situations, be there, be available, and be helpful. That's what you mean. And I'm open to those ideas.

I think Senator Codey's right when he says it's not just minority, it's poor. Can you afford it? Are you poor? Do you think you can afford it? A lot of this is attitude, too. Do you think you can afford it? Look at the KidCare program, look at the suggestion the Governor has made about the working poor, with respect to an insurance program for adults.

I know that your bill, in defining how the tobacco money should be distributed-- Your bill addressed that to some degree, Senator Sinagra. I'm trying to think of the term you referred to it as -- Access to Care Study Commission or Access to Care Program, whatever that may be.

Look at that. I mean, we want to just not do a program -- just say, "Okay, we're going to spend \$70 million, and we're going to have an adult insurance program." What should that program be? What should the parameters of that program-- You should address that issue, too. I think that you should be all-encompassing and deal with these issues. Let's not just say me too, or that we're going to go along with this. Let's investigate into what the best possible program could be. What will work? We want to know what will work, and not just say-- I don't want to just say, "Hey, I sponsored a KidCare program," if it's not working. I want you to tell me how we can make it better, how we can insure all the children -- that our goal was to insure all children. Why aren't we? Why aren't we? And how can we do it?

That's why I thought we should do it this way, not just introduce a bunch of bills, let's find out what's out there. It takes time. You're going to

have to spend some time on this, listen to a lot of testimony. But I would appreciate it. I thank you for it. And I look forward to working with you.

SENATOR SINAGRA: I want to thank you for coming today, and the confidence in this Committee. I think I've told all the members of the Committee that everything is on the table. You have charged us with a difficult task. All of us have had some experience -- everyone -- with some sort of health-care crisis, whether it was cost, whether it was access, whether it was-- You know, there has been different aspects of a crisis, but today, all of them are in play.

It's hard to believe that, you know, with the economy today, where it is, that we have more uninsured in New Jersey than we've ever had before. It's just illogical. It's wrong. We need to address it. We need to do more than we're doing today. Everyone's dissatisfied, whether it's the hospitals, the doctors, the patients, with some form of how their health is being taken care of.

And I want to thank you, Mr. President, for being here today.

PRESIDENT DiFRANCESCO: Thank you, Senator.

SENATOR SINAGRA: Today, we're going to hear testimony from four different companies involved in the insurance aspect of health. The first will be Horizon Blue Cross Blue Shield.

**HANK MEISNER:** Mr. Chairman, my name is Hank Meisner. I'm the Director of Government Affairs at Horizon Blue Cross Blue Shield.

SENATOR CODEY: Is that on, Hank? (referring to PA microphone)

SENATOR SINAGRA: Is the red light on?

MR. MEISNER: To my right, I have Dennis Marco, Vice President of External Affairs; and John Lynch, our Actuary, to come talk to you today about the health-care issues -- as requested by staff to address some issues, talk about what's going on in the marketplace, and offer you some considerations for solutions to the problem.

**D E N N I S M A R C O:** I think, if you look at the information that we passed out, what we did, based on the request from the staff, we've broken out some information based on the rising health insurance cost over the last five years by product. And we looked at the fee for service programs, HMOs, point of service, and PPO programs.

If you look over those five years, I believe the lowest one that had the increases was the HMO product. And that's proven to be the employer-of-choice product for most employers. In the packet, also, you'll see a Hewitt Associates survey study that was done, and in it, it talks about some of the reasons in the high increasing costs for health insurance. And most employers that were surveyed believed that over the next five years, they expect increases of anywhere between 25 to 45 percent.

And again this is a Hewitt study of about 600 corporate executives. And they also cite that for that, there have been rising prescription costs. I think, Senator Codey, you stated the concern that those prescription costs could have for the State's PAAD program. And we see anywhere over the last couple of years, that prescription costs have added about 14 to 16 percent to our premiums.

And the other cause for concern with most employers is the malpractice liability. If Congress passes that new liability law -- there are about

36 percent responded -- that what they would do is they would go to a defined contribution program, basically get out of the health insured programs and give a voucher to their employees and let their employees go and shop and look for health care.

So, you know, we've been monitoring that. That's moving in the Congress. There's a conference committee that's scheduled to meet and make a report to bill out in March. The Congressional Budget Office has already estimated that if the Senate version passes, I believe it's a 1.3 percent increase for premiums. If the House version passes, they're looking at about a 4.1 percent increase. And that was a CEO estimate.

In New Jersey here, I think over the years a lot of health plans have been dealing with the implementation of the HMO regulations, the Health Care Quality Act, which was passed, I believe, two years ago. We've not seen regs on that, yet. So we're waiting to see what kind of impact that will have on us.

Another issue that we've been working at and trying to educate a lot of the members of the Legislature on are the costs of mandates. If you look, New Jersey has passed some of like 38 mandates. I believe 10 of them--

SENATOR SINAGRA: That's all?

MR. MARCO: Excuse me?

--10 of them in 1999, and I believe 13 more have been reintroduced. With each mandate that's passed, we see a 1 percent increase in premium cost, which gets translated to 9000 to 10,000 more uninsured. So mandates are definitely having an impact on the cost of health insurance. And if you look in the report there, there was a state-funded report by the state of

Maryland, which showed that mandates caused about 15.4 percent, or an annual increase of about \$604 on premiums.

We also have worked very closely over the years on the individual and small employer boards, and we still believe that that's a landmark legislation that is modeled for the rest of the nation to look at. We get a lot of our other plans throughout the country calling us about that legislation, and they've modified it to fit their marketplace or their geographic area.

We are looking to, you know, work closely and try to improve that program. We have a legislation that has been in -- it's going to be reintroduced, I believe -- S-728, A-1609, with Senator Bassano's help. And we're looking at providing another product, an EPO product, which would be an exclusive provider network. Hopefully, with that network, we could try to attempt to get to the issue of affordability.

That was not one of the issues that we addressed in 1991, and the affordability issue gets to be a very difficult one to address when you look at technology that's changing constantly, new drugs coming onto the market. And we think that there will be some opportunities on our side, by getting involved in more disease management programs and also the use of the Internet, to try to help and reduce some of our administrative expenses.

MR. MEISNER: Just one of the other things in your package-- Also part of the proposed legislation, is an effort to move the individual market from pure community rating to modified community rating.

I'd like to have our Actuary talk a little bit about the data that's in your package and why we feel that will, overall, have a beneficial effect.

In your package, and one of the statistics you should look at, is what's happened in the individual market. In the fourth quarter of 1995, there are 220,000 enrollees in the individual market. In the third quarter of 1999, there were 120,000 people enrolled in the individual market; almost a 50 percent decline in the number of enrollees in the marketplace. Part of that could be attributable to a strong economy, but I don't think that's the only answer. The price increases we've had are causing that market to become more and more unaffordable.

And I'd like our Actuary to talk to you a little bit about moving to a modified community rating, which would put in on the same basis as the small employer market. There's some very interesting statistics on age differentials between the two markets, which is caused, in our opinion, by that community rating.

**JOHN J. LYNCH:** Thank you.

As Hank mentioned, we have seen a pretty steady decrease in the individual enrollment. It's been running about 15 percent a year, and we expect that a lot of that is driven by affordability issues.

We've also seen the average age in our individual book increase. In fact, right now, the average age of our individual subscriber is about five years older than the average of our small employer subscriber. And we think that if everyone is charged an average price, the folks who perceive that to be a better value participate in greater numbers. The folks who are disadvantaged are primarily the younger folks or are also, likely, the healthier folks.

The modified community rating, which would mean -- would raise the rates for the older folks and lower the rates for the younger folks, would

provide greater access for more people to come into the system. We think a rating structure that brings more people into the program is better than a rating structure that reduces or decreases.

We look at the-- There are only two states, to the best of our research-- There are only two states in the country that use a pure community rating for individuals, us and New York. And our enrollment-- I think our IHC story is basically a very good one, but the last several years, the enrollment has been going down at a pretty significant clip, and we think something should be done about that. And we think introducing more affordable products -- the EPO that Dennis mentioned is one such example -- and combined with the modified community rating, which would allow us, we think, together to bring the younger and healthy folks into the pool that we need to have a sustainable risk pool in the long-term.

That's what our proposal--

MR. MEISNER: The other statistic, just to mention, is that those two community rating states, New York and New Jersey, in 1990, had a -- New York had a 13 percent uninsured population; New Jersey had an 11 percent. We were both, in 1996, at 19.1 percent uninsured versus an all-states average of 17.6 percent.

Senator.

SENATOR BASSANO: The programs that are being offered right now are, basically, programs -- that was the original legislation -- had a so-called bare-bones bill. And then we had very comprehensive coverage in the next four plans, with the difference being the copays.

Do you feel that we would be better off if we offered additional plans that didn't cover a lot of the, well, the bells and whistles that the floor plans cover now, even though you have a differential in the copays, so that people can modify the type of coverage they want?

I see heads bobbing, but if we could get some comments, though.

MR. MEISNER: There's probably several different opinions because there's several different consequences.

If you allow people to select a rider for a specific disease, then what happens is the only people that buy that specific rider are those that need that disease coverage. And the price is--

SENATOR BASSANO: Hank, I'm not referring to riders. What I'm referring to is specific policies that would cover specific items and not cover other items that maybe the more ambitious, the more expensive programs do cover.

Right now, the differential between the very lowest policy and the other four policies-- There's a great difference in coverage between those, but we need something maybe to fill in that gap in between and not just try to do that with copays. And that's what we've been trying to do.

I don't think that was the intent of this Legislature, by the way, when we passed that original legislation. The boards went ahead and did that. That's not what I intended when I worked on that legislation. That's why I throw that out to you. Maybe that's one of the areas that needs to be examined, where there would be programs that aren't as rich in coverage but do provide certain elements beyond just hospital care and paying for a doctor

while you're in the hospital, but not to the point where you're covering everything in creation.

MR. MEISNER: I understand. Yes, I think that's something that should be explored.

SENATOR SINAGRA: Senator Matheussen.

SENATOR MATHEUSSEN: Following up on that, and Hank, you and I already talked about this to some degree, it would seem to me that we need to explore some more basic policies, eliminating some of the mandates that we hear about all the time that you don't like what we put into it. Well, why don't you sell some products then -- why don't we allow you to sell some products then that did not include all those mandated particular coverages.

In addition to that, it would seem to me that we need to make sure and push ahead with not only KidCare, but family care that was announced this year before we go-- Just because there's only two states that are on a community-based rating, I'm not so sure that the other 48 are right, and we're wrong. And I hesitate to go to a modified community-based rating knowing that there will be a cause and effect to that as well, and driving the cost up for someone else may not be the answer to our problem when we haven't finished, yet, with some of the other suggestions made by Senator Bassano, Senator DiFrancesco with KidCare, the latest round of family care, which also will have some long-term effects on charity care that some of our providers are going through right now.

So before you have my support for getting rid of or modifying community-based ratings, I think we need to do some other things first.

SENATOR SINAGRA: Senator Bassano.

SENATOR BASSANO: I think I'm in the same camp with John. I think I'm one of the people who was in favor of community rating because I felt that those people that are paying less today because they're young, eventually do get old and do get sick. So the playing field, over a lifetime, does average out.

But the question that, I think, this Committee would like to have answered is, if we went to a modified community rating, can you tell us how much premiums would drop for the young 30-year-old and how much they would increase for the 65-year-old. I think that's -- that would give us some idea as to what we're talking about.

MR. LYNCH: The scheme that we're thinking about is an issue where, in terms of an average rate, we might have premiums that might range as high as 133 percent of the average. We're thinking of it just like the other small employer would think of the two-to-one -- the highest rate can be no more than twice the lowest rate. That's the scheme that we have in mind. That's the scheme that we've talked to you about, Senator.

Under that sort of a scheme, the oldest folks would pay 133 percent of the average, but the average rate would be lower because we think-- The whole point of this is to bring other people in. The people who are now choosing not to participate in the program would come into the program, we expect. When we net that out, the average goes down. We're thinking about, frankly, about a 20 percent increase for the oldest folks. The average participant would pay about a 10 percent decrease. And the youngest folks would have a 40 percent decrease. So the younger folks would, basically -- in our own book, we see participating less and less each year -- they would have

a significant premium discount, hopefully, enticing them back into the program. So the enrollment curve, instead of going down like this (indicating), might actually start up. And everybody wins if the health pool becomes healthier, more viable.

So the older folks, no question, get an increase. And I guess, right now, I'm thinking maybe about 20 percent -- a 33 percent increase on the average, but a 10 percent decrease in the pool's average results. So the net is that they pay about 20 percent more than they might otherwise.

SENATOR BASSANO: I understand what you're saying. I appreciate the figures that you're throwing out. But I go back to what insurance really is, and that's pooling money to take care of people when and if they do become sick.

And while that young person that's 25 years old today may be relatively healthy, that young person is going to eventually become old and is going to get sickly and is going to need care.

So the playing field does stay level. I would much rather see us leave the differential in place that we're talking about and stay with community rating and do something with the policies to offer, maybe, not as much coverage so the policies become more affordable than to play with that community rating. But that's something that the Legislature may agree with me, may disagree. But that's my personal opinion.

MR. LYNCH: The EPO bill does also address the affordability of two different versions, which have the same target -- producing a more affordable target -- throw it on the table.

Thank you, Senator.

SENATOR SINAGRA: Senator Vitale.

SENATOR VITALE: Can you tell me a little bit about the guidelines you use in making medical care decisions on who you will and will not cover?

MR. MEISNER: We, medically, cannot underwrite. We have to accept everybody that comes in.

MR. LYNCH: A guaranteed issue.

MR. MEISNER: A guaranteed issue.

SENATOR VITALE: Everyone that comes in?

MR. MEISNER: Yes, it's a State law. All carriers have to do that.

SENATOR CODEY: Dennis, you mentioned before about drugs -- the inflationary rate of drugs have increased your premiums 14 percent. Maybe I'm missing--

What percentage are you seeing, in terms of your group's renewals. What is the rate of increase?

MR. LYNCH: The increases that we're seeing-- I think that's 14 or 15 percent of every dollar of health care spent out, right now, is for drugs. The average rate of increase, though, is more like 20 percent. That 15 percent of the total pie is going up 20 percent.

SENATOR CODEY: So what you're telling me is that we are now back to the early '90s rate of inflation in health care, correct?

MR. LYNCH: In drugs--

SENATOR CODEY: No, no. I say in health care.

MR. LYNCH: I'd say high single digits, Senator.

SENATOR CODEY: Your colleague is saying yes, you're saying no.

MR. LYNCH: High single digits is what I'm saying.

SENATOR CODEY: No, I meant--

MR. LYNCH: Maybe it depends on how far back we go. If we go back to the glory days when, maybe, the medical trend factor was in the middle teens, we're better than that.

SENATOR CODEY: What's the rate of inflation on health care?

MR. LYNCH: I would say -- across our plans, it's the high single digits, sir.

SENATOR CODEY: So you're saying nine.

MR. LYNCH: Eight or nine percent. That's ugly. It's certainly uglier than it's been. And drugs are way beyond that.

SENATOR CODEY: Right. I understand that.

MR. LYNCH: The composite, I would say, is 8 or 9 percent, sir.

SENATOR CODEY: But it continues-- The chart continues to spike upwards.

MR. LYNCH: Point north, yes.

MR. MARCO: And also, the costs for drug (indiscernible) is higher than our inpatient hospital cost right now.

MR. MEISNER: The other thing that is impacting the trend, Senator, is the cost sharing. As the costs go up, people buying health insurance are absorbing more of the cost themselves, which mitigates that increase. And we've seen larger and larger deductible policies.

SENATOR CODEY: Yes, but that's not my issue. My issue is what is the cost, whether it's borne by the employer or the employee or shared.

SENATOR SINAGRA: I tend to think Senator Codey's more accurate because all the business -- and knowing the company I'm with and talking to other business people, their increases, when they're getting their new insurance policies, is certainly not anywhere in the single digits. They're in the 20 to 25 to 35 percent range on basic policies. And according to some small businesses, their prescription plans are going up by 100 percent, as it pertains to premiums. You know, we're not talking about the inflation rate, we're talking about the premium rate, which is affecting businesses and individuals.

And the only other side thing I'll say that where New Jersey and a lot of people, as it pertains to the costs of prescriptions-- The drug companies, and we'll have them come before us, are saying that it's more the utilization today than the increases in the costs of the prescription itself. And part of that is due to this little minor change that the FDA did years ago, that allows advertising for prescription drugs.

And there's no question -- and you talk to any practicing practitioner -- someone goes in -- "I saw this commercial. I want that." And if they insist enough, they're going to get that drug.

SENATOR CODEY: Yes, that's an interesting fact because what you're doing is you're advertising to people who can't buy your product.

SENATOR SINAGRA: Exactly.

SENATOR CODEY: They have to go to a physician and ask for the product that you are advertising to them.

SENATOR SINAGRA: Well, they got smart. They used to market to the physician. Now they market to the consumer. And they have more influence to the consumer, in many cases, than they have on the physician.

SENATOR CODEY: Right, but as you said, they weren't allowed to--

SENATOR SINAGRA: Advertise.

SENATOR CODEY: --advertise to consumers.

MR. MARCO: In 1998, I believe it was, the pharmaceutical industry, as a whole, spent \$2 billion in direct consumer advertising.

So you're absolutely right, Senator.

On the cost issue, in the Hewitt Associates study, again, on Page 5, it gives a summary of what employers are expecting. And in 1999 to 2000, they felt it was a 9 percent increase, but 45 percent of the respondents are predicting 10 percent or more after 2000.

SENATOR SINAGRA: We're going through that same period we did years ago, where employers are asking their employees to pay a bigger percentage of their health-care costs. They're changing the policy every year on them. Something that was covered the year before-- Deductibles are larger. It's really-- We're going through that horrible period again that we went through years ago. But in addition to that, everything else around us is falling apart in health care, also. So it's a pretty serious time.

Dick, did you have anything else?

SENATOR CODEY: Excuse me?

SENATOR SINAGRA: Are you done? (affirmative response)

Great.

MR. MARCO: Thank you very much for your time.

SENATOR SINAGRA: Aetna U.S. Healthcare.

**DAVID NORCROSS, ESQ.:** Mr. Chairman, I'm David Norcross, Counsel to Aetna U.S. Healthcare in New Jersey, and I have with me this afternoon, Frank McCauley, who is the General Manager of Aetna U.S. Healthcare, and Dr. Jay Krakovitz, who is the Senior Medical Director in charge of the New Jersey market. We're here at your invitation to discuss managed care, current trends, affordability, accessibility of health care.

And I want to commend you all and the Senate President for your willingness to look at this extremely difficult and challenging problem.

Mr. McCauley.

**FRANK G. McCAULEY:** Thank you, David.

Hit the mike. (referring to PA microphone)

SENATOR SINAGRA: The red light's supposed to be on.

MR. McCAULEY: Thank you, David.

We'd also like to echo Senator DiFrancesco's sentiments on the opportunity, again, to have an open forum to discuss such an important topic.

We're going to focus our discussion, really, on three areas that come into health-care evolution and where we are today: health-care costs, trends, and then a focus on quality and where we see that moving for the future.

I'm going to begin by going back to 1992 and, really, where we were faced with what seemed to be an uncontrollable upward spiral in health-care costs and, really, a near crisis brought on by the Federal court's decision

undermining the State's highly regulated hospital rate setting system, the New Jersey Legislature, and, in fact, this very Committee, passed the Health Care Reform Act of 1992. The Legislative Findings and Declarations to that Act leave little doubt as to the Legislature's motivation and intent, noting that, notwithstanding the State's considerable rate setting mechanism, health-care costs have continued to increase at an alarming rate.

We move in the direction of a truly competitive market environment, thus the Act of 1992 was, for all intents and purposes, a cost-containment measure. It was widely understood, at that time, that managed care would be one of, if not the principal vehicle relied upon to achieve the cost containment objectives of that Act.

Hospitals, and by the extension other health-care providers who relied primarily on hospitals as the core of their health-care system, were generally considered to be largely uncompetitive, insulated, and inefficient due primarily to the effects of years of operation under a regulatory system that, among other things, sought to guarantee their financial stability.

Operating on behalf of hundreds of businesses and thousands of individuals who demanded more affordable health care, New Jersey looked to managed care for the efficiencies that the rating system had failed to produce. And for the better part of the 1990s, the plan worked and is still working today.

Aetna U.S. Healthcare began offering benefits to New Jerseyans years ago through traditional indemnity insurance through Aetna and, starting in the early 1980s, began offering HMO plans through U.S. Healthcare and Aetna Health Plans. At the time of the 1992 reforms, both HMOs were just

beginning and had relatively little penetration into the health insurance market.

Today, Aetna U.S. Healthcare actually insures over 1 million members in the State of New Jersey through some form of managed care program.

The changes we've undergone, over the past few years, is a reflection of the tremendous changes taking place in the entire health-care system in New Jersey. As indicated at the outset, the deregulation of the hospital industry in 1992 brought the State into a competitive health-care marketplace. That should have brought the market pressures on not only hospitals, but the entire system. While HMOs have been able to keep their premium increases to a minimum during the 1990s, medical costs have continued to increase. As an example, the hospital system that was deregulated in 1992 is still, by third-party accounts, inefficient and not ready for competition.

According to the Advisory Commission on Hospitals' report, released at the end of 1999, it states that the cost of this excess capacity, which could be as much as \$1 billion annually, puts New Jersey hospitals at a staggering competitive disadvantage in today's marketplace. The excess capacity in that statement refers to the fact that one out of every three staffed acute care hospital beds in New Jersey is empty each day. Instead of making the difficult decisions required to compete and become more efficient, we have seen hospitals affiliate with each other, resulting in increased costs and reduced efficiencies. This, in addition to the legitimate concerns on behalf of the

hospitals regarding Medicare cutbacks and general governmental budget restraints, has led to the current hospital situation.

Because of these problems, hospitals have been seeking relief from HMOs, in terms of higher rates of reimbursement. While you hear the complaints from your constituents about the increasing Medicare premiums or commercial premiums, not discussed are the 30 to 40 percent rate increases the hospitals are demanding from other HMOs, as well as us, across the state. While we understand the need to receive a reasonable payment for services provided, the current rates being demanded, in light of the above report, make these difficult decisions.

The other major cost driver in the health-care premiums is pharmaceutical costs. While we recognize that pharmaceuticals have played a key role in improving people's lives, this has not come without a cost. In 1999, Aetna U.S. Healthcare's pharmacy costs increased by about 25 to 30 percent per year. This increase is partly a result of increased utilization brought on by the direct advertising campaign of certain drugs and the direct cost increases of these drugs.

Knowing the importance of a pharmaceutical benefit to both seniors in our Medicare program and to the commercial market, we have tried to contain these costs while still offering comprehensive drug benefits. We have achieved this by introducing various formulary programs and utilizing generic and brand-name drug alternatives. The goal is to offer more flexibility and choice to the consumer so they can choose the drug benefit that best meets their needs, balancing cost and choice.

The cost of mandated benefits can also not be ignored when we discuss what issues make health insurance more expensive. While we do not agree with the efforts to mandate various services in a health-care benefits package, we do think this is more of a societal issue or discussion of the associated costs and corresponding benefits to those who actually purchase the coverage.

As noted earlier today, New Jersey has over 38 mandated benefits. The issue here is, if you understand, when you look at the actual mandated benefits relative to the uninsured population, there is becoming a direct correlation throughout the United States. For every 1 percent increase in actual premiums, 400,000 individuals become uninsured.

It must be noted that State mandated benefits only cover about 30 percent of the population and that as costs increase, employers and individuals respond in different ways. Aetna U.S. Healthcare applauds Governor Whitman's decision to appoint a panel to look at the cost of proposed mandates and the issue of the uninsured.

In 1999, Aetna U.S. Healthcare responded to the issue of increasing costs and the increasing number of uninsured Americans by introducing a new product called Affordable HealthChoices. Now approved in 32 states, but not approved in New Jersey, this plan is a hospital indemnity product that attempts to address the issue of employers wanting, but not able to afford, some type of health-care coverage. It has not been approved in New Jersey because of all the small group laws that forbid plans such as this. Premiums for this plan range from \$46 to \$91 per month for single employees and about \$150 to \$275 for families. The benefits are structured as an

employee reimbursement, after they incur the costs, and range from \$500 to \$1500 coverage for three days of hospitalization and \$50 per doctor visit.

This plan was developed in an effort to offer employers currently not offering coverage some choice and affordability in benefits coverage. The difficulty in creating this product was navigating the complex Federal and State laws that regulate health insurance. Due to the Federal HIPAA law and various State laws on mandated benefits and small group reform, Affordable HealthChoices was the only product we could develop and still keep the price competitive.

We are always interested in discussions to create flexible and affordable products in the small group market that consumers can afford. We are interested in what some other states are doing legislatively to create health benefits plans that do not cover mandated benefits, a clear reflection of the price sensitivity in the health insurance market.

The debate as to the relative value of indemnity and managed care has taken place for years, but in reality, the question has been settled. Managed care has proven its value to employers, consumers, and the government by delivering access to quality health-care benefits at an affordable price and being able to measure the quality of the benefits that are delivered. Even the most basic indemnity product on the market uses various forms of managed care techniques that have become the standard, not the exception, in today's environment. It's all about quality, cost, and access and the ability to measure results. It's all about continuous quality improvement and better doctor-patient and doctor-doctor communication.

Despite all the anecdotal problems with managed care that the media has vigorously reported, the truth of the matter is that managed care remains the best health-care delivery system in the United States.

I would now like to turn the remaining testimony over to Dr. Krakovitz, who will discuss the benefits that managed care has brought, and will continue to bring, to increase the quality of the health-care system.

**JAY A. KRAKOVITZ, M.D.:** Thank you, Frank.

Good afternoon, and thank you for the opportunity.

We live in very interesting times, and I, as a physician, feel the pain of the citizens of New Jersey and, in fact, the country -- and probably need more than just a very large tablet of Tylenol to get us out of this issue.

I believe that, until recently, health care was a reactive issue, where physicians viewed patients as an illness or disease. That's how I was trained. And even today, in today's medical schools, the curriculum has not varied that much.

People were in need of treatment. The approach led physicians to go down the route of -- and develop an entire medical delivery system to focus on the sick, rather than on the well.

It's a world where hospital use varied from one part of the country to another; from one county to another in the state, along with the use of medical procedures. And indeed, medical costs vary all over the place. It's a world of waste, duplication, overutilization, underutilization, misutilization, and poor communication. We're going from a world of incentives to do everything possible to incentives to keep people healthy and do only what is necessary and appropriate.

Before managed care, childhood immunizations and well baby care were rarely covered by health-care insurance companies. As a result, families with limited incomes were frequently unable to afford these needed services. To combat this problem, managed care plans provided not only coverage for immunizations, but also encouraged this behavior by patients and physicians and then measured how well these services were delivered. The immunization rates for managed care plans such as Aetna U.S. Healthcare are up year over year and is far superior to the national averages and in the indemnity world.

Furthermore, before managed care, there was no attempt by insurers to validate the quality of care delivered by physicians. In fact, there was no incentive built into the system for physicians to attend to preventative care, let alone the ability to measure this.

One area in which we focused on in our company for over 20 years is attention to cancer prevention. We began a program in 1988 to educate every woman about the necessity of having mammographies. And we followed that up with almost a dunning campaign to make sure that people understood, were educated, and got that mammogram.

While New Jersey and the Federal government have recently begun to cover this service, it was almost 10 years after Aetna U.S. Healthcare provided coverage for mammography. The same thing can be said for colon cancer. And I personally, in practice, saw people diagnosed because they received the mailer in the mail, looking for that hidden blood in their stool, and I'm proud to be part of a company that takes that proactive stance to get people the care that they need.

Another area that illustrates the approach of managed care is in the area of chronic diseases. Diabetes is a disease with a high prevalence rate. Maybe 1 in 10 Americans will get this disease. And despite the fact that it has been unequivocally proven, for example, that eye examinations in the diabetic population can prevent blindness, the frequency of yearly eye examinations in this country is dismally low.

My colleagues recognized this years ago and developed a program to increase the frequency of eye examinations in diabetics by using our computerized databases. We were able to identify thousands of diabetics, mail them information, tell them when their last eye exam was, and get them to the eye doctor's for care. And because of that, I can sit here and feel comfortable knowing that people are not blind today because of the efforts of this particular managed care program.

These programs that I've just mentioned and others are only part of a system that educates physicians and patients and helps identify those patients in need of further care. Our quality-based compensation system strives to reward physicians for keeping their patients healthy, a different paradigm than in the fee-for-service world.

In this system, physicians who excel in audits of comprehensive care, chronic disease, preventive health care, and member satisfaction are rewarded with increased compensation, as opposed to the fee-for-service system, which merely pays piecework for the amount of services provided. The fee-for-service system has led to overutilization and poor coordination of care.

We strive to uphold the strictest quality standards in the industry. And our NCQA accreditation in New Jersey, both North and South, and across

the country, speaks to that in the Aetna U.S. Healthcare and Prudential HealthCare plans. In fact, across the country, 9.2 million members covered by Aetna U.S. Healthcare are in NCQA accredited plans, the good housekeeping seal of approval in the industry.

The fact is, as a regional medical director overseeing the care for all of the patients -- 3 million patients in the mid-Atlantic region, I work with nine other full-time physicians and dozens of experienced nurses. And we oversee the care being received by our members hospitalized in New Jersey. Attention is focused on patients receiving appropriate care at appropriate sites in an efficient manner.

Situations that do not appear to meet these criteria are always presented to a medical director for review. Physicians in the State of New Jersey are never told what to do or not to do. Hospital reimbursement issues are subject to concurrent discussion with the attending physician in a retrospective review, and the patient is always held harmless of any financial obligation.

Aetna U.S. Healthcare deploys seven physicians, 11 registered nurses, and 30 field coordinators to visit with doctors and hospitals in our New Jersey networks. Due to our rigorous credentialing process for providers, we feel that there's no need for day-to-day oversight of the referral process. Doctors are free to refer to whomever they choose whenever they want from our large participating network without requesting permission from anyone.

Now, we share performance information with our doctors regarding their care of diabetics, asthmatics, and cardiac patients, and we're

sometimes able to identify individual patients to the doctor who may have been missed or overlooked.

My role is also to oversee a process that protects members' rights and responsibilities in a managed care system. The complaint and grievance process has been very effective over the years in giving members a voice, should they disagree with any decision that is made or if they're dissatisfied with the quality of care or service received.

A mechanism is in place for investigating the members' issues, and responses from physicians and hospitals are obtained. The information is tracked and trended in the spirit of continuous quality improvement. But the fact of the matter is, at Aetna U.S. Healthcare, we're accessible 24 hours a day to prevent the need for a grievance in the first place.

The future of medicine involves not how much a doctor knows, but how well he or she knows how to access quality information. The Internet brings a wealth of information to physicians and patients alike. Our members can access the Internet to learn about a doctor's board certification status; the availability of night and weekend hours; survey information, such as the ability to obtain test results; and even the personal concern of the doctor in question. Our physicians increasingly have access to our policies and procedures and best practice guidelines on-line.

We have developed an integrated and coordinated community of physicians, hospitals, and ancillary providers who will increasingly be better able to communicate with each other electronically, thus ensuring the continuation of a greater than 20-year journey of health-care improvement and access to quality care in the State of New Jersey.

The pain is there. The solution is there. All the answers are not in. But let's not throw out the baby with the dishwater in terms of getting to the best possible solution for New Jersey citizens.

And I thank you.

SENATOR SINAGRA: Thank you.

Any questions?

SENATOR CODEY: Yes.

SENATOR SINAGRA: Senator Codey.

SENATOR CODEY: Mr. McCauley, what is your inflationary rate now for your subscribers -- your large groups?

MR. McCAULEY: Right now, on average, 8 to 10 percent.

SENATOR CODEY: Eight to ten percent.

So you're basically facing the same thing as Blue Cross Blue Shield. And you would agree with them, in terms of the inflationary rate of prescription drugs?

MR. McCAULEY: Correct.

SENATOR CODEY: One of the things that has happened-- I mentioned-- I forget the name of the movie that Jack Nicholson was in where he played an obsessive-compulsive person. What was the name of the movie?

DR. KRAKOVITZ: *As Good as it Gets*.

SENATOR CODEY: There's a line in the movie where he criticizes HMOs, and I guess everybody in the movie theater says, "Right on."

And one of the things that has come about as a result of those changes within the health-care delivery system-- It's state Legislatures, like ourselves -- are making medical decisions, which I don't think is necessarily

right, but we're forced to because you've done such things as saying to new mothers, "All right, you had the baby 23 hours ago, get the heck out of the hospital because we don't want to pay for it any longer." I'm not saying that Aetna did that. I don't know whether you did or did not. But some of them obviously did. So we have to react to what you're doing because we're reacting to our constituents. And of course, we did it with mastectomies, and I'm sure there may even be other things that are on the next wave to be done, as well.

One of the other things-- And that, obviously, goes into your medical judgements because your medical judgements can be seen, and I'm sure, at some times are made to save money, as opposed to good, healthier subscribers. There's obviously an inherent conflict within your business. The quicker you get them out of the hospital, the less doctors visits, the more competitive your price can be. I mean, that's just the nature of the business.

One of the things I want to discuss with you, which is now, obviously, in press, is the issue of your contracts with hospitals. Now, hospital administrators would say that they want to get reimbursement at a rate that's lower than my cost. Now, you want to get the best price to be competitive, and, of course, when you are -- get the best price, that's not necessarily -- not within the consumer's best interest as well because they are, in effect, in some way, consumers. It's through the workplace or individual coverage.

But it seems now that the hospitals are saying, "I just can't do that. I can't continue to lose money." And obviously, if you look at the state of New Jersey's hospitals, it's not too good. They're in worse shape than some of their patients. That's rather obvious.

I'd like to hear your comments in regards to what's going on now in the marketplace where some hospitals are saying, "You know what, I don't want your business because I'm losing so much money on your business."

DR. KRAKOVITZ: The hospital is really a bricks and mortar facility where health care is delivered by physicians. And clearly, the ultimate answer, in terms of how we get out of this situation, is to look for better efficiencies, both of physicians taking care of patients in the hospital and the hospital's ability to deliver those services on a 24 by 7 basis.

But more important than that would be if the patient is healthy enough, through preventative measures, never to end up in the hospital, we take the hospital cost out of the equation of health-care increases.

The unfortunate situation is that, if you look at Aetna U.S. Healthcare as a whole across the country, we have thousands of contracts in place with health-care facilities and hospitals. You don't read about them when they're in place because there was a mutually agreed contract.

What's happened in New Jersey, and sporadically in other places, is the movement of these discussions into the press, which, I think, is unfortunate for all concerned, particularly the citizens of New Jersey who are sitting on the brink about whether they will have access to their hospital and their citizens.

The solutions to a hospital situation, the concerns that I hear from the doctors when I talk to the New Jersey Medical Society-- They're all real. But the solution of how we and how this Committee ultimately needs to come to the answer is to take off the combative postures that everybody has and to sit down and work together towards a solution that satisfies most people.

Here's the conundrum. Americans want the best quality health care that somebody else will pay for. That's the problem.

SENATOR CODEY: You're talking about whether or not they went public. I've got to notify people if, in fact-- I don't want to cut you out of your contracts. I don't know if that really is an issue here. It certainly is not with me.

But when I speak to people like yourselves, they will admit -- I don't know if you will -- that the inflation rate of health care today is not being driven by hospitals, in terms of their costs to you -- are way up, not at all. The cost of the hospital portion of the bill of health care has, in the last 10 years, gone down remarkably, without question, based on the contracts that you have entered into with these hospitals. But unfortunately for them-- I think, in many cases, they made some bad business decisions. And they cannot provide to you the services at the rate of reimbursement you've given to them.

In addition to that, they accuse you, the health care industry, of -- when they submit their claim, you're withholding claims -- payment to make money on the float. That's an old insurance trick that we all know. That is driving up costs for them. And I think if you looked at staffing numbers today, as opposed to 10 or 12 years ago -- New Jersey hospitals, all of them, across the board, are down. The ratio of employees to patients is way down. Maybe in some cases it should have been. The number of registered nurses per patient is down all across the board. And I think, in some degree, that obviously affects the quality of health care. They're not able to give, I think, a quality of health care today that they might have been able to give a few years ago.

DR. KRAKOVITZ: Perhaps Frank can answer. But I will say that, just in the past several months in the State of New Jersey, several hospital systems, not just individual hospitals, have very happily come to agreement with us for long-term contracts to be able to provide service to our members.

So yes, I can read the same newspapers you do about individual hospitals, but I think we have to be careful that we don't just paint too broad a stroke that every hospital is having the problems. And we have to look internally, not just to the per diem rate, but the doctors who are practicing in those hospitals, as well as the empty beds that are sitting in those hospitals, while the fixed cost persists.

SENATOR CODEY: By the way, just let me say something.

I would take exception to your characterization to a hospital as bricks and mortar. For many of us, it's a heart and soul of the community. They don't view it as bricks and mortar. Believe me when I tell you that.

MR. McCAULEY: I mean, the factual numbers at a local level in the last year, within our mid-Atlantic region, which makes up Pennsylvania, New Jersey, and Delaware, we've actually reached agreement with 38 hospitals -- that we actually renegotiated and recontracted with during that time period.

It is, unfortunately, the minority that do take it. And we mean, to the public, meaning -- actual, regarding the discussions and rate of increase that are being asked there.

It's unfortunate that, at the time of managed care's growth, you also have significant reductions occurring through the balanced budget here, which is also putting tremendous pressure on all providers, but particularly

hospitals. And so, consequently, they're coming back to managed care to foot that bill, and that's difficult.

What's also difficult is when you look relative to other areas of the country. We, as a national carrier, certainly, look to see how cost structures are from one state to one region to another. And when you see a region or a particular state that is out of line with other cost structures within the country, you have to say to yourself, you need to become more efficient in that area. And we've done a lot of things (indiscernible) through your recollection of claims payment -- were a huge proponent of electronic connectivity and actually are working very proactively not only with our hospitals, but also with the entire physician community, relative to their submission of all claims to us electronically.

Just real quickly, one of our programs, E-Pay, which allows, if a provider submits to us their claim electronically, we guarantee payment within that claim within 15 days. And on average today, it's actually all E-Pay claims are turned around in 5 days. So again--

SENATOR CODEY: Yes, but if you denied a claim, they don't get paid.

MR. McCAULEY: That would be correct, but again, we would deny a claim if it was not a covered service offered by the benefit program.

SENATOR CODEY: But it doesn't get into that. It seems to be there is a huge discrepancy between what they feel is correct and what you feel is not. And they accuse you of making money on the float.

MR. McCAULEY: Correct.

SENATOR CODEY: It's as simple as that.

MR. McCAULEY: Right.

SENATOR CODEY: And when you do that, you've already -- you have, by your contract, already cut their cost tremendously, so they're always precarious, in terms of cash flow, because they have millions and millions of dollars of receivables that are not getting paid on time, not within 15 days, not within two months, or not within six months because when you deny it, they have to go through this whole process. And the longer the claim gets denied, the more you make on the float and the less they're able to do, cash wise.

MR. NORCROSS: Senator, if I might, you've got your finger on a question that you all can constructively examine. We keep hearing that making money on the float -- and I can tell you that my client has never told me anything that supports that notion, but I know that notion is there. The extent to which that can be part of the examination of the time of payment, the percentage of declinations, that is clearly helpful in ferreting out some of these problems.

SENATOR CODEY: Yes, but Dave, I don't think Aetna has any money in noninterest-bearing accounts.

MR. NORCROSS: But I don't think Aetna's sitting on a consequential amount of money purposely to make money on that float. And if you think so-- I mean, if you can establish that that's the case, either with us or anybody else, clearly you have advanced the ball.

SENATOR CODEY: Oh, you're talking about millions and millions of dollars--

MR. NORCROSS: I understand.

SENATOR CODEY: --without question about it.

MR. NORCROSS: But I don't think that if you look into this you will find that that is a conscious decision made, at least, by this company. If it is or if it's made by others, you found a place to drive home.

MR. McCAULEY: The fact is, though, in reality, you actually have the opportunity to audit any carrier, and you've actually done that in the past, and we've always passed those audits. And that's looking directly at the claim system, the adjudication process, and the actual -- if there happened to be a provider complaint -- provide a complaint.

SENATOR CODEY: You had mentioned physician profile. I'd be interested if you could meet with Clark Martin, who represents the Med Society, and tell him how good that is. It's a consumer issue. I certainly appreciated that aspect of your comments because we're trying to pass a physician profile bill in the State of New Jersey over his objections.

We welcome your help there.

SENATOR SINAGRA: Is there anybody from banking and insurance out there? (no response)

No? Nobody is willing to admit to it? (laughter)

Oh, you are here.

When was the last time we audited U.S. Healthcare.

HEARING REPORTER: Mr. Chairman, can they please come up? They won't be on the record, Mr. Chair, if it's -- the microphones--

SENATOR SINAGRA: You can just shake your head if you know that we've audited them in the last 10 years.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Yes.

SENATOR SINAGRA: Okay, thank you.

SENATOR CODEY: And the record notes that.

SENATOR SINAGRA: And the record notes that.

Senator Codey asked a question. I think he was making a statement, but it really was in the form of a question. I'd like the answer to it.

When he was talking about the inflation of 10 percent last year, and anticipated 9 or 10 or 15 percent this year, he asked the question, is that coming from hospitals? He doesn't believe, knowing what we hear from the administrators of hospitals, that you're actually asking for deeper discounts than they've had in the past rather than giving them an increase of 8 or 10 or 20 percent. So if it--

Is it, or is it not, as part of this inflation, a cause of hospital system -- for your reimbursement of the hospital?

MR. McCAULEY: Certainly, it's a part of that 8 to 10 percent, without a doubt, Senator Sinagra.

SENATOR SINAGRA: Could you explain that to me, though?

MR. McCAULEY: Well--

SENATOR SINAGRA: I don't know of any hospitals that are telling me that you're increasing what you're paying them by 10 percent.

MR. McCAULEY: Without a doubt.

SENATOR CODEY: Excuse me if I'm wrong, but if you look at what you're reimbursing the hospital today, saying the daily rate for a private room, I'll bet you it's less than it was 10 or 12 years ago.

MR. McCAULEY: But outpatient services, as an example, might be 10, 15, or 20 percent higher than we were paying previously.

SENATOR CODEY: But my question is, is it less than it was 12 years ago? I think that answer is yes.

MR. McCAULEY: Overall, I would actually say, in the last three-year period, absolutely not. And in almost every contract for which we renegotiate now on a go-for basis, you're looking at an incremental increase over the total book of business that goes at that facility year after year.

And in some of those instances, actually--

SENATOR SINAGRA: No, no, I'm not talking in the aggregate.

MR. McCAULEY: Okay.

SENATOR SINAGRA: I understand in the aggregate you can easily have more patients. We can be a circa population, we can go through all of the gyrations of-- In the aggregate, you're paying this hospital more money. But it's more-- Well, it could or could not be true.

SENATOR CODEY: As what they're paying under the DRG?

SENATOR SINAGRA: But I'm talking about specific rates for the room rate, the surgical rate. Aren't those less than they were?

MR. McCAULEY: Less than 10 years ago?

SENATOR SINAGRA: Less than five years ago.

MR. McCAULEY: I would say, no, on average. Again-- But you have to look at if you assume the same number of members went to that facility, have the same exact number of services, overall, year to year, moving forward, those rates are actually increasing. And the overall revenue to those facilities is substantially increasing under a number of new agreements.

SENATOR CODEY: But for the same service that you're providing today at the hospital for your members, if you would trend that,

inflationary wise, that is the lowest factor in your cost over the past 10 years -- past couple of years under the new system.

MR. McCAULEY: I would not say it's the lowest. I would not be able to agree to that. I mean, inpatient hospitalization cost--

SENATOR CODEY: Well, other than salaries to your employees, maybe. I don't know.

SENATOR SINAGRA: Profits, dividends, all the other stuff.

MR. McCAULEY: Actually, profits and profit margins in the state, as you know, for every managed care plan, have been actually treading in the opposite direction.

SENATOR CODEY: Yes, you're right, recently.

MR. McCAULEY: Correct.

SENATOR SINAGRA: Anyone else?

SENATOR MATHEUSSEN: Yes, I just wanted to-- It sounds to me like maybe what we really need is to get everybody in the room at the same time. That would be a real interesting turnout because, in all due respect to your testimony, you're very clear in where you think your company stands, but yet, I'm sure I'm not the only one, as a legislator, who gets phone calls from patients, consumers out there, as well as health-care providers, who complain, perhaps, not about your company in particular, but about HMOs and the entire network of insurance companies that are out there.

Some of it has to take the blame. All sides have to take the blame, in my opinion. If we don't, then we're not going to get any place. We're going-- Then we're going to sit here as a judge and jury and make some decisions that may not please everyone. I don't suspect they will anyway. But

there are some things that are out there that you cannot deny, and again I'm not particularly picking on your company, but, you know, poor bedside manner brought a lot of the mandates that we put in place over the years.

Had it not been for the fact, and Senator Codey said, that we asked women to leave the hospital in 24 hours after giving birth, and that was driven by providers, as well as insurance companies, we wouldn't have had to mandate a law that says leave them stay in for 48 hours. If we hadn't done the same thing with mammograms -- with mastectomies, we probably wouldn't have had to mandate that one, as well.

Now, in your testimony, you indicated that these are some of the things your company did but your peers did not do, apparently, because I go over a list of mandates, starting back in 1966 -- the first one mandating coverage for newborns, in 1975. We had to mandate that. We had to mandate home health care, which now is a very terrific trend, on helping hold down costs. Home health care, second surgical opinions we had to mandate. Mammogram screening we had to mandate. Home health wellness coverages we had to mandate. These are listed on this.

You're telling me I'm wrong.

MS. PUROLA (Committee Aide): I don't think the home health care is a mandate.

SENATOR SINAGRA: That's our next mandate.

SENATOR MATHEUSSEN: Maybe that's our next mandate.

But in any case, the Legislature is taking the blame for some of the mandates, and you're sitting there, now, taking credit for some of the things that you did before they were even mandated.

DR. KRAKOVITZ: That's exactly what I was doing.

SENATOR MATHEUSSEN: That's great. I applaud you. Too bad you couldn't have convinced your competitors to do the same thing.

The bottom line I'm trying to make here is that I think we're going to have to get everybody in the same room because not more than a few months ago we had a lot of the providers in the room -- the doctors and the hospitals saying, "Guess what, they're holding on to our money for 180 days." And you're telling me you never do that. The doctors said the same thing. Well, somebody is telling us something wrong here, and in order to get to the bottom of it, maybe everybody has to be in the room at the same time.

But I don't want everybody to keep coming up here and telling us that the mandates are no good, when some of you are putting them in place. So apparently you thought they were pretty good. The Legislature did, too.

SENATOR SINAGRA: On that -- just differentiating between companies. The problem with managed care and HMOs as a group is-- We'll always hear about the worst provider, and the whole group has to be-- Unfortunately, we have to legislate towards the worst. And, in fact, one of the things I was convinced -- this Committee was convinced not to do was, in our appeals process, not to make it a binding appeal when someone goes through the entire appeals process. But we're going to change that. At least we've introduced a bill to now-- If somebody goes through all the -- internal appeal and external appeal and gets to that point, that appeal's going to be mandated -- the finding-- We just know of two cases or three cases this year where -- not necessarily your company, but others -- somebody went through the entire

process and just said, "Listen, we're not going to do it. We're not going to pay for it. It was a mistake."

DR. KRAKOVITZ: I think an observation would be that Aetna U.S. Healthcare is nothing without hospitals and doctors. Doctors need hospitals. We all need each other. And, in fact, the solution is very much interrelated and intertwined. It would not just be fun, but probably progressive to get the different parties together in the room and talk through solutions, as opposed to--

What's happening right now is that there's a lot of misinformation -- I'm hearing some of it today, and I heard it when I sat down with the medical society -- in terms of what we do. And I think if we'd sit down and we agree to the problems that we both have, we can come and work forward to solutions. There needs to be a better way, and open communication will do it. As it points to health care, in general, the better the communication, the better the patient's ultimate result.

SENATOR SINAGRA: Thank you.

Anyone else?

SENATOR MATHEUSSEN: Best testimony I heard all day.

SENATOR ADLER: If we're talking about who has to be at the table for this group discussion to work out issues, we have to have employers who actually pay for health insurance because they're putting pressure on the carriers to reduce costs. And sometimes, to reduce costs, some carriers choose to reduce certain sorts of benefits and services.

You guys, of course, never do that. And I see-- But your competitors sure do.

So they have to be at the table, too. And I think if we're talking about that, we're going to also have to talk about -- somebody's got to be a voice for the uninsured, other than just the hospitals and providers who want to get reimbursed for the uninsured. I know the Senate President talked about somehow expanding coverage. But they have to be at the table, or some advocate for them at the table, to talk about how this is not a fee-for-service system where it's just two people in a relationship. It's lots of different parties in this multiparty relationship. All of them have legitimate perspectives, and all of them, from the different perspectives, push the system in different ways that are now dysfunctional.

We now have 19 percent uninsured, and hospitals and doctors are out so much money that they don't get back from the State because the State doesn't pony up. A lot of great employers provide coverage, but some employers choose not to. And there are free riders in system that cost the rest of society the money through taxes, and through doctors and hospitals eating the costs.

So I love the idea of a big table with lots of seats, but there have to be enough seats to include the employers who are playing and somehow a voice for the employers and other uninsured who are not in the system at all but who want to get in.

SENATOR SINAGRA: Thank you, gentlemen.

MR. NORCROSS: Thank you.

MR. McCAULEY: Thank you.

DR. KRAKOVITZ: Thank you.

SENATOR SINAGRA: AmeriHealth, if you still want to come up here.

**RICHARD J. GILFILLAN, M.D.:** Good afternoon, Senator. Thank you very much for the opportunity to be here.

My name is Rick Gilfillan. I'm the General Manager for AmeriHealth HMO of New Jersey and AmeriHealth Insurance Company of New Jersey. And I want to echo the thanks given to Senate President DiFrancesco for convening these hearings and to you all as a Committee for inviting us to be here today.

I am a physician by background -- a family practitioner who spent four years, from 1985 to 1989, practicing in Trenton, also working as a medical director part-time then. And for the past 10 years, I have worked in various capacities for our parent company, Independence Blue Cross of Philadelphia.

AmeriHealth and its affiliates currently cover about 4.2 million members in four states and the Caribbean. We're very proud that AmeriHealth is also fully credentialed and approved and accredited by NCQA and has also done very well in the recent HMO report cards issued over the last three years. We've been at the top each time, so we're proud of that, and we think that's been an important part of our success.

But I'm here today not so much to talk about that. I wanted to come and be a resource to you all and answer any questions you have, offer some ideas about what the system looks like at, perhaps, a little more microlevel than some of the discussion we've had so far. We agree with a lot of the stuff that has been said by our colleagues in the insurance industry.

I must point out that *As Good as it Gets*, the issue was Helen Hunt saying something-- blank HMO would not allow my son, who had asthma, to see a specialist. And it was, indeed, an incredibly ironic point, if you're in the managed care industry, to hear that statement and know that we have staff full-time working to get asthmatic kids to see doctors who specialize in taking care of that problem.

I sat there and heard all those people clap, and I felt, I guess, sad and confused because there are a lot of places where you can get us, and man, that was a bad shot. It was one of those that just missed the mark entirely.

SENATOR SINAGRA: It was a good movie, though, wasn't it?

DR. GILFILLAN: It was a good movie. I did enjoy it, and I had some patients it reminded me of, as a matter of fact.

You know, as several people have said today, when you view the system as a consumer of services, health care is, as we all like to think and should be, a right for about, I guess, 8 million people in New Jersey to receive everything they need, everything their physician says they need, when they need it, where they would like to get it, and, ideally, with excellent and perfect outcomes.

And I want to say I agree with that one. I'm a consumer of care, and I don't want to shortchange the issue of quality and outcomes today. But my understanding is the issues before us really have more to do with the affordability and accessibility. So I'm going to really try and direct my comments and thoughts to that.

Having fully acknowledged what, I think, is an excellent health care system in the State of New Jersey from the standpoint of outcomes, there

are opportunities to get better, and we all know that, particularly as we've heard recently about medical accidents or errors. But if we look at health care as a business for a moment, what we see is something-- It looks different, it feels different, and you understand how the system works in ways that are different from what we would like to expect as a consumer.

When you look at it as a business, health care in New Jersey is a marketplace in which 8 million people will consume \$13 billion worth of services ordered by somewhere around 18,000 to 20,000 physicians next year or this year.

This is a great business opportunity for participants in the health-care industry. And every day, moment to moment, thousands of physicians, hospital administrators, and yes, even HMO and managed care executives, look and see a business opportunity, and they're behaving that way. They behave that way every moment of every day. We think about quality, we work to fix quality and improve quality, but the reality is, they're in business. It is a for-profit system in every sector. It is not just a matter of for-profit health plans. The reality is, the profit margins we operate on, as health-care plans, is less than the typical operating margin of hospitals over the last five years.

Combined, we have lost, as an industry, \$250 million over the last two and a half years. So the margins are negative, nonexistent if you will. So, in a very real sense, hospitals are as much driven by the need to see a little something on the bottom line as our HMOs and managed care organizations.

Doctors, and I'm speaking as one, having practiced not only here, but in Massachusetts and in Washington, D.C., are clearly focused on driving revenue, on profits, on take-home income. And you cannot understand how

the health-care system works, why we have the problems with affordability and accessibility, if you did not confront that fundamental reality of what drives the system of care today.

I'll come back to that in a moment.

Let me briefly touch on a couple of issues that have come up and been asked about in terms of products. We offer HMO, point of service, PPO and indemnity products, although not much in the indemnity line these days.

Trends on our HMO medical only are running, as others have said, 8 to 10 percent. The drug piece is about a 30 percent trend. Today, the drug piece adds up to 15 percent. About three years ago, it was around 11 percent. It's increased, as a percentage, almost 50 percent of the health-care dollar.

If you step up to a PPO, the increased cost for us is about 20 percent. If you step up beyond that to an indemnity plan, it's another 15 percent. So if you look at an indemnity plan today, in our business, it costs about 35 percent more than an HMO. The trends are, as I mentioned, 8 percent on the HMO, 8 to 10 percent -- 10 to 12 percent on a PPO, and about 12 to 15 percent on indemnity. The base is significantly higher. The trend lines are similarly much higher.

Let me take an example of what -- where the dollars go. If the total premium on a typical HMO POS product today -- and I'm going to use numbers that are not exact or specific to our plans but I think are consistent with what most people are experiencing today. You'll see the total premium, on average, and this does not correspond to the individual premium paid by -- under the IHC plans-- But if you took all commercial members and said, "How much is an employer paying every month for every member covered?"

the answer is about \$160 -- in that neighborhood or ballpark. About 15 percent of that, or \$25, is going to administration. Of that, we hope that there's a 1 to 3 percent profit margin. As I have mentioned, it has not been there over the past three years. That leaves a medical loss ratio, or a medical cost, of about 85 percent, or \$135.

Where do those dollars go? Today they go -- 22 percent to inpatient care -- ballpark -- \$30; 13 percent to outpatient care, \$18; about \$48 or 35 percent, to hospitals today.

Nobody goes to the hospital without a physician. And if I go back to that point about what drives health-care costs, it is fundamentally the interaction of a patient with a physician.

So, 35 percent hospital costs -- physician cost today -- 37 percent -- ballpark -- \$50, if you add it all in, including primary care and speciality costs. Other providers -- other types of ancillary providers is another 13 percent, or \$16 ballpark.

Drug costs are running about 15 percent, as I mentioned, or about \$21. They've gone from \$13 or so three years ago to \$21. That's an increase, in the total premium, of about 4 percent; and of the cost of the insurance itself for drugs, about 50 percent.

So what drives medical costs? The number one issue is the practice patterns of physicians. And if we ignore that, if we don't come to grips with it, the reality is it will keep going and going and going.

The second key issue is the efficiency in delivering the services that are ordered. We've talked a little bit about efficiency today. The truth of the matter is, in commercial HMO experience in New Jersey today, we're using

anywhere from 40 to 60 percent more hospital days than other areas of the country. If we take, as an average -- that in New Jersey today, if you asked HMOs -- ballpark -- days per thousands, as reported over the last two years, it's around 250 per 1000, and you go to the most effective managed care entities on the west coast-- And today, in other parts of the country, those numbers are running down in the range of 160 -- 160 days in the hospital over the course of the year for every 1000 members. And in New Jersey, we're running 250. That's an increase -- difference of 50 percent.

SENATOR ADLER: Can I ask a question?

SENATOR SINAGRA: Sure, go ahead.

SENATOR ADLER: Is it your testimony that the primary cause of that differential between New Jersey's hospital days and the rest of the country, on average, is physician overuse of hospital days, or are there other factors like the age of our population and--

DR. GILFILLAN: I've asked that question--

SENATOR ADLER: Let me finish my--

DR. GILFILLAN: I'm sorry.

SENATOR ADLER: --maybe the urban nature of our population--

DR. GILFILLAN: Right.

SENATOR ADLER: --or the fact that we don't have, maybe, enough people in preventative care and regular doctor-patient relationships that other states might have? Do those factors contribute more heavily than physician abuse?

DR. GILFILLAN: I would not want to sit here and say in my testimony that there is physician abuse in the system. I don't think that's what's going on, Senator.

But indeed, your-- The issues you mentioned are a part of it, I believe, but I do not believe that they are the major cause of that difference. And I've asked actuaries that very question, at least, with regards to the health status and age, etc., of the population. And that is not our experience.

Let me cite, if I could -- this may be a little provocative, but let me cite the experience that many people have had on the mental health side as an example.

I was reminded when a comment was made before about benefits -- about, you know, whether we -- if we provide more benefits, people will avail themselves of it. And it's kind of like highways. If you build them, they will be used. The health-care system, as a whole-- If the benefit is there, it will be used. And the best example I've ever seen of that is in mental health, and I've had this experience in two different states and three different companies.

If you go and measure the days per 1000 use for mental health and chemical dependency in an unmanaged care system, you will find that those days range, on an average, ballpark -- they could be 70 to 90 days per 1000 members per year.

When you bring in a managed care approach, those days per 1000 in those facilities have historically and repeatedly decreased to the range of 20 to 25 days per 1000 for exactly the same population. If you build it, they will be used, and they will come. And that is the degree and the potential degree of overuse of services that can occur in the system. And I would add that every

one of the mental health providers who used those 90 days per 1000 believed, fundamentally, they were doing the right thing clinically, and the right thing for the patient. It's just that the system allowed it to occur, and they had, quite honestly, very strong financial reasons for behaving in that manner. And when they do, they use to that extent.

Now, whether the 50 percent differential I cited is 100 percent due to the physician practice pattern's differences or 30 to 40 percent due -- I'm sorry -- 50 to 60 percent, I think, at a minimum, of that difference is a result of physician practice patterns. Yes, I believe that. It also is a function, in a secondary way, of the fact that the hospital beds are available. If they were not available, they would not be used, and we would find more creative ways, and I suspect more effective, and potentially higher quality, ways of providing the services that those patients need.

Did I answer your question, Senator?

SENATOR ADLER: I think so.

DR. GILFILLAN: Okay, on the Medicare side, the number is 2500 days per 1000 members per year, ballpark. In managed care, in aggressive, if you will, and effective managed care settings, that number can come down to 1500 days per 1000. That's a decrease, again, of almost, if my math is right, 50 percent.

That's remarkable. It seems unbelievable, but it has happened in other places, and it's not just California, where the weather's good and the surf's up, I guess.

So practice-- And I don't want to be-- I'm not trying to blame those of us who are physicians. I'm simply explaining the dynamics and structure of a system.

SENATOR SINAGRA: You're doing a very good job of it.

DR. GILFILLAN: Then I take my share of it. But the truth of the matter is, we, in managed care in the Northeast, have been unsuccessful at driving significant change in that fundamental practice pattern. And the result is higher costs, more uninsured, and higher premiums, obviously, paid by employers when they are insuring their employees.

The efficiency of the system also goes to the issue of -- that's been mentioned already, of underutilization of the hospitals. And the simple reality is, I think, the hospital advisory commission made clear -- we cannot have both optimal care from an efficiency standpoint -- and I would suggest the highest quality care, and keep open every hospital that exists in the State of New Jersey. They're fundamentally incompatible objectives that need to be resolved. And there is a plan put forward by the advisory commission to look at that.

Another key driver is the system of marketing strategies of nonphysician components and physician components, for that matter. But the reality is, it's a business, people are trying to drive revenue, they're trying to drive business, and they have marketing strategies that are very effective. We also have heard about today, patient demands for services. They're critical. And it, clearly, is a major driver, as we've seen in the pharmaceutical advertising campaigns.

The underlying health status of the population is important, it's gradually aging, it's a component, it's a distinction from community to community, but it's not something that's terribly different from one marketplace to the next in a macro sense. And the technology of health care is a key driver of, you know, that inflation as well.

The result of those drivers being unbridled, in many ways, is increasing costs with the trends that we've talked about today. And the HMO losses we have seen over the past three years are a result, fundamentally, of not recognizing what those trends were soon enough.

So what are we doing? On the managed care side, we are increasing premiums, and quite honestly we are, kind of, gradually seeing insurers and individuals limit their benefits accordingly. We're seeing copays that went from \$2 for doctor visits to \$10 and \$20. And in the individual market there are \$30 visits to doctors. We're, kind of, partially deinsuring, if you will.

But the reality is we cannot have patients -- all of us as patients, be operating in a system where it feels like it's for free. We have a responsibility, and we have to make judgements ourselves about when to access care because fundamentally, if it's free, we will use it, and we will use it, perhaps, more than it's necessary to do.

The result after that of higher rates is more and more uninsured, as we've talked about today. And bad quality for those individuals. Women will die because they don't have insurance and they don't get mammograms, and men will die from colon cancer for the same reason. That is the

fundamental end result of people not being insured and having the opportunity to get preventative care.

There's a lot of noise today. We're hearing it. And we've talked about a lot of it. Why is it there? Much of it is the inherent complexity of the system. It is very hard to pay physician bills and hospital bills for a whole lot of reasons. Simply put, if you have like we do, 300,000 members seen by 20,000 doctors and about 120 hospitals, all of whom have different ideas about the right way to bill, it can get very complex, very fast. And notwithstanding everyone's best intentions to pay quickly, there are times when we don't. That's true. It is, fundamentally, in our business interest to pay faster so we know what our costs are and so we can price our products appropriately. Notwithstanding the issue of float, the reality is, we would like to get our bills paid accurately and fast the first time. And I think we need to work with providers, and there are efforts underway to try and work with providers to make that more effective.

There also is a great deal of resistance in efforts to push for efficiency. When you hear about denials, it's important to think about two aspects of it. One is a claim that was denied and the member's told they're liable. That is a very unusual circumstance, for the most part, in managed care plans. The second issue is hospitals complaining about denials, today, of hospital days. "A patient was in for seven days, they're only going to pay me for three."

I can't speak to everybody's practices, but the reality is, one of the reasons we have that incredible discrepancy in days per 1000 I described earlier is because the hospitals in New Jersey are not very efficient today, in

terms of length of stay and moving patients through it. If we do nothing, as managed care organizations, nothing will change, they will not get better. We do see it as part of our role today to work with hospitals and to try and improve that efficiency. But the reality is, if it doesn't cost them something at some point, the chances are they're not going to change.

Senator.

SENATOR VITALE: If had you reconciled-- You're telling me that your length of stay issues in New Jersey and that hospitals are unwilling to move patients through the system as quickly you'd like to see them move through the system. Let me, sort of-- The basic question is, who is making those decisions, and don't you think that the physicians and the hospitals ought to make those decisions? That is a very basic question--

DR. GILFILLAN: Yes.

SENATOR VITALE: --with lots of pitfalls and, I'm sure, lots of answers.

DR. GILFILLAN: Right.

SENATOR VITALE: But you're saying that some of these for seven days should have been only for three. You have your medical staff that says it ought to be three. They have their doctor on staff that says it ought to be seven.

DR. GILFILLAN: Let me just take one step back.

SENATOR VITALE: I don't think they keep patients in the hospital for the money.

DR. GILFILLAN: I'm sorry?

SENATOR VITALE: Do you think-- Are you saying that they keep patients for additional lengths of stay because they profit from it?

DR. GILFILLAN: Do I think doctors and hospitals do that, yes.

SENATOR VITALE: Really. Could you explain why you think that way? Why do you think--

DR. GILFILLAN: I think-- I mean, they're businesses.

Again, I want to be very -- try and--

SENATOR VITALE: You used the example three to seven days.

DR. GILFILLAN: Yes.

SENATOR VITALE: So you're saying that the hospital potentially keeps the patient there four additional days for the sheer sake of earning four days--

DR. GILFILLAN: Nobody does anything in health care for the sheer sake of any one thing. What happens is, there is a way of practicing that develops, and I really don't want to sit here and impugn the judgement or the interest in the quality of care that doctors and hospital administrators and hospital staff have for patients. It's not about that. It's about the way we develop practice patterns over a long period of time. And it plays-- From the doctors' side, I believe, it happens in two places. It happens, one, with the decision to admit a patient to the hospital. And if you look at admission rates in Medicare, as an example, total days are made up of two pieces: the number of admissions multiplied -- times the length of stay.

If we look at the markets that I described before, that have more or shorter or smaller days per 1000 -- fewer days per 1000, their admission rate per 1000 members in Medicare is approximately 250 admissions per 1000. In

New Jersey, that number runs on the order of 325 to 350 or more admissions per 1000.

So point one in this -- in the practice pattern issue, is the decision to admit. Now, that has to do with lots of things like what other alternatives are available, what alternatives the health plan or the community has established, but it also has to do a lot with how a doctor practices. And many doctors who start with, and are very comfortable, putting a patient in the hospital who is sick. They feel better about being able to see that patient daily. They don't know of another way of practicing, perhaps, that would allow them to be comfortable with that patient at home. And in the back of their minds the doctors think that if I have 10 patients in the hospital, there's going to be income, yes, they do. That's just the nature of health care as it's being delivered and financed in this country and in New Jersey.

Now, the interesting thing is, how did those places get to 150 days per 1000, or in Medicare, 1500 days per 1000? And the answer is, frequently, doctors were at risk for the whole bill. And they found ways, and were incented to find alternative ways of caring for patients that didn't necessarily involve putting them in the hospital. And as a result, their days in the hospital decreased dramatically. So if, in the commercial population, you admit 70 times per 1000 members in this environment -- that when they were at risk, they went down to 55 admissions per 1000.

So it happens. It has happened repeatedly in communities across the country, and the reality is, we have been unsuccessful, in the managed care business in New Jersey, at creating that environment -- risk has a spotty history as we all know -- risk contracting with providers. And so one of the things that

we are currently doing -- I think all the plans are doing -- working with hospitals more aggressively to try and introduce some of those practice patterns that were learned elsewhere into the New Jersey marketplace.

SENATOR SINAGRA: Thank you.

Any other questions? (no response)

Are you done?

DR. GILFILLAN: I just want to wrap up and say, I know you're going to consider a lot of alternative proposals for legislation. I think there are key issues that need to be thought about and some questions. I will suggest -- will any initiative that you all take lead to higher premiums, and if so, know that you will have more uninsured members. Will any initiative lead to less efficiency, efficiency in the way care is delivered? If you do-- If it does, it will lead to higher medical costs, higher premiums, and more uninsured. Will any initiative lead to product selection for patients to choose the product that fits them well, perhaps with lower benefits, and if it does, it may very well lead to more insured coverage. And therefore, I think it will be a very positive thing. And we will provide some written documentation and testimony to the Committee regarding specific products, many of which have been discussed previously today.

But we are concerned, and most specifically, as an example, we're concerned about the lack of a formulary for the small employer health market. And that is, today, causing an increase in premiums for drug products in that marketplace, probably on the order of 12 to 15 percent more than what we can provide in the over-50 market.

In conclusion, I'd like to thank you, Senator, and all members of the Committee for the opportunity to be here today. I'd be happy to answer any questions. We'd be happy to answer any other questions that come up as you go through your varied hearings. And we'd be happy to participate in any mixed meetings or hearings if you think that would be helpful.

SENATOR SINAGRA: Well, what will happen is we will have three meetings with other vested interests in the health-care delivery system, including the patients. And after that, there will be a -- the Committee will have a package of bills, and then there will be a full hearing where everyone will be allowed to testify on whatever the actual outcome of these hearings is.

So until then, I don't think I'm going to take everybody in the same room at one time.

Thank you.

DR. GILFILLAN: Thank you.

SENATOR SINAGRA: The last person that will be testifying today is Wardell Sanders.

**WARDELL SANDERS:** Good afternoon.

My name is Wardell Sanders, and I'm the Executive Director for the New Jersey Individual Health Coverage Program, known as the IHC Program, and the Small Employer Health Benefits Program, known as the SCH Program.

The Individual and Small Employer Boards are responsible for regulating the individual and small employer markets in conjunction with the Department of Banking and Insurance. The boards are composed of interested members of the public, including carriers, appointees of the Governor, and

representatives of State government, including an appointee of the Commissioner of Banking and Insurance.

One of the first -- just briefly talk about the origins of New Jersey's health insurance reforms to understand where we came from, and some of the other speakers have touched upon this, as well. These bills were signed in 1992 by Governor Florio, creating the Individual and Small Employer Programs. The reform laws were designed to address a number of problems faced by individuals and small employers.

In the individual market, prior to reform, individuals lacked choice and access to health coverage, and the burden of covering higher risk individuals was concentrated with Horizon Blue Cross Blue Shield, which was required, under the law, to accept all persons. As a result of this burden, Horizon was in financial jeopardy, partly as a result of this.

In the small employer market, prior to New Jersey's reforms, the small employers were having a difficult time finding coverage and being able to keep that coverage, especially where they had high risk individuals, employees, or dependents within the group.

So the purpose of the reforms was to address these problems by creating better access to health insurance coverage and also to distribute the risk in the individual market to a broader range of carriers.

Just to touch briefly upon the features of the reforms-- There are really five key features of the reform. The first was guaranteed access and renewal of coverage for individuals who are residents of the State of New Jersey not eligible for Medicare and not eligible for group coverage. They're guaranteed access to health coverage, regardless of their health status or their

prior claims history. In the small employer market, that's employers with between two and fifty employees. All small employers are guaranteed access to coverage as well and guaranteed renewability of that coverage.

The second is portability and limitations on what carriers can do, with respect to preexisting conditions. In short, all conditions are covered when a person is enrolled if they haven't had a significant lapse in coverage, and that significant lapse period is going to differ, depending on which market of insurance you're in.

The third item, and I'll discuss this at a little greater length because there's been some interest here today about the standardized plans. All carriers are responsible for offering five standardized plans that have been developed by the Individual and Small Employer Boards or through an HMO carrier -- the standardized HMO contract.

The implementing legislation for both of these programs set forth the parameters for a basic or bare-bones plan, which has been labeled Plan A. The rest of the plans were designed really, and have been developed, to contain a common comprehensive set of benefits, with the policy holder coinsurance levels being modified to create the different actuarial value in the plans. So Plan A is sort of a separate creature, and it's primarily a catastrophic or bare-bones hospitalization plan. Plan B has a policy holder coinsurance of 40 percent; Plan C is 30 percent; Plan D is 20 percent; and Plan E is 10 percent, and then there's the standardized HMO contract.

The plans, other than Plan A, all cover hospital care; prenatal and maternity care; immunizations and well child care; screenings such as mammograms, pap smears, and prostate exams; Xrays and laboratory services

and mental health and substance abuse services; prescription drugs and a preventative care benefit, which is \$300 for every individual or member of the group, and \$500 in the first year of life. So those are the-- As you can see, it's a comprehensive set of benefits that these plans cover.

The individual board looked at the standard offerings and did make some modifications to those standard plans. There had not been much interest in Plan A or Plan E, so the boards dropped those plans and developed a, sort of, new Plan A, Plan A-50, that was not a bare-bones plan. That provided for 50 percent of coinsurance -- policy holder coinsurance. So it really is very much the same as B, C, and D, just with that difference of policy holder coinsurance.

The Small Employer Board is just now going through a comprehensive review of its policy forms, clearly with an eye toward making coverage more affordable. My office handles a lot of the inquiries from consumers, many of whom had contacted your offices first. And probably the largest complaint we get is about the affordability of coverage. There's no question about it.

So the small employer board is looking at these comprehensive plans to look at what modifications can be done to make coverage more affordable. And one of those things that was talked about today was the issue of prescription drug formularies. The Small Employer Board is interested in developing, within the standardized forms, the ability for carriers to offer a prescription drug formulary to address the cost.

In addition, there's no prohibition, right now, in a carrier from filing a rider to these standard plans, which is allowed in the small employer

market, to use a prescription drug formulary. There's certain regulations that the Department of Banking and Insurance and the Department of Health have, with respect to how those formularies may be structured to include consumer protections.

The fourth element of New Jersey's reforms dealt with rating restrictions. Small employer plans may be rated only on the basis of age, gender, geographic location of the group, and the family structure that's purchasing -- employee only or employee independents. Individual plans are community rated, meaning that there's no factors an insurance company can look at other than the family structure in issuing the plans.

Lastly, the fifth element of reform is really one of the items in the law that was designed to address affordability of coverage, and that's a loss ratio requirement. At the end of every calendar year, carriers have to demonstrate to the State that, for every dollar that they've collected in premium across the book of business, they've paid out \$.75 in benefits on the dollar. So it gives them a window of 25 percent. If they don't meet that -- if they have, for example, a -- \$.50 on the dollar that they had returned, then they have to provide a refund to the consumers that were covered under those plans during that time.

To date, in the small employer market, there's about \$50 million that has been refunded to small employers since 1994. And in the individual market, somewhere between \$4 million and \$5 million has been refunded as a result of this provision.

Now, one other item I wanted to touch upon was that, in developing changes, we will be constrained by what the Federal government

has done. The Federal government passed a Health Insurance Portability and Accountability Act in 1996. It addresses many of the same features that New Jersey's reforms have addressed. The first three items I list: guaranteed reissue and renewability, limits on preexisting conditions, and portability of coverage.

New Jersey's laws, in most cases, met and, in many cases, exceeded these Federal reforms. There's not going to be an ability, after the passage of this, without a change of Federal law, to go back on some of those things that have been enacted now in Federal law.

The last element of reform is really an element of the individual market, and that's the loss assessment mechanism. It provides that any carrier offering health benefits coverage in the state, whether it's in the individual market, the small group market, the large group market, they're going to have a responsibility to the individual market. And they have a number of ways in which they can meet their obligation: they can sit on the sidelines and pay an assessment to those carriers that do get into the market and have reimbursed the losses; they can get into the market and seek reimbursement of any losses that they have; or they can choose to seek an exemption by agreeing to write a certain number of nongroup persons in the individual market.

Losses, pursuant to this mechanism, range from about \$78 million in 1995. The loss assessment mechanism has shifted to a two-year cycle. In 1997 and 1998 combined, the losses were \$30 million. This was designed to encourage carriers to get into the individual market. And where we previously had one carrier offering coverage in a guarantee issue basis of Horizon, we've had up to 30 carriers in the individual market offering coverage. That number has since decreased with mergers and acquisitions and with some carriers

withdrawing from the market. Today there is 24 carriers offering coverage, with the bulk of the enrollment with the HMOs and with Horizon as -- for indemnity coverage.

Over the past couple years, I've had the opportunity to speak at a number of national forums on individual and small group reforms. And even prior to HIPAA, most states enacted the individual and small group reforms similar to New Jersey's. In short, there-- I think our experience in these two markets has been very similar to what's happened in other states. Small group reforms across the country have been seen as successes, providing more fairness, especially for those with higher health risk and bad claims experience.

Individual markets across the nation, however, have struggled, largely, as a result of higher morbidity rates than those markets and inherent risk selection problems. Every state that I've spoken to, and there have been a number of them, have had significant problems trying to provide inexpensive coverage in the individual market when people with significant health risks are included.

You should have received some packets -- some information about rates. The individual board does a monthly comparison of rates for every single plan that's offered. Additionally, the small employer market-- Since carriers are permitted to rate based on age, gender, and geography, we couldn't provide every employer with rates. We do a sample, as is done in other markets of insurance, based on a fictional six-person group.

Clearly, there are some lessons to be learned. The first, for consumers, is that they need to shop around for coverage because the prices can vary pretty dramatically. You'll see some of the carriers, especially in the

individual market, with rates that are four or five times the lowest carrier in the market. There is a provision in New Jersey State law, and now embodied in Federal law, which prohibits a carrier from reentering a market if they withdraw for-- There's a five-year ban on reentering. So, I think that some carriers, probably, are constructively withdrawing by dramatically increasing their rates. So if you look at that rate sheet, you'll be startled by some of the rates, but I think there's very few people actually enrolled under those more expensive plans.

With respect to plan selection, the trends in both markets have been for individuals and small employers to shift to plans with greater policy holder contributions. So they've sought out plans with greater deductibles, they've sought out plans with greater policy holder coinsurance, and for HMO plans with larger copays.

There's a fact sheet that I also distributed that lists the coverage by plan type in the market. At one time there was a fair number of people covered in Plan *D*. There's been a migration, definitely, to Plan *C* and Plan *B*. The bare-bone plans, and I know Senator Bassano is interested in that-- In the small employer market, there was 111,000 contracts that were issued in that market. There are only nine contracts that were issued to small employers who wanted Plan *A*. So it really has not been a popular option. It's available today for people, it just has not been very popular. Even Plan *B* in the small employer market really represents only 4 percent of the plans in the market. I think the boards would be very interested in looking at lower cost options and bare-bones plans. We probably would have to structure, I think,

differently our experience -- differently that Plan A, as our Plan A plan, has not been popular in either market.

The other feature of plan selection that's very obvious is that, in the small employer market, there has been a definite shift in managed care plans. There's very few indemnity plans left that the small employers have. Twenty-three percent of the plans in the small employer market are closed panel HMO products, where you can only go to in-network physicians or -- except in the case of an emergency -- the rest of the plans -- almost all the rest of the plans are PPO or POS plans issued by either indemnity carriers or HMO carriers.

With respect to the enrollment in the market, the-- In the small employer market, enrollment has increased steadily since the inception of the program. At the end of 1994, when we first measured enrollment, there were 690,000 New Jersey residents covered under small employer plans. That includes both employees and dependents. As of October 1, 1999, there were 898,000 people covered under small employer plans. Again, that includes both employees and dependents. So it's almost an increase of 200,000 lives in four or five years.

Enrollment in the individual market resembles more of a bell curve. Initially, the program was successful in reaching out to people who previously didn't have insurance. And since January of 1996, enrollment has decreased at a steady pace. There's probably a number of factors that could explain this, and I think Mr. Meisner, from Horizon, touched on some of these. One he didn't mention was the Health Access Program, which was a program that provided subsidized coverage for people to purchase individual

coverage. They accept -- stopped accepting applications in December or January -- January of 1996. I think there was about 23,000 people, at its height, covered under that, but they stopped accepting new applications because of funding issues.

Secondly, the individual market is, by its very nature, a transitional market. You lose eligibility for coverage when you become eligible for group coverage, and most people will choose Medicare coverage when they become eligible for Medicare. New Jersey's economy has been fairly good, so, presumably, a number of those people covered in the individual market have sought coverage in the employer based market when they became eligible for it.

Third, we've seen a migration from family owned businesses from the individual to the small group market, where you have a husband and wife both working for a common enterprise, and they both can demonstrate that they're working 25 hours a week or more, they become eligible for the small group market. And I think that some, faced with the prices in the individual market, have sought relief by going to the small employer market. And they just have to demonstrate to the carriers, in one fashion or another, that they have both members of the family working for the company.

And lastly, clearly, the increases in the rates in the individual market have led some people to drop coverage.

Are there any questions?

SENATOR SINAGRA: Any questions? (no response)

Thank you very much.

MR. SANDERS: Thanks.

SENATOR SINAGRA: Thank you for-- We will send out a notice as to our next meeting. It will either be-- It will not be here. It will either be in the North or the South, depending on whether I want to make Senator Adler happy or Senator -- depending on who--

SENATOR VITALE: Well, just for the record I want to just recognize that the Middlesex delegation stayed to the bitter end.

SENATOR SINAGRA: Well, see-- If some of you noticed, the people who live the furthest are the senators that leave the earliest. Senator Vitale and I can't leave early because we're not that far away.

Thank you very much.

SENATOR VITALE: I would not leave in the middle of your testimony.

MR. SANDERS: Thank you.

**(MEETING CONCLUDED)**