
Public Hearing

before

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

*“Testimony concerning the continuing impasse
between Horizon Blue Cross Blue Shield of New Jersey and
Cooper University Hospital with regard to negotiating contractual reimbursement rates*

LOCATION: Rutgers, The State University of New Jersey
Camden Campus
Camden, New Jersey

DATE: February 10, 2004
10:30 a.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblywoman Loretta Weinberg, Chair
Assemblyman Herb C. Conaway, Vice Chair
Assemblyman Jack Connors
Assemblyman Robert M. Gordon
Assemblyman Robert Lewis Morgan
Assemblyman Douglas H. Fisher
Assemblyman Guy R. Gregg
Assemblywoman Joan M. Quigley
Assemblyman Samuel D. Thompson



ALSO PRESENT:

David Price
*Office of Legislative Services
Committee Aide*

Wali Abdul-Salaam
*Assembly Majority
Committee Aide*

Tasha M. Kersey
*Assembly Republican
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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ASSEMBLYWOMAN LORETTA WEINBERG (Chair): Good morning, everyone.

Is this working as a speaker out there (referring to PA microphone)? We're learning what all this equipment is.

For the members of the Committee, the small microphones are for the recording equipment, and the larger microphones are for amplification. So hopefully we will share these.

First of all, good morning, everyone, on behalf of the Assembly Health Committee. Most of us, I guess, are happy to be here. Some of us came a very long distance. So my apologies for starting so late, but there were a variety of traffic and parking problems.

This hearing this morning is to -- for us in the Assembly Health and Human Services Committee to find out if there are any issues, legislative actions we should be taking when these kinds of apparent impasses arise, which affect, first of all, the residents that we represent in the State of New Jersey; secondarily, the hospitals that they want to access; and third of all -- not necessarily of importance -- the insurance company, who provide coverage to those very same residents that I spoke about at the beginning. So that is the parameters.

We are going to try -- I don't guarantee -- I can't speak on behalf of all the members of this Committee -- but we are going to try to not get into the nitty-gritty of negotiation that is taking place and, in fact, is now a judicial proceeding. So there are certain areas that we are going to attempt to stay out of.

I'm going to ask Committee members to introduce themselves, if you would, because the microphones aren't working.

Who's sitting down there on the-- Oh, on the very right, substituting for my colleague, Assemblywoman Charlotte Vandervalk-- If you would start off, just introduce yourselves.

ASSEMBLYMAN GREGG: I am Assemblyman Guy Gregg. I hail from Northwest New Jersey, District 24, all of Sussex County, parts of Morris and Hunterdon. Nice to be in Camden.

ASSEMBLYMAN THOMPSON: Assemblyman Sam Thompson. I represent portions of Middlesex and Monmouth County.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Can't hear you.

ASSEMBLYWOMAN WEINBERG: Is your microphone on there?

ASSEMBLYMAN GREGG: It is.

ASSEMBLYMAN THOMPSON: Assemblyman Sam Thompson. I represent portions of Middlesex and Monmouth County.

ASSEMBLYWOMAN QUIGLEY: Assemblywoman Joan Quigley. I represent District 32, which is Hudson and part of Bergen County.

ASSEMBLYMAN FISHER: Good morning. Assemblyman Doug Fisher, Cumberland, Salem, and Gloucester County, 3rd Legislative District.

ASSEMBLYWOMAN WEINBERG: And I am the Chairperson of the Health and Human Services Committee, Assemblywoman Loretta Weinberg, and I come from Bergen County. I tell everybody I used to think Trenton was South Jersey. (laughter)

ASSEMBLYMAN CONAWAY: Herb Conaway -- Dr. Conaway. I'm Vice Chair of the Health and Human Services Committee. In interest of

full disclosure, I am on staff at Cooper Hospital and a member of all of the Horizon networks.

I want to thank the Chairwoman for holding this very important hearing to address what is a serious problem with our health-care delivery system in this state.

I look forward to the testimony that will be provided today.

ASSEMBLYMAN MORGAN: Good morning. I am Robert Morgan. I represent parts of Monmouth and Mercer County, the 12th Legislative District.

Also in the interest of full disclosure, as my colleague Herb, I am a physician on faculty at UMDNJ. And there are financial contracts with Horizon products in those relationships.

Thank you.

ASSEMBLYMAN GORDON: Good morning. I'm Bob Gordon. I represent the 38th District of central Bergen County.

ASSEMBLYMAN CONNERS: Assemblyman Jack Connors. I represent the 7th District, which is parts of Camden County and Burlington County.

ASSEMBLYWOMAN WEINBERG: Okay. Thank you very much, everyone.

Just another technical issue, particularly if you come in groups to testify-- And we do have this being recorded. Please identify yourself by giving your name and your affiliation so that it will be properly recorded when we get the hearing information.

And as we do, we usually call on members of the Legislature who might want to testify, first. And I see, sitting in the front row, a very good representative from this area, and she reminds us constantly of that. And that is my colleague, Assemblywoman Nilsa Cruz-Perez.

Would you come forward?

A S S E M B L Y W O M A N N I L S A C R U Z - P E R E Z: Good morning, Chairwoman Weinberg and members of the Health and Human Services Committee -- for holding this public hearing today.

I just want to take this opportunity--

Can you hear me?

UNIDENTIFIED SPEAKER FROM AUDIENCE: No.

ASSEMBLYWOMAN CRUZ-PEREZ: Good morning.

I just want to take this opportunity to welcome all of you to the beautiful, blooming city of Camden. As you see, everything is nice in here, and it will get even better, thanks to your help.

Thank you, Chairwoman Weinberg and members of the Health and Human Services Committee, for holding this public hearing today.

Camden County patients are being held hostage by a business dispute between Cooper Hospital and Horizon, a contract dispute that threatens to leave hundreds of Horizon customers without health-care services. If payment for services rendered at Cooper is not guaranteed for Horizon customers, these patients, ultimately, will suffer.

Local community hospitals provide a safety net for families and patients who are stricken with an illness or require urgent medical care. For patients who are fortunate enough to have health insurance, being discharged

from the hospital begins their recovery from illness without worrying about expensive medical bills.

Everyday, underinsured and uninsured patients seek necessary medical care from the quality health-care professionals at community hospitals, like Cooper University Hospital, only to worry about how to pay the bill. Cooper and many other community hospitals continue to treat uninsured or underinsured patients, even when charity care funding runs out. And I'm a good witness of that -- how they take care of patients with no insurance, whatsoever -- whether they have their money or not.

We cannot afford to add patients, whose care should be paid for by Horizon, to the list of people who struggle to pay ever-increasing health-care costs, simply because an insurance company and a hospital cannot agree on contract terms. Our bottom line should be insisting upon uninterrupted, quality health-care services provided at our local community hospitals. A company's profit margin should not overshadow quality health care that all residents of Camden County deserve.

Local hospitals like Cooper are partners in our community. Not only does Cooper employ hundreds of workers from Camden County and South Jersey, but their presence is felt through community partnerships and outreach efforts that let residents know service is available for them at any time of the day and night. Cooper Hospital has done their part in caring for Camden County residents. Now Horizon must do theirs.

There should not be a final date, determined by an insurance company, when health care will cease to be provided at affordable rates for insured patients. Patients can not predetermine the date when they will need

emergency surgery, or when their child will require stitches after a fall, or if their newborn will be premature.

I also am concerned about how much say big insurance companies, like Horizon, have in decisions about which medical procedures are necessary and will be allowed under insurance benefits. Our doctors, not insurance executives, know best when it comes to treatment for patients.

It is wrong for an insurance company to deny health-care coverage for patients simply because of cost. It is unfair to tell insured patients that their full range of benefits will end in two months. It is unreasonable to lower reimbursement rates for provided care, while health-care costs continue to skyrocket. It is unfair for any insurance company to tell me what hospital I should go to. It is irresponsible to use a full-page newspaper advertisement to sway public opinion in a business's favor and create fear in patients. Public relations battles waged in the newspapers don't treat patients, health-care professionals do.

Today, I urge Horizon and Cooper to remain seated at the bargaining table in the best interests of Camden County patients and New Jerseyans. Health-care benefits for patients should not be terminated in the face of insurer-hospital contract negotiations.

More importantly, health-care insurers must be required to fulfill promises of expansive coverage made during the contract negotiations. Writing hospital-insurer contracts for patient services is not enough. Hospitals and insurance carriers have a responsibility to follow through on these services and payment for them, as agreed upon.

As we struggle to provide, in New Jersey, care coverage for all the residents, we have an inescapable responsibility to protect care for Horizon patients at Cooper and other hospitals.

Madam Chair, I am committed to doing everything I can to end this looming health-care crisis in Camden County and all over New Jersey.

I want to thank the Health Committee members for holding this hearing, and I look forward to a quick and fair resolution to this problem.

Thank you so much.

ASSEMBLYWOMAN WEINBERG: Thank you, Assemblywoman.

Do we have any questions of Assemblywoman Cruz-Perez? (no response)

Thank you for coming down and sharing with us.

One of the things we hope might come out of these hearings is an idea for some legislation, whether we're talking about binding arbitration or whatever else might be required, in these kinds of generic situations.

And I'd like to point out that Cooper Hospital is not the only hospital with Horizon Blue Cross Blue Shield that's been involved in negotiations of this kind, but it's happened in my own district with Hackensack Hospital, with Saint Barnabas Hospital.

And I would suggest for those who have written and said that this Committee should not get involved in private negotiations, it was not this Committee that put all the newspaper ads in. So those negotiations became public by virtue of full-page ads in many of our local newspapers, and caused constituents that we all represent to call, who are concerned about their access to health care.

So I just want to point out that we did not interject ourselves into some kind of closed-room negotiations. It was both parties' decision to fight this out in newspaper ads that caused us to become involved. So that's my disclaimer at the beginning.

ASSEMBLYWOMAN CRUZ-PEREZ: Madam Chair.

ASSEMBLYWOMAN WEINBERG: Yes.

ASSEMBLYWOMAN CRUZ-PEREZ: I have received hundreds of calls from constituents who are worried about their coverage, and I'm here representing them. And I'm going to be at the front table, working with your Committee, and all the Legislature in Trenton, to try to solve the problem.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Are there any other legislators here who wish to testify? (no response)

Assemblyman Conaway is enabling me to point out we have a Freeholder present from Camden County. If you'd like to come forward and give us your name.

Freeholder Joe Ripa.

ASSEMBLYMAN CONAWAY: We call him *The Famous Joe Ripa*.

ASSEMBLYWOMAN WEINBERG: You're definitely famous, but for other reasons than being a Freeholder, obviously. At least I know who you are. (laughter)

Go ahead, Freeholder.

F R E E H O L D E R J O S E P H R I P A: Good morning, Assemblywoman Weinberg and the rest of the members of this Committee.

I want to tell you just a little bit about myself. I spent about 18 years of my life as a labor leader with the Amalgamated Transit Union and have negotiated many, many, many contracts. And what I find absolutely appalling is that we have never negotiated a contract in the newspapers.

I think, to sit down and negotiate contracts, you go behind closed doors, take the gloves off, and wrestle around, and that's the way it's done. I think it's absolutely appalling that Horizon Blue Cross and Blue Shield -- whom I might add has insured my family for the better part of 43 years through New Jersey Transit-- Never have we negotiated contracts in this fashion.

It appears to me that an institution like Cooper Hospital, here in Camden and South Jersey -- in Camden County -- does more than just cover medical services to our community. They are involved in our community in many, many ways -- in social ways -- to uplift our young people, to provide employment for Camden County residents.

And for Horizon to tell the residents of Camden County that they should go to other hospitals, especially in other states, for their health care, to me is just ludicrous. I mean, here we are, in the city of Camden, where the Governor of this State, and the Legislature -- yourselves -- provided \$175 million in an effort to help the city of Camden revive itself. And as you may see around you, it is coming back. Camden is coming back. And for us to export our dollars across the river is just a pity and a shame.

There are a few things that I think the Committee -- some questions should be asked, and they are: Why has a not-for-profit Horizon accelerated its accumulation of excess reserves, nearly doubling them, over the past four years, which are in excess of \$700 million? How is it that Horizon was able to receive

approval for premium increases of 11.7, 9.6, and 19 percent in 2000, 2001, and 2002? Was there any review of consideration by State officials of Horizon's overall financial status and extraordinary level of profitability in New Jersey's health-care insurance market? What tactics has Horizon employed in order to accumulate such large excess revenues?

Health-care providers across New Jersey have been complaining about a pattern of business activities: improper, reduced payments; unreasonable contract terms; and even outright withholding of payments to accumulate nearly \$1 billion in profits.

How is it that Horizon can bully its network providers and violate Department of Banking and Insurance HMO regulations, failing to provide an appeal process for payment disputes, and ignoring the requirements of Unfair Claims Settlement Practices Act?

Why has there not been careful regulatory scrutiny of Horizon's unparalleled domination of the insurance market and Horizon's attempts to set prices throughout the market by demands for a most-favored rate contract provision?

Why does Horizon seek anticompetitive arrangements, in separate letters of agreement, outside of the formal contracting process, violating Horizon's obligations under the HMO regulations to seek prior Department of Banking and Insurance approval of all contract terms for hospitals?

Why is Horizon able to delay or deny authorization and payments for its members' health care?

Why is Horizon able to delay payments of its hospital patients in need of rehab or skilled nursing facilities, and then deny payments to hospitals for part of the patient's hospital stay?

Why is Horizon able to get away with only paying for emergency room treatments based on the discharge diagnosis, rather than the presenting diagnosis, turning down payment for triage and medical workup that rules out serious illness?

How is it Horizon is able to use its market domination, and single-handedly restructure the health-care delivery system in South Jersey and block New Jersey's citizens access to the widest range of critical hospital services, and some specialty physicians practices, in the region?

As a not-for-profit company, why is Horizon not contributing to some form of charitable mission in New Jersey?

Why does not Horizon direct any of its revenues to assist those who are uninsured or underinsured in New Jersey -- for example, by contributing to help pay for charity care in the State of New Jersey?

At a time when New Jersey's Medicaid rates are among the lowest in the country, reimbursing care at below cost -- and when the State of New Jersey pays only \$381 million in charity care for the nearly billion-dollar price tag for charity care throughout New Jersey -- why is it that not-for-profit, tax-exempt Horizon does not pay a dime for its nearly billion-dollar excess revenues?

The hearings need to focus on Horizon's corporate practices over the past four years, where it appears that this not-for-profit insurance company has expressly attempted to generate excess retained earnings and inflate the value

of the company for the expressed purpose of converting Horizon into a for-profit company. The Legislature should explore how Horizon has used its privilege -- tax-exempt position, and 60-year history as the State's insurer of last resort, and the administrator of the State of New Jersey's own health plan, as well as that of many municipalities throughout the state -- to amass its dominant market share and billion-dollar profits, and then plan to go public for the enrichment of its executives and its directors.

Thank you.

Have you any questions of me?

ASSEMBLYWOMAN WEINBERG: Thank you.

Does any--

FREEHOLDER RIPA: I can go on and on. (laughter)

ASSEMBLYWOMAN WEINBERG: You certainly seem to have a belief in what you're testifying to, and we appreciate that.

Does anybody have any questions of the Freeholder?

Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: I will just make a comment or two. I mean, you covered many questions there, with regards to Horizon and its operations, etc.

Some of these I have received answers to. That's a number of the HMO regulation violations that were asserted. I've been provided a copy of material from the Department of Health, suggesting that they were not in violation of the regulations that were questioned in this previous session here.

Many of the other questions I had relayed to the Department of Banking and Insurance, seeking an answer to, and have not received them as of

this date. We are looking into those things. But, of course, a majority of these things, if there are violations, etc. -- excess profits -- they'll be -- the Department of Banking and Insurance is the one that must enforce the regulation.

ASSEMBLYWOMAN WEINBERG: Just to answer that question, if I may, because that's been part of our search-- The Department of Banking and Insurance sets minimum standards for reserves but, under current law, sets no maximum for reserves. So there is no legal limit, from what I have been told, on the amount of reserves this insurance company, or any other, can be putting away. They have a minimum floor that they have to make sure -- in order to make sure they have enough money put away to, obviously, cover their claims.

FREEHOLDER RIPA: Might I?

ASSEMBLYWOMAN WEINBERG: Yes, certainly. Go ahead.

FREEHOLDER RIPA: I have something else here I can tell you about.

Horizon retained profits -- were reported in its consolidated balance sheet on 12/31/02, as of, 700,376,000 -- more than 10 times the statutory reserve requirement of New Jersey's Department of Banking and Insurance, and 600 times in excess of Horizon's own national Blue Cross and Blue Shield organization's reserve requirement.

We have reason to believe that these excess reserves have continued to increase over the past two years, accordingly, to profitability reported to the New Jersey Banking and Insurance--

Horizon's top six executives receive million-dollar salaries. According to the 2002, 990 IRS filings -- in 2002, Horizon's Chief Executive Officer, Bill Marino, was compensated over \$2.8 million, with \$1.8 million as

a bonus. I'd like to have his job. (laughter) His 10-member executive team is listed as having been compensated nearly \$10 million. I believe it to be -- the Committee member's to draw their own conclusions.

But we at Cooper believe Horizon is abusing its mission as for a not-for-profit insurance company, and is so doing consciously as a part of a well-developed plan to convert to a profit-orientated company.

ASSEMBLYWOMAN WEINBERG: Thank you, Freeholder.

Are there any other questions? (no response)

Thank you very much.

We have two more elected officials that -- whose names I've been given -- that we will call on, and then we will move to the CEO of Cooper Hospital, and then we will hear from Horizon.

Mayor Faison, the Mayor of Camden.

Oh, there you are.

Welcome Mayor. Or you should be welcoming us, I guess.

(laughter)

MAYOR GWENDOLYN A. FAISON: Good morning, everyone -- to Chairwoman Weinberg, and Vice Chairman Conaway, and all the Committee persons, and to all of you.

I consider it a privilege to sit here and give my remarks concerning our Cooper Hospital, today. I'm here to speak about Cooper Hospital and to bring the attention to just how important this institution is to the city of Camden, because of the way they deliver the health care and health services to the citizens of Camden, and to the South Jersey region.

Now, there's no other health-care provider like Cooper Hospital. There's a network in the city of Camden -- that it provides over 70 million of charity care services. Do you hear that? Charity care services. It's more than any other provider that we have in South Jersey.

Seriously, how is it possible that a large, profitable, North Jersey insurance company is able to come down here to the city of Camden and decide that the safety net hospital that provides most of Camden's care to the resident is out of the network?

And I had such an unfortunate experience. And you need to hear this.

Everyone talks about Camden not knowing what to do, and we're poor, and what have you. I'm coming another direction that may surprise you. We need you to work together.

I had the unfortunate experience of taking my own brother to the accident ward. It looked like a third-world -- a war zone. Cooper cannot even continue with their expansions. You had patients-- There were patients lined up on every inch of the wall, seriously ill -- I.V.s, tubes, I can't even count the numbers.

As you looked at it -- and I was thinking about it as the city of Camden. How can this happen to residents in the city of Camden? These are our people. If the city of Camden fails, all of South Jersey fails. And we have to be concerned about our residents here in the city of Camden.

Just think about all the things that they provide, the Cancer Institute. Think about all the infant mortality that we have. Think about the

critical care center. We're not looking at just any other medical center. We are looking at a hospital that provides services.

And we're talking about the charity cases. You know it's easy to take advantage of poor people, and it's wrong, it's immoral. And I don't like to get involved in nobody's religion, but I think it's just down right -- it's just -- God doesn't like it. You can't treat poor people that way -- to line them up sick and not take care of them.

And when I saw what Cooper Hospital was trying to do that day, my heart went out. I mean, people were crying. It didn't even look like Camden.

That is why I'm here, as a Mayor, making a sacrifice for our residents of the city of Camden. Thank God we have Cooper Hospital where there is over 300 doctors taking care of tens of thousands of Camden residents.

So what is happening? Why can't we work together?

We're talking about discrimination. Discrimination comes in a lot of ways. It's that ethnic groups -- racial. When you can't help your poor brother, or sick brother, it is discrimination. I don't care what you call it.

And I feel I'm responsible, with all my other legislators here today-- We have to be all about residents. And I guess I get a little emotional, because everything we do in Camden -- city officials -- is for the residents. Talk about all the doggone economic development, which is good -- we need the money, we need the resources. But it's people -- it's our people. We can't be treated that way. And what I've seen -- I just don't like it.

So we're talking about the effect that we have on South Jersey economy. There are tens of thousands of patients that will migrate to

Philadelphia. We can't afford that. Why should they go across the bridge when we have the services right here at Cooper Hospital? All it takes is just a little cooperation, working together.

If I, as a Mayor, can fight a legislation in the State of New Jersey and Trenton -- to have my Governor take a care for me, and I continue to fight, doggone it, you people can fight, too, to help my residents of Camden. If I can do it, you can do it. Because you know the way that I feel? I don't care what you take away from me as a Mayor, I'm going to still survive and take care of my residents. And you're not taking nothing away from me God gave me. And if I can stand up and do it, as this one person, Cooper Hospital, Horizon Insurance, you can get it.

You talk to me about partnership, working together, coordination, collaboration, strategic planning. That don't mean a doggone thing if my people are suffering.

Do you understand where I'm coming from?

Use all the fancy medical terms you want to. We're talking about getting the job done. Just do it.

People are not coming here because of just the resources or the 175 million. They're coming here because we have good people, qualified people, no corrupt government. They know their job.

So I'm asking you, Horizon, Cooper Hospital, let's get together and put our people first. There's a need to work together. Our people are suffering. We need the care.

I'm here to help make life better. And I'm going to challenge you. Can't you share some of that care, also?

Horizon -- come on Horizon. Come on Cooper. I know you need the money and want the money, but it's people first. If you don't have the people, you don't have any jobs either. Don't let my people suffer in Camden.

I'm a Mayor who's going to stand firm, and I'll be here fighting for a long time. I'm one of your senior representatives, and I'm still kicking. And I'll be here for you.

Thank you. (applause)

ASSEMBLYWOMAN WEINBERG: Mayor, just before you leave-- Does anybody here have any questions?

ASSEMBLYMAN CONAWAY: Just a comment.

Mayor Faison, I just wanted to thank you for your inspiring comments. And to amplify one of your themes, as I understand it-- And that is that the focus of Cooper Hospital and Horizon, and indeed this legislative body, is on the people who are most affected by this conflict. We have to make sure that the health-care services that the people in Camden need are delivered. And I believe that if that focus is kept, we will get through this problem and make sure that the residents that you are protecting so well, and whose interest that we have, and we hold -- that we'll achieve those things that need to be achieved here for the residents of Camden.

MAYOR FAISON: Thank you.

ASSEMBLYMAN CONAWAY: Thank you for your testimony.

ASSEMBLYWOMAN WEINBERG: Don't go yet.

I do have a question.

Members of this Committee have received letters from both -- very lengthy letters from both Cooper Hospital and from Horizon Blue Cross Blue Shield. And they certainly will each testify on their own behalf.

But in the letter that we received from Horizon Blue Cross Blue Shield, they mentioned that medical care will not be compromised in Camden, because they have contracts and will continue to operate with Our Lady of Lourdes Hospital, Kennedy Memorial, and Virtua West. And they mentioned some Pennsylvania hospitals, which -- I agree with you, people shouldn't have to go across the bridge to get medical care.

But of those three: Our Lady of Lourdes, Kennedy Memorial, and Virtua West-- Are those hospital networks that your residents access, or use? Are you familiar with them? Are they geographically appropriate? That kind of thing.

MAYOR FAISON: Yes, they are here, we use them. But what we don't understand-- There's still a great need for the services at Cooper Hospital, because you know, the West Jersey -- Mount Ephraim Avenue was closed; and you could hardly get into Our Lady of Lourdes or the other one-- And with Cooper Hospital -- you have created that big burden on just these couple of hospitals. So that's why Cooper Hospital is so very much important, also.

ASSEMBLYMAN CONAWAY: Just to amplify that point, Cooper Hospital-- As you look at the region of health-care delivery -- Camden and greater Camden -- Cooper Hospital, really, is so important to protecting -- to making sure the residents of Camden get their service. But I think if you talk -- and I have spoken to leaders at Our Lady of Lourdes, and elsewhere -- that if Cooper were not where it is, taking care of the residents of Camden -- and they

do provide, and I think all would agree, the bulk of the charity care service for the residents of Camden, and even surrounding Camden -- that if Cooper were not able to fulfill that role, you would not be able to send that excess capacity into Lourdes and the other systems. And you would see a very definite decline in the health-care access of the residents of Camden, but others outside of Camden City as well.

So it is absolutely critical that Camden be able to function and provide services here in Camden, not only for the residents of Camden, but for even those outside of Camden itself.

MAYOR FAISON: And I will mention, you can bring all the economy in you want to. If you do not have a healthy community, you don't have anything. Your city is dead.

ASSEMBLYMAN CONAWAY: That's exactly right.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Are there any other questions.

Thank you.

I'd like to call on Camden City Council Member, Fuentes -- Council President. I'm glad I have somebody from this area to correct me. Council President Fuentes.

And I've been forgetting to remind everybody. Please, everyone, state your full name for the record.

C O U N C I L M A N A N G E L F U E N T E S: For the record, Angel Fuentes, President of Camden City Council, for the city of Camden.

Madam Chair and Committee members, good morning.

Before I read my speech, I just want to, for the record -- and I'll provide you a copy -- that I sent to Mr. William Marino, the President and Chief Executive Officer, back on December 30 -- a letter. And to this date -- and just for the record, I did have -- they didn't provide me with, at least, a decency -- or professional response to my letter. So then--

I guess, as I read my comments, you'll understand my level of frustration with Horizon Blue Cross Blue Shield of New Jersey. But, again, it was just a simple letter. And I'm just going to read. It says, "Furthermore, I understand the disruption--"

In fact, Madam Chair, the question regarding Our Lady of Lourdes, and West Jersey, and even Cooper-- If you don't address this issue with Cooper, there will be a disruption. And I believe that we need-- This has to be an issue for all of you, even for us here in Camden, and throughout the state. And I hope that, in the end, we can accomplish some type of goal or, even as you mentioned, legislation that would assist and help. And I see Cooper as the turning point, or the -- making this issue loud enough in South Jersey. I know you mentioned a couple hospitals in northern Jersey.

But as this letter -- back, again, on December 30-- "Furthermore, I understand the disruption of the once-cooperative partnership previously enjoyed between Cooper and Horizon threatens not only the residents of Camden in Horizon/Mercy Medicaid plan, but also the thousands of Horizon members in South Jersey who come to Cooper for medical services. Through this period of rehabilitation and recovery for Camden City, all of us have a strong interest in ensuring that Camden City's major institutions and their business relationships work well together. Horizon's and Cooper's mutual

clients must continue to come to Camden and not be forced to look elsewhere for their health-care services.”

And if I could, I would like to simply second the Mayor’s request -- remarks. As I understand it, Cooper University Hospital has attempted, over the past 16 months, to reach agreements with Newark-based Horizon Blue Cross Blue Shield of New Jersey on a contract to continue to provide its nearly 40,000 members in Camden County with quality health-care services.

At the end, Horizon simply let its contract with Cooper expire, because Cooper could not afford to sustain the financial losses imposed on it by Horizon. Cooper loses over 7 million each year in caring for Horizon patients. In spite of being one of the most efficient teaching hospitals in the entire State of New Jersey -- according to the New Jersey Hospital Association-- On top of losing 7 million on Horizon/Mercy’s business, Horizon has withheld 2.7 million in payment to Cooper for services provided to its Horizon Blue Cross patients.

This is a multibillion insurance company that is bullying -- and I repeat, bullying -- Camden’s safety net hospital -- and even re-echoing the Mayor’s remarks. And the entire region will be hurt by Horizon’s action.

Cooper provides some of the most complex health care available in South Jersey. And out-of-network charges will present us a great economic hardship for South Jersey’s businesses, municipalities, and hard-working families throughout the region.

Cooper University Hospital is a charitable institution by it’s charter, founded by Quakers 117 years ago. Cooper has and will continue to pursue its mission to care for those who are unable to pay for their care. And we know,

we witnessed -- by talking to residents in Camden City. Cooper's reputation for caring for the poor and disadvantaged is as well-known as its reputation for quality care in treating the most complex and seriously ill patients in the region.

Cooper is a safety net, health-care provider for the city of Camden, and provides more charity care than any other health-care provider in South Jersey. It is regrettable that Horizon cares so little for ensuring access to Cooper's services for the 33,000 Horizon Medicaid patients in Camden County, and mostly reside in the city of Camden.

Horizon's actions will have a huge economic impact on the city of Camden. Cooper is one of the largest employers in Camden, and the combined goods, services, that Cooper purchases represent half of the city's economy. It just does not make any good economic sense for Horizon to just tell its tens of thousands of patients to migrate to Philadelphia.

I, as an elected official, see that as a disrespect to Camden's economy, the county, its region, and even throughout New Jersey.

This will have the effect of exporting tens of millions of dollars of goods and services in health-care dollars to Pennsylvania. This just does not make any sense. And even as the Freeholder made it so, so eloquently clear -- that this New Jersey insurance company is able to do this to the city of Camden and the South Jersey region-- It goes against what the State of New Jersey is trying to accomplish with a municipal revitalization and economic recovery act, and the reinvestment of 175 million to revitalized and redevelop the city of Camden, in which the Governor signed into law.

The Committee should do all it can to help to reverse this situation with Horizon. There should be a way for Horizon to keep this important safety net hospital in its network.

And furthermore, the Legislature should demand -- and I mean demand -- that Horizon assist those who are uninsured or underinsured in New Jersey by contributing to help pay for charity care in the State of New Jersey.

Thank you.

Any questions?

ASSEMBLYWOMAN WEINBERG: Thank you, Council President.

Are there any questions?

Assemblywoman Joan Quigley.

ASSEMBLYWOMAN QUIGLEY: I was quite shocked, Council President, when you said that Cooper is half of the city's economy. That's a shocking proportion of the city's economy to be put at risk.

If Cooper already has a very heavy share of charity care patients, and the insured patients go elsewhere for care, what is that likely to do to Cooper, and what will the effect on Cooper be likely to do to the city of Camden?

COUNCILMAN FUENTES: Assemblywoman, it would be detrimental for Cooper.

I, as the President of City Council, know that Cooper has made efforts beyond in helping our residents find good jobs. And for this to happen, there's a potential of layoff. And I think it is critical for this Committee--

Camden has the highest unemployment. We all know that. And perhaps, in 10 years, with this Camden recovery bill, we can reduce that number.

But as the Mayor mentioned, the infant mortality rate is high in Camden. So I think it is critical for some type of legislation coming from this Committee.

I would welcome, and I'm sure the residents of Camden would welcome, the employees of Cooper will welcome -- and I'm sure it will not be welcomed by Horizon -- but at least we have to look-- And the Mayor was passionate about this. It's our people, the people who suffer. And we can't allow for this to happen. We cannot go back. We need to go forward. With your help, we will go forward.

ASSEMBLYWOMAN WEINBERG: Thank you.

Any other questions? (no response)

Thank you very much, Council President.

COUNCILMAN FUENTES: Thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: I understand one more elected official did come in.

Senator John Adler.

Oh, there you are.

S E N A T O R J O H N H. A D L E R: Madam Chairwoman and members of the Committee, first of all, thank you for taking the time to come to Camden.

ASSEMBLYWOMAN WEINBERG: Close to the microphone, because the amplification is not good.

SENATOR ADLER: I'm new at this. I'm sorry. (laughter)

I don't envy your task today, and the task that's before you for the weeks and months to come. It's clear to me, as I think it's clear to you, that in many ways, our health-care system in New Jersey is broken. We have so many uninsured. We have so many people who get their basic treatment in the emergency room, not with preventative care. Your colleague, the Vice Chair, Dr. Conaway, sees people and would love to be able to see them in a preventive and pre-emptive way, and not to have to treat them when they're acutely ill.

The city of Camden is also acutely ill. It's not unique in that way. I'm sure there are other cities, in other areas of our state, that have economic needs. But the convergence of health-care crisis and economic crisis in Camden, probably, is unique. So I'm glad that you symbolically chose to come here to talk about a statewide problem with Horizon.

I'm not sure I have the answer. I'm not sure you all, yet, have the answer. But I do urge you to think outside the box. We have an obligation to preserve the public trust. We recognize that Horizon is, itself, a public trust with extraordinary reserves right now, an unprecedented amount of excess capital, some of which should be disgorged to policyholders -- to individual policyholders who've been left out of the recent rebate system. Some of the money should probably be adjusted with the hospitals in Hackensack, in Camden, and everywhere else in between, so that we have a fair balance between the needs of a carrier to remain solvent and the needs of hospitals to remain solvent; and the needs of patients to get treatment in the hospitals of their choice throughout the state and the need to keep health care affordable for

the businesses and for the individuals who are finding it more and more burdensome to pay for health care.

If I had the answer, I'd hand it to you. If it were on a single page of paper, it would be easier for you. But I hope, as you listen to the people in this room, and the people of New Jersey, you take the courage, and show the courage, to take steps that maybe haven't been taken before, to look at our ways of regulating nonprofits, to make sure that we meet the needs of our hospitals, of our patients, of our health-care consumers, our businesses throughout the state so that we strike a balance better than the balance that's been struck up to now. Because, right now, I think, many components of the system are truly broken. Many people in our society, many businesses in society are suffering as a result of the imbalance that's been struck over the last couple of years.

And I think you all have the courage, have the intelligence, and the insight to solve a problem. But don't be scared to take bold steps, because bold steps are definitely needed right now. Just as we all together have taken bold steps to help Camden City recover, let's take some bold steps with the Committee, and with this Legislature, with this administration to have the health-care system of New Jersey recover and, maybe, to strike a balance that's fair for the people of New Jersey, for the hospitals in Jersey, for the long-term health care of New Jersey overall.

I thank you for being here. I'm not going to belabor it, because I, sort of, cut in line of better speakers. But I thank you for letting me speak here today, and I wish you luck with your efforts.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Senator.

Does anybody have any questions? (no response)

Thank you.

Well, we've certainly heard how the elected representatives of this particular geographic area feel about the importance of their hospital, and the importance of the continued viability of that hospital.

So, with that, I'd like to call on Mr. Sessa, who is the CEO of Cooper Hospital.

Mr. Sessa.

Again, for the record, please identify yourself.

CHARLES E. SESSA JR.: Charles Sessa, Chairman of the Board of Trustees, Cooper University Hospital.

I'd like to thank you, Madam Chairperson and members of the Committee.

I'd especially like to thank Senator Adler for setting me up here, in terms of the better speakers to follow.

But I do, particularly, want to thank you for convening these hearings today, and for giving me the opportunity to speak to the Committee.

First, let me say that Cooper University Hospital does want to have an ongoing relationship and contract with Horizon Blue Cross Blue Shield. But I will tell you that our hospital has learned a valuable lesson. Our 3,500-plus employees, the over 500 physicians that practice at Cooper, the residents of the city of Camden, and the 60,000-plus Horizon Blue Cross Blue Shield members from South Jersey have all learned what happens when one questions the business practices of the largest, multibillion dollar, not-for-profit, tax-exempt, New Jersey insurance company, Horizon Blue Cross Blue Shield.

And I'd like to remind you of what happens, and give you some examples.

Newspaper ads, which salute the region's outstanding network hospitals: Deborah; Kennedy; Virtua; Lourdes; and, better yet, Philadelphia-based hospitals such as the University of Pennsylvania Health System-- Noticeably absent from the list: 117-year-old Cooper University Hospital. Letters written to South Jersey physicians informing them that, effective immediately, they may no longer direct patients to the Cooper University Hospital.

Horizon subscribers in South Jersey who, after not being told of the potential contract termination with the region's primary tertiary care hospital during the open enrollment period, now being sent letters instructing them to make alternative provider arrangements-- These are the examples that Cooper has to work with that are the basis for which we are to determine whether Horizon wants to do business with us going forward.

Why? Because we stood up for our rights. And we have heard, as you have begun to hear today, from the citizens of the city of Camden, from the leaders from the city of Camden and throughout South Jersey, from people who work everyday at Cooper University Hospital, from business leaders and patients throughout South Jersey, and from physicians and hospitals throughout the entire state on what it is like today for a health-care provider to do business with the state's largest, not-for-profit insurance provider.

You must ask yourself questions that have been asked already today. Is Horizon attempting to hold down rising health-care costs, as they say, or is Horizon, as stated in their 2002 annual report -- and I quote -- "Whether

our future means converting to a public, for-profit company, or remaining not-for-profit.” Are they preparing for their for-profit future? Has the privileged, State-designated insurance company abused its public trust and, instead, are they single-handedly disrupting the health-care delivery system in South Jersey and, in fact, throughout the entire State of New Jersey?

I have to provide you with additional background. As you know, Horizon is a \$4-plus billion not-for-profit insurance company. They have made over a half billion dollars over the last four years, and they have done it through a pattern of business practices that abuses it’s not-for-profit, tax-exempt status and it’s market share dominance in New Jersey’s health-care system, and New Jersey’s health-care market.

They have been unrestrained in employing these business patterns: increasing members’ premiums while squeezing health-care providers and physicians on reimbursements, by leveraging its market-share dominance in the health-care market. Under the protection of their tax-exempt status and privileged position as the beneficiary of New Jersey’s health-care insurance contracts, Horizon has obtained a dominant market-share position of nearly 40 percent. As a result, Horizon has been able to stockpile massive reserves that are now approaching a billion dollars, clearly in excess of what is required by the State of New Jersey.

And what is also very clear is that New Jersey citizens, and the health-care providers in the state, are not the ones that have benefited from Horizon’s claim of providing affordable health care. Who has benefited from their excessive profits over the last four years, and who will benefit from their

excessive retained profits that exceed regulatory and industry standards, is a question that the legislators should answer.

These Committee hearings, Madam Chairperson, are extremely important, because this insurance company has unfortunately been able to carry out its plan, and to amass these reserves, and build these profits under the radar screen of public scrutiny without the careful scrutiny of New Jersey's executive branch, its legislative authorities, and even the watchful eye of the news media.

How have they subjected -- how have they accumulated these profits? The answer begins by double-digit premium increases to their subscribers of 40 percent over the past three years, while at the same time engaging in a pattern of denying claims throughout New Jersey to the providers, paying them below cost for the services that they provide and, in some cases, even withholding payments.

This is not a Cooper University Hospital issue only. The recent announcement of contract terminations at Cooper, as well as at Hackensack University Hospital, are only the most recent episodes of a pattern of bitter disputes between Horizon and hospital providers. There have been published accounts of other providers with serious difficulties in contract negotiations and payment practices with Horizon: Saint Barnabas Health System, Virtua Health System, Rahway Hospital, Lourdes Health System; as well as large physician groups throughout the state, such as Southshore Health Services, an independent physician association of some 470 private-practice physicians in southeastern New Jersey.

You have heard that the proof is in the numbers. You have heard the amount of their excess reserves. It has been reported, most recently, that those reserves are now approaching \$1 billion.

But I'd like to review with the panel how powerful Horizon can be, how Horizon has been able to use its market share dominance in this marketplace to single-handedly restructure the delivery of health care in South Jersey.

After withholding millions in payments from Cooper, Horizon used this payment dispute as a means to extract concessions on a new contract, and to insist on Cooper accepting an anticompetitive -- what is referred to as a *most-favored-rate* -- clause in a separate letter agreement outside of our basic contract, and outside the review of the Department of Banking and Insurance.

Horizon allowed its contract with Cooper to expire, thus forcing Cooper to be out-of-network for 60,000 Horizon Blue Cross Blue Shield members in South Jersey. These members of working-class families will have to pay more out of their own pocket as a result of this action, or find a different doctor.

Using its domination of this health-care market, Horizon decided for its 60,000 South Jersey customers -- our friends, our neighbors, your constituents -- that these people should not have access to Cooper and the wide range of critical hospital services that Cooper provides in this region: our cardiac surgical program and interventional cardiology services that are available at the Cooper Heart Institute; the comprehensive -- and I pause over this, because it boggles my mind -- the comprehensive cancer-care services available at the Cancer Institute of New Jersey at Cooper University Hospital. The Governor,

and Assemblyman Greenwald, and others were just down here within the last six months to announce this program at Cooper University Hospital. The Level III neonatology center at Cooper, the largest program for caring for the most fragile premature infants in the region; the high-risk maternity services, delivering over 1,700 babies this past year, primarily mothers from the city of Camden; the comprehensive orthopedic care at the Cooper Bone and Joint Institute; the largest critical care transport program in the entire region. One out of two critical care patients come to Cooper University Hospital. And the largest general and subspecialty pediatric clinic in the city of Camden and throughout South Jersey--

Horizon has determined for its 60,000 members that they will not be able to consult with Cooper University physicians. Our faculty of over 300 physicians that practice at Cooper University Hospital, that provide the most extensive range and depth of medical and surgical subspecialties in the region, with over 40 clinical subspecialties-- All of these services and these physicians will now be out of the Horizon network.

Horizon tells its members that they can go to other South Jersey community hospitals -- our partners, by the way -- regardless of what medical conditions they have, or leave the State of New Jersey and take their medical dollars over to Philadelphia. At the very time that we are trying to keep those medical dollars here in the State of New Jersey, Horizon openly advertises to take your medical dollars over the bridge to Philadelphia.

Horizon's actions will have a staggering impact on the South Jersey economy, as tens of thousands of patients migrate to Philadelphia, with the economic impact and multiplier effect in the tens of millions of dollars being

exported over to Philadelphia. This economic impact will be particularly severe in the city of Camden, where Cooper represents, as you've heard before, nearly half of the city's economy.

Again, it is mind boggling to me that this multibillion dollar, not-for-profit insurance company is able make a decision that directly contradicts the State of New Jersey's concentrated effort to invest the taxpayers' good money, \$175 million, to revitalize and redevelop the city of Camden. What one kind, compassionate government hand offers, this other angry, callous insurance company takes away.

I hope that the Assembly panel will continue these hearings and get comprehensive answers to the following questions: How is Horizon able to discriminate against the citizens of the city of Camden by denying them access to Cooper University Hospital?

Why does Horizon seek anticompetitive letters of agreement as side agreements outside the review of the Department of Banking and Insurance?

Why has Horizon been allowed to continue to use these business practices in order to accumulate what is clearly excess reserves? I find it such an ironic coincidence of the recent dividend announcement, as these Assembly hearings were on the horizon.

Health-care providers across New Jersey have been complaining about a pattern of business activity: improper, reduced payments; unreasonable contract terms; and even outright withholding of payments.

How has Horizon been able to put through the premium increases over the last three years that you've heard -- 12 percent, 10 percent, and 19 percent in 2000, 2001, and 2002? Was there any review or consideration of

Horizon's overall financial status and the excess -- and the extraordinary level of their reserves and profitability?

And the most compelling question-- I saw one of the leading health-care executives on cable on Sunday night, Ron Del Mauro, from Saint Barnabus Health System. And he was talking about the crisis with regards to the revenue cycle that, right now, hospitals in this state are under at this point in time. The obligation, particularly for safety-net hospitals, to provide charity care, and the lack of proper reimbursement that is received from that, the low Medicaid rates -- the lowest in the State of New Jersey -- and now -- who is supposed to be your partner -- the large, not-for-profit insurance companies conducting themselves, clearly, from a for-profit mode-- As a not-for-profit company, if that is what they truly are, why is Horizon not contributing to some form of charitable mission in New Jersey? Why does Horizon refuse to direct any portion of their revenue to assist those who are uninsured, who are underinsured in New Jersey -- for example, by contributing to help pay for set charity care in the State of New Jersey.

Finally, and perhaps more importantly, your hearings will need to focus on Horizon's corporate practices over the last four years, whereby this not-for-profit insurance company has expressly attempted to generate these excess retained earnings and inflate the value of their company for the expressed purpose of converting Horizon into a for-profit company.

The Legislature should explore how Horizon has used its privileged, tax-exempt position, and its 60-year history as the State's insurer of last resort, and the administrator of the State of New Jersey's own health plan, as well as that of municipalities throughout the entire state, to amass a 40 percent market

share -- which I must say is dangerous -- and billion-dollar profits, and then plan to go public for the enrichment of whom?

As Chairman of the Board of Trustees of Cooper University Hospital, I respectfully request that this Committee, in concert with your legislative colleagues, take whatever action is necessary to restrain Horizon from its abusive business practices.

Further, I ask you to use your authority, and your influence, to restore South Jersey citizens' access to Cooper University Hospital and the health-care services that we deliver in this region.

Thank you very much for your time.

ASSEMBLYWOMAN WEINBERG: Thank you, Mr. Sessa.

Are there any questions?

ASSEMBLYWOMAN QUIGLEY: Just one.

May we have copies of his remarks?

ASSEMBLYWOMAN WEINBERG: Do you have copies for us?

MR. SESSA: I will get you copies.

ASSEMBLYWOMAN WEINBERG: Assemblyman Thompson and then Assemblyman Gregg.

ASSEMBLYMAN THOMPSON: Of course the reason we're here today is because of the failure of Horizon and Cooper to reach an agreement to continue the provision of services, and the impact that this will have on the citizens of Camden.

You cite questions about their excess reserves -- or you refer to them -- questions about the profits they've made, etc., and so on. Even if one examined these questions, I don't see where that would advance us any closer

to resolving your problem, or preventing the recurrence of these problems (applause). These are matters, clearly, that should be looked at. But, of course, as a legislative body, we are a body who is about enacting laws and statutes.

Do you have any suggestions or recommendations on legislation that might prevent the recurrence of these types of problems between carriers and hospitals? That's the problem. That's where we should be focusing our attention here primarily, to see that these kinds of things are avoided and, therefore, patients' health care is not placed at risk.

MR. SESSA: Assemblyman, I do, and I would repeat a comment that I made in my presentation. And that is that in order to provide health care to the citizens of this state, it requires a partnership. It requires a partnership between the health-care provider, the physicians and nurses that provide that service, and the health-care insurance companies. And if you're going to represent yourself as a tax-exempt, not-for-profit company, and if you are going to enjoy the privileges of the State-designated insurer in this state, what comes along with that is a responsibility.

What is clearly obvious is the fact that when you enter into contract negotiations with Horizon, you are, effectively, entering into contract negotiations with a for-profit company. And the problem is that as a single university hospital that we are, we don't have the benefit of a 40 percent market share. We don't have the benefit of getting together with Virtua and Lourdes in our marketplace to make sure that the pricing is appropriate. We all must negotiate, individually, on our own.

They must fulfill their responsibility as a partner here, and fulfill their responsibility given their not-for-profit mission as it's so stated, or change

and have the State react accordingly with regards to its designation and awarding of business.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gregg.

ASSEMBLYMAN GREGG: Thank you, Madam Chair.

Mr. Sessa, we have a number of folks that are going to be testifying today, and I'm sure we're going to hear the other side at some point. And I'm going to ask both sides this question.

I come from the North, so I don't have the privilege of being served by this hospital. I have the privilege of being served by a number of hospitals up north.

Specifically, if I go back to my home hospital in Morris County -- and I ask them, as I'll ask you -- is your contract with Horizon that you wish to have better or worse than the contract my hospital has? Are you asking for more or less, specifically? I think that's what people want to know because, in essence, this is a contract dispute that I don't think should be in this room, but I'll reserve comments later on that.

But at this point, I would like to know the answer to that.
(applause)

ASSEMBLYWOMAN WEINBERG: I'm going to ask -- please. We're not going to be deciding anything today based upon audience participation on the applause meter. So please keep that down.

ASSEMBLYMAN CONAWAY: Thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: I'm sorry. Assemblyman Gregg, continue.

ASSEMBLYMAN GREGG: You guys -- you don't have to give your money back on that one. (laughter)

Mr. Sessa, if you could.

Thank you, Madam Chair.

MR. SESSA: Sir, I would welcome the -- and encourage you to ask any health-care executive in this state what they think of the business practices of this insurance provider. I would encourage you to ask them whether they feel that they are being properly compensated for the services that they were providing. I would encourage you to ask them if it is, in fact, fair, as Cooper has been asked, to enter into a most-favored-rate clause.

Let me explain what that does. That is a request that whatever rates are paid to any of the other 30-plus insurance companies that we do business with, and any component of those contracts -- to the extent that we would offer rates that are below the rates that we negotiate with Horizon, we immediately must lower Horizon's rates.

What that does -- besides guarantee and continue to protect a 40 percent market share -- it actually has the impact of raising the cost of health care, because we deal with many small health-care plans that the State, itself, encourages to get started. And some of those plans we do offer -- not to the magnitude, because their plans don't cover the magnitude of services that we receive from Horizon -- but we provide them with better rates. We would not do that going forward if we entered into this clause. There should be no reason that we should have to enter into that clause with this insurance company, or any other insurance company in this state.

ASSEMBLYMAN GREGG: Through the Chair -- Madam--

Mr. Sessa, that was an excellent answer, but not my question. (laughter) My question was, if I take a procedure in Morristown Memorial Hospital, and I equal that to a procedure in your hospital -- under what you wish to receive -- will it be higher, lower, or the same? That's a very specific, three-dimensional answer: higher, lower, the same, or I can't answer, which I'll accept, too.

ASSEMBLYWOMAN WEINBERG: Excuse me, Assemblyman Gregg, but we will be hearing -- following Mr. Sessa, we will be hearing from the New Jersey Hospital Association, so they might be able to give you a more generic or statewide picture. But feel free--

ASSEMBLYMAN GREGG: Well, I'm happy with any of the four answers: higher, lower, the same, or I can't respond, because it's in litigation or something of that nature.

MR. SESSA: Sir, I would be glad to answer that question, and I would say it to you this way -- and I can hear whispering in my hear, although he's not sitting next to me -- our attorney -- because we are in litigation at this point in time, as you know -- ask Horizon.

ASSEMBLYMAN GREGG: As I said, it's equal opportunity. They are going to get the exact same question. They just have a little more time to think about it.

MR. SESSA: We wouldn't be here today if we were being properly compensated for the services that we provide, compared to any hospital in this state -- north, central, and in our own backyard.

ASSEMBLYMAN GREGG: Thank you, Madam Chair.

Thank you, Mr. Sessa.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Thank you very much.

Mr. Sessa, your attorney has probably advised you not to answer hypothetical questions, too, but I'm going to ask you one. Because we, like the Mayor and the other legislators we've heard today, are interested in the impact of this impasse -- let me call it -- on the people of Camden, the potential patients of Cooper Hospital-- If six months or a year goes by, and this contract dispute is not resolved, what is likely to happen to Cooper and, thus, the patients that we're concerned about?

MR. SESSA: It would be a disaster.

ASSEMBLYWOMAN QUIGLEY: I'm sorry?

MR. SESSA: It would be a disaster in the city of Camden.

Restating the facts: We're the largest employer in the city, we're half of the economy in the city, we're the fifth largest employer in South Jersey. Horizon subscribers represent 15 percent of our revenue. We are fully aware of our mission.

It's interesting. Horizon has accused us of increasing our charges over 300 percent. We started doing business with Horizon, and entered into our contract with them, in 1992. From 1992 through the year 2000, Cooper University Hospital's charges were in the bottom 10 percent quartile of all hospitals in the State of New Jersey. Quite candidly -- and I joined the Board in 1995 -- it was probably the single-most important reason for our financial difficulties, and why we were unable, almost unable, to fulfill our mission in the city of Camden.

So what we began to do in the year 2000 is, we targeted for the 75th percentile -- to increase our prices, to bring us in line with all of the other hospitals in this state. Today, we are only at the 65th percentile with regards to our prices, our charges. And we are still below the average of the six teaching hospitals in this state. What we did was a prudent business decision to bring our prices in line.

Once we did that -- in the past two years, where we have gone from an operation that loses money to one that makes money -- what did we do with our profitability? Well, utilizing the money that we are going to receive from the Camden Revitalization bill -- \$13.3 million, which is -- the requirement is that that money be matched by \$4.5 million from Cooper University Hospital. Our Board has approved us matching that with \$80 million to expand the hospital, because it is needed in order to service the patients in southern New Jersey. But we cannot do that if we do not have a contract with Horizon Blue Cross Blue Shield.

And when I speak about the partnership, there is our Medicaid Mercy contract, and then there is our commercial contract. We lose \$7 million a year on our Medicaid contract. Horizon -- and I would ask you to ask them this question-- They make money from their business of providing Medicaid services, overall, as stated in their annual report. We lose \$7 million.

So when Ron Del Mauro talks about the crisis with regards to the revenue cycle at hospitals, you have got to be able to realize income from other aspects of your business in order to continue your mission.

ASSEMBLYWOMAN QUIGLEY: Thank you. It answered my question, and I think you probably answered Assemblyman Gregg's, as well.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gordon.

MR. SESSA: If I-- May I also add one other point to your question, in terms of the impact?

Cooper University Hospital has 73 physicians that are primary care physicians, that only have privileges at Cooper. Those 73 physicians have, approximately, 5,000 Horizon patients. These Horizon patients are members of Horizon's New Jersey Plus program. They're members of unions, municipal employees, Camden County employees, New Jersey Transit employees, and even employees of the casinos in Atlantic City. Those patients, to be even more specific -- in terms of the answer to your question -- will now face two choices: find another doctor, or go out of network and provide higher cost.

With our specialists -- we have 194 physicians that are specialists in the areas of cardiology, oncology, neurosurgery, orthopedics. Their patients will now have one choice: find another doctor, or take their medical dollars over to Philadelphia.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gordon.

ASSEMBLYMAN GORDON: Thank you, Madam Chair.

Mr. Sessa, you just spoke about your efforts to try to improve the revenue picture over the last few years. There have been specific allegations made by Horizon about overbilling. Can you respond to those?

MR. SESSA: Horizon's allegations have to do not with overbilling, but have to do with increasing our charges -- increasing our charges 300 percent. And that's why I was looking forward to the opportunity to clarify what, specifically, Cooper did.

ASSEMBLYMAN GORDON: Could you elaborate, specifically?

MR. SESSA: In the period 1992 through the year 2000, our charges -- the prices that we charge for our services -- were in the bottom 10 percent quartile. A teaching university hospital, and a hospital that provides the types of services that we do-- There's no reason to be at that level. So beginning in the year 2000, we began to increase our charges, and with a targeted range of the 75th percentile of all hospitals in the State of New Jersey. And where we find ourselves at the end of 2003 is in the 65th percentile.

And I look forward, when you have the opportunity, for some of the industry people from the New Jersey Hospital Association and the New Jersey Council of Teaching Hospitals, who will specifically speak to that--

And we are still below the average of the other teaching hospitals in this state. There was no overbilling. It was just a question of increasing our charges.

ASSEMBLYMAN GORDON: Thank you.

ASSEMBLYWOMAN WEINBERG: Let me just follow up with a question, and then I'll call on you.

Were those charges set contractually?

MR. SESSA: The charges are the basis for each of the contracts that we enter into with all 33 of the insurance providers that we do business with. We're not having any trouble with any of those other insurance providers.

ASSEMBLYWOMAN WEINBERG: Assemblyman.

ASSEMBLYMAN CONAWAY: Thank you.

Just to put some more clothes on that point. I mean, as a practicing physician, I know that I could charge \$1,000 for an office visit, but I know what I'm going to get paid. How is it that -- because I think it's important, at

least for this Assembly person, and I think probably for others, as well, to understand this question of moving to profitability.

I own a small business. I provide care to people. I know that my small business cannot go forward and continue without bringing enough revenue to pay myself, to pay my staff, to pay for property taxes, and all of those things.

And much of what we see in health care, in terms of crisis, has to do with the revenue side -- there's efficiency questions, of course, for patients' safety -- but a revenue side of the problem. And one of the things I know Cooper has faced over the years with its profitability picture -- and indeed all hospitals across the state, when you think of the conversions, of decrease in Federal reimbursement, problems with State reimbursement for care, tough negotiations by commercial insurers -- that the revenues are really not keeping up with the cost to provide care.

Now, what is the process for -- when Cooper -- when you decided to embark on bringing your charges in line, really, with other hospitals in the State of New Jersey -- perfectly reasonable business decision for Cooper to make-- How is that done? Is that done within the context--

I mean, I have signed a contract. I change. It doesn't matter, they're going to pay me the same thing under the contract.

How are you able to move your charges to bring your revenues in line with your costs so that you can remain a viable institution here for the city of Camden?

MR. SESSA: Right now, my chief financial officer is sitting next to me whispering into my ear.

ASSEMBLYMAN CONAWAY: You're not seeing things, are you?

(laughter)

MR. SESSA: There are many coded codes for the different types of services that any hospital provides. They're referred to as DRG codes. What is done at specific points in time is that those specific codes, and the corresponding charges associated with those codes, are increased. What Cooper chose to do in that period from 2000 through 2003 is to provide -- is to increase them on a semi-annual basis, and then, ultimately, on an annual basis.

What is necessary, what then must follow, is to provide notice to the insurance carriers of those charge increases so that they can respond accordingly.

Now, again, without trying to get into the specifics with regards to the differences that we have with Horizon on this issue right now, I can't help but say that what has been published is the fact that there are differences with regards to several million dollars. In the overall scheme of things, as it pertains to both Horizon's profitability -- and I'm not understating these dollars at all -- but as it pertains to Horizon's profitability, and Cooper's overall profitability -- is that really what this discussion is all about, or is this discussion about most-favored-nation clauses? And is this discussion about an insistence that you will be paid overall at this level, as opposed to the dollars that competitors are paid in this marketplace?

ASSEMBLYMAN CONAWAY: So, obviously, the hospitals operate a little differently than I, as a private physician, in terms of this notice and being able to increase your charge.

But you also touched on this question -- and I tread there, as I'm going to speak generally -- about this concept of this most-favored-nation rate now. As -- never being involved in these negotiations-- But it seems to me that that kind of a policy would achieve-- Isn't that like a monopoly kind of -- a monopolistic kind of tactic?

If I can't, with my competitors, sit down and set a price, one way for me to do that, perhaps, is through negotiations with a provider such as Horizon; then bring in this most-favored-nation status; and then achieve what you cannot achieve -- which I think would be illegal -- to collude with other insurance companies to set a price.

Now, is that-- You know, I've said it as a proposition. I don't know that that's true or not. But is that what you believe is happening here, using this contractual term to, really -- as a substitute for negotiations, legal negotiations, that might take place between competitors, in terms of setting prices?

MR. SESSA: Assemblyman Conaway, I believe that you will find that there are a number of Federal and State authorities that share your opinion with regards to MFNs being anticompetitive and of questioned legality.

ASSEMBLYMAN CONAWAY: Another question, if I may, through the Chair.

ASSEMBLYWOMAN WEINBERG: Go ahead.

ASSEMBLYMAN CONAWAY: In the question of -- and you touched on it -- I think it's very important, because we are focused on what happens to patients in particular.

Now, as part of the notice requirements in the negotiation process -- and I know that we have rules on this at the State -- that when, I guess, a contract expires, there's an obligation, as an individual physician and institutions, to continue to provide care.

Now, I want to be sure, because as Assemblyman Thompson has mentioned, we need to -- it might be important for us to look for avenues to help, from a legislative point of view.

Now, when that happens -- the moment that notice is given, and the contract ceases, a patient then comes to the hospital. That patient, then, is going to be -- is going to have to pay an out-of-network rate which, of course, usually means there are higher costs for the patient, which I think we should want to try to avoid. It's not their fault that this has happened.

The practical implications of a contract ceasing and moving to out-of-network status, as I understand it, is that the patient is going to have more out-of-pocket costs, generally, when that happens. Is that correct?

MR. SESSA: Absolutely. That is correct. When a notice is -- Horizon notified us of their intent to -- for the contract to expire. That occurred as of December 28. There is a mechanism in place with regards to such contracts that allow for a four-month grace period. So as of April 28, any Horizon Blue Cross Blue Shield subscriber -- after that date -- would then -- Cooper University Hospital would then be an out-of-network hospital.

ASSEMBLYMAN CONAWAY: After which date? I'm sorry.

MR. SESSA: April 28.

ASSEMBLYMAN CONAWAY: After April-- So you do get--

MR. SESSA: So between now and April 28, we still are in-network, but we don't qualify for one of those hospitals recognized as such in the region.

ASSEMBLYMAN CONAWAY: Through the Chair, if I may, you mentioned the -- just to clarify -- because you mentioned this 40 percent market share. Is that statewide or for the South Jersey region?

MR. SESSA: Statewide.

ASSEMBLYMAN CONAWAY: And the 60,000 members, that's for--

MR. SESSA: South Jersey.

ASSEMBLYMAN CONAWAY: That's also for South Jersey.

Now, one of the things that -- and I'll close with this question -- that I see as a theme of your statements, and some of the other statements that I think are going to be made today, and have been made -- and that is the special status that Horizon enjoys as a nonprofit provider of health insurance.

And one of the larger questions is, what obligation -- it seems to me your position -- what obligation to someone does an entity with those -- operating in that way have beyond just running a business. Now, you have, obviously, folks out there that are for-profit entities, and we can talk about corporate responsibility-- But I think your position is that when you're a not-for-profit entity, and you enjoy the benefits of that, that there are special obligations that those entities have that are apart from others who are for-profit. Is that your position, and can you elaborate on that some more?

MR. SESSA: That is correct, and yes I can.

Why should the responsibility for providing health-care services to the uninsured fall only on the shoulders of the hospitals and the physicians,

private-practice physicians, that provide those services? Doesn't a not-for-profit, tax-exempt insurance company, that realizes the benefits of the State-designated business in this state -- don't they have some responsibility to deal with the issue of charity care? That's exactly what I'm talking about.

Right now, because of reasons that you know better than I, the amount of health-care services being provided by hospitals in this state is approaching a billion dollars. Last year, the industry was compensated, from the State, the maximum amount that it could, \$381 million. That's a significant shortfall. What responsibility do the health insurance companies have for dealing with that issue, particularly those that have a designation as a not-for-profit, tax-exempt insurance company?

ASSEMBLYWOMAN WEINBERG: Mr. Sessa, thank you very much. I don't see any further questions here. We appreciate your participation in the hearing today.

MR. SESSA: Again, thank you very much.

ASSEMBLYWOMAN WEINBERG: And I understand that Assemblyman Lou Greenwald has joined us.

Assemblyman, would you like to come forward?

Mr. Sessa, just before you leave, I have one more question.

We passed a prompt payment law in the State of New Jersey. I know that's not necessarily on point here, but could you please tell me, from your point of view, very quickly, is that effective or not effective?

MR. SESSA: I'm getting the whispers again.

There are folks here from Cooper who could tell you whether Cooper is being promptly paid. The answer is, no. But your question is

probably more to the point with regards to the industry overall, hospitals throughout the state. And if I may, I would defer from the folks from the New Jersey Hospital Association, who are here, that have the statistics that can answer that question. And they can also answer the question, as it pertains to slow pay and no pay, which insurance company in this state is the worst offender.

ASSEMBLYWOMAN WEINBERG: Thank you.

Okay. I won't call you back, I promise.

Assemblyman Greenwald.

A S S E M B L Y M A N L O U I S D. G R E E N W A L D: Madam Chairwoman, members of the Committee, thank you for coming to South Jersey today to hear this ever-important issue.

As a member of our South Jersey legislative caucus, made up of Republicans and Democrats alike, we appreciate your recognition of such an important issue to the economy and the vitality of South Jersey.

I would also say to you, as Chairman of the Assembly Budget Committee, I've heard many questions presented today. But I think one of the things that I hope is being brought upon this Committee and, hopefully, the State--

And my friend Guy Gregg made a point -- and I appreciate his travel south. He's from North Jersey, not as familiar with some of the issues here.

Friends, make no mistake, whether you are from North, Central, or South Jersey, the discussions that you are having today are a stake in the heart of the economy of New Jersey, and of the region in which you sit.

I take you back to the budget hearings of last year, and the \$175 million investment into this city. Regardless of what your position may have been on that investment, no one, regardless of who we have talked to, and our colleagues in the Legislature, will deny the vitality that is existing now in Camden City.

There is an excitement that is being generated from that investment. That investment was centered, primarily, on two entities. You're sitting in one of them, the universities. The second was our hospitals. The most vibrant hospital in this region is Cooper Hospital. An attack at Cooper, on this entity, as it has been on other hospitals around the state, is an attack on the vitality of our economy.

My legislative district, the 6th Legislative District -- its five largest employers are hospitals. None of them are bigger than Cooper. If there is, God forbid, a tragedy in Toms River, as there has been in the past, where a State Trooper was injured, he is medivaced to Cooper Hospital. If your life is in jeopardy, you want to be at Cooper Hospital.

I have not been privy to the negotiations with Horizon and Cooper. None of us have, nor should we be, maybe. We are thrust into an issue and a problem that is, maybe, foreign to many of us. But the people within this negotiation have included us through e-mails and copies of letters, which I probably question.

But I will tell you the one that troubles me the most is the one that I got from the representatives of Horizon, which list a cast of thousands, but it's probably just 120 legislators at the top. My trouble is -- and I will read briefly from the letter where it says that, "By means of this letter, Horizon is responding

to the January 19 letter sent to members of the New Jersey Legislature by Cooper. We regret that Cooper has chosen to take such a negative and public approach to a private contractual dispute, first, because Cooper's January 19 letter is part of an orchestrated campaign designed to alarm the public.

“Horizon must address one critical issue raised in Cooper's letter, namely the health-care coverage of Horizon members in Camden County. To advance its own financial interest, Cooper is spreading confusion and fear about access to health care in South Jersey.”

On the second page, in response to that alleged fear tactics by Cooper, Horizon's solution to that problem -- “Don't worry. A number of Philadelphia hospitals, including Methodist, University of Pennsylvania Health Systems, Presbyterian Medical Center, Childrens' Hospital of Philadelphia, and Thomas Jefferson University Hospital, are also accessible to Camden County residents.”

There is not a person in this room, who is a New Jersey resident, who should not be offended and outraged that the solution to this problem is send your loved ones over the bridge to Pennsylvania, and bypass the number one trauma center in this region, where people from all over New Jersey, when their life is in jeopardy -- when people that help defend and protect our lives -- are medivaced to Cooper Hospital-- Horizon's solution to these negotiations is, go to Pennsylvania. You know, ladies and gentlemen, I don't know. I haven't been privy to the negotiations, but I am offended when people suggest that that is the solution to our problems. We have some of the finest medical providers in this state here in South Jersey.

I ask you, what has Horizon done to help promote the cause in this horrific deficits that we have faced for the last two-plus years? What have they helped contribute to charity-care funding like the five hospitals here in South Jersey, and Cooper -- none more than Cooper Hospital.

As their executives are making millions of dollars, what are they doing to allow for an appellate process for those people who are denied claims? As they have gotten excess increases in double-digit premium relief, year in and year out dating back to 1999, what have they used with the excess funds -- almost a billion dollars -- to help relieve the stress of New Jersey residents?

Ladies and gentlemen, the two most critical issues that face this state -- you all know them -- are property taxes and affordable health care. It is a crisis in this state.

Their solution for us on the issue of affordable health care: Go to Pennsylvania. I say, no. This is a stake in the heart of our state and our economy. We cannot allow this. We must ask the questions. And I would like to see, based on Chuck Sessa's comments-- If they are referencing us to go to these hospitals in Pennsylvania, don't we have the right to know the contracts that they have entered into with those facilities? Are they putting us at a competitive disadvantage with Pennsylvania hospitals? What is the premium contracts that they have negotiated with those facilities that they can so quickly brush aside the number one trauma center in this region? Should we have the right to know that? I think we should.

I don't appreciate the eleventh-hour negotiations. I don't appreciate -- and it's not just Cooper Hospital. This is not the first time that this has happened with this company. There are other hospitals in the northern

part of the state -- up in Bergen County and other parts of this state -- that have entered into these same problems. It would be one thing if, as we sat here today, this was the first incidence of this nature with this provider. They have been given an unbelievable credit here in New Jersey. They've been given a huge leg up on their competitors. We ask very little in return.

And you know, ladies and gentlemen, people have said to us, "You're Chairman of the Budget Committee. Dance on this issue lightly. We have this issue of conversion in New Jersey. There's a billion dollars in excess revenue. Clearly, we have billions of dollars of deficit problems. This could be helpful in our never-ending battle to solve the fiscal crisis in this state." Well, to the members of this Committee, I say to you, stand strong.

We have closed \$14 billion in deficit without a single penny from Horizon. We will continue to do it, and we will not be held ransom to close a deal and jeopardize the taxpayers of this State to take pennies on the dollar, while millionaires make millions more. We stood up to the casino industry, and we will stand up to this industry. And we will do what is right by the taxpayers of this State. Stand by what you believe in. Stand up for the residents of New Jersey. And no matter where you live, on this Committee, no one's solution to this problem should be: Go to Pennsylvania for quality care. Your loved ones and your families deserve better, and Horizon should be ashamed, for them, to make that as the solution to our problem, their negotiations, and this crisis.

Ladies and gentlemen, thank you for your time.

ASSEMBLYWOMAN WEINBERG: Thank you, Assemblyman.

Do we have any questions?

ASSEMBLYMAN CONAWAY: Just one.

I appreciate very much your passion as regards the issue of health-care dollars leaving South Jersey. The point's been made by the executives at Cooper, and I think needs to be made again -- and by the Mayor of Camden City, Council President -- how important Cooper is to the economic survival, really, of Camden City.

And I ask you to touch on this question, again, of responsibility, particularly of Horizon, given its nonprofit status. Of -- and I think you've probably expressed -- but your view of someone who has that important role in the State of New Jersey, who now seems to be encouraging our health-care dollars to leave the State of New Jersey, particularly at a very difficult time for us, budgetwise, and particularly when you look at the serious economic difficulties that Camden has had now for very many years.

Could you comment on what those kinds of entities ought to be doing, with regard to sending our health-care dollars out of state?

ASSEMBLYMAN GREENWALD: Dr. Conaway, because Horizon has never contacted me in any means other than this letter, we have not been privy to their discussions, we have not been privy to their discussions with Treasury. But by way of example, we can point to discussions last year to bring the Cancer Institute of New Jersey to South Jersey. Because, by comparison, that entity, in 10 years, up in New Brunswick -- in stopping the migration of cancer patients to New York -- now generates, for the State of New Jersey, \$500 million a year based on vendors who supply, the sales tax revenue, and income tax revenue from that site. That is why the component was so important -- to bring that site south -- to stop the migration to Pennsylvania.

As we talked about that, as many members of this Committee and people, regardless of political party, recognized the need for that site, here again is the solution from people who are not from our region, do not understand our needs, and say, "Just go over the bridge to Philadelphia."

No one, Doctor, as far as I'm aware, has done a study. But you can imagine, if you take the largest medical provider in this state, take out one of the largest health-care providers that provide to them, and say to their patient population, "You can go over the bridge and get treated at facilities out of state," that would have a debilitating impact, not only on Camden City-- I recognize the Mayor's concern for this city. This is bigger than Camden City. This is the regional outgrowth to all of South Jersey that Cooper represents. And that is why this is so critical.

Yes, it would devastate the city's recovery and the excitement that has been built. But the impact, statewide -- the impact on our economy throughout this region that would affect our state's economy -- would be dramatic.

ASSEMBLYWOMAN WEINBERG: Thank you.

Are there any other questions for Assemblyman Greenwald? (no response)

Thank you very much for--

ASSEMBLYMAN GREENWALD: Chairwoman, thank you again for coming here.

ASSEMBLYWOMAN WEINBERG: --appearing before us.

ASSEMBLYMAN GREENWALD: Thank you.

ASSEMBLYWOMAN WEINBERG: Hopefully, we do not have any other elected officials present to hear. (laughter) That was nothing personal.

ASSEMBLYMAN GREENWALD: Did I hear clapping for that? (laughter) That upsets me.

ASSEMBLYWOMAN WEINBERG: No, I already ruled applause out of order.

But we do have a statement, which I'm not going to read, for the record from Assemblyman Neil Cohen, a colleague of ours, who is Chair of the Assembly Financial Institutions and Insurance Committee, who has some of the very same issues that have been articulated here, and is thinking about having some hearings from the insurance angle. So this will certainly be part of the record.

Next, I would like to call Valerie Sellers and Sean Hopkins, from the New Jersey Hospital Association. And then, following that, will be Christy Bell, from Horizon.

And remember to please state your name, full name, before you get into your testimony.

VALERIE SELLERS: Chairwoman--

Is this on (referring to PA microphone)?

ASSEMBLYMAN CONAWAY: Bring it towards you.

ASSEMBLYWOMAN WEINBERG: Keep the microphone close, okay?

MS. SELLERS: Chairwoman Weinberg, members of the Committee, good morning.

My name is Valerie Sellers, and I am Senior Vice President for Health Planning and Research at the New Jersey Hospital Association, with responsibilities for issues related to managed care.

I'd like to thank you for the opportunity to comment on the concerns that you, among others, have with the current hospital/HMO relations in New Jersey.

Through the testimony you have heard, and will hear, today, it becomes apparent that the issues facing HMOs and providers are extremely complex, and any effort to simplify them into an issue of rates or negotiating tactics on the part of hospitals undermines the very purpose of this hearing, which is to better understand and address a potentially flawed business relationship that has a profound impact on the citizens of New Jersey.

There is no one specific reason why a hospital terminates a contract with an HMO, but rather a culmination of reasons. I don't know of a single hospital that would go through the process and the challenge of terminating a contract, having to ensure that all of their physicians are supportive of that decision, with the understanding that they can no longer refer their patients to the hospital, may no longer be able to treat some of their patients, recognizing that they run the risk of alienating their community, and also recognizing the financial implications of terminating that contract -- that any outstanding debt, they're unlikely to see. And, as important, those individuals in the community will continue to rely upon the use of the emergency department; and the chances that that hospital will ever see reimbursement for the care that they're providing in that ED is slim to none.

As complex as it is, it's also very simple. If the hospital, through an exhaustive assessment, understands that it will continue to lose revenue for every patient they serve for a particular HMO -- and that loss will compromise its ability to offer the programs and services that are needed by the community -- then the hospital's left with little option but to terminate its relationship with that HMO.

HMOs will argue that terminations are simply a negotiating strategy to get better rates. In reality, however, it doesn't matter how good the rates are when the HMO doesn't pay its claims.

In addition, the administrative costs associated with simply doing business with managed care plans can far exceed any conceivable rate that can be negotiated. This is, in fact, what is occurring with hospitals throughout the state.

Some examples of the financially burdensome administrative actions include: inappropriate denial of medically necessary care; the overwhelming volume of appeals that hospitals must file to be compensated for that care, and the reality that they really only can file a percentage of appeals, and forego reimbursement for all the other care that they provided; inappropriate denials and payments for emergency room care; late payments, incorrect payments that delays reimbursement for months and months; unilateral changes to contracts, absent mutual consent; arbitrary determinations to downgrade payment for services; and unnecessary barriers placed before providers in their efforts to resolve problems.

While there are many HMOs operating in the state that are creating administrative and financial problems for hospitals, the focus of this hearing has

been on Horizon because of its unique position as one of the state's largest HMOs, accounting for 37 percent of New Jersey's insured population. This plan's size, and the fact that it contracts with more than 80 New Jersey hospitals, means that the administrative burden associated and the financial impact of Horizon's business practices are significant.

For example, NJHA's most recent Prompt Pay Survey, which we've conducted on a quarterly basis since 2000, hospitals -- 44 hospitals reported that during the third quarter of 2003, Horizon complied with State regulatory requirements less than half the time for eight of the nine categories surveyed. In fact, Horizon's compliance in paying the proper amount of the claim is only 24 percent, the lowest rate of compliance demonstrated by this payer since NJHA began surveying four years ago.

Looking at how timely and properly HMOs pay claims is only one part of the story. In September, NJHA surveyed hospitals to determine denial rates for both commercial and Medicaid managed-care payers. We looked at data at a sample of hospitals reporting for a six-month period from January to June 2003. We learned that while commercial HMOs denied more than \$11 million in care for the first six months of 2003, Horizon's denials accounted for more than half of that denied reimbursement. The financial impact of Horizon's denied days was more than \$5.9 million among the 13 hospitals providing data, well-above Aetna's impact of \$2.5 million, and substantially more than other payers. And that does not reflect the costs associated with downgrading -- what we call *sniffing* -- paying for less than an acute level of care, despite the provider -- the physician believing that acute-level care was necessary.

While the statistics I've shared with you are in relation to Horizon, the reality is that hospitals and physicians experience problems with many of the HMOs conducting business in New Jersey today. You've asked for possible solutions or remedies to avoid termination, which is truly an action of last resort. I would encourage you to examine and support NJHA's claims denial legislation, which was first introduced in 1998 and subsequently introduced in every legislative session.

The purpose of this legislation is to address the administrative problems experienced by providers, to ensure that there is accountability and, most importantly, to improve the efficiency of the operations between HMOs and providers. The provisions of this bill would eliminate, or certainly reduce, the administrative issues I've identified for you. This legislation has been vigorously opposed by HMOs over the past several years, as they've argued that it will cost them too much money.

NJHA has countered that good business practices should already be in place, and that any short-term increase in cost to ensure such practices are in place will, ultimately, save money on both sides through efficiencies gained. Interestingly, there has been little concern about the excessive costs hospitals had to absorb as a result of doing business with HMOs over the years.

I hope that, following this hearing, you will come to understand that when hospitals terminate their contract with an HMO, it is not simply a negotiating tool but, rather, a decision of last resort. And, most important, there are concrete actions that can be taken to lead to better working relationships between HMOs and the provider community in New Jersey.

Thank you.

If you want to wait--

ASSEMBLYWOMAN WEINBERG: Go ahead, Mr. Hopkins.

Give your full name for the record, please.

SEAN J. HOPKINS: Thank you, Assemblywoman.

My name is Sean Hopkins. I'm the Senior Vice President of Health Economics at the New Jersey Hospital Association.

Really, thank you again for the opportunity to speak at this hearing.

I'd like to try and take some time to place some of the discussion that you're hearing today in context from a financial perspective. These are, clearly, trying times. These are, clearly, trying financial times for hospitals in New Jersey.

We are a \$14 billion industry made up, predominantly, of charitable institutions. Our hospitals provide approximately 150,000 jobs, oftentimes being a community's largest employer. As charitable institutions, any excess revenues, overcosts that hospitals generate are put back into services, back into the refurbishment of the physical plant, back into new technology, outreach programs, new and additional services.

Based on our ongoing analysis, hospital margins continue to hover at or below break-even, and cash reserves are being systemically drained from hospitals as they dip into those reserves to offset these annual losses. At some point, that well will run dry.

In the last six years, our hospitals -- as an industry, our hospitals have either lost money or broken even, collectively. Posting a loss from operations during that period, hospitals are clearly being placed at risk. At any given time during the last six years, anywhere from a third to two-thirds of our

hospitals have finished the year operating in the red. There are a variety of driving forces that are contributing to that financial performance. In many instances, it is referred to as the *perfect storm*.

Out of Washington, we receive, on an annual basis, reductions to our payments from the Medicare payments system for the services we provide. In New Jersey, our data shows that the Medicaid program reimburses hospitals approximately 70 percent of their cost -- the cost of providing those services. Our State-run charity care system that provides health-care coverage for New Jersey's working uninsured pays hospitals over a half a billion less than the cost of providing that care. You've heard several other people testify today that the cost of providing care to the charity care population is approaching \$1 billion. We receive a \$381 million payment as an industry. That is a \$600 million shortfall.

Underpayment and denied payment for services by managed care companies -- which Valerie just elaborated on -- are also woven into this mix. The hospital payment system is severely broken. Reimbursement is inadequate across the board. Without appropriate payments by the major payers -- Medicare, Medicaid -- our charity care program, which has underpaid hospitals -- has paid hospitals \$1.8 billion less than what Medicaid would have paid for those services over the last six years. Now, remember, I said Medicaid is only a 70-percent-of-cost payer, as well as managed care. If these trends continue, access to care will be continually eroded.

I'll be more than happy to take any questions.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gordon.

ASSEMBLYMAN GORDON: Mr. Hopkins, I wonder if you could comment -- or Ms. Sellers. Are you able to compare Cooper as an economic institution, in terms of cost, in comparison with other urban teaching hospitals? I mean, is it a high-cost institution, somewhere in the middle, reasonably efficient? Can you characterize it in that way?

MR. HOPKINS: When we look at the finances of the State, we usually look at them in aggregate, and we're looking at them in total for all of our acute-care hospitals, collectively, as an industry. We monitor that periodically on an annual basis. We release information on an annual basis. We do not dissect that information down to the hospital-specific level.

ASSEMBLYWOMAN WEINBERG: Is that it?

ASSEMBLYMAN GORDON: So you can't comment on how they compare, in terms of length of stay, or patient days?

MS. HOPKINS: I don't have that information at the hospital-specific level. As I said, we monitor this information as an industry, collectively, on a statewide basis.

ASSEMBLYMAN GORDON: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: You mentioned -- actually, CEO Sessa mentioned that there are losses that -- for Cooper, in specific, there are losses under their contract with Horizon/Mercy, and I want you to speak sort of globally on -- being as you're, sort of, an umbrella organization for hospitals. What other-- How are other hospitals fairing under this -- under the Horizon/Mercy contract, in particular? And I point to that one, because a lot of hospitals probably have both Horizon/Mercy and also the, sort of,

commercial payers in that. And the hospitals, I think, are probably right to see them as one.

And comment on the cost shifting. It seems to me these folks that have Horizon/Mercy have insurance, and so someone should be paying for their care. And it is, therefore -- it seems to me -- wrong that the care provided under that contract is not meeting the cost of the services that are being rendered, and actually represents a cost shift to the hospital -- the institution itself. I know it happens at the micro level at my own office.

Can you comment on this question of how to deal with this -- the losses under it? Do you believe that there are losses, and do you think it represents cost shifting?

MR. HOPKINS: Sir, we do not have access to individual contractual information between hospitals and payers of records. So it's impossible for us to do any kind of contractual analysis at the level that you say.

However, as I said earlier, when we look at the industry collectively, and the net patient revenues that they receive, and the expenses that they incur, what we have seen is, over the last -- probably the last six years, as an industry, we have collectively, over that time period, lost money as an industry. And in three of those six years, our industry has collectively lost money from operations, and in the other three years done nothing more than break even with an overall profit margin of somewhere between maybe 1 and 1.2 percentage points, at best.

MS. SELLERS: Assemblyman, I think one of the points that you raised in your question is that while we don't know the individual rates -- and

we assume that they are trying to offset what may be -- negotiating at less than cost-- The problem is that even if they negotiate -- and I made this point in my testimony -- even when they're negotiating rates that may, in fact, be at cost-- If they're experiencing exceptionally high denial rates, if they're having to have additional staff on board to file appeals, if they're seeing the high-end cases typically being denied, or-- Particularly with a Medicaid managed care population, when they use the emergency department and those claims are denied -- and there's an extremely high percentage of ED claims that are denied by Medicaid managed care plans in the state -- it is almost impossible to move forward with an appeal on those claims, because one needs to get the patient's consent to do so. And so once those patients leave the ED, the claim is denied. The hospital then bears the administrative burden of going out and trying to reach that individual, secure their consent, then file an appeal. It can take-- If the hospital is successful in doing that, it can take months before that hospital can actually submit an appeal and be reimbursed.

So you have to-- Even with the rates, you really have to look at the costs associated with doing business with these plans. And I think you heard some of that today.

ASSEMBLYMAN CONAWAY: Can you comment, again being that you're statewide in your perspective, on this business of the most-favored rate? Is this something new, is it something that other hospitals have reported that they have faced in their negotiations?

MS. SELLERS: It's anecdotal. I would tell you we don't survey on that. We walk a very, very fine line. We stay away from discussion of rates. We stay away from specific provisions reflected in contracts because of the

antitrust issues, particularly as an association. We're in a very difficult position. It is not something that is new to me. I've certainly heard it through discussions that have taken place, but I can't say definitively that I've seen it in any particular contract. I'm not surprised by it.

ASSEMBLYMAN CONAWAY: Lastly-- And also touching on this issue, just generally, perhaps providing some historical perspective to the Committee on how other negotiations have gone -- it's been alluded to in some of the testimony with other hospital systems across the state-- What are the trend lines?

I imagine that with the money being reduced from all sorts of payers, that these negotiations are getting more difficult. Are you seeing-- How many hospital network -- how many instances have institutions canceled contracts, say, in the last year or so, as opposed to 10 years ago? Or how many doctors have -- perhaps that's a Medical Society question -- have decided not to continue on with their contracts? What are you seeing out there, statewide, in terms of negotiations, terminations of contracts in general?

MS. SELLERS: Well, I can tell you in the discussions that take place, I think the negotiations are extremely difficult. And I think what puts Horizon in a unique position -- and what you've heard from others testifying -- is that when you hold 40 percent of the market share, you're the big gorilla. And so you have leverage that some of the smaller plans may not necessarily have. On the other hand, perhaps some of the smaller plans are not creating some of the challenges that a large Horizon may have.

In terms of contract terminations, we don't gather that specific information. It's usually if we know about a particular plan that we see a trend

in contract terminations. And there is one particular plan where we saw that a number of hospitals were moving forward with contract terminations. We then went out, and we said, “What are you attributing this to? Why are you terminating? How many of you are even giving consideration to terminating, and what are the reasons?” so that we as an association can attempt to resolve some of those issues.

We have, as you’ve seen-- We’ve observed hospitals, basically, coming to a place where they no longer think it’s economically feasible to continue their business relationship. And when you take systems such as Barnabas, or Cooper, or others that have walked the road of termination, the cost of termination is excessive. It is very, very costly for a hospital to walk that road. So I don’t think it’s a decision taken lightly.

But I don’t have specific figures on how many hospitals have moved forward with terminations. I have not seen a lot of action being taken. We can provide you with that information if it would be helpful to you. We can do so very quickly.

ASSEMBLYMAN CONAWAY: Through the Chair, please.

MS. SELLERS: Absolutely.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Thank you, Madam Chair.

In the interest of speed, I’ll be quick. But I’d like to ask Ms. Sellers a question.

You listed here some of the administrative costs associated with doing business with the HMOs that are unnecessary. Unfortunately, I have

knowledge and experience with most of them. But there's one that evades even me. What is recapping payments, that were made as long as five years ago?

MS. SELLERS: HMOs will go back, and what they do is called their *retrospective audit*, where they can go back three, four, and five years, and review records, and determine that they may have overpaid and, therefore, they're going to take that revenue back. And you can only imagine it reeks havoc on somebody's budget when they've anticipated certain revenues.

ASSEMBLYWOMAN QUIGLEY: Is that permitted under the contracts that currently exist?

MS. SELLERS: I know of only one hospital that's been able to include a provision that prohibits retrospective audits. Most are not capable of doing so.

ASSEMBLYWOMAN QUIGLEY: Thank you.

Every time I learn something new, it's bad news. (laughter)

MS. SELLERS: Especially from me.

ASSEMBLYWOMAN WEINBERG: It was great news on how well our prompt payment legislation is affecting the payment to hospitals and physicians. That gives me lots of confidence in what we've been doing.

If there are no other questions, thank you both.

Senator Wayne Bryant is here, and would also like a few moments to address the Committee.

Senator.

S E N A T O R W A Y N E R . B R Y A N T: Thank you very much, madam Chair. And I thank the Committee for coming to the hub--

ASSEMBLYWOMAN WEINBERG: Senator, please keep that microphone close to you.

SENATOR BRYANT: I thank the Committee for coming to the hub of my region, which is Camden City.

This issue struck me, as it probably struck most of southern New Jersey, like a bolt of lightening that was going to do mass destruction to an institution and our collective communities that we cannot tolerate.

Let me explain. One of the things I am really concerned about, and hope this Committee takes up -- besides just hearing the things that we find that are going to hurt, ultimately, if this is not resolved, the actual patients that need this service-- But it is the whole notion that have we, in public policy, created a monopoly that is out of control.

Any time you allow one entity to have 40 percent of the entire market-- We are now starting to reach monopoly proportions, and that needs, in itself, to be examined -- whether that's good for New Jersey.

Secondly, as you look at an institution such as Cooper Hospital that services the region in many areas -- trauma area, other areas that-- They're the only ones that provide the services. They give acute care. And for us to have, or be threatened with, the thought that many patients could be denied this care. Or, under the thought, in New Jersey we are under the assumption that an HMO could say to the citizens of the southern region that you must go to Philadelphia in order to get some of this tertiary care -- is something beyond something I could believe, in 2004, we could even consider.

New Jersey has to be concerned about providing the best care it can within its borders. And we should be enhancing that ability, and not allowing folks to maybe denigrate that ability.

I think, secondly, there needs to be looked -- when we deal with institutions such as Cooper, which does, for this region, more charity care than any institution in the entire southern portion of the state-- There has to be some correlation between what we're allowing the HMOs to do and this public policy of New Jersey. This is our public policy about charity care -- and that all hospitals cannot deny those that need care. They must serve. So, in essence, the public policy is not one of election, it's a public policy that mandates that you take that service.

Then it strikes me that we have allowed an HMO of such proportion to have such reserves that are 10 times what it is that we require by Banking and Insurance. And it's nonprofit.

So it brings in the question, what does nonproficiency (*sic*) mean, as it relates to HMOs and health care? Whether, in fact, that, at some point in time, becomes something that becomes so inherent to what you think as a nonprofit, that we've allowed rates to increase by 40 percent in four years, in order for a nonprofit to put reserves away which is 600 times the amount that they do across the nation.

Now, we have to think about that. Is that where our health care should be going in New Jersey? Or should those who are in the nonprofit sector providing health care not only participate to make sure that we actually have access to care, but we also should be participating, maybe, in the charity care

when they're making these excess profits, and especially in the institutions that are providing them?

So I guess I say to the Committee this: If we don't come out of these hearings with some clear direction as to what we're going to require those who want to do business in the health-care industry in New Jersey -- so that they do not inhibit the ability of folks to get care-- This is America, this is not some third-world country. This is the United States of America, where access to health care ought to be guaranteed by us. And we do, indirectly, by telling hospitals, such as Cooper, they must take all comers. So we can't have it both ways as a Legislature, as policy makers -- that we require hospitals, on one hand, to take all comers; and on the second hand, we allow them to be in jeopardy by allowing monopoly types of companies to interfere with that care.

Now, let me tell you -- when I bring it down to not only South Jersey but Camden City, this does not only jeopardize what's happening to Horizon, but it's also Horizon/Mercy. Now, if folks don't understand what that means, that's our Medicaid and Medicare populations. This city, right now, being the second poorest in the nation, has a high population that needs either Medicare or Medicaid -- so disproportionate to the outside region. And we have a hospital that has put blinders on when it comes to its own economic well-being, to make sure that there's not a citizen in this city, or in the region, that hasn't gotten care.

Now, instead of us applauding that -- and for us to make sure that we keep it whole -- we're at the brink, by March, to turn thousands of people away.

As long as I sit in the Senate of New Jersey, that is not going to be something we're going to tolerate. We're going to review all these different commitments.

And then when I read that we review contracts by the Department of Health -- I mean Banking and Insurance -- and some folks who have power decide to make side deals -- really a noncompete deal -- and we don't want to expose that to the regulators. There's something wrong with the system, and we must correct it. If we don't do anything else, we ought to outlaw any side deals that are not examined by New Jersey.

We ought to do another thing. We ought to make sure that these types of situations, from nonprofits that we legitimize in New Jersey, have some responsibility in the field, in which we allow them to operate in order to invest back into that field, and as it relates to our overall mission of making sure there's health care in New Jersey, in a hospital sense, for everybody.

March is fast approaching so, Madam Chair, I want to say to you and the Committee, I am most thankful that you have not idly sat by, but you are here taking in information. And I know there are actions that are going to come from what you take in.

I'm here to tell you that on behalf of the citizens of the city of Camden, all the way through the 5th Legislative District, that if, in fact, we here do not do something about this contract with this hospital, you will have ultimately hurt the citizens of southern New Jersey. And the irreparable harm that we may cause may never be corrected, because if it costs a life because they can't get to an emergency room or trauma center, you can't restore that. So if we don't do anything else but say, "Stop!" until we have the time to fully

understand -- if it's that we don't have all the information -- we've got to do that. It's not that this place is going to go bankrupt. So we're not talking about a bankrupt situation. As a matter of fact, we're talking about folks flush with cash.

And then lastly, I don't mind anybody making a fair wage for the dollar in which they create. But when you start to have nonprofit status in this state for health care, and we have folks paying 40 percent more for their insurance over four years, and we're paying top executives \$10 million, there's something wrong. There is something wrong with that equation.

So we better look at what ought to be reasonable if we're going to give you this monopoly, so that we don't have, at the expense of folks' health care -- that we put flush and cash with the executives that run it. There has to be some rational reasoning behind that, also.

So, Madam Chair, thank you for giving me the opportunity to testify. I'm here to answer any questions.

ASSEMBLYWOMAN WEINBERG: Thank you, Senator.

Are there any questions of the Senator?

Assemblyman Gregg.

ASSEMBLYMAN GREGG: Senator, good afternoon.

SENATOR BRYANT: Good afternoon.

ASSEMBLYMAN GREGG: Sorry it had to be you, but sooner or later I had to ask a legislator a question. So you just drew the wrong card.
(laughter)

I certainly can't disagree with a number of the things that you talked about today, specifically charity health care, and how hospitals get

funded. Unfortunately, that's not the title of what we're discussing today. But I think, since they're up on the table, it should be reinforced.

Cooper Hospital Hospital is a large provider of charity health care in the state, and the largest in South Jersey. Regardless of this contractual issue, charity health care will be provided after March no matter what, correct?

SENATOR BRYANT: Charity health care will be provided because we absolutely mandate it by the State of New Jersey.

ASSEMBLYMAN GREGG: It's mandated. And, ultimately, whatever occurs in that contract--

SENATOR BRYANT: That's the issue.

ASSEMBLYMAN GREGG: --for worse or better, that it may require the State to have a larger--

SENATOR BRYANT: I didn't say charity care would be cut off. I'm saying that there ought to be a causal connection between a nonprofit making the kind of money it does, and the ability of us demanding upon an institution to do charity care.

ASSEMBLYMAN GREGG: I ask the question, through the Chair, just to clarify for some of the folks out here who may not be as educated as some of us -- that it might have been perceived that people would not have access to health care in March, and those people would be the less -- people who have less income or have no insurance. And I want it to be clear that that door is not going to be shut.

SENATOR BRYANT: Let me clarify, the folks on Medicare and Medicaid will not be able to go to the largest server of folks in this city.

Understand that. And it's not that other places are quite accessible. And we do not have--

So let me put it all in perspective. The transportation network that you have in rail and buses in North Jersey -- so you might be putting folks out of reach of health care.

ASSEMBLYMAN GREGG: And at this point, I'm certainly not portraying that that's where I think the world will end, but, in that case, that an individual couldn't get some place, and came to this hospital, still would be serviced, because that is the mandate in the State of New Jersey. And that's the only point I'm making.

ASSEMBLYWOMAN WEINBERG: Just to clarify so that we make sure we're not talking about two different things.

First of all, the contract termination is April 28, it's not March. So let's not make it shorter than it already is. And second of all, if you are covered by Blue Cross Blue Shield, you won't be getting charity care.

ASSEMBLYMAN GREGG: I understand that. But the portrayal that I wanted to be clear out here was the folks who are not insured -- and the other folks are still in a contract dispute that I'll discuss later, and my thoughts on it--

The only other point I wanted to ask, and I would have asked it as well to the Hospital Association, or any of the other folks who testified, regarding this premise that any entity should be contributing back to the charity health care that may provide insurance.

Senator, I know-- Maybe I waited for you, because I know you're seniority in government. That was a program that we did many, many decades

ago, and we used to surcharge insurance companies so the people who paid insurance bills would actually pay more for the people who don't have insurance. And the State of New Jersey had changed that policy, with bipartisan support, realizing that the idea of having insured people pay even more for uninsured people wasn't the appropriate collection device. And then we moved to surcharging the unemployment fund, as I'm sure you remember. And then from there, we went to the tobacco funds, and some other funds that we put together. And, unfortunately, this administration has expended all of the tobacco revenue we received in a humongous lawsuit that could have been a tremendous asset to our charity health-care program. That, unfortunately, is the direction we've been in.

So I, again, wanted to clarify that -- that that's where we were. Where we go, and how we fund charity health care, I think, is an incredibly important issue to discuss. And I'm always appreciative to be involved in that debate as the conference chair on our side of the aisle. But I'm not so sure that was totally the subject of today's discussion, even though it's come up any number of times.

And I thank you for your diligence on that, Madam Chair.

And thank you, Senator, for clarifying it for me.

ASSEMBLYWOMAN WEINBERG: Thank you, Assemblyman.

Assemblyman Morgan.

ASSEMBLYMAN MORGAN: Thank you, Madam Chair.

I would just like to clarify. Yes, there is an absolute mandate that hospitals provide care to all comers. But having spent a whole career in medicine and health care, there's two ways that you can control patient flow.

One is money. The only other access point you can control is time -- waiting time. And what happens is, when hospitals are forced to cut back because of financial constraints, the wait for necessary service becomes longer, and longer, and longer. Women go without mammograms longer, necessary surgery gets put off, diagnostic tests get put off, and there's a huge impact, through this, on both preventative and curative services. And even though the light may be lit in the emergency room, still, the reality is that the system doesn't function, and many, many people become harmed by that.

ASSEMBLYWOMAN WEINBERG: Thank you.

Thank you, Senator Bryant.

I have the other co-star of our hearing today, who has been waiting patiently. And that is-- Well, I don't know how patiently, but been waiting. Christy Bell, from Horizon Blue Cross Blue Shield.

CHRISTY W. BELL: We've shrunk our cast for you.

ASSEMBLYWOMAN WEINBERG: Oh, okay.

My apologies. I know somebody said one of you had to leave by 1:00, and I said, "Oh, we'll get there well before 1:00."

MR. BELL: I thought you didn't want to hear from us at all.

Thank you very much.

Good morning, Madam Chair and members of the Committee.

My name is Christy Bell, and I'm the Senior Vice President for Horizon Blue Cross Blue Shield -- Senior Vice President of Healthcare Management for Horizon Blue Cross. I am responsible for Horizon's hospital and physician contracts and relationships, as well as oversight for the delivery of care to over 2.9 million members.

To my left is Dr. Philip Bonaparte, Chief Medical Officer of Horizon/Mercy health plan. And to my right is Karen Clark, our Chief Operating Office of Horizon/Mercy, who will assist me in answering the broadest questions around Horizon.

While we understand that this hearing has been convened as a result of publicity surrounding private contract disputes, we want to thank the Committee, hopefully, for allowing us to participate in what we believe will be a broader, impartial discussion on the state of health care in New Jersey, and what is driving rising health-care costs. Additionally, we hope these discussions will help clarify the causes giving rise to the fact that over 1.2 million people are uninsured, and that is a serious issue.

At the end of the testimony, we'd be glad to answer any questions you may have.

We are the state's largest health insurance company, serving more than 2.9 million residents. As such, we feel we have a tremendous responsibility to the people of New Jersey to deliver high-quality care and high-quality service at the most affordable costs, and that we provide the best possible access for those residents.

As you know, our health-care system is quite complex. Many people do not understand the role that we play. At Horizon, our mission is to provide members with a strong network of providers to enhance access to quality, affordable health care. But part of that responsibility includes acting as an intermediary for our members, negotiating fair rates on their behalf. The fact is that Horizon, and other insurance companies, are often the last line of

defense between a hospital's ever-present need, and sometimes demand, for price increases and a consumer's desire for quality, but affordable health care.

In addition, we also develop and provide a variety of products to meet the diverse needs of our members. And, in fact, we've made the broadest commitment in the state to the Medicaid-Medicare populations, as well as individual and small-group employers. We process 32 million medical claims, 50 million claims in total, and we answer 12 million phone calls a year.

We also develop and support innovative quality programs to prevent and help manage a variety of diseases. We support doctors in their clinical practice and help ensure members receive evidence-based medical care. And of every premium dollar taken in by Horizon, nearly \$.85 goes directly to pay for medical care and services for our members.

I would like to take a moment to provide the Committee with a frame of reference for our contracting practices, since this is what we're here to discuss today.

As you know, the national health-care system, and New Jersey's health-care system, are facing extraordinary challenges. Employers and employees are experiencing repeated, double-digit rate increases; litigation and malpractice issues remain unresolved; and New Jersey's hospitals' Medicare and charity care payments have been reduced by over \$500 million and \$200 million, respectively, in the past year. This situation has created serious challenges for our New Jersey hospitals. It has also made fair and effective contract negotiations an even greater challenge. For many of these hospitals, the charity Medicare and Medicaid patients represent over 60 percent of their volume of business. And when a shortfall takes place in those payers, and a

shift into the 30 to 40 percent that are commercial payers -- it means the impact is sometimes one-and-a-half or two times as high on the commercial payers. And hospitals, of course, have nowhere else to look. We know that, we're sympathetic, we realize that, but it means we may start negotiations being asked for a 20, or 30, or 40 percent increase to make up for a serious shortfall the hospital is facing.

We value every hospital and every physician in our networks. We do not believe any of our network providers should lose money on our contracts. At the same time, we have an obligation to our members to negotiate assertively to obtain the best possible rates on their behalf. We have to take that obligation seriously.

This means that during hospital contract negotiations, we must challenge, at times, excessive rate demands, or inefficiency in comparison to other hospitals, or excessive lengths of stay, or unreasonable demands in other areas. We balance these demands against our desire to retain our network of excellent facilities for our members. And at all times, we try to understand the unique problems that each individual hospital faces.

We have completed over 500 contract renewals during my seven years with the company. During that time, we have added almost a dozen new hospitals to our New Jersey networks. In all but three of the 500 contract renewals, we settled prior to any contract lapsing. Two of those three hospitals have already rejoined our network. And the third has asked to open discussions again to rejoin the network, as well.

Unfortunately, some hospitals have been advised that creating publicity will aid in pressuring insurance companies like Horizon to settle

contract terms on more favorable terms, or their terms. Our experience demonstrates that quite the opposite is true. The danger is, publicity creates polarization, which precludes the ability to resolve differences. There's no willing parties to listen any longer.

For example, our widely publicized contract negotiations with Hackensack University Hospital were satisfactorily resolved recently, we believe. This was successfully accomplished without the intervention of the courts or the Legislature, but, notably, after the cessation of the public relations campaigns on both sides.

However, the rising health-care costs continue to provide a challenge in the contracting process. On January 9 of this year, the Centers for Medicare and Medicaid, CMS, reported that hospital spending had been rising at the rate of 9.5 percent nationally, reflecting the increasing use of hospitals -- that is, increased utilization; increased wages and wage demands, reflecting the nursing shortage; but also reflecting the growing ability of the hospitals to more aggressively negotiate with the insurance carriers.

As the Federal government report noted, hospitals are becoming more powerful, not less, in negotiating with us, and all this means higher, out-of-pocket expenses and higher insurance premiums for businesses and consumers.

For Horizon, in the past two years, we have experienced hospital spending increases 25 to 35 percent above the national average. Given this fact -- and this is due to not only rates of increase that we negotiate with the hospitals, but increased utilization patterns reflecting the more broadly open-accessed plans. But we believe it's now difficult to criticize Horizon for being

unfair in our negotiations when, in fact, our experience is substantially beyond the national average spending increases with hospitals.

In fact, we've gone out of our way to work with our hospital partners. In a recent case, a hospital came to us in the middle of a contract to ask that we renegotiate based on the hospital's changing and catastrophic financial circumstances. While we're under no obligation to do so, we did meet and negotiate with them, and we came to terms with the hospital that were mutually acceptable, thereby avoiding a catastrophic event for them.

We're working with the New Jersey Hospital Association, believe it or not, on a number of issues, including improving the payment of claims -- which we want to improve the payment of claims -- improving the quality of care, where we are the only insurer who's risen to work with the Hospital Association and Medical Society, and to improve the quality of care in New Jersey, working to establish a healthier New Jersey, and aggressively, together, attack the very disappointing results achieved in quality scores for New Jersey, which rank them in the bottom quadrant of the country. We need to change that, and we need to collaborate to change that. That, I submit, is unacceptable to any New Jersey resident. We're also working to reduce claim denials. And we agree, there should not be substantially denied claims. There will always be some, but we should get that to a minimum.

We've also established numerous collaborative partnerships to help manage utilization with hospitals, reward clinical excellence, enhance clinical quality, and focus on improving delivery of medical services. In fact, we provide our members, in collaboration with hospitals, more information about our network providers, medical care, and clinical outcomes than any other health

plan in New Jersey. People want this information, they want to make choices of their hospitals based on that information.

We've worked hard to maintain good working relationships with the state's hospitals. These are, clearly, challenging times. Hospitals are a valued community resource. We're also proud to have risen, at the same time, to become the state's top plan for customer service and clinical quality, in fact, leading all health plans in New Jersey in eight of the 11 quality indicators.

In conclusion, I'd like to thank the Committee for giving me the opportunity to explain a little bit about the hospital contracting process, and the events that have led us to the hearing today. It is our desire to contribute appropriately to the delivery of high-quality and affordable health care in the state.

We thank you for your time, and we'd be happy to answer any questions that you might have.

ASSEMBLYWOMAN WEINBERG: Thank you.

Mr. Bell, before you introduce the two folks who are with you, I think Assemblyman Fisher has a question.

ASSEMBLYMAN FISHER: Thank you, Chairwoman.

Mr. Bell, these comments are very, very global in nature, in terms of Blue Cross Blue Shield and health care. And I know that they are carefully chosen, and they're well-received.

But we are here today, specifically, in this regard, at this campus -- or at Cooper -- to ask questions on the impasse that we've, sort of, come to -- and knowing that negotiations have -- I don't know if they're -- I guess they're ongoing, or they're broken down. But you've suggested--

MR. BELL: They're ongoing.

ASSEMBLYMAN FISHER: They're ongoing and in court.

MR. BELL: We are officially in court-appointed mediation, and we are meeting and attempting to work collaboratively, which is why my remarks stayed away from discussing Cooper specifically, because when you're trying to mediate, I don't think it's fruitful to insult the other side and antagonize them any further. So we're trying to stay away from anything that would antagonize and, potentially, diminish the likelihood of that mediation from being successful.

ASSEMBLYMAN FISHER: Well, that's--

ASSEMBLYWOMAN WEINBERG: We're legislators who are quite used to being insulted, so it's okay. Go ahead. (laughter)

MR. BELL: I'm not used to that.

ASSEMBLYMAN FISHER: Of course, that's very encouraging.

But my question to you is, without regard to any of the negotiations-- There is a message, though, however, that you must be delivering to a hospital system that has not been able to come to an agreement with you. And what I would ask you is, specifically, there is some message that you're trying to deliver to this health-care system that says, "You're either not doing something, or you should be doing something, or you're different from all the other hospital systems." My question to you is, what would you say to them?

MR. BELL: I'm looking at our attorneys to make sure I don't get any daggers in my back by going beyond. We've been cautioned by the judge to avoid issues that may be coming up in mediation, so I have to be a little careful.

But, obviously -- I guess it's the best way to characterize it -- that we have two strong, very strong, opinions. They believe they're right, and we believe we're right. We've gone to the fullest extent possible with those opinions. We hope to resolve that, those differences, in mediation. And there's a variety of issues that we disagree on. We're trying to narrow them down to issues where we can find agreement. And if we can find agreement, then we'll try to wrestle with the ones where we've been at sorts.

And I know that's a somewhat political answer, and I apologize for that -- if that's somewhat evasive. But I'm trying to keep in mind the judge's very explicit orders to avoid anything that would derail the mediation if it hasn't been derailed.

ASSEMBLYWOMAN WEINBERG: I gave some leeway to Assemblyman Fisher. But before we go to other questions, I'd like to know if your two colleagues want to be introduced and if you have anything further to add.

MR. BELL: I believe Karen and Dr. Bonaparte will both be submitting their own testimony, because we think the issues around Mercy are so significant that we should simply have them testify around those issues separately. But we felt there might be issues regarding the entirety of the relationship that might be best served by all of us answering.

ASSEMBLYWOMAN WEINBERG: Okay, then you'd prefer to hold off their testimony.

MR. BELL: Right. Thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: Who's hand did I see up, down there?

Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Thank you.

Mr. Bell, I'd like to ask you the same question that I asked Mr. Sessa before. I think his answer was devastating. Yours probably isn't going to be the same.

But if there were to be no contract signed between Cooper and Horizon, what would be the impact on Horizon itself; what would be the impact, do you think, long-range, on your subscribers, both the employers and the patients, who would be potentially represented? What does it mean for the real people?

MR. BELL: What it means to our subscribers, and what it means to Horizon is, we will have subscribers who desire to see Cooper Hospital doctors, who are only on staff at Cooper Hospital. And the good news in Camden County is, that's a minority of physicians. It's not our preference to ever disengage our members from those excellent clinicians at Cooper Hospital. We don't want to send them across the river to Children's Hospital, or the hospital of University of Pennsylvania, or Jefferson. That's not our desire either. So, first of all, patients would be separated from excellent clinicians, where there's a long-standing relationship. That is not our preference, and that is not our desire.

We also, frankly -- we would lose members. Mercy would lose members, because they have a number -- 6,000 or 7,000 members who go directly to primary care doctors at Cooper. And that would be a severe loss for us. We also would lose our commercial members whose companies, or individuals, would specifically wish to use Cooper Hospital, and they'll join

other insurance companies. There is also a consequence for Cooper Hospital, and we're aware of that, so we take that consequence seriously, as well, even though that's not our -- necessarily our problem. It is a problem for New Jersey, and that makes it, in part, our problem. We consider that an issue, as well. We don't want people who would otherwise want to go to that facility not to be able to go. And I think that's true for Karen, as well.

ASSEMBLYWOMAN WEINBERG: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: I do have several questions.

First, a clarification on one point you made. You said in the past two years, Horizon has experienced hospital spending increases 25 to 35 percent above the national average. When you say hospital spending, what are you relating to? Are you relating to what you've been paying the hospitals, are you relating to what their charges are, the number of people? Where does this figure come from?

MR. BELL: The figure comes from the combination of the increased reimbursement we have paid to the hospitals -- that's the unit price increase for the price of services that are consumed. In addition, the increasing use of those hospitals, that's the utilization factor. And together, those generate revenues for the hospitals, and those revenues have been well into the double digits for the last several years.

ASSEMBLYMAN THOMPSON: Okay. So when you say hospital spending, it's actually what you are reimbursing the hospital.

MR. BELL: It's the amount we're incurring in an average monthly basis per member for hospital spending. And we watch -- that growth has gone up well beyond the national averages over the last several years.

ASSEMBLYMAN THOMPSON: We've heard a number of witnesses testify that Horizon Blue Cross Blue Shield's reserves are 600 percent higher than Blue Cross Blue Shield reserves in other states. Is this correct, according to you? If it is, why is it so?

MR. BELL: I'm glad you asked the question, because as we've had the discussion around reserves and reserve levels, there have been a lot of facts and figures out there. Let's see if we can get the record straight. And we'll go back from a while ago, when Blue Cross was actually in a negative reserve position. And some of you were holding hearings to find out whether Blue Cross would survive, and what would happen to the State if we didn't survive.

Since that time, we've grown our reserves. And there are different minimum standard reserve requirements. We exceed the minimum standards of the state. We are below the average reserves of other Blue Cross plans. The 600 percent that you've heard is a very complex figure that's referred to -- and I hope if I start to bore you, I would be more than happy to cease. But it refers to the risk-based capital, and that's an actuarial formulation -- a series of actuarial calculations that look at the type of members we have to assess the risk of those members. Medicare and Medicaid members are much higher-risk members than a self-insured employer.

They look at the risk of the way we invest moneys, the risk of our assets, and they look at the risk of our business and the business environment. And the actuaries put all of that together and determine a formulation for risk-based capital. That formulation that you've heard-- The important numbers, we think-- It takes 500 percent of that calculation -- that's a National Insurance Association -- National Association of Insurance Commissioners

calculation -- to be beyond the minimum threshold to be off probation as a Blue Cross plan.

ASSEMBLYWOMAN WEINBERG: Off whose probation?

MR. BELL: Off the Association's probation. Their requirement is you have to be at least 500 percent. So the 600 percent you've heard is where we are, and that's below the average Blue Cross association.

Now, risk-based capital doesn't mean a thing to the average person. We look at our reserves as the average claims exposure, how many months of claims could we cover in a catastrophe? And right now, we have about 2.2 months worth of claims in our reserves. Most would suggest that you need at least a minimum of three months, and it may be as much as six months, of claims to have adequate reserves. And those are the levels that people will talk about. And there's a great deal of discussion around: is two months enough, is three months enough, is four months? But three to six months of claims in reserve is probably an adequate number.

We also have seen several health insurance companies go bankrupt. We've dealt with the HIP catastrophe where doctors, and hospitals, and the insurers shared in that catastrophe, and we've seen Benefit Mutual go bankrupt. We don't want to see those again, and certainly the State -- I think the last thing the State wants to see is a company the size of Horizon face those types of financial disasters. We've been down the road once before. It was almost a disaster for the State. We'd like to stay off of that.

But the reserve levels are above the State minimums. The State has deemed those to not be excessive, but to be above the minimum requirements. They reflect 2.2 months worth of claims exposure in reserve. They're below the

Blue Cross average. And those are the measures that, probably, we should put on the table to talk about the reserves.

ASSEMBLYWOMAN WEINBERG: Assemblyman Thompson, before you go on, I'm going to interrupt for a moment, because you just said something that I plan to ask based upon the letter that you addressed to each of us.

The first was the two months of reserves. You're saying this \$736 million is two months of reserves.

MR. BELL: That's correct.

ASSEMBLYWOMAN WEINBERG: And the second is that, you said that the State does not consider your reserves to be too high. Albeit, they might not have done a complete search of their archives, but I asked the State insurance department about that, and they -- as I announced earlier, they said there are minimums, but there are no maximums, and they can't find where they might have said that to you. It doesn't mean that they didn't say it. But I'd appreciate getting a little further information on how and when did the State say that these reserves are not too high.

MR. BELL: I believe that was in response to a number of articles. They were asked, and they officially commented. I'll be glad to provide that citation to you and the individual who provided the citation.

ASSEMBLYWOMAN WEINBERG: Based on a number of articles?

MR. BELL: They were responding to, sort of, inquiries about our reserves, based on information that came out of Cooper. And they were asked, and responded, and I'll be glad to provide the citation.

ASSEMBLYWOMAN WEINBERG: So that's a very recent response that they made.

MR. BELL: Right, yes, very recent response, yes.

ASSEMBLYWOMAN WEINBERG: That would be interesting for us to find out.

MR. BELL: Literally, the last two weeks. I'll have that for you, probably, before we leave the room.

ASSEMBLYWOMAN WEINBERG: Okay. I'm sorry for interrupting. Go ahead, Assemblyman.

ASSEMBLYMAN THOMPSON: I got a little bit lost in your answer about how the 600 percent figure comes up. But one thing you did say there tends to suggest a statement. As I understood what was being said before -- was erroneous. That is, they were saying that your reserves are 600 percent above those of other Blue Cross Blue Shields in other states. But you're saying it's actually below the average of the others -- the other Blue Cross Blue Shields in the other states. Is that correct?

MR. BELL: That's correct. Yes, sir.

ASSEMBLYMAN THOMPSON: So if they were making that statement, then that would not be correct.

MR. BELL: That would not be correct. There's a lot of confusion about reserves. And, certainly, there were a lot of misstatements about the reserves, the reserve levels, and what the 600 percent represented, etc. So, hopefully, we've cleared some of that.

ASSEMBLYMAN THOMPSON: We've also heard a number of comments suggesting -- now, I'm not sure whether some of the people were

mixing reserves and profits together, back and forth -- but a number suggesting that you have excess profits and suggesting-- You know, as we hear the figures of 600 percent reserves are in excess of what you need, excess profits, and so on -- and this is followed up by the suggestion that Blue Cross -- Horizon -- should be contributing to the uncompensated care.

Now, obviously, if you've got money running out of your ears, you've got money to do something with, whether it's give higher rates to the hospitals, or put it into uncompensated care. But if you're running closer to a reasonable profit level, if you're nonprofit, then, obviously, in order to put money into uncompensated care, you would have to either increase your rates or decrease what you're going to pay the hospitals, right?

MR. BELL: We'd have to increase our rates, become less competitive in the marketplace against the for-profit competitors that we face, because they would not be doing the same; or we decrease our reserves and put the company in another type of jeopardy.

So I think because we are a nonprofit doesn't mean we have a special need to be the only insurer that pays for uncompensated care. In fact, we think all insurers pay for uncompensated care by the margins that hospitals should have in our business. So we all should be paying something towards that. But to single out an insurer and say, "You're a special case, and we're going to strip your reserves away to pay for uncompensated care," would probably put us in the position we were a number of months ago, whereas -- not months, but a number of years ago, where we were in negative reserves, and faced -- the State had a serious crisis on their hands when we were the insurer of last resort.

ASSEMBLYMAN THOMPSON: It's been cited that a number of hospitals that have reached very critical phases of negotiations to the point of, essentially -- they were going to be terminated, or contracts were going to be terminated. Are you guys being far tougher, and so on, in the negotiations than the rest of the insurers out there?

MR. BELL: I think that's a good question. I don't believe we've ever terminated a contract. And in this current situation, we did not terminate the contract, either. We will allow extensions. And, hopefully, we'll continue to negotiate, in good faith, through those extensions to try to resolve the impasses.

I don't think our situation is any different than any others'. Contracts come up at different times. So I think that some of our competitors will go through several rounds of their problems. They've had longer-term contracts on the table. Their turn up in the box will be shortly. And I think other competitors have had similar situations. Aetna, Cigna, others have faced very similar situations around the state. So it's not an uncommon situation. We try to keep it from achieving an impasse. We try to keep it out of the press. We don't think that we need to overly alarm members, even if we're having a difficult negotiation. We usually can get through that. But I would say that Horizon's experience is no different than, virtually, every other insurers of any size or consequence.

ASSEMBLYMAN THOMPSON: You mentioned granting extensions. I don't recall. Have you granted an extension here on the Cooper contract?

MR. BELL: The contract lapsed, and they refused to give an extension.

ASSEMBLYMAN THOMPSON: Oh, they refused to give an extension, you're saying.

MR. BELL: Right.

ASSEMBLYMAN THOMPSON: They would not agree to extending.

MR. BELL: They would not extend it any further, no.

ASSEMBLYMAN THOMPSON: Oh, okay.

MR. BELL: I think I'm working the line in mediation, so I have to be a little careful.

ASSEMBLYMAN THOMPSON: Thank you very much.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gregg.

ASSEMBLYMAN GREGG: Thank you, Madam Chair. I just want to revisit that last question so I understood it. The question was whether an extension was granted.

In prior testimony, I understood that the contract ended in December and will continue until April.

ASSEMBLYWOMAN WEINBERG: April 28.

ASSEMBLYMAN GREGG: Which is automatic.

MR. BELL: Yes, that part is automatic.

ASSEMBLYMAN GREGG: So at this point, would I be correct in assuming that you're not at the point of when you would wish to extend?

MR. BELL: When a contract lapses, it sets a four-month process into effect, and hence the April date. So the contract lapsed officially April 28,

because there were no more extensions allowing continued negotiations. We would accept an extension, yes, and allow continued--

ASSEMBLYMAN GREGG: I understand.

MR. BELL: It's kind of a moot point, since we're in mediation.

ASSEMBLYMAN GREGG: I understand.

Fulfilling my contract with Mr. Sessa in the back, I'll ask you the same question I asked him, which I'm sure you heard earlier, but may not have remembered. It is the question reflecting whether the contract that you are portraying with Cooper is equal to, greater, or less, or you can't comment on, as it relates to being competitive in the rest of the state.

MR. BELL: I would comment two ways. One, it is hard to evaluate contracts and compare them, because there are different contract provisions, different types of contractual provisions for different types of payments, which makes it hard to match up, because hospitals all have unique needs and services that they want to have special attention to. So it's a little hard to match it up.

But I would say, right now, in the spirit of resolving this, and the spirit of hearing from the Mayor of Camden and other places, that I would be prepared to give the mediator your hospital contract at Morristown, and the Robert Wood University Hospital in New Brunswick, and the University Hospital in Newark -- give the mediator those contracts. And I would be more than happy to ask the mediator to take all the terms, put them together, give us a rate, and offer that to Cooper right here, right now, to settle this problem.
(applause)

ASSEMBLYWOMAN WEINBERG: Please, ladies and gentlemen. I've asked, please, no applause here.

But I don't know if the Chairman of the Board of Cooper is still here, but maybe the two of you will go into the hallway there and negotiate this out. (laughter)

MR. BELL: After his testimony, I'll need a couple hours to simmer down, and then we'll be talking again. (laughter)

ASSEMBLYMAN GREGG: Through the Chair, I guess you've got to bring somebody down from Morris County to get these things solved. (laughter)

MR. BELL: Since I live in Chester, I would say it.

ASSEMBLYMAN GREGG: Ouch. We'll talk later.

ASSEMBLYWOMAN WEINBERG: Assemblyman Morgan.

ASSEMBLYMAN GREGG: No, I'm continuing. I'm not done yet.

ASSEMBLYWOMAN WEINBERG: Oh, I'm sorry. I thought that was a closing line, Guy. I'm sorry. (laughter)

ASSEMBLYMAN GREGG: I get one question. This is tough. Just because I solved it doesn't mean I don't have any more questions. (laughter)

ASSEMBLYWOMAN QUIGLEY: I thought you solved it all.

ASSEMBLYMAN GREGG: One never knows when we read the papers tomorrow.

I do want to ask you a question I didn't ask Mr. Sessa -- and follow up on a couple of those thoughts.

I'm not aware of, at any time, any place in my legislative tenure, that we have ever come to a hearing like this in the midst of a contract negotiation, and certainly in the midst of a legal situation. And one of the reasons I asked you that question was purposeful.

I saw your lawyer's eyes getting very big as you were responding -- I have a perfect view of her -- and getting closer to you, I might add, in the midst of that answer. (laughter) So I was waiting for the hands to go around you. And I certainly understood that.

I am aware, I guess you're aware, there's certain things you're uncomfortable in being able to respond to. And part of that is because there's a legal issue going on, and you're in court.

That puts us in a difficult situation in this legislative body. Do you think this is an inappropriate venue, and an inappropriate place for you to have to be today?

MR. BELL: I think that there are legitimate community issues at hand, but I think that it's a private contract dispute. And I think the less publicity and the more chance that people have, in good faith, to get together and try to resolve it without the political intrigue, shouting, screaming at each other, or attempting to inflict harm on one another, probably gets it resolved a lot faster.

ASSEMBLYMAN GREGG: I have to ask, also, at any point in this dispute -- and I'll just call it a dispute at this point -- did the administration, the current administration, come in and help mediate in any way, manner, or form -- whether it be the Department of Insurance and Banking, or whether it be the Department of Human Services -- folks that one would think would be a

stopgap between this type of a hearing, understanding that those folks deal directly with some of the negotiations?

MR. BELL: Not to my knowledge. I think Senator Bryant reached out early on to try to bring the parties together. And in the court-appointed mediation, we are using the State mediation services so that it is working through the State on that basis in the mediation. So the answer was no, other than Senator Bryant. And there's been a number of letters imploring us to get together and whatever axe needs to be buried, bury it somewhere else other than each other's heads, and get to the table, and negotiate.

ASSEMBLYMAN GREGG: And you eluded when you said all the extensions have been completed, there were extensions prior to the December deadlines.

MR. BELL: Yes.

ASSEMBLYMAN GREGG: So one would say that this discussion has been happening longer than the perceived month or two that it may have been back-- In fact, I'll ask you, how long has this been going on?

MR. BELL: It's been going on right through the 2003 renewal process. Actually, it started in '02, with some of the disputes. They became heated this year, and has continued for a fairly lengthy period of time without resolution.

ASSEMBLYMAN GREGG: Well, I truly appreciate your answers. And, quite frankly, I'm appreciative to all the time I've spent here today, because even though it may or may not have been an appropriate venue, it certainly was informative on every person who testified, as it deals with health care. I look at the sign back there, and certainly it's the most purposeful sign

in the room, “Health Care Only Works When It’s Affordable.” That would have been a far better title, I think, for what we’re doing today. So we could have talked about the issues that, virtually, everybody talked about, starting with the Mayor, saying it’s not about Cooper, it’s not about Horizon, it’s about the people. And it is about the people.

And health care is about affordable insurance. It’s about having a system that is well-regulated and operated in the private sector, with the public sector watching it. And it deals with more than just one little contract. It deals clearly with issues that were brought up today like charity health care, prompt payment, allowing individuals to have access to affordable health care, talking about some of the things that need to be talked about. And this kind of a forum, in this kind of a place, is an absolutely perfect place for that to occur. And having folks being able to give us their ideas, on all of those issues, as opposed to what appears to be a little bit more of a targeted scenario of using an example, as opposed to coming together in that open point of view of bringing everybody together.

I hope you do solve the situation. And I want to say that I came down here hoping that the best thing we want to hear is that there is a contract settlement, and that Cooper is insured by you folks, because citizens deserve it. It’s a very important institution in this side of the state.

We come from the North, but we care about the South. And I hope it does happen, and I hope it happens quickly. But, most of all, I hope when we come to the next hearing, that the hearing is about moving forward on affordable health care, ensuring that individuals can have affordable health care, small businesses can have affordable health care, hospitals can move forward,

as opposed to creating somewhat of a little witch hunt that may have perceived to have occurred today.

Thank you for your honest answers.

Chairwoman, thank you for your latitude.

ASSEMBLYWOMAN WEINBERG: Okay, Assemblyman Gregg, as the Chairperson of the witch hunt that you just described-- (laughter)

ASSEMBLYMAN CONAWAY: Can we clap for that?

ASSEMBLYWOMAN WEINBERG: No, you can't.

ASSEMBLYMAN GREGG: Perhaps I should have used the word *sorcerer*. It would have been a--

ASSEMBLYWOMAN WEINBERG: And since I was the person, as the Chair of this Committee, who called this hearing -- which I think I spoke about at the opening of this hearing -- came from the calls I received from constituents after full-page ads in the *Bergen Record* from both Hackensack Hospital and New Jersey Blue Cross Blue Shield.

Now, you prefaced your remarks -- and I will take the prerogative of the Chair to answer a couple of them -- that this is the first time, in your experience, that we've had a hearing of this kind. I would suggest to you, Assemblyman Gregg, it might not be the last time in your experience, under the new leadership in the Legislature today, and in the Governor's Office. You might see other kinds of hearings that you haven't experienced during the prior 10 years. So we will be delving into all kinds of issues.

And I know that you're not a regular member of this Committee, and that you're filling in for Assemblywoman Vandervalk. But at our last Committee hearing, we did release a bill that is going to begin to delve into the

issue of unaffordable health care. And we had a very lengthy discussion on that. So I can assure you that all of us here are going to be able to chew gum and walk at the same time. We are going to delve into all of these issues. And when issues of access to health care affect any one of our constituents, every one of us has a right to get involved. And that's what we're doing here this morning, and this afternoon, and we will continue to do that.

And with that, Assemblywoman Quigley, you had your hand up.

ASSEMBLYWOMAN QUIGLEY: Thank you, Madam Chair.

I think Assemblyman Gregg is having a good day. He not only solved the problem down here, but he's thrilled the marketing agency of Horizon Blue Cross Blue Shield, I'm sure. (laughter)

But let's get back, if we may, to the more general--

That is your slogan, is it not?

MR. BELL: No.

ASSEMBLYWOMAN QUIGLEY: No? All right, it sounds a lot like Mr. Marino says on my television commercials.

MR. BELL: Making health care work.

ASSEMBLYWOMAN QUIGLEY: Okay.

Let's get back, if we might, to the overall picture, and get away, for the moment at least, from this specific contract.

In some of the other testimony you've heard today, there may have been some implication that denial of claims, delay of payments, problems encountered between hospitals and the third-party payers -- not alone Horizon -- may be part of a deliberate effort.

Whether or not that's true, you can certainly address. But if there is any merit to it, from the State's own report card, it looks like Horizon is the best of a bad lot. So maybe you can tell us what you're doing to address that.

MR. BELL: I appreciate that. Let's start with the issue of prompt payment, because that's a serious issue. And insurance companies have been notoriously accused of denying claims outright, or delaying payment to make money on the float or the -- payments.

With the 32 million claims we pay each year, we pay about 99 percent of them within the guidelines of 30 days for electronic claims, and 45 days for paper-submitted claims. That still leaves hundreds of thousands--

ASSEMBLYWOMAN QUIGLEY: With the Chair's permission, may I interrupt you?

MR. BELL: Right.

ASSEMBLYWOMAN QUIGLEY: Are those clean claims, as the legislation says, or are they just all claims?

MR. BELL: Those are clean claims.

ASSEMBLYWOMAN QUIGLEY: Clean claims. And would you tell the audience -- I guess a lot of them are yours -- but would you tell the rest of us what a clean claim is? (laughter)

MR. BELL: There's requirements that the claims come in with the information that allows you to process that claim on a predetermined basis. So if it comes in with all the information there, it's therefore a clean claim. If it comes in without a referral, or it comes in without the patient's name, or no identifying marks, then it's considered it can go back.

One of the problems that, actually, the legislation passed on prompt pay -- it's one of the down sides that was in the act of no good deed goes unpunished -- is that it actually encouraged insurance companies to try to -- instead of fixing those claims up, to actually send them back and be done with it, because there's penalties if you try to sit on them, and hold them, and fix them up. That's an unintended consequence.

ASSEMBLYWOMAN WEINBERG: So you're saying, because of the prompt payment-- If we hadn't had that law in effect, you would have just been able to just clean those up.

MR. BELL: If there was a provision in the prompt pay that would allow us to make modifications to the claims and attempt to get at some of the issues in a relatively timely manner, without penalty, we probably would be more willing to try to work those claims through, rather than just send them back. So it's just an unintended consequence that you want to get -- dispense with it quickly, because it represents a liability if it's in your shop, because it could go over 30 days. And that's something, I think, we could collaboratively work and try to resolve that.

It costs us six times to touch a claim more than once, than to get it right the first time. So if it cost \$10 to pay a claim correctly, \$60 on average if you pay it incorrectly, or touch it more than once. And usually if you touch it more than once, you touch it multiple times.

Secondly, there are interest penalties that if you delay a claim payment, you're going to pay a 10 percent interest penalty. Now, no one's making 10 percent on their bank accounts these days. That is a severe penalty. And I think only a very uninformed person would think that an insurance

company would intentionally sit on a claim to try to make half or three-quarters of a percent profit, and pay a 10 percent penalty. That simply doesn't make sense.

We would like to get all the claims out the first time, get them right. This year, we've gone through a system conversion. And when you do a system conversion, nothing ever goes as well as you would like. And we saw a blip in our third-quarter of claims. We've worked through that backlog. We've paid the proper interest penalty. We think that the doctors and hospitals will be far better off by retiring an antiquated system that actually inhibited flexibility in contracting with both doctors and hospitals. But we had a blip in the claims payment. We are going to pay the price for that. But in the end, we'll be a better company and get things done even more appropriately.

We also, as part of our relationship with doctors and hospitals, would like to see the ability to get claims paid faster. We've set up Internet access. We can check health status. We can check claim status on the Internet, streamline that ability. And we'd like, actually, to get claims submitted on the Internet so we can turn them around even more promptly. Claims, to us, are-- The absence of throughput is a liability to us we do not want. We would like to get them out right the first time and be done with them.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gordon.

Oh, I'm sorry, Assemblyman Morgan, you--

ASSEMBLYMAN GORDON: Thank you, Madam Chair.

I'd just like to return, for a moment, to this issue about the surplus. A few minutes ago, you referred, Mr. Bell, to the risk factors that come into play when you make decisions on how much surplus to build up.

In just doing a quick calculation, based on your 2002 annual report, I see that retained earnings, which represents most of surplus, increased by nearly 100 percent over three years. And it appears as if that is attributable, based on some of the notes in your annual report, to rate increases, in a small amount -- to increases in enrollment. What happened over those three years to change the risk situation or whatever, that led your organization to decide that it needed to increase its reserves by so much so quickly?

MR. BELL: There was no decision to increase reserves that quickly. What we have looked at is, we need to get, we believe at a minimum, to get to the Blue Cross average reserves. And we focused that. I think what you've seen is the company becoming far more focused on execution, improving clinical quality, getting better results, getting throughput for claims better, reducing administrative costs. And I think all of that had an effect on the bottom line, as well.

In addition, the reality is, the insurance business is fairly cyclical. And nationally, all insurers have gone through several good years. That's not anticipated to last forever, but you tend-- In the old days, you would have three good years, three poor years. We are in a cyclical type of business, and we're having three very good years. And I think, probably the biggest single contributing factor to that last year was the absence of a flu season. It was an extraordinarily light flu season at the end of 2002 into 2003, remarkably light, almost the exact opposite of what this year was, where every hospital was full in November, December, and into January. And we're seeing, now, a very substantial number of claims coming in, which reflects -- that's why you have reserves. And as good as it was last January, or first quarter for us, it's going to

be equally as bad, probably, this first quarter, reflecting that increased utilization. So that's cyclical, as well.

ASSEMBLYMAN GORDON: Just another question. Your organization clearly has a statewide impact. We've heard testimony today about the impact on South Jersey. There are decisions made, I assume in the board room, that have statewide public policy implications.

Being a new member of this Committee, I'm not familiar with the details of the governance of Blue Cross Blue Shield. Could you explain how your board of directors is selected?

MR. BELL: It's an independent board of directors. There are four governmental appointees by the State. There are 17 directors, I believe, at present.

ASSEMBLYMAN MORGAN: Okay, so the State appoints four.

MR. BELL: Four.

ASSEMBLYMAN GORDON: Okay, thank you.

Thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: Assemblyman Morgan.

ASSEMBLYMAN MORGAN: Thank you, Madam Chair.

Just a few questions, if you'll indulge me, because I know it's growing late and all, but I still have very, very real concerns about the system of health-care finance insurance. Albeit, Horizon is 40 percent of the marketplace now, so you have a preponderant responsibility.

What of the issue of subscribers who aren't informed of these ongoing problems in their health product, while this open negotiation period is there for them to change? What have these systems that we've taken decades

and decades to build up-- A health-care system such as Cooper or many of the others around this state -- they cannot just be duplicated again one year from now someplace else. We have a responsibility to have a continuing lack of brinkmanship in this process. We can't plan this way, we can't attract health-care professionals to come to the area and replace our aging nursing workforces and everything. There's no continuity with that. We have a whole health-care finance system that's -- I don't know how to put it otherwise but to call it fraudulent-based.

We've had testimony from both sides, and they're completely different. I applaud the efforts that will go forward from here to solve this one particular problem. But there's such discrepancy in how we view the money flows, where they're going towards, and who has the high ground and who doesn't, that for those of us who are not accounting experts, there's no logical way we can really assess those arguments.

I just know from my personal practice that when we have a system that we have to do upcoding and downcoding to be where we need to be-- When we have to submit a claim for \$650 to get a \$73 reimbursement, the whole integrity of our system is fractured. The public doesn't understand why these things are in place.

Here, again, you happen to be sitting in the hot seat, and I appologize if this is on you. But to whom much is given, much is expected. And we have to have a see-the-light moment very, very soon in New Jersey, and nationally, with going towards a two-tiered health system, where the underserved will not have the access to the care they need. We have to prevent

that from happening. The largest players have to come forward and help us solve that problem.

MR. BELL: I think that's a great point. In fact, over the last year, Horizon has recognized the somewhat catastrophic direction that the health-care system in New Jersey has been moving. And what we felt is, rather than pointing fingers, we needed collaboration among all the parties. And the first place we have to start is education, because people don't understand health care. They don't understand when they get an explanation of benefits, why their insurer paid a half or a tenth of what was charged. They don't know if those charges are reasonable or not.

I will tell you, in my own experience-- You wanted to pick on Philadelphia hospitals. My father recently had an occurrence in those Philadelphia hospitals with a one-day stay to replace his defibrillator. And the bill was \$177,000. He's taking that up with his congressman, because he didn't think he got a \$177,000 of anything in 24 hours. So patients don't understand. I couldn't explain it to him either. I lost that argument at home, and I was accused of being part of the problem. So I agree.

But we believe, with our dollars and cents campaign, we wanted to educate consumers, we wanted to bring together all the parties: doctors, hospitals, the State government, employers, and employees, consumers, and labor and say we have a crisis of monumental proportions.

We can't go on in the direction we're going. We have to make some changes. And we think we need to start with education, because probably the simplest change in health care that makes a difference is consumers start taking responsibility for themselves. We have an obesity crisis, we have a

diabetes crisis in this country, and most doctors -- and I try not to practice medicine, because I'm way over my head -- most doctors will tell you that probably 50 percent of the diseases that they treat are self-induced, or are induced by the individual contributing in that direction.

So consumers can begin to take on a huge amount of responsibility, seek prevention, screening, get the tests they need. And then we need to put our heads together, collaboratively, to figure out if there's a better way to do this and not have health-care costs spiral out of control.

One of the other important aspects here with the uninsured -- and I think this has been lost in this today, although it was referenced. I think you referenced it, as well. The consequences to the uninsured are the ultimate penalty you pay, because the Institute of Medicine's study recently revealed -- a several-year-old study -- that, in fact, out of 30 million uninsured Americans, 18,000 of them died each year simply because they couldn't afford insurance. Translating that it means -- into New Jersey -- 600 New Jersey residents die each year simply because they don't have insurance. They put off preventive services, mammographies, they don't take drugs they should take, they put off seeing physicians, they put off getting the care they need, and ultimately, approximately 600 die each year solely because of the absence of insurance.

That's a crisis that we need to start addressing collaboratively together. We should spend a little less time feuding and a little more time constructively, I believe. And that's probably the greater issue that we face -- is the direction we're heading in health care.

ASSEMBLYMAN CONAWAY: A couple of questions, if I may--

Now, the question of this most-favored-nation rate -- excuse me, most-favored-rate status-- Could you comment on its use in your experience there at Horizon for the past, I think you said, seven years? And perhaps you've been involved with other institutions beyond that. But this particular contract clause, at first blush I find quite troubling, and I think I indicated that in some prior statements.

But talk to me about that kind of provision, why Horizon feels that it needs to have that. And aren't there, really, rather negative consequences to that, as it regards the operations of an institution like Cooper, if they would choose to make that a part of a contract, bilateral contract?

MR. BELL: Let me, unfortunately, deflect specifics around Cooper. That's, clearly, part of the court-ordered mediation, and I'm going to have to stay away from Cooper specifics. But let me address standard contracting practices. Horizon does not have a most-favored-nation clause, and it is not our standard contracting practice.

We have, in one circumstance, when a hospital came to us with an enormous, catastrophic crisis facing them and -- as the largest insurer -- asked us to step to the line, because if we stepped to the line, and reopened the contract with them, and made provisions that would help them get through this crisis, we were going to be placed at an enormous competitive disadvantage, because we were first up making the concession, helping them through this, and our competitors would all enjoy a better rate.

And in that one case, we said, "Okay, in the first couple of years, we've stepped to the line. It's going to take you a couple years to resolve this with all your contract holders -- contracts. At the other end of the scale, we

would like our members to get a benefit out of this, as we take the loss at the beginning and are uncompetitive. For a finite period of time at the end of this contract term, we would like to be assured that we have the best rate you offer.” And we’ve reached a mutual agreement that worked for both of us -- that we’d step to the line, we’d take the hit early, and at the end, they would create some equality around that. And that seemed to be a pretty fair way to go and resolve their crisis. And that’s the case where we have used it in a contract where it actually is in one of our specific contracts.

I can’t comment further, because the contracts are, obviously, confidential.

ASSEMBLYMAN CONAWAY: But I take from your answer there is some historical experience then -- past experience -- that Horizon has as it regards that kind of clause. And you might relate to the Committee whether or not that’s been reviewed in our court system, or in other court systems, as to its legality, antitrust kinds of questions, as well, please.

MR. BELL: It is not something that we have, or we have reviews, because we simply have not put it -- it’s not part of our contract, we don’t put it in our contract, we don’t ask for it.

What we do ask for, always, in negotiations-- We want to get the best rate for our subscribers that we possibly can, and we always ask for that. Do we always get it? The answer is, absolutely not. We don’t always get it. Do we want to come as close as we can? Yes. Do we want to get rate equality wherever we can, meaning that we have at least as good a rate as the best competitor? Absolutely. And not doing that would be a disservice to our subscribers.

At the same time, hospitals routinely say, “Am I getting paid fairly for this?” and, “I want to be paid what some of your other hospitals are paid for similar types of services.” And, obviously, we can’t disclose that to them, but they at least feel they’re treated fairly if they get something in the ballpark of the other hospitals, and there’s a little bit of comfort. So when you get a new service like bariatric surgery, shy of the CFOs calling each other and saying, “What are we going to set our charges at?” they want to be in the ballpark and try to get a fair rate of reimbursement.

ASSEMBLYMAN CONAWAY: Now, Horizon, as it’s well known, does operate as a nonprofit here in the State of New Jersey. And one of the questions -- one of the, I think, larger questions are -- what special responsibilities may arise from that?

And let’s start with this question -- and that is, what benefits-- Could you-- Of course you have -- there’s a tax consequence or benefit. But can you outline for us what other benefits flow from that to Horizon from having that status as a nonprofit here in the State of New Jersey, please?

MR. BELL: Certainly. Let me begin by clarifying a couple of points. One is, all insurers pay premium taxes, and we also have assessments. So we probably pay about \$13 million a year to the State of New Jersey in assessments for premium taxes, DOBI assessments, etc. In addition, we pay about \$54 million a year in Federal income tax. So even though we’ve been touted as not paying any taxes, we do pay a premium tax, we do pay Federal taxes. So we have a unique status as a taxable nonprofit in some respects.

Now, the tax status of the organization really becomes a moot point when you’re in a competitive insurance market. We have to exist in a very

competitive market. The fact that there are no other nonprofit insurers in New Jersey-- There were some, they've all gone away. So it's a difficult standing. The fact that they were a nonprofit and the fact that they went away doesn't mean the tax status gives you any special leg up on any competitor.

The competitors that we face in New Jersey, and one of the issues of being in New Jersey, is we have jobs here in New Jersey. We are part of the State. If we moved out of state, if we take our business out of state, obviously, that hurts the economy, as well. So we are a 5,500 employee employer in New Jersey. We're very much a part of Newark. Our corporate headquarters are in Newark. They're going through their renovation. They're clawing back from their status of where they were. We can appreciate what Camden is going through. We understand that, because we've seen that and been there in Newark in many respects.

So the profit, nonprofit status is not as relevant as who we have to compete against. And we have to compete against some of the largest insurers in the country: Aetna; United, the single largest insurer; right on -- Cigna, United, Aetna -- right on down the list -- Health Net, and others -- all are for-profit companies. The advantage they bring is they can spread their costs over millions more members than we can, and they actually get a leg up. So we have to be that much more vigilant and competitive to survive against those nonprofit (*sic*) competitors in this state. And that's as great a challenge as we have. And I'm not sure being not-for-profit gives us any serious advantage over them.

ASSEMBLYMAN CONAWAY: No other State benefits that you can think of that come from being here?

ASSEMBLYWOMAN QUIGLEY: Herb, may I ask a question specifically to that?

ASSEMBLYMAN CONAWAY: Please, Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Thank you, Mr. Chairman.

Mr. Bell, reading your annual report, 2002 annual report, I believe I read something that all the Blue Crosses, nationwide, were given a break on the Federal income taxes when your status changed. How much is that break, and is it still in effect?

MR. BELL: The break is in effect. Instead of paying a corporate, for-profit company tax rate, we pay a 20 percent rate. So the break was, you're still going to pay taxes, but you're not going to pay as much as if you were publicly traded, or distributed your profits to shareholders. So it's a 20 percent rate, not what would normally be 35.

ASSEMBLYWOMAN QUIGLEY: Thank you.

ASSEMBLYMAN CONAWAY: It has been touched on, this question of the conversion proposed, not proposed, perhaps it's off the table. But you might want to take the opportunity now to clarify whether or not Horizon plans to convert itself from nonprofit to for-profit status.

MR. BELL: The conversion is officially off the table. We've taken that off the table. We are a not-for-profit company, we're staying nonprofit. It is off the table and not in discussions. That's the director -- the board of directors.

I wanted to, if I could, clarify another issue, because -- and that's the issue of enrichment, if we converted. If we convert -- if we had converted -- and it is off the table-- But if there is a conversion, the State is the one who

benefits from 100 percent of the value of the company in that conversion. Secondly, executives don't get enriched, because by the State provisions for conversion, we can't own stock, and we can't be enriched by that conversion for a substantial number of years. So we've got to run that company, and then we would have the opportunity, and all employees would have the opportunity, to share -- own stock, or others. But it wouldn't happen right away, and there's no guaranteed conversion.

In fact, this chilling statement on conversion for the executives at Horizon is, three-quarters of the executives on conversion aren't there a year after they convert. And with us, when you can't own stock for a year, that's not something that thrills me terribly, in terms of the--

ASSEMBLYMAN CONAWAY: Just so that I understand, you are barred from holding stock in the company at the time of conversion. You may decide to buy stock-- I mean, you don't have stock that you have to hold, that you can then-- You cannot have--

MR. BELL: Right, you have no stock.

ASSEMBLYMAN CONAWAY: No stock at all.

MR. BELL: You get no stock upon conversion, and you can't own options for at least a year. It is the first time you can be granted options. And as you know, they take three years to vest. So you couldn't enrich yourself for, fully, four years upon conversion. So there's no huge payout for the executives.

And the fact of the matter is, nationally, companies -- when companies convert-- I misspoke. It's half the executives aren't there, and three-quarters of -- aren't there after four years. So that's something we've learned as we go through that process, as well.

ASSEMBLYMAN CONAWAY: Assemblyman Connors.

ASSEMBLYMAN CONNERS: Thank you, Chairman.

Mr. Bell, earlier this morning, I don't know whether there was one or two people who talked about salaries of top management. And I guess the implication was -- and whoever it was that was testifying -- that perhaps they might be excessive. And I think they were talking -- the CEO may be earning in excess of \$2 million.

As a nonprofit, where does that stack up, I guess across the country, with insurers who are for-profit, in looking at the salaries? Where would that--

MR. BELL: I think you've raised a very important point and subject of discussion. If I can elaborate for a second--

Even though Horizon is a nonprofit, we're part of the Blue Cross system. We compete against the for-profits rigorously. And as any not-for-profit insurance company, or not-for-profit hospital, the board of directors has a responsibility to recruit and retain the executive talent they need to run the company. And we're a \$5 billion industry. And as they recruit any of our executives, the first thing they do is, they look around and say, "What are comparable executives paid in the health industry or the insurance industry?"

Now, Horizon is one of the top, probably, 20 largest insurance health plans in America. So they're looking around and competing with the Aetnas, Uniteds, and others. And they look and see what it would take to recruit the type of talent they need and retain that type of talent. And that's what the independent board sets that salary scale at -- using, usually, an outside consulting firm to make sure it's market-based.

And when you look at the executives' salaries and compensation of Blue Cross, yes they are a lot, but they're quite comparable to what the industry standards are. They are not excessive. In fact, they're less than many of our for-profit competitors. And they're quite comparable to what not-for-profit hospital executives and other Blue Cross executives make in this state -- or Blue Cross executives nationally, but quite comparable to what the hospital, not-for-profit hospital, executives make in this state, as well.

In the aggregate, if you took all our executives, and all their salaries, and put them together, and eliminated them -- which I don't suggest the Committee look to do, please-- (laughter)

ASSEMBLYMAN MORGAN: Motion, Mr. Chair. (laughter)

ASSEMBLYMAN CONAWAY: Do I have a second on that?

MR. BELL: I'd probably take a chance and head down that path.

But I think the important point is that all those executives salaries put together amount to less than two-tenths of 1 percent of our premium. So I don't think they drive premium costs. I would submit, because they are quite comparable to the nonprofit hospitals, they're quite comparable to Blues' plans, they're well less than most of the for-profit companies, that the board has probably been judicious in setting those rates, even though they are substantial. And like many hospital CEOs, those are substantial salaries. I don't begrudge you that.

ASSEMBLYMAN CONAWAY: One other question, if I may, and it follows from what Assemblyman Dr. Morgan has said about this question of assessment of cost. And it gets into a touchy area, I guess. But one of the

things that concerns those of us who provide care is what it costs to provide that care, and if we're reimbursed appropriately for the care that's provided.

There seems, to me, to be a lack of either an arbiter or perhaps all the information we need to properly assess costs on both ends of the equation: doctors' office, hospital systems, and indeed insurers. I know there are national bodies that look at the, sort of, relative value units, trying to set some standard. Medicare uses this kind of thing.

Do you see a role for that kind of an agency or mechanism here in the State of New Jersey to help meet the problem that so many of us who provide care face? And that is that there just is an imbalance between what it costs us to deliver care and what we're reimbursed. Do you see some role for some kind of a body, statewide, to deal with this question of making cost assessments to provide care in a variety of setting?

Any comments, I'd appreciate them.

MR. BELL: Sure. I think there is a danger in having the costs -- the State get involved in that. And I would use the example of Medicare itself. And as you know, physician reimbursement has been compressed by Medicare over the last several years. And that creates pressure to look to commercial payers or others. So you have the Federal government -- which now they set costs, and they determine, based on their budgets, that those costs can go up. And in many times, those costs go down. In the last three years, physician reimbursement had actually gone down, not up. So I think there is a danger in that type of rate-setting mechanism for doctors. And likewise, in the State, when you look at the Medicaid rates, Medicaid has been set, frankly, at about half of the Medicare rates. And that's the the State rate.

Now, when Dr. Bonaparte and Karen go out and negotiate, they're given the equivalent amount of money that the State used to pay doctors for the Medicaid rates. They've got to go out and build a network, compensate physicians, and in most cases, in order to get the physicians to work with us, we often pay more than the State would have paid that doctor for that care -- quite often -- to get the best providers into the Medicaid network and make sure we're reimbursing them. And there are many examples of where we've had to do that.

So when you get involved in that rate setting, it usually is going to penalize the providers. It may penalize the insurers. But the mech of this, those who set the rates don't have any skin in the game, and they may have constraints, such as budgetary or others, that they may not be able to deal with it. I'm not sure that the market is in a better place. And, frankly, we sit down with doctors, the best doctors, and we want to retain them in our network, and value them, and work with them to make sure we can retain them. So there is a market aspect to that, that Medicare doesn't give you and Medicaid doesn't give you, frankly, outside of the managed care companies.

So I think it's better to have market forces set those rates based on the experience we've seen with both State and Federal government, is my short answer.

ASSEMBLYWOMAN WEINBERG: I tried to help you out by giving everybody a little sugar fix up here so they wouldn't be quite so cranky.
(laughter)

ASSEMBLYMAN CONAWAY: I'm not cranky.

ASSEMBLYWOMAN WEINBERG: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: I've noticed ads in the newspapers in recent days from a number of health-care carriers -- Aetna, for example -- that they intend to reduce their rates, their co-pays, and a number of other things as a consequence of the Medicare Reform Act. Will this have any impact on Horizon Blue Cross Blue Shield, the Medicare Reform Act, in terms of assisting financially, etc.?

MR. BELL: I think that's a great question. The answer is, absolutely. We, as the State's largest Medicare contractor now-- Horizon has remained in all 21 counties in New Jersey, when most of our competitors got out. We have worked with the Federal government and our national association, the American Association of Health Plans, now American Association -- HAP, HIAA -- to work with the Federal government to restore the fiscal integrity of the Medicare program. That was actually done this year, as part of the Medicare reformation that went on. One of the good consequences of that bill was the fact that it had stabilized the Medicare risk programs.

We are going to -- we have announced that we will be increasing benefits and substantially reducing rates for those Medicare risk beneficiaries in all our counties. In addition, we think we will be offering a program with no premium. So we'll be back to a zero-premium Medicare supplement with fairly good benefits. It doesn't have prescription drugs and all the things we'd like to see. But for an uninsured senior, they'll have access to a good, affordable health plan at no premium, in the very near future.

ASSEMBLYMAN THOMPSON: So if you reach an agreement here at Cooper, then the Medicare recipients will be, ultimately, even better off than they are today.

MR. BELL: I believe so, yes. I would say that would be another benefit of reaching conclusion with Cooper. Although I would like to say that one of the things that was left out of all the testimony is, in an emergency, patients can use the nearest hospital in or out of network so that in a crisis, they're going to go to the nearest hospital. The coverage will differ by the types of coverages they have. But in an HMO environment, they can go to the nearest facility in a crisis, and it's going to be paid in full. That also is a downside of no Cooper contract, because that could be very expensive care for a very short period of time.

ASSEMBLYWOMAN WEINBERG: Thank you.

Are there any other questions? (no response)

I just have one more question, then, because I talked about this earlier when you first came before us. And that is about what the Department of Insurance has said about the reserves. And actually, there was something in a *Courier Post* article, which says that -- again, not a direct quote -- that based on State formula, Horizon should have approximately \$262 million in reserve. Horizon has \$676 million, she said. And she is Mary Cozzolino, spokeswoman for the department. Then she goes on to say the State prefers to have 250 percent of the authorized control level in order to maintain stability. And she -- and, again, not a direct quote -- Cozzolino said there is a point when the reserves get too large, but Horizon hasn't reached it. And then, this is a quote: "If we feel the company is grossly excessive, the Department does have some steps to take." And I think, on behalf of this Committee, we're probably going to ask the Department what grossly excessive actually means.

MR. BELL: That was the quote I was getting for you before.

ASSEMBLYWOMAN WEINBERG: Right. So I answered, partially, my own question, although some of this is not in direct quotes. And no offense to the *Courier Post*. I guess I'm in their readership area. But since it's not in direct quote, and the Department has not yet been able to provide us with information that says they don't think your reserves are too large, we will need to get that information directly from the Department. But that might be from where everybody got their information.

Thank you.

ASSEMBLYMAN CONAWAY: It reported that \$676 million that you have in reserve -- and you pointed out that that's 2.2 months-- That means that -- I mean, I presume it's simple arithmetic -- that you pay \$338 million in claims per month. That's what you're doing now.

Now, recently, Horizon announced that it--

MR. BELL: I'm not sure about the arithmetic, but I'll believe you. But it's approximately.

ASSEMBLYMAN CONAWAY: It's about that. Check it.

Recently, Horizon announced that it was going -- that it had a program of giving back some premiums. So I assume that somebody in the board of directors suggested that perhaps we have too much in reserve and that we're going to give some money back. I think it was \$55 million. I think \$5 million was going to health-care providers, and--

Would you discuss that, the reasons for that, the rationale for it, please? I'd appreciate it.

MR. BELL: We describe that as the affordability dividend. And the board looked at the performance of Horizon in 2003. And as I indicated,

we had an extraordinary first quarter. We had-- The first quarter was due, we think, to the total absence of a flu season. I have not seen that in my 30 years in health care. There was lower admissions on respiratory issues, on flu-related issues. And the hospitals, frankly, last year, were saying they were really seeing a lot of empty beds, where this year they're saying they're putting them in the halls. So it can change quickly.

We have to set our premiums well in advance. We have to project what our costs will be. And in this year, our costs came in substantially below what we projected for that period of time. The board determined to provide an affordability in health-care dividend, which they felt was important. There are a lot of people that are borderline becoming uninsured in the small group market. So this would help -- in the medigap market, this would help those individuals through that potential crisis.

In addition, we said we want to do a better job with our providers, and we allocated \$5 million to work with physicians on enhancing their office practice, which means making sure they're Internet connected, which is actually providing PCs and high-speed connectivity lines so they can work with us; and for doctors who have connectivity, prescribing a suite of E-prescribing capabilities that would allow doctors, we think, to save as much as an hour or an hour and a half of their day not taking prescription renewals, etc., in their office, and would free them up to see patients, and also help pay their claims faster. Likewise with the hospitals, we want to set up high-speed connectivity directly with Horizon, which saves the hospitals money from submitting claims and allows a quicker turnaround. So we thought there were dividends that would be appropriate for providers, doctors, hospitals, as well as the many

consumers. And that was a direct result of this year's performance being better than we thought, directly attributable to the first-quarter results. And the board made a one-time dividend.

At the same time, they made it very clear that they don't think our reserves are excessive, because we're continuing our pattern and path of growing our reserves. We want to be, at least, to the average reserve level of Blue Cross plans nationally. And we do need -- we think we need to be in that vicinity of three to six months worth of claims on reserve to protect our members. It would only take one terrorist attack, or one SARS outbreak, and we could devastate those reserves almost overnight. They can go-- As we lost -- as our experience -- Horizon incurred a loss of some \$72 million in one of its product lines not that far ago, not that long ago. So it can -- things can change very quickly in our business.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Your two colleagues have been sitting here quite patiently.

MR. BELL: They are very patient. I will turn it over to Karen Clark and--

ASSEMBLYWOMAN WEINBERG: Neither one of them leaped over the table during the course of this.

MR. BELL: --Phil Bonaparte. I'll turn it over to Karen to talk about Horizon/Mercy.

ASSEMBLYWOMAN WEINBERG: If you would--

And let me just say, I know, through no fault of this audience -- but it is 2:20. And I do want to hear from some community members, so I'm going to be calling on some folks afterwards. And we might not be able, I know we

will not be able to hear from everybody in this audience who signed up. If anybody has written testimony, we'd appreciate getting it. And if you don't, we'd appreciate -- if we can't call on you -- we'd appreciate hearing from you. I would like to adjourn this no later than 3:15, so that those of us who do live in the north can get home before tomorrow.

So with that, would you state your full name?

KAREN L. CLARK: Is this working? (referring to PA microphone)
Can you hear me?

Thank you, Chairwoman Weinberg.

ASSEMBLYWOMAN WEINBERG: Please give us your name so they'll have it for the record.

MS. CLARK: Yes, thank you.

My name is Karen Clark, and I serve as the President and Chief Operating Officer for Horizon/Mercy. We're responsible for health-care coverage for 270,000 New Jersey residents who happen to have Medicaid and FamilyCare as their form of health insurance.

ASSEMBLYWOMAN WEINBERG: Excuse me. Hold on.

MS. CLARK: Yes.

ASSEMBLYWOMAN WEINBERG: I know-- I guess my announcement caused several people to leave. But having said that, would you please try to do it as quietly as possible? The acoustics in here are not great.

Go ahead, Karen. I'm sorry.

MS. CLARK: I'll try to be brief with my comments. I do appreciate the opportunity.

I'm here for one reason, and that is to voice my concern about the Medicaid and FamilyCare members in Camden. We feel that they have been unfairly pulled into this negotiation between Cooper Hospital and Horizon Blue Cross Blue Shield's commercial business, although we have separate contracts.

We had a three-year contract with Cooper Hospital and good relationships. We served the membership jointly and had many good partnerships. But as part of the kinds of issues we're talking about today, we were pulled into this matter, and our three-year contract was terminated in its first year. And we do have some immediate issues, because, in fact, someone mentioned earlier a March date. Our contract does, in fact, terminate in March. So we're talking about disruption of care for thousands and thousands of some of our most disadvantaged people here.

ASSEMBLYWOMAN WEINBERG: It was terminated by the hospital, I'm assuming.

MS. CLARK: Yes.

ASSEMBLYWOMAN WEINBERG: In the middle of your contract here.

MS. CLARK: Yes, in the first year of the contract. We had a three-year contract.

We're really about servicing the disadvantaged here in South Jersey. In fact, we're in all 21 counties of New Jersey. As I said, we have 270,000 members. Our membership consists of people who are traditionally overlooked, who don't always get access to care. These are minorities, where we've seen these huge disparities in health-care outcomes; they're single mothers who happen to be poor and have children; they're the chronically disabled, or the

severely disabled; and, of course, persons with all kinds of chronic diseases. These are the people that we take care of.

We have 33,000 members in Camden. It's a large number of members. And I can tell you this is about quality and access for us, because I can't see lawyers at my back or whatever -- but this is not in my testimony -- but I will say that Horizon/Mercy is losing money in this area. I know there were questions, and people were careful not to talk about details. But I had reason to see the third-quarter 2003 rates reports -- is what the State calls them -- and, in fact, we lost \$3.5 million year-to-date for the first nine months of the year in Camden County. So this is, in fact, about our mission. This is not about making money down here.

And I looked at the costs in Camden County. Again, maybe to answer some questions, we're running 20 percent per member, per month over the medical costs for the rest of the state. So, again, this is about taking care of members down here.

I am very much concerned with the kind of disruption that I know will take place when we have to start sending letters to members. And the State very strictly mandates that we begin notifying members about these impending changes. It has taken a lot of case management, and outreach, and care amongst a care system that's been set up. And that system includes Cooper. They're important. Our relationship with Cooper is great. I've heard all the good things said about Cooper. Our experience has been very, very good with Cooper, and they're part of a partnership that includes Cooper, other hospitals, of course physicians, and it also includes a lot of grassroots agencies and organizations, with which we work.

So we'd ask that perhaps the -- if right now, given all that's going on, the termination can't be rescinded, that, at least, we'd be able to push out this termination date so that we don't have to upset these thousands. These are literally thousands of members. There are 33,000 in Camden County, and many of them access care at Cooper.

I brought with me today Dr. Bonaparte. Philip Bonaparte is our Chief Medical Officer. He's a fabulous doctor, who has dedicated his life to caring for the disadvantaged. That's what he does day in and day out. So he's going to speak about some of our concerns.

ASSEMBLYWOMAN WEINBERG: Doctor, would you move that microphone, the large one, so that (referring to PA microphone)-- Thank you. And give your name, too, for the record.

PHILIP M. BONAPARTE, M.D.: Philip Bonaparte, and I'm Chief Medical Officer for Horizon/Mercy.

Good afternoon, and thank you Karen.

Good afternoon, Chairwoman Weinberg, and members of the Committee.

The typical Horizon/Mercy member is most likely a minority mother with two to three children. Over the years, Horizon/Mercy has helped her in finding the quality provider or dentist, when she was having trouble, actually, finding someone who would accept her Medicaid; finding providers who specialize in treating members with special needs; and finding transportation to health-care appointments when necessary; obtaining support from licensed social workers with social issues, which impeded her; providing access to health information in Horizon/Mercy's nationally recognized health

programs that were designed to meet her and her family's need, such as managing asthma, getting prenatal care, getting timely immunizations for her children, and controlling diabetes, just to name a few of our programs.

During our partnership with Cooper, we've worked with Cooper Hospital in helping us help our members receive access to quality health care.

One recent example of this was a case involving a young diabetic woman who had multiple ER visits and in-patient admission at Cooper over the past year, where she spent more than 200 days in the hospital. Last month, our medical care management team reached out to Cooper and met on site with its physicians. Together, we developed a treatment plan that will result in reducing admission and untimely -- and ultimately, rather, improving the quality of life for this less-fortunate member. As of today, we have seen a reduction of admissions for this member compared to that same time period over a year ago.

I have many other examples that demonstrate the impact we have on our members.

One recent case is that of an 18-year-old mom, who was in a car accident and gave birth prematurely to a very ill child. Another example is that of a two-and-a-half year old boy who was born with profound mental retardation and Down Syndrome, and had severe asthma. In both cases, our care management and social case management teams have worked with the members and their families to get the necessary care and support to improve their quality of life.

Over the years, we have made great strides to improve the lives of these members, and many others in Camden, which is why we are disappointed in Cooper's decision to terminate. We are also disappointed because we have

remained in Camden, even though the State reimbursement has not been adequate to cover medical expenses for the population, as Karen mentioned earlier.

We could have easily made a business decision to focus away from that part of the state, as some other plans have done, but we didn't. We stayed true to our mission, and the publicly insured in Camden County, and continued to focus on improving care for those most in need.

When the termination at Cooper, as initiated, is finalized, the care that many Camden County residents are receiving will be disrupted. Members will be forced to make a difficult decision of staying with their health plan, or deciding to remain with their provider. If they do switch health plans, in order to continue to use Cooper, they will no longer be case managed by the Horizon/Mercy staff with whom they have built relationships.

Many members who have experienced so many barriers in the past will be confused by what is going on. They will receive variations of letters from different organizations, instructing them what they need to do. They may miss appointments with providers, they may go to a provider who is no longer participating in their health plan, and may be sent bills. Although they may not be liable for those bills, those individuals may think differently, adding to the possible confusion.

At this point, I will turn the mike back to Karen.

MS. CLARK: In the interest of time, I'll just conclude.

ASSEMBLYWOMAN WEINBERG: Please use the--

MS. CLARK: In the interest of time, I'll just conclude that, whatever the outcome, we're going to remain committed to the publicly insured

in South Jersey, and to the provision of quality care and access. And we know that Cooper shares much of the same mission, and we're really hopeful that they will join us again and continue the good relationship that we've had for the last 10 years.

Thank you, again.

ASSEMBLYWOMAN WEINBERG: What will happen to these 33,000 patients?

Let me backtrack, because according to a letter that was circulated from Cooper, they stated that they currently lose \$7 million annually on the Horizon Medicaid business, and that over the past 16 months, they've attempted, without success, to reach agreement with Horizon over a new contract for its commercial business that would continue to enable Cooper to subsidize these losses. So they're linking -- rightly or wrongly, they're linking those two together. And they say that their willingness to continue to incur losses shows their concern for Horizon members. And they said that Cooper's willingness to extend the agreement-- So I was under the impression that there was some kind of an extension under your agreement. That letter, actually, goes -- is really at the end of last year.

MS. CLARK: Well, I certainly hope that is true. I hope so. That's not our understanding now, but it would be a very--

ASSEMBLYWOMAN WEINBERG: Well, this letter is a little bit over a month old, so I don't know if something happened in the interim.

MS. CLARK: That would be a very good thing.

I can't speak for a \$7 million loss. I know that we negotiated a contract, and I know that was very lucrative. It's one of the best in the state.

I think I can't say more than that. But we're paying well-above rates that Medicaid is paying in many areas, especially for the physicians. I would say they're rates that are above the commercial rates.

We're losing \$3.5 million through the first three quarters of 2003. And I've said this before, that there is no place in this United States of America -- and I've been working in Medicaid a while -- where any provider I know is being paid what that provider justly should get for Medicaid. I know that we pay well-above the rates that are paid by the State, and that's why we've been able to attract the kind of network that we have.

But with our kinds of losses -- and I can't vouch for any of the numbers Cooper gives -- there's someplace else we need to be talking, and it's probably not to each other, if those are the kinds of the numbers.

ASSEMBLYWOMAN WEINBERG: So where would these 33,000 people go if, in fact, this contract is terminated?

MS. CLARK: If Cooper permits them to continue to come to the Cooper facilities, that's where we want them to go, because, obviously, these are people who have chosen either primary care doctors there, or have been sent to specialists. In some cases, these are really critical specialists to us.

We have certainly been able -- and we work very hard. Dr. Bonaparte didn't speak to this, but we work very hard, through our case management, not to send, especially children, across the river. So there probably would be some leakage in that way. That's not what we prefer. I know that Cooper sends some of their more difficult cases over to Children's Hospital in Philadelphia, anyway. But I think that would happen. That is not our preference, by a long shot.

And, of course, there are other hospitals in the area and other providers, other physicians. Some of the physicians -- I think Cooper spoke to that -- have admitting privileges at other hospitals.

But I think the best thing, especially for Medicaid recipients that have not felt welcome at many health facilities in the past -- in fact, they have not been welcome at many health facilities -- is just not to disrupt this care, now that we've moved ahead with breaking down some of these barriers.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gregg.

ASSEMBLYMAN GREGG: Thank you, Madam Chair.

Through the Chair, I just received some compelling information, and I imagine everybody back here probably feels the same way. You just testified to this Committee that the cancellation was Cooper canceling the Medicare, Medicaid portion. And they're separate in the Mercy side. Is that what you just testified?

MS. CLARK: Speaking about the Medicaid program, yes.

ASSEMBLYMAN GREGG: Is that what you just said?

MS. CLARK: Yes.

ASSEMBLYMAN GREGG: So it was canceled by the hospital, not by you.

MS. CLARK: No, no, not at all. We're very desirous of continuing that three-year contract.

ASSEMBLYWOMAN WEINBERG: That's the Horizon/Mercy, the Medicaid.

MS. CLARK: Horizon/Mercy.

ASSEMBLYMAN GREGG: No, I understand. But we've been listening to this big contract issue we have and how it will affect Medicaid people. And now I've been told at two something in the afternoon it is self-inflicted, for lack of a better term, on the hospital. I'd like to know if there's somebody out from Cooper who wants to come back and redress this, as far as I'm concerned, so I can hear them say that that ain't so. And if it is so, how it can get fixed, because, certainly, that's a piece of the puzzle that has nothing to do with what's going on in court, unless the young lady behind you with the glasses, who is the attorney, who gets excited when people speak (laughter) can say that perhaps it ain't so, or shouldn't be talked about. I think this Committee needs to have clarification as to this piece of the puzzle, which is the most at-risk people in the Medicaid program -- that that contract should never have been ended, and there's no reason it should have been ended. And it shouldn't have anything to do with the legal dispute that's happening as we speak.

And that's through you, Madam Chair.

MS. CLARK: I will say our relationships continue to be good. That's from my view, anyway. I'll see if I see any of my colleagues--

ASSEMBLYWOMAN WEINBERG: This is certainly a question for us. And if, when you're finished, anybody from Cooper is still here, and would continue to address that, we'll be happy to hear from them.

Assemblyman Morgan.

ASSEMBLYMAN MORGAN: When you say cancel, did-- Was this a contract that was in force, and before it expired, they canceled it?

MS. CLARK: Yes.

ASSEMBLYMAN MORGAN: It wasn't just nonrenewed at the end of the contract term.

MS. CLARK: No. We were at the beginning of a three-year contract. We had rates negotiated for three years. It was a good negotiation, as far as those things go. And it was in place. As I say, we have good relationships. It was canceled. I received a termination letter. And as I say, I talked to people at Cooper, and they were certainly sorry that needed to happen, but they see it as part of these negotiations.

ASSEMBLYMAN MORGAN: And if I remember correctly from Dr. Bonaparte -- or one of the testimonies was that the Medicaid side of the business at Cooper was being subsidized by the private side of Horizon. And that's how they explained they were not able to continue to take those losses.

ASSEMBLYWOMAN WEINBERG: That's from Cooper. That's in the letter that we received from Cooper, Dr. Morgan.

MS. CLARK: I don't know. I can only speak to our losses in Camden County. I know we lost \$3.5 million.

ASSEMBLYMAN MORGAN: See, this comes back to this whole problem of contracts, and money flows, and everything. We're trying to compare apples and oranges. And this is just part of everything in health care right now, in terms of the administration, and the finance, and everything. And we're never going to get to the bottom of these problems unless we can get a common language and have sunshine upon all these closed contracts and money flows.

ASSEMBLYWOMAN WEINBERG: Assemblyman.

ASSEMBLYMAN CONAWAY: A following on that, because we've had two statements of proported fact. Cooper says that it's lost \$7 million on a contract, and you have testified you've lost \$3-plus million in the first three quarters.

MS. CLARK: Through three-quarters of 2003, in Camden County alone.

ASSEMBLYMAN CONAWAY: Now, how do we then, as policy makers having some responsibility to make sure that there's a health-care safety net for folks not only here in this region, but elsewhere-- How do we decide amongst-- How do we reconcile those two statements? How do we find out what's right, what's wrong, whether people are losing money or not? That's one question.

Two: Cooper canceled this contract. Did they act legally and cancel this -- in this contract? Are there-- I presume a lot of these contracts have provisions in them that will provide for cancellation when a certain number of things happen. I suspect one of them is, "I'm losing my shirt." That perhaps I'm allowed to-- I don't know, you might enlighten me on that.

MS. CLARK: There's the ability to terminate without cause in every contract with 90 days notice. And they gave proper notice.

ASSEMBLYMAN CONAWAY: So they haven't done anything illegal.

MS. CLARK: No, not at all.

ASSEMBLYMAN CONAWAY: Good.

So how do we reconcile, again, the two statements of proported fact that Cooper is losing money and that Horizon is losing money? How should

we, as policy makers, assess that and decide who's right, who's wrong, what kind of solution ought to be brought to it? Your help with this would be appreciated.

And, two-- My second question is, then -- changing it -- is, can you talk a little bit about the competitive environment for this kind of health-care delivery? I, in my office, have, I think, two or three that provide -- I'm a provider for services under -- for Medicaid under HMO contracts. What percentage -- and looking at the Medicaid population alone -- does Horizon have in South Jersey? Are there other players involved down here in a competitive environment? Can you talk a little bit about that?

MS. CLARK: To your first question regarding losses, I don't think there's any right or wrong. I think you're going to find that both sides have facts that are facts, and that are correct. The numbers that I quoted come from the State of New Jersey Rate Sell Report, (phonetic spelling) in which they've brought in their actuaries and looked very, very, very carefully to make sure that we're comparing apples to apples, and that those reports are correct. So that's why--

ASSEMBLYMAN CONAWAY: Your books -- looked at your books.

MS. CLARK: Yes, yes.

ASSEMBLYMAN CONAWAY: Okay.

MS. CLARK: The auditors for the State.

So I'm saying that that's why I didn't throw out any other numbers. I chose only to stay with those State report numbers.

And I can't, again, speak for Cooper's \$7 million. But it may be that what they believe they should get to take care of a Medicaid member, and what they get, has that kind of a delta. I don't know that.

But now we're speaking to the health-care crisis beyond New Jersey, in the country. And if we could solve that, right now, with some magic pot of money, I think they'd be looking for us all over. We'd probably all get those million-dollar salaries.

ASSEMBLYMAN CONAWAY: And on the competitive environment, your competitors with market share and those kinds of things-- What's happening in this--

MS. CLARK: Yes. In general, we have 42 percent of the market share in the state. But in the southern part of the state, we're better than 50 percent. We're more like the 54 percent -- in the 54 percent arena. Again, as I spoke earlier, Horizon/Mercy stayed focused in the southern part of the state, even as we saw losses.

ASSEMBLYMAN CONAWAY: And that's of the Medicaid business, 54 percent down here.

And who are your other -- who are your competitors down here, please?

MS. CLARK: Well, the major competitors in this marketplace are AmeriChoice, United, AMERIGROUP -- I think I saw some of them here today -- Health Net, and what did I leave out. Oh, Centene University Health Plan.

ASSEMBLYMAN CONAWAY: So Health Net has a Medicaid portion.

MS. CLARK: Yes, a smaller one. But yes.

ASSEMBLYWOMAN WEINBERG: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: I'm not sure. They said they were losing \$7 million on Medicaid patients, or \$7 million on Medicaid patients in Horizon.

ASSEMBLYMAN CONAWAY: Horizon. They meant the Horizon/Mercy contract.

ASSEMBLYMAN THOMPSON: It was strictly Horizon.

ASSEMBLYWOMAN WEINBERG: What they said is, \$7 million annually on its Horizon Medicaid business.

ASSEMBLYMAN THOMPSON: Okay.

Of course, you did say you cover both Medicaid and FamilyCare, as well.

MS. CLARK: Yes, many refer to that as the Medicaid program, but we do cover the uninsured, who the State of New Jersey has included in the Medicaid program, or through the Medicaid insurance.

ASSEMBLYMAN THOMPSON: And you said that they have terminated in the first year of a contract, and it's due to expire in March -- the termination is due to take effect. Is that the first of March or the end of March?

MS. CLARK: March 11.

ASSEMBLYMAN THOMPSON: March 11, so that's much closer.

If they give a-- While they can terminate for no cause, did they state a reason for the termination?

MS. CLARK: Yes. I do understand that reason, and that reason is that it's leverage with Horizon Blue Cross Blue Shield's commercial business.

ASSEMBLYMAN THOMPSON: I'm sorry. Leveraging that?

MS. CLARK: Yes, again, with the contract.

ASSEMBLYWOMAN WEINBERG: Well, they stated it in their letter, so I'm assuming we can take that from what they said. And they said that the commercial business continues to enable Cooper to subsidize their losses on Horizon's Medicaid business. So they are linking the two, because, according to them, financially, they are linked.

ASSEMBLYMAN THOMPSON: On the other side, the termination required a four-month period before it was effective. But this only requires a three-month period?

MS. CLARK: No, there's a continuity-of-care period that goes up to four months. So when there are persons receiving care at a facility -- in this case at Cooper -- they'll be able to continue for up to four months. It's a way to take care of pregnant women, people in care, and others.

ASSEMBLYMAN THOMPSON: So the continuity, as far as your program goes, will begin in March.

MS. CLARK: Yes.

ASSEMBLYMAN THOMPSON: So they will not actually lose it until four months after March 11.

MS. CLARK: Yes.

ASSEMBLYMAN CONAWAY: July 11.

MS. CLARK: Exactly. It's the disruption that starts, because the State requires that we start sending out letters and, by the way, at major expense. Because as you can imagine, to 33,000 or better multiple letters, postage, and printing, and all that sort of thing -- money that could much better be spent on some of the outreach programs for asthma or whatever.

ASSEMBLYMAN THOMPSON: Are there currently any negotiations, or so on, relative to reinstating that, or is it just sitting there waiting to see what happens on the other contracts, and they'll think about it?

MS. CLARK: Well, we've traded letters and phone calls, and I've made my desire to continue the contract known. But, again, I'm sure it's tied up with what's going on, legally.

ASSEMBLYMAN THOMPSON: So we don't know whether that's going to require separate negotiations or whether -- just be restored if the other contract--

MS. CLARK: My money -- it should be separate, because I have a separate contract. These are two separate contracts, so I feel it should be.

ASSEMBLYMAN THOMPSON: But there's no negotiations going on, specifically related to Mercy at the moment.

MS. CLARK: No, it's bound in. I would love to negotiate.

LENORE BRADY, ESQ.: I'll just clarify that.

ASSEMBLYWOMAN WEINBERG: Give your name, please.

MS. BRADY: Sure.

My name is Lenore Brady. I'm an attorney for--

ASSEMBLYMAN CONAWAY: Say it again. Start over.

MS. BRADY: My name is Lenore Brady. I'm an attorney for Horizon.

Just to clarify, as part of the ongoing mediation, the Horizon/Mercy contract is being addressed.

ASSEMBLYMAN THOMPSON: That is ongoing negotiations, too?

MS. BRADY: Yes.

ASSEMBLYMAN THOMPSON: Okay, thank you.

Thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: That's actually good to hear. But while we're talking about how the postage could be used, I would suggest that even full-page ads in the newspaper, about the \$55 million health-care affordability dividend, could also go towards a larger than \$55 million health-care dividend.

ASSEMBLYMAN CONAWAY: Loretta Weinberg, priceless.
(laughter)

ASSEMBLYWOMAN WEINBERG: I didn't hear any applause on that one.

Assemblyman Gregg.

ASSEMBLYMAN GREGG: Could you just explain to me, through the Chair, what will happen on March 12 if there is no contract settlement?

MS. CLARK: Well, on March 12, persons, technically, who are receiving care can continue through this continuity-of-care period. The fact is, though, once letters go out, people become very confused about whether they can go or can't go, doctors start making all kinds of statements, closing their doors, and that sort of thing. So it is very disruptive, in fact.

ASSEMBLYMAN GREGG: And I hate to, through the Chair, bring your attorney back -- or perhaps you can answer the question. The question was, what will happen if the contract negotiations are completed. The answer was that your problem would be solved, because you're inside of the negotiations.

My question is, is there anything that stops Cooper Hospital from fixing your problem outside of that negotiation, which was part of my questioning before?

MS. CLARK: From my standpoint, and I think I can speak for Horizon enterprise, no. I've never been told that I can't continue with that contract. And I want to reiterate, I'm very desirous of that.

ASSEMBLYMAN GREGG: In your opinion then, the only thing stopping that contract to be reinstated is just the will of Cooper Hospital.

MS. CLARK: Yes.

ASSEMBLYMAN GREGG: Thank you.

ASSEMBLYWOMAN WEINBERG: I think-- I've been told that somebody from Cooper is here, who would address that status.

But before, does anybody have any further questions of these two witnesses? (no response)

Thank you very much, Ms. Clark, Dr. Bonaparte. Thank you.

MS. CLARK: Thank you very much for the opportunity.

DR. BONAPARTE: Thank you.

ASSEMBLYWOMAN WEINBERG: Who from Cooper was going to address the Medicaid Horizon/Mercy issue?

And after that, I would like to call -- just to let you know -- Elena Bostick, if she is here, from the Hemophilia Association. I really want to hear from some community service providers. And then the Council of Teaching Hospitals, and then Barbara Marcella, who is just listed as a patient. It would be nice to hear from them.

I'm sorry, Mr. Sessa. Go ahead.

MR. SESSA: No problem.

I'll make sure that everyone can hear me.

It is correct that we had provided notice of the termination of the Medicaid contract. But let's put that in the proper context. As I reported to you, Cooper loses over -- on this particular contract -- \$7 million annually. If we're going to be able to keep our doors open, we have to be able to realize a fair profit from the for-profit contracts, from the commercial contracts that we have with Horizon, as well as the other insurance providers in this state.

One of the things that was interesting, as I listened to the previous testimony, Cooper negotiated on the commercial contract for 14 months. Cooper accepted -- and, in fact, specifically requested -- 60-day extensions during that 14-month period that began at the end of 2002 and rolled into 2003 for the purpose of trying to come to a settlement on that commercial contract.

But something else that was not noted in the previous testimony began to happen, starting in April of 2003. Payments to Cooper stopped, reimbursements to Cooper stopped, hundreds of thousands of dollars became millions of dollars, by the time that we got towards the end of 2003.

Now, did we stop negotiating during that time period? No. We continued to negotiate right up to the beginning of the open enrollment period. And, in fact, we agreed to continue the negotiations through the open enrollment period, based on the premise that we had come to certain understandings, both financial as well as nonfinancial terms. And one of those terms dealt with the most-favored-nation clause, or specifically the lack thereof.

At the end of the open enrollment period, where now the amount of dollars withheld from Cooper was approaching \$3 million -- and put that \$3

million in the proper context, relative to the finances of this inner-city hospital, based in the city of Camden, versus the finances of the billion-dollar company, Horizon Blue Cross Blue Shield -- put those dollars in perspective, relative to the impact that they had to the overall cash flow of each of their respective institutions.

At the end of the open enrollment period in November, we were notified by Horizon's attorneys that the language that Cooper was willing to accept, with regards to trying to provide Horizon with some assurances with regards to pricing going forward, was no longer acceptable. And we had to accept the pure definition of a most-favored-nation clause if we wanted a new contract at the end of the open enrollment period.

So as we came to the end of the most recent 60-day extension, which expired on December 28, we now found ourselves in the same position that we were in the beginning of 2003, with regards to trying to come to reasonable, fair terms on the commercial side of this contract. And we were -- we also had just gone through a period in the beginning of November, the beginning of the open enrollment period, as opposed to the end of the open enrollment period, where what we were specifically being asked for, as it pertained to a most-favored-nation clause, was now right back on the table at the end of that time period.

So, as a company, we made the decision that we had to bring this thing to a head on December 28. We could no longer continue to accept 60-day extensions, because we were getting nowhere with regards to the dollars that were being withheld from us. And those dollars were now three, approaching \$4 million that were being withheld from us on our commercial contract.

And so the comment was--

So there were two things that we did. We took legal action, with regards to the contract dispute, so that it could be clearly determined by the courts, because we had offered--

ASSEMBLYWOMAN WEINBERG: That's the commercial contract.

MR. SESSA: On the commercial contract. That is correct.

And we also notified Horizon that if we're not going to turn a fair profit on our commercial business, we can't keep the doors of Cooper University Hospital open and lose \$7 million on our Medicaid business. So we notified them that we could no longer be the primary hospital for the Medicaid business that takes place in South Jersey. One-third--

ASSEMBLYWOMAN WEINBERG: And what is the status of that now? Have you given an extension on that notice?

MR. SESSA: It has an automatic 120-day extension to it. So on -- sometime in March will be the period that the contract-- We gave our 90 days notice so that effective in March -- that the contract would be terminated. But then in the same way that there is a grace period that follows -- for four months -- the commercial contract, there's also a grace period that follows the Medicaid contract.

ASSEMBLYWOMAN WEINBERG: So it's four--

MR. SESSA: And so it would not be until July of this year, of 2004, where there would be any Medicaid patient that would not be able to--

ASSEMBLYWOMAN WEINBERG: So we have time to come back here again and beat up on all of you again.

MR. SESSA: That's correct.

But I felt it was important to put those circumstances in the proper perspective, because that is what happens when you are a billion-dollar company, and you're negotiating with individual hospital systems that have no idea what the other hospital systems--

It was interesting to hear that the other hospital systems -- whose terms and conditions -- that we might be willing to accept, because that's information that Horizon has, as a company, relative to all of the health systems that do business in this state. But we don't even know the contract terms that Virtua Health System, that Our Lady of Lourdes-- We all have to negotiate in a vacuum.

ASSEMBLYWOMAN WEINBERG: Well, Mr. Bell did state that he would be willing to turn all of those over to the judge to make a decision.

MR. SESSA: We welcome it.

ASSEMBLYWOMAN WEINBERG: Dr. Morgan.

ASSEMBLYMAN MORGAN: Just a question.

Are those \$3 million still outstanding now?

MR. SESSA: Yes.

ASSEMBLYMAN MORGAN: So that's for services that have been rendered and you've not been paid for.

MR. SESSA: That's correct.

ASSEMBLYMAN MORGAN: Can I get an explanation for that from the other side of the table?

ASSEMBLYWOMAN WEINBERG: I'm sorry, but you have to use the microphone. And state your name, please.

JAMES P. FLYNN, ESQ.: My name is Jim Flynn, and I'm the outside counsel in the litigation for Horizon.

And this is Bill Tambussi, who's my counterpart on the other side.

Those numbers are, I think, part of the current discussions of the mediation.

ASSEMBLYWOMAN WEINBERG: The numbers for the other hospitals.

MR. FLYNN: No, no, the \$3 million figure that was referred to.

ASSEMBLYWOMAN WEINBERG: Okay, the outstanding.

MR. FLYNN: There's been an allegation in the complaint that was filed, and is public, that the number was \$2.7 million. And I don't think-- And there's a whole bunch of reasons why both sides disagree as to how to characterize that, and whether it's actually owed to us or owed to them. But any other discussion of the \$3 million, I think, is part of the mediation process.

And Mr. Tambussi can say whatever he believes is appropriate.

ASSEMBLYMAN CONAWAY: You should not be discussing it. Is that what you're saying?

MR. FLYNN: I do not believe it should be discussed.

WILLIAM M. TAMBUSI, ESQ.: I agree that we should not be discussing this.

ASSEMBLYMAN MORGAN: Okay, we won't discuss that, but explain to me how you have a situation where there's this discrepancy. Services are rendered, and money is not paid. I mean, this is a generic question, not specific to Cooper or Horizon.

ASSEMBLYMAN CONAWAY: That we know a lot about.

ASSEMBLYMAN MORGAN: Anybody, enlighten me.

MR. FLYNN: Services were rendered, and amounts were paid. The issue in litigation is whose version, or whose understanding of the contract should be adhered to. I can't give you any better answer other than there were medical services provided, and there were payments made to them. There is a dispute, which is now currently in litigation and mediation, as to what the contract meant, and how both sides adhered to it, or didn't.

MR. TAMBUSI: Assemblyman, if I could add to your answer, there are hundreds of claims that Cooper has submitted that have not been paid.

ASSEMBLYWOMAN WEINBERG: Okay. You know what? I don't want to get any further into this discussion, because that, obviously, is before the court or in whatever your ongoing mediation is. So I prefer not getting into it. It's obviously a matter of interpretation.

So, if you have another subject--

ASSEMBLYMAN CONAWAY: I'm not going to go there.

ASSEMBLYWOMAN WEINBERG: All right.

ASSEMBLYMAN CONAWAY: I've been taking notes, because one of the things I hope that we are doing in this hearing -- I'm sure all of my colleagues are doing -- are thinking about ways to prevent this kind of a problem in the future, and what kinds of changes in law need to be brought forward to prevent these kinds of problems.

And the thing, Chairman Sessa, that you mentioned to me that struck me as something that, perhaps, ought to be changed, is this question-- And somebody needs to oversee it. You know, you're in negotiations, and all of a sudden payments, under the current contract, stop. Now, that, to me --

and, of course, services are being rendered this whole time. Now, that, to me, seems like something that, at the very least, should be the subject of the Department of Banking and Insurance overview, and ought to be, it seems to me, prohibited outright.

Could you comment on that as a negotiated-- I mean, just -- that's a tactic in negotiations. And we need to look at that.

MR. SESSA: My comment will not be specific to Cooper. I would refer back to the testimony of the representatives from the New Jersey Hospital Association that spoke specifically to the issue of late payment and no payment. And I think what you will find is there is a direct correlation there to contract negotiations, as you go from one health system to the other.

That is -- that's how you arrive at \$100 million per year profits. Slow pay and no pay on the outside, while increasing the premiums on the inside 40-plus percent. And that would be fine in a for-profit environment, but this is a not-for-profit company. This is a company that has the State contracts.

ASSEMBLYMAN CONAWAY: Understood. I got that.

You mentioned in your testimony about the interplay of -- and this is something I think we, as policy makers, also ought to understand -- and that is, how -- this sort of tolling period of the contracts, and how they might relate to the open-enrollment period, and what it means to have--

MR. SESSA: That's another excellent idea, because as--

ASSEMBLYMAN CONAWAY: It seems we need to look and focus on that.

MR. SESSA: That's right. As subscribers are getting ready to sign up with their insurance companies, they are completely kept in the dark, with

regards to the status of those insurance companies' negotiations with the providers. That is information that they should be made aware of. They should be made aware of the status of contract negotiations with large health-care providers in the state, so that they can make decisions that will ensure that the doctor that they want to go to, and the hospital that they want to go to -- that those will be in-network as opposed to out-of-network.

ASSEMBLYWOMAN WEINBERG: okay.

Thank you very much, Mr. Sessa and colleagues.

MR. SESSA: Madam Chairwoman, if I may make one other comment.

ASSEMBLYWOMAN WEINBERG: Very quickly.

MR. SESSA: I will.

It is important to recognize that if the Cooper Health System and Cooper University Hospital is going to be able to stay in business, and keep its doors open, and handle these emergency care cases, you can't have it where you provide \$65 million worth of charity care, where you lose \$7 million on your Medicaid contract, and not turn a reasonable profit with regards to your commercial contract.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

MR. SESSA: Thank you.

ASSEMBLYWOMAN WEINBERG: Is Elena Bostick here?

(affirmative response)

Please come forward.

I'm going to use the prerogative of the Chair now to keep you all a little quieter so we can get through a couple more people before we adjourn.

ELENA BOSTICK: Good afternoon.

I'm Elena Bostick.

ASSEMBLYWOMAN WEINBERG: Use the large microphone, please, Elena.

MS. BOSTICK: I'm Elena Bostick, Executive Director of the Hemophilia Association of New Jersey, and presenting--

ASSEMBLYWOMAN WEINBERG: Closer.

MS. BOSTICK: --presenting on behalf of the Association is Julie Frenkel, Social Service Coordinator. And she's held that position for the past 16 years.

JULIE FRENKEL: Good afternoon.

I'm honored to testify here today.

I wanted to stress that we are not providers, we are consumers. And we represent a community group that struggles and lives every day with a chronic, life-long condition. Some of them actually have three chronic conditions besides hemophilia. They are also living with HIV and Hep C, which they have contracted through contaminated blood products.

As Social Services Program Coordinator for the Association, I spend a great part of my day working on various insurance problems and issues.

ASSEMBLYWOMAN WEINBERG: Ms. Frenkel, I'm going to interrupt you, because we do have this written. So if you could, kind of, summarize it and not read through all of it, and give us a summary of what's here--

I don't mean to put you on the spot, but I am.

MS. FRENKEL: That's okay.

Basically, we have noticed a trend within the last six months with Blue Cross as consumers -- all of the issues that you've been talking about today. Issues of delay, delay for authorization of services, delay for processing of applications have all become very problematic, not only for our community, but for any community that deals with either an acute or an ongoing disability.

We don't have great numbers, because we are a small community, but some of the trends, a developed strategy that we've seen in the past six months, have created havoc with our community. For example, as I have said, I have been in charge of the insurance grant program. We purchase insurance for our members who are either not eligible for group insurance or other entitlements, and if they meet the financial criteria.

And we have had a very long-term and, until recently, a very productive relationship with Blue Cross Blue Shield. When we first began this program in 1987-'88, Blue Cross was the only game in town. They were the only ones who accepted individuals with a pre-existing condition. So that development has been going on for a long time. That's why we have been extremely upset over the last six months with some of the strategies we've been seeing through Blue Cross Blue Shield.

For example, in the last six months, we have submitted six new applications for processing. Two of those applications went through the processing time in a very, relatively normal short period of time, which meant that we received ID cards, premium bills within the two to three weeks. Also, those two individuals that were processed so quickly came to us without any prior insurance. So we knew that they would have a pre-existing condition per year. The other four applications that have been going through have been a

nightmare, refaxing the same information four and five times, follow-up phone calls, trying to get through -- either myself, because I act as their advocate, or the families that are involved. Three of those had been solved after a six to eight week period. And the last one that I am still working on was a young man who had to roll off his family policy. We submitted that application on October 13, and it was to be initiated on November 1. And at that time, we had -- I had spoken to the salesperson that I had sent the application. Everything was fine. By the way, these four applications had prewaived pre-existing. We sent all the data and the documentation to prove they had had prior coverage. And after 15 phone calls from myself and from the mother -- and I call my contact at Blue Cross, and she has been trying to notify the customer service people and refaxing the same information four to six times.

We had not received any benefit cards, we had not received any premium bills. And, of course, this is a young man with a pre-existing condition. That 30-day time period, which you know is what you have when you roll over from one policy to another, is gone. So we cannot go to another insurance company at this point. We have to ride it out with Blue Cross, because we don't want this young man to have to go through a year pre-existing.

For the first time, yesterday, I was told, "Well, it's noted in the records this application was sent out in October." And I said, "But how can that be when I have been on the phone a half a dozen times, as have the family, and have been told, 'Well, we're looking into it.' And four times we were told, 'Yes, we see this process. This application has been processed. There should be no problem. You'll be receiving the cards at the end of the week.'" That was in November, December, and January, we heard the same story. And for the

first time yesterday I heard that, “Well, they had been sent out and terminated because of no payment of the bill,” which we pick up. So it’s a delay tactic that I see has been going on very steadily.

The other issue that I’m talking about, that I would like to bring to your attention, is the standards of care bill, when it was passed for hemophilia home care, when it was passed in the year 2000. It very specifically put, in the domain of the hemophilia treaters, lab and testing that could be done at the hemophilia treatment centers rather than sent out to the large lab like LabCorp and -- I’m at a loss.

MS. BOSTICK: Quest.

MS. FRENKEL: Quest. And it would be done if there were either time constraints, if it was an emergent situation, or if it was a very complex testing.

And in the last two months, I’ve had at least five different calls from the different hemophilia treaters stating, “We’ve told them, and they keep denying us.” I had a nurse that was on the phone for four hours trying to get authorization to do an emergent test, and was denied it from Blue Cross.

These are the issues which we find very troubling and very concerning. This community cannot wait.

And when we’re talking about price increases, I would like to put things in perspective, because, again, I deal with this situation. I pay these bills. We have 60 individuals now on the insurance grant. And that has gone up drastically in the last year -- not drastically, but 10 have been added because of the economy. And we’ve picked up COBRA.

And what I wanted to say -- which completely went out of my head -- was in regards to the rates. I'm sorry. I have noticed that Blue Cross raises their rates -- because we get the notices -- every four to six months. Maybe not for all the plans at a time, but for different plans. At least twice a year the rates are raised on each plan.

I just received the February 1 statement. Now, when we first started purchasing insurance policies in 1987, a family plan -- which is what we purchase, because children were not allowed to have their own plans -- with traditional plan D, \$500 deductible, was \$235 a month. That same plan today -- and I will be happy to show you the Blue Cross statement -- is \$5,500 a month. These plans have increased way beyond. My math is not so good. They've increased way beyond what I can do.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

MS. FRENKEL: I'm sorry.

ASSEMBLYWOMAN WEINBERG: I think you-- I wanted to get in a few minutes of testimony from a consumer point of view.

Does anybody have any-- (no response)

Thank you, both. And thanks for your patience.

MS. FRENKEL: Thank you.

ASSEMBLYWOMAN WEINBERG: I'd like to call on the Council of Teaching Hospitals, and then Barbara Marcella, who is a patient. And then that might finish us.

And I will-- To be fair, I'm going to end-- We do have written testimony from the Association of Health Plans. And I'm going to call on them to give me a two-minute summary of what you've written here.

Go ahead.

J. RICHARD GOLDSTEIN, M.D.: Madam Chairwoman Weinberg, and members of the Assembly Health Committee, I am Dr. Richard Goldstein. I'm President and CEO of the New Jersey Council of Teaching Hospitals, and I'm a former New Jersey State Commissioner of Health.

Our Council is a teaching hospitals' trade association. We represent a few relatively small teaching hospitals, but primarily represent very large ones such as Robert Wood Johnson University Medical Center, Meridian, Atlantic Health, and University Hospital.

We also represent Cooper Health System. Collectively, our members account for about \$3 billion of business out of the \$14 billion New Jersey health-care industry. Cooper, alone, is about a half-a-billion dollar enterprise. So here we are testifying at a hearing concerning the fact that Cooper -- and this issue, obviously, is not Cooper's alone -- a half-billion dollar enterprise is no match for Horizon. Horizon holds all of the cards, and it has elected to throw them in, abandon the citizens of Camden. It holds the Damocles' sword at every negotiation. "If you don't accept our offer, you're off the list."

The issue is always money. Cooper's situation is simple enough. It has asked Horizon to raise its commercial rates so as to offset the losses on Horizon's Medicaid business. Horizon said no and will direct its enrollees elsewhere.

Certainly, there were other issues, as well, but all involving basic fairness. The answer on all issues was the same. And you can do that when you own 40 percent of the market. And by the way, that 40 percent of the market

is only the market that we know about. Horizon also contracts with many large ERISA companies that want to take advantage of their discounted network, and that's a management contract. And it doesn't include -- it's not in the statistics.

Horizon has been in New Jersey for over 70 years. It knows the game. It knows that hospitals must cost shift their underpayments from one carrier to the rates it charges other carriers. The truth is that if all payers in New Jersey paid the same rates -- and this was once the case, as was pointed out by the Committee -- that there was an add-on payment of 19 percent in the '90s -- that that payment would be, today, approximately 34 percent.

You may be shocked to learn that many payers, in fact, pay more than 34 percent over cost to subsidize for the underpayments. But is it fair for those other payers to subsidize Horizon? What sense does that make?

As for Cooper, it is a relatively low price when compared to its northern brethren. In fact, Cooper is a particularly efficient hospital in New Jersey. It ranks ninth in the state, in terms of its average length of stay. And the Blue Cross contract is based on a per diem basis, which means the length of stay greatly affects the bill.

Also, everyone certainly knows by now, from listening to me, that teaching hospitals cost more than nonteaching hospitals. It's not just the cost of teaching -- although in New Jersey that cost is \$534 million, and it, too, is underfunded by over \$200 million -- but teaching hospitals need to have the latest technology, the latest treatments.

In refusing to reach an agreement with Cooper, the ramifications to society are unacceptable. For a not-for-profit insurer to abandon major teaching hospitals like Cooper -- and it is one of the three major teaching hospitals in the

state, hospitals that provide Level 1 trauma services, clinical research, and train tomorrow's physicians -- flies in the face of its own charter, and it flies in the face of the needs of our society.

Horizon not only has a social responsibility to protect hospitals like Cooper, it is supposed to keep its premium down by keeping health-care costs down. It is not supposed to do the opposite and keep the difference. But that is exactly what it has been doing. Over the past three years, it has raised its premiums by over 40 percent; squeezed lower rates from providers by threatening to take it's business elsewhere; and it has kept the difference, building a record reserve approaching \$800 million.

Now, it's been pointed out in their testimony that that reserve may be appropriate to all the other Blue Cross plans. But a lot of those other Blue Cross plans are for-profit. And for-profit companies have great incentives to build up large reserves as it stabilizes stock prices. It can be used in additional mergers, it has lots of other meanings.

Horizon should be using some of its profits to reduce the charity care burden that our hospitals endure. The charity care bill now, as this Committee knows better than probably any other committee, is approaching \$700 million -- or over \$700 million -- with about half reimbursed by State subsidies. The financing system in New Jersey is already precarious. Horizon should use some of its extraordinary reserves to reduce the charity care that hospitals carry rather than attempt to save up a fund to pay off the State in order to gain its permission for an IPO that will, three years after, make hundreds of millions of dollars of profit for the company. It does that, because it already has the networks in place, it already has the contracts, it already

knows who's who, their Rolodex is fabulous, and they would dominate the market.

Our health-care system is built on the premise of negotiations, but when insurers have 40 percent of a market, it is not negotiating rates, it is dictating rates. And when that company's reserves reach record levels well beyond the legitimate need of money for a rainy day, it is time for the Legislature to send Horizon a message. A for-profit player, with a 40 percent market share -- which is essentially a monopoly -- is answerable only to itself.

I'll conclude with that.

ASSEMBLYWOMAN WEINBERG: Thank you both very much.

DR. GOLDSTEIN: Why don't you ask me for some suggestions?

(laughter)

ASSEMBLYWOMAN WEINBERG: Oh, okay. Would you like to give us some specific suggestions while I can still say those two words that both begin with an *S*?

DR. GOLDSTEIN: Well, we feel it's wrong to allow large ERISA companies to take advantage of the discounted network and avoid cost shifting. And we don't think that that should be permitted.

Secondly, there was a fascinating piece of information revealed in all this. And that is, if the absence of a flu season saved them \$50 million, I just can imagine what universal flu vaccination will do for New Jersey, and on top of that I would add the pneumonia vaccine. The more people that we can vaccinate in New Jersey, there is, obviously, as we've just learned, a tremendous payback.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Okay, I've also been asked -- and I'm not going to argue with God -- but the Black Clergy of this area wanted to give some testimony. Do we have representatives here? I didn't have the heart to turn you down.

Be very careful.

REVEREND JAMES C. JONES: The Lord's going to bless you real good.

ASSEMBLYWOMAN WEINBERG: You know, those of you who are most patient, and stick throughout the whole day, end up with the short shrift. Sorry about that.

Go ahead.

REVEREND JONES: My name is Reverend Jones. I'm President of the Concerned Black Clergy here in Camden.

This is Reverend White, our Executive Secretary for the Concerned Black Clergy.

I'm here for two reasons. First of all, because it's needed that this situation get settled, because it affects the people in the community. And I'm also here to support Cooper, because I'm a friend of Cooper.

Let me explain something, right quick. First of all, I respect Cooper. I have a relationship -- I know Dr. Sessa (*sic*), I know Dr. Levy (phonetic spelling), I know Gary Young. They meet with community people on a regular basis to let us know what's happening in the community, and also to find out from us how they can better serve the community.

He's been to my church. We've had fellowship. I met him at a groundbreaking one day. And in a conversation, I told him my wife had two sisters in the hospital. He wrote their names down. Later on that evening, I

found out that he had personally stopped to visit them. Someone might say, “Well, that’s because you are a community leader.”

But let me tell you about my relationship, quickly, just as a resident of Camden. I got sick one day. Every time I bent over I got dizzy. I went to my doctor -- Cooper physician. He examined me, sent me to the emergency room. Now, when I went in his office, he sent me in the next room that was available because of my situation. And there’s people in the waiting room that were waiting to go in, and that even made me nervous, because if you’re familiar with this area, there ain’t nobody in Gloucester look like me. But yet, I got serviced immediately.

I went to the hospital. They worked on me, found me a bed about 10 o’clock that night. They called transport to take me up to my room. One of the nurses came by about 10 minutes later and said, “They didn’t come get you yet? Tell transport to forget it. I’m going to personally take you up.”

I was treated with what I consider the best of care. One of the nurses even made a copy of my chart and took it home to study it to make sure nothing was missed.

ASSEMBLYWOMAN WEINBERG: I hope she had your permission to do that. (laughter)

REVEREND JONES: Oh, yes. She told me she wanted to do that. No problem.

ASSEMBLYWOMAN WEINBERG: Otherwise, don’t tell me about it.

REVEREND JONES: I got a call one day, my godson had gotten messed up -- had a drug problem. He was in a place over in Philly -- drug

infested area. I went and picked him up. I took him to a place down in Millville that we had a relationship with. The only problem is, they won't admit you unless you've seen a doctor and had some blood work done. If you get the blood work, they will admit you until they get the results. Most places won't even admit you until they get the results.

He lived in Glassboro, came back to Glassboro, called the place up that could have done it, but they were closed at 3:30. It's ten minutes to four. I called Cooper physicians in Gloucester, explained the situation, they said, "Bring him up." I said, "It's five minutes to four. You close at four o'clock." They said, "We will wait until you get here." They went past their office hours, waited until I got there, examined the man. He got in the rehab. Today, he is drug-free and working every day, thanks to Cooper.

So this is something that needs to be done. People, I feel, get quality care here in Cooper. I don't want to go nowhere else except to Cooper physicians, because of the way I'm treated. And I've got a list of hospitals. I tell my people, "If something happens to me, don't take me there." I got one hospital, and I say, "Take me to Cooper if anything happens to me."

Thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: Thank you. Thank you very much.

Your name, again, please, for the record.

REVEREND FLOYD L. WHITE III: Yes, ma'am.

I'm Reverend Floyd White III. I'm the Pastor of the Woodland Avenue Presbyterian Church, and also the Secretary for the Concerned Clergy

of Camden City. And I also, in my spare time, am a trustee for the Cooper Foundation.

I'm very concerned about the Horizon-Cooper relationship, particularly in the area of Medicaid, the Medicaid population.

In 1995, several of us worked in consultation with Horizon/Mercy to admit a lot of the people to the managed care population. It is my belief, unless there is a resolution of these contractual issues, thousands of Horizon Medicaid patients will not be able to receive services from Cooper.

I want to put this in a proper perspective, in terms of Camden City. People say, "What is the impact?" The city of Camden is the second poorest city, in the richest state, in the richest nation, in the world. We applaud you for the county revitalization plan, thank you for the \$175 million. From health care, to education, to child care, this is very important. But when we think about the impact of people not having access to health care or treatment--

Let me just break it down, in terms of my neighborhood. I'm in the Morgan Village community of South Camden, here in the city of Camden. I've been here about 16 years. The median income in my neighborhood is \$7,500 per household. The bottom line is, the people that I serve cannot navigate the medical system the way I can.

I'm here today for two reasons, because I think that we, oftentimes, have to be the moral conscience of those who are in power for the powerless. And secondly, I'm sympathetic and want to work in consultation with both parties -- but secondly for a more personal reason -- in closing.

Cooper Hospital -- Dr. Melvin Pratter, who is the chief pulmonary specialist, saved my wife's life. My wife has sarcoidosis, has pulmonary

hypertension, and is on the lung transplant list at Temple. The reason why I say that, I understand the dynamics of health care. I've been on some committees, and have navigated the system, and things of that nature. But my people that I serve, the young people that I serve, probably don't have that type of sophistication to navigate the system. And this is tied in, largely, to revitalization.

Thirty-five percent of the population is under 18. About 50 percent of the population is under 25. There's about 11,000 kids in this city under five years old. So health care is intimately tied into employment and education.

So I urge you today to work in consultation with both parties, I urge you to look at the basic regulations concerning health care, and I urge you to help us bring this to a speedy resolution.

On behalf of all the young people in this city that I serve, I pray that you will work in consultation with both parties to bring this to a speedy resolution so that the children that I serve can have access to health care, as well as access to treatment.

Thank you for the opportunity to speak to you. (indiscernible) your comments. This concludes our testimony.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Any questions? (no response)

I think you have eloquently explained why this institution is so important, particularly to the area in which you function. And we appreciate your sitting so patiently through so many hours.

Thank you very much.

I'd like to call Barbara Marcella, who has just listed herself as a patient, if she's still here.

And I do want to call to the attention of the Committee members, we do have written testimony from the Health Care Payers Coalition, which will also be the other side of, perhaps, the coin, just from leafing through here. These are people who purchase health insurance, and have a vested interest, on behalf of the people for whom they purchase it, to keep the cost as low as they possibly can. So you all have that testimony.

And following your testimony, I am going to call on the Association of Health Plans to come forth and summarize what they've said.

Barbara. Which-- Is that you?

BARBARA MARCELLA: Excuse me?

ASSEMBLYWOMAN WEINBERG: Are you Barbara?

MS. MARCELLA: Yes.

ASSEMBLYWOMAN WEINBERG: State your name for the record, please.

MS. MARCELLA: Barbara Marcella.

ASSEMBLYWOMAN WEINBERG: Yes, talk very close to the microphone.

Thank you.

MS. MARCELLA: Barbara Marcella.

Since I've had all day I took some notes, because when I got up here, I'd be very nervous.

I'm here because I'm a parent of two children that have been admitted to the Cooper Trauma Unit. This is where they were taken. They

were in accidents, and it wasn't by choice, but they were taken to Cooper Hospital. I've had a wonderful experience with them. They have a team of doctors that saved their lives. I've had other experiences with hospitals in New Jersey, but my confidence lies with Cooper. If anything ever happened to my children, or anybody in my family, Cooper would be my choice. The team of doctors in the trauma department is just unbelievable.

When a child gets injured, and you have this trauma, you're not really -- you're in shock yourself, so you're not really thinking clearly. If this happens, if this health-care issue does not get solved, I'm really worried about people that would be in that situation, because if they get taken to the hospital, and they're dealing with the trauma, and they have doctors, what's going to happen when they have the follow-up care? Are they going to have to go someplace else to find new doctors after they've been -- had these treatments? When you go into trauma, they could have five different doctors. There could be so many things wrong with them. So my concern, really, is that if it is a trauma, they're going to get taken there, because it is the only trauma hospital in the area.

I don't live in the city, but Cooper helps people that live in the suburbs, too. If you get hurt in the suburb, you go to Cooper. And I just feel that if-- They're getting the care that they need in the trauma unit. But once that's over, what's going to happen? You're not in the right frame of mind to go and find different doctors because of health care.

So that's really where I'm coming from. Hopefully, I'll never have to go there again, but for the others, I'm here on their behalf, really.

MEREDITH COTÉ: Madam Chairperson?

ASSEMBLYWOMAN WEINBERG: You have to use that other microphone.

MS. COTÉ: Sorry.

Madam Chairperson, my name is Meredith Coté. I was asked to come here today to tell you my story, and put a face to the questions that you have here today, because I am one of those faces.

Four years ago, I was diagnosed with breast cancer. I went to Cooper Hospital. Dr. Grana is here. She's my physician. In November I was diagnosed with it coming back. It is now in my system. I have chosen Cooper Hospital as my facility.

What we have here today with Horizon is, Horizon is telling me that I have two choices. I can change my doctors, doctors that I have lived with four-and-a-half years, who have tried, and are desperately trying to help me survive this disease; I can go to strangers, people that I don't know, hospitals that I don't trust; I can go across the river; or I can make the choice of paying out-of-network costs. Horizon doesn't care which choice I make. But if I make the out-of-network cost choice, then I risk financial ruin because the CEO who makes \$2 million, the lawyers who sit there and make whatever money they make -- they're not going to pay my out-of-network costs.

I am the impact of what is going on right now with Cooper Hospital. I live it every day since this has started. I need all of my strength, all of my energy, all of every resource that I have to fight this disease. And part of that energy is now going to worrying about what is going to happen after April 28, when my contract with Horizon and Cooper ends. What do I do? Where do I go?

This is what Horizon says they care about? They care about their subscribers? This is their level of care? No, ladies and gentlemen of this Committee, they don't care about me. They don't care about the person that they are affecting. They care about their bottom dollar. And I implore all of you to think about that, to think about your constituents, because I'm not alone in this. There are hundreds of others out there like me.

I utilize that facility that Governor McGreevey came down the other day -- not the other day, but several months ago -- to dedicate, the Cooper Cancer Institute. That's where I go. I go there, and I've gone there for radiation treatments, over 37 treatments that I just finished. And because of where it was located, and because of the quality of that facility, I actually was able to go to work every single day. I didn't miss a day. I wasn't even late for work, because that facility was there, and I could utilize it.

During my first battle with cancer, four-and-a-half years ago, I underwent surgery, chemotherapy, and radiation. I missed, out of eight months worth of treatment, only two-and-a-half months of work. And I did that because of the care, and the treatment, and the emotional support that I received from Cooper doctors and Cooper Hospital. That's a remarkable, remarkable statistic for me. If any of you know what chemotherapy and radiation is like -- to go through eight months of that and only miss two-and-a-half months worth -- all told -- of work. This is what Cooper is about. This is what the Cooper Cancer facility is about.

I beg you, I implore you, make sure that those of us who really need this facility don't lose this facility, and don't face financial ruin because of the uncaring and unfeeling nature of a large-scale insurance company, who really

does not care about their bottom-line subscriber, but cares only for themselves.
(applause)

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Thank you, both. I know it's difficult to talk about these things.

MS. COTÉ: Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you both for coming.

The Association of Health Plans.

Michele Guhl, are you--

S T E P H A N I E K A N W I T, ESQ.: Madam Chairwoman, I'm Stephanie Kanwit. I really appreciate the opportunity to be heard this afternoon. I'm Special Counsel to the American Association of Health Plans-HIAA, a long-winded name.

We're the association representing 1,300 health plans and insurers in the United States. That includes Horizon. And we provide coverage to 200 million Americans. So we're talking not only commercial health-care plans and insurers, but we're talking the plans and insurers who deliver services to Medicare, Medicaid, SCHIP, TRICARE, etc.

I'm going to give you the Cliff Notes version of my testimony, because it's eight pages long, and in view of the late hour here-- So I really appreciate it.

But I think I can give you some very important context. Context number one is cost, and context number two is what health plans and insurers really want, which is to cooperate with the provider community, both doctors and hospitals. We need them to carry out our mission. We need them to assure affordable, accessible, and quality health care; very, very critical.

Cost crisis-- We all know what the cost crisis is. The Federal government, just last week, reported that health-care spending shot up 9.3 percent in 2002. One of the drivers of that is hospital spending. We've got--

ASSEMBLYWOMAN WEINBERG: Does that also include the cost of health insurance?

MS. KANWIT: Yes, it does. And we're spending \$1.6 trillion. It's hospital insurance, and it's all involved in that. We're talking hospital care spending at \$486.5 billion. That's up 9.5 percent.

All right, what's happening here? Our economy is growing at 3.6 percent, our health-care costs are growing at 9 percent. Employers have to think, "What are we going to do? Are we going to reduce jobs, lower wages, shift health-care costs to employees, or even refuse to have health-care benefits at all?" And the government has the same conundrum, as it is.

What we need here, everyone-- We need more cooperation to improve the system. And I detail in my paper many ways in which that can be done, Madam Chairwoman.

But I also want to mention that we are seeing -- our Association is hearing from members out there about hospital contracting techniques that are causing disruptions in service, and concern, and uncertainty for consumers. And I think this is very important.

What are we seeing: huge increases in charges, hospital charges, 40 percent, 60 percent. Secondly, no notification of charge increases. They just put them into effect; again, disruption and havoc for consumers.

Number three, refusal to accept negotiated payments. Number four, all or nothing. Take all of our hospitals in this particular network or none

at all. Some hospital systems, by the way, have 26 hospitals in them in California. Forced contract with ancillary--

ASSEMBLYWOMAN WEINBERG: Does that--

MS. KANWIT: I'm sorry.

ASSEMBLYWOMAN WEINBERG: I'm interrupting you, I know.

MS. KANWIT: That's fine.

ASSEMBLYWOMAN WEINBERG: When you say, take all of our hospitals or nothing, is that a common practice in New Jersey?

MS. KANWIT: It is a common practice across the country.

ASSEMBLYWOMAN WEINBERG: What about in New Jersey?

MS. KANWIT: It is not in New Jersey, as far as I know.

We're looking at forced contracting with ancillary facilities. For example, "If you want our hospital, you need to take our laboratories and radiology." And we're looking at termination rather than negotiation.

All right, what do we want here in the Association, in the payer community? We want a level playing field. We want free and open competition. We want innovation and efficiency. And we all need to work to do what I said in the beginning, which is deliver affordable, accessible, and quality health care.

My paper details what we can do in that area in four specific ways. I'm not going to cover it in detail except to say that number one is to reform the broken and destructive medical malpractice system. Our tort system is broken, as you know, in New Jersey, and it threatens access to care.

Number two: reform costly benefit mandates. And you have a commission here in New Jersey for which we commend you. I think that's absolutely critical, Madam Chairwoman.

Number three: explore initiatives to address the uninsured. That's a problem we all need to deal with.

And number four: improve health care quality through what we call *evidence-based* medicine.

And that is my testimony, Madam Chairwoman.

ASSEMBLYWOMAN WEINBERG: You know, I probably should have addressed this earlier to Blue Cross Blue Shield, but I found it kind of interesting, having been very involved in the medical malpractice field. And that cycle seems to say that the medical malpractice insurance companies are not doing well, whereas Blue Cross Blue Shield said we are in the cycle where insurance companies are doing well.

So there is, certainly, some split there. But I can assure you that this Committee, along with the Banking and Financial Institutions Committee -- where we have had many hearings -- will be addressing medical malpractice, and it will be done before the first quarter of this year is over.

MS. KANWIT: And I commend you, because it's a problem. We're all picking up the tab, and it's a huge tab, billions of dollars in the United States.

ASSEMBLYWOMAN WEINBERG: All right, any other quick questions or comments? (no response)

You finally wore Herb Conaway out. Thank goodness.

I said, you finally wore Dr. Conaway out. That usually doesn't happen if I haven't given him sugar during the course of the day. (laughter)

I know I have lots of notes here, which are going to take me a little while to digest, that I've made on various pieces of paper here. I'm sure that other members of the Committee feel the same way.

ASSEMBLYMAN GORDON: Madam Chair, do we have more testimony?

ASSEMBLYWOMAN WEINBERG: Oh, I'm sorry Michele.

MICHELE GUHL: That's all right, Assemblywoman.

ASSEMBLYWOMAN WEINBERG: I'm so used to seeing you that-- (laughter)

MS. GUHL: I know. I'm an old shoe.

ASSEMBLYWOMAN WEINBERG: My deep apologies.

Thank you, Bob.

Michele, go ahead.

MS. GUHL: Thanks.

I'll spare a lot of the amenities, but thanks for having me.

I think you know who I am -- Michele Guhl, President of the New Jersey Association of Health Plans.

Can I go on record as saying that my membership thinks Cooper is a wonderful facility? Can I say that publicly? This is not about the quality of care of Cooper. It's an outstanding hospital system. So I just wanted to set the record straight on that.

But you know what? On the surface, it's not hard to figure out, when there's any kind of issue between a health plan and hospital, where public

sentiment is going to fall. It's just kind of a natural thing. But like so many health-care issues, the minute you scratch a little bit under the surface, you find it's a much more complicated world than many of us think.

What are the larger problems? Some of them have been mentioned. I'm going to just bullet them out, and I'm also going to have the audacity to tell you what I think, as Stephanie does, some of the solutions for your public policy considerations may be.

I do know this from my former role with the State of New Jersey: public programs do not carry their fair share of health-care costs. Public programs do not carry their fair share of health-care costs. And because of that, our public programs in New Jersey -- Medicaid, it's already been said, pays quite poorly in this state. That's accurate. But because Medicaid and Medicare pay poorly, and providers -- like hospitals and physicians -- can't negotiate with those public payers, with whom can they negotiate the health plan?

So necessarily, what you see is much more emphasis and aggression, as it were, put -- aggressive; I shouldn't say -- aggressive negotiation happening, because that's the one payer where there's flexibility, where there's some possibility of a real income change.

According to the Medicare Payment Advisory Commission, which you call MedPAC, the Medicare program pays hospitals, on average, 1 percent below cost. According to the same source -- and this is not me -- private insurers average payments 13 percent above cost. Since -- and think about this -- according to CMS, the Center for Medicaid and Medicare Services, public funds represent close to 59 percent of a hospital's revenue, in the aggregate. It's not hard to see the predicament that hospitals fall into.

In a related and extremely important area that's been mentioned -- uncompensated care -- charity care is, as you all know, significantly underfunded in New Jersey.

I want to talk real briefly about a concept that hasn't come up, but I had to learn it, and it's very relevant-- There's no relationship between hospital costs and hospital charges. Every hospital maintains a master list of prices for specific services, called a *charge master*. Hospital markups have been raised significantly over the past five years. New Jersey has the fifth -- and there's an economist here who argues with me, saying it's the first -- worst-highest average markup among all the states. I'm quoting from *National Journal*, October 2002. That markup is 181 percent. Okay, folks? Markup charge over cost.

Now, in fairness, hospital costs have surely increased, particularly labor costs in this state. We all know about the nursing shortage and the result and impact on hospital budgets. Nonetheless, the markup is often astronomical.

Let me give you an example that is not Cooper -- I need to say that. The cost -- this the real example -- cost of a pacemaker and attendant leads -- the little wires or whatever, I'm not quite sure, that go with a pacemaker -- cost \$30,000. The bill charged to a health plan in New Jersey: \$372,000.

ASSEMBLYWOMAN WEINBERG: That doesn't mean that's what the health plan pays.

MS. GUHL: Yes, let me--

Now, while hospitals will argue that charges are merely sticker price -- which I think is where the Chairwoman is going -- and that, like an

automobile, no one pays that amount, the issue is more subtle. First of all, it's the uninsured, mostly low-income, working people with no health insurance, who are actually charged these incredible amounts. Those at the bottom, the very bottom of the income ladder, of course, get government programs.

Secondly, private payers often pay a percentage of charges. Accordingly, one can quickly see the motivation for excessive charges insofar--

ASSEMBLYWOMAN WEINBERG: And, Michele, does that not vary from hospital to hospital?

MS. GUHL: It does.

ASSEMBLYWOMAN WEINBERG: Some have a flat rate for a specific procedure.

MS. GUHL: Yes, that's why I said *often*.

ASSEMBLYWOMAN WEINBERG: And others are a percentage.

MS. GUHL: Yes.

ASSEMBLYWOMAN WEINBERG: So that's a function of the contract between the insurer and the hospital.

MS. GUHL: It is, but you can see how then it would benefit to escalate, extraordinarily, your charges if that becomes the base from which discounts are negotiated. So you're starting with a higher base.

Part of the problem relative to charging the uninsured full charges is that Medicare requires hospitals to treat Medicare and non-Medicare exactly the same, relative to gross charges. They have to do that. Hospitals have been concerned that they would lose their Medicare contracts were they to treat the uninsured differently.

Hospitals now have significant clout at the bargaining table. You may not believe me in this, so I have, in fact, attached -- and you'll have it here -- some articles from the *Wall Street Journal* and other sources that talked to the fact that the consolidation and mergers of hospital systems have given them incredible leverage, compared to what they used to have. And it's much more a level playing field than people thought.

The other point I wanted to make is that New Jersey hospitals need to become more efficient. This would save money and enhance quality.

And, as you've heard, hospital charges are the largest cost driver in rising health-care spending. People use more hospital services, and hospital services are costing, and marked up, more and more. But understand that when you quote these increases, that the hospital costs are the largest -- hospital charge is the largest component of our increasing health-care spending.

What are the answers? Let me respectfully submit for your consideration-- First and foremost, we have to address the problem of the uninsured. This is the right thing to do for the people themselves. But it's -- an important ancillary effect would be to significantly enhance the revenue for hospitals. It sounds-- As you know, it's a simple sentence, fix the problem with uninsured -- very complicated issue. The Association would be very happy to be at any table to discuss ways to do that.

Number two--

ASSEMBLYWOMAN WEINBERG: I think we did put you on the commission that's going to, hopefully, delve into this.

MS. GUHL: I think you put--

ASSEMBLYWOMAN WEINBERG: Well, I don't mean-- We put a representative of your group on that.

MS. GUHL: Thank you.

You are putting us on a lot, so I do appreciate that.

Work on all public levels to ensure that government payers do the right thing. They are the key problem here, and I was one of them.

Resist any cuts to New Jersey's Medicaid and FamilyCare programs. These are important parts of the safety net. To cut them in any way -- which I know is very tempting with the way the State budget has been -- is only going to make matters worse.

And the last thing is, work to increase accountability for all parts of the health-care system. In this regard, hospitals need to be held accountable -- we all do -- much more than we are, relative to quality, efficiency charges, and so on and so forth.

I'm going to stop and just tell you I appreciate, at this late hour, being given a couple of minutes. I do have my testimony here and a few attached articles, which I do very much urge you to take a look at in your deliberations.

ASSEMBLYWOMAN WEINBERG: Okay. Thank you very much, Michele.

MS. GUHL: Thank you.

ASSEMBLYWOMAN WEINBERG: And, first of all, on behalf of the Committee members, I want to thank those of you who stuck through-- Let's see, we started at about 10:30, so it's about five-and-a-half hours now -- stuck through this whole hearing. A particular thank you to the staff, who -- I

don't know where they get trained, but they didn't move. David Price, who represents the Office of Legislative Services; our hearing -- for the person who makes sure that actually there is a transcript of everything that took place today.

I don't know your name. What is it?

HEARING REPORTER: Rebecca Sapp.

ASSEMBLYWOMAN WEINBERG: Rebecca Sapp.

ASSEMBLYMAN CONAWAY: Good show, Rebecca.

ASSEMBLYWOMAN WEINBERG: She did not move all day.

(laughter) I don't know why you haven't made a B-line out of here. I brought her one little tiny piece of chocolate, and it seems to have done--

ASSEMBLYMAN CONAWAY: She even has a bottle of water there.

ASSEMBLYWOMAN WEINBERG: --the trick.

And, certainly, our other staff members who are here with us. We appreciate all the help you've given us. And we appreciate all the input.

I'm sure you will be hearing from this Committee in some way, shape, or form in the not-too-distant future. And in the mean time--

ASSEMBLYWOMAN QUIGLEY: Can I ask one question?

ASSEMBLYWOMAN WEINBERG: --hopefully you will settle.

ASSEMBLYMAN CONAWAY: If you get one, I want one.

(laughter)

ASSEMBLYWOMAN WEINBERG: No.

ASSEMBLYWOMAN QUIGLEY: Oh, but I feel the former commissioner left us with an incomplete picture of something. She said that the

hospital cost was \$30,000 for the pacemaker, the charge was \$300,000. What did the health plan pay?

MS. GUHL: Obviously, they pay what they negotiate to pay. I don't--

ASSEMBLYWOMAN WEINBERG: It could be a percentage or a flat fee.

ASSEMBLYWOMAN QUIGLEY: Yes, it was a lot closer to \$30,000 than \$300,000.

MS. GUHL: The problem becomes, if you use that charge--
You're right, I'm not going to fight you.

ASSEMBLYWOMAN WEINBERG: Okay, you can all discuss that after the Committee meeting is over. (laughter)

(HEARING CONCLUDED)