

Medical Society of New Jersey



APPROVAL OF PREVIOUS ACTIONS PROCEDURAL RULES OF THE HOUSE OF DELEGATES

2007 Transactions

The House of Delegates approved the Transactions of the 2007 Annual Meeting, as posted on the Medical Society of New Jersey web site.

❖ACTION TO LIMIT DEBATE ❖

The House of Delegates agreed, upon motion duly made and seconded, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House of Delegates, and that floor time in each instance shall be limited to two minutes unless exception is made by the House of Delegates.

❖Officers ❖

Richard J. Scott, MD, President
Rajendra Prasad Gupta, MD, President-Elect
Joseph H. Reichman, MD, First Vice-President
Donald J. Cinotti, MD, Second Vice-President
Charles M. Moss, MD, Immediate Past-President
Ruth J. Schulze, MD, Secretary
Robert S. Rigolosi, MD, Treasurer

❖Trustees ❖

Rafael Attiya, MD
Steven Berkowitz, MD
Michael H. Bernstein, MD
Mary F. Campagnolo, MD
Paul J. Carniol, MD
Shahid N. Haque, MD
Eugene J. Lind, MD
Alan J. Lippman, MD
Richard A. Menghetti, MD
Bruce A. Monaghan, MD
Niranjan V. Rao, MD
Michael J. Richardson, MD
Bernard J. Saccaro, MD
John S. Salaki, MD
Thomas Bojko, MD, Section on Academic Medicine
Robert A. Fuhrman, MD, Organized Medical Staff Section
Janusz S. Kornicki, MD, International Medical Graduates Section
Edward Von Der Schmidt, III, MD, Medical Specialty Societies
Sally Ilagan, MSNJ Alliance
Phyllis P. Romano, MSNJ Alliance
Erica Dommasch, Student Member
Brian Rissmiller, Student Member

❖ **Judicial Councilors** ❖

Robert A. Fuhrman, MD, Chair, First District
Michael B. Kesselbrenner, MD, Second District
Christopher E. Gribbin, MD, Third District
Stephen J. Pilipshen, Fourth District
Harry L. Chaikin, MD, Secretary, Fifth District

❖ **Appointments** ❖

Michael H. Bernstein, MD, Speaker, House of Delegates
Francis J. Lumia, MD, Vice-Speaker, House of Delegates
M. Arif Hashmi, MD, Chief Teller
Ronald A. Rigolosi, MD, Assistant Teller
Harry L. Chaikin, MD, Chief Sergeant-at-Arms
A. Ralph Kristeller, MD, Sergeant-at-Arms
Robert L. Wegryn, MD, Sergeant-at-Arms

**ALERT!!! N.J. Mandates Cultural
Competency Training for Physicians**

Election Results

OFFICE	Term	From	To	Physician/County
President-Elect	1 year	May 2008	May 2009	Joseph H. Reichman, MD Camden
1st Vice-President	1 year	May 2008	May 2009	Donald J. Cinotti, MD Hudson
2nd Vice-President	1 year	May 2008	May 2009	Niranjan V. Rao, MD Middlesex
Trustees				
2nd District	2 years	May 2008	May 2010	John W. Poole, MD* Bergen
2nd District	3 years	May 2008	May 2011	Steven P. Shikiar, MD Hudson
3rd District	3 years	May 2008	May 2011	Linda Z. Korman, MD Middlesex
3rd District	3 years	May 2008	May 2011	Michael J. Richardson, MD Middlesex
4th District	3 years	May 2008	May 2011	Mary F. Campagnolo, MD Burlington
Member-at-Large	3 years	May 2008	May 2011	Laurie S. Nahum, MD Passaic
*Elected to fill unexpired term of Bernard J. Saccaro, MD, who resigned.				
Judicial Councilors				
1st District	3 years	May 2008	May 2011	Steven A. Maser, MD Morris
4th District	3 years	May 2008	May 2011	Richard C. Hartwell, MD Ocean
AMA Delegates				
	2 years	Jan 2009	Dec 2010	S. Manzoor Abidi, MD Burlington
	2 years	Jan 2009	Dec 2010	Donald J. Cinotti, MD Hudson
	2 years	Jan 2009	Dec 2010	Rajendra Prasad Gupta, MD Mercer
	2 years	Jan 2009	Dec 2010	Walter J. Kahn, MD Monmouth
	2 years	Jan 2009	Dec 2010	Joseph H. Reichman, MD Camden
	2 years	Jan 2009	Dec 2010	R. Gregory Sachs, MD Union
AMA Alternate Delegates				

OFFICE	Term	From	To	Physician/County
	1½ years	May 2008	Dec 2009	Joseph J. Fallon, Jr., MD Camden**
	1½ years	May 2008	Dec 2009	Michael J. Richardson, MD Middlesex***
	2 years	Jan 2009	Dec 2010	David A. Ingis, MD Burlington
	2 years	Jan 2009	Dec 2010	Charles M. Moss, MD Bergen
	2 years	Jan 2009	Dec 2010	Nancy L. Mueller, MD Bergen
	2 years	Jan 2009	Dec 2010	John W. Poole, MD Bergen
	2 years	Jan 2009	Dec 2010	Niranjan V. Rao, MD Middlesex
** Elected to fill unexpired term of Eileen M. Moynihan, MD, who resigned.				
***Elected to fill unexpired term of Bernard J. Saccaro, MD, who resigned.				
Administrative Councils				
Legislation				
1st District	2 years	May 2008	May 2010	Michael P. Wujciak, MD Essex
2nd District	2 years	May 2008	May 2010	Nancy L. Mueller, MD Bergen
3rd District	2 years	May 2008	May 2010	Christopher E. Gribbin, MD Middlesex
5th District	2 years	May 2008	May 2010	Kurt W. Kaulback, MD Gloucester
Member-at-Large	2 years	May 2008	May 2010	Roderick J. Clemente, MD Essex
Medical Services				
2nd District	2 years	May 2008	May 2010	Vincent J. Giardino, MD Passaic
3rd District	2 years	May 2008	May 2010	A. Paul Rossos, MD Mercer
3rd District	2 years	May 2008	May 2010	Thomas S. Vates, III, MD Middlesex
5th District	2 years	May 2008	May 2010	Vacancy
Member-at-Large	2 years	May 2008	May 2010	Thomas E. Simpson, MD Hudson
Public Health				
1st District	2 years	May 2008	May 2010	Augusto G. Salvatore, MD Union
2nd District	2 years	May 2008	May 2010	Scott W. Zucker, MD Bergen
3rd District	2 years	May 2008	May 2010	Ted Louie, MD

OFFICE	Term	From	To	Physician/County
				Middlesex
4th District	2 years	May 2008	May 2010	Vacancy
5th District	2 years	May 2008	May 2010	Vacancy
Standing Committees				
Annual Meeting	2 years	May 2008	May 2010	Nicole A. Henry-Dindial, MD Union
	2 years	May 2008	May 2010	Tariq A. Rizvi, MD Middlesex
Finance & Budget	2 years	May 2008	May 2010	Janusz S. Kornicki, MD Union
	2 years	May 2008	May 2010	A. Paul Rossos, MD Mercer
Medical Education	2 years	May 2008	May 2010	John W. Marcus, MD Bergen
	2 years	May 2008	May 2010	Josephine Jasper, MD Passaic

Reference Committee on Constitution and Bylaws/A

❖MEMBERSHIP❖

Scott R. Schaffer, MD, Chair

Cynthia A. Kocsis, MD

David E. Konigsberg, MD

Linda Z. Korman, MD

Michael J. Spedick, MD

Guy A. Taylor, MD

Reference Committee B

❖MEMBERSHIP❖

John W. Poole, MD, Chair

Roderick J. Clemente, MD

Kevin M. Fleming, MD

James A. Fox, MD

Robert D. Huang, MD

Teresa E. Thomas, MD

President and Chair of the Board of Trustees

RICHARD J. SCOTT, MD

House Action: Filed

When we change the way we look at things, . . . the things we look at change.

ALBERT EINSTEIN

The Medical Society of New Jersey, now in its 242nd year, has faced the challenges of 2007 with renewed commitment to our founding principles—*“the advancement of the profession . . . and the betterment of the public good.”* With these goals in mind, the Board of Trustees has placed the Society firmly on a path of economic stability and sustained success. We have continued to build upon lessons learned and the value of bringing all the voices of New Jersey medicine together on behalf of the patients we serve. As we enter 2008, we find that medicine has never been more united, more organized, or more effective.

There has been a great deal of progress since the tort reform battles of 2003. We have been rebuilding, reinventing, and refocusing on our core mission. The hard choices made previously have led to a new sense of fiscal integrity and an evolution in how we communicate with each other, and with the legislature. *MSNJ e-News* now brings the issues to our desktops in real time. Calls to Action allow us to respond to concerns in minutes, not months. The entire organization is now poised to serve the next generation of physicians with an efficiency never dreamed of a decade ago. It has taken time to put these changes in place, and the Board, willing and eager for change, has embraced them.

From a functional standpoint, we have replaced the time honored traditional committee structure with one that is more nimble. Beginning in 2007, we combined many of the free-standing committees under one administrative umbrella, the Policy and Strategy Panel, which is currently chaired by Drs. Joseph Reichman and David Swee. This committee, which is comprised of the members of the Councils on Public Health, Legislation, and Medical

Services, and the Committee on Biomedical Ethics, discusses public policy in a proactive manner and with the participation of the members of these committees meeting together at one time, in one room. Issues that once were referred back to one or more of these committees or councils, at a separate meeting and at a later time, are now discussed and settled, with input and amendment by the many. By developing policy that reflects our underlying principles, we declare our positions with consensus and in a timely manner.

Now, nearly nine months into the pilot, we have already seen benefits. This forum acts like a mini–House of Delegates and involves dozens of physicians in the process. Regulators, chief medical officers of large insurance companies, and think-tank legislative groups have addressed and engaged the medical community on a variety of topics this past year. Among them are universal health care, physician rating systems, and the crises facing the New Jersey hospital healthcare delivery system. It has become a forum that is seen as the legitimate sounding board for medical issues affecting us statewide. Our traditional committees continue to meet when needed and provide input to decision making now in parallel, rather than in sequence. As it continues to evolve, the policies developed in this new forum will define us as an organization.

In 2007, we have re-established ourselves in the eyes of the physician community and the public as a legitimate partner in the formation of public health policy. Newspaper editors, public television, and even many radio stations now actively seek our positions. We have had the chance to weigh in on the proposed Medicare cutbacks, SCHIP, end-of-life care, and the need for parity when mental health and addiction services are needed. The *Philadelphia Inquirer*, *Asbury Park Press*, *Star-Ledger*, *Bergen Record*, *Courier Post*, *Press of Atlantic City*, *Trenton Times*, and NJ 101.5 have all helped us get our message out as never before.

When medicine speaks out on behalf of the public, we reclaim our position of moral authority. And the patients we serve will remember our efforts; for without their good will and commitment, we will not prevail in our future battles. New Jersey patients often have no other voice.

The Distinguished Lecture Series has drawn physicians, policy makers and the media to our new MSNJ Conference Center in Lawrenceville. Among the speakers have been Commissioner Fred Jacobs of the New Jersey Department of Health and Senior Services (DHSS), Commissioner Steven

Goldman of the Department of Banking and Insurance (DOBI), and U.S. Attorney Chris Christie, who have addressed us on a wide range of topics. The series has again established MSNJ as a center for public debate and discourse when it comes to New Jersey health policy.

We have gone a long way toward defining our collective conscience—drawing strength from our similarities, and working past our subtle differences. As the big tent under which the house of medicine unites, we have enjoyed a year of unrivalled successes. We have continued to build our excellent relationships with many specialty societies and have used our resources to unite efforts in response to economic and legislative perils. Among them:

Wrongful Death Bill—Despite heavy lobbying by the trial attorneys, a coordinated effort involving our specialty societies, New Jersey businesses, the New Jersey Hospital Association, and MSNJ flooded the governor’s offices with faxes and calls resulting in a pocket veto.

Personal Injury Protection (PIP) Fee Schedule—Proposed changes in the PIP fee schedule, which would have mortally wounded community hospitals and their ability to staff their emergency room call schedules, were vigorously opposed by MSNJ and the state’s specialty societies. After working collaboratively with DOBI to try to craft a solution, MSNJ joined litigation seeking an injunction against the schedule, maintaining the position that the statutory requirement of a fee schedule incorporating reasonable-and-prevailing fees at the 75% level “had not been met by the insurance industry/DOBI proposal.” MSNJ provided the only expert witness in the discussion, Stephen Foreman, PhD, a leading healthcare economist and professor of economics at Robert Morris University. On September 28, 2007, two days before the new schedule was to be implemented, the court agreed with our position that a full hearing was required to review whether the DOBI proposal met the requirement. Since that time, Ingenix Inc., the consultant for the insurance carriers who helped craft their proposed fee schedule, has been investigated by the N.Y. State Attorney General, Andrew Cuomo, for “. . . distorting the data which they use to determine usual and customary fees,” which, in New York, has led to higher payments by policy holders. The New Jersey trial, which begins in late spring, should prove quite interesting. In the meantime, we continue to support proposed legislation in the senate and assembly that supports our position, while working with the DOBI to see if an agreeable fee schedule can be designed

that will insure continued trauma coverage in both trauma centers and community hospitals.

Proposal on Out-of-Network (OON) Fee Regulation—This significant change, proposed by DOBI in December 2006, led to a series of MSNJ town hall meetings with state government and to the formation of a work group comprised of an alliance of stakeholders. As a result, the commissioner noted that he and his staff learned a great deal about both out-of-network and in-network fees, and the potentially detrimental effect of the proposal. As a result, it was allowed to sunset in December of 2007.

Aetna Fined for Underpayments to OON Physicians—After receiving complaints from the New Jersey State Society of Anesthesiologists (NJSSA) and their surgical colleagues, MSNJ formally protested to DOBI the practice of unilaterally setting out-of-network fees at 125% of Medicare because doing so devalued the health insurance policies and led to higher out-of-pocket expenses for consumers. DOBI responded in dramatic fashion, levying a \$9,457,500 fine on the insurer. More important, it sent a clear message to other carriers who were carefully monitoring the situation and no doubt planning a similar course.

United HealthCare/Oxford—The Aetna fine was the second time DOBI had intervened on behalf of the Garden State’s physicians to protect them from managed care abuses in 2007. In late 2007, United HealthCare/Oxford declared its intention to penalize network physicians when they sent insured patients to other than the preferred lab for testing. MSNJ took the position that such a change would require contract amendment and should not be condoned from a regulatory standpoint. DOBI agreed, and New Jersey providers were spared from another onerous and costly condition of participation. Well aware of the support DOBI has shown for medicine in New Jersey, and equally aware of MSNJ’s successes in their class-action lawsuits against Horizon, Cigna, and others, United HealthCare has reached out to MSNJ and the specialty societies to develop a strike force with the intention of addressing process and provider-relations issues. It’s a step in the right direction.

ASC’s: Court Rules on Self-Referral—A New Jersey Superior Court case, *Garcia v. Healthnet of New Jersey*, recently considered whether physicians with ownership interests in ambulatory surgical centers (ASC) committed healthcare fraud or violated the Codey Law that prohibits a practitioner from

referring a patient to a healthcare service in which the practitioner has a significant beneficial interest. While the court found no healthcare fraud, its finding, with respect to the Codey Law, is troubling. The court found that physicians who perform surgery on their own patients at ambulatory surgical centers in which they are owners violate the Codey Law, even though they meet all the requirements set forth by STARK II. This is the first such interpretation of the Codey Law and is inconsistent with prior advisory opinions of the New Jersey Board of Medical Examiners (BME) that have recognized an exception for a “medical office” that can include more than one site, as well as with federal guidelines that define “safe harbors.”

When the BME weighed in with proposed emergency regulations, the cure quickly became more problematic than the disease. With our attorneys from WolfBlock at our side, we were able to get the in-network requirement removed from the proposal, but still opposed the remainder of it, believing that there was no “imminent peril to the public health” that required circumvention of the usual rulemaking process. The New Jersey Attorney General agreed with our position, and now we are working with Sen. Richard Codey to find a legislative solution. As I write this, we continue to support the position that would preserve the status quo and allow future physicians coming to New Jersey to build and invest, with their hospitals and others, in the competitive delivery of high quality healthcare. Anything less will make New Jersey an even less competitive choice for the next generation of medical talent as they consider where they wish to live, and practice.

Aetna Anesthesia Policy Change—Representatives and legal counsel for the New Jersey State Society of Anesthesiologists (NJSSA), the New Jersey Gastroenterology and Endoscopy Society (NJGES), the Pennsylvania Society of Anesthesiologists (PSA), and the Medical Society of New Jersey met in February 2008 with Troy Brennan, MD, senior vice-president and chief medical officer, to discuss Aetna’s policy change to not cover full sedation for colonoscopies, effective April 1, 2008. After meetings with both DOBI and Aetna on behalf of these societies, Aetna agreed to postpone implementation of this policy.

Colonoscopy continues to be one of the most effective tools in the screening of colon and rectal cancer. Any restriction on the anesthesia that would make anxious patients less likely to submit to annual screening is poor public

policy. For years, the standard of quality care has been the sedation of patients by an anesthesia provider who is qualified to administer Propofol.

MSNJ is also working toward a legislative solution, in the event Aetna and our physicians who provide care do not reach agreement. We are actively supporting A-2056 and several other bills that have been introduced in the beginning of this year's legislative session. These bills will address the policy change through a legislative prohibitive mandate, and the legislative support is very strong.

In the meantime, should legislators present for their annual procedure, offer them Valium and ibuprofen and ask them for their support as you transit the sigmoid colon. But seriously, wouldn't it be nice if all our lobbying on the public's behalf could be so effectively addressed? Nothing would crystallize the point like direct personal experience. Just because something can be done without anesthesia, doesn't mean the two approaches are equal. Ask any mother who's had an epidural help her through a difficult labor.

Scope of Practice—We continue to stand guard against the ever present economic forces that repeatedly attempt to confer, through *legislation*, what was not earned through *education*. The title of physician has been sought by physician assistants, physical therapists, and chiropractors. As each bill is brought forward, MSNJ stands ready to make sure the public is not misled by deceptive titling of non-physicians. Twice this past year, we have worked to oppose bills that would have changed dramatically the scope-of-practice of chiropractors. Incredibly, this misguided legislation would have allowed them the ability to perform sports physicals and insurance evaluations, further confusing the public as to what constitutes a true primary care physician.

Although it has been said that all politics is local, all healthcare policy is not. As a nation we are bracing for a presidential election that could change significantly our healthcare delivery system. Congress has yet to find a long-term solution to Medicare funding, and we have only a six month reprieve from a 10% cut in physician reimbursements. New Jersey hospitals face an 11% cut between 2009 and 2013, translating into a \$2.9 billion dollar decrease. The AMA and our specialty societies will continue to make our case to congressional leaders that the healthcare of our senior citizens should remain a priority.

As I turn the reigns over to Dr. Raj Gupta in May, I wish you all to know that I am proud of the effort MSNJ has put forth in 2007 on behalf of all the physicians in New Jersey and their patients. The county executives should be commended for their willingness to pilot new models. Michael T. Kornett, our CEO, has assembled a first-class organization and helped us navigate through some troubled waters. In just a few years, working with an activist Board of Trustees, he has refocused on our core mission. We have changed our approach to membership, worked in synchrony with our specialty societies, embraced new membership models, and reclaimed our rightful place in the public debate. The MSNJ Conference Center now plays host to medical, political, and business leaders from, not just New Jersey, but, often, the entire nation. Our members benefit from the expertise of Julie Lynch, CFO/COO; general counsel and director, public health, Larry Downs; senior manager, physician practice advocacy, Melinda Martinson; and manager, member outreach, Lisa Hibbs. I would especially like to make mention of two superb additions in 2007. Director, legislative affairs, Eileen Kean, has proven to be a wonderful in-house complement to the excellent representation MSNJ enjoys from Clark and Tim Martin of MBI GluckShaw. Between them, MSNJ stays on top of the issues and gets our points made on both sides of the aisle. She deserves a great deal of the credit, with MBI, in our many successes this past year. Senior manager, marketing and communications, Daniel Klim is our other Rookie of the Year. Working above and beyond the call of duty, Dan has accompanied me to many medical staff meetings around the state and has been instrumental in reinvigorating our relationships with the media. Thanks to Dan, and Judith Martin Waterman, we get our hard work into the store window for all to see. They have given us a state-of-the-art web site that reflects the sophistication and level of service we now provide. And working with Michael Kornett to deliver added value, the team has grown our member-benefit list to include discounts from Verizon, Geico, and WolfBlock—*the value of which now far exceeds the cost of membership.*

On a personal note, I'd like to thank you, the membership, for the opportunity to be your leader this past year. You have welcomed me to your counties and into your hospitals, with grace, professionalism, and enthusiasm. Your passion has made light the work.

It has been an honor of which I will be proud all the days of my life.

Committee on Revision of Constitution and Bylaws

Robert A. Fuhrman, MD, Chair

House Action: Adopted as Amended

❖**Bylaw Amendment Creating a New Category of Membership**❖

In 2007 the Board of Trustees recommended amending the Bylaws to create a new category of membership. This matter was properly referred to the Standing Committee on Revision of Constitution and Bylaws for action.

The committee met twice to outline the standards, eligibility, and privileges of Associate Membership. The committee balanced the competing need to grow the MSNJ membership with the need to retain a strong federated County–State membership model. After study, the committee makes the following recommendations:

1. The committee recommends reserving the current Affiliate Member category for non-physician employees of MSNJ members.
2. The committee recommends creating a new membership category of Associate Members.
3. The committee recommends the new category of Associate Member be reserved for those physicians who are Never Members of MSNJ and those previous members who have lapsed in their membership for at least two years.
4. The committee recommends that Associate Membership be offered only to academic, research, and administrative physicians and members of New Jersey–based physician organizations that are approved by the Board of Trustees.
5. The committee recommends that Associate Members may not vote or hold office. Associate Members will enjoy only such benefits and

privileges authorized by the Board of Trustees. Associate Members will not have access to any county level programs or services unless they are participants in reciprocal county level memberships.

CHAPTER I — MEMBERSHIP

Section 1 — Composition

This Society shall be composed of Fellows, officers, delegates, all members of component societies in good standing, emeritus members, and complimentary members. Honorary members may be elected, but they shall not be members of the corporate body. Affiliate and Associate membership may be granted, but recipients may neither vote nor hold office.

(a) Fellows

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall, at the completion of this term, become a Fellow of this Society. (Footnote: The "immediate past-president" is that living past-president between whom and the presidency no succeeding living past-president intervenes.)

(b) Officers

The officers shall be the President, President-Elect, First Vice-President, Second Vice-President, Immediate Past-President, Secretary, Treasurer, and elected members of the Board of Trustees.

(c) Members of Component Societies

All members of component societies in good standing are hereby constituted members of this Society and are entitled to full privileges.

Any physician-in-training members in good standing of component societies are hereby constituted associate members of this Society, but they may not vote or hold office.

(d) Emeritus Members

A member seeking emeritus status must be so approved by vote of the House of Delegates. To be eligible for consideration, a member must be in good standing and have paid all current state and county dues assessments. The member must be fully retired from the practice of medicine and have no other gainful employment or any practice income. If the member has retired because of illness or disability, that condition must be documented. Members retiring because of age must be at least 65 years of age.

Emeritus members shall have all privileges of membership except the right to vote and hold office. They shall not pay dues and are not to be included in the membership count for apportionment of delegates or allocation of Trustees.

(e) Complimentary Members

Complimentary memberships shall be extended to the non-member presidents and non-member incoming presidents of all acute care hospital medical staffs in New Jersey.

(f) Honorary Members

Any person other than members of the Medical Society of New Jersey may be nominated by the Board of Trustees for election as honorary members. Nominees shall be elected by a two-thirds vote of the House of Delegates during any session. Honorary members shall not be members of the corporate body and at no time may the number of living honorary members exceed 25.

(g) Affiliate Members

Affiliate members shall be non-physician employees of member physicians.

Affiliate members may not vote or hold office, but may participate in meetings, educational programs, receive publications, and are otherwise eligible for certain membership benefit programs as determined by the Board of Trustees.

The dues for affiliate members shall be established by the Board of Trustees pursuant to recommendation from the Committee on Finance and Budget.

(h) Associate Members

Associate members shall be physicians having achieved the degree of MD or DO who are:

1. working in academia, research, or administration, or
2. members of New Jersey–based medical societies or other large groups of physicians as approved by the Board of Trustees.

Associate members may not vote or hold office but may participate in MSNJ meetings, educational programs, receive publications, and are otherwise eligible for certain membership benefit programs as defined by the Board of Trustees.

Component medical societies may offer reciprocal Associate membership at their discretion.

The dues for Associate Members shall be established by the Board of Trustees pursuant to recommendation from the Committee on Finance and Budget.

All associate members of the state must become members of a county of their choice with county dues determined as a percentage of the state dues as determined by the Board of Trustees.

CHAPTER XI — COMPONENT SOCIETIES

Section 1 — Charters

(a) County medical societies of this state that shall adopt principles of organization in accordance with the Constitution and Bylaws of this Society may, upon application to the House of Delegates, be granted a charter, and thereby become a component society in affiliation with the Medical Society of New Jersey as hereinafter provided.

(b) Charters may be issued, under the Seal of this Society and signed by the President and the Secretary, to county societies having at least ten members. There shall be only one component society chartered in each county. Upon recommendation of the Judicial Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and Bylaws.

Section 2 — Qualifications of Members

(a) Membership may be initiated either through a component society or this Society. Component societies shall have the responsibility to judge the qualifications of applicants for any type of membership and alone shall have the power to elect them, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society. Resident physicians shall apply simultaneously to the Society and a component society. If the credentials are in order, the State Society may grant a provisional membership for six months. During that time, the physician shall complete the county application process.

(b) To be eligible for membership, the applicant must:

- Be fully licensed to practice medicine and surgery by the New Jersey state Board of Medical Examiners;
- Be legally registered under that license in a county of New Jersey;
- Be of good moral and ethical standing; and
- Not support, or practice, or claim to practice, any exclusive system of medicine.

(c) When a physician applies to a component society for membership in any category, or for membership by transfer from another state, the secretary of the component society shall forward the name and address of the applicant to the physician's biographic records department of the American Medical Association for such information as may be on file relative to the applicant's record.

(d) All records of formal actions concerning new and transfer members shall be compiled on forms to be supplied by the Committee on Credentials.

(e) Members are expected to engage in continuing medical education programs and earn credits equal to the standards of MSNJ's Physician Recognition Award. The award program is administered by the Committee on Medical Education according to policies approved by the Board of Trustees and the House of Delegates.

Section 3 — Transfers

An applicant for membership by transfer who holds membership in a component society in this or another state society, and whose credentials have been formally approved, may be elected to membership without a probationary period at the discretion of the component society.

Section 4 — Physician-in-Training Members

(a) Physician-in-training members shall be those physicians admitted to component societies who otherwise comply with Section 2 of this Chapter, be they licensed or unlicensed to practice medicine and surgery in New Jersey, who are serving in approved internships, residency programs, or fellowships or are members of the Medical Society of New Jersey Student Association.

(b) Physician-in-training members shall have such privileges in component societies as the constitution and bylaws of the respective societies may provide, except the right to vote and hold office.

(c) The dues for physician-in-training members shall be established by the Board of Trustees on recommendation of the Committee on Finance and Budget.

Secretary

RUTH J. SCHULZE, MD

House Action: Filed

The Office of the Secretary has continued its usual activities, including maintenance of membership records, correspondence, minutes of Board of Trustees meetings, telephone inquiries, and completion of numerous questionnaires from various sources. During the administration year, the secretary attended meetings of the Board of Trustees and the several committees of which she is chair, member, or advisor.

Membership. The following table shows the membership figures through December 31, 2007.

Active	Paid	4,974
	Exempt	277
Resident	Exempt	21
	Subtotal	*5,272
Associate	Exempt	43
Affiliate	Paid	11
State emeritus		1,842
Medical staff presidents		12
	TOTAL	7,180
Student members		217
New and reinstated members	Active paid	510
	Active exempt	12
	Resident	21
	Associate	42
	Emeritus	1
Transfers within the state		44
Transfers out of state and resignations		52
		60
Members deceased		
Members dropped		783
Active members:		
a. Nonpayment of dues		778
b. New Jersey license revoked		3

<i>Affiliate members:</i>		
a. Nonpayment of dues		5

Associate membership (non-licensed in New Jersey) designated interns and residents.

Affiliate membership designates physicians who no longer practice in New Jersey.

*Adjusted for transfers out of state, resignations, and deaths.

A comparison of December 31, 2006, to December 31, 2007, by county shows the following net changes of active paid membership:

Atlantic	-20	Gloucester	+7	Ocean	-14
Bergen	-38	Hudson	-19	Passaic	-11
Burlington	-25	Hunterdon	+5	Salem	-2
Camden	-14	Mercer	-10	Somerset	-8
Cape May	-2	Middlesex	+5	Sussex	+3
Cumberland	-6	Monmouth	- 4	Union	-20
Essex	-39	Morris	-16	Warren	-3

AMA Membership. A total of 6,304 New Jersey licensed physicians are active AMA members. MSNJ has 9 delegates in the AMA House of Delegates—one for each thousand members or fraction thereof.

Credentials. The Committee on Credentials reviewed and acted upon membership applications and the supporting credentials as submitted through the component societies. The following statistical breakdown reflects the Committee on Credential’s activities during the period January 1, 2007, through December 31, 2007.

	Residents Associate	Residents Licensed	Medical Staff Presidents	Active	Grand Total
Received	29	6	1	328	364
Reviewed and found					
Satisfactory	29	6	1	320	356
Unsatisfactory	0	0	0	0	0
Pending	0	0	0	5	5
Withdrew	0	0	0	3	3
GRAND TOTAL	29	6	1	328	364

Associate membership (non-licensed in New Jersey designated interns and residents).

The Committee on Credentials extends appreciation to the directors and secretaries of component societies, to those who assist them, and to the county credentials committees, for their cooperation in processing membership applications. The chair wishes to thank the members of the Committee on Credentials.

Nominations for Emeritus Membership

House Action: Approved

The following nominations for election to emeritus membership at the 2008 Annual Meeting have been received from the component societies. Those listed below conform to the provisions of the Bylaws, Chapter I – Membership Section 1 – Composition (d).

❖Atlantic ❖

Elliott M. Kraus, MD, Margate City, age 67
Daniel M. Kwa, MD, Somers Point, age 66
Gastone Anthony Milano, MD, Ventnor City, age 81
Marc R. Peck, MD, Atlantic City, age 70

❖BERGEN ❖

Frank De Maria, Jr., MD, Mahwah, age 73
Sybil E. N. Duchin, MD, Wyckoff, illness
Randolph R. Estwick, MD, Harrington Park, age 83
Martin N. Hochberg, MD, Ridgewood, age 71
John Kandra, MD, Park Ridge, age 77
John Paul Mudry, MD, Franklin Lakes, age 75
Leslie Joel Shalan, MD, Closter, age 75
Michael S. Slade, MD, Fair Lawn, age 65
David M. Stewart, MD, Hillsdale, age 65
Arundhati H. Vinod, MD, Tenafly, age 66

❖BURLINGTON ❖

George Geoffrey Flamm, MD, Beverly, age 77
Brian D. Geary, MD, Medford, age 65
Allen J. Steinberg, MD, Mount Laurel, age 77
Saul M. Tischler, MD, Cherry Hill, age 68

❖CAMDEN❖

Jonathan H. Cilley, Jr., MD, Moorestown, illness
Nils Gustaf Herdelin, Jr., MD, Haddonfield, age 69
Mark Stern, MD, Cherry Hill, age 67

❖ESSEX❖

Mercy K. Co, MD, North Caldwell, age 66
Frederick W. Fuller, MD, Newton, age 81
Stanley Robert Kern, MD, West New York, age 80
George Schneider, MD, Livingston, age 69

❖HUDSON❖

Joseph Francis Inzinna, MD, Secaucus, age 80
Bernabe Loret De Mola, MD, West New York, age 74
Lino O. Mier, MD, Cresskill, age 71

❖HUNTERDON❖

Richard Wilson Oliver-Smith, MD, Westfield, age 88
Robert L. Pierce, MD, Clinton, age 84
Kenneth G. Stern, MD, Somerset, illness

❖MERCER❖

Joyce R. Zissman, MD, Princeton, age 70

❖MIDDLESEX❖

Edward L. Blackman, MD, Monroe Twp., age 66
Irwin Litt, MD, Princeton, age 71
Smita M. Modi, MD, Colonia, age 67
Virgilia G. Nebab, MD, Piscataway, age 72

❖MONMOUTH❖

Joseph Gordon Boak, MD, Ocean, age 66
James P. Cashman, MD, Spring Lake, age 70
Sae Chan Chang, MD, Holmdel, age 66
Anand Swaroop, MD, Neptune, age 65

George A. Williams, Neptune, age 70

❖**MORRIS**❖

Lawrence P. Floriani, MD, Florida, age 69
Edward J. Hymes, MD, Maine, age 71
Philip K. Keats, MD, Bernardsville, age 65
Meryl H. Ram, MD, Chester, age 66
Rajindar G. Sawhney, MD, Short Hills, age 73
John G. Valeri, MD, Basking Ridge, age 74

❖**OCEAN**❖

Charles A. Binder, MD, Toms River, age 71
Gregory M. Borsuk, MD, Brick, age 72
Ralph Kuhn, MD, Manahawkin, age 70

❖**PASSAIC**❖

Eva Muller, MD, Wayne, age 80
Vida T. Vida, MD, Wayne, age 70

❖**SALEM**❖

Jin-Pill Kim, MD, Salem, age 77

❖**SOMERSET**❖

Ching-Ming Chen, MD, Martinsville, age 70
Richard Gilbert Lathrop, MD, Warren, age 78
Michael J. McCarthy, MD, South Carolina, age 75

❖**UNION**❖

Frederick C. Braun, Jr., MD, Westfield, age 79
Roy C. Cabrera, MD, Warren, age 67
John W. Ferrante, MD, Edison, age 72
Jerold B. Graff, MD, Scotch Plains, age 66
Carl H. Herman, MD, New Providence, age 70
Watkins Fletcher John, MD, Edison, age 80
Frank J. Laudonio, MD, Arizona, age 75

Thomas Logio, MD, Mountainside, age 67
Esteban R. Lomnitz, MD, Westfield, age 70
Francisco J. Miranda, MD, Scotch Plains, age 82
Michael Marcel Plate, MD, Cranford, illness
Abdulwahab Qaraman, MD, Cranford, age 72
Bernard Louis Rosenberg, MD, Linden, age 85

Nominations for Emeritus Membership Supplemental

House Action: Approved

❖**MORRIS** ❖

William Carroll Colston, MD, Morristown, age 73

Treasurer

Robert S. Rigolosi, MD

HOUSE ACTION: FILED WITH COMMENDATION

These interim financial statements reflect the financial position and results of operation of the Medical Society of New Jersey through January 31, 2008.

Since they are interim statements (the Society's fiscal year is June 1 – May 31) the figures are unaudited. A complete audit of the financial records of the Society will be conducted as of May 31, 2008, and an audited report prepared as of that date. A complete audit was made for the fiscal year that ended May 31, 2007.

Medical Society of New Jersey
BALANCE SHEET
For the Eight Months Ending January 31, 2008

ASSETS

Cash		\$2,311
Investment in Money Market Fund		527,313
Marketable Securities	3,034,947	
Adjust to Market Value	<u>(134,317)</u>	
		2,900,630
Accounts Receivable - Member Dues		669,885
Medical Student Loans	101,766	
Less Allowance for Doubtful Loans	<u>(38,500)</u>	
		63,266
Property, Plant, and Equipment		
Furniture and Fixtures	<u>761,274</u>	
	761,274	
Less Allowance for Depreciation	<u>(531,210)</u>	
		230,064
Prepaid Expenses		44,880
Deferred Tax - Current		16,488
Other Assets		36,267
Deferred Tax - Non-Current		259,346
Investment in Lawrenceville Realty Associates, LLC		615,000
Investment in Subsidiaries		<u>(3,246)</u>
Total Assets		\$5,362,206

LIABILITIES AND FUND BALANCE

Accounts Payable		\$4,598
Payable to AMA		7,620
Accrued Annual Meeting Costs		53,508
Other Accrued Expenses		293,322
Unfunded Pension Liability		341,528
Deferred Rev. from Member Assessments		2,178,000
Deferred Revenue/Other		58,425
Deferred Gain on Sale of Building		1,506,125
Deferred Revenue-Advocacy Educational		96,116
Deferred Revenue-Advocacy Political		26,540
Fund Balance - Prior Years	975,519	
Fund Balance - Current	(330,626)	
Restricted Balance -NJ Spine Society Section	127,030	
Restricted Balance- NJ Pain Management Society	<u>24,500</u>	
		<u>796,422</u>
Total Liabilities and Fund Balance		\$5,362,206

MEDICAL SOCIETY OF NEW JERSEY
STATEMENT OF REVENUE AND EXPENSES
For the Eight Months Ending January 31, 2008

	F/Y '04-05	F/Y '05-06	F/Y '06-07	F/Y '07-08
Revenue				
Membership Dues	\$1,446,502	\$1,461,374	\$1,566,101	\$1,528,646
Investment Income	135,137	139,617	132,863	185,016
Equity Ownership Income	25,200	32,700	39,900	39,900
Corporate Partner Program	60,552	43,110	100,165	167,492
Annual Meeting Contributions	16,415	39,480	16,850	16,300
Contribution from MSLF	266,667	133,333	166,667	
Advocacy Income	78,583	143,642	196,146	262,101
CME Fees and Registration Income	48,750	37,925	27,650	51,040
Claims Review				6,760
Legal Defense Fund	30,000	5,250		
Management Fee re: MSLF	1,297	968	362	972
Management Fee re: Health Ins. Trust Fund	4,304	4,396	3,904	3,983
MRAC Indirect Cost Reimbursement	3,333	3,333	3,333	
Medical Practice Manager Dues and Fees	2,368	12,930	10,650	14,320
Gain on Investment	23,638	39,184	35,773	27,803
Gain on Sale of Building	54,893	54,893	61,755	61,755
Other Income	698,278	127,635	23,355	58,516
Total Revenue	\$2,895,917	\$2,279,771	\$2,385,474	\$2,424,604
Expenses				
Councils, Committees, and Communication	\$194,163	\$150,898	\$180,018	\$212,633
Advocacy Expenses Educational	47,221	10,313	46,146	62,101
Advocacy Expenses Political	31,362			
Membership Recruitment & Retention	16,136	20,535	41,715	98,835
Claims Review				2,414
Membership Services	596,085	105,754	89,169	85,108
Program Expenses	884,966	287,500	357,048	461,090
General and Administrative	1,934,762	1,784,790	1,786,255	1,748,100
Reorganization Expense	171,289	(29,000)		
Rent Expense	235,198	215,550	206,848	164,470
MSLF Operating Expenses	401,297	136,937	167,028	712
Legal Defense Expenses	49,162			
Loss on Sale of Investment	24,544	36,301	77,036	75,623
Depreciation	21,477	25,243	27,929	29,368
Total Operating Expenses	3,722,696	2,457,322	2,622,144	2,479,363
Total Gain (Loss) from Operations	(826,779)	(177,551)	(236,670)	(54,759)
Unrealized Loss (Gain) on Investments	122,394	(77,772)	(189,339)	266,060
Total Operating Expenses and Unrealized Investment Activity	\$3,845,089	\$2,379,550	\$2,432,805	\$2,745,423
EXCESS OF REVENUE OVER EXPENSES (Before Federal Income Taxes)	(949,172)	(99,779)	(47,331)	(320,819)
Provision for Federal Income Tax	14,809	9,807	9,807	9,807
EXCESS OF REVENUE OVER EXPENSES	(\$963,981)	(\$109,587)	(\$57,138)	(\$330,628)

**MEDICAL SOCIETY OF NEW JERSEY
ANALYSIS OF EXPENSES
Period Ending January 31, 2008**

	<u>2007</u>	<u>2008</u>	<u>Budget</u>	<u>Over (Under) 2008 Budget</u>
Compensation				
Salaries	\$1,088,377	\$1,104,839	\$1,125,333	(\$20,494)
Personnel Insurance	132,809	115,688	153,333	(37,645)
Payroll Taxes	73,508	78,206	93,333	(15,127)
Pension Plan	100,000			
Employer Contribution 401(K)	(9,654)	61,289	68,000	(6,711)
	<u>1,385,040</u>	<u>1,360,022</u>	<u>1,439,999</u>	<u>(79,977)</u>
Professional Fees				
Audit	15,333	15,333	20,000	(4,667)
Legal	42,987	24,270	63,333	(39,063)
Actuarial	21,747	1,050	10,000	(8,950)
Special Consultants	9,361	8,121	18,667	(10,546)
	<u>89,428</u>	<u>48,774</u>	<u>112,000</u>	<u>(63,226)</u>
Councils, Committees, and Communication				
Communications	33,644	38,153	30,000	8,153
Internet Site	1,871	21,332	13,333	7,999
Legislation	46,968	42,864	40,000	2,864
President and Presidential Officers	756	7,535	10,000	(2,465)
AMA Delegation	61,557	58,193	41,333	16,860
IMG Section			1,333	(1,333)
Young Physician Delegates	2,156		2,000	(2,000)
Medical Education	12,143	15,826	26,667	(10,841)
Board of Trustees	7,183	6,275	13,333	(7,058)
Other Councils and Committees	7,856	10,406	10,000	406
Medical Student Association	2,251	8,379	6,667	1,712
Medical Practice Managers Section	3,633	3,670	6,667	(2,997)
Recruitment and Retention	41,715	98,835	63,333	35,502
	<u>221,733</u>	<u>311,468</u>	<u>264,666</u>	<u>46,802</u>
Member Services				
Annual Meeting	69,904	58,667	58,667	
Newsletter	19,226	25,376	26,667	(1,291)
	<u>89,130</u>	<u>84,043</u>	<u>85,334</u>	<u>(1,291)</u>
General Admin. & Operating Exp.				
Bldg. Operations w/Depreciation	82,357	79,606	84,000	15,606
Rent Expense	206,848	164,470	176,667	(12,197)
Corporate Insurance	76,858	62,356	83,333	(20,977)
Other General Office Costs	180,540	227,774	171,333	56,441
	<u>546,603</u>	<u>534,206</u>	<u>495,333</u>	<u>38,873</u>
Total	<u>\$2,331,934</u>	<u>\$2,338,513</u>	<u>\$2,397,332</u>	<u>(\$58,819)</u>

Committee on Finance and Budget

Steven Berkowitz, MD, Co-Chair
Bruce A. Monaghan, MD, Co-Chair

HOUSE ACTION: FILED

The Committee on Finance and Budget met via conference call on Tuesday, March 4, 2008, for the purpose of reviewing the proposed budget for the 2008–09 fiscal year. The proposed budget was approved by the Board of Trustees on March 16, 2008.

- The 2009 assessment will be set at \$525.00 per regular dues-paying member. (No change from prior year.)
- The 2009 dues payment will be set at \$60.00 per member for affiliate members. (No change from prior year.)
- There will be no dues assessment in 2009 for associate members (interns-residents-fellows non-licensed in New Jersey) and licensed residents, provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school. (No change from prior year.)
- There will be no dues assessment for 2009 for medical students. (No change from prior year.)

**MEDICAL SOCIETY OF NEW JERSEY
PROPOSED BUDGET
FISCAL YEAR ENDING MAY 31, 2009**

REVENUE	Budget Y/E 5/31/2008	Budget Y/E 5/31/2009
Membership Dues Revenue	\$ 2,410,000	2,410,000
Investment Income	195,000	175,000
Equity Ownership Income LRA, LLC	62,700	62,700
Equity Ownership Income MSNJ Insurance Agency	-	55,000
Corporate Partner Income	300,000	325,000
Claims Review Revenue	-	20,000
Management Fees	50,000	97,000
Medical Practice Mgr. Dues & Program Income	12,000	12,000
CME Fees & Registration Income	86,000	127,000
Annual Meeting Sponsorship	40,000	60,000
Advocacy Donations	300,000	300,000
Other Income	50,000	50,000
	<hr/>	<hr/>
TOTAL REVENUE	\$ 3,505,700	\$ 3,693,700
EXPENSES		
Councils and Committees	\$ 397,000	\$ 412,000
Member Services	128,000	128,000
	<hr/>	<hr/>
TOTAL PROGRAM EXPENSES	\$ 525,000	\$ 540,000
General and Administrative	\$ 3,071,000	\$ 3,152,400
	<hr/>	<hr/>
TOTAL EXPENSES	\$ 3,596,000	\$ 3,692,400
Revenue Over Expenses	<hr/>	<hr/>
(Expenses Over Revenue)	\$ (90,300)	\$ 1,300

MEDICAL SOCIETY OF NEW JERSEY
Proposed Budget for Fiscal Year Ending 5/31/09

	Budget Y/E 5/31/2008	Proposed Budget Y/E 5/31/2009
COMPENSATION		
Salaries	\$ 1,688,000	1,740,000
Personnel Insurance	\$ 230,000	195,000
Payroll Taxes	\$ 140,000	130,000
401K Plan	\$ 102,000	104,400
	<u>\$ 2,160,000</u>	<u>2,169,400</u>
PROFESSIONAL FEES		
Audit	\$ 30,000	25,000
Legal	95,000	95,000
Actuarial	15,000	15,000
Special Consultants	28,000	28,000
Claims Review	0	8,000
	<u>\$ 168,000</u>	<u>\$ 171,000</u>
COUNCILS & COMMITTEES		
Communications	\$ 45,000	45,000
MSNJ Website	20,000	20,000
Legislation	60,000	72,000
President & Presidential Officers	15,000	15,000
AMA Delegates	62,000	62,000
Young Physician Delegate	3,000	3,000
IMG Section	2,000	-
Medical Education	40,000	40,000
Board of Trustees	20,000	20,000
Other Councils & Committees	15,000	15,000
Medical Student Association	10,000	10,000
Membership Recruitment & Retention	95,000	100,000
Medical Practice Manager Section	10,000	10,000
	<u>\$ 397,000</u>	<u>\$ 412,000</u>
MEMBER SERVICES		
Annual Business Meeting	\$ 88,000	88,000
Newsletter	40,000	40,000
	<u>\$ 128,000</u>	<u>\$ 128,000</u>
BUILDING OPERATIONS		
Depreciation	\$ 41,000	45,000
Rent	265,000	270,000
Light, Heat, & Power	30,000	40,000
Building Maintenance	25,000	25,000
	<u>\$ 361,000</u>	<u>\$ 380,000</u>

GENERAL ADMINISTRATIVE &
OPERATING EXPENSES

Postage	\$ 15,000	25,000
Stationery & Supplies	36,000	36,000
Telephone	35,000	42,000
Rent & Service Equipment	34,000	34,000
Printing	35,000	35,000
Membership Dues	3,000	3,000
Subscriptions & Services	10,000	10,000
Miscellaneous Expenses	8,000	8,000
Dues Rebates	17,000	15,000
Travel & Education	45,000	45,000
401K Administrative Fees	9,000	9,000
Financial Fees	-	40,000
Temporary Help	10,000	10,000
Corporate Insurance	125,000	120,000
	<u>\$ 382,000</u>	<u>\$ 432,000</u>
 TOTAL	 <u>\$ 3,596,000</u>	 <u>\$ 3,692,400</u>

Judicial Council

Robert A. Fuhrman, MD, Chair

House Action: Filed

The Judicial Council of the Medical Society of New Jersey (MSNJ) serves as the dispute-resolution arm of MSNJ. The Council receives and reviews complaints from the public and others regarding physician conduct, billing practices, and various disputes. The Council accepts complaints, refers matters that involve an MSNJ member physician to local judicial councils for review and decision. Decisions of the Judicial Council and local judicial committees are binding.

Original jurisdiction concerning complaints rests with the judicial committee of county medical society in which the subject physician holds membership. The MSNJ Judicial Council holds appellate jurisdiction.

In 2007–2008 the Judicial Council received fifteen complaints from various sources. Of those complaints, four were referred to county medical societies, and the MSNJ Judicial Council retained one complaint to review at the request of the Sussex County Medical Society. The rest involved non-members, and these complainants were referred to the New Jersey State Board of Medical Examiners.

One complaint was referred to the New Jersey Neurosurgical Society for review.

This year no appeals have been submitted by county medical societies for action.

Policy and Strategy Panel

Joseph Reichman, MD, Co-Chair
David Swee, MD, Co-Chair

House Action: Filed

This report encompasses the collective work of the following Councils and Committees:

- Committee on Bio-Medical Ethics
- Council on Legislation
- Council on Medical Services
- Council on Public Health
- Medical Liability Task Force
- Scope-of-Practice Task Force

In 2007 the Medical Society of New Jersey began a pilot program to streamline the policy development process of the organization. The Policy and Strategy Panel (PSP) is a joint meeting of the standing committees and administrative councils. The PSP meeting brings experts in various fields to discuss issues of importance with MSNJ. The chairs of the PSP appoint ad hoc work groups to develop draft policy. The policy is refined by the PSP and forwarded to the MSNJ Board of Trustees for approval. This process allows the organization to become more “policy driven” and less reactionary to the policy environment.

The goal of the pilot program is to create substantive policies on major health and healthcare issues in advance of legislative, regulatory, or programmatic developments within the healthcare arena. The PSP model will be reviewed in July 2008.

❖Presentations and Policy Statements ❖

The PSP heard the following presentations:

Universal Healthcare

David Knowlton, chief executive officer of the Health Care Quality Institute, presented information on a plan for universal healthcare coverage in New Jersey. Please visit www.hcqi.org for the details of the plan. Senator Vitale is likely to introduce legislation in the spring of 2008.

The Panel appointed a work group to develop policy positions on universal healthcare from the physician-stakeholder perspective. The purpose of creating policy positions in this arena is to prepare the Society to evaluate multiple healthcare system reform programs as they are proposed.

These policy positions will be public information and will allow various policy makers and opinion leaders to understand the physician perspective on healthcare reform measures in New Jersey.

The work group developed the following policy positions and recommended they be adopted by the MSNJ Board of Trustees.

MSNJ PROPOSED POLICY STATEMENT

Principles of Coverage of the Uninsured

I. New Jersey Must Take an Active Role in Providing Coverage for the Uninsured

This statement, while seemingly obvious, is actually an important starting point for any contemplation of how to address the problem of the uninsured. Historically, government has played a passive role in influencing access to healthcare coverage, taking steps such as manipulating the marketplace through regulation or monetary policy. MSNJ is advocating for the state to take a more active role—such as offering insurance products, providing coverage directly, or subsidizing insurance premiums—in its efforts to address this problem. Minimizing office administration for all practitioners should be a common approach for implementation of existing and new products. In doing so, the state must be bound by the same ethical principals that govern a physician’s provision of care to an individual regardless of that person’s economic ability, lifestyle, or citizenship.

II. New Jersey Must First Ensure a Necessary Healthcare Infrastructure, but Participation Can't Be Tied to Licensure

It stands to reason that in those areas in which the uninsured are concentrated, market forces could result in a reduced healthcare infrastructure, including a shortage of physicians and facilities. As the uninsured are given coverage, the areas in which they are concentrated are expected to experience a rapid spike in healthcare utilization, during which the existing infrastructure could prove to be inadequate.

If these deficiencies are, in fact, prevalent in areas in which the uninsured are concentrated, then the success of any plan to bring coverage to those who are uninsured would be partially dependent on the success of preceding efforts to address service shortages. In doing so, the state must also be mindful of the impact its plans will have on the future availability of care. Unattractive mandates on physician participation would most likely result in the migration of physicians away from those very areas in which the state is trying to increase access. In other words, those regions that would see larger spikes in covered persons must first attract an adequate number of providers, then keep them there, in order to assure that there is, in fact, accessible care.

III. Physician Networks for Any New Products Must Be Adequate and Networks Must Be Periodically Reviewed

While attracting adequate numbers of providers to regions in which we anticipate large increases in covered persons is a critical element of any plan, simply having large numbers of physicians as neighbors doesn't necessarily help the uninsured. They must be offered a product with a sufficiently large network to allow access to needed services. Attracting a physician to a network involves a number of considerations, including, but not limited to, fair reimbursement that reflects the costs of practicing medicine and the administrative burdens associated with utilization management. New Jersey should closely study the shortcomings, not only of Medicaid, but also of private sector networks and carefully apply those lessons to the development of any new plan.

In addition, network adequacy must apply to both primary and specialized care, including preventive healthcare and mental healthcare, and patients must have the option to see out-of-network providers to ensure that they have access to the right physician.

IV. New Jersey Must Consider the Market Share of Carriers per Region

The common speculation is that any effort to provide coverage to the uninsured will entail the state's partnership with a private sector carrier. Even if this partnership is limited to administrative services, the introduction of a large number of insured lives to a carrier with an already inappropriate share of a region's market raises the specter of monopsony power—or the improper influence a health insurer has over the terms of its contracts with physicians and patients.

Different metropolitan statistical areas in New Jersey are currently dominated by different carriers. Therefore, the state/carrier partnerships should be regionally based, with an emphasis on stimulating competition in a given region in a way that preserves or, in fact, strengthens the physicians' and patients' standing in negotiation with carriers. If executed correctly, a plan to increase coverage could have the dual benefits of bringing coverage to the uninsured, while stimulating regional competition in ways that could radically benefit those already in the healthcare marketplace. New Jersey has a golden opportunity in moving forward with these plans; we must take advantage of it.

Legislative CME Mandates

David Swee, MD, presented the proposed regulation implementing *NJSA 45:9-7.2 et seq.* requiring physicians to obtain 6 credits of continuing medical education (CME) in cultural competency.

After lengthy discussion on the merits of cultural competency, the Panel determined the larger issue was the concept of legislatively mandated CME. The PSP appointed a work group to develop a broad policy on legislatively mandated CME topics.

After discussion the PSP forwarded the following policy to the Board of Trustees. It was adopted.

MSNJ POLICY STATEMENT

Mandated CME

MSNJ has developed the following principles to help guide policymakers with respect to mandated CME topics.

MSNJ, and the entire medical profession, recognize the essential role of continuing medical education in the provision of high-quality healthcare. However, MSNJ opposes state imposed topical CME in virtually all circumstances. In those instances where specific subjects may be appropriate, MSNJ supports the following guiding principles for policymakers:

- The primary purpose of continuing medical education is to maintain and improve clinical performance.
- Selection of specific CME topics is at the discretion of, and remains the prerogative of, the individual practitioner.
- Any CME topic mandated by law, regulation, licensure, or policy should meet the following criteria:
 - The topic must have achievable objectives, and meet all standards of the ACCME.
 - The mandated topic should be chosen in consultation with, and with the concurrence of the Medical Society of New Jersey, relevant specialty societies, and medical educators.
 - Credit hours for chosen topics must be included within statutorily mandated minimum requirements—not in addition to them.
 - The state should subsidize physicians for their participation by direct payments, credits against license fees, or other means that compensate them for their time.
 - Any mandated CME program must give the physician flexibility in accomplishing the program. Methodologies may include attendance at conferences or use of electronic media.
 - Mandated CME programs must count for Category 1 credit.

Organ Donation

The PSP heard a presentation by Mr. Joseph Roth, president and chief executive officer of the New Jersey Sharing Network on organ and tissue donation in New Jersey. There are twenty-eight organ procurement organizations in the country with forty-three hundred patients waiting for

tissue or organ donation in New Jersey alone. The Uniform Anatomical Gift Act was enacted in all states in 1968. Due to numerous amendments, anatomical gift regulations are no longer uniform in all fifty states.

MSNJ does not have standing policy on organ donation. The PSP referred this matter to a work group to develop a policy position and communication strategies to better inform the medical community of the issues surrounding organ donation.

The Panel recommended the following policy position be adopted by the MSNJ Board of Trustees.

MSNJ PROPOSED POLICY STATEMENT

Organ Donation

The Medical Society of New Jersey (MSNJ) recognizes the critical role organ donation plays in saving the lives of many chronically ill patients in our state.

MSNJ pledges its best efforts to improve the infrastructure and capacity of the organ donation network serving New Jersey.

MSNJ will assist in expanding the awareness of the benefits of organ donation through education and advocacy.

MSNJ supports the efforts of the Sharing Network, Inc., and requests that its physician members assist patients and their families with questions and concerns about organ donation.

MSNJ encourages all physicians in New Jersey to become organ donors themselves and to promote organ donation among their colleagues.

Medical Marijuana

The PSP heard a point-counter point presentation on the issue of using marijuana for therapeutic purposes. Legislation has been proposed in New Jersey to allow physicians to prescribe marijuana under certain circumstances.

The Panel has not yet determined whether to proceed in altering MSNJ's existing policy statement on the use of marijuana for clinical purposes.

Tiered and Narrow Physician Networks

The PSP heard several presentations on managed care issues from Troyen Brennan, MD, of Aetna, and designees of Reed Tuckson, MD, of United HealthCare, including Sam Ho, MD, executive vice president and chief medical officer, and Lawrence Lee, MD, medical director, Premium Designation Program, UnitedHealth Group. The issue MSNJ is currently addressing is tiered networks and how physicians are ranked within those networks.

Some managed care companies are engaging in efforts to rank physicians for the purposes of placing certain doctors in “premium” or “elite” networks. Health insurers are attempting to classify doctors on how efficiently they provide care.

The medical community has many concerns about physician ranking. Primary among these concerns is how the criteria for ranking are being weighted. Measuring quality of care, resource utilization, and patient outcomes is a complex undertaking. MSNJ will develop a series of policy positions regarding physician ranking methods.

The Panel has recommended the following policy position be adopted by the MSNJ Board of Trustees.

MSNJ PROPOSED POLICY STATEMENT

Physician Ranking Programs

MSNJ is committed to all quality-of-care initiatives and is sensitive to cost pressures in the delivery of healthcare. We are concerned that the ranking of physicians by healthcare insurers, ostensibly designed to address these two issues, may not result in higher quality of care or a more cost-efficient healthcare delivery system, and we make the following observations:

- Physician ranking programs can be harmful to patients, since they may be misleading and induce patients to change physicians, even though there is no medical need to do so, which may have a negative impact on the continuity of their care.
- Physician ranking programs can be harmful to physicians and patients because they may interfere with established physician–patient relationships and may steer patients to other, less qualified, physicians.

- Physician ranking programs are inherently in conflict with patients’ “best interests,” since the lowest cost physician may not be the best physician.
- Physician ranking programs can be harmful to physicians and patients if statistically-flawed data is used to publicly report a physician’s skill or quality of care. This may unfairly deprive or reduce a patient’s access to that physician and limit the ability of the physician to continue in the practice of medicine.

Given these inherent tensions, all physician ranking programs must be carefully scrutinized to ensure that they are: accurate, fair, transparent, and understood by all stake-holders (including, patients, physicians, employers providing healthcare insurance, and regulators), and subject to independent review and oversight. These systems should truly promote quality of care for patients and improvement in performance, rather than just cost-savings for insurers.

Therefore all physician ranking programs must meet the following minimum standards:

- **DATA:** Assessments must be based on accurate, current, and adequate data that can be validated. The data must be risk, severity, and outcomes adjusted. Clinical data, including chart review, must be used to verify and support administrative claims data, which should never be the sole source of information. Sample size must be sufficient to produce statistically significant results.
- **METHODOLOGY:** Quality assessments must be based on nationally recognized quality standards, such as those established by the National Quality Forum (NQF), using evidence-based medicine. The methodology for determining cost-efficiency must be clearly disclosed. To the extent that cost-efficiency is based on costs outside the control of the particular physician (including pharmaceuticals, DME, referrals, facility costs) it should be identified and disclosed to patients. Methodologies should be uniform and standard throughout the industry.
- **TRANSPARENCY:** The physician ranking program should be transparent to physicians and all stake-holders in terms of the data and methodologies used. Quality and cost-efficiency should be determined separately, but to the extent that they are combined, there must be full disclosure of the allocation to quality and to cost-effectiveness. The burden is on the entity ranking physicians to ensure that all stake-holders have full disclosure and that there is a meaningful “plain-language” explanation of the ranking system. The physician ranking must make clear to patients/consumers that no negative inference should be drawn about a physician who is not ranked.
- **APPEAL AND OVERSIGHT:** The physician ranking program must allow adequate time for review and correction of incorrect data. There must also be adequate time to review and dispute rankings, which

should include independent review. Physicians should have the option of opting-out of an assessment, either before or after the assessment takes place. All physician ranking programs should be reviewed by an independent body that includes physicians and other stake-holders, to assure that the program incorporates minimum standards. All physician ranking systems should be reviewed continually to ensure that the implementation is in accordance with minimum standards. An independent body should report compliance to all stake-holders on a periodic basis. If there is non-compliance, either in program structure or implementation, the independent body should have the authority to require remedial action in a timely manner. Remedial action might include correcting ranking status with an explanation to all stake-holders.

Medical Liability

The PSP listened to a presentation by Keith Mauer, from the National Arbitration Forum, on the use of arbitration to resolve medical malpractice claims. Peter Leone and Thomas Hawkins from The NIA Group, LLC, discussed the current practice environment and the need for liability reform.

Many industries use alternative dispute resolution (ADR) systems rather than traditional litigation to handle disputes. ADR can result in faster settlements and lower costs, in many cases. ADR is also used when specialized knowledge is required to understand disputes in highly technical industries.

The Panel formed a work group to study the concept of using alternate dispute resolution systems to address medical malpractice claims. The work group will be charged with creating a policy position on this topic.

Mental Health Parity

The Policy and Strategy Panel members listened to a presentation by John Hulick, MS, CPS, director of Public Affairs and Policy for the National Council on Alcoholism and Drug Dependence (NCADD) – New Jersey, and Laurie Cancialosi, MPH, chief of staff for Senator Joseph Vitale.

Ms. Cancialosi and Mr. Hulick presented brief updates on the state and on federal mental health parity legislation. The state legislation has been introduced in prior sessions of the legislature (in 2002 and 2004) and is

currently the closest it's ever been to passing (current bill numbers S-807 and A-2512). MSNJ continues to work closely with the New Jersey Psychiatric Society in active support of this legislation.

The PSP convened a work group to develop a policy position for MSNJ. The PSP recommends the following policy be adopted by the MSNJ Board of Trustees:

MSNJ PROPOSED POLICY STATEMENT

Mental Health Parity

- **COVERAGE LIMITATIONS SPECIFIC TO MENTAL ILLNESS ARE ROOTED IN STIGMA:** Nearly 98% of private sector health insurance plans impose some form of unfair, discriminatory limits on mental illness treatment, such as higher co-payments, fewer allowable outpatient visits and inpatient days, and lower annual and lifetime benefits caps than are provided for other medical illnesses. This disparate approach toward mental and other physical illnesses is rooted in a stigma the Medical Society of New Jersey (MSNJ) has historically worked to end.
- **THERE IS NO MEDICAL RECOGNITION OF “NON-BIOLOGICALLY BASED”:** In fact, there is no statutory recognition of “non-biologically based” illness (NBBI). New Jersey statute references “biologically-based” mental illnesses (BBI) in P.L. 1999 c. 106, which requires parity in coverage for specific illnesses which, for the purposes of legal expediency, were designated “biologically-based.” This new term was subsequently used by insurance carriers to define illnesses not specifically referenced in the statute as “non-biologically based,” as a means for enforcing specific treatment limitations in their coverage of those conditions. The terms “biologically-based” and “non-biologically based” are not recognized in the *Diagnostic and Statistical Manual of Mental Disorders* and should not be used by corporations to describe what are, in fact, medical conditions.
- **NEW JERSEY SHOULD AMEND ITS LAWS TO END THE BBI / NBBI DISTINCTION:** All mental illnesses in the *Diagnostic and Statistical Manual of Mental Disorders* are medical conditions and should be treated and understood as such. MSNJ supports legislation that would change our laws to end the practice of applying disparate terms and conditions to the coverage of illnesses deemed, through loose interpretation of statutory definitions, to be “non-biologically based,” and eliminate treatment limitations applied specifically to mental illness.

Resolutions

❖Resolution 1 ❖

Introduced by: Bergen County Medical Society

Subject: Motor Vehicle Safety

House Action: Adopted as Amended

RESOLVED, that the Medical Society of New Jersey support proposals to encourage drivers and passengers to wear seat belts and to encourage drivers to observe the speed limit.

❖Resolution 2 ❖

Introduced by: Essex County Medical Society

Subject: Communicating with Central Command During a Disaster

House Action: Adopted as Amended

RESOLVED, that the Medical Society of New Jersey work with the commissioner of the New Jersey Department of Health and Senior Services, the director of New Jersey Homeland Security, and the Health Emergency Preparedness Advisory Committee (HEPAC) to develop pilot programs using the Local Information Network and Communications System to connect physicians with the command centers.

❖Resolution 3 ❖

Introduced by: Essex County Medical Society

Subject: Task Force on Ethical Decisions During a Disaster

House Action: Referred to the Board of Trustees, with the suggestion that the resolution be referred to the Policy and Strategy Panel.

RESOLVED, that the Medical Society of New Jersey establish a task force to study and suggest guidance on ethical decisions concerning shortages of hospital beds, medicine, respirators, blood, and vaccines during a disaster and invite those who will head central command posts to serve on this task force.

❖Resolution 4❖

Introduced by: Essex County Medical Society

Subject: Evacuation Centers for Special Needs Population

House Action: Referred to the Board of Trustees, with the suggestion that the resolution be referred to the Policy and Strategy Panel.

RESOLVED, that the Medical Society of New Jersey form a task force to look into helping provide shelters for the special needs population and to establish guidelines for local communities; and be it further

RESOLVED, that the Medical Society of New Jersey work with county medical societies and local community groups to find resources and establish mechanisms to reach out to their special needs population; and be it further

RESOLVED, that the Medical Society of New Jersey discuss with the New Jersey Hospital Association the feasibility of a countywide group of hospital administrators who could meet and further assist with such endeavors.

❖Resolution 5❖

Introduced by: Essex County Medical Society

Subject: Expedite Respiratory Syncytial Virus Prophylaxis

House Action: Adopted as Amended

RESOLVED, that the Medical Society of New Jersey meet with the New Jersey commissioner of the Department of Banking and Insurance to find a way to expedite the process of procuring respiratory syncytial virus prophylaxis with the appropriate urgency for those infants who meet the American Academy of Pediatrics guidelines and to seek state legislation that would make it mandatory.

❖Resolution 6❖

Introduced by: Essex County Medical Society

Subject: Expediting Enrollment Process for KidCare and FamilyCare

House Action: Adopted as Amended

RESOLVED, THAT THE MEDICAL SOCIETY OF NEW JERSEY WORK WITH THE COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES TO FIND WAYS TO EXPEDITE THE PROCESS OF ENROLLING QUALIFIED PERSONS IN KIDCARE AND FAMILYCARE.

❖Resolution 7❖

Introduced by: Essex County Medical Society

Subject: Affordable Long-Term Care Insurance

House Action: Adopted as Amended

RESOLVED, that the Medical Society of New Jersey work with the commissioner of the New Jersey Department of Banking and Insurance and the leadership of the senate and assembly to create a voluntary, affordable long-term care insurance package.

❖Resolution 8❖

Introduced by: Essex County Medical Society

Subject: Seek Liability Shield for Doctors Who Give Disaster Aid

House Action: Referred to the Board of Trustees, with the suggestion that the resolution be referred to the Policy and Strategy Panel.

Based on the testimony heard, the Reference Committee recommends that the following be considered: comparing the American Medical Association's model state law on liability protection for physician volunteers with New Jersey's Health Powers Act (N.J.S.A. 26:13-6); working toward eliminating the need for physicians to specifically register for this protection, and, instead, to have their licensure application and fee include automatic registration; and reviewing the current Good Samaritan Law in New Jersey to be sure that it provides adequate liability protection for physicians.

RESOLVED, that the Medical Society of New Jersey obtain a copy of the new American Medical Association model state law on liability protection for physician volunteers during a declared disaster and make the passage of such a law in New Jersey a high priority.

◆Resolution 9◆

Introduced by: Union County Medical Society

Subject: Hearing Loss Warning

House Action: Adopted

RESOLVED, that the Medical Society of New Jersey seek legislation making it mandatory for manufacturers of cotton swabs to have a warning label, in a minimum of 10 point type and enclosed in a box on the container, that reads: "Warning: use of this product or any product with a rod in the ear has been known to cause ear infection, further ear wax impaction, hearing loss, and other ear damages"; and be it further

RESOLVED, that the New Jersey delegation submit a resolution to the American Medical Association House of Delegates for their consideration and action.

❖Resolution 10❖

Introduced by: Union County Medical Society

Subject: Affordable Medical Liability Rates for Retired Physicians

House Action: The following Substitute Resolution 10 was adopted in lieu of Resolutions 10, 12, and 18:

RESOLVED, that the Medical Society of New Jersey petition the New Jersey State Board of Medical Examiners and the New Jersey Department of Banking and Insurance to review medical liability insurance premiums for retired physicians in the active, reduced-fee category and that liability insurance not be required, but, for those physicians who wish to purchase it, that it be available at a minimal rate; and be it further

RESOLVED, that the New Jersey State Board of Medical Examiners allow retired physicians who volunteer on hospital medical staff committees and who neither admit nor treat patients to maintain active medical staff status; and be it further

RESOLVED, that the Medical Society of New Jersey request the New Jersey State Board of Medical Examiners to consider changing their requirement for active, reduced-fee licensees from “may not hold any hospital privileges” to “may not hold any hospital clinical privileges.”

❖Resolution 11❖

Introduced by: Morris County Medical Society

Subject: Out-of-Network Fees

House Action: Not Adopted

RESOLVED, that healthcare insurance carriers be required to supply patients and their physicians with the amount of reimbursement for out-of-network services prior to the services being rendered.

❖Resolution 12❖

Introduced by: Morris County Medical Society

Subject: Medical Liability Insurance for Retired Physicians

House Action: The following Substitute Resolution 10 was adopted in lieu of Resolutions 10, 12, and 18:

RESOLVED, that the Medical Society of New Jersey petition the New Jersey State Board of Medical Examiners and the New Jersey Department of Banking and Insurance to review medical liability insurance premiums for retired physicians in the active, reduced-fee category and that liability insurance not be required, but, for those physicians who wish to purchase it, that it be available at a minimal rate; and be it further

RESOLVED, that the New Jersey State Board of Medical Examiners allow retired physicians who volunteer on hospital medical staff committees and who neither admit nor treat patients to maintain active medical staff status; and be it further

RESOLVED, that the Medical Society of New Jersey request the New Jersey State Board of Medical Examiners to consider changing their requirement for active, reduced-fee licensees from “may not hold any hospital privileges” to “may not hold any hospital clinical privileges.”

❖Resolution 13❖

Introduced by: Camden County Medical Society

Subject: Government and Insurance Companies Assume Risk When “Practicing Medicine” Through Pharmaceutical Switching

House Action: Adopted as Amended

RESOLVED, that it is the position of the Medical Society of New Jersey that government and insurance companies are “practicing medicine” when they strongly encourage physicians and patients to switch patients’ medications to those that are on the patients’ insurance companies’ formularies; and be it further

RESOLVED, that the Medical Society of New Jersey develop a web-based reporting system to document instances in which insurance company–initiated medication substitutions are contrary to the medical judgment of the physician and when the outcome for the patient was negative or adverse; and be it further

RESOLVED, that the Medical Society of New Jersey seek regulation that insurance companies should pay physicians at the physician’s usual and customary rates for the time spent in seeking exceptions to their so-called clinical or quantitative limits on medications.

❖Resolution 14❖

Introduced by: Joseph J. Fallon, Jr., MD
Delegate, Camden County

Subject: Doctor–Patient Right to Procure Pharmaceuticals in Life-Threatening Situations

House Action: Adopted

RESOLVED, that the Medical Society of New Jersey petition the American Medical Association to explore legislation allowing subsets of patients needing urgent intervention, in conjunction with their physicians, to have the right and mechanism to procure and apply innovative pharmaceutical technology that has been proven effective, yet remains delayed, deferred, or rejected by the Food and Drug Administration.

❖Resolution 15❖

Introduced by: Monmouth County Medical Society

Subject: Term of the President of the Medical Society of New Jersey

House Action: Not Adopted

RESOLVED, that the presidents of the Medical Society of New Jersey may serve two terms, when endorsed by the MSNJ Board of Trustees and recommended by the Nominating Committee; and be it further

RESOLVED, that there be a maximum of two, one-year terms, which will serve the best interests of the Society.

❖**Resolution 16**❖

Introduced by: Ocean County Medical Society

Subject: Discrimination Against Physicians Based on Geographic Location

House Action: The following Substitute Resolution 16 was adopted:

RESOLVED, that the Medical Society of New Jersey petition the American Medical Association to investigate whether or not the current geographic differential used by Medicare fairly compensates physicians and is based on accurate and current data.

❖**Resolution 17**❖

Introduced by: Middlesex County Medical Society

Subject: Continuing Medical Education Offered by Component Medical Societies

House Action: Referred to the Board of Trustees.

RESOLVED, that component medical societies may apply to become Medical Society of New Jersey continuing medical education accredited providers; and be it further

RESOLVED, that component medical societies shall not be subject to application or annual fees.

❖**Resolution 18**❖

Introduced by: Middlesex County Medical Society

Subject: Medical Licensure: Active, Reduced-Fee Status

House Action: The following Substitute Resolution 10 was adopted in lieu of Resolutions 10, 12, and 18:

RESOLVED, that the Medical Society of New Jersey petition the New Jersey State Board of Medical Examiners and the New Jersey Department of Banking and Insurance to review medical liability insurance premiums for retired physicians in the active, reduced-fee category and that liability insurance not be required, but, for those physicians who wish to purchase it, that it be available at a minimal rate; and be it further

RESOLVED, that the New Jersey State Board of Medical Examiners allow retired physicians who volunteer on hospital medical staff committees and who neither admit nor treat patients to maintain active medical staff status; and be it further

RESOLVED, that the Medical Society of New Jersey request the New Jersey State Board of Medical Examiners to consider changing their requirement for active, reduced-fee licensees from “may not hold any hospital privileges” to “may not hold any hospital clinical privileges.”

❖Resolution 19❖

Introduced by: Hudson County Medical Society

Subject: Election of Speaker and Vice-Speaker of the House of Delegates

House Action: Not Adopted

RESOLVED, that the Bylaws of the Medical Society of New Jersey be amended to allow for the annual election of the Speaker and Vice-Speaker; and be it further

RESOLVED, that this election proceed through the Nominating Committee; and be it further

RESOLVED, that the same term limits apply as for any other MSNJ Board member; and be it further

RESOLVED, that the Speaker and Vice-Speaker thus elected may not hold additional Board seats; and be it further

RESOLVED, that the Speaker and Vice-Speaker thus elected be voting members of the Board of Trustees.

❖Resolution 20❖

Introduced by: Hudson County Medical Society

Subject: Election of Chair and Vice-Chair of the New Jersey Delegation to the American Medical Association

House Action: Not Adopted

RESOLVED, that the Bylaws of the Medical Society of New Jersey be amended to allow for the annual election of the chair and vice-chair by the AMA delegation.

❖Resolution 21❖

Introduced by: Hudson County Medical Society

Subject: Insurance Company Non-Payment of Hospital Bills When Patients Are Admitted by Out-of-Network Physicians

House Action: Not Adopted

RESOLVED, that the Medical Society of New Jersey seek legislation and regulation that would force managed care organizations to honor their contracts with hospitals regardless of the “network” status of the admitting physicians.

❖Resolution 22❖

Introduced by: Camden County Medical Society

Subject: Interstate Healthcare Insurance Competition for New Jersey Patients

House Action: Resolution 22 and the amended version suggested by the Reference Committee were referred to the Board of Trustees.

(Original resolution)

RESOLVED, that the Medical Society of New Jersey should initiate action to repeal the Domicile Rule so as to allow out-of-state insurance companies, who are adequately capitalized, to offer policies to New Jersey residents.

(Reference Committee version)

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Department of Banking and Insurance (DOBI) to permit adequately capitalized non-Domicile insurance companies to offer policies to New Jersey residents if they meet DOBI requirements; and be it further

RESOLVED, that insurance companies must honor assignment of benefits and that the New Jersey State Commissioner of Insurance will have jurisdiction over these companies.

❖**Resolution 23**❖

Introduced by: Hudson County Medical Society

Subject: Immunizations Not Covered by Insurance Companies

House Action: The following Substitute Resolution was adopted:

RESOLVED, that the Medical Society of New Jersey recommend that the American Medical Association advocate for legislation that would mandate that all insurers cover the total cost of vaccinations for their covered patients, both adult and pediatric; and be it further

RESOLVED, that the Medical Society of New Jersey advocate for legislation to mandate that all insurers cover the total cost of vaccinations for their covered patients, both adult and pediatric.

❖**Resolution 24**❖

Introduced by: Hudson County Medical Society

Subject: Medicare Managed Care Protection of Established Physician-Patient Relationships

House Action: Adopted as Amended

RESOLVED, that the Medical Society of New Jersey promote legislation that will require that all potential enrollees in managed care Medicare programs be informed of the limitations and restrictions that will be placed on their attending physicians' referral patterns, in-office testing, and reimbursement; and be it further

RESOLVED, that organized medicine at all levels lobby legislatures at all levels to enact legislation to protect the life and health of patients by protecting the physician-patient relationship and promoting truth in advertising to Medicare recipients; and be it further

RESOLVED, that the Medical Society of New Jersey encourage insurers to improve disclosure of Medicare Advantage programs' coverage, restrictions, and limitations to their prospective and current patients; and be it further

RESOLVED, that the Medical Society of New Jersey petition the American Medical Association to require insurers to improve disclosure of Medicare Advantage programs' coverage, restrictions, and limitations to their prospective and current patients.

New Business

❖Resolution A ❖

Introduced by: Henriette E. Abel, MD, Delegate
Robert H. Stackpole, MD, Delegate
Union County Medical Society

Subject: Objection to Cultural Competency Legislation

House Action: Not Adopted

Whereas, many members of the Medical Society of New Jersey have recently taken the required course on cultural competency; and

Whereas, those Medical Society of New Jersey members who have taken the course did not learn anything new, but rather were presented with material that was designed to increase their cultural sensitivity, but which they already learned in medical school, continuing education, and exposure to many diverse cultural, racial, and ethnic groups in the course of practicing medicine in New Jersey; and

Whereas, we maintain that the practice of medicine itself, with exposure to many diverse groups, produces a widespread understanding of the difference in activities and responses to medical advice and medical care from different individuals; and

Whereas, we assert that we understand and provide for these differences already; and

Whereas, the practice of medicine consumes many hours of the day, and additional required activity is onerous; and

Whereas, the imposition of requirements by the New Jersey legislature for educational activity, which knowledge the members of the Medical Society of New Jersey already possess, is counter productive and wasteful of our time; now therefore be it

Resolved, that the Medical Society of New Jersey registers its strong objection to the New Jersey legislature to their requiring a course in cultural competency, and request that the course no longer be required for renewal of the license for the practice of medicine.

❖Resolution B❖

Introduced by: Robert S. Rigolosi, MD, Delegate
Bergen County Medical Society

Subject: Support for New Jersey Hospital Association Rally

House Action: Adopted

Whereas, the New Jersey Hospital Association gave the Medical Society of New Jersey its full support, both moral and financial, for our Tort Reform March in February 2003; and

Whereas, Governor Jon Corzine has proposed massive cuts to charity care in the FY 2009 budget that will result in millions of dollars being cut from hospital charity care programs; and

Whereas, the New Jersey Hospital Association is planning a rally at the State House on Monday, May 12, 2008; now therefore be it

Resolved, that the Medical Society of New Jersey enthusiastically endorse and support the New Jersey Hospital Association's May 12, 2008, rally at the State House, in opposition to the governor's proposed FY 2009 budgetary cuts to charity care.

Memorial Resolution

**Howard D. Slobodien, MD
1923–2007**

House Action: Received with Sorrowful Concurrence

Whereas, our almighty Father has called to Him, our beloved friend and colleague, Howard D. Slobodien, MD; and

Whereas, as a fellow and officer, Doctor Slobodien provided distinguished leadership to the physicians of New Jersey and singular service to the people of New Jersey; now therefore be it

Resolved, that the Medical Society of New Jersey expresses its profound grief at the passing of Doctor Slobodien and extends its heartfelt sympathy to his beloved family; and be it further

Resolved, that this resolution be spread upon the minutes of this meeting in remembrance of Howard D. Slobodien, MD.