

APPENDIX



**Statement Submitted by Linda J. Schwimmer, President & CEO of the New Jersey Health Care Quality Institute to the Senate Commerce Committee and the Assembly Health and Senior Services Committee and the Assembly Regulatory Oversight Committee
December 2, 2015**

Narrow, tiered, and closed networks: what does it all mean for consumers and our health care system?

These plan designs are here to stay and will grow in number. Thus, what should New Jersey be doing about it? Here are three suggestions:

- Be an active purchaser – NJ should exert its market power and demand quality and access for all residents;
- Insist that quality outcomes be the most heavily weighted measure in product design;
- Insist that these measures be transparent to consumers and taxpayers.

As health care plans look to find ways to offer comprehensive, patient-centered, quality coverage at affordable prices, we will be seeing more innovation in plan design. Nationally, Aetna has been replacing its fee for service reimbursement model with value-based contracts and partnering with providers to market health plans that enable enrollees to use hospitals in the providers' accountable care organization network. Here in New Jersey, we are just starting to see innovative new plans that will be offered in the upcoming open enrollment season. Quality Institute Leadership Council Member, Horizon BCBSNJ, recently announced a new alliance with about 23 hospitals and physician groups called OMNIA. This alliance will further Horizon's move towards more value-based purchasing and away from volume-based fee for service payments. The OMNIA alliance is also the core of Horizon's up-coming tiered insurance plan product. Under this product, employers and individual consumers may choose a plan product with two tiers of providers. If consumers go to a Tier One provider, their out of pocket costs will be lower than if they choose to see a Tier Two provider. Aetna, the other insurer that administers benefits for the State, is also offering a two-tiered.

The introduction of these products has caught the attention of the media and health care leaders. Here are some of the key questions and issues to think about:

1. What are tiered insurance plan products and how do they differ from narrow network products?

Leonard Leto
Chairman of the Board
Manager, Policy & Planning
NJ State Health Benefits Plan
(Retired)

Robert "Rob" Andrews, JD
Former Congressman, NJ
1st Congressional District;
Of Counsel, Dilworth Paxson, LLP

Andrea W. Aughenbaugh, RN
CEO, NJ State Nurses Association (Retired)

Donald Bryan, JD
Director, Division of Insurance,
NJ Dept. of Banking & Insurance (Retired)

Rick Fair
Former NJ State Auditor

James J. Florio, JD
Former Governor of New Jersey;
Senior Partner, Florio, Perrucci, Steinhardt &
Fader, LLC

Heather Howard, JD
Former NJ Health Commissioner;
Director of State Health Reform
Assistance Network; Woodrow
Wilson School of Public & Intern'l
International Affairs, Princeton, NJ

Fred M. Jacobs, MD, JD
Former NJ Health Commissioner
Executive Vice President & Chair
of Department of Medicine,
St. George's University School of
Medicine

George R. Laufenberg, CEBS
Administrative Manager,
New Jersey Carpenters Fund

Zak Maniya, MD
Chief, Section of Nephrology,
St. Francis Medical Center

Suzanne M. Miller, PhD
Senior Professor/Director,
Psychosocial & Behavioral
Medicine; Fox Chase Cancer Center/ Temple
University Health System

Judith M. Persichilli
President Emeritus,
CHETrinity Health

Michael A. Sedrish, MD
Medical Director,
MediSys Management

Christine A. Stearns, JD
Counsel, Government Affairs,
Gibbons P.C.

Linda J. Schwimmer, JD
President & CEO,
New Jersey Health Care Quality Institute

Phone 609-452-5980
Fax 609-452-5983

Stone House at Carnegie Center
3628 Route 1
Princeton, NJ 08540
www.njhcqi.org



A tiered product is one where the in-network providers are divided into levels based usually on cost-share to the consumer. The consumer may access the plan's entire network but will pay differing amounts depending on what tier the provider is in. Tiered networks differ from narrow networks in that tiered networks often include a larger sum of providers, ensuring network adequacy and sufficient access, but the providers fall within different tiers, with varying levels of consumer cost-share, and some tiers are more financially accessible than others.

2. Why would consumers or purchasers purchase a tiered or narrow network product?

Consumers and employers consistently rank health care costs as one of their greatest concerns. Indeed, according to a 2014 NJBIA survey, cost was the most common reason cited by NJ businesses as to why companies might discontinue offering coverage. Moreover, according to an Urban Institute study, the most common factor consumers consider in choosing a health plan is cost (premiums, deductibles and maximum out of pocket spending limit). Therefore, to the extent that these products can offer consumers and employers lower premiums and out of pocket costs in exchange for less choice or choice constraints, consumers are willing to purchase them.

Another reason large employers and unions may be interested in these plan designs is because of the so-called Cadillac Tax. Starting in 2018, if the value of a health care plan exceeds \$10,200 for individual coverage, or \$27,500 for family coverage, employers will have to pay a 40% non-deductible excise tax to the federal government. Lower priced plans such as these are one strategy to help employers avoid that tax.

3. What is the trade-off for lowering out of pocket costs in tiered, narrow, or closed network plans?

Consumers who want the out of pocket cost savings in premiums offered by these products will have to accept choice constraints in physicians and hospitals. These plans can offer such savings because they have negotiated preferred contracts with a more limited network of providers. In looking at the Horizon products recently announced, Tier One includes about half of New Jersey's general acute care hospitals, including most of its largest health systems, with at least one facility in almost every county – excluding Warren and Burlington counties. And, Tier Two, in which consumers will have to pay more in out of pocket expenses, includes most of New Jersey's remaining general acute care hospitals and does provide some out-of-state coverage. There will likely be other tiered plans offered by other health plans in this season's open enrollment that will offer different ranges of choice.



4. Are there larger system implications that should be considered when examining these plan products?

Absolutely. While these products can be viewed as a cost-saving mechanism, there are serious implications at the system level, especially when an insurer has significant market share in a region. If an insurer's commercial consumers are financially incentivized to use Tier One providers, providers in Tier Two may lose a large share of their commercial patients, and therefore, a large portion of their revenue. Some of the hospitals in Tier Two are urban safety-net hospitals who serve a disproportionate share of Medicaid and uninsured patients. Such hospitals rely on their commercial patients to offset the cost of their Medicaid patients, especially in light of New Jersey's significantly lower Medicaid reimbursement rate compared to the national average (.77 for all care, and .53 for obstetric care). Urban hospitals operate on very slim margins, and a shift in their commercial patient volume – their most profitable – can have significant implications on their bottom line. Furthermore, many of these hospitals are mission-driven non-profits that take very seriously their commitment to improving the health of their communities, so it is important that they are financially viable, and remain so.

This is a serious issue for the State. Policymakers need to look at the sustainability and equity of our Medicaid program, and the overall State budget support and commitment to "essential hospitals" that are financially pressured and serve a large share of the under-served population. Indeed, it is time to look back to the well-reasoned proposals in the New Jersey Commission on Rationalizing Health Care Resources Final Report of 2008 (the "Reinhardt Commission") at chapters 12 and 13, wherein the Commission urges the State to develop a framework for identifying hospitals that are essential to maintain to ensure access; to review their essential nature and financial viability on a regular basis taking into consideration market changes (e.g. introduction of disruptive and innovative products and other market forces); and, to consider what financial support the State should provide to these hospitals. This is an opportune time, with the potential market disruption brought on by these newly designed tiered and narrow network products.

Moreover, when the State, as the largest purchaser of health care services in New Jersey, makes purchasing decisions such as it did when it approved the tiered product for its benefit program, it should consider what implications those decisions will have on the financial viability of its essential hospitals. State leaders who manage the State's purchasing decisions should also put the State's best interests first and ask themselves ---- what type of health care system do we want for all New Jersey residents and what factors should we make a priority in designing products that encourage people to use one provider or service over another? These decisions and factors should be transparent.



Another issue that must be addressed when financially impacting consumer choice in providers is that of quality. Will patients who are financially steered towards a specific group of providers have sufficient information about the quality of care offered by the Tier One and Two providers? Making quality a weighty and transparent criteria in the development of the tiers and networks will enable consumers to choose not simply on cost but on quality as well. Research shows that in these initial efforts to offer tiered and narrow networks, little attention has been paid to the question of quality. Cost of premiums in designing networks has been the driving factor and generally, quality was not a criterion for exclusion or inclusion in a network.

Another important tool available to the state is the announcement last month by the National Association of Insurance Commissioners. NAIC issued a model law for network adequacy. The state should look to the provisions of this model act to evaluate the adequacy of plans offered not only in the State Marketplace but also for our state health benefit plans. Important market considerations and consumer protections are contemplated in the NAIC model and it offers a well-considered guide for evaluating products against a meaningful set of evaluative measures.

As consumers are faced with more choices in plan design and cost, accurate information regarding the network, its tiers, the consumer's cost-share and its differential between tiers, and the quality and accessibility of the providers is essential. Again, the State can use its buying power to demand transparency around quality and can drive quality improvement through the power of the purse -- but it has to exert that power through an active, deliberate process.

Testimony of Steven M. Goldman, Esquire
Before Joint Hearing of the Assembly Regulatory Oversight Committee and Assembly Health
and Senior Services Committee

December 2, 2015

Thank you for the opportunity to submit written testimony concerning the Omnia Plan. I am a former Commissioner of the New Jersey Department of Banking and Insurance ("DOBI"), having served in that capacity from March 2006 through early July 2009. During that time, I also served as a member of the Commission on Rationalizing Health Care Resources (commonly known as the "Reinhardt Commission"), which then-Governor Corzine created to consider the economic conditions of New Jersey's health care system, with a particular emphasis on its hospital system and those hospitals which were providing the bulk of charity care in the State. That report also examined whether those hospitals were being appropriately reimbursed for the charity care they were providing. *See New Jersey Commission on Rationalizing Health Care Resources, Final Report, January 24, 2008, at p. 1.* I currently am a partner at the law firm of Kramer Levin Naftalis & Frankel LLP and represent 11 hospital groups (17 hospital facilities) that have filed an appeal in the Appellate Division challenging DOBI's approval of the Omnia Network.¹

While the goal of tiered plans to provide high value/lower cost health care is praiseworthy, any such tiered system must be implemented in a fair and transparent manner that achieves those goals over the long term. That did not happen with the Omnia Plan. There has been little to no transparency concerning the criteria used by Horizon, how those criteria were developed, the weight given to those criteria, or the actual scores received by any hospital. Hospitals that serve urban areas, particularly the urban poor and minority populations and the often otherwise underserved population, (including every single Catholic hospital in the state of New Jersey with the exception of St. Joseph's in Paterson), was left out, notwithstanding the high value services provided by those hospitals to this important population. Many of these hospitals were the ones determined by the Reinhart commission to be providing disproportionate charity care and receiving inadequate charity care reimbursement. For these reasons, and those discussed below, implementation of the OMNIA Plan should be suspended until that plan and the consequences for the health care system in New Jersey are properly vetted to ensure that it will not have a possibly irreparable detrimental impact.

¹ The members of the Hospital Group are Capital Health Regional Medical Center, CentraState Medical Center, Holy Name Medical Center, Inc., The Community Hospital Group, Inc., t/a JFK Medical Center, Kennedy Health, Our Lady of Lourdes Health Care Services, Inc., St. Francis Medical Center, Inc., St. Luke's Warren Hospital, Inc., Trinitas Regional Medical Center, Valley Health System, and Virtua Health, Inc.

Horizon and the Omnia Plan Generally

Horizon is the state's sole nonprofit health services corporation, with a share of more than 50% of the commercial insurance market in the state. DOBI Life & Health Actuarial, "New Jersey Commercial Market Share," (2013), available at http://www.state.nj.us/dobi/lifehealthactuarial/2013commhealth_market.pdf (last accessed November 18, 2015). (132a). Horizon reports that it serves 3.8 million members in New Jersey, including all New Jersey state employees. Horizon, "Annual Report" (2014) at 12, available at http://www.horizonblue.com/company_reports/pdf/2014-annual-report (last accessed November 18, 2015). (136a). As a unique tax exempt nonprofit charitable and benevolent corporation required by law to operate for the benefit of its members, and with public members of its Board of Directors appointed by the Governor, Horizon is a quasi-public entity in the same manner and to the same extent as a nonprofit hospital and holds its powers in trust for the public in the same manner and to the same extent. Horizon therefore has a fiduciary duty to exercise its power over its members' access to health care in a fair, transparent and open manner that will rationally advance the public good. Implementing an insurance product that at its essence is designed to shift market share from disfavored Tier 2 hospitals to favored Tier 1 hospitals chosen in a secretive and non-transparent manner in exchange for Tier 1 hospitals agreeing to lower reimbursement rates is a violation of this obligation.

The OMNIA Plan results from a collaboration between Horizon and six of New Jersey's largest hospital systems as well as a physician group – the OMNIA Health Alliance (the "OMNIA Alliance"). Among other things, the OMNIA Plan designates certain hospitals – including members of the OMNIA Alliance – as Tier 1 facilities, while demoting other hospitals, including the Hospital Group members, to Tier 2 status. Subscribers who utilize Tier 2 hospitals must incur increased costs compared to the savings built into the Tier 1 hospitals and their services. Horizon has announced an effective date of December 26, 2015 for certain State Health Benefits Program members and January 1, 2016 for all other members.

The DOBI Process Was Inappropriately Rushed

Documents made public after the October 5 Senate hearings show that Horizon informed DOBI on June 25, 2015, that it planned to submit a tiered network plan for approval. Horizon Submission to DOBI, June 25, 2015, at 1. (173a). It was not until September 3, 2015, that Horizon submitted details about its plans for hospitals, and it did so solely as a result of DOBI's prompting. Horizon Submission to DOBI, September 3, 2015, at 1-2. (179a-180a). Two weeks later, on September 18, DOBI approved OMNIA, notwithstanding Horizon's explicit acknowledgement that it failed to meet certain network adequacy standards as of that date. (1a; 165a). DOBI made its approval effective as of September 15.

DOBI held no public hearings in connection with its approval of the OMNIA Plan. DOBI did not notify any parties beyond Horizon of its consideration of the OMNIA network, nor did it

seek input from any of the Tier 2 hospitals that I represent prior to its decision to approve the plan.

In my experience, given the potential ramifications of a proposed tiered plan by the state's sole nonprofit health services corporation that services more than 50% of the commercial insurance market in the State, a careful review should require some months, not a mere 2-weeks, of consideration. In addition, all of the various constituents impacted by this new plan should have been given an opportunity to be heard prior to any approval decision.

DOBI Abdicated its Responsibility to Ensure that the OMNIA Plan Was Not Contrary to the Public Interest

DOBI has a legal obligation to ensure that the OMNIA Plan is not contrary to the public interest. See N.J.S.A. §§ 17:1C-19; 17:48E-4(a). Unfortunately DOBI has refused to undertake any such analysis of impact on the public. To the contrary, just this past Monday, in a written denial of my clients' request that it stay the OMNIA Plan on its own, DOBI took the position that in reviewing and approving a new insurance product, it has NO obligation to protect the public interest. It claims it merely has to ensure network adequacy and that in and of itself is the extent of its obligation to protect the public interest. I believe DOBI is wrong. Someone certainly needs to consider this plan's broader public impact. And unfortunately, numerous aspects of the OMNIA Plan will have deleterious effects on consumers, the healthcare industry, and New Jersey residents.

First, the OMNIA Plan jeopardizes the stability and quality of the New Jersey hospital system as a whole. The entire plan is designed to encourage members to choose Tier 1 hospitals over Tier 2 hospitals, and is based on projections that patient volumes at Tier 1 hospitals will increase as patients migrate away from Tier 2 hospitals. A loss of patients with high quality commercial health insurance could endanger the financial viability of the Tier 2 hospitals. Moreover, there is a real risk that the Tier 2 label, along with Horizons wide spread media campaign touting its new product and its Tier 1 participants, will cause consumer confusion and lead patients to mistakenly believe that the label is indicative of an inferior quality of care, further increasing patient migration. Strikingly, the Tier 1 sub-network largely excludes hospitals located in urban communities, while many of the Tier 2 hospitals are located in such areas. These Tier 2 hospitals serve as important social safety nets in these communities as well as providing thousands of high quality jobs. Thus, OMNIA's seemingly arbitrary categorization of these facilities as Tier 2 will likely disproportionately penalize residents of these communities.

Second, Horizon's methodology used in the development of its Tier 1 and Tier 2 sub-networks lacks transparency, making it impossible for consumers to make informed choices about their healthcare. Although Horizon announced that it made its tier determinations based on six criteria, it has failed to explain how the criteria were developed, weighted or how any hospital scored against another. Horizon's methodology appears particularly dubious in light of the exclusion of high-value, low cost hospitals as rated by the Leapfrog Group, an independent

national organization established to measure and recognize the quality of institutions in the healthcare industry and its inclusion of other institutions with lower Leapfrog ratings.

Faced with public pressure, Horizon recently has provided some limited details concerning its evaluation of hospitals, but those limited details have raised more questions than they answered. For example, Horizon now admits that "out of the six criteria used, clinical quality and commitment to value-based care were the two most heavily weighted" and that "the commitment to value-based care was more subjective than any other criteria." NJBIZ Exclusive: Horizon offers more details about how hospitals earned OMNIA Tier 1 status, at http://www.nj.com/politics/index.ssf/2015/11/11_nj_hospitals_challenge_state_approval_of_horizo.html#incart_river_home. A tiered plan with far reaching implications, such as the OMNIA Plan, where Horizon itself makes subjective decisions about who to include is inappropriate. There is no way for a Tier 2 institution to determine what would be necessary for it to accomplish to achieve Tier 1 status and no way to determine whether current Tier 1 hospitals should no longer be entitled to that status. Most importantly, there is no way for a consumer to determine independently based on objective criteria which hospitals they might prefer because no list of object criteria is publicly available. Horizon has arrogated to itself the sole judgment as to which hospitals belong where and through its media campaign is persuading consumers that its secretive choices should be followed.

Third, the OMNIA Plan will also make it unnecessarily difficult for patients to receive continuity of care. For instance, under OMNIA many physicians have been designated as Tier 1 while the hospitals with which they are affiliated have been designated as Tier 2, making the system cumbersome to navigate for both patients and providers. This has cast doubt in the minds of physicians as to whether they should change their hospital affiliation to Tier 1 hospitals from Tier 2 hospitals, which would result in their patient population also transferring from Tier 2 to Tier 1 hospitals. The effect of this would be to further undermine the financial stability of institutions designated as Tier 2.

Similarly, Horizon has suggested carving out certain services provided at Tier 2 hospitals as Tier 1, complicating a patient's ability to receive coordinated care within a single hospital. Take as just one example the suggestion that a Tier 2 hospital be designated as Tier 1 solely for OB services. What happens if a woman or her newborn child has complications and needs other services lines? Worse yet, what happens if that woman goes home and later that day starts to hemorrhage, which happens in approximately 4-5% of women. Can she return to the hospital where she originally delivered, or does she need to switch hospitals, and should she be forced to engage in such considerations? I think not.

Fourth, given that OMNIA is the first of its kind in New Jersey, the manner in which OMNIA was created and approved by DOBI has the potential to set a dangerous precedent. Other insurance companies that wish to roll out similar insurance products may do so in the same haphazard manner that occurred here, which would undermine the existing regulatory structure which is designed to prevent just these sorts of problems.

Finally, undermining the financial viability of Tier 2 hospitals is also against the public fiscal interest as it increases the risk of default by these hospitals, which in the aggregate have been issued approximately \$3 billion in tax-exempt debt by the New Jersey Healthcare Facilities Financing Authority. This could require, were it to become a reality, that the State step in and make good on these bonds further taxing an already overtaxed State budget.

The Omnia Network did not Meet Network Adequacy Regulations at the Time it was Approved

Although much of the administrative record is still unavailable to the public, based on the information that has come to light from the Senate Committees' investigation and from DOBI's recent written denial of a stay of the OMNIA Plan, it is clear that the Omnia Plan failed to meet DOBI's own network adequacy regulations at the time the Omnia Plan was approved.

In addition to considering the effect of any health insurance plan on the public as a whole, DOBI is responsible for ensuring that proposed health plans meet state requirements that all residents have access to an adequate network of primary-care providers, medical specialists, and hospitals within a certain geographic range. N.J.A.C. § 11:24A-4.10. Getting most of the way there is not enough. For example:

- With respect to hospitals, insurers must maintain in-network contracts, or acceptable arrangements, with at least one acute care hospital with licensed medical-surgical, pediatric, obstetrical, and critical care services in any county or service area that is no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of covered persons within the county or service area. N.J.A.C. § 11:24A-4.10(b)(3)(i).
- When an insurer subdivides a network into tiers, each tier must independently satisfy network adequacy requirements, as if it was the only network being offered to the consumer.

The Omnia Plan failed to meet DOBI's network adequacy requirements at the time of approval in several respects:

First, Horizon did not have agreements with each Tier 1 hospital in place at the time of approval, making it impossible for DOBI to evaluate compliance of the OMNIA Plan with its own regulations on network adequacy.

DOBI also approved the OMNIA Plan even though Horizon expressly acknowledged to DOBI that the OMNIA Plan was not compliant with respect to obstetrical services in Burlington County at the time of approval. Providing such services at a Tier 2 hospital at Tier 2 costs is unacceptable for the reasons I discussed earlier.

Conclusion

The implementation of the OMNIA Plan will have far-reaching consequences for the healthcare delivery system in New Jersey. Because the plan was not properly vetted, and due to the serious questions about the manner in which hospitals were chosen, the Plan should be suspended pending a proper vetting process and complete compliance with DOBI regulations.

Hearing Testimony, Wednesday, December 2, 2015
Vincent Costantino, St. Francis Medical Center

Thank you for the opportunity to testify concerning Horizon's OMNIA network. We greatly appreciate your collective effort to examine the potential impact that Horizon's OMNIA network will have on the healthcare landscape in New Jersey. And we appreciate those of you who have already spoken out on this important public health issue.

As an organization with century-old roots in our community, St. Francis Medical Center is committed to being a people-centered healthcare provider that enables better health, better care and lower costs. Our organization embraces value-based agreements and the goals that a tiered network aims to provide. And as a faith-based health system, ethics and social responsibility are central to our culture and mission. We recognize the sensitivities and access barriers our community may face, and have always had the utmost commitment to providing convenient, quality care to our patients.

Yet Horizon Blue Cross, the state's largest commercial insurer has created a preferred Tier 1 network without first sharing information or criteria for how it made its decision about which hospitals to include and which to exclude, showing a complete lack of transparency in its decision making process. Moreover, the OMNIA plan was approved by the Department of Banking and Insurance in record time and with knowledge that the plan did not meet the Department's own network adequacy standards.

Here is what Horizon has revealed about their criteria:

First, that hospitals were chosen for quality. But that doesn't square with the facts surrounding our hospital's quality performance. St. Francis was awarded Horizon's own High Performing Hospital Award, and most recently we received an A score from Leapfrog, which is a widely recognized standard for comparing hospitals' performance on the national standards of safety, quality, and efficiency.

Horizon has also stated that hospitals were chosen based on their willingness to embrace a value-based pay structure. Here again, our commitment to embracing value-based care is clear. St. Francis, as well as our partner hospital Lourdes Medical Center, were the first two hospitals in the state to establish PACE programs, which are all-inclusive care programs for the elderly. Because we support and embrace different pay structures, we agreed to a monthly capitated fee from Medicare/Medicaid. We embrace payment reform and pay-for-performance structures, as well as support the growing need for population health models. But clearly, that wasn't considered.

Last, and most importantly in our case, Horizon has stated that hospitals were chosen based on their location. Yet OMNIA's network does not include a single Tier 1 hospital in the city of Trenton. This means that our residents who are part of the OMNIA network

would have to travel 20 or more miles to access a Tier 1 hospital. For OB services, the distance would be even further. The alternative for Trenton residents would be to visit their local hospital, and be faced with much higher out of pocket costs. Despite these gaps, the DOBI determined that the OMNIA Network was adequate to meet the health care needs of Horizon's members. It's impossible to imagine how a health network can be considered adequate when it would require an expecting mother to travel upwards of an hour to access Tier 1 care at a hospital.

Based on Horizon's own criteria, we feel St. Francis – as well as many of the other hospitals it chose to exclude – is not only qualified to be part of OMNIA's Tier 1 network, but that patients and our community would be better served if we were.

Beyond negative impacts on patient access, OMNIA's exclusion of St. Francis has serious financial ramifications for excluded hospitals.

OMNIA has the potential to shift a significant number of commercially insured patients away from our hospital. Since Horizon has excluded us from its preferred network, it has essentially shrunk the number of insured patients we will serve by steering them to other hospitals that are part of its first tier, which could have a direct impact on our hospitals' financial health. In the City of Trenton, it will threaten the "health safety net" that has been established by this Legislature and the Department of Health to protect the health of residents. I would ask that the Legislature exercise its oversight responsibilities by examining how Horizon OMNIA impacts state health planning, particularly when it comes to cardiac care, high-risk deliveries and trauma.

Both the DOBI and Horizon claim that the OMNIA network will not shift much business. We cannot rely on that assumption. Variables such as the rising cost of healthcare and new healthcare reform regulations are causing employers to shift more of the financial responsibility to its employees. And plans like the one approved by the DOBI will cause employers and consumers to switch providers. That's specifically why OMNIA was created, otherwise they would not have put this much effort into a new network they don't expect a lot of people to use.

The construct of the OMNIA Network and the way in which it was developed runs contrary to the New Jersey Hospital Association's "Principles" regarding tiered networks. Those principles recognize the need to reduce healthcare costs while also maintaining access to healthcare. The principles require that the factors and criteria used to profile providers and place them in tiers or limited networks should be transparent to all involved. NJHA's principles also demand that the DOBI update its regulatory framework for review of limited networks to ensure network adequacy before a plan is certified and marketed to the public and that DOBI obtain sign off on the network adequacy from the Department of Health which has a better understanding of the healthcare providers in New Jersey so that access to care is maintained for all New Jerseyans.

St. Francis is an essential part of the access that our state's poorest residents have to healthcare. We are a safety net for those who can't afford care or are uninsured. Yet, we can't provide that

essential service to our community if we are not financially sound. Our bottom lines are already very stretched. As a result, anything that erodes our ability to serve commercially insured patients impacts our financial viability.

This is a very serious matter for us – one that could have significant impacts on our ability to serve our patients. Despite our pleas, and the grassroots outpouring of concern from local residents, legislators and the news media, neither the DOBI nor Horizon have addressed the major flaws in its OMNIA network, or the serious ramifications it can have for hospitals that are excluded from its first tier.

We will continue our effort to challenge the Department of Banking and Insurance's decision and to push Horizon to reconsider its position, but we urge this body to use the authority you have to find answers to the serious questions that remain about the impact that Horizon's OMNIA network will have on the healthcare landscape in New Jersey.

I'm happy to answer any questions you may have. Thank you for your time and consideration.



Assembly Health and Senior Services Committee
Assembly Regulatory Oversight Committee
Joint Legislative Hearing on the Impact of Tiered Health Insurance Networks
December 2, 2015

Matt Zuino
Senior Vice President, Hospital Services, Virtua

Chairman Conaway, Chairman Gusciora and Members of the Committees:

I am Matt Zuino, Senior Vice President of Hospital Services for Virtua, which is one of the largest health systems in the state providing a broad continuum of healthcare services from health and wellness services to post-acute care. We are recognized by The Joint Commission and Leapfrog as a high quality health system. More people select Virtua for their care than any other hospital in South Jersey.

Thank you for your leadership in conducting this hearing about the impact of tiered health insurance networks. At Virtua, we fully support the transformation of our healthcare system to one that rewards all providers – hospitals, physicians and others – for delivering value and favorable outcomes for our patients but we have concerns regarding the network design of OMNIA.

We know that new insurance products with narrow networks and tiers will become more common and we support that direction.

Our *chief concern* is the way that Horizon created the OMNIA Health Alliance will adversely impact NJ residents' access to high quality healthcare, particularly from the hospitals and physicians that Horizon did not include in Tier 1.

The Horizon OMNIA plan has just one Tier 1 hospital to serve nearly one million residents of Burlington and Camden counties. For the rest of the state, on average, there is one Tier 1 hospital for every 200,000 people.

There is no Tier 1 hospital in Burlington County, the state's largest county by area.
There is only one Tier 1 hospital in Camden County.

During its review process of the OMNIA plan, the State Department of Banking and Insurance notified Horizon that the plan did not meet network adequacy requirements for OB services in Burlington County, falling 2% short.

According to our analysis of available data, we believe that that the deficiencies are significantly greater than DOBI identified – specifically, **that OMNIA fails to meet network adequacy requirements for about one third of Burlington County**, falling short in 15 of Burlington County's 46 ZIP codes.

That means people in certain parts of Burlington County will need to drive a considerable distance to access an OMNIA Tier 1 hospital in the City of Camden in Camden County or at Plainsboro in Middlesex County.

Isn't there something wrong with this picture? Even Horizon's own map of Tier 1 providers reveals this huge, gaping geographic hole in our part of the state.

Horizon announced on November 25 that OMNIA Health Plan members can receive obstetric services at any hospital in Burlington and Mercer Counties at an OMNIA Tier 1 level of benefits *as a benefit exception*.

A Horizon representative told us that that are keeping Virtua in OMNIA Tier 2, but for women covered by OMNIA delivering at Virtua Memorial in Mount Holly, they will handle the women's claims as if they were in Tier 1. This is a wholly unsatisfactory plan because it leaves women and their babies exposed to potential Tier 2 costs as well as concerns such as the following:

- What if a woman develops complications after delivery and needs to be transferred to a medical unit other than maternity?
- What if those complications are other than obstetrical?
- What if the baby requires transfer to the Virtua Voorhees Neonatal Intensive Care Unit at our Voorhees Hospital? Or to our partner The Children's Hospital of Philadelphia?
- How are Horizon's customers supposed to navigate this information?

Virtua delivers more than 8,000 babies a year at its Mt. Holly and Voorhees hospitals. At Virtua Memorial, we are a state-designated Level 2 Maternity Service. At Virtua Voorhees, we are designated as a Regional Perinatal Center with a Neonatal Intensive Care Unit.

But Horizon's plan means people in certain parts of Burlington County will need to drive a considerable distance to access an OMNIA Tier 1 hospital in the City of Camden in Camden County or at Plainsboro in Middlesex County for maternity services – or any other services.

We are disappointed that Horizon did not give us the opportunity to participate in OMNIA Tier 1 even though we have enjoyed a favorable relationship with them:

- We participate in **Horizon's Patient Centered Medical Home (PCMH) program** – ours is Horizon's largest program in the area of Burlington and Camden Counties. Virtua has 13,000 Horizon members, adults and children, cared for by Virtua Medical Group primary care physicians. In fact, Horizon has rewarded us for achieving quality measure targets each program year. However, our PCMH medical patients electing OMNIA as their insurance product will have to pay a higher co-pay to stay with the physicians in the Virtua Medical Group.
- In addition, in July, Horizon executives presented Virtua with **quality awards for the performance of our three acute care hospitals** in the areas of patient safety, quality and cost-of-care measures.

Horizon has exceptional responsibilities to New Jersey and its residents as the leading health services corporation covering nearly half of all residents. That's all the more reason that transparency about the OMNIA family of insurance products is essential.

In conclusion, the way Horizon created the OMNIA Health Alliance will adversely impact NJ residents' access to high quality healthcare. Thank you for taking the time to consider these critically important issues and what remedies the Legislature may consider.

ADDENDUM: More about Virtua

As one of New Jersey's largest health systems, Virtua helps people be well, get well and stay well through a comprehensive range of health care services. Services are delivered through three health and wellness centers, two major ambulatory care centers, three fitness centers, three acute care hospitals, primary and specialty physician practices with 287 physicians plus 87 additional practitioners, three urgent care centers, 11 ambulatory surgery centers, home health services, two long-term care and rehabilitation centers, 12 paramedic units and a wide range of outpatient services.

A leader in maternal and child health services, Virtua delivers more than 8,000 babies a year. Virtua also provides employment and wellness services to 1,700 businesses and corporations.

An innovator in clinical and information technology such as electronic medical records, Virtua is recognized for its groundbreaking partnerships with GE Healthcare, The Children's Hospital of Philadelphia (CHOP) and Penn Medicine.

Virtua has demonstrated its commitment to and capabilities in value-based approaches to providing and coordinating care.

- We formed and operate a Medicare ACO, VirtuaCare.
- And we participate in the CMS joint replacement bundling demonstration project.
- Virtua employs 22 community-based care managers who work with our patients, physicians and community providers.
- Over the past 10 years, Virtua has invested close to \$200 million in health information technologies, electronic medical records and communications.
- For more than 10 years, Virtua has been a leader in our state in deploying a range of telemedicine technologies.

Our hospital in Voorhees reached the top five percent of hospitals nationwide in the latest Press Ganey survey of patient satisfaction.

Our Voorhees hospital again won the Consumer Choice Award from the National Research Corporation.

Our intensive care units in Marlton and Voorhees were honored with Beacon Awards for Excellence from the American Association of Critical Care Nurses.

Virtua employs more than 8,700 people and has been honored as the #1 Best Place to Work in the Delaware Valley every year since 2007. It is the recipient of the Consumer Choice Award from the National Research Corporation. For more information, visit www.virtua.org or www.virtuabroadcastnetwork.org.

Testimony
Kristen Silberstein, Vice President, Managed Care
Valley Health System
December 2, 2015

Valley Health System appreciates the opportunity to testify and applauds the Assembly for holding this important hearing on the significantly flawed OMNIA Health Alliance and OMNIA Health Plans.

Horizon dominates the health care market in NJ, controlling over 42% of the HMO market and over 60% of the individual insurance market – that’s individual policies sold both on and off the federal market exchange. A dominant insurer should not be allowed to dictate which providers succeed in this state and which ones fail nor should it be allowed to damage the reputations of quality hospitals by designating them as “Tier 2.” More importantly, a dominant insurer should not be allowed to market a product based on the false premise that it provides better care coordination and better quality when the product actually has the opposite effect by separating consumers from high performing, high quality physicians.

Horizon’s decision to exclude Valley Hospital from its Tier 1 network yet include Valley’s multispecialty physician group as a Tier 1 provider is evidence of the fact that Horizon’s selection process had very little to do with care coordination or population health and everything to do with demanding deeper hospital discounts in exchange for geographic exclusivity and long term contracts.

With over 15,000 Horizon patients, Valley Medical Group is one of Horizon’s largest Patient Centered Medical Homes. Our extensive multispecialty group practice has over 240 physicians dedicated to population health. In fact, this spring, Valley Medical group received NCQA Level 3 Designation – the highest patient centered medical home designation available – it’s the “Good Housekeeping Seal of Approval” as far as patient centered medical homes go.

What doesn’t make sense to us is how an insurer can put its highly regarded physician partners who only have privileges at Valley Hospital in the untenable position of having to hand off their patients to an unknown physician at a Tier 1 hospital or make our physicians explain to patients that they will have to incur significantly greater out of pocket costs so they can care for them at Valley Hospital. Which option should a patient choose? Be cared for by a stranger at an unfamiliar hospital or stay with their trusted physician and hospital but be financially penalized? The answer is NEITHER. No insurer should be allowed to force a consumer to make such a decision, yet that is precisely what the OMNIA Plans could do to the 15,000 Horizon patients that Valley Medical Group cares for and countless more statewide.

This disconnect is clearly contrary to the concept of population health and jeopardizes the longstanding relationships that patients have with their physicians. If Horizon was truly concerned about better care, why would they offer a product that has the potential to separate patients from the very physicians who have been coordinating their care and doing it in a high quality, efficient manner, at least according to Horizon’s own Patient Centered Medical Home standards? The answer is simple, Horizon is not concerned about population health or better care. Horizon is merely concerned about deep hospital discounts and its own profitability. Physicians and patient

relationships be damned. OMNIA is forcing consumers to make a "loose/loose" decision – my physician or my pocketbook. And for this as well as many other reasons the OMNIA plans should be pulled from the market until all of their flaws can be fixed. With two full months of open enrollment to go, consumers have more than enough time to select a new plan on the health exchange. It is disconcerting that DOBI feels differently. At the very least, new legislation is needed to ensure payers follow a fair, objective and transparent selection process when forming limited provider networks. Thank you.



Treating you better...for life.

**Joint Meeting of the Assembly Health and
Senior Services Committee and the
Assembly Regulatory Oversight
Committee**

Testimony

December 1, 2015

Good morning. I am Ronald C. Rak, JD, CEO of Saint Peter's Healthcare System. I'd like to extend my gratitude to Assemblyman Herb Conaway, Chairman of the Assembly Health and Senior Services Committee, and Assemblyman Reed Gusciora, Chairman of the Assembly Regulatory Oversight, for allowing me the opportunity to present this written testimony today about this very important subject to all New Jersey citizens on behalf of Saint Peter's Healthcare System.

A new partnership between Horizon Blue Cross Blue Shield of New Jersey and several major health care systems was announced in September. Dubbed the OMNIA Health Alliance, Horizon intends to offer lower-cost health insurance for consumers who use select hospitals and doctors in this alliance as well as 12 other hospitals identified as "Tier 1" providers in New Jersey. Those Tier 1 providers will move from a traditional fee-for-service model of health care to a so-called "fee-for-value" model. Fee-for-value models will improve the health of populations they serve, while Horizon claims it is reducing costs. As explained by Horizon, it will give patients strong financial incentives to use Tier 1 hospitals even though the Tier 2 hospitals nominally remain part of the Horizon network.

Unfortunately, without giving Saint Peter's University Hospital any notice or opportunity to state its case, Horizon excluded Saint Peter's from membership in the favored Tier 1 group. Instead, Saint Peter's and 33 other hospitals were ranked as Tier 2. For reasons it has not explained, Horizon has excluded all but one of New Jersey's eight Catholic hospitals from Tier 1. Saint Peter's fears, with good reason, that the OMNIA product will do great harm to our institution, and to the patients we serve, by exerting financial pressure on patients to use Tier 1 hospitals regardless of quality.

Saint Peter's agrees that fee-for-value models are best for the future of health care because fee-for-service models encourage greater use of health care services. In fact, we have several fee-for-value health care initiatives in process designed to improve the quality of care provided at a reduced cost.

But Saint Peter's strongly disagrees that the way to implement fee-for-value is for New Jersey's largest health insurer to discriminate among hospitals and impose financial pressure for patients to use the hospitals Horizon has favored. We also strongly object to the secretive and arbitrary means by which Horizon has implemented this decision.

Specifically, we are very troubled that Horizon launched this product under a cloak of secrecy without disclosing the standards it uses or giving affected hospitals the right to comment. Horizon's CEO has publicly stated that Horizon did not use a RFP process to determine which hospitals it would favor with Tier 1 status. Instead, he said that Horizon "asked no hospitals to participate" but "identified the potential partners that we wanted and approached them." This arbitrary selection process, responsible to no one, is not the way New Jersey's largest health insurer should be making decisions that affect the fate of hospitals throughout the state.

Moreover, it violates the provisions of Horizon's Network Hospital Agreement that give hospitals the right to know Horizon's criteria and standards for new networks or subnetworks, to have advance notice of such new networks or subnetworks, and to join them if the hospital meets

Horizon's criteria. It also appears to violate Department of Banking and Insurance regulations under the Health Care Quality Act of 1997.

The purpose and impact of discriminating between Tier 1 and Tier 2 hospitals is to put financial pressure on patients to use Tier 1. The State Health Benefit Plan has announced that Tier 1 hospitals will provide covered state employees with "lower member cost sharing" than Tier 2. We do not know the financial arrangements between Horizon and the Tier 1 hospitals – and we hope the Committee will thoroughly inquire about them – but it is only reasonable to assume that economics is driving this rather than health care. Saint Peter's and the other Tier 2 hospitals had no chance to protect their interests because Horizon acted in secret. Whether Horizon in fact acted without consulting the favored Tier 1 hospitals is another issue that we hope the Committee will thoroughly investigate.

In an interview last week, Horizon's CEO said that the OMNIA product would give patients who use a Tier 1 hospital "substantial savings in their out-of-pocket cost in the form of lower deductibles, [and] in some cases no deductibles," and that OMNIA "is an incentive based product design for Tier 1." In the same interview, he said that "there isn't any disincentive to use a Tier 2 provider." This defies common sense. On the contrary, we believe that the OMNIA product cannot work unless patients are migrated away from Tier 2 hospitals to Tier 1 hospitals to compensate them for financial concessions they make to Horizon.

The benefits for individual New Jersey residents who opt to enroll in the OMNIA product may also be grossly overstated by Horizon. Take state employees as one example. The average state employee contributes about 20 percent of their annual premium, or roughly \$500. Yet they would expose themselves to a \$1,500 deductible and 80 percent co-insurance and a \$4,500 in-network out-of-pocket maximum, if they are admitted to a Tier 2 hospital, compared to zero deductible, 20 percent co-insurance and 2,500 out-of-pocket maximum at a Tier 1 hospital. (Attachment No. 1.)

The secrecy and financial pressure on patients are all the more troubling because Horizon has arbitrarily assigned many high quality hospitals, including Saint Peter's, to Tier 2. In particular, as shown by the objective quality and patient satisfaction data, in the attachment to our testimony, we are equal to or better than our competitors. (Attachment Nos. 2 and 3)

As a faith based institution Saint Peter's is also troubled that all but one Catholic hospital in New Jersey was excluded from Tier 1. That one hospital appears to have been included because it was the only facility in its catchment area. Whether the exclusion of Catholic hospitals is a coincidence is something that we trust the committee will examine. While we engage in this discussion, we should not ignore the unique quality of care that faith-based institutions deliver to its patients and that there is a huge portion of our state's population that prefer to be treated in a religious-based setting. (See op-ed piece written in the West Palm Beach Times by a family member of a former Saint Peter's hospital patient. (Attachment No. 4.)

Finally, Saint Peter's believes that the long-term impact of Horizon's discriminatory two-tier system in the OMNIA plan could be disastrous for New Jersey's healthcare marketplace, eroding

the quality and availability of patient services, along with the financial stability of those hospitals and healthcare systems that are relegated to second-class status in Horizon's equation. We believe the Horizon model may actually imperil the very existence of some New Jersey hospitals.

The Selection Process

Horizon has not made public the specific criteria it used to select Tier 1 hospitals or the relative weight it gave those criteria. Speaking in generalities, Horizon's CEO said last week that Horizon unilaterally used six "broad categories" to select Tier 1 hospitals:

- Clinical quality
- Service offering across the continuum of care
- Consumer preference data from publicly available sources
- Value-based care capabilities
- Scale of the organizations
- Commitment to value

Saint Peter's appears qualified to be an OMNIA member by every one of those listed measures, yet Saint Peter's was not invited to Tier 1. Instead, as referenced in attachments Nos. 2 and 3, hospitals with lesser safety and quality ratings, clinical expertise, breadth of clinical programs, and reach of marketplace are part of OMNIA. Horizon has given no explanation. We hope the Committee will require one.

Horizon has not disclosed the particulars of its "broad categories." It has not disclosed what consumer preference data it used. It has not disclosed how it measured a hospital's "commitment to value," which seems to be a very subjective standard.

Most importantly, Horizon has not disclosed how it weighted "scale of organizations" against quality of care, scope of services and consumer preference. It is entirely possible that Horizon was willing to sacrifice quality and consumer preference in order to favor larger hospitals or multi-hospital systems. Saint Peter's hopes that the Committee will require Horizon to explain in detail its evaluation process and to justify the selection of the hospitals it chose for Tier 1 and the rejection of those it consigned to Tier 2.

Saint Peter's was only the sixth hospital in the world to be ranked as a Magnet Hospital for Nursing Excellence by the American Nurses Association for four consecutive four-year terms.

The Joint Commission, America's leading accreditor of health care organizations, rates Saint Peter's as one of the nation's Top Performers on Key Quality Measures for positive patient outcomes in the areas of heart attack, heart failure, pneumonia, surgical care, and childhood

asthma. Saint Peter's is the lone New Jersey hospital to be cited for quality care of childhood asthma.

The Saint Peter's NICU is the only such unit in New Jersey to receive a Beacon Award for critical care excellence in the delivery of neonatal intensive care nursing, and the Intensive Care Unit at Saint Peter's is the only ICU in New Jersey to receive a Beacon Award for critical care excellence on five separate occasions.

Health care consumers also rate Saint Peter's highly, as revealed by our Hospital Consumers Assessment of Healthcare Systems and Providers, or HCAHPS scores, which show that patients place Saint Peter's in the 99th percentile, or No. 1 among all hospitals in New Jersey, in environment of care, pain management, use of medicines, discharge instructions, and care transitions, while we rank in the 98th percentile in the responsiveness of medical and support staff. Those rankings are for the most recent May through July reporting period. (Attachments No. 2 and 3.)

Please consider this example of quality from a cost-of-care perspective. Saint Peter's is recognized as a superior hospital for high-risk pregnancies and maternal fetal medicine. Good perinatal care in high-risk/MFM results in fewer babies who are born prematurely and thus fewer babies born with complications requiring NICU admission. In 2014, the average payment made by Horizon for our NICU was \$50,000 per NICU admission.

If good perinatal MFM/high-risk care equals fewer NICU babies, then conversely poor perinatal MFM/high-risk care will equal more NICU babies. Patients in the OMNIA product may not use Saint Peter's highly rated MFM/high risk services because of cost and thus may end up with less than the best perinatal care, resulting in a higher percentage of NICU babies. If even 10 more babies are placed in the NICU, that is \$500,000 to Horizon. Twenty babies equal \$1 million, etc. Our excellent MFM/high-risk services are a cost-saver (and quality producer) to Horizon, the community, and of course to the patient.

In neonatology, when treating our most precious and vulnerable patient population, according to the Vermont-Oxford Network Report, which includes data from more than 1,000 centers, our NICU is a leader in not just saving lives but ensuring our infants do not suffer long-term health complications once they are discharged from the intensive care setting. For example, in 2014, for very low birth weight babies, only 19 percent required oxygen at 36 weeks as compared to 30 percent of all hospitals in the network; only 18 percent of Saint Peter's NICU very low birth weight babies developed chronic lung disease at 36 weeks versus 25 percent of all hospitals.

(Attachment No. 5.)

To illustrate how non-transparent Horizon has been, instead of the six "broad categories" set out by CEO Marino, Horizon is now making public statements that its only criterion for Tier 1 status is the ability of any healthcare system to move from a fee-for-service to a fee-for-value model of care. Even if this is the sole criteria, Saint Peter's is well along on that path:

Examples include:

- Saint Peter's is actively engaged in building and growing our population health strategy. Our state-sponsored Delivery System Reform Incentive Payment (DSRIP) program in diabetes management is but one example of the type of care Saint Peter's is delivering and embarking upon. Our five-year, \$20.5 million program performs early screening of all patients who arrive in our emergency department, our inpatient units and in our ambulatory network for diabetes. We also screen patients via our mobile van, which travels to communities to promote healthy lifestyles. Once a patient is identified as diabetic (or potentially diabetic) we enroll them in DSRIP, which incorporates nutritional support, dietary education, and aggressive prevention of complications from diabetes such as blindness or amputations due to foot ulcers. In our initial pilot of DSRIP, our initiatives resulted in an average absolute reduction in the benchmark laboratory blood test measure of diabetes control, Hemoglobin A1C (HbA1C). A higher HbA1c equates to poorer control, a lower value means better. Furthermore, for those patients enrolled in our DSRIP program, we are witnessing less emergency department visits and less hospital admissions.

- Saint Peter's, in partnership with the New Jersey Hospital Association, has aggressively enrolled its physicians in a new federal program known as the Gainsharing Project. The Gainsharing Project is a creation of the Center for Medicare and Medicaid Innovation. The program enables physicians to focus on treatments that lead to measurably improved outcomes and result in lower costs of care and better quality outcomes. More than 110 physicians at Saint Peter's have joined up thus far.

- Saint Peter's Healthcare System and Partners In Care, New Jersey's oldest physician-owned provider network and healthcare management company, have also entered into an innovative agreement for the hospital's adult medicine primary care and multi-specialty employed physicians and extenders to join the Partners In Care Medicare Accountable Care Organization program. Under this arrangement, Saint Peter's in-house physicians have access to the Partners In Care ACO's full suite of services designed to improve the efficiency and delivery of care for the unmanaged Medicare population.

- Saint Peter's is enrolled in The Centers for Medicare and Medicaid Services (CMS) Value Based Payment Program, which captures data that indicates how well a hospital is performing based upon an established set of quality measures. This program is a de facto reflection of a hospital's commitment to improving health outcomes and providing a safe and nurturing environment for patients. It reviews data on patients who are treated for heart failure, pneumonia, and heart attacks; it incorporates an organization's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) score, which is a standardized survey of hospital patients that captures their unique perspectives on the care provided. Saint Peter's performance score has ranked higher than the New Jersey average for each of the past three years; and for our calendar year to date, based upon a standardized advisory board impact modeler, we are on target to be in the 91st percentile of all hospitals in the nation who participate in Value Based Purchasing. (Attachment No. 6.)

Our commitment to value-based care is further illustrated by our ranking as one of the lowest cost, highest quality health care providers among our competitors in central New Jersey, as reported by Pricewaterhouse Coopers based on measurements by the Centers for Medicare and

Medicaid Services, whose value-based purchasing scores rank providers based on mortality, process of care, efficiency, and patient satisfaction, among a number of clinical quality indicators. (Attachment No. 7.)

The “value” of our services is also reflected by Saint Peter’s status as the go-to provider for a wide range of services, including specialty care that is often difficult to find elsewhere in New Jersey: Saint Peter’s operates the largest Neonatal Intensive Care Unit in New Jersey with 53 bassinets; Saint Peter’s is a designated children’s hospital and a Regional Perinatal Center that operates one of the largest maternity services in New Jersey and in the country; in 2014 alone, the hospital delivered 5,579 babies, the most of any hospital in central New Jersey; and the Saint Peter’s Department of Medical Genetics and Genomic Medicine is among the largest in the Northeast, while its Regional Center for Newborn Screening and Genetic Services is a comprehensive program providing confirmatory diagnostic testing, management, treatment, education, research, and counseling for all disorders currently screened for in New Jersey.

Saint Peter’s is a volume leader in New Jersey in the following clinical areas, based upon 2013 statistics, the most recent available: No. 1 in obstetrics discharges; No. 2 in NICU admissions; No. 3 in epilepsy discharges; and No. 5 in the total number of in-hospital pediatrics cases. (Attachment No. 8.)

Community

Saint Peter’s is also deeply troubled by Horizon’s unexplained exclusion of Catholic hospitals, which would have been included had Horizon considered the quality and reach of their care, and their cost-effectiveness.

Horizon must not ignore that Saint Peter’s, as a faith-based organization, delivers a certain quality of care that is unique to our institution and the seven other Catholic institutions denied access to OMNIA.

Last year, Saint Peter’s treated 16,889 uninsured patients as charity care. Unfortunately, the state’s subsidy to hospitals that provide free or reduced cost of charity care to the uninsured does not fully cover the cost. Catholic hospitals including Saint Peter’s rely on payments received from commercial insurers such as Horizon to defray the costs of providing charity care to economically distressed populations. Horizon’s proposed plan may have the undesirable long-term effect of reducing or eliminating service lines and care options for Medicaid and charity care recipients across New Jersey. This has the potential to create a segregated New Jersey of the haves with private insurance vs. the have-nots with Medicaid, charity care or no insurance.

Catholic hospitals also extend their faith-based mission in support of many other religions and groups. At Saint Peter’s, for example, we have partnered with the Jewish community to sponsor a bedroom suite where families of observant Orthodox Jews may stay, enabling them to walk to see their loved ones who are patients at Saint Peter’s on the Sabbath in accordance with their faith; Saint Peter’s sponsors free ethnic-specific health fairs to a variety of groups, including the Hindu, Asian, Jewish, Muslim, Latino and African-American communities, and the hospital has

launched a bloodless medicine program for the Jehovah's Witness community, to list but a few of our many efforts.

Again, the only conclusion that we can reach, based upon Horizon's actions, is that while Horizon publicly states that the religious nature of any institution was not a qualifying factor, the genesis of this program, whether intended by Horizon or not, is a true threat to faith-based institutions in New Jersey.

Impact

Finally, Saint Peter's treated more than 16,500 individuals in 2014 who were covered by Horizon health insurance. Of that number, 6,500 would be potentially at risk of switching to OMNIA. Saint Peter's estimates that Horizon's OMNIA network, if fully implemented, could result in a \$36 million loss in revenue to Saint Peter's, a significant drain on our operations, impinging upon our ability to sustain programs, grow health networks, and invest in new and needed technology. (Attachment No. 9.)

Conclusion

Saint Peter's opposes the OMNIA plan. As things now stand, it appears decisions were driven as much or more by financial considerations than they were by quality of care or patient choice.

I urge the Committee to stringently examine the following:

- The specific criteria Horizon used to select Tier 1 hospitals and the weight it gave them.
- The balance between size of the hospital or hospital system on the one hand and quality of care, scope of services and patient preference on the other.
- The specific reasons that Horizon selected hospitals for Tier 1 or Tier 2 status.
- The difference in pricing and reimbursement between Tier 1 and Tier 2 hospitals.
- Whether Horizon has made any internal analysis or any statements to Tier 1 hospitals about an increase in patient volume due to Tier 1 status
- Whether Horizon has made any internal analysis or any statements to Tier 1 hospitals about the financial consequences of Tier 1 status.
- Whether Horizon has made any internal analysis of the financial impact of Tier 2 status on hospitals.
- Whether Horizon has made any analysis of the impact on New Jersey residents' access to quality hospital care if non-Tier 1 hospitals are forced out of business as a result of this plan.

- The extent to which Horizon expects the OMNIA Healthcare Alliance to reduce premiums.
- The way in which Horizon expects to realize savings on claims that will support those premium reductions.
- The reason Horizon has excluded all but one Catholic institution from Tier 1 status.
- What discussions if any did Horizon have with regulatory authorities regarding the OMNIA program?

Looking forward, what do I also ask of this Committee on behalf of my healthcare system and others designated Tier 2 in the OMNIA plan?

I plead before this Committee, elected to represent the people of this state

First, for leadership in compelling Horizon to suspend the OMNIA program while the necessary facts are gathered and to implement a process by which all stakeholders can determine how best to create a fair and equitable marketplace that aids systems and consumers alike. And if it should be decided that a two-tiered system best suits the needs of our citizens, I refer to my written testimony, to which I have appended a very instructive article entitled "*Tiered Physician Networks: A New Twist On An Old Issue*," which gives a synopsis of how various state legislatures have addressed the issue of tiered physician reimbursement by insurers. Although this article refers to physician networks its written recommendations starting on Page 19 are applicable to the development of any tiered healthcare network. (Attachment No. 10.) I call upon this Legislature to give serious consideration to the adoption of similar measures with regard to tiered reimbursement to hospitals by insurers of hospitals;

And, second, for leadership in recognizing that while the delivery of healthcare in this state must be rationalized, it cannot and must not be done by the decision of a few insurance executives acting without the input of providers and citizens.

In sum, I am here to hopefully begin a constructive public dialogue about how best we as a state can improve the delivery of healthcare – particularly to our most vulnerable citizens – recognizing those providers who do put quality of care above the bottom line and who bring to the patient experience a level of compassion and commitment to the dignity of all who enter their doors, and also recognizing that the transformation of health care delivery cannot be left to the will of a self-interested few but must be driven by the needs and wishes of our patients.

This discourse that I ask for is long overdue in my opinion. The reconfiguration of healthcare delivery should not – if we have the best interest of the patient at heart – be driven by a powerful insurer and the largest healthcare systems in the State. Size does not always equate with quality of care or with compassion. All healthcare providers should be invited into this discussion and in the process invited to prove their worth.

Thank you for your time.

Attachment 1

State Active Employee Plans

Exhibit 6A – Plan Year 2016 Employee Plan Option Summary

	\$15 copay		1525		2030		2035		Tiered Network Plan Option		HD1500	HD 4000
	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	Tier 1	Tier 2		
Member Cost Sharing	\$15	\$15	\$15	\$15	\$20	\$20	\$20	\$20	\$5	\$20	NA	NA
Primary Care Copays	\$15	\$15	\$25	\$15	\$30 for adults/ \$20 children	\$35	\$35	\$35	\$15	\$30	NA	NA
Specialist Care Copays	\$75	\$75	\$100	\$75	\$125	\$200	\$200	\$200	\$100	\$100	NA	NA
Emergency Room Copay	None	\$100 for medical appliances and DME	None	None	None	\$200*	\$200*	\$200*	None	\$1,500	\$1,500**	\$4,000**
In-Network Deductible	10% on ambulance, prosthetic devices, DME	None	10% on ambulance, prosthetic devices, DME	None	10% on ambulance, prosthetic devices, DME	None	20% on facility charges, imaging, ambulance, prosthetic devices, DME	None	None	80%	20% on all in-network charges	20% on all in-network charges
In-Network Coinsurance	\$400	\$5,480	\$100	\$5,480	\$800	\$5,480	\$2,000	\$2,000	None	None	r/b	r/b
In-Network OOP Maximum*	\$100	NA	\$100	NA	\$200	NA	\$800	\$800	NA	NA	\$1,000 (does not include deductible)	\$1,000 (does not include deductible)
OON Deductible*	30%	NA	30%	NA	30%	NA	30%	30%	NA	NA	combined with in-network deductible	combined with in-network deductible
OON OOP maximum	\$2,000*	NA	\$2,000*	NA	\$5,000*	NA	\$5,500**	\$5,500**	NA	NA	40%	40%
OON Inpatient Hospital Deductible	\$200 per stay	NA	\$200 per stay	NA	\$500 per stay	NA	\$600 per stay	\$600 per stay	NA	NA	NA	NA
Employer HSA Funding	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Prescription Drug Copays												
Retail Copayments	\$3	\$3	\$7	\$3	\$3	\$7	\$7	\$7	\$7	\$7		
Generic	\$10	\$10	\$16	\$10	\$16	\$16	\$16	\$16	\$16	\$16		
Preferred Brand	\$25	\$25	\$35	\$25	\$45	\$35	\$45	\$45	\$45	\$45		
Non-Preferred Brand	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5		
Generic	\$15	\$15	\$18	\$15	\$18	\$18	\$18	\$18	\$18	\$18		
Preferred Brand	\$20	\$20	\$28	\$20	\$28	\$28	\$28	\$28	\$28	\$28		
Non-Preferred Brand	\$7	\$7	\$7	\$7	\$7	\$7	\$7	\$7	\$7	\$7		
Rx OOP Maximum*	\$1,370	\$1,370	\$1,370	\$1,370	\$1,370	\$1,370	\$1,370	\$1,370	\$1,370	\$1,370		
*Family amounts are 2.5 x per member amounts listed in table.												
**Family amounts are 2 x per member amounts listed in table.												

The 1525, 2030, and 2035 plans are offered on a PPO plan basis only. Tiered Network Plan Option does not have OON benefits.

SHBP State Employee Group
Plan Year 2016 Tiered Network Rates
July 2015

30x

Attachment 2

Quality and Performance Improvement Highlights across Central New Jersey

(SPUH, RWJ:NB, RWJ:Rahway, RWJ:Hamilton, Princeton, Raritan Bay)

All data relative to information below is from Hospital Compare and The Leapfrog Group

HCAHPS (data source Hospital Compare 10/1/2013-9/30/2014)

- SPUH is the number 1 hospital in our service area for HCAHPS
- SPUH out performs all hospitals in our service area in the overall patient experience of care
- SPUH out performs and is ranked higher all hospitals in our service area for Communication with RN's, Communication with MD's, Receiving help when needed, Pain control, and recommending the hospital
- SPUH ranks in the top 10% out of service area and most Tier 1 hospitals. Only Hackensack ranks higher
- Better than Clara Mass, Pallasades, and Community in all HCAHPS domains

Core Measures (data source Hospital Compare 10/1/2013-9/30/2014)

- Saint Peter's has been a Top Performer in TJC since 2012- present for Acute Myocardial Infarction, Congestive Heart Failure, Pneumonia, and Surgical Care Improvement Project.
- Additionally SPUH is a top performer in TJC for children's asthma care since 2013- present
- Better in all core measure areas in AMI than RWJ: Rahway and Princeton
- Better in all core measure areas in CHF than RWJ: NB, RWJ:Hamilton, Princeton and Raritan Bay
- Better than all service area hospitals in the surgical care improvement project
- Better than all service area hospitals in the influenza immunization
- Better than or the same in all Stroke metrics compared to SPUH service area hospitals
- Better than RWJ:Rahway, Princeton and Raritan Bay in overall VTE core measure compliance
- Surgical Care Improvement Project better than Hackensack, Community, Newton, and RWJ:Hamilton
- ED throughput better than Clara Mass, Hackensack, Newark Beth Israel, Community, and Newton in all throughput timing measures
- Influenza better than all Tier 1 hospitals

- Stroke SPUH is better than Princeton, Hackensack and Newton hospitals in all stroke measures
- VTE better than Newton

Complications, Hospital Acquired Infections, Readmissions/Mortality (data source Hospital Compare 10/1/2013-9/30/2014)

- SPUH overwhelmingly shows no difference than the surrounding service area hospitals related to
 - Hip/knee sx complications
 - catheter associated urinary tract infection
 - Serious sx complications
 - SSI colon
 - Central line infection rate
 - SSI hysterectomy
 - MRSA prevalence (better than ALL)
 - C.diff prevalence (Better than All)

LeapFrog (Data source The Leapfrog group)

- SPUH has fully met all Leapfrog standards related to CPOE, ICU MD coverage/skills, Steps to avoid harm and the management of serious errors. Same/ Better than 100% of hospitals in this group
- SPUH has fully met Leapfrog standards related to early elective delivery, maternity care standards and high risk delivery. SPUH is the same/better than 76% of all hospitals in this comparison group across the metrics of maternity care.
- SPUH has fully met Leapfrog standards related to hospital acquired pressure ulcers and hospital acquired injuries.
- SPUH is better than RWJ:NB in all areas within The Leapfrog Group Hospital Acquired Conditions
- SPUH is better than RWJ:NB and RWJ: Rahway in LOS

Data Period 6/15-8/15	SPUH	RWJ:NB	RWJ:Rahway	RWJ: Hamilton	Princeton	Raritan Bay
-----------------------	------	--------	------------	---------------	-----------	-------------

Leapfrog Safety Score Spring 2015	B	C	A	B	B	C
-----------------------------------	---	---	---	---	---	---

The Leapfrog Hospital Survey is the gold standard for comparing hospitals' performance on the national standards of safety, quality, and efficiency that are most relevant to consumers and purchasers of care. The survey is the only nationally standardized and endorsed set of measures that captures hospital performance in patient safety, quality and resource utilization. Hospitals that participate in the Leapfrog Hospital Survey achieve hospital-wide improvements that translate into millions of lives and dollars saved. Leapfrog's Hospital Safety Score® assigns A, B, C, D and F grades to more than 2,500 U.S. hospitals based on their ability to prevent errors, accidents, injuries and infections.

Data Period 6/15-8/15	SPUH	RWJ:NB	RWJ:Rahway	RWJ: Hamilton	Princeton	Raritan Bay
General Information						
CPOE	fully implemented	fully implemented	substantial progress	substantial progress	fully implemented	some progress
ICU MD	fully implemented	fully implemented	willing to report	some progress	fully implemented	fully implemented
Steps to Avoid Harm	fully implemented	fully implemented	fully implemented	some progress	willing to report	substantial progress
Managing Serious Errors	fully implemented	fully implemented	fully implemented	willing to report	fully implemented	fully implemented
Maternity Care						
Early Elective Delivery	fully implemented	fully implemented	NA	some progress	fully implemented	substantial progress
C-Section	some progress	some progress	NA	willing to report	fully implemented	some progress
Episiotomy	willing to report	some progress	NA	substantial progress	substantial progress	willing to report
Maternity Care Standard Precautions	fully implemented	fully implemented	NA	fully implemented	fully implemented	fully implemented
High Risk Delivery	fully implemented	some progress	NA	NA	NA	NA
High Risk Sx	These are volume related indicators and performance measurement					
AAA repair	substantial progress	fully implemented	some progress	NA	substantial progress	willing to report
Pancreatic Resection	some progress	substantial progress	NA	NA	NA	willing to report
Hospital Acquired Conditions						
CLABSI	substantial progress	some progress	fully implemented	some progress	substantial progress	substantial progress
CAUTI	some progress	willing to report	fully implemented	substantial progress	fully implemented	willing to report
HAPU	fully implemented	fully implemented	fully implemented	willing to report	fully implemented	some progress
HA Injury	fully implemented	substantial progress	fully implemented	substantial progress	fully implemented	fully implemented
Resource						
LOS	some progress	willing to report	willing to report	substantial progress	some progress	some progress
Readmission	some progress	substantial progress	fully implemented	some progress	substantial progress	substantial progress
Leapfrog Safety Score Spring 2015	B	C	A	B	B	C

Better than SPUH
Same as SPUH
Worse than SPUH

Attachment 3

	SPUH	RWJ:NB	RWJ:Rahway	RWJ: Hamilton	Princeton	Raritan Bay
Data period 10/1/13-9/30/14						
HCAHRS (measure in %; higher is better)						
Communication with RN	83	79	77	78	76	76
Communication with MD	80	79	77	79	78	78
Received Help when needed	66	65	65	63	61	62
Pain Control	74	68	72	74	67	67
Communication about Meds	62	62	61	66	62	58
Cleanliness	71	68	71	70	75	69
Quietness	56	50	52	60	64	55
Overall Hospital Rating	73	70	64	63	74	60
Recommend Hospital	70	76	66	67	77	60
Core Measures						
AMI (measures are in %; higher is better)						
PCI within 90 minutes	88	98	89	98	95	91
Aspirin at Discharge	100	99	100	100	95	99
Stat in at Discharge	99	100	98	100	95	97
CHE (measures are in %; higher is better)						
Discharge Instructions	98	98	100	98	81	95
Eval of Left Ventricular Function	100	100	100	100	100	100
ACE/ARB for EF < 40%	100	100	100	100	100	100
PNE (measures are in %; higher is better)						
Right Antibiotic	94	99	96	98	98	97
Sx Care Improvement Projects (measures are in %; higher is better)						
Right Antibiotic for outpt sx	100	99	98	98	100	93
Antibiotic within 1 hour	100	99	100	98	100	99
Antibiotics stopped within 24 hours	98	99	97	97	100	93
VTE proph for the surgical pt	100	100	100	100	100	100
cardiac pt with sx: beta blocker therapy	100	100	100	100	100	100
Urinary catheter removal by end of POD2	100	100	100	97	97	100
ED Timeliness (measurements in minutes; lower is better)						
Avg time for fracture pt to rec pain med	51	46	32	50	62	63
Avg time in ED before admitted	381	538	318	321	301	341
Avg time from MD to admit	180	312	133	114	79	118
Avg time tx & release	134	143	113	160	163	146
Door to Doc time	25	23	21	35	20	66
Preventative Care (measures are in %; higher is better)						
Influenza Immunization	98	93	98	95	87	99
CVA (measures are in %; higher is better)						
Received Med to breakdown clot	98	97	100 NA	98	82 NA	99
VTE Proph for the CVA pt	100	100	99	98	96	100
Blood Thinner	95	99	94	100	86 NA	100
Statin therapy education	98	98	87	100	88	87
Rehab assessed and offered	100	99	98	100	92	95
VTE (measures are in %; higher is better)						
VTE Proph	100	99	98	99	98	100
VTE Proph in th ICU	97	98	79	97	86	88
VTE recommended treatment	98	98	97	100	89	89
Blood thinner with blood work checked	100	100	92	86	90	82
education	100	97	100	100	100	99
Periatal Care (measures are in %; lower is better)						
Early Elective Delivery	86	100	97	87	93	84
	0	0 NA		5	0	12

Better than SPUH
 Same as SPUH
 Worse than SPUH

36x

	SPUH	RWJ:NB	RWJ:Rahway	RWJ:Hamilton	Princeton	Raritan Bay
Complications	SPUH no different than national average and same/better than 97% of this comparison group					
Hip/knee sx complication	no different	no different	no different	no different	no different	no different
serious complications	no different	worse	no different	no different	no different	no different
Hospital Acquired Infection	SPUH is better than the national average in CLABS, MRSA and C diff. SPUH is the same/better than 94% of this comparison group					
CLABS	Better	better	better	no different	no different	better
CAUTI	no different	worse	better	no different	no different	no different
SSI colon	no different	no different	NA	no different	no different	no different
SSI hysterectomy	no different	no different	NA	no different	no different	no different
MRSA prevalence	better	worse	NA	NA	no different	NA
C diff Prevalence	better	no different	no different	no different	no different	worse
Readmissions and Mortality	SPUH no different than national average. SPUH is same/better than 90% of this comparison group (except overall readmission rate of which SPUH is worse *)					
COPD readmission	no different	no different	no different	no different	no different	no different
COPD mortality	no different	no different	no different	no different	no different	no different
AMI readmission	no different	no different	no different	no different	no different	no different
AMI mortality	no different	no different	worse	no different	no different	no different
CHF readmission	no different	no different	no different	no different	no different	no different
CHF mortality	no different	no different	no different	no different	no different	no different
PNE readmission	no different	no different	no different	no different	no different	no different
CVA readmission	no different	no different	no different	no different	no different	no different
CVA mortality	no different	worse	no different	no different	no different	no different
Hip/knee sx readmission	no different	no different	worse	no different	no different	no different
30 day Hospital wide readmission *	worse	no different	no different	no different	no different	no different
Ratings						
Better than Nation						
No Different than Nation						
Worse than Nation						

Data Source: Hospital Compare

Better than SPUH
Same as SPUH
Worse than SPUH

Attachment 4

"No one wants to outlive their child. And yet, that is what sometimes happens in those worst of scenarios for any parent."

By Barbara Yoresh

"A 37-year-old woman died last week on the oncology floor of a leading New Jersey hospital. Only six weeks prior, she had been admitted to that same hospital to undergo tests to determine the cause of the anemia which was sapping her strength. A CAT scan revealed a tumor in her colon and a subsequent procedure determined that it had metastasized to her liver. Doctors said that the size of the tumor and level of involvement indicated that the cancer had been 'growing' undetected for at least three years.

The diagnosis came as a complete, unexpected shock.

A day or so later – on Father's Day – she called her father in Florida with the news. Less than 36 hours later, he was at her bedside. Surgery was scheduled to remove the primary tumor and because the cancer was advanced, aggressive chemotherapy treatment was advised as soon as she had sufficiently recovered from the operation. But her weakness lingered, along with raging 'tumor' fevers that necessitated a delay in administering the toxic chemical brew that was hoped would shrink the liver tumor – for a time.

She was re-admitted to the hospital and once again, the father in Florida received a call. After a brief morning conversation with his daughter's doctor and chief oncology nurse, the father was told it would be advisable to come once again to the hospital 'as soon as possible.' By the wee hours of that same night, he and his wife were once again at the bedside of his daughter whose face was now drawn and whose abdomen was severely distended from the liver's cancer.

Bending low over his sleeping daughter – his firstborn – the father whispered a greeting in her ear and kissed her. Her eyes opened and she smiled in recognition and asked him what made him come more than one week ahead of a planned visit. He smiled and said he just wanted to be with her. And for one week she was in the truest sense of togetherness.

Dying in a hospital is surely not on anyone's list of preferences but this was no ordinary hospital. St. Peter's University Hospital in New Brunswick, N.J. is a 500-bed Catholic hospital that lovingly and compassionately tends to the emotional and spiritual needs of its patients as well as providing the highest quality medical care. The 'whole person' is nurtured here – including the patient's family and friends – in a manner which ministers to everyone regardless of race, creed or religious affiliation.

The daughter had a fiancé and they had hoped for an August wedding in which Dad would give her away. But August was beyond the reach of her survival and when they realized it, the head oncology nurse, hospital staffers and others rushed to plan and execute a wedding ceremony and celebration right there in the hospital's healing garden room. Family, friends, co-workers, hospital staff and chief executive officers and administrators jammed the flower-filled room while the daughter, dressed in a bridal 'gown' of white nightgown and satin robe, adorned with an actual bridal veil borrowed from her friend and carrying a 'bouquet' of three pink roses brought by her step-mother was wheeled into the room by her father and exchanged wedding vows. She remained awake and alert during the ceremony through sheer will and later nearly collapsed back into her bed from complete exhaustion.

The father's wife had been in many hospitals and years ago had been Director of Public and Community Relations for an acute-care facility in Palm Beach County. Yet what she and her husband witnessed and experienced at St. Peter's was beyond any conception of good patient and family care. For most of her life, the wife played 'hide and seek' with God. She wanted to believe that a benevolent supreme being saw and met the needs of mortal men. Though she tried her best to live by the Golden Rule of 'doing unto others,' she somehow failed to find the God she so desperately wanted to know.

By the end of the week at Saint Peter's, she realized she had been looking in the wrong places. Unlike corporate 'bigwigs' ensconced in unreachable ivory towers, she finally learned that God wasn't confining himself to looking down from heaven but rather was out and about with mankind – acting through blessed individuals to reach the souls of those in need. The wife learned this through the kindness and compassion of those working on that oncology floor. And she and her husband – both Jewish – experienced a life-altering rebirth of spirit through the wise counsel of a nun who serves as chaplain there. They learned that God is not fettered by the confines of a house of worship or by specific religious doctrine. And they learned from her that even those who profess to devoutly 'practice' their religion oftentimes do not live it. Sister Barbara told them that sometimes there are people so embittered and closed spiritually, that they become a poison to the souls of others and must therefore be avoided.

The father and wife had known what the Sister said was true but her affirmation of those truths gave them strength to face the imminent death of the daughter and deal with other family members who were deaf and blind to the gifts of compassionate love those at St. Peter's (and God himself) so unselfishly offered to any and all. The wife realized she no longer had to search for an elusive God. He had been with her all along but she had been looking in loftier places. Who knew that God wore street clothes instead of a white robe? Who knew that He wore many faces? ...

The face of the head oncology nurse – a woman whose highly-skilled professionalism is equaled if not exceeded by her godliness, kindness and ability to make magic happen on her floor ...

The face of a spunky, compassionate nun whose wit and wisdom were a marvelous blessing and testament to the life of service to others she chose ...

The face of a 24-year-old nurse on that cancer floor who chose to care for terminally sick patients rather than mothers in childbirth on an upper floor ...

The face of a West Indian nursing assistant who took the hands of the husband and wife and prayed a secular prayer over the body of the young woman now mostly asleep and only hours from death ...

The faces of the doctors who gently, tenderly cared for the daughter and told her – with the highest level of compassion – that things were now taking an irrevocable slide toward an imminent end but that it would be peaceful and pain-free ...

The face of the patient herself – who found a gentle peace and appreciation for those caring for and about her that had eluded her until those final days ...

The face of family members from adjoining rooms whose own loved ones were battling for their lives and yet who found the time to pray and give comfort to others ...

The face of a twenty-something volunteer – a painfully thin young man who willingly and without pay went from room to room refilling water pitchers but who could have been with his friends enjoying the gaiety of youth ...

The face of the hospital's health care system CEO and president – a lawyer who at age 45 wanted to enter the priesthood but who instead was gently guided and encouraged by a Cardinal at the Vatican to take on the ministry of St. Peter's University Hospital ...

All the faces at St. Peter's – filled with a beatific benevolence and goodness that was out of this secular world.

There was ... is ... an aura there and it is divine. For the life of the daughter which was lost, so much was also gained. With the grief came grace, peace and love.

And now, her father – my husband – will eternally carry her memory in his heart and we will carry the blessings of St. Peter's University Hospital in our souls.

Attachment 5

Center 55 and Network Values
Key Performance Measures - All VLBW Infants

Measure	Center (2014)			Network (2014)		
	Cases	N	%	N	%	Q3
Mortality						
Mortality	12	102	11.8%	60,200	14.4%	18.0%
Mortality Excluding Early Deaths	11	101	10.9%	57,234	10.0%	12.8%
Death or Morbidity						
Death or Morbidity	35	102	34.3%	60,148	43.5%	49.5%
Chronic Lung Disease						
Chronic Lung Disease	17	92	18.5%	51,418	25.1%	30.6%
CLD: Infants < 33 Weeks	17	84	20.2%	47,179	26.7%	32.8%
Pneumothorax						
Your Center	7	102	6.9%	58,669	4.1%	5.6%
Any Location	7	102	6.9%	58,671	4.4%	5.9%
Late Bacterial Infection						
Your Center	9	96	9.4%	56,100	8.1%	10.0%
Any Location	9	96	9.4%	56,101	8.3%	10.3%
Coagulase Negative Staph						
Your Center	6	96	6.3%	56,119	5.2%	6.7%
Any Location	6	96	6.3%	56,119	5.4%	6.8%
Nosocomial Infection						
Your Center	9	96	9.4%	56,099	11.6%	14.4%
Any Location	9	96	9.4%	56,099	11.9%	14.8%
Fungal Infection						
Your Center	0	96	0.0%	56,128	0.8%	0.7%
Any Location	0	96	0.0%	56,128	0.9%	0.8%
Any Late Infection						
Your Center	9	96	9.4%	56,098	12.0%	14.8%

Report Generated on 9/30/2015. Data from your center was last received on 9/5/2015 and is normally available on the day after submission. Information contained in this report is generated for quality assessment and improvement and is subject to the Vermont Oxford Network Membership Agreement and Policy on Data Use: <http://www.vtoxford.org/dataset>.

Copyright © 2015 Vermont Oxford Network. All rights reserved.

43x

Center 55 and Network Values
Key Performance Measures - All VLBW Infants

Measure	Center (2014)			Network (2014)			
	Cases	N	%	N	%	Q1	Q3
Any Location Any IVH	9	96	9.4%	56,098	12.3%	4.0%	15.4%
Your Center Any Location Severe IVH	24 24	89 89	27.0% 27.0%	53,154 53,227	23.1% 24.5%	12.5% 13.8%	26.9% 28.8%
Any Location ROP	6	89	6.7%	53,227	8.0%	3.1%	10.5%
ROP Severe ROP Cystic PVL	25 1	74 74	33.8% 1.4%	43,066 43,066	31.5% 6.3%	12.5% 0.0%	38.1% 8.1%
Cystic PVL Necrotizing Enterocolitis	1	94	1.1%	54,082	2.8%	0.0%	4.0%
Your Center Any Location Extreme LOS	4 4	102 102	3.9% 3.9%	58,672 58,673	4.9% 5.4%	0.0% 0.0%	6.4% 6.9%
Extreme LOS (survivors only)	4	90	4.4%	51,227	4.4%	0.0%	6.3%

44x

**Center 55 and Network Values
Respiratory Outcomes - All VLBW Infants**

Measure	Center (2014)			Network (2014)		
	Cases	N	%	N	%	Q3
Respiratory Distress Syndrome	94	102	92.2%	58,649	72.9%	87.0%
Respiratory Distress Syndrome Pneumothorax	7	102	6.9%	58,669	4.1%	5.6%
Your Center	7	102	6.9%	58,671	4.4%	5.9%
Outcomes at 28 Days						
Oxygen	38	88	43.2%	47,651	46.0%	54.3%
Outcomes at 36 Weeks						
Oxygen	17	86	19.8%	41,150	30.3%	36.9%
Chronic Lung Disease	17	92	18.5%	51,418	25.1%	30.6%
CLD: Infants < 33 Weeks	17	84	20.2%	47,179	26.7%	32.8%
Conventional Ventilation	3	86	3.5%	41,144	3.5%	4.0%
High Frequency Ventilation	0	86	0.0%	41,150	0.7%	0.0%
High Flow Nasal Cannula	8	86	9.3%	41,144	14.9%	21.3%
Nasal IMV or SIMV	4	86	4.7%	41,146	2.2%	2.6%
Nasal CPAP	5	86	5.8%	41,141	6.5%	7.7%

Report Generated on 9/30/2015. Data from your center was last received on 9/5/2015 and is normally available on the day after submission. Information contained in this report is generated for quality assessment and improvement and is subject to the Vermont Oxford Network Membership Agreement and Policy on Data Use: <http://www.voxford.org/dataset>.

Copyright © 2015 Vermont Oxford Network. All rights reserved.


45x

Attachment 6

46x

Hospital Value-Based Purchasing (VBP) is part of the Centers for Medicare & Medicaid Services' (CMS') long-standing effort to link Medicare's payment system to a value-based system to improve healthcare quality, including the quality of care provided in the inpatient hospital setting.

- The program attaches value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country.
- Participating hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide.

Value Based Purchasing (data source CMS.gov)	FY2014 *	FY2015	FY2016	
SPUH Total Performance Score *	62.51	34.6	33.89	SPUH has ranked higher than NJ average
NJ average Total Performance Score	47.66	33.6	32.00	SPUH has ranked higher than NJ average
SPUH Percentile Rank (higher is better)	NA	43%	48%	Using the current data FY 2017 projection is  91% per advisory board calculator**








*FY2014 criteria was different (Total Performance Score-FY2014 was process and experience only) FY2015 and FY 2016 the Total Performance Score is a comparison with process, experience, outcomes and efficiency metrics.

**The advisory board calculator is a customized Medicare Value Based Purchasing Impact Modeler that allows an individual hospital to concurrently evaluate their Value Based Purchasing Impact

SPUH has shown consistent growth and commitment to value based care versus fee based care evidenced by

- Total performance score which has outperformed the NJ statewide average FY2014-FY2016

- The percentile ranking increase by 5% from FY2015 to FY2016

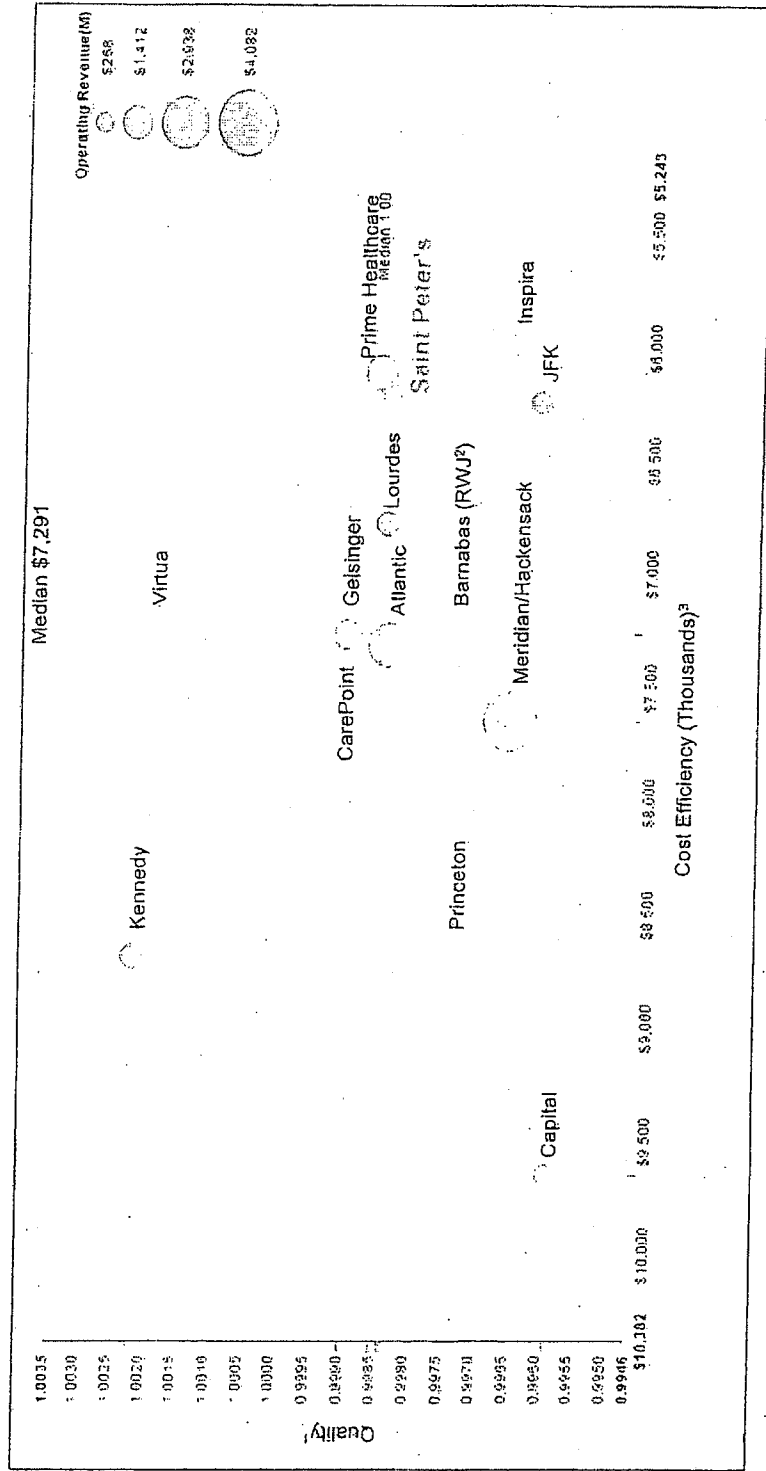
Hospital	Total Performance Score FY2015 (higher is better)
SPUH	34.6
RWJ NB	26.48 
Princeton	31.7 
Overlook	29.7 
Morristown	35.94 
St. Barnabas	38.82 
Newark Beth Israel	21.05 
Hackensack	36.61 

SPUH total Performance score is higher than all service area

Attachment 7

Quality: Cost of Care Comparison

Saint Peter's Quality is higher than most of their competitors, including several of the larger players in the market, while their cost profile is very favorable and among the highest quartile



¹ Quality - CMS Value Based Purchasing Scores. Released on annual basis and based on a ranking. CMS defines twelve measures for process of care, five measures for mortality, one measure for efficiency, and nine measures for patient satisfaction. ² RWJ included in Barnabas numbers. ³ CMS Cost Reports (expense per adjusted admission Area Wage Index (AWI) CMI)
 Sources: AHD.com, CMS

49x

Attachment 8

According to the New Solutions Statewide Databank, in 2013 the below volumes of patients show a large attribution to SPUH.

Statewide Discharges and rank in NJ 2013

Overall largest volume in area attributed to SPUH

Hospital	Neonate	Epilepsy	Pediatrics	Obstetrics
SPUH	1142 (2)	588 (3)	3036 (5)	6521 (1)
RWJ: NB	517	411	3236	2487
Princeton	295	151	641	2047
St. Barnabas	881	1096	2376	5948
Newark Beth Israel	865	344	2946	3535
Morristown	658	347	2088	4587
Monmouth	572	193	2066	4820
Overlook	246	528	759	2715

Attachment 9

Saint Peter's University Hospital

Payor Name	Service	Count	Payments	Potential Payment Movement to OMNIA*
HORIZON BLUE CROSS ACA	Inpatient	128	\$766,861	
HORIZON BLUE CROSS INDEMNITY	Inpatient	51	\$894,112	
HORIZON BLUE CROSS HMO	Inpatient	150	\$1,243,148	\$1,243,148
HORIZON BLUE CROSS POS	Inpatient	1,952	\$22,250,019	\$22,250,019
HORIZON BLUE CROSS PPO	Inpatient	2,457	\$24,189,010	
	Inpatient Total	4,738	\$49,343,150	\$23,493,167
HORIZON BLUE CROSS ACA	Outpatient	180	\$203,366	
HORIZON BLUE CROSS INDEMNITY	Outpatient	375	\$706,373	
HORIZON BLUE CROSS HMO	Outpatient	1,115	\$677,957	\$677,957
HORIZON BLUE CROSS POS	Outpatient	7,470	\$11,938,493	\$11,938,493
HORIZON BLUE CROSS PPO	Outpatient	18,404	\$16,372,808	
	Outpatient Total	27,544	\$29,898,998	\$12,616,451
	Grand Total	32,282	\$79,242,148	\$36,109,618

Horizon Plan Membership	Membership Count	Potential Membership Movement to OMNIA*
HORIZON BLUE CROSS ACA	223	
HORIZON BLUE CROSS HMO	695	695
HORIZON BLUE CROSS INDEMNITY	225	
HORIZON BLUE CROSS POS	5,827	5,827
HORIZON BLUE CROSS PPO	9,871	
Grand Total:	16,841	6,522

* If full implementation of OMNIA Plan occurs

Attachment 10

TIERED PHYSICIAN NETWORKS: A NEW TWIST ON AN OLD ISSUE

Christine C. Rinn, Esquire
Crowell & Moring LLP
Washington, DC

Over the last few years, there has been a flurry of activity involving the design and implementation of tiered physician networks, challenges to the legality of such networks, and regulating these networks. Although the tiered network initiative is relatively new, the underlying concept of categorizing physicians for coverage purposes is not. Similarly, challenging and regulating such categorization is nothing new. This member briefing examines the origin of tiered physician networks, the legal challenges managed care organizations (MCOs) face from physicians and others in implementing such networks, and state efforts to regulate tiered network programs and the performance-based evaluations used to establish these programs.

At its core, a tiered network program offers financial incentives (e.g., lower out-of-pocket costs) to MCO enrollees to obtain healthcare services from physicians in a preferred or higher tier (i.e., tier one). The tiering initiative is an evolution of the basic tiering mechanism that has long been fundamental to health maintenance organizations (HMOs) and other MCOs—the division between participating providers and non-participating providers. Aside from signifying a provider's willingness to contract on terms acceptable to the MCO, inclusion of a provider in an MCO's provider directory also signifies that a provider has met the credentialing criteria and other qualifications used by the MCO in selecting providers. Having separate tiers of

participating providers is a refinement of that basic model, permitting MCOs to recognize quality and cost-effectiveness and provide signals and incentives to consumers to utilize providers who are so recognized. Such programs may also incentivize providers to work to satisfy the screening criteria used to qualify for preferred tiered status:

There are several forces that are driving tiered networks and the performance-based evaluations that underlie them. One force is employers who seek to control the costs of providing health benefits to employees while still providing employees with access to quality healthcare services. Another force is consumer-directed healthcare and consumers' need for information to make quality and cost-minded decisions. A third force is the federal government, which has sponsored and otherwise encourages pay-for-performance initiatives that reward the provision of quality care in a cost-effective way.¹

Potential Bases for Challenge

Before tiered networks, physicians and other healthcare providers sought relief in the courts for their exclusion or termination from MCO participating provider networks. A key case in this area is *Harper v. Healthsource, Inc.*² In *Harper*, a physician who participated in the Healthsource HMO as a surgeon and primary care physician challenged the HMO's decision to terminate his participating surgeon status for failure to meet credentialing criteria. Healthsource members accounted for approximately 40% of the physician's patient panel. Among his many allegations, Dr. Harper claimed that the termination without cause provision in the participating agreement, or the termination in his case, was void as against public policy, and that the HMO violated state law in refusing to provide him with certain records related to the credentialing decision.³ The court held that Dr. Harper was entitled to proceed upon the merits of his claim that the

¹ CMS Press Release, "Medicare 'Pay For Performance (P4P)' Initiatives," (Jan. 31, 2005).

² 674 A.2d 962 (N.H. 1996). See also *Potvin v. Metropolitan Life Ins. Co.*, 54 Cal. App. 4th 936, 63 Cal. Rptr. 2d 202 (1997) *affirmed and superseded by* 22 Cal. 4th 1060, 95 Cal. Rptr. 2d 496, 997 P.2d 1153 (2000).

³ Dr. Harper claimed that Healthsource was "manipulating and skewing the records of treatment he had provided to several of his patients and that such inaccuracies adversely affected other subsequent reports." 674 A.2d at 963.

HMO's decision to terminate its relationship with him was made in bad faith or violated public policy.⁴ According to the court, "[i]f a physician's relationship is terminated without cause and the physician believes that the decision to terminate was made in bad faith or based upon some factor that would render the decision contrary to public policy, then the physician is entitled to review of the decision."⁵ The court further noted that the public has a substantial interest in the relationship between an HMO and their preferred provider physicians because this relationship is perhaps the most important factor in linking a particular physician with a particular patient. "We conclude that the public interest and fundamental fairness demand that a health maintenance organization's decision to terminate its relationship with a particular physician provider must comport with the covenant of good faith and fair dealing and may not be made for a reason that is contrary to public policy."⁶

Why Does Provider Tiering Pose New Legal Challenges?

Unlike the initial decision not to contract with a particular physician or the subsequent decision to terminate a physician's participation status, physicians who are placed in a less advantageous tier are nevertheless allowed to remain in the MCO's participating provider network. So what is all the fuss about? One reason is the public availability of a physician's tiered status as well as the general or specific basis for the tier assignment. MCO marketing and benefit materials as well as provider directories include some sort of description of the tiered network, the basis for assigning a physician to one tier versus another, and the advantages to the consumer for seeking care from a physician in a higher tier. A related reason is that MCOs actively market tiered networks to employers. Thus, being a preferred tier presents better opportunities to grow and maintain a physician's patient panel. Conversely, being in a higher-cost tier

⁴ In his petition, Dr. Harper asserted that his efforts to correct errors made in patient records played a role in Healthsource's decision, and he argued on appeal that public-policy should condemn "an insurance company which, upon receipt of a letter from a medical provider asking for assistance in correcting . . . records of patient treatments, terminates the doctor's services." 674 A.2d at 966-967.

⁵ 674 A.2d at 966.

⁶ *Id.*

could result in patient panel reductions. Finally, there is the concern for the potential interference with existing physician-patient relationships caused by tiered networks.

As the lawsuits and other challenges that have been brought to date regarding tiered networks demonstrate, regardless of the force behind the tiered network initiative, these programs expose MCOs to potential liability. The features (or flaws) that are areas of exposure to liability include:

- Lack of transparency with providers, members, and the general public in the measurement methodology and process
- Failure to include providers and members in developing methodology
- Errors in data/wrong data used
- Over-reliance on cost measures
- Questionable quality measurement methodology
- Wrongful inclusion or exclusion in tiered provider network based on rankings
- Communications to patients and providers
- Lack of or failure to adequately implement dispute remedies
- Sharing information

Potential Causes of Action

As with exclusion and termination decisions, there are a number of avenues by which tiering programs could become legally risky. Claims could potentially be made by aggrieved providers, by law enforcement officials, or MCO regulatory bodies, or in some instances by enrollees themselves. The grounds for possible challenges are many:

1. Breach of Contract. Participating but disaffected physicians could claim that exclusion from the MCO's top tier or ranking is a breach of the physician's provider agreement with the MCO. At a very basic level, a physician could claim that the provider agreement contains an implicit, even if not explicit, commitment by the MCO to give the

physician the full benefits of "participating provider" status. A physician could seek to claim that a commitment to give equally preferred status to all participating providers, in contrast to non-participating providers, was a fundamental *quid pro quo* for any price discount or concession given by the physician to the MCO. In short, the physician would claim that the "steerage" advantages of participating provider status were part of the consideration from the MCO in exchange for price concessions by the physician. There may also be specific contract language or other evidence to support such a claim.

2. Defamation/Libel. A physician could claim that communications to enrollees or other providers of his placement in a lower tier constitutes defamation or libel. In essence, the physician would claim that the MCO had wrongfully labeled the physician as providing poorer quality care than other providers.⁷

Taking Pennsylvania⁸ as an example, in order to make a *prima facie* case for defamation against the MCO, a plaintiff provider must prove: (1) the defamatory character of the communication; (2) its publication by the defendant; (3) its application to the plaintiff; (4) the understanding by the recipient of its defamatory meaning; (5) the understanding by the recipient of it as intended to be applied to the plaintiff; (6) special harm resulting to the plaintiff from its publication; (7) abuse of a conditionally privileged occasion.⁹

3. State Unfair Trade Practices and Consumer Protection Law. A state Attorney General could claim that communications made in connection with the development and implementation of a tiering program constitutes an unfair method of competition or unfair or deceptive act or practice in violation of the state's unfair trade

⁷ State law will determine whether the implication, not just the literal statement, can be the basis for a claim. For example, under Pennsylvania law, a publisher can be held liable "for the implications of what he has said or written, not merely the specific, literal statements made." *Dunlap v. Philadelphia Newspapers, Inc.*, 448 A.2d 6, 15 (Pa. Super. Ct. 1982).

⁸ 42 Pa. Cons. Stats. § 8343 (2007).

⁹ See also *Offen v. Brenner*, 402 Md. 191; 935 A.2d 719 (2007). Under Maryland law, to present a *prima facie* case of defamation, a plaintiff must establish four elements: (1) that the defendant made a defamatory statement to a third person, (2) that the statement was false, (3) that the defendant was legally at fault in making the statement, and (4) that the plaintiff thereby suffered harm. A defamatory statement is one which tends to expose a person to public scorn, hatred, contempt or ridicule, thereby discouraging others in the community from having a good opinion of, or associating with, that person.

practices and consumer protection law. These laws typically prohibit, among other things, disparaging the goods, services, or business of another by false or misleading representations of fact, making a statement that is false or maliciously critical of or derogatory to the financial condition of any person, and that is calculated to injure such person, or engaging in any other fraudulent or deceptive conduct that creates a likelihood of confusion or of misunderstanding. Specifically, for example, a state Attorney General could claim that the MCO engaged in unfair and deceptive practices by making misleading implied representations to members or referring providers that physicians not in the top tier or ranking render inferior healthcare services compared to physicians listed in a higher tier or ranking. A state Attorney General could claim that the tiering or ranking methodology employed by the MCO, as presented, conveys a relative quality representation and that the methodology is flawed and does not accurately measure the quality of a provider's care or the provider's efficiency.¹⁰

4. Unfair Insurance Practices Act. These state laws, which are enforced by the state commissioners of insurance, bar an MCO from making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission or comparison, advertisement, or announcement, that is untrue, deceptive or misleading, that misrepresents the benefits, advantages, conditions, or terms of any coverage policy or that misrepresents the financial condition of any person.¹¹

5. Tortious Interference with Contractual Relations. Providers could claim that the tiering initiative communications wrongfully interfere with their business and contractual relations with patients. In order to succeed on a claim of tortious interference with contractual relations, a provider must prove: (1) the existence of a contractual or beneficial relationship, (2) the defendants' knowledge of that relationship, (3) the defendants' intent to interfere with the relationship, (4) the interference was tortious, and a loss suffered by the plaintiff that was caused by the defendants' tortious conduct.

¹⁰ See Complaint at 3; 5, *Washington State Medical Association v. Regence Blue Shield* (Wash. Super. Ct., No. 06-230665-1SEA).

¹¹ See Cal Ins Code § 790.03 (2008). Misleading communications about the tiering initiative could be targeted as misleading consumers about their benefits, if consumers are misled about the criteria on which providers are assigned to the tiers used for determining benefit levels.

Unlike other torts in which liability gives rise to nominal damages even in the absence of proof of actual loss it is an essential element of the tort of unlawful interference with business relations that the plaintiff suffers an actual loss.¹²

6. **Fraud.** A physician could make a fraud claim in the event that the provider is induced to contract with the MCO or to participate in the tiering initiative on false pretenses. Thus, if the physician relies on a false statement by the MCO to his detriment he could pursue a fraud claim against the MCO.

7. **Conspiracy.** In general, in order to succeed on a claim of civil conspiracy, a provider "must show that two or more persons combined or agreed with intent to do an unlawful act or to do an otherwise lawful act by unlawful means."¹³ Unlike a claim for tortious interference with contractual relations, "[p]roof of malice, i.e., an intent to injure, is essential in proof of a conspiracy."¹⁴ To the extent an MCO collaborates with providers and/or consultants in developing a tiering or ranking system, excluded and/or disaffected providers could try to use that interaction to support a conspiracy claim. In one instance, providers have claimed that a health plan conspired with other insurers to create an improper provider ranking program.¹⁵

The above legal grounds could be asserted in support of demands for monetary damages or for injunctive relief.

Legal Actions Addressing Provider Tiering

Both private plaintiffs and state law enforcement officials have brought actions against particular provider tiering programs.

¹² *Nextmedia Outdoor, Inc. v. McClary et al.*, 2007 Conn. Super. LEXIS 1997.

¹³ *Skipworth by Williams v. Lead Indus. Ass'n*, 690 A.2d 169, 174 (Pa. 1997).

¹⁴ *Id.* See also *Williams v. Aetna Fin. Co.*, 83 Ohio St. 3d 464, 700 N.E.2d 859, 868 (1998). Under Ohio law, the element of "malice" required to establish a civil conspiracy is defined as, "that state of mind under which a person does a wrongful act purposely, without a reasonable lawful excuse, to the injury of another."

¹⁵ Complaint at 34-35, *Fairfield County Medical Association v. Cigna Corp.*, No. CV-075002943 (Conn. Super. Ct., filed July 26, 2007).

1. **Washington Regence litigation.** In *Washington State Medical Association v. Regence Blue Shield*,¹⁶ the plaintiffs sued after Regence excluded nearly 500 doctors from its "Select Network," which provided services to Boeing employees and their families.¹⁷ Plaintiffs sought monetary damages and an injunction to prevent Regence from implementing a plan alleged to have used a "flawed methodology," relied on old data, and focused on the amount charged rather than patient medical records to determine quality and efficiency.¹⁸ On August 8, 2007, the parties reached a settlement agreement to implement a performance measurement program that includes the "meaningful input" of providers, relies on timely and relevant data, gives providers advance notice of their scores, and allows providers to appeal their score. The plaintiffs had alleged a violation of Washington State's Consumer Protection Act, defamation, libel, intentional interference with contract, and breach of contract.

2. **Connecticut CIGNA litigation.** In *Fairfield County Medical Association v. Cigna Corp.*,¹⁹ plaintiffs alleged that CIGNA and its co-defendants conspired in the "unilateral implementation of purported 'elite' physician designation programs."²⁰ The plaintiffs seek monetary damages and injunctive relief claiming that defendants excluded them from the "elite" provider designation programs based on inaccurate data that does not actually measure quality of care.²¹ Plaintiffs allege that this tiered network constitutes a breach of their contract with the defendant MCOs, tortious interference with their contractual relations with their patients, libel, and violation of the Connecticut Unfair Trade Practices Act. The litigation remains ongoing.

3. **New York State Attorney General's Office (OAG) Actions & Agreements.** The New York Attorney General has made public announcements of concerns

¹⁶ (Wash. Sup'r. Ct., No. 06-230665-1SEA) (complaint filed Sept. 21, 2006).

¹⁷ See Complaint at 2-3, *Washington State Medical Association v. Regence Blue Shield* (Wash. Super. Ct., No. 06-230665-1SEA).

¹⁸ *Id.* at 3-5.

¹⁹ No. CV-075002943 (Conn. Sup'r. Ct., filed July 26, 2007).

²⁰ Complaint at 2, *Fairfield County Medical Association v. Cigna Corp.*, No. CV-075002943 (Conn. Super. Ct., filed July 26, 2007)

²¹ *Id.* at 4.5.

regarding specific plans' tiering initiatives and has reached settlements with CIGNA, Aetna, Empire, United HealthCare, and GHI/HIP about their programs.

Attorney General Andrew Cuomo publicly warned United HealthCare, Aetna, and CIGNA to cancel their plans to release "quality of care" provider rankings or face legal action, including the threat of injunction.²² The OAG indicated concern that consumers were being steered to "Premium Designation" providers based on faulty data and criteria and encouraged to select inexpensive doctors rather than quality doctors, and that the insurance companies' profit motives would have an adverse impact on the accuracy of their quality rankings.²³

Attorney General Cuomo announced that his office was conducting an "industry-wide inquiry" of insurance companies' existing and planned tiering programs, specifically "CIGNA Care Network," "Aetna Aexcel," Empire's "Blue Precision," and United Healthcare's "Premium Designation Program." The OAG's investigation included a review of documents, meetings with representatives from various insurers, medical societies and organizations, and experts in the field of measuring physician performance.²⁴

In a similar letter to Preferred Care, dated October 18, 2007, the OAG requested that Preferred Care, a subsidiary of MVP Healthcare, "refrain" from launching its

²² See Letter from Linda A. Lacewell, Counsel for Economic and Social Justice, State of New York Office of the Attorney General, to Thomas J. McGuire, Esq., Regional Deputy General Counsel, United Healthcare (July 13, 2007);

²³ *Id.*

²⁴ See In the Matter of Connecticut General Life Insurance Company And Cigna Healthcare Of New York, Inc: Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs Pursuant To Executive Law Section 63, Subdivision 15 at 3 (effective date, October 29, 2007) (available at www.oag.state.ny.us/press/2007/oct/CIGNA%20Settlement%20Final.pdf); In the Matter of Aetna Life Insurance Company and Aetna Health Inc.: Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs Pursuant To Executive Law Section 63, Subdivision 15 at 3 (effective date, November 13, 2007) (available at www.oag.state.ny.us/press/2007/nov/Aetna%20Life%20Insurance%20Company.pdf); Attorney General of the State of New York, Agreement Concerning Physician Performance Measurement, Reporting and Tiering Programs at 2 (effective date November 14, 2007) (available at www.oag.state.ny.us/press/2007/nov/agreement_11_14.pdf); In the Matter of United Healthcare Of New York, Inc., United Healthcare Insurance Company Of New York, Oxford Health Plans, Inc., Oxford Health Insurance, Inc.: Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs, at 2 (effective date, November 15, 2007) (available at www.oag.state.ny.us/press/2007/nov/United%20Final%20Executed.pdf).

proposed physician-ranking program.²⁵ OAG questioned Preferred Care's methodology for assessing patient satisfaction, failure to adequately use patient questionnaires about physician performance, sample size, and reliance on cost measures in its quality and efficiency rankings.²⁶ The OAG also requested that GHI/HIP, which had not yet implemented a physician ranking program, "submit any proposed physician-ranking program for [] review ...[to] ensure that consumers are not deceived or misled even inadvertently."²⁷

On October 29, 2007, Attorney General Cuomo announced that CIGNA had reached a settlement agreement with the OAG establishing standards to ensure the accuracy and transparency of its tiered programs and to further develop a physician ranking program that was not based solely on cost.²⁸ Aetna and Empire entered into substantially similar agreements with the OAG on November 13, 2007 and November 14, 2007, respectively. United HealthCare and GHI/HIP also entered into substantially similar agreements on November 15, 2007 and November 20, 2007. Under these agreements, CIGNA, Aetna, Empire, United HealthCare, and GHI/HIP (hereinafter, the Settling MCOs) will maintain insurance programs that rely on national standards to measure quality, will be able to rely on cost measurements and comparisons, take measures to ensure more accurate provider comparisons, disclose to both providers and consumers how the program is designed (and any changes to the program), and establish independent appeals and compliance mechanisms.²⁹

According to the OAG, the principal objectives of these settlement agreements are to establish and maintain "*accuracy and transparency of information, and oversight*"

²⁵ See Letter from Linda A. Lacewell, Counsel for Economic and Social Justice, State of New York Office of the Attorney General, to Denise Gonick, Esq., Executive Vice-President and Chief Legal Officer, MVP Health Care and Preferred Care (October 18, 2007) (*available at* www.oag.state.ny.us/press/2007/oct/Preferred%20Care%20Final.pdf).

²⁶ *Id.* at 2-4.

²⁷ See Letter from Linda A. Lacewell, Counsel for Economic and Social Justice, State of New York Office of the Attorney General, to Nicholas P. Kambolis, Associate General Counsel, HIP Health Plan of New York and Timothy F. Smith, Assistant Vice President, Legal Services, GHI, at 2 (October 18, 2007) (*available at* www.oag.state.ny.us/press/2007/oct/GHI%20HIP%20Final.pdf).

²⁸ See generally, *id.*; In the Matter of Health Insurance Plan of Greater New York and Group Health Incorporated: Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs (effective date November 20, 2007).

²⁹ *Id.*

of the insurance companies' physician performance measurement, reporting, or tiering programs.³⁰

Under the terms of the agreements with CIGNA and Aetna, those Settling MCOs did not admit to the Attorney General's Findings, and the Attorney General accepted the agreements in lieu of commencing a statutory or other proceeding against the Settling MCOs pursuant to New York State Executive Law § 63(12).³¹ CIGNA and Aetna voluntarily accepted the terms and conditions of the agreements and waived any right to challenge them in a proceeding pursuant to New York law.³² The Empire, United HealthCare, and GHI/HIP agreements do not contain similar provisions. However, none of the agreements limits the Attorney General's power to "investigate or take other action with respect to any non-compliance at any time by [the insurer] with respect to this Agreement."³³ The agreements also do not and should not be construed to "deprive any consumer or other person or entity of any private right under the law."³⁴ If CIGNA, Aetna, or Empire violate the terms of their respective agreements, evidence of such violation will be "prima facie proof of a violation of General Business Law § 349 in any civil action or proceeding thereafter commenced by the Attorney General."³⁵ The United HealthCare and GHI/HIP agreements contain no such provision regarding the effect of a breach.

In order to ensure compliance with the terms of their respective agreements, and facilitate the collection and presentation of relevant information to consumers and physicians, the Settling MCOs must appoint an independent Ratings Examiner (Rx) to conduct oversight.³⁶ The Rx must be a nationally-recognized standard-setting

³⁰ See Cigna Agreement at 4; Aetna Agreement at 3; Empire Agreement at 3; United Healthcare Agreement at 3; GHI/HIP Agreement at 2 (emphasis added).

³¹ See Cigna Agreement at 3; Aetna Agreement at 3.

³² See Cigna Agreement at 11; Aetna Agreement at 11.

³³ Cigna Agreement at 11; Aetna Agreement at 11; Empire Agreement at 11; United Healthcare Agreement at 9; GHI/HIP Agreement at 11.

³⁴ Cigna Agreement at 13; Aetna Agreement at 12; Empire Agreement at 12; United Healthcare Agreement at 10; GHI/HIP Agreement at 12.

³⁵ See Cigna Agreement at 13; Aetna Agreement at 12; Empire Agreement at 13.

³⁶ See Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 9; United Healthcare Agreement at 8; GHI/HIP Agreement at 9.

organization, nominated and paid for by the Settling MCO, and approved by the OAG.³⁷ The Settling MCOs must promptly complete and maintain their physician performance measurement and reporting process with the Rx.³⁸ The Settling MCOs with existing tiered programs must hire their oversight monitor within 30 days of entering into the agreement.³⁹ For future tiered programs, at the time the program is made public, each Settling MCO must document that it has already completed or has applied to complete a review by the oversight monitor.⁴⁰ The Settling MCOs must also "directly and prominently" display this information on their websites and other appropriate locations.⁴¹

The Settling MCOs' agreements outline specific procedures relevant to each of the stated objectives: accuracy and transparency in developing performance measurements, use of data, and oversight.⁴² Performance ratings may include "quality of performance" and "cost-efficiency" measurements.⁴³ The agreements also set standards for data collection, including that the Settling MCOs must "use the most current claims or other data to measure physician performance, consistent with the time period needed to attain adequate sample sizes and to comply with the requirements of [the agreement]."⁴⁴ The Settling MCOs must utilize their best efforts to ensure that their data is accurate, including establishing a process for medical record verification, if necessary.⁴⁵ In determining a physician's performance for quality and cost-efficiency,

³⁷ See Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 9; United Healthcare Agreement at 8; GHI/HIP Agreement at 9-10.

³⁸ See Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 10; United Healthcare Agreement at 8; GHI/HIP Agreement at 10.

³⁹ See Cigna Agreement at 7; Aetna Agreement at 6; United Healthcare Agreement at 7; GHI/HIP Agreement at 7-8.

⁴⁰ See Cigna Agreement at 8; Aetna Agreement at 7; Empire Agreement at 7; United Healthcare Agreement at 7; GHI/HIP Agreement at 8.

⁴¹ Cigna Agreement at 8; Aetna Agreement at 7; Empire Agreement at 7; United Healthcare Agreement at 6; GHI/HIP Agreement at 7.

⁴² See *generally*, Cigna Agreement; Aetna Agreement; Empire Agreement; United Healthcare Agreement; GHI/HIP Agreement.

⁴³ See Cigna Agreement at 4; Aetna Agreement at 3-4; Empire Agreement at 3; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.

⁴⁴ Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 9; United Healthcare Agreement at 7-8; GHI/HIP Agreement at 9.

⁴⁵ See Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 9; United Healthcare Agreement at 8; GHI/HIP Agreement at 9.

the Settling MCOs are required to use appropriate risk adjustment to account for the characteristics of the physician's patient population.⁴⁶

The Settling MCOs' agreements take numerous steps to ensure that quality and cost efficiency measures are not conflated. Any public information must separately calculate and disclose measures of cost-efficiency and measures of quality of performance.⁴⁷ If individual scores for quality of performance and cost efficiency are combined for a total ranking, the proportion of each measure must be clearly disclosed.⁴⁸ The Settling MCOs must include patient experience as a factor in measurements.⁴⁹ CIGNA, Aetna, and Empire must rely on nationally-recognized evidence and quality standards from entities whose work in the area of physician quality performance is "generally accepted in the healthcare industry" such as National Quality Forum (NQF) or the AQA.⁵⁰ They also must disclose the extent to which their ratings rely on any or all of these guidelines.⁵¹

Disclosure and notice to both consumers and providers are important components of the agreements as well. The Settling MCOs must disclose to consumers where physician performance ratings for their existing programs can be found, explain the methodology for the ratings system, encourage consumers to consult with their own doctor when deciding about changes in their healthcare package, and indicate how the consumer may register a complaint with the insurer and the oversight monitor.⁵² For any of the Settling MCOs' existing programs, this disclosure must occur within 30 days of

⁴⁶ See Cigna Agreement at 5; Aetna Agreement at 5; Empire Agreement at 5; United Healthcare Agreement at 4; GHI/HIP Agreement at 4.

⁴⁷ See Cigna Agreement at 4; Aetna Agreement at 4; Empire Agreement at 3; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.

⁴⁸ See Cigna Agreement at 4; Aetna Agreement at 4; Empire Agreement at 3-4; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.

⁴⁹ See Cigna Agreement at 5; Aetna Agreement at 4; Empire Agreement at 4; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.

⁵⁰ Cigna Agreement at 5; Aetna Agreement at 4; Empire Agreement at 4; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.

⁵¹ See Cigna Agreement at 5; Aetna Agreement at 4; Empire Agreement at 4; United Healthcare Agreement at 4; GHI/HIP Agreement at 4.

⁵² See Cigna Agreement at 7-8; Aetna Agreement at 6-7; Empire Agreement at 7; United Healthcare Agreement at 6; GHI/HIP Agreement at 6-7.

the company entering its agreement.⁵³ For future programs, disclosure must occur prior to implementation of the tiered program.⁵⁴

At least 45 days before making available to consumers any new or revised quality or cost-efficiency or tiering, the Settling MCOs must notify their providers of the proposed change, explain the methodology and data used for particular providers, and inform providers of their right to make corrections and appeal.⁵⁵ At least 45 days prior to implementation of a material change to one of the Settling MCOs' programs, the company must inform its providers of the change and explain the new measures or other criteria for determining quality performance, cost-efficiency, or placement in a performance network.⁵⁶

Under the terms of their respective agreements the Settling MCOs must allow their providers to submit supplemental materials relevant to the rankings process, correct errors, review data, and promptly appeal their rankings.⁵⁷ If a provider makes a timely appeal, the insurers are barred from changing the provider's quality and cost-efficiency rankings or designation until the appeal is completed.⁵⁸ The oversight monitor shall have oversight and review of the provider appeals process.⁵⁹

The agreements also include provisions requiring the Settling MCOs to participate in any summit meetings the Attorney General convenes related to evaluating provider performance.⁶⁰

⁵³ See Cigna Agreement at 7-8; Aetna Agreement at 6-7; United Healthcare Agreement at 6; GHI/HIP Agreement at 6-7.

⁵⁴ See Empire Agreement at 7.

⁵⁵ See Cigna Agreement at 9; Aetna Agreement at 8; Empire Agreement at 8; United Healthcare Agreement at 7; GHI/HIP Agreement at 8.

⁵⁶ See Cigna Agreement at 5; Aetna Agreement at 5; Empire Agreement at 4-5; United Healthcare Agreement at 4; GHI/HIP Agreement at 4.

⁵⁷ See Cigna Agreement at 9; Aetna Agreement at 8; Empire Agreement at 8; United Healthcare Agreement at 7; GHI/HIP Agreement at 8.

⁵⁸ See Cigna Agreement at 9; Aetna Agreement at 8; Empire Agreement at 8; United Healthcare Agreement at 7; GHI/HIP Agreement at 8-9.

⁵⁹ See Cigna Agreement at 9; Aetna Agreement at 8; Empire Agreement at 8; United Healthcare Agreement at 7; GHI/HIP Agreement at 9.

⁶⁰ See Cigna Agreement at 11; Aetna Agreement at 10; Empire Agreement at 10-11; United Healthcare Agreement at 9; GHI/HIP Agreement at 10.

Although they are not identical, there are only a handful of notable differences among the Settling MCOs' agreements. The GHI/HIP agreement makes no mention of a specific tiered network plan or of an inquiry conducted by OAG; the agreement only refers to an "industry-wide inquiry" conducted by OAG.⁶¹ At the time Empire entered its agreement, the "Blue Precision" program was only in its planning stages. Thus, Empire's agreement does not contain provisions regarding disclosures for existing programs. In addition, each company is required to submit a plan for the aggregation or pooling of data, as a supplement to test its own data to its oversight examiner.⁶² However, CIGNA, Aetna, United HealthCare, and GHI/HIP are required to complete this task within three months of entering their respective agreements.⁶³ Empire must make this submission three months prior to the use of "Blue Precision."⁶⁴ Unlike CIGNA and Aetna, Empire, United HealthCare, and GHI/HIP were not required to pay a sum up to \$100,000 to a nonprofit 501(c)(3) organization, insurer nominated and approved by the OAG, to facilitate consumers' meaningful participation in medical decisions.⁶⁵

The requirements of these settlement agreements are not necessarily needed to be in compliance with the law, but they do provide guidance as to what at least certain authorities and perhaps providers would hope to find in an MCO's tiering program.

State Legislative Activity

Tiered networks and their underlying performance-based evaluations have and continue to be a source of state legislative activity. While there is no model law, there are several common elements of these laws including:

1. The MCO must make available to the physician his economic profile including the written criteria by which the physician's performance is measured.⁶⁶

⁶¹ GHI/HIP Agreement at 1.

⁶² See Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 8-9; United Healthcare Agreement at 8; GHI/HIP Agreement at 9.

⁶³ See Cigna Agreement at 10; Aetna Agreement at 9.

⁶⁴ See Empire Agreement at 9.

⁶⁵ See Cigna Agreement at 11; Aetna Agreement at 10.

⁶⁶ See e.g., Miss. Code Ann. § 83-41-409 (2007); Tenn. Ann. Code § 56-32-230(e) (2007); CRIR 14-000-022 §5.7.4 (2007); and Tex. Ins. Code § 1301.058 (2007).

2. The MCO must give the physician an opportunity to review data and to submit corrections and additions of explanations.⁶⁷

3. The MCO must adjust the physician's economic profile to recognize characteristics of the physician's practice that may account for variations from expected costs. State law may also dictate the specific factors or characteristics to be considered, including, but not limited to:⁶⁸

- Specialty utilization
- Practice patterns
- Information comparing the physician to his/her peers in the same specialty
- Case mix
- Severity of illness
- Age of patients

4. Meaningful provider involvement in the development of profile methodology including collection methods, formatting methods, means for release, and dissemination.⁶⁹

5. Periodically reevaluate the quality and accuracy of practice profiles, data sources, and methodologies.⁷⁰

Possible Federal Preemption of State Law Challenges

As tiering and related activities are being challenged at the state level, MCOs might pause to consider the legal basis for the challenge and what is being challenged. Depending on the answers to those questions, such challenges and/or the basis for the challenge may be preempted by federal law. Preemption also may be an increasingly

⁶⁷ See e.g., Tenn. Ann. Code § 56-32-230(e) (2007).

⁶⁸ See e.g., Ca. Ins. Code § 10123.36(a)(2007); Conn. Gen. Stat. § 38a-478f (2007); KRS § 304.17A-525(1) (2008); ORC Ann. § 1735.05 (2008); CRJR 14-000-022 §5.7.3 (2007); and Tex. Ins. Code § 1301.058 (2007).

⁶⁹ See e.g., N.D. Cent. Code § 26.1-36-41(2) (2007) and Tenn. Code Ann. § 56-32-230(e)(1) (2007).

⁷⁰ See e.g., N.D. Cent. Code § 26.1-36-41(2) (2007).

important issue as the federal government as a customer/purchaser focuses on quality and efficiency.

ERISA Preemption

The Employee Retirement Income Security Act (ERISA)⁷¹ broadly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan..."⁷² State causes of action are also preempted. By virtue of ERISA's "savings clause" states can regulate "the business of insurance."⁷³ However, through its so-called "deemer clause," ERISA prevents states from regulating self-funded employee benefit plans.⁷⁴ Thus, in the context of employee benefit plans, ERISA permits states to regulate tiered network programs to the extent that the state regulation is in the form of insurance regulation. However, ERISA's savings clause does not extend to self-funded plans, which often times are administered by state-licensed MCOs.

Applying an ERISA preemption analysis to challenges brought by the New York Attorney General, the first question to consider is the basis for the investigation. Although the target MCOs were asked to explain how they complied with certain provisions of the New York insurance code focused on provider rights, the underlying basis for the investigation appeared to be New York's consumer protection law and not enforcing New York's insurance laws. Moreover, although New York law gives the Attorney General the authority to enforce some portions of the insurance code, the question is raised whether that is in fact what the attorney general was doing. If not, and he was acting pursuant to state consumer protection laws or other non-insurance law, was there an ERISA preemption argument?⁷⁵ The complicating factor with respect to an ERISA preemption argument is that where an MCO both insures and administers

⁷¹ 29 U.S.C. § 1001 *et seq.*

⁷² 29 U.S.C. § 1144(a).

⁷³ 29 U.S.C. § 1144(b)(2)(A). See *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985).

⁷⁴ 29 U.S.C. § 1144(b)(2)(B). See *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

⁷⁵ It should be noted that the laws in other states may differ as regards to the authority of the attorney general to bring enforcement actions based on provisions of the insurance code.

employee benefit plans that utilize tiered networks, separating the two activities may not be practical or worth the effort in order to assert ERISA preemption.⁷⁶

Preemption under the Medicare Modernization Act of 2003

The Medicare Modernization Act broadened the scope of federal preemption with respect to the Medicare Advantage program. Federal law provides that "[t]he standards established under this part [Part C, Medicare Advantage program] shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA [Medicare Advantage] plans which are offered by MA organizations under this part."⁷⁷ The legislative history confirms the breadth of federal preemption: "The conference agreement clarifies that the MA program is a federal program operated under Federal rules. State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency."⁷⁸ With respect to preemption generally, the Centers for Medicare & Medicaid Services (CMS) clarified that there must be a federal standard in order for a state standard to be preempted:

The preemption in section 1860D-12(g) of the [Social Security] Act is a preemption that operates only when CMS actually creates standards in the area regulated. To the extent we do not create any standards whatsoever in a particular area, we do not believe preemption would be warranted.⁷⁹

Although the full scope of the MMA's preemption is not yet clear, key to the question of whether there is preemption is identifying any federal standards in the area. With respect to tiered physician networks and the quality analyses that underlie them, several federal standards are relevant:

⁷⁶ See Rosenbaum, Knornblet and Borzi, *An Assessment of Legal Issues Raised in "High Performing" Health Plan Quality and Efficiency Tiering Arrangements: Can the Patient Be Saved?* (Sept. 2007) available at www.rwjf.org/programareas/resources/product.jsp?id=22571&pid=1142

⁷⁷ 42 U.S.C. § 1395w-26(b)(3). See also 42 C.F.R. § 422.402.

⁷⁸ H.R. Conf. Rep. No. 108-391, at 557 (2003).

⁷⁹ 70 Fed. Reg. 4194 at 4320 (Jan. 28, 2005).

1. While federal regulations prohibit discrimination against providers, these regulations do not prohibit:

- Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty, or
- Implementation of measures designed to maintain quality and control costs consistent with MA organization's responsibilities.⁸⁰

2. CMS has permitted tier cost-sharing based on provider. However,

- All members must be charged the same amount for the same service with the same provider, and
- All members must have reasonable access to providers at the lowest tier of cost-sharing.

3. CMS indicated that all parties—providers, patients, insurance plans, and payers—should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively-priced healthcare.⁸¹

Whether these standards are sufficient to carry a preemption argument remains to be seen.

Recommendations

Given the current enforcement environment and heightened level of physician scrutiny, MCOs should develop their tiering program mindful of the potential legal risks. To minimize potential legal risk, MCOs should consider adhering to principles that can be distilled from other MCOs' experience and the litigation and enforcement activity summarized above. Adherence to all of the points listed below may not be required, insofar as the negotiated resolutions may reflect in part what the enforcement officials would consider corrective or prophylactic actions, but each MCO should thoughtfully

⁸⁰ 42 C.F.R. § 422.206.

⁸¹ Memorandum from Abby L. Block, Director, Center of Beneficiary Choices, to Medicare Advantage Organizations *et al* (Sept. 19, 2007).

assess its ability to follow these strictures without undermining the efficacy of the program or adding undue delay or administrative expense or hassle.

1. Prior to implementing any new performance methodology, consider the viability of seeking meaningful input from the provider community and/or its participating providers on the data to be used for tiering and ranking, the methods used to compare provider performance, and the methods of communicating ratings, scores, and rankings.

2. Be explicit on which measurement elements are based on quality considerations, irrespective of cost measures, and which are based more fundamentally on cost-related factors.

3. Be careful to assure that all aspects of the program are considered and adopted by the MCO unilaterally, to mitigate any concerns that the MCO has conspired with other MCOs on the criteria, weighting factors, or benefit distinctions, or has conspired with one set of providers to disadvantage another. Thus, the MCO should be clear that while it is consulting with the affected provider community and with national standards for quality measurement, it is making its own decisions.

4. Except where justified and explained by specific plan needs, use a tiering or ranking methodology that relies on generally accepted national standards of quality and that employs appropriate risk adjustment and sampling mechanisms.

5. Assess whether the MCO's provider contracts pose any obstacle to, or authorization for, a provider tiering and ranking program. Consider adding language about the tiering program in the provider manual to enhance provider understanding and also to improve contractual defensibility of the initiative, insofar as compliance with the provider manual may be included in the provider agreement language.

6. Plan for the disclosure to providers of the nature and timing of the tiers, rankings, and criteria, and how they are designed and amended over time and for plain explanations of provider reimbursement mechanisms and member benefit levels, as they vary by tier or ranking.

7. Consider posting scores, rankings, and/or tiers in electronic format, along with an explanation of the tiering or ranking methodology, the source of data relied on, and the type of patients included in the calculation of the score.

8. Plan for disclosing to customer groups and enrollees how the program and criteria are designed and how providers are ranked. Consider adopting a process through which consumers could voice comments, concerns, and complaints about the program.

9. In communications with providers, clients, and enrollees alike, give strong consideration to use of prominent and carefully worded disclaimers and/or statements that describe the program, but disavow any implication that providers who are not included in a higher tier or ranking are inefficient or provide lower quality services. MCOs may wish to temper the degree and character of their explanations, to mitigate risk that they are making a definitive statement of relative quality or efficiency. MCOs should consider indicating that the tiers and rankings are based on specific measurement indicia and are by necessity imprecise, while doing so in a manner that does not undermine the propriety of its using them.

10. Consider whether to grant physicians an opportunity to make a timely, internal appeal of any initial and/or revised tiering, ranking, or scoring. MCOs might consider utilizing an independent external reviewer for the resolution of such appeals. Consider employing language that permits the internal review, but that does not create a contractual right for judicial review, particularly not on a de novo basis.

11. Consider retaining an independent rating ombudsman to monitor compliance with aspects of the new tiering or ranking program. The ratings ombudsman could provide compliance reports on a regular basis.

Conclusion

Whether tiered networks will provide the desired results in terms of quality and efficiency remains to be seen. What we do know is that tiered networks and the related performance-based evaluations pose significant challenges for MCOs, healthcare purchasers, and providers.

Tiered Physician Networks: A new Twist on an Old Issue © 2008 is published by the American Health Lawyers Association. All rights reserved. No part of this publication may be reproduced in any form except by prior written permission from the publisher. Printed in the United States of America.

Any views or advice offered in this publication are those of its authors and should not be construed as the position of the American Health Lawyers Association.

"This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought"—*from a declaration of the American Bar Association*

Copyright 2008 American Health Lawyers Association, Washington, D.C.

Reprint permission granted.

Further reprint requests should be directed to

American Health Lawyers Association

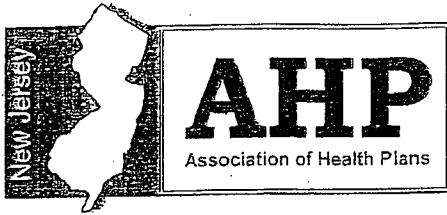
1025 Connecticut Avenue, NW, Suite 600

Washington, DC 20036

(202) 833-1100

For more information on Health Lawyers content, visit us at

www.healthlawyers.org



New Jersey Association of Health Plans • 50 West State Street • Suite 1012 • Trenton, New Jersey 08608 • tel: 609.581.8237 • fax: 609.278.4496

Wardell Sanders
President

Sarah M. Adelman
Vice President

**Testimony of the
New Jersey Association of Health Plans
For the Assembly Health & Senior Services
and Regulatory Oversight Committees
December 2, 2015**

Hearing on Tiered Health Plans

Chairmen Conaway and Gusciora and Members of the Assembly Health & Senior Services and Regulatory Oversight Committees:

The New Jersey Association of Health Plans (“NJAHPP”) is a non-profit association representing leading health care plans in the state which cover nearly seven million New Jersey residents. Our members include Aetna, AmeriGroup, AmeriHealth, Cigna, Health Republic, Horizon Blue Cross Blue Shield of New Jersey, Oscar, United Healthcare, and WellCare.

Thank you for the invitation to provide comments on tiered health plans.

As an initial matter, New Jersey’s health plans work diligently on behalf of consumers and purchasers to ensure that every individual has access to high quality, high value health care services from a robust network of health care providers and facilities across the state. New Jersey’s health plans also hear from their members that health care costs are unsustainable. Consumers and purchasers are demanding more affordable options, especially in light of the Affordable Care Act’s mandate for coverage and the impending “Cadillac Tax” on high-cost plans. To that end, tiered health plans can be an attractive option and solution to help contain costs. Tiered health plans offer individuals and employers a new choice as they shop for coverage; they create healthy competition across health insurers; and they serve as an affordable alternative for individuals with high-deductible plans and those who simply go uninsured.

Narrow Networks v. Tiered Health Plans

Both narrow networks and tiered health plans help reduce costs and premiums, but narrow networks are typically products that cost less in exchange for a limited network of providers and facilities. Tiered health plans are preferred provider arrangements which maintain broad network access for all health care services and provider types, while offering lower cost-sharing when a consumer selects a preferred-tier provider.

Demand for Tiered Products

New Jersey is home to some of the highest health care costs in the nation. Hospital costs represent about half of medical spend, while pharmacy costs are growing at the highest rate. If your annual individual premium exceeds \$10,200 or your annual family plan premium exceeds \$27,500, your plan will be subject to a 40 percent excise tax — the ACA’s so-called “Cadillac Tax” — beginning in 2018. The excise tax also applies to government health benefits, and the New Jersey Pension and Health Benefits Study Commission has projected that the tax will increase the State Health Programs’ costs by an additional \$58 million in

FY2018, rising to \$284 million by 2022. Innovation is not optional, and health plans are responding with new products such as those that move from a fee-for-service model toward fee-for-value and consumer directed services. Tiered products are an attractive option for many consumers who are willing to choose from a preferred tier of providers in exchange for lower premium and out-of-pocket costs.

Tiered Products in New Jersey

Tiered networks are now common in New Jersey and throughout the nation. Ten tiered networks have been approved in New Jersey over the past five years, and almost every carrier has offered or is currently offering a tiered network product. Insured markets. Self funded plans do not require state approval and there may be additional tiered products in that market. Aetna, AmeriHealth, Health Republic, Horizon Blue Cross Blue Shield, and Oscar currently offer tiered health plans in New Jersey. They can be statewide or regional, and they offer consumers lower levels of cost-sharing when receiving services from a preferred tier provider. In fact, many hospitals offer tiered network products to their own employees, where lower cost sharing is available when employees use services within their own hospital system.

Network Adequacy and Consumer Protections

New Jersey has some of the most consumer-oriented and strict network adequacy requirements in the nation. Network adequacy requirements are designed to protect consumers by ensuring adequate access to in-network providers according to time, distance, availability, and cost-sharing. New Jersey's tiered health plans must meet network adequacy requirements, and most exceed those requirements. In fact, New Jersey's Department of Insurance has instructed plans that the top or preferred tier must meet network adequacy requirements if it were to stand alone, even though tier two or non-preferred providers remain in-network. Additionally, the Maximum Out of Pocket (MOOP) is a consumer protection set by law to ensure that no individual or family will spend more than a certain dollar threshold on their healthcare costs. Tiered health plans will help reduce out of pocket expenses, and consumers will always be protected by the MOOP.

Factors for Tiering

There is no mandatory criteria for developing tiers, nor should there be. To prescribe specific criteria would dictate that all health plans use the same factors and thus design identical tiers, essentially creating two classes of providers. However, there are a number of factors that a health plan might consider and give weight to in forming these arrangements, including but not limited to: overall value, quality metrics and ratings, outcome data, safety scores, cost to charges ratios, existing partnerships (e.g., Accountable Care Organizations and Patient Centered Medical Homes), willingness to innovate, consumer/ member preference, regional factors (e.g., high volume or high costs in a certain geographic area, etc.).

Greater Competition & More Choice

Kathy Hempstead, director of the Robert Wood Johnson Foundation's programs on health insurance coverage made the point in the press that, "you can't make an omelette without breaking eggs and you can't make a tiered network without excluding providers, so it's no mystery why some perfectly good hospitals are not part of [a health plan's] network." If a provider is not in one health plan's preferred tier, it is very likely that they will be in another health plan's preferred tier. Tiered network arrangements will create a new and lower-cost choice for consumers and will create a new opportunity for health plans and providers to both innovate and compete together.

Thank you for considering our comments.

Dr. William Lesko: OMNIA's Second Class System Plagues Patients

Horizon Blue Cross Blue Shield (HBCBS) of New Jersey's announcement of their OMNIA Health Alliance caused more than just a few ripples throughout the state. The largest health insurer in New Jersey, HBCBS, revealed that its new plan will incorporate lower-priced insurance policies that offer discounts for care provided at 34 "Tier 1" designated hospitals.

So what's the catch? The demotion of physicians to the Tier 2 category will inadvertently punish disadvantaged and disabled patients. These patients frequently visit their doctors multiple times a year, and as a result of this Tiered Network, they will no longer be able to see the same physicians who have been treating them for up to 30 years. Even further, this new Network has excluded a few dozen of the state's key hospitals, including those that serve the inner cities. These health care systems and doctors that are being left out of the OMNIA Plan were not even informed who would be designated to what tier. Further, only a few days ago did HBCBS state what criteria was used to distinguish "Tier 1" from "Tier 2" hospitals. The lack of transparency for this plan, limited communication between HBCBS and hospitals in both tiers, and the numerous detrimental effects this system will have on limiting doctors and their care for disadvantaged patients, should not be ignored.

Since most of my patients are covered by HBCBS, many will be forced to travel far for their treatment, instead of going to their regular health care facility which is local, accessible, and most importantly, familiar. About 80% of the patients who enter North Jersey Eye Associates, an ophthalmic care and treatment facility, require assistance in getting to this facility. This can include disability transportation services, wheelchairs, walkers, and many other types of assisted care and transportation. In light of the OMNIA Plan, these patients will have to travel great distances for their care. Our doctors provide over 95% office and outpatient Ophthalmological care. These patients will no longer be receiving affordable and quality care, but instead under the Alliance, they will now have to pay a significant deductible for each Tier 2 doctor visit of \$50 or more. Undoubtedly, as a result of this Tiered Network, the patients' care and cost will be compromised.

For my patients, their access to our facility, as well as their comfort, is priority. Most patients have appointments several times a year at our facilities, while glaucoma patients come in every four months. They come to North Jersey Eye Associates not only because our doctors provide quality ophthalmic care and services, but because they are comfortable with our team and have a routine or system in place of how to get here. Not many ophthalmologists are covered under "Tier 1" and if this Alliance is to take place, many of my disabled and near-blind patients will have to go further just to spend less on adequate care, and consequently they will suffer.









At first glance, care at a low cost seems favorable, but the real cost is the quality of care for the patients. We offer same day surgery, including no stitch cataract surgery, cataract intraocular lens implantation, LASIK and PRK laser vision correction, and laser techniques including Yag, Argons and SLT laser treatments for glaucoma, post cataract membranes, and retinal disease. We also provide treatment for Diabetic Retinopathy and Macular Degeneration, Corneal transplantation, Strabismus (cross eyes) Surgery for eye turns, Ocular Plastic Surgery, Routine Eye care and contact lenses fitting and dispensing. Though there are four of us in our practice, we have served more than 100,000 patients throughout the state, and that is because we prioritize the medical needs of our patients, rather than the whims of the insurance company. The variety of services we provide enable patients to build a relationship with us based on comfort and trust, and as a result, many of them seek multiple services from us. This relationship would not exist if the OMNIA Plan had been in place, and the care and attention given to our patients will surely dissipate if such an Alliance takes place.

The OMNIA Plan will result in a direct prejudice against urban disabled people whose healthcare access is already limited. Instituting this Plan would only limit our patients' time and resources even further, rather than helping provide the less fortunate with easier accessibility and more health care options. Our patients are being punished by not living near a "Tier 1" hospital or if they are physically incapable of going to a designated health care facility. OMNIA may seem appealing at first glance, but it really only serves to further discriminate against our patients.

Dr. William S. Lesko, of North Jersey Eye Associates, is one of the most respected physicians in the state. Dr. Lesko has served on many influential national, state, and local organizations and was a member of The Board of Councilor of the American Academy of Ophthalmology and served as President of New Jersey Ophthalmology Society.

12/1/2015

Horizon Omnia Plan

 Reply  Reply to all  Forward |   X |  |  | Close |  Help

From: Robert.Schermer1@verizon.net [Robert.Schermer1@verizon.net]

Sent: Fri 11/20/2015 3:46 PM

To: Olsaide AHE

Cc:

Subject: Horizon Omnia Plan

Attachments:

[View As Web Page](#)

This is to let you know that I am very much in favor of the planned Horizon Omnia health insurance plan now receiving so much attention. I am a health services planner and have no connection with that plan or its network members.

Its proposed integrated and collaborative services is a breakthrough as compared with the current fragmented delivery of services, a feature recommended by a variety of national health services authorities. The plan's expectation of lower health care costs, and the elimination of certain deductibles is certainly a welcome feature with extraordinary public benefits.

Opposition to the plan seems to be by organizations that have no similar proposals- but would be well advised to organize along similar lines.

Bob Schermer
225 Highland Avenue
Ridgewood, NJ, 07450

80x

Written Testimony
Before the New Jersey Senate
Committee on Commerce and Committee on Health, Human Services and Senior Citizens
Hearing on the OMNIA Health Alliance formed by Horizon Blue Cross Blue Shield of New Jersey
October 5, 2015

By
Joel C. Cantor, ScD.
Director, Center for State Health Policy and Distinguished Professor of Public Policy
Rutgers, the State University of New Jersey

Good day Chairpersons Gill and Vitale and distinguished committee members. Thank you for the invitation to comment today on the OMNIA Health Alliance.

I am Joel Cantor, director of Rutgers University Center for State Health Policy and distinguished professor of public policy. The Center for State Health Policy was established in 1999 to inform, support and stimulate sound and creative state health policy in New Jersey and around the nation. The views that I express in this testimony are mine alone and do not necessarily reflect those of Rutgers University or the agencies and organizations that sponsor the work of the Center for State Health Policy.

The OMNIA Health Alliance addresses long-standing and serious deficiencies in New Jersey health care and I believe it has potential to improve care and "bend the cost curve". However, while I see considerable potential benefits arising from the OMNIA plan, I believe that it may also have some unintended consequences.

I will begin by commenting on why I believe that without innovation New Jersey health care is on an unsustainable path, and then I will turn to what I see as the potential benefits and risks of OMNIA.

Serious Gaps in New Jersey Health System Performance

The recent *Commonwealth Fund Scorecard on State Health System Performance* and other sources clearly show poor performance on key health care metrics for New Jersey. Here are some examples (the Table below provides additional metrics):

- New Jersey ranks 44th among states in our Medicare *30-day hospital readmission* rate.
- We rank 49th in the share of *hospitalized* patients reporting that they do not get the information they need to successfully *transition to home* at discharge.
- New Jersey ranks 31st in the rate of *potentially avoidable* hospital stays for conditions such as diabetes and heart failure among Medicare beneficiaries aged 75 or older.
- We rank 35th in *asthma admissions* among children, and
- According to the *Dartmouth Atlas of Health Care*, over 57% of Medicare patients with chronic illnesses who died visited *10 or more different physicians* in the last six months of life, the highest percentage of any state.¹

These statistics demonstrate that gaps in health care delivery performance in New Jersey are leading to high preventable and avoidable costs, suggesting that better care can lead to savings. In recent years, some of our system performance statistics have improved, but overall our standing relative to other states has remained stubbornly low.

¹ *Dartmouth Atlas of Health Care*. Available at:
<http://www.dartmouthatlas.org/data/table.aspx?loc=32&loct=2&ind=6>.

Table: Selected Indicators from the Commonwealth Fund State Scorecard Health System Performance

Measure	Rate	State Rank
Medicare 30-day hospital readmissions, per 1000	57	44 th
Hospitalized patients given information about what to do during their recovery at home, %	79	49 th
Hospitalized patients who reported hospital staff always managed pain well, responded when needed help, and explained medicines and side effects, %	61	46 th
Medicare hospital ambulatory care sensitive (potentially avoidable) admissions, ages 75+, per 1,000	72	31 st
Hospital admissions for pediatric asthma, per 100,000	159	35 th
Long-stay nursing home residents hospitalized within a 6-month period	23	39 th
High-risk nursing home residents with pressure sores, %	9	49 th
Total Medicare Parts A & B reimbursements per enrollee	\$9,551	45 th

Source: Radley DC, D McCarthy, JA Lippa, SL Hayes, & C Schoen, *Aiming Higher: Results from a Scorecard on State Health System Performance, 2014*, The Commonwealth Fund, May 2014. Available at: <http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard>. Note: New Jersey performance is lowest in the *Scorecard's* metrics of "Avoidable Hospital Use and Cost", in other areas, such as its "Healthy Lives" dimension, New Jersey ranks much better.

How OMNIA Could Bring Change

Horizon Blue Cross Blue Shield of New Jersey is the state's largest health insurer, covering roughly half of state residents with private plans (including some Medicare and Medicaid beneficiaries). Traditionally, private health plans have paid providers on a piecemeal, fee-for-services basis in which they are paid *more* for delivering *more* care without regard to the potential benefits to patients. Historically, payers have sought to contain health care costs mainly by negotiating lower reimbursements to providers. This dynamic too often has fostered mistrust and acrimony between providers and payers while failing to promote optimal care.

In recent years, Horizon and other insurers have pursued alternative care delivery models, such as Patient Centered Medical Homes and Accountable Care Organizations. While these models have met with some success, they have not yet changed the fundamental problems of fee-for-service payment.

OMNIA moves in a different direction. In this new approach, Horizon is forming partnerships with health system organizations to manage the *total cost of care*. It delegates significant responsibility

for managing care and cost to the health systems and moves away from piecemeal fee-for-service. It is my understanding that OMNIA partner health systems will take on substantial new responsibilities for the covered populations, and, subject to meeting quality standards, will have a significant stake in achieving cost savings.

There is a growing belief that larger health care delivery enterprises that integrate care across settings – including ambulatory care, hospital, home health and rehab services – are best positioned to improve the overall health of the populations they serve while reducing cost. Such systems can invest in the infrastructure needed to facilitate better care using health information technology and adopting higher-performance care management strategies. With the right accountability and financial arrangements, such organizations have strong incentives to collaborate closely with community physicians and other practitioners to help patients manage complex health conditions so they can improve patient outcomes and reduce cost.

A controversial element of OMNIA is that Horizon has limited the number of “Tier 1” health systems in its network. Horizon reports that they have selected Tier 1 partners that they believe have the greatest chances of success. OMNIA’s tiered benefit structure entices partners to join the program with the promise of increased patient volume. Substantially lower premiums, deductibles and other cost sharing will provide strong incentives for patients to use the Tier 1 providers. It is likely that Tier 1 partners accepted payment discounts in return for the expected higher patient volume and the promise of financial rewards if they achieve quality outcomes and savings. Lower reimbursement rates, in turn, very likely contributed to Horizon’s ability to offer lower premiums cost-sharing to consumers purchasing OMNIA plans.

If OMNIA is to succeed, their health system partners will have to think differently than they did in the predominantly fee-for-service environment. They will have to invest in high-value, often low-tech

but under-utilized services including preventive care, patient coaching and education, and other population health improvement measures. They will have to pivot away from a culture of maximizing admissions and the volume of highly remunerative specialty procedures when effective and less costly alternatives are available. This is a major paradigm shift that could pay dividends for patients and premium payers.

From consumers' perspectives, OMNIA also departs from the long-standing trend toward rising premiums, deductibles and other patient cost sharing. Users of the OMNIA Tier 1 network will face significantly reduced out-of-pocket costs, although some will have to change providers to take advantage of Tier 1. Those using the Tier 2 network will continue to face cost sharing that is typical of many plans in the marketplace.

Possible Unintended Consequences and Risks

There is emerging evidence that total-cost-of-care models are promising,² but there is considerable uncertainty about the impact of OMNIA. I want to highlight four specific concerns that warrant close scrutiny.

First, it is likely that the OMNIA will deliver on its promise to shift patient volume to Tier 1 health systems. The success of the model depends on this movement. But if the shift is significant, Tier 2 facilities will experience lower volume and lower revenue. While there are regions of the state that have more hospital beds than they need, even hospitals in areas that not over-bedded could experience new financial pressures. Hospitals facing such financial challenges are unlikely to be able to sustain money-losing but important service lines or to invest in care improvements, such as programs to reduce

² See, for example, Chernew ME, RE Mechanic, BE Landon, & DG Safran. Private-payer innovation in Massachusetts: the "alternative quality contract." *Health Aff.* 2011; 30(1):51-61.

readmissions. Given these potential impacts, OMNIA could exacerbate disparities in the accessibility and quality of care in some areas. This potential is of greatest concern for facilities serving large numbers of Medicaid patients and other vulnerable populations.

Second, there is a risk that some OMNIA health system partners may not succeed. History tells us that some health care delivery systems are poor managers of financial risk. Horizon is positioning its delivery system partners achieve costs savings by improving care, but there is no guarantee that they will. While the consequences of mismanagement would fall mainly on Horizon and its partners, we should be concerned about possible consequences for patients and communities. OMNIA delivery system partners that struggle to find the "sweet spot" of better care at lower cost may face pressures to stint on needed care. Close monitoring for possible under-delivery of necessary services is important.

Third, with the implementation of the Affordable Care Act and for the first time in many years, New Jersey's private health insurance market has grown more competitive. We have two new carriers participating in the individual market. To the extent that engagement in OMNIA discourages Tier 1 health systems from entering into innovative contracts with other insurers, we could see diminished competitiveness in insurance markets, particularly for persons buying in the individual market.

Finally, competition among health delivery organizations is also a concern. There is strong evidence that hospital market consolidation leads to higher costs.³ Hospitals have undergone significant consolidation in recent years nationally and in New Jersey, and it is possible that OMNIA could accelerate such consolidation.

³ See for example Gaynor M, R Town. (2012). The impact of hospital consolidation—update. The Synthesis Project. Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

Conclusions

Lagging health system performance in New Jersey is a serious, persistent problem that should be addressed. It is essential that the current system which is driven by fee-for-service incentives that reward greater volume be replaced by systems that reward higher quality of care, better population health, and lower costs. The OMNIA Health Alliance seeks to make such a paradigm shift, but does so by providing strong incentives for patients to select OMNIA Tier 1 delivery systems. I believe that OMNIA has substantial potential to promote better care, lower cost and more affordability for patients. But there are also potential risks to the institutions left out of Tier 1, to vulnerable patient populations, and to our health care delivery and insurance markets. It is important that Horizon and its delivery system partners commit to transparency in implementation and that regulatory agencies pay careful attention to possible negative unintended consequence of this major system change.

Barnabas Health

MARC E. BERSON
Chairman

BARRY H. OSTROWSKY
President and Chief Executive Officer
Barnabas Health

MICHELLENE DAVIS
Executive Vice President for Corporate Affairs

December 1, 2015

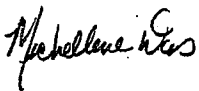
The Honorable Herb Conaway
The Honorable Reed Gusciora
State House Annex
PO Box 098
Trenton, NJ 08625-0098

Dear Assemblymen Herb Conaway and Reed Gusciora,

On behalf of Barry Ostrowsky, President and Chief Executive Officer of Barnabas Health, I would like to thank you and extend our appreciation for the invitation present testimony at a joint meeting of the Assembly Health and Senior Services Committee and the Assembly Regulatory Oversight Committee scheduled for Wednesday, December 2, 2015, at 10:00am concerning the impact of tiered health insurance networks in New Jersey. Consequently, due to timing and schedules, we are unable to participate and provide testimony at this time.

However, as the state's largest health care system, we believe in healthcare delivery models that focus on improved integration of care, incentives based on improved quality and cost reduction and those that lead to improved coordination of care. Managed care products that reduce costs to employers and individuals must be tied with an obligation for everyone, including a patient to be involved in their care and decisions as to where that care should be delivered, along with transparency around those costs. New Jersey needs to take a step forward in developing programs that truly reduce health care costs as part of the country's migration to population health which will result in the omission of some providers. Those decisions should be based on value, quality, and cost. The out-of-network activity in New Jersey which results in two of the highest priced hospitals in the country is indicative of the lack of innovation in our state's healthcare delivery models. Insurance products such as tiered health insurance networks are an attempt to change a very high cost structure that has minimal ties to quality or efficiency.

Sincerely,



Michellene Davis, Esq.
Executive Vice President, Corporate Affairs
Barnabas Health



223 North Van Dien Avenue
Ridgewood, NJ 07450-2736

December 2, 2015

Assemblyman Herbert Conaway
Chairman, Assembly Health and Senior Services Committee
8008 Route 130 North
Building C, Suite 450
Delran, New Jersey 08075

Assemblyman Reed Gusciora
Chairman, Assembly Regulatory and Oversight Committee
226 West State Street
Trenton, New Jersey 08608

Dear Assemblymen Conaway and Gusciora:

On behalf of the Valley Health System, which has been serving the residents of northern New Jersey for over 60 years, I am writing to express my deep concern with the formation of Horizon Blue Cross and Blue Shield's OMNIA Health Alliance.

We recognize that healthcare is changing and that tiered networks may be one way of reducing the cost of care. However, we strongly object to the manner in which the OMNIA Alliance was formed. The selection process was created by the state's largest insurer, shrouded in secrecy and devoid of any logical criteria for participation or exclusion.

Of the state's 8.9 million residents, 22% of them are enrolled in HMOs with Horizon controlling over 42% of the HMO market. According to the Department of Banking and Insurance (DOBI), Horizon controls an overwhelming 62% of the individual market, which by all accounts is expected to grow exponentially as healthcare reform initiatives continue to evolve. This dominant insurer chose a limited number of hospitals from the 72 acute care hospitals operating in New Jersey, which greatly limits network adequacy and ultimately access to care. One of the more extreme examples involves obstetrical care where a woman may have to travel greater distances to access a Tier 1 hospital.

While Horizon justifies its selection process by touting the "quality" and "value" of its limited Alliance network, many high quality hospitals that have received various quality and patient safety awards and recognitions were excluded from the network. Even more puzzling is the exclusion of many hospitals acknowledged by Horizon's own quality recognition program just this past spring, while others not so recognized were included as Tier 1 hospitals. Given these disparities, one may infer that Horizon agreed to exclude its Alliance partners' largest competitors as a *quid pro quo* to garner concessions from Tier 1 hospitals on lower reimbursement rates in exchange for increased patients, thereby increasing its profitability as well as its already dominant market share.

In addition to the questionable tactics Horizon used to form the OMNIA network, DOBI failed to follow its own regulations governing network adequacy. At the Joint Senate hearing of the Health and Commerce Committees held on October 5th, representatives from DOBI testified that the agency approved Horizon's plans to market the product knowing that there were access issues and that

89x

Assemblyman Herbert Conaway
Assemblyman Reed Gusciora
Page 2

contracts were not in place at many of the facilities included in the network. This revelation prompted your colleagues Senators Joseph Vitale and Nia Gill, to request that the Attorney General's Office investigate the approval process. This investigation is pending.

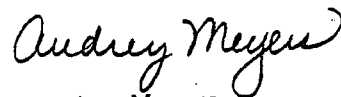
Hospitals excluded from the OMNIA Alliance requested DOBI to stay its approval of the OMNIA plan pending resolution of an appeal of the decision which was filed with the Superior Court on November 19, 2015. DOBI denied this request citing concerns about market stability since the plan is already being marketed. The market destabilization argument is not supported by the fact that there are two full months remaining in the open enrollment period on the healthcare exchange, which provides ample time for consumers to select another comparable product and for federal subsidies to be recalculated.

The OMNIA Alliance is bad for New Jersey consumers. It disregards the value of continuity of care and patient accountability, which are fundamental components of population health management. Through the use of significant economic incentives, OMNIA will direct volume to Tier 1 hospitals and separate patients from their trusted physicians and hospitals. This jeopardizes the health and wellbeing of New Jersey's citizens.

In closing, we urge you to work with the DOBI to ensure a fair and transparent process that safeguards quality, access and affordable care for all New Jersey consumers. A dominant insurer should not be allowed to act in a reckless manner adversely impacting patient care throughout the state or be permitted to unilaterally decide the fate of New Jersey's hospitals by allowing certain select hospitals to dictate which of their competitors participate in preferred networks.

Thank you for your consideration.

Sincerely,



Audrey Meyers
President and CEO

Copy: Members of the Assembly Health and Senior Services Committee
Members of the Assembly Regulatory and Oversight Committee