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# *Joint Committee Meeting*

of

ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE

ASSEMBLY REGULATORY OVERSIGHT COMMITTEE

*“The Committees will meet jointly to receive testimony  
concerning the impact of tiered health insurance networks”*

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**LOCATION:** Committee Room 11  
State House Annex  
Trenton, New Jersey

**DATE:** December 2, 2015  
10:00 a.m.

**MEMBERS OF COMMITTEES PRESENT:**

Assemblyman Herb Conaway, M.D., Chair  
Assemblyman Reed Gusciora, Chair  
Assemblyman Daniel R. Benson, Vice Chair  
Assemblywoman Patricia Egan Jones  
Assemblywoman Elizabeth Maher Muoio  
Assemblywoman Nancy J. Pinkin  
Assemblywoman Shavonda E. Sumter  
Assemblywoman Cleopatra G. Tucker  
Assemblyman Chris A. Brown  
Assemblywoman Nancy F. Munoz  
Assemblyman Erik Peterson



**ALSO PRESENT:**

Michael D. Fahncke  
Jamie E. Galemba  
*Office of Legislative Services  
Committee Aides*

Jade Mostyn  
Brian Quigley  
*Assembly Majority  
Committee Aides*

Natalie Ghoul  
John F. Kingston  
*Assembly Republican  
Committee Aides*

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

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HERB CONAWAY, M.D.  
Chairman

DANIEL R. BENSON  
Vice-Chairman

TIMOTHY J. EUSTACE  
ANGEL FUENTES  
JERRY GREEN  
ANGELICA M. JIMENEZ  
NANCY J. PINKIN  
SHAVONDA E. SUMTER  
MARY PAT ANGELINI  
AMY H. HANDLIN  
NANCY F. MUNOZ  
ERIK PETERSON



**New Jersey State Legislature**  
**ASSEMBLY HEALTH AND SENIOR SERVICES**  
**COMMITTEE**  
STATE HOUSE ANNEX  
PO BOX 068  
TRENTON NJ 08625-0068

MICHAEL D. FAHNCKE  
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**COMMITTEE NOTICE**

**TO: MEMBERS OF THE ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE**  
**FROM: ASSEMBLYMAN HERB CONAWAY, M.D., CHAIRMAN**  
**SUBJECT: COMMITTEE MEETING - DECEMBER 2, 2015**

*The public may address comments and questions to Michael D. Fahnccke, Committee Aide, or make bill status and scheduling inquiries to Kimberly Prihoda, Secretary, at (609)847-3860, fax (609)943-5996, or e-mail: OLSAideAHE@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.*

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**The Assembly Health and Senior Services Committee will meet on Wednesday, December 2, 2015 at 10:00 AM in Committee Room 11, 4th Floor, State House Annex, Trenton, New Jersey.**

The Assembly Health and Senior Services Committee and the Assembly Regulatory Oversight Committee will meet jointly to receive testimony concerning the impact of tiered health insurance networks.

Issued 11/25/15

For reasonable accommodation of a disability call the telephone number or fax number above, or TTY for persons with hearing loss 609-777-2744 (toll free in NJ) 800-257-7490. The provision of assistive listening devices requires 24 hours' notice. Real time reporter or sign language interpretation requires 5 days' notice.

For changes in schedule due to snow or other emergencies, call 800-792-8630 (toll-free in NJ) or 609-292-4840.



REED GUSCIORA  
Chairman

TIMOTHY J. EUSTACE  
Vice-Chairman

CLEOPATRA G. TUCKER  
CHRIS A. BROWN  
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**New Jersey State Legislature**  
**ASSEMBLY REGULATORY OVERSIGHT COMMITTEE**  
STATE HOUSE ANNEX  
PO BOX 068  
TRENTON NJ 08625-0068

**COMMITTEE NOTICE**

**TO: MEMBERS OF THE ASSEMBLY REGULATORY OVERSIGHT COMMITTEE**  
**FROM: ASSEMBLYMAN REED GUSCIORA, CHAIRMAN**  
**SUBJECT: COMMITTEE MEETING - DECEMBER 2, 2015**

*The public may address comments and questions to Jamie E. Galemba, Committee Aide, or make bill status and scheduling inquiries to Sophie Love, Secretary, at (609)847-3890, fax (609)777-2998, (609)847-3855, fax (609)292-0561 or e-mail: [OLSAideARO@njleg.org](mailto:OLSAideARO@njleg.org). Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.*

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**The Assembly Regulatory Oversight Committee will meet on Wednesday, December 2, 2015 at 10:00 AM in Committee Room 11, 4th Floor, State House Annex, Trenton, New Jersey.**

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ASSEMBLYMAN HERB CONAWAY, M.D. (Chair): Good morning, everyone.

As we--

ASSEMBLYWOMAN MUNOZ: We're all ready.

ASSEMBLYMAN CONAWAY: She knows the program.  
(laughter)

We'll start with the pledge, and then we'll proceed. (all recite the Pledge of Allegiance)

Well, again, good morning. I don't think it is a surprise to anyone here that we are -- this Joint Committee of the Assembly Regulatory Oversight Committee and the Health and Senior Services Committee will hear testimony on the impact of tiered networks, here in New Jersey; on the hospital delivery systems and patient care, in general -- including the impact on physicians and cost.

We will be taking, in general order, those hospital systems, physicians; and then we'll hear from insurance companies -- in that general order, as we proceed through the day.

Anyone wishing to testify, please fill out a slip that looks like this (indicates); for the unwashed, if you wish to speak, please fill out one of those slips and bring it to the attention of staff, and we will make sure that you have an opportunity to be heard.

As we always do, please put your -- I will remind myself -- cell phones on *stun*.

ASSEMBLYMAN PETERSON: *Stun?* (laughter)

ASSEMBLYMAN CONAWAY: Vibrate -- *stun* sounds better, I think, (laughter) -- so that we won't have the testimony interrupted by

rings, and chimes, and all those sorts of other sounds at inopportune moments.

All right. We'll have our clerk (*sic*) call the roll. We'll proceed to some opening statements, and then we'll get started.

MS. GALEMBA (Committee Aide): Assemblyman Fiocchi. (no response)

Assemblyman Brown.

ASSEMBLYMAN BROWN: Here.

MS. GALEMBA: Assemblywoman Tucker.

ASSEMBLYWOMAN TUCKER: Here.

MS. GALEMBA: Assemblywoman Muoio.

ASSEMBLYWOMAN MUNOZ: Here.

MS. GALEMBA: Chairman Gusciora.

ASSEMBLYMAN REED GUSCIORA (Chair): Here.

ASSEMBLYWOMAN MUNOZ: Wait -- did you say *Munoz* or *Muoio*?

MS. GALEMBA: Muoio.

ASSEMBLYWOMAN MUNOZ: Oh, I'm not-- That's her (indicating).

ASSEMBLYWOMAN MUOIO: I'm *Muoio*; she's *Munoz*.

ASSEMBLYWOMAN MUNOZ: I'm Munoz. (laughter) It sounded like *Munoz* from here.

ASSEMBLYMAN PETERSON: Wrong Committee.

ASSEMBLYWOMAN MUNOZ: Yes, wrong Committee; right. Okay, sorry.

MR. FAHNCKE (Committee Aide): Assemblywoman Egan Jones.

ASSEMBLYWOMAN EGAN JONES: Here.

MR. FAHNCKE: Assemblyman Peterson.

ASSEMBLYMAN PETERSON: Here.

MR. FAHNCKE: Assemblywoman Munoz.

ASSEMBLYWOMAN MUNOZ: Here -- again.

MR. FAHNCKE: Assemblywoman Sumter.

ASSEMBLYWOMAN SUMTER: Here.

MR. FAHNCKE: Assemblywoman Pinkin.

ASSEMBLYWOMAN PINKIN: Present.

MR. FAHNCKE: Vice Chairman Benson.

**ASSEMBLYMAN DANIEL R. BENSON (Vice Chair):** Here.

MR. FAHNCKE: Chairman Conaway.

ASSEMBLYMAN CONAWAY: Here.

Let me take the opportunity to welcome newcomers to this Committee.

Mr. Brown, you're going to get, I guess, a little initiation to the goings on in the Health Committee. Hopefully, maybe we'll see you back; maybe we won't see you again. We'll see. (laughter)

Welcome, new Committee member Ms. Egan Jones. Congratulations on your election; and we're very pleased to have you join us, here on this Committee.

Ms. Muoio, I think you're a substitute today, but we're very glad to have you today.

And with that, I'll turn it over to my Co-Chair for opening remarks and comments.

ASSEMBLYMAN GUSCIORA: Thank you, Dr. Conaway.

Today, the question here is whether efforts by Horizon and other carriers who offer healthcare plans to insured on a tiered basis -- arbitrarily designating some hospitals Tier 1 and others Tier 2 -- is either adequate or within the public interest.

Sadly, both Horizon and our Department of Banking and Insurance turned down our request to testify. And I think this is an important healthcare issue that will determine the affordability for many people in our state, particularly those in urban areas.

Also, sadly, DOBI, under the lead of an Acting Commissioner, took no active role to ensure that the plans were either adequate or within the public interest -- at least, in my opinion. If you take the capital City of Trenton, both urban hospital systems were designated Tier 2 status by Horizon; yet they were acknowledged for their price containment and performance in being the only Mercer County hospitals to offer cardiac care, trauma, and site treatment, as well as maternity care. Nearby, the only other Mercer Tier 1 hospital closed its maternity ward the previous year, and offers no cardiac care or trauma as a Certificate of Need; and the Acting Commissioner, when I met with him, was not aware of this fact.

The secondary treatment, the designation of Tier 2 status, was repeated throughout the state to other urban hospitals, as well as to Catholic hospitals, whose missions have always been to serve the poor. Horizon, acting as a for-profit entity, consciously chose suburban hospitals and gave them Tier 1 status and, in effect, said, "We'll give you less

reimbursements, but you will get a greater market share since other non-participating hospitals will be designated Tier 2 status.” Strangely, the capital City of New Jersey has also been designated as a Tier 2 community by Horizon, causing its citizens who want premier treatment, particularly with regard to cardiac care, trauma, and maternity care, to travel outside the county for those services.

Again, DOBI sat by and rolled over. Within weeks, the tiered plan was approved and the question is, for me especially, should we care that urban, working poor who are enticed to sign on to an OMNIA plan -- and I’m sure everyone heard a commercial on their way in -- are relegated to second-class treatment, both by the State -- DOBI -- and by the very insurance company that is a so-called non-profit entity whose mission should be to serve the public interest?

So I look forward to the testimony of both the hospitals and people from the insurance community; as well as those representatives from the communities that have been designated *Tier 2*.

Thank you, Mr. Chair.

ASSEMBLYMAN CONAWAY: Anyone else with a comment?

(no response)

I would just say that it is important for this Committee -- and I think some have questioned it, which is a surprise to me -- to take up this issue. This action in the marketplace will have impacts on the cost reimbursement for hospitals and physicians. They will affect consumer choices. They will certainly impact hospital delivery. Most people know hospitals in their particular jurisdictions are the largest employers in their communities and drive a lot of other economic activity. And so, that which

affects hospitals, affects our economy as a whole; and it is important for this Legislature to take cognizance of that.

And reflecting on the Senate hearings -- I think we need to return to the questions of access to care; how that's measured by the Department; whether or not regulatory changes should be sought by this Legislature to -- in respect to access to care, particularly for those who live in urban areas. I think it's important for this Legislature to have an understanding of hospital delivery at large, and what it will mean for jobs and our economy; what will the impact be on physicians who find themselves involved with both Tier 1 and Tier 2 hospitals; and what actions their patients may take with respect to these insurance plans.

So there are a number of issues here which will need to involve policymakers at the State level. I am a big fan of hearings such as this to bring these issues to the forefront in the public space so that, certainly, my colleagues here in the Legislature, but also the public at large, has an opportunity to look and understand changes such as this -- that touches on what, for many people, is a top-tier issue.

What will be my interactions with my physician? If I need hospital care, where will I get it? Where will my family members be able to get that care? And what will be, indeed, the viability of the hospital that serves my community? Where communities have lost hospitals, the impacts have been, by and large, very negative. And so we need, as a people, as communities of government, to pay close scrutiny to the regulatory process that impacts hospitals as greatly as this one portends to; and great scrutiny to the impacts on patients and their access to care, as this

plan posits it will; and whether or not -- and what the negative eventualities of any of those actions will be on our communities.

So I look forward to the testimony today.

Anybody else have anything they want to say about this before I call up the first testifiers? (no response)

Well, we'll start with Mayor Jackson of the City of Trenton. And I see Mayor Bollwage from the City of Elizabeth. Please come up and take the microphone.

When you push the button and the red light comes on, that's when the mike is on and you can speak.

Does anyone else need to come up with you at this time? (no response)

You guys have got it.

So Mr. Jackson, please.

**M A Y O R   E R I C   E.   J A C K S O N:** Thank you for the opportunity to come and testify this morning on this very important and critical issue, Dr. Conaway.

You articulate a lot of concerns -- so has Assemblyman Gusciora -- that I have, as the Mayor of the capital City of Trenton. And I look at this from the perspective of, certainly, being the Mayor of Trenton; but also being the Mayor of the Capital City. And when we talk about this decision by OMNIA to go with this tiered process -- but layered with what I believe is the inadequacies of the process that DOBI went through, in a two-week process, to look at this decision -- I believe, right from the door, we can see that there are some issues that enough vetting and looking into this matter -- did not have the proper time to access it.

Points that I would like this Assembly to consider when I offer that statement: In the capital City of Trenton -- an urban center, 85,000 people -- most people don't have transportation. Left out of that scenario -- both hospitals in the capital center are Tier 2. Cardiac care, best in the region at Saint Francis Medical; Capital Health Systems received awards from OMNIA the year prior. How, then, do these hospitals not qualify?

Then, in conversation -- there was no transparency in this process for those individuals who were left out to figure out how could they could participate and be a part of that. The impacted individuals -- residents of my city -- who have trusted their doctors, their physicians, and their hospitals for years and decades now will be moved to another location based on price. And when I met with the leaders of OMNIA and Horizon, they said, "Well, people have options." And we need to be candid about this discussion. On the surface, individuals will look at all these ads; they will look at the bottom line to what does it cost me out of my paycheck -- unknowing to the details, to the fine print. If you're having a baby in the City of Trenton, the capital city, originally no OB was included. They have since made an adjustment to this end, that the OB unit of Capital Health will be included in Tier 1, but not the balance of the hospital.

So I raise the question: So because we have high-risk pregnancies in our city, if there is a medical need because of some unknown or unforeseen complication, is that mother, then, moved, or that child moved to another hospital because the balance of the hospital is Tier 2? We have to make rational sense out of these decisions. And I am further troubled that DOBI did not look into these matters. Someone working here in this building has an OMNIA card and has a heart attack. They

can't go to Saint Francis, one of the best heart centers in our entire region? They're going to be taken 30 miles away from this city? I think we have to look at what this means.

Then we want to talk just a little bit about the economic impact. The plan is to really move patients away into Tier 1 institutions. What, then, happens to the hospitals that are left out of that? Physicians will ultimately go where their clients are -- to the Tier 1 hospitals. They will leave a city like our capital in despair if we lose one and/or both of our hospitals. Capital has the Trauma Center for the region, where people go when they're injured and hurt. We cannot afford to have this happen.

And I would suggest to you this: This is not just a local problem for the City of Trenton. This is a problem for the entire state, because I would suggest to you that the capital city is not a Tier 2 city; we're a Class 1 city on every level. And where the nation is moving toward affordable and accessible health care, why would we not want to have that here in New Jersey; and not based on zip code and/or based on the economic factors of what access people have, monetarily.

I thank you for listening; thank you.

ASSEMBLYMAN CONAWAY: Thank you, Mayor.

Mayor Bollwage.

**MAYOR J. CHRISTIAN BOLLWAGE:** Thank you, Mr. Chairman. Thank you, Chairman Conaway and Chairman Gusciora, for this opportunity.

I would also like to echo Mayor Jackson's words, but also talk a little bit about the City of Elizabeth and the announced exclusion--

ASSEMBLYMAN CONAWAY: Mayor, I want you to put your light on; and Mr. Jackson, would you push your light off. There you go.

MAYOR BOLLWAGE: Mine is on, right?

Once again, thank you, Mr. Chairman -- Chairman Conaway and Chairman Gusciora and members of the Joint Committee. I appreciate this opportunity to share our thoughts in the City of Elizabeth on the Horizon's OMNIA plan.

What baffles me, as the Mayor of the fourth-largest city, is how does Horizon get to decide which hospitals throughout the state are Tier 1 and Tier 2, complacent with the Insurance and Banking Commission here in the State of New Jersey? I find it to be extreme collusion; I find it an effort to just raise the salaries of the members of Horizon at the expense of health care for the people who live in our communities.

The exclusion of Trinitas Regional Medical Center from the list of Tier 1 hospitals under this plan is extremely disappointing and, collectively, challenging for the residents of my city. Trinitas is the sole hospital in our city and eastern Union County; it provides quality healthcare services for the people of Elizabeth; and it does so without regard for the ability of the patients to pay. We're the fourth-largest city, as I said. We're a growing population for an urban center. In order to get care from a Tier 1 hospital, the residents who live in our community -- they're faced with traveling to Robert Wood Johnson -- good for Robert Wood in Rahway; bad for Trinitas in Elizabeth -- an institution that has half the services and sees a fraction of the patients that Trinitas serves.

Many residents of Elizabeth are hardworking families who cannot afford the luxury of travel, and they certainly cannot afford the out-

of-pocket expenses that they'll have to endure to receive care at a non-Tier 1 hospital, like Trinitas.

I often wonder, with everything going on in this country today, about discrimination. Why is this not an issue of discrimination when a group of people, who clearly don't look like the residents they serve, get to decide who the Tier 1 and Tier 2 hospitals are? It's ironic that Trinitas is of sufficient quality and cost competitiveness to be the preferred provider in Union County for Horizon's exchange product; but as that product will cease at the end of this year, it is clear that the new OMNIA plan will cater to the larger health systems at the expense of smaller, independent, and Catholic hospitals in New Jersey. Many of these hospitals, like Trinitas, have experience in providing quality, low-cost care to a vulnerable population. The people at Horizon do not care about the vulnerable population; they care about the bottom line of increasing profit to their organization.

I would strongly urge this Committee to recommend amendments to the OMNIA plan so that Elizabeth and other urban centers in New Jersey will benefit.

Treatment with excellence is the standard at Trinitas, where dedicated professionals and staff have performed their duties with distinction. This will be threatened under the Horizon OMNIA plan, as well as patient access to quality, affordable care. Limiting accessibility to these vital medical resources is an insult to the residents of my community and many other urban centers throughout the State of New Jersey.

Our State has been known for closing a bridge for political purposes. I'm hopeful that we do not close the bridge to health care for urban residents.

Thank you, Mr. Chairman.

ASSEMBLYMAN CONAWAY: Thank you.

Questions for these presenters?

Mr. Gusciora.

ASSEMBLYMAN GUSCIORA: Thank you, Mayors, for coming down here.

I was actually talking to former Mayor Douglas Palmer the other day. He was noting that 50 percent of the Trenton residents do not have -- they rely on public transportation. And he challenged me to take a bus, if I had one of those -- needed, particularly cardiac care, or trauma, or maternity. Can you give us an idea of how far the citizens of your communities would have to travel to get to Tier 1 services?

MAYOR JACKSON: For the capital city, the closest hospital would be Princeton. So we would have to travel to Princeton, and that's not a straight route by our local bus system -- multiple buses. And I would urge you to consider this: On a bright, sunny day, probably not the worst ride in the world. But when you're sick and/or in trauma, that's a ride that many just cannot afford to take.

MAYOR BOLLWAGE: Mr. Chairman, the closest to us would be Rahway or Summit, and there are no direct bus routes; and cabs would be at a premium -- they're at the station; it's just very inconvenient. I went by the healthcare booth -- the OMNIA healthcare booth at the League of Municipalities convention. And I looked at four or five people who were

standing there; they were all dressed the same way, they all cut their hair the same way, they all had the same shirt and tie in the same way. They don't represent the people who are going to need health care. I'm baffled how they get to make these decisions for a very vulnerable population.

ASSEMBLYMAN GUSCIORA: Thank you.

ASSEMBLYMAN CONAWAY: You know, I work with marginalized populations, economically, in primary care. And I see, often, the impacts of getting to and fro for patients who don't have their own transportation; who have to rely on, perhaps, someone else to get them into the hospital, into the clinic. That person might have limited time and can't -- has to leave, and sometimes people leave appointments because their ride -- somebody has to get going, "I can't stay."

It surprises me -- and I think this is something this Committee and other, perhaps, Committees in the Legislature are going to have to address -- when we look at the regulatory environment around questions of access to care, it would seem that those challenges that economically, marginalized people face in getting to care do not seem to be adequately reflected in the regulations around access and distance to travel. If you are not driving, if you do not have a car -- which many of my patients don't -- what does that mean for your access, and what does it mean for true access to care for those patients? And when you're, sort of, putting a dot in the middle of a circle and drawing an arc, and saying, "Well, you know, you sort of meet the criteria," it doesn't really fully appreciate the challenges that -- the transportation challenges that many people have. And we're going to have to address that in regulation; I think that perhaps we might see a different calculus made by the Department if that kind of assessment

was made -- an assessment that truly took account of the transportation barriers that economically marginalized people face in trying to get access to care.

Anyone--

Ms. Sumter.

ASSEMBLYWOMAN SUMTER: Thank you, Mr. Chairman.

Thank you, Mayors for, one, understanding the value of health care to our communities; two, I'd also like to thank you for recognizing that healthcare hospitals are the economic engines for your community, and sometimes the largest employers, next to the cities.

Some of the questions that I have for OMNIA -- which is not here: If a doctor or physician is practicing in a Tier 1, and also is on the physician medical staff for a Tier 2, would they at some point opt out of the Tier 2 hospital because of the value-based services offered by the Tier 1 system? So access, quality providers, as well as being able to have a patient flow so that you can support the economic growth of your healthcare systems is also a great concern of mine.

So I thank you for at least presenting your testimony today.

ASSEMBLYMAN CONAWAY: Ms. Munoz.

ASSEMBLYWOMAN MUNOZ: Yes; thank you, Mayors.

You know, I live in Union County. I do want to make one point here -- because I'm having some thoughts.

We want to make sure that we make everyone aware that you can get access to -- the Tier 2 hospital, you're going to be able to get the service. But my point is that people are going to have to pay more for Tier 2 hospital access; I think that we have to make that point very clear.

Because I think there is a sense that we can't get to Tier 1s, and I think that goes to the point about access. You know, because people are going to pay less -- their premiums are going to be less for the Tier 1s. So I'm supporting what you're saying; I'm just making it not so much of a -- it's more of an issue of the access issue. You're going to pay more for the Tier 2 programs; therefore, you're going to have access to those hospitals.

So when we are looking at equity and access, you can still have access -- but you're going to pay more for it. And I think that that's really an important concept here that we have to stress -- not just being able to get there -- but the people who choose the Tier 1 plan will have lower premiums and they'll have access to those hospitals. Therefore, the people who -- in Union, in Summit -- want to go to Trinitas -- people from my District use Trinitas, a very fine hospital. University Hospital -- finest medical-- The Medical Center that trains 600 residents -- not included. So you're going to have to pay a higher premium for Tier 2 policies to get access to this excellent care. I think we have to keep that in mind; separating it from just--

So I'm agreeing with you about access, but I think we really need to-- Because people are saying, "Well, you're still going to have access if you're in a Tier 2 program," but you're going to pay more for it. And that's really, in my view, one of the main issues -- is that you're going to offer up these big healthcare systems, which are already doing quite well -- look at what they pay their CEOs and their salaries -- they're doing very well. So you're offering them increased number of -- you're narrowing the network for the doctors, you're increasing the volume, and you're saying you're going to pay less for that. You're going to pay more for Tier 2, which

means that the residents of your two cities are going to have pay more for access to your hospitals. It's a lose-lose, in my view, for not only the hospitals in the Tier 2s, but also for your patients and your constituents who want to have access to this. And that's where I think we have to really see that that's really what's going on here.

MAYOR BOLLWAGE: May I, Mr. Chairman, emphasize the point that -- supporting the Assemblywoman -- that the people in our communities are less economically viable to meet those costs as well. And I agree with the Assemblywoman 100 percent.

ASSEMBLYMAN CONAWAY: Mr. Gusciora.

ASSEMBLYMAN GUSCIORA: Mr. Chair, if I could follow up. I agree with you; thank you, Assemblywoman Munoz.

This is the chart that I got in the mail, as a State employee, to pick plans. (indicates) And one of them is the Horizon OMNIA, and notes that it has a Tier 1, Tier 2 program. If you choose a Tier 2 hospital, you have to pay a \$4,500 co-pay. And I was wondering how many of your constituents, per visit, can afford \$4,500.

MAYOR BOLLWAGE: I can't. I'm a Horizon member, and if you said to me that I have to pay another \$4,500, that's going to take something out of the budget in my own household. Where do I go? Do I have to drive to Overlook or Robert Wood Johnson? I'm a member of the Horizon plan. So my family now has to travel to visit me further.

ASSEMBLYMAN GUSCIORA: And unfortunately, yes, you were enticed by this chart because you would have a lower co-pay -- \$5. But it doesn't say, "Oh, by the way, if you live in the City of Trenton or Elizabeth, don't bother with these plans." So my fear is that there is going

to be a lot of workers who are going to choose the OMNIA plan specifically after hearing all the nice music on their advertising that we have been inundated with. You choose the plan, but you have no idea-- It doesn't say, "Oh, by the way, the Tier 2 hospitals are probably in your area."

ASSEMBLYMAN CONAWAY: Ms. Muoio.

ASSEMBLYWOMAN MUOIO: Thank you.

I just want to thank the Mayors for also bringing up the transportation issue. And Assemblywoman Munoz, we keep being put on the same Committees, and we have this issue every time we have a Committee hearing.

ASSEMBLYWOMAN MUNOZ: Yes.

ASSEMBLYMAN CONAWAY: People aren't paying attention, then. (laughter)

ASSEMBLYWOMAN MUOIO: Exactly.

ASSEMBLYWOMAN MUNOZ: And you just called me *Muoio*, so-- (laughter) You just-- And we don't even look alike.

ASSEMBLYMAN CONAWAY: You called her *Muoio*.

ASSEMBLYMAN GUSCIORA: Oh, did I?

ASSEMBLYWOMAN MUOIO: But the issue-- And that's the danger with the tiered system, frankly, is that you can consider all the hospitals in network, but they are very different in terms of what you have to pay out for expenses.

Also, on the transportation issue -- this is why -- one of the reasons I'm so disappointed DOBI is not coming. Because I was going through their 40-page opinion from Monday regarding the plans. And they're obliged to evaluate public transportation travel times for their

system, and in any county or approved service area in which 20 percent or more of a carrier's projected or actual number of covered persons-- So in terms of Horizon, if we're going to speak about a specific tiered plan, they're projecting a very low buy-in over the next year in terms of this program. So this 20 percent rule was only applicable to what they projected -- who they projected might join the new plan, or the actual number of covered persons.

On the other hand, we have heard them say that this is the wave of the future; this is the type of healthcare system -- they're trying to revolutionize health care and bring down cost; a laudable goal. But the actual number of covered persons and the projected number are not going to hit a lot of these areas that we're talking about. We brought this up at a meeting with DOBI back in late September -- about the public transportation issue regarding Trenton, specifically, Mayor. DOBI, in this decision, said that they looked into our concerns. They looked at the percentage of Mercer County residents who depend on public transportation and said that, according to U.S. Census data, only 7.6 percent of Mercer County residents rely on public transportation; thus, Mercer County did not meet the 20 percent or more standard in the rule.

Clearly, we have -- this is a very diverse economic county; and we were not talking about Mercer County. There were other people in this room who were at that meeting. We were talking specifically about Trenton -- the needs of Trenton residents. We're trying to get the data on exactly how many -- what that percentage is for the city. That is something, moving forward, that I think we need to work on as a Legislature, ensuring that this standard of review more accurately reflects the residents of this

state as a whole, and is not held to projected standards that are self-projected, frankly.

So I want to thank you for bringing up the transportation issue, because it's one way we could do something about this problem; and the regulations I don't think -- either weren't followed accurately or need to be changed.

ASSEMBLYMAN CONAWAY: Well, thank you for raising that point.

Going through the Senate testimony, this issue certainly bubbled to the top as one that is going to need addressing and, certainly, review by this Legislature.

We are talking here about projected numbers. If the Department was here -- and we'll ask them by letter, by the way -- when does the Department expect to review the actual numbers, and what actions will they take in respect to the questions of access when the actual numbers are known? I think that's very important; it might cause some adjustments. If we're focused on access as an important part of getting care, then the Department is going to -- then I hope, and we need to find out -- if the Department looks beyond these projected numbers to what's actually going on, and has a process for obtaining the true number, and then going to the insurance companies and causing adjustments to be made in their networks in respect of the actual numbers of enrollees in a plan. I, for one, want to know that that kind of process takes place.

In addition, then, as you mentioned, we do have to look at these methodologies to make sure that we're talking about true and real access to care, and something that's not theoretical -- so that the

methodology is one. Now, they're government, the thing is, and so we can bring them in here and we can cause them to -- let us know what's going on; we can just feed them information. One of the problems that we have, that is going to come up, is that other important aspects of this plan are in a black box and we can't see them. And given the gravity of the kinds of decisions that are being made in that box, outside of what one would consider transparency, we need, I think, as a Legislature, to think about that process as well.

You wanted to respond?

ASSEMBLYWOMAN MUOIO: I was just going to say that by the time that-- If the hospitals that are easily accessible to our urban centers are able to tread water for long enough for DOBI to figure out projected versus actual number of residents in need of public transportation, it could be too late. So that's why it's such a -- it's not as sexy an issue; but it's clearly a critical issue in terms of regulatory oversight.

ASSEMBLYMAN CONAWAY: Thank you, Ms. Muoio.

Mr. Jackson.

MAYOR JACKSON: If I could, Mr. Chairman.

I would like to just echo what the Assemblywoman said -- as I certainly heard your comments and respect that.

I would only urge this body to understand -- or at least consider while, yes, you want to see what projected versus the real numbers are-- But I would ask: What damage has been done in the meantime, not only to the institutions; but how many lives have been impacted by -- individuals who not only have a \$4,500 deductible, but find out, when they get a Tier 2 physician or hospital, that their co-pays are more than double of what they

saw on that sheet that the Assemblyman had. Because that's the real reality. And I think by the time that Horizon gets back, and this is their plan, "Oh, we'll come back in three months, six months, in a year and we're happy to show you the numbers." Think of the damage that will have been done, not only to the institutions, particularly those that are serving the underserved and are the safety nets in our urban centers that serve those who need charity care, etc. -- they're in an imbalance by losing these patients and by not receiving these rates; but to the individuals from this community and all of our urban centers whose lives, every day, starting in January, could be impacted by a lack of full transparency on the policies, on what this costs, and access to where your Tier 1 hospitals are.

And there's a psychological component I want us to consider too. When you're signing up, who wants to sign up for a Tier 2 anything? "Let me be a Tier 2." Nobody wants to sign up for a Tier 2. We all want to be Tier 1. Because the psychological consequence is, if I go to a Tier 2 hospital I'm going to get Tier 2 care. Who wants to sign up their constituents for that? I don't, as the Mayor of my city. We are a Tier 1 city all the way around.

I'm asking if there is anything that this body can do beforehand -- that's my request. Let's take some action where you can legally do it beforehand. When the horse is out of the barn, I fear it might be much too late.

ASSEMBLYMAN CONAWAY: I'm going to move on after this.

Ms. Pinkin.

ASSEMBLYWOMAN PINKIN: Thank you.

I think what you're saying, and what the Committees are saying, is that we're really-- This is a case of maybe throwing out the baby with the bathwater. We really are losing our focus on regional health planning. And having that policy planning with the Department of Health, the Department of Banking and Insurance, and making sure we have that oversight. Because we're forgetting about the long planning process, the costs involved, the developing the services, of having the tertiary services when needed. Not only the capital funds that the State has already invested in these programs; and then the funds that are needed to put them together and to plan them.

And so we're looking at the end result -- a short-purchase option that an insurance company can make and does not have to take into consideration the policy planning that goes with it -- and making sure that we cover all of these issues on the access to care.

I have a paper that I came across, which is the Employee Benefit Research Institute's 25th Anniversary paper that they wrote on tiers. And what they said is that tiers are going to actually cause shifts in uncompensated care, because it's going to make that problem even bigger. And while it has a short-term benefit for the individual; from a healthcare policy point, and from the overall cost, it's actually going to drive costs up.

Thank you.

ASSEMBLYMAN CONAWAY: Thank you.

This question was raised, and then I'm going to move on to the next testifier in a moment.

About the tiering -- I think is a very interesting point. I met with Horizon, and they will say that they are concerned about the Tier 1

and Tier 2 categories that were established as part of the plan, and understand that it's going to cause a perception problem on the part of the public. You were correct; people want to go to a number one provider, they don't want to go to a number two. We're America, after all; we're number one in everything, aren't we? (laughter)

And so it is a problem, certainly, for those hospitals that get this label. I would say -- and Horizon's not here -- that they are concerned about that, and we'll see how they address that concern. But it's real; and it is just one of those other items that will go to marketability and, therefore, viability of some hospitals in this new post-OMNIA world.

Thank you, gentlemen.

MAYOR BOLLWAGE: Thank you, Mr. Chairman.

MAYOR JACKSON: Thank you.

ASSEMBLYMAN CONAWAY: Next, I'll bring up Ed Smith, Warren County Freeholder Director.

**F R E E H O L D E R   D I R E C T O R   E D W A R D   J .   S M I T H :**  
Thank you, Chairman Conaway, Chairman Gusciora. It is a pleasure to see you both. It brings back a lot of memories being here.

I appreciate the opportunity to address this important Committee of the General Assembly. My name is Edward Smith; I'm the Freeholder Director of Warren County. Warren County has 108,000 residents; 363 square miles. We are a Tier 2 County; so, unlike being just a particular town in a County, my entire County is Tier 2. I echo the Mayors' sentiments: We're not a Tier 2 County; we're a Tier 1 County.

Hackettstown Regional Medical Center and Saint Luke's-Warren -- our only two hospitals in the entire 363-square-mile area -- both

failed to make the Tier 1 category. However, Hackettstown Regional Medical Center would become Tier 1 if it becomes acquired by Atlantic Health System (indiscernible) pending.

But let's take a look at the specifics, which would mostly be Saint Luke's-Warren. And I really want to just touch a little bit on the history there. Warren Hospital had a difficult history in the past of trying to be able to make ends meet, because we have a significant lower-income population. It is an Abbott District -- Phillipsburg is, or was, formerly known as; as well as reduced sales tax provided to stimulate the economy.

I can't begin to emphasize how important it is that our largest employer survives, and that they have the opportunity to continue to offer the important services that are there and that are a vital lifeline to jobs.

But let's take a look at western Warren County. And while I talk about Phillipsburg, there are areas north where these distances will be even further.

So Warren County -- where a resident who happens to subscribe to the new OMNIA plan may need care at a Tier 1 hospital, they may not even be able to be referred, necessarily, to the Tier 1 hospital because their relationship is now with a Tier 2 hospital. So they would have to actually -- that close relationship they have with their doctor is compromised.

So that means a 20 mile-ride -- or, practically, a 25-mile ride to Hackettstown Regional Medical Center. But, whoops! Hackettstown Regional Medical Center, our other hospital, isn't a Tier 1 either. So let's look at our next option: 25 miles -- actually, 26 miles to Hunterdon County; and this is just from the western portion -- a 40-minute drive; or

they could choose to go to Newton Medical Center in Sussex County, 35 miles, no direct road, most likely an hour. Meanwhile, there is a quality hospital right in Phillipsburg that would be able to provide the services to them immediately. But again, when we look at affordability -- that can be provided to them at a higher cost. So how is this translating into affordable health care without there being certain winners and losers?

I might also point out that we border Pennsylvania almost 50 miles along the Delaware River. But Pennsylvania hospitals are not included. So for my areas in the extreme northwest portion of the county, they're looking at an even more difficult ride.

Here's the real key: There is virtually no public transportation in Warren County. So it's not a case of whether or not people would use it; there isn't any. Car, taxi, or ambulance transportation is very expensive, thereby contradictory to the premise of being affordable and accessible. Family members, similarly, will be impacted by inconvenience and expense, because if they choose to provide support to the person who's in the hospital, they are also looking at a 45-minute or an hour drive.

Phillipsburg, the westernmost town in our County, continues to have challenges keeping (*sic*) the need. And that need is clearly present, because we just went through a Certificate of Need process to establish that Saint Luke-Warren should be there. But the ability to sustain this viable operation will be hampered by a significant charity care demand that now is going to become exacerbated. And I want to emphasize that, while we talk about that it's going to be more expensive, if there's an individual who is low income or disadvantaged and who does not have the ability to go to these other hospitals, they're going to come knocking on the door of Saint

Luke's-Warren, and they're going to be provided with care that, most likely, the hospital won't be paid for. Their position, financially, gets compounded because while they're going to have to charge the person more for services, they're also going to have to absorb more charity care -- which just throws them further behind the eight ball.

So what stands to happen with Saint Luke's with no Tier 1 status in the subgroup? There will be significant diversion of needed revenues. These were provided to me by the hospital staff: \$2.7 million in 2016, \$4.7 million in 2017, and \$8.5 million in 2018. These collectable amounts are the difference between a hospital being able to sustain itself, or not.

ASSEMBLYMAN CONAWAY: I'm sorry; what do those last three numbers represent? They represent what?

FREEHOLDER SMITH: Those are the anticipated diversions of revenue, that has been provided by hospital staff, with the assumed growth of the OMNIA plan and if they stay as a Tier 2 hospital. And that's the cash money. That's what I'm saying -- is that the charity component and the ability for us to be able to get payment on those areas, ultimately get written off on bad debt. I mean, I'm not necessarily talking that it's just Phillipsburg here, because there is a huge surrounding suburban area and that is the only hospital. It's not like there's a choice, and it's not like there's a choice locally.

The impact, ultimately, would be catastrophic, economically. Saint Luke's-Warren is the largest employer in Phillipsburg.

My final thoughts here are, let us not be fooled into thinking that a plan such as OMNIA -- one that squeezes hospitals for lower rates

and consumers for higher deductibles -- translates into more affordable or accessible health care. It does, however, set the stage for winners and losers in the medical marketplace, setting quality providers up to fail by diverting needed revenues to certain other providers at the expense of others.

Winners and losers, as it was talked about earlier. The insurance provider will still be financially whole. Even those providers who may have made the concessions will feel the pinch of the give-backs that they had to make to be in the tiered subgroup. Consumers will pay higher deductibles and significantly higher prices to the hospitals that are not Tier 1, in this subgroup for the lower, affordable premium.

Hard decisions face lawmakers here. I had the experience of serving down here in the Legislature. There are many maladies that have been included under the blanket of healthcare coverage, making New Jersey's healthcare coverage extremely expensive. The costs have skyrocketed. As the CEO of my County, I have watched health care spiral out of control. It's a budget breaker for us, in terms of being able to keep up.

While this has happened, we look at advertising -- for instance, prescription drug direct advertising continues to soar, under the cover of proprietary patent protections, marketed by direct consumer advertising that's only implemented in the United States and New Zealand. In fact, on November 16, the American Medical Association called for a halt to this prescription drug advertising, saving an estimated \$4.5 billion of diverted healthcare dollars to endless advertising that only further exacerbates demand upon our overburdened system. We need to cut these expenditures if we really want to address true, affordable health care.

In closing, these comments and observations would have most likely been presented had there been a hearing process; but there was none. Providers such as Saint Luke's or others may have been willing to even meet the demands to become a Tier 1 group participant, but they were not even given the opportunity -- even the opportunity to say "no." I said to the CEO there, "If you had said no, then I would have been yelling at you, saying 'Well, why aren't you willing to provide these services for our people?'" Inaction on this rating system of an affordable healthcare plan could well lead to the elimination of key medical services in struggling areas that desperately need them. How can this be? How can such far-reaching actions upon the delivery of health care in this state ever get to this point, with no transparency? I am sure that this is not what the Legislature ever intended and, most respectfully, ask that this body promptly and effectively move to address this urgent situation.

Thank you, Chair.

ASSEMBLYMAN CONAWAY: Questions for Freeholder Director Smith?

ASSEMBLYWOMAN SUMTER: I do.

ASSEMBLYMAN CONAWAY: Ms. Sumter.

ASSEMBLYWOMAN SUMTER: Freeholder, can you just clarify what hospitals were in your district? Was it Hackettstown?

FREEHOLDER SMITH: Hackettstown Regional Medical Center, and also Saint Luke's-Warren.

ASSEMBLYWOMAN SUMTER: Okay

FREEHOLDER SMITH: Which is the most isolated one, because there is really -- there is no other service in northwest Jersey.

ASSEMBLYWOMAN SUMTER: Okay. A point of clarification: Am I reading correctly from our spreadsheet that Hackettstown Regional Medical Center is part of the Tier 1 system, or is excluded? I have that it is part of it.

ASSEMBLYMAN CONAWAY: I believe they are Tier 1.

ASSEMBLYWOMAN SUMTER: I have them as Tier 1. Hackettstown is Tier 2?

FREEHOLDER SMITH: It's--

ASSEMBLYMAN PETERSON: It's a Tier 2.

ASSEMBLYMAN CONAWAY: Hackettstown's Tier 2? Okay.

ASSEMBLYMAN PETERSON: They're Tier 2.

ASSEMBLYWOMAN SUMTER: It's Tier 2.

ASSEMBLYMAN PETERSON: There might be some confusion because they were going to merge with Atlantic Health, but it didn't happen.

ASSEMBLYMAN CONAWAY: Oh.

ASSEMBLYWOMAN SUMTER: Okay; so it's part of their consideration of being a part of Atlantic Health.

ASSEMBLYMAN PETERSON: That's probably why your information is not accurate.

ASSEMBLYWOMAN SUMTER: Okay; thank you.

ASSEMBLYMAN CONAWAY: That deal's off?

ASSEMBLYMAN PETERSON: As far as I know.

ASSEMBLYMAN CONAWAY: Anyone else? (no response)

Thank you for all the--

FREEHOLDER SMITH: Thank you, Chairman.

ASSEMBLYMAN CONAWAY: Next, Linda Schwimmer, New Jersey Healthcare Quality Institute.

LINDA J. SCHWIMMER, Esq.: Good morning. Thank you for inviting me to testify before you today.

My name is Linda Schwimmer; I'm the President and CEO of the New Jersey Healthcare Quality Institute. The Quality Institute is a nonpartisan entity; we are what is called a *Regional Health Improvement Collaborative*, which means that we have all the stakeholders of the healthcare system in our membership, and we work on initiatives and projects which try to improve the quality of health care, as well as reduce costs and increase transparency across New Jersey.

I submitted written testimony for you; but I wanted to summarize a few things, and then answer any questions that you might have. I also testified before the Senate Committee that looked into this issue, and I know some of you have listened to that testimony, and have it. So I will try not to be repetitive in any way.

I think it's important to look at this in a broader context -- and I know certainly that was the intent of this hearing when you called it, and I applaud you for that because I think it's a very important step to take. Tiered, narrowed -- and, actually, closed networks, where there's not even as much choice as a tiered network -- are taking part or are happening across the country, and they're happening in New Jersey. They've actually been happening in New Jersey since the Affordable Care Act came into being. And I think that you're going to continue to see these types of products. I think that, actually, you're going to see more of them, as opposed to less of them.

So I think it's important to look at this in a broader context, and to ask why are we seeing this, and what do we want for our State? What do we want for our citizens, for our employers, for our consumers?

There are three general reasons why you're seeing more and more of this. First of all, it's the lack of affordability of health care and health insurance. I mean, I think you're probably hearing from your constituents; particularly small businesses, people who are self-employed, self-insured, individuals who are trying -- who now have to purchase on the marketplace with after-tax dollars. And they're looking at the choices, and they're very disappointed. It's really hard for working-class families, individuals to purchase insurance. And even when they do purchase it, there's very high cost-sharing. So they are reluctant to use that health care, which is certainly not good for public health, and not good for them, and not good for their families.

So health plans are struggling to figure out products and product design--

ASSEMBLYMAN CONAWAY: Well, they're not struggling for profits. They might be struggling, but they're not struggling to make money.

MS. SCHWIMMER: I would not argue that point, Assemblyman. But they're struggling to figure out market design to be competitive.

The second reason is, that because there's so much cost-sharing, and because these high deductible plans are very unpopular with consumers, they're trying to figure out alternative ways to design products.

And the third reason that's really driving this is the Cadillac Tax -- which impacts the State of New Jersey and every municipality and county in New Jersey. Come 2018, if the cost -- the annual premium price, so to speak, of your insurance is above \$10,500, that employer -- in this case, the State or municipality -- is going to be paying a 40 percent excise tax, which goes straight to the Federal government on the amount above that set amount. So they're looking for strategies to make sure that they stay under that number, because that's a very high price tag.

So what can you do about this? I raised several points in my testimony, but I want to focus on, really, three main points for that.

First of all, the existing network adequacy regs, which DOBI is responsible for overseeing and executing for the insured market -- which is about 25 percent of our market here in New Jersey -- are antiquated. They were enacted in the late 1990s; they haven't been revisited in a long time. They don't reflect a lot of the issues which were raised already this morning, which are really important issues.

And I just want to circle back to the transportation issue, for instance. Mercer County and Trenton had enough foresight to realize when they worked on their Community Health Needs Assessments, that it made absolutely no sense to look at Mercer County as one big county. It made a lot more sense to have Trenton, led by the Trenton Health Team, look at the community needs of the City of Trenton; and then the rest of Mercer County, together, did a separate Health Needs Assessment, looking at the rest of the County. If you look at the County all together, it becomes so watered down that a statistic like "7 percent of people use public

transportation” is meaningless to the City of Trenton; but it’s probably very reflective of West Windsor, or Princeton, or Hopewell.

So I would suggest to you that the regulatory guidance that DOBI has in front of them really needs to be revisited -- sooner, rather than later. Also, because the regulatory process takes so long, the Legislature might want to think about being more detailed in that directive so that you could move more quickly.

Another aspect of that is, the National Association of Insurance Commissioners, about a month ago, released a proposed Network Adequacy Law that I would suggest you take a look at for some guidance and consideration. That law specifically had issues that we don’t have in our law here in New Jersey today. For instance, it specifically requires that it publicly disclose, in plain language, the standards that a health plan uses when it designs its product, and tiering, and choosing network providers. I think that that goes to certainly one of the Quality Institute’s priorities about transparency. It’s important for consumers, when they’re purchasing a product, to know what’s included in that product; that they have accurate information; that they’re able to utilize the product as best as possible; and that they understand how those determinations were made -- particularly when it comes to quality and accessibility.

So, certainly, that’s something to look at. They also have more specifics in their -- specifically, they address the issue of essential community.

ASSEMBLYMAN CONAWAY: Excuse me; who’s *they*? Who’s *they*? They keep asking me; maybe I missed that part.

MS. SCHWIMMER: Oh, so there's an entity called the National Association of Insurance Commissioners.

ASSEMBLYMAN CONAWAY: NAIC; yes, okay.

MS. SCHWIMMER: It's all of the insurance commissioners across the country coming together. They have a committee process; there's a committee just on health insurance issues. It went through the committee, and then it was adopted by the full NAIC as a model legislation -- proposed model legislation for states to adopt.

Another thing that's in that proposed legislation is looking at the impact on essential community providers -- which is another point that was raised. That in designing these tiered networks, even though the tiered networks or the closed networks might be focused on the commercial population, there is always collateral damage, so to speak, or another impact on other markets.

And I think that that really goes to the next point that I wanted to share with you -- which is, New Jersey severely underfunds Medicaid and our Medicaid system. Administrations like to say that we've had some of the lowest growth in terms of the amount of money we spend, per capita, on Medicaid. One of the reasons for that, though, is because we pay substantially less to Medicaid providers than they do in other states, even though we're one of the most highest cost states to live and to run a business in. So the impact of that is that providers then are forced to raise their prices in other markets; and the other markets are subsidizing our Medicaid system.

I would submit that's a pretty short-sighted strategy, because when we're spending State dollars we get Federal match. But when we're

spending money from the State Health Benefits system, or when we're making individual consumers and small employers pay higher premiums to cover those costs -- which is really what we're doing -- there is no Federal match for those. We're just making it more expensive to live here in New Jersey. So one strategy in a global, broader way would be to revisit how we fund our Medicaid system.

And finally -- and this is a really big point, and this is the point I spent most of my testimony on in the Senate -- you have been speaking a lot about DOBI today. But DOBI only regulates the insured marketplace, which is 25 percent. DOBI does not regulate and does not have oversight over the State Health Benefits plan, for instance. The State is the largest purchaser of health benefits in the State of New Jersey. It's not insured, as you all know; the State purchases those benefits. And so the State is the purchaser, and the State has the power of the purse strings, and the State can say, "Here's what we would like to see in our plan. We're paying for it; here's what we would like to see. And we would like to design this, based on our priorities and our vision for what a State plan would look like."

Now, one of the things you might want to consider is -- and I think Assemblywoman Munoz raised this -- we have a State university where we educate our residents. Maybe we would want it to be a priority -- particularly since we pay for that university -- that that university be included in any priority tiers that are in a State plan. We also have many hospitals which we -- not many, but some -- hospitals where we've guaranteed some of the bonds. That might be something we might want to look at. I would certainly hope we would also want to look at quality, and we would want to have transparency.

So it's not for me to tell you what the priorities should be; but I think my point is that, as an active purchaser, the State can design what's in the best interest of the State. If you're not an active purchaser, what ends up happening is your vendors, or the health plans that they are administering -- they're really the third-party for you -- they'll design it based on what's in their best interest; which is, frankly, what capitalism is all about. But if you want to design it, you need to put that in an RFP or bring that to the design committee and say what you want included.

So thank you, again, for the opportunity to discuss this at a broader level. And I would say I would welcome to be a resource to all of you.

Also, I think is a very important conversation, and I wanted to invite all of you to a further symposium that we're going to be having on the topic at Princeton University on January 21, which is open to the public. And we'll have that on our website as well.

Thank you.

ASSEMBLYMAN CONAWAY: Great; thank you very much for your testimony.

I had read your Senate testimony, and also found it compelling. And you raised, I think, a very important point about the power of the State government to take action here to protect what needs protecting. You are going to hear from this Committee and from others about the impact of these plans on inner-city communities, on safety net hospitals. The State certainly has a stake in their viability, going forward. There are arguments about that, certainly, that you'll hear from some of the folks who are on the tiered networks; and there's going to be the other side of people who are

actually in there, running these hospitals, who know what their margins are and know about the need to have a viable and ongoing institution.

But the government, here, with 800,000 employees; and the Medicaid program -- another -- what is it, \$1.7 million?

MS. SCHWIMMER: I think \$1.75 million.

ASSEMBLYMAN CONAWAY: I think that's what is said there in your testimony to the Senate. There is quite a lot that the State can do to protect what needs protecting. And they have a lot of power here, because in those programs, the State really is in position to dictate, or to have its values -- hopefully, values that are reflective of the values of the people in New Jersey at large, who I think are going to have a concern -- not only about cost efficiencies, which they need to have, but also about the ability and the sustainability of teaching institutions, safety net hospitals, economies where hospitals are based. And it's an important involvement.

I think people expect us to take cognizance of such items because these hospitals and the hospital care that's provided there, both inpatient and outpatient, are critical to the life, and the satisfaction, and happiness of the people here in New Jersey. Government has to reflect those interests on the part of the people.

And one of the big questions that remains, and we haven't heard -- I think it's probably fair to say we haven't heard from the Administration on this -- is just where the Administration stands on these issues that you've raised, and its use of its buying power in the marketplace with respect to tiered plans or other insurance products that are offered here in New Jersey.

But we need to raise that flag, and we need to bring that to the folks' attention. And I appreciate very much your raising it here for us today.

Ms. Sumter.

ASSEMBLYWOMAN SUMTER: Sure. Thank you, Mr. Chairman.

I'd also like to highlight your point of increasing rates for Medicaid providers, because that's something that has been at issue for us. We have providers who are willing to take care and treat the population, but access becomes an issue, delays in care become the issue, because the rates are miserable, at best, when you have the cost of educating yourself as the medical profession.

So if we can tackle that issue-- We've talked about it in the years that I've been here, but we have not made any headway, if you will, in increasing those rates. And now may be part of that opportunity -- in improving the system -- to do that.

ASSEMBLYMAN CONAWAY: Mr. Benson.

ASSEMBLYMAN BENSON: Yes, I also want to thank you for your testimony, because I think that it brings into stark relief that there's a series of interrelated issues that are going on here in the State.

You know, I think, first, is the outdated regulations and State policies that we have; kind of a lack of a modern vision for our State safety network hospitals, here in the State.

And here in the State, the Medicaid issue, I think, is a prime one that needs to be revisited. Not just the payment rate; it's the timeliness

of payments, it's how these things are handled, working with hospitals to be able to make sure they process these payments in a regular manner.

Second, I think you brought up the lack of action in leadership at the State level, either as a purchaser -- but on these other issues and up, trying to keep regulations up-to-date with these.

And then, lastly, I think the issues that you brought up, just related to the OMNIA plans. How much do you see the OMNIA plans themselves -- those issues that you brought up, transparency -- how much of that is just bringing into stark relief those other two issues that may not be with OMNIA itself, but because the impacts that it's having on health care in the state then reflects back on these two areas that, had we been more in line with, may have been less of an issue here? So in other words, not having strong support of our safety-net hospitals, not having processes in place for Medicaid, and others. How are these things making the OMNIA plan look even harder on these hospitals -- because of the lack of leadership at the State level?

MS. SCHWIMMER: So I think the best indicator of that is as follows: When the Affordable Care Act first started, Horizon, and probably others -- I just know of Horizon, in particular -- did have a tiered product. So there was an opportunity to have a lower premium if you went to certain hospitals. And I believe that that was based, frankly, on cost. It was the hospitals that were willing to accept the lower rates. And it was only in the individual marketplace; so it was pretty silent. You didn't have any hearings; you didn't have a roomful of people complaining, because the individual marketplace was about 90,000 people -- a little bit more after the

Affordable Care Act -- but it was pretty small. And those rates were never really so great for hospitals anyway.

Now, when this plan design is across the board in all of the markets and, in particular, in the State Health Benefits plan, now you have a roomful of people. Because the other products are much richer, and those are the products that hospitals rely on to survive, because the Medicaid rates are so low. So it's all very interconnected. By having such low Medicaid rates, the State Health Benefits plan ends up subsidizing Medicaid anyway.

ASSEMBLYMAN CONAWAY: Well, one of the things that the government can do with this and its purchasing power, I would think -- and I guess I'm asking to see if you agree with this statement -- is that it can insist on transparency with respect to how hospitals are tiered and how physicians are tiered. One of the problems -- and we're going to hear about that today, and I'm certainly going to raise it *ad nauseam* -- is that we don't know how decisions have been taken with respect to the tiering process for hospitals and physicians. The government can say, "Look,"-- just as the Federal government does with respect to its national standards, whether it be JCAHO or whether it be Leapfrog -- "we put a standard out there that everyone can see. We want hospitals to succeed; we want people to strive to be the best, and the way for that to happen is for people to know what the standards are." But that is not happening here in the OMNIA case; and I think our government might want to follow suit of the Federal government to say, "We want to have the standards out there for people to see so that every hospital here can strive to be in that lowest (*sic*) tier, or to do as well as they can in the marketplace. And the physicians ought to be in the

same--” And we do so because it is -- as a policy matter it prevents things like conflict of interest, prevents things like collusion; and it gives everyone confidence, and often that’s very important; perception, that’s very important; confidence that there’s fair play in the marketplace.

So that’s something else that the State can do with its buying power, isn’t it?

MS. SCHWIMMER: Absolutely, Chairman. And I know that you’ve been, over the years, a huge proponent of transparency when it comes to health information and data. And the State, right now, frankly, doesn’t look at its data; doesn’t make its data publicly accessible so we can see about variations, and cost, and utilization, and efficiency. As you know, as a physician, there’s wide disparity in both cost and quality for procedures such as hip, and knee, and other scheduled procedures. And we could get a lot of information as a purchaser, and make more tactical decisions as to how to design a plan if we had that information. We don’t have an all-payer claims database--

ASSEMBLYMAN CONAWAY: We need one.

MS. SCHWIMMER: We don’t have any other database to make informed decisions.

ASSEMBLYMAN CONAWAY: I agree with you; I saw that in your testimony. It reminded me of legislative initiatives on that -- I think I have had others -- on the all-payer database. It is one of the essential pieces of information that we need here, in my view, to do the kind of planning that you’re talking about. And we need to push to get that. The more information we have, in my view, the better we will be at empowering consumers to make good choices in the marketplace; and to help

competitors to move to improve their services and their service delivery, too, of patients.

So I'm all in favor of that. More data is always better than less, it seems to me. And it's one of the problems, I think, with -- as pointed out in some of the testimony and some of the things I've read -- that it is -- that our gaps in data make the *leap*, as some have called it, to these kinds of arrangements problematic. The hospitals don't know if this is going to work out for them. And they are going to take -- or offering to take, contracting to take rather steep cuts in reimbursement. Is that reimbursement going to be made up in volume, or not? Are they going to be able to -- do they have the information systems that they need to drive down costs? These are questions that, right now, are unknown. And depending on where you are -- if you're in the alliance, or there is going to be shared savings -- will there be shared savings for you? If you're not one of -- if you're in Tier I but in a non-alliance, I understand the compensation is different there for them.

But this-- You know, there are different levels of risk that these Tier I hospitals are taking on. And I think it's arguable that they're taking this risk on in an environment where they don't really have all the information one would want to make that kind of decision to go in and be involved in it. And I think it is our responsibility to address that issue, quite frankly. And it will be one of the topics for the next term, for sure.

Anyone else?

ASSEMBLYMAN GUSCIORA: Yes.

ASSEMBLYMAN CONAWAY: Mr. Gusciora.

ASSEMBLYMAN GUSCIORA: Linda, welcome.

One of the things that I'm disappointed in is that both DOBI and Horizon declined our invitation. I think it speaks volumes of their sincerity in all of this. And so, unfortunately, you're the only one we have a shot to talk to. (laughter)

Do you know if there's a trajectory for Horizon to become a for-profit entity?

MS. SCHWIMMER: I have no idea. And as you know, I'm not an employee of DOBI or Horizon, so I really can't speak to that.

ASSEMBLYMAN GUSCIORA: Horizon's a member of your organization, kind of a funder?

MS. SCHWIMMER: They are; yes, yes -- as are many of the Tier 1, and Tier 2, and other insurers as well.

ASSEMBLYMAN GUSCIORA: Okay. And the other thing is that -- because-- It seems that Horizon, in this, is chasing the dollars in the suburban areas by giving Tier 1 status to suburban areas -- where the people would be able to more afford the health care for the premiums, afford the co-pays -- and then leaving the urban areas as collateral damage, or the working poor as collateral damage. And I'm wondering if you know if Horizon-- Was that their thinking -- to chase after the suburban dollars?

MS. SCHWIMMER: Again, I think it would be better if they spoke.

But my understanding is that this was designed for the State Health Benefits plan and for commercial payers -- I'm sorry; commercial clients -- so, businesses and the individuals in the marketplace. So they looked at what was attractive to the marketplace. And so that might have ended up being brands and systems-- I think they also looked at the ability

to enter into these alternative payments models, where you get a smaller amount of money upfront with the hope that you're able to work efficiently and not only have high quality, but also produce savings. And then, on the back end, 18 months later, you would share in that savings.

As Assemblyman Conaway said -- just stated -- I think that there's definitely some business risk involved there. And so a hospital system has to have the financial wherewithal to be able to enter into those sorts of contracts. And I think what you're ending up seeing in this tiering is some of the fact that certain hospitals -- again, in Horizon's estimation, not mine -- but I think that that's the process that they went through -- at least, from an outsider looking in, that's what it appears to be.

I mean, there are some hospital systems that have an urban presence, of course, that are in their Tier 1 networks, such as Saint Joe's and parts of the Barnabas system.

ASSEMBLYMAN GUSCIORA: Now, the other observation I'm making is that DOBI left the adequacy rule and the public interest rule on the cutting-room floor in approving this. Can you rationalize how the collateral damage, the working poor who live in the urban areas -- how is that adequate for them? How is this tiered network adequate for them? Somebody who has a cardiac care issue, a trauma issue, a psych issue, a maternity issue in the City of Trenton, how is this plan adequate if they're snookered into getting the OMNIA plan?

MS. SCHWIMMER: So I actually had the pleasure of reading the 40-page order last night, and I have to say if you really want to dig deep into this, it's extremely well written and it's basically a treatise on existing regulations. You may or may not agree with DOBI's interpretation of what

they believe their regulatory authority is. I think it's -- sometimes, it's a lose-lose for regulators. And I used to work at DOBI, and have worked in both the Legislature and the Executive Branch, so I get this. I think legislators like regulators to be expansive if the outcome is what they want; and they like them to be narrow if the outcome is not what they want. And so they're put in a position of interpreting the law and the regulations as they are today.

And I go back to my earlier statement: I think the law and the regulations as they are today are woefully outdated. They were created in the 1990s and they really don't anticipate a lot of the things that -- most of the things that we're talking about today. And they don't mention the impact on the essential community providers, which you're raising, which is a very important issue. And I think that's an issue that should be addressed immediately.

The Reinhardt Commission talked about this a lot; they made very, very, I think, rational and just really important recommendations; and the State-- We went to the effort of putting that Commission together -- probably many of you worked on that -- and we should be following many of those recommendations. And they go to this exact point -- that we really need to be looking at our safety-net hospitals and, as we're making decisions, we should be making sure that we're taking into consideration the impact on those hospitals and other providers. I mean, that wasn't done here; but the regulations, as they exist today, don't require that that be done. I'm not saying that that's right or wrong; I'm saying I think you need to revisit the law and the regulations.

ASSEMBLYMAN GUSCIORA: What about the Public Interest Rule? How is that in the public interest -- to leave urban poor and working poor on the cutting-room floor as *collateral damage*, as you say?

MS. SCHWIMMER: Again, I think looking at the order, the Department -- and I'm not speaking for them -- but they laid out their rationale of why they thought it was outside the scope of their regulatory authority to do that.

ASSEMBLYMAN GUSCIORA: Do you think that, under-- Has the Health Care Quality Institute taken a position on whether a Tier 2 hospital, particularly the urban hospitals, can survive with OMNIA treating them as Tier 2 status?

MS. SCHWIMMER: So I know that Horizon has projected, in the scheme of things, relatively low uptake rates for these plans.

ASSEMBLYMAN GUSCIORA: They also said that they weren't projecting in the future, which is arguably--

ASSEMBLYMAN CONAWAY: They did say they were projecting. They did say there's a limit--

ASSEMBLYMAN GUSCIORA: How many years; how many years?

ASSEMBLYMAN CONAWAY: They expect a linear growth in the uptake and (indiscernible).

But anyway, go.

MS. SCHWIMMER: I think that these types of plan designs and products -- whether it's OMNIA or whether it's anybody else's -- are here to stay and are going to grow. I think you're not only going to see tiered products, I think you're going to see regional products. You already

have that in South Jersey with the AmeriHealth Cooper plan. I think you're going to see regional products; I think you're going to see closed networks. All of this, again, is going to the fact that health insurance is just way too expensive. People can't afford to even utilize the health care once they've purchased it because the cost sharing is so high.

So all of these types of products are here to stay; that's why it is so important to revisit how they're regulated and what you want to see in the regulations, sooner rather than later.

ASSEMBLYMAN GUSCIORA: You think there's going to be a further consolidation of hospitals -- in fact, urban hospitals closing?

MS. SCHWIMMER: I do think there's going to be further consolidation of hospitals. I think it's largely driven by everything that's coming out of the Federal government, and the fact that as we move to alternative payment models, it's very, very hard to manage a population if you don't have a robust health information exchange, and other technology, and interoperability to be able to support it. And that's expensive.

And also, again, going back to the earlier comment about entering into these contracts -- you have to have the financial wherewithal to wait the 18 months. I think it's very -- it's going to be very hard to be a stand-alone entity. I think there always will be some; you'll also see cross-border alliances. We're seeing that more and more, where you have academic centers -- whether it's in Philadelphia, or New York -- and then you have the community hospital providing the care more locally. But I do think you are going to see further consolidation.

ASSEMBLYMAN GUSCIORA: Thank you.

ASSEMBLYMAN CONAWAY: Ms. Jones, then Ms. Muoio.

ASSEMBLYWOMAN EGAN JONES: Thank you; and I appreciate both the Chairmen putting this together.

As the newest serving Legislator, never mind Committee member, I've been working diligently to get up to speed. I'm still not there.

One thing I would like to ask Chairman Gusciora: You mentioned the co-pay for using a Tier 2 hospital at \$4,500. Is there a co-pay, and what is it, for the Tier 1?

ASSEMBLYMAN GUSCIORA: (consults chart) Tier 1 -- the maximum is \$2,500.

ASSEMBLYWOMAN EGAN JONES: Okay. So there is a substantial gap there.

I really appreciate all the testimony.

ASSEMBLYMAN GUSCIORA: But that--

ASSEMBLYWOMAN EGAN JONES: I'm sorry -- you wanted to say something?

ASSEMBLYMAN CONAWAY: Please, please, go ahead.

ASSEMBLYMAN GUSCIORA: I'm sorry I interrupted you.

ASSEMBLYWOMAN EGAN JONES: I really appreciate all the testimony, both for and against. We can see that, in certain areas -- Trenton, certainly, is a glaring example -- where access, not the kind that they're talking about -- healthcare access-- It's actually getting there; it's the transportation issue, making sure people are comfortable where they're being served.

Coming from the place I came from two months ago, I would have celebrated the fact that I could buy lower-cost health care, and that's

what everybody is striving for. It seems to me, at this point, our job from now forward would be to look at the laws and the regulations so that we're not sitting here blaming one insurer when, silly me, I thought OMNIA was the only one that was doing this. But there are five insurers that follow this same kind of plan. It seems to me that outcome-based health care is really important; I know it's important to everybody sitting in this room. And so we need to know how to better deliver it so that hospitals in Trenton are not left out of the system -- where people are forced to pay more -- because the whole idea is for people to pay less. I certainly want to see that for my constituents, and for the rest of the people in the State of New Jersey.

So I appreciate everybody's comments, and your bringing us together to look at this. But I think we should talk about the broader package that all the insurers are providing, and not just hit on the (indiscernible).

ASSEMBLYMAN GUSCIORA: Well, my consternation is that OMNIA is the 800-pound gorilla.

ASSEMBLYWOMAN EGAN JONES: Well, it is the biggest.

ASSEMBLYMAN GUSCIORA: And if you look at a pie, what's the OMNIA plan -- what's Horizon at?

ASSEMBLYMAN CONAWAY: Half of it. (laughter)

ASSEMBLYMAN GUSCIORA: Yes.

ASSEMBLYWOMAN EGAN JONES: Right; that's true.

ASSEMBLYWOMAN MUNOZ: About 47 percent.

MS. SCHWIMMER: Well, Horizon is about 50 percent of the market, and across the state it's obviously more in certain parts. Probably Mercer County--

ASSEMBLYMAN GUSCIORA: And the other consternation is the disingenuousness of their advertising. If you listen to their advertising -- and I'm sure every single one of us listened to it on the way in -- about the nice music and how everybody-- And the larger networks -- that's totally disingenuous, that you have a larger network. There are people who are going to be snookered, and I'm talking about the collateral damage that you talked about -- the working poor, who will be snookered into getting an OMNIA plan, who live in the City of Trenton, and then, lo and behold, they find out that they have a \$4,500 co-pay when they show up at one of their hospitals.

And it's more than transportation; it's the ambient -- the sphere of where the health care is provided. And for OMNIA to say they don't care, "If you want a Tier 1, just travel 30 miles," and that's about it--

ASSEMBLYWOMAN EGAN JONES: But we do need to look at the other 50 percent.

ASSEMBLYMAN GUSCIORA: And that's grossly unconscionable, and I think the State, particularly the Democrats, should be concerned about the urban poor who have been left at the back of the bus and who have been totally frozen out of the OMNIA plan.

ASSEMBLYMAN CONAWAY: Good, good.

Now, turn your light off.

ASSEMBLYMAN GUSCIORA: I did, Mr. Chair.

ASSEMBLYMAN CONAWAY: I wasn't talking to you.

(laughter)

Ms. Muoio.

ASSEMBLYWOMAN MUOIO: Thank you.

Ms. Schwimmer, I just wanted to ask a couple of questions based on some information that you brought up.

One, you mentioned the risk to Tier 1 hospitals -- that they will have to-- I think you and the Chair, Chair Conaway, were talking about that it's a risky venture for Tier 1 hospitals in this new system, and it's something that has to be taken into consideration.

My understanding is that what helps to reduce that risk is market share being driven to these Tier 1 hospitals; almost a guaranteed percentage of market share, because there are only a certain number of these hospitals that are being allowed into Tier 1. Would that reduce the risk? Do you think that reduces the risk for these hospitals?

MS. SCHWIMMER: It's certainly part of the design element. The question is whether they'll be able to survive at the rates that they're being paid on the front end, and whether they'll successfully control that population and produce quality outcomes, and then receive any shared savings on the back end. And the difference between the cost of delivering that care versus what they're getting on the front end -- I can't answer specifically for each of those systems, but that's the calculus that their CFOs and boards have to make.

ASSEMBLYWOMAN MUOIO: One of the big letters in that calculus -- in that formula, though, would have to be, "We may take a hit at the beginning, but eventually market share will be ours." It would make that more palatable, I would think.

MS. SCHWIMMER: That's right.

ASSEMBLYWOMAN MUOIO: Okay.

And because, as I see it, the market share we're on is sort of a two-prong trajectory here: First, the ads -- there are the ads that we're hearing that are from the insurance companies. But I'm also hearing ads from providers now, holding up the fact that they're a Tier 1 provider in the new OMNIA system. So it's being used by providers to try and entice patients.

So if the pool is limited to a certain number, there is no question that they will eventually gain more market share. The goal is-- Clearly there have been some Tier 1 programs prior to this. Aetna's now picked up the Tier 2 hospitals and now are including them as Tier 1 in their program. But the concern is that as market share is driven away from these Tier 2 hospitals by the largest insurer in the state, they're becoming -- most of them already are disproportionately seeing the Medicaid and Medicare patients who -- you mentioned our rates are abysmally low for Medicaid. Realistically speaking, is there any way for a hospital to survive when they're losing the limited amount of insured patients they have to a Tier 1 hospital and their proportion of Medicaid and Medicare patients increases? I mean, is there any way for a hospital -- an urban hospital, particularly -- to survive that?

MS. SCHWIMMER: Well, you raise really important questions. I think another reason why this room is full is because of the market share that Horizon has, versus the market share that other insurers have. And that's something that I don't think has been discussed in either of the hearings yet, but I think it's something that is a fair factor to look at.

So as plans are proposed, what the impact of market share should be. For instance, if Health Republic -- not to pick on them, but

they're a smaller-sized player in the market, at this point -- the co-op -- I don't think this room would be full if they had designed a tiered product. I think a lot of this is because of the issue of market share. So as you sort through these things, that's one factor to look at.

There are other health plans that have these products, and there are other health plans that are partnering with hospital systems. And I think that will be the path forward for them for their financial viability. And I think you're already seeing that.

ASSEMBLYWOMAN MUOIO: And DOBI, actually, in the -- I read that same 40-page decision as you did (laughter) and DOBI actually did acknowledge in the statement that their regulatory oversight rules were written before Tier 1; they did not anticipate the arrival of Tier 1 systems. So I want to thank you for also making that point clear -- that these regulations have got to be overhauled in light of this. Because I've sat in several meetings with Horizon, and they begin each meeting, "We are looking to change the way health care is delivered and financed." This is something that we needed to get on top of two years ago, but we didn't. So we have to get on top of it now.

But thank you for all your points.

ASSEMBLYMAN CONAWAY: Thank you.

I think we should move on.

MS. SCHWIMMER: Thank you.

ASSEMBLYMAN CONAWAY: Thank you for your testimony. I'm sure you will try to be there in January, where members of the Committee will reach out to you for further information on this important topic.

Let me just make, sort of, a point. It is true that Horizon is not here today. But those of you who have been following this issue know that Horizon is also subject to litigation by the non-Tier 1 hospitals. And given the involvement of, or use of the prior testimony as part of that litigation, you can understand why they might not be present today. I think the same thing applies for the Department of Banking and Insurance, as they are also in litigation. And generally, when you're a litigant, you're advised to keep your mouth shut.

Now, the same does not go for some of these other insurers who are involved in tiered networks. And as the Chair of this Committee and as a member of the General Assembly, I am disturbed that when we call for a hearing on tiered networks, that those insurance companies that are not subject to litigation -- Aetna and United -- they ought to be here to talk about their methodology, and what they're doing with respect to tiering, and hospitals, and physicians. Hopefully, they will think on it some more and, at some point, present themselves to this Committee or to members with respect -- and enlighten us with respect to what they're doing. So just to be clear on that.

Next we need to bring up -- I understand he's pressed for time -- former Commissioner Goldman, to offer us information on the tiered plans, particularly in regard to those hospitals that are not in the first tier.

Mr. Goldman.

**S T E V E N M. G O L D M A N, Esq.:** Thank you, Mr. Chairman; and thank you for inviting me to testify this morning, Chairman Gusciora and Chairman Conaway.

I appreciate the opportunity to be here. I am a former Commissioner of DOBI; I served in the Corzine Administration from March 2006 through July 2009. And I also served, during that time, as a member of the Reinhardt Commission, which was formerly known as the *Commission on Rationalizing Health Care Resources*, which the Governor created to consider the economic conditions of New Jersey's healthcare system, with a particular emphasis on the 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 that they were providing.

Currently I am a partner at a law firm in New York City, Kramer Levin, and I represent 11 hospital groups, 17 hospital facilities that have filed an appeal in the Appellate Division challenging DOBI's approval of the OMNIA network.

While the goal of a tiered plan to provide high value/lower cost health care is praiseworthy, the tiered system must be implemented in a fair and a transparent manner that achieves those goals over the long term. Unfortunately, we don't believe that that happened with OMNIA.

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, as has already been mentioned this morning -- particularly the urban poor and minority populations, and the often otherwise underserved population, which includes every single Catholic hospital in the State of New Jersey with the exception of Saint Joe's in Paterson -- were left out, notwithstanding the high-value services that those

hospitals provide to this important population. Many of these hospitals were the ones determined by the Reinhardt Commission to be providing disproportionate charity care and receiving inadequate charity care reimbursement.

For these reasons, and for the ones I'll mention soon, implementation of the OMNIA plan should be suspended until that plan and the consequences for the healthcare system in New Jersey are properly vetted, so that we can ensure it will not have a possibly irreparable, detrimental impact on the system in New Jersey.

Horizon is New Jersey's sole nonprofit health services corporation, with a share of more than 50 percent of the commercial insurance market. Horizon reports that it serves 3.8 million members in New Jersey, including every member of the State Health Benefits plan. 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 on 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 it holds its powers in trust for the public in the same manner and to the same extent. Therefore, Horizon 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, which were chosen in a secretive and a non-transparent manner in exchange for those Tier 1 hospitals agreeing to lower reimbursement rates, violates this obligation.

The OMNIA plan results from collaboration between Horizon and six of New Jersey's largest hospital systems, as well as a physician group -- the OMNIA Health Alliance. Among other things, the OMNIA plan designates certain hospitals, including members of the Alliance, as Tier 1 hospitals, while demoting other hospitals, including the hospital group that I represent, to Tier 2 status. Subscribers who use Tier 2 hospitals incur increased costs compared to the savings that are built into the Tier 1 hospitals and their services.

Horizon has announced an effective date of December 26 for State Health Benefits program members, and January 1 for all others.

The documents that were made public after the Senate hearing on October 5 show that Horizon informed DOBI on June 25, 2015, that it planned to submit a tiered network plan for approval. But it wasn't until September 3 that Horizon submitted details about its plans for hospitals, and it did so solely as a result of DOBI's prompting. 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. DOBI made its approval effective as of September 15.

No public hearings were held in connection with its approval. None of the parties were notified, beyond Horizon, by DOBI of its consideration of the OMNIA network; and no input was sought from any of the Tier 2 hospitals that I represent prior to this decision to approve the plan.

In my experience, given the potential ramification of a proposed tiered plan by the State's sole nonprofit health services corporation, serving

more than 50 percent of the commercial insurance market in New Jersey, a careful review should have required some months, not two weeks. In addition, all of the constituents impacted by the plan should have been given an opportunity to be heard prior to any plan approval.

DOBI has a legal obligation to ensure that the OMNIA plan is not contrary to the public interest. Unfortunately, DOBI has refused to undertake any such analysis of impact on the public. I'm in agreement with the fact that some of the regulations are outdated; but the fact that some of the regulations are outdated doesn't excuse the inability or the refusal on the part of DOBI to consider the broader public interest.

In fact, this past Monday, in the written denial of my clients' request that DOBI stay the OMNIA plan of its own accord, DOBI took the position that in reviewing and approving a new insurance product, it has no obligation to protect the public interest beyond ensuring that network adequacy exists; and that network adequacy -- if it exists -- in and of itself is sufficient to protect the public interest. I believe DOBI is wrong about that.

Someone certainly needs to consider this plan's broader public impact. And unfortunately, numerous aspects of the OMNIA plan will have a deleterious effect on consumers, the healthcare industry, and New Jersey residents. First of all, the OMNIA plan jeopardizes the stability and quality of the New Jersey hospital system as a whole. The entire OMNIA plan is designed to migrate members and encourage them 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.

There is a real risk that the Tier 2 label, along with Horizon's widespread media campaign touting its new product and its Tier 1 participants, will cause consumer confusion and lead patients to mistakenly believe that the Tier 2 label is indicative of an inferior quality of care -- and that would further increase patient migration. Strikingly, the Tier 1 subnetwork largely excludes hospitals located in urban communities, while many of the Tier 2 hospitals are located in those communities.

As was said already, 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 subnetworks lacks transparency, therefore making it impossible for consumers to make informed choices about their health care. Although Horizon announced that it made its tier determinations based on six criteria, it's failed to explain how the criteria were developed, weighted, or how any hospital scored against any other hospital. Horizon's methodology is 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 by Horizon's inclusion of other institutions with lower Leapfrog ratings.

Faced with public pressure, Horizon recently 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 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. A tiered plan, with such far-reaching implications as OMNIA, where Horizon itself makes subjective decisions about who was included and who was excluded, is inappropriate. There is no way for a Tier 2 institution to determine what's necessary for it to accomplish Tier 1 status. And there's no way to determine whether a Tier 1 hospital, initially designated as Tier 1, is no longer 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 there's no list of objective criteria 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 makes 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 and have admitting privileges have been designated as Tier 2. That makes the system enormously cumbersome for a patient to navigate and for providers to navigate. This has cast doubt in the minds of physicians as to whether they should change their hospital affiliations to Tier 1 hospitals from Tier 2 hospitals. And if that were to occur, it will result in their patient populations also transferring from Tier 2 to Tier 1 hospitals. And 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, which complicates a patient's ability to receive coordinated care within a single hospital. Just as one example: The suggestion that a Tier 2 hospital be designated as Tier 1 solely for OB services would cause tremendous confusion; or the patient is allowed to be charged at the Tier 1 rate for the OB service in order to fill out the adequacy of the network -- as took place here with DOBI approval of the network.

What happens if that woman or her newborn child has complications and needs other services within the hospital? Or what happens if the woman goes home and, later that day, starts to hemorrhage? Can she return to the hospital where she originally delivered, or does she need to switch hospitals; and most importantly, why should she be forced to even think about that? That's really not a continuity of care that makes sense from a patient point of view.

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 very dangerous precedent. Other insurance companies wishing to roll out similar products may do so in the same haphazard manner that happened here, and this would undermine the existing regulatory structure which is designed to prevent just that.

Finally, undermining the financial viability of Tier 2 hospitals is against the public's fiscal interest, because it increases the risk of default by these hospitals which, in the aggregate, have been issued about \$3 million (*sic*) in tax-exempt debt by the New Jersey Healthcare Facilities Financing Authority. This could require, if it became a reality, that the State step in

and make good on those bonds, which would further tax an already overtaxed State budget.

Although much of the administrative record is unavailable to the public still, based on the information that has come to light from the Senate Committee's investigation and from DOBI's recent written denial of a stay of the OMNIA plan, it's clear that OMNIA failed to meet DOBI's own network adequacy regulations at the time the 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 adequate access to a network of primary care providers, medical specialists, and hospitals within a geographic range. A plan that gets there most of the way doesn't make it. These are minimum standards. And if you can't even meet the minimum standards, it's questionable whether that plan should have ever been approved.

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's not greater than 20 miles or 30 minutes' driving time -- whichever is less -- from 90 percent of covered persons within the county or service area. It's questionable whether that's been met.

When an insurer subdivides a network into tiers, each tier -- according to DOBI regulations -- must independently satisfy network adequacy requirements as if it was the only network being offered. The OMNIA plan failed to meet DOBI's network adequacy requirements at the

time of approval in a number of respects. First of all, it didn't have agreements with each Tier 1 hospital in place at the time it was approved, 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 wasn't compliant with respect to obstetrical services in Burlington County. Providing such services at a Tier 2 hospital at Tier 1 cost is an unacceptable solution for this problem.

In conclusion, I think that the implementation of the OMNIA plan is potentially having 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 the hospitals were chosen, the plan should be suspended pending a proper vetting process and complete compliance with DOBI regulations.

Thank you.

ASSEMBLYMAN CONAWAY: Thank you, Mr. Commissioner.

I have some questions.

Now, you mentioned that the plan was approved, and you mentioned that there weren't public hearings. Now, is that the usual process? So, if I come in for a plan amendment or to offer a new product in the marketplace, does the Department typically hold some hearings on those plans? I'm not sure that they do. I mean, you mentioned that--

MR. GOLDMAN: The answer, Mr. Chairman, is no.

ASSEMBLYMAN CONAWAY: Okay.

MR. GOLDMAN: In the normal course of events, public hearings are not held.

ASSEMBLYMAN CONAWAY: So, I mean, I'm certainly not the lawyer here, but the argument that a hearing wasn't undertaken with respect to the OMNIA plan is not -- would be the usual course of business.

MR. GOLDMAN: It's not the usual plan. So in a usual plan situation, where the impact is potentially what I described, at a minimum -- whether you held a public hearing or you didn't hold a public hearing -- what is the usual course of business is to meet with affected constituencies before you approve it if the plan could potentially have detrimental effects on those constituencies. Whether you ultimately decide to approve it or not, at least you got the input of people and institutions potentially affected.

ASSEMBLYMAN CONAWAY: Now, you mentioned-- And so the Commissioner might exercise the option to have hearings and discussions in public if he or she so chose, with respect to this plan approval or any plan approval?

MR. GOLDMAN: If the evaluation of the plan was such that the consequences could potentially be that enormous, then holding public hearings would certainly be an option. But again, whether you held public hearings or you didn't, it is a matter of course that when you have a proposal that has these sorts of potential consequences, you do meet with affected constituents in order to get input before you make a decision.

ASSEMBLYMAN CONAWAY: Now, you mentioned the OB services; and this is something that, as I prepared for this hearing today -- and you raised the question -- if the Commissioner were here, while I have

to talk to the former Commissioner -- these fixes that were the two issues: one, it would seem, from the testimony that was offered by Acting Commissioner Hartt, that there was nothing improper or unusual about the Department approving the OMNIA plan, or any other such plan, presented to the Department for approval before such time as all the various regulatory hurdles had been met. I mean, there was a lot of testimony in the Senate about when the plan was approved and what actions or deliberations were undertaken with respect to the provision of obstetrical services. So who's right here? Is this -- is their approval of this plan before the obstetrical services were, sort of, tied down -- was that appropriate, inappropriate, just sort of a mistake that maybe--

MR. GOLDMAN: Well, it wasn't just a fact that obstetrical services weren't tied down. I mean, I think it was acknowledged at the Senate hearing that contracts weren't even signed with some of the critical providers. Some of them refused to come to the hearing and testify in favor of the plan because they hadn't signed an agreement. And DOBI's position -- for those of you who read the 40-page refusal to grant the stay we requested -- was that, "Well, you don't need a signed contract. We're satisfied even without a signed contract that it will be implemented; then that should be okay."

ASSEMBLYMAN CONAWAY: You think the consumer fraud bar agrees with that?

MR. GOLDMAN: I can't answer for the consumer fraud people. But I can tell you that, from my perspective, if I-- I mean, I think the proof is in the pudding. The fact is, they were negotiating contracts for the reason that they felt they needed them. Because if they didn't think

they needed them, they wouldn't be negotiating. I'm talking about Horizon and the providers, now.

So to approve a plan before you know the network is actually in place, or on the expectation that the network is going to be in place, seems to me a little bit precipitous.

ASSEMBLYMAN CONAWAY: Now, if I understand the testimony given by Acting Commissioner Hartt, in looking at access to care, they look at the numbers of persons who are, I suppose, in the -- who are expected to enroll in the plan, and then begin their geographic or GeoAccess analysis based on those enrollment projections. Is that correct?

MR. GOLDMAN: Yes.

ASSEMBLYMAN CONAWAY: The concern I have as I look at this map -- and representing Burlington County as I do -- is that you look at this map, and it's a big County; the largest County in the state. We have nobody in this County who is Tier 1. Now, you raised a point about whether or not it makes sense for a hospital to just be Tier 1 with respect to a subset of their services and what that might mean. Could you elaborate on that some more -- the problems with that?

MR. GOLDMAN: Well, whether it's the hospital -- whether it's a particular service in a hospital that's designated as Tier 1, or whether it's an arrangement with the patient to say that if you use that particular designated service in the hospital, you will only pay Tier 1 rates, the point's the same. You don't have the continuity of care that you would normally expect to have in a hospital. I mean, think about it. How would that work? I'm a mother, I'm pregnant, I'm about to have a baby. There's a complication. I now need a different service. Am I supposed to get in an

ambulance and have the ambulance drive me to a Tier 1 hospital so now I'll pay Tier 1 rates? Or should I stay in the Tier 2 hospital, pay Tier 2 rates, because I'm now in a Tier 2 hospital?

On the ground, in the real world, this sort of a patchwork set-up is not conducive to adequate continuity of care for patients.

ASSEMBLYMAN CONAWAY: I'm glad you brought that up, because I was going to bring it up myself. Absolutely -- the reason why we have these obstetrical services and we looked at them in isolation, or at least as we make sure that they're taken care of, is because we're concerned about women, and children, and their health care. I'm concerned about this question of just looking at OB and dealing with the OB situation, because women have health problems that go beyond that, and continuity of care with their physicians is an important thing.

So if I go and deliver a baby, and I have a relationship with an obstetrician-gynecologist, I now-- Perhaps there's a delayed -- a complication that comes up with respect to the pregnancy. Where do I go to get care, then? And now it's not -- is it obstetrical, still? Is it gynecologic? And if it's -- how do we sort of divide the female body with respect to this kind of care? It doesn't make sense to me.

MR. GOLDMAN: Well, I think what it reflects is that this is cobbled together to try to meet the letter of the adequacy of the network, but without taking into account the reality of how people live. I mean, that doesn't work.

ASSEMBLYMAN CONAWAY: Someone wrote an article, and we were looking at this -- if I have a baby and now -- I shouldn't have said it

that way (laughter) -- somebody has a child, and happens to have complications, and they need to go to a neonatal intensive care.

MR. GOLDMAN: A neonatal unit somewhere; right.

ASSEMBLYMAN CONAWAY: Now, those are not inexpensive places to receive care. If I'm at the hospital and expect that my co-pay is going to be at this lowest rate, I've chosen that because it seemed to be the best fit for my family. Now I have -- we have a child; the baby has a problem and needs to go to a unit. I now-- And my cost share is going to be, maybe, dramatically different than it might have otherwise been. Isn't that so?

MR. GOLDMAN: It appears that way; yes, it sure does.

ASSEMBLYMAN BENSON: Chairman, I have a question on that point.

ASSEMBLYMAN CONAWAY: Mr. Benson.

ASSEMBLYMAN BENSON: Just on that point, because I completely share some of the concerns you've raised about the impact on the hospitals themselves. But you just raised a very specific example for consumers.

MR. GOLDMAN: Yes.

ASSEMBLYMAN BENSON: So within Tier 1 and Tier 2, you raised that question, "Well, if I want to save that \$2,000 maximum out-of-pocket difference between Tier 1 and Tier 2, I would have to travel."

MR. GOLDMAN: Yes.

ASSEMBLYMAN BENSON: So, say you win your court case, and we halt the OMNIA plan. So, okay, all the State workers who have chosen that now have to choose the existing plans. What's the difference

for that consumer for that maximum out-of-pocket between even Tier 2 OMNIA versus the existing plan? Are they paying more or less?

MR. GOLDMAN: I don't know the rates of the existing plan.

ASSEMBLYMAN BENSON: Okay.

MR. GOLDMAN: What I would say is this. The goal of having lower cost health care is the appropriate goal.

ASSEMBLYMAN CONAWAY: Yes.

MR. GOLDMAN: The issue here is not a quarrel over the goal. The issue here is the fairness in the mechanics that were used to attempt to implement the goal. You cannot have a fair system if it doesn't have a transparent and objective level of criteria to qualify. And then a hospital or a doctor, or any other provider who meets the quality criteria, can then make an economic decision as to whether or not they want to accept the proposed rates and the risk, that was referred to earlier, about potentially sharing in whatever savings there might be, or not. That, at least, is a fair system which allows everyone the opportunity -- everyone who qualifies on a quality basis to participate, and determine on an economic basis whether they choose to or not.

ASSEMBLYMAN BENSON: Again, the reason-- I agree on the fairness issue, the transparency issues -- but a couple of times we've brought up a very specific cost case for a consumer. And I just have a concern that -- again, if we take it to its logical conclusion, we stop the OMNIA plan or it's frozen at a court hearing -- those who are even using the Tier 2 hospitals to have a child -- if they're in the existing plans, I think their out-of-pocket maximum is actually higher in the existing plans.

MR. GOLDMAN: Well, no, but a temporary stay to correct what's been wrong isn't a permanent block on putting it in right. You may have a -- you do have an enrollment period that's coming to an end, which is why I think it's important for this to be decided promptly. But the fact is that this can be done right; it just wasn't done right here. Just because it is stayed temporarily while the process is properly undertaken, doesn't mean that it should be forever blocked. Just quite to the contrary.

ASSEMBLYMAN BENSON: Yes, and I don't disagree. I just want to make sure, as we're discussing these issues, that if we're not -- we're only comparing Tier 1 and Tier 2. If there is no OMNIA plan, there are different out-of-pocket costs.

MR. GOLDMAN: Oh, sure; yes.

ASSEMBLYMAN BENSON: And we need to understand -- I want to make sure we understand what the numbers are.

MR. GOLDMAN: I'm not familiar with the numbers, so I really can't speak to them.

ASSEMBLYMAN BENSON: I was just looking at the chart that the Chairman has.

ASSEMBLYMAN CONAWAY: Well, that is so. And Horizon would say -- at a meeting with them, they would say that you still have access to their broad network which, according to them, will have essentially the same sort of cost structure and co-pay structure in the non-OMNIA plans. So their argument is that there is not an impact; all things being equal, if OMNIA is off the table, that people will -- there will be this sort of the usual increases or decreases in reimbursement cost of the plan and the cost shifting -- which is moving at pace, by the way, which is not

particularly -- we're not particularly addressing that today. But one of the other phenomenons that is going on is that more and more costs are generally shifting onto individuals who are buying these insurances.

But let me get back to the OB case.

ASSEMBLYMAN BENSON: Thank you, Chair

ASSEMBLYMAN CONAWAY: You're welcome.

Let's get back to this OB case. Now, there were two options that were raised by, I guess, the Director of the Department of Insurance -- you've raised one of them -- that you can have-- If you end up in a Tier 2 hospital, one fix would be that that OMNIA patient would have an out-of-pocket cost that was consistent with a Tier 1 hospital.

MR. GOLDMAN: Right.

ASSEMBLYMAN CONAWAY: The other option was that Horizon, in this case, could contract separately to four Tier 1 OB services with a hospital. So one was, sort of, driven by contract and one, I guess, not. I'm not sure I'm characterizing that the right way. My concern was, how does the Department regulate the use of the services by individuals? If I-- How does it know, and who watches out for the consumer, under a plan wherein you're using a Tier 2 hospital but get a Tier 1 rate. It seems to me that-- You know, people get bills; they pay them. If they don't seem to be outrageous, they're probably not going to complain. I think the Department is probably complaint-driven by individuals bringing concerns to the Department. If you have a contract in this, sort of, second option that was proffered, is that contract reviewed and then, sort of, managed and watched by the Department? And in that latter scenario, are patients -- do patients receive more protection than they might -- more protections than

they would receive with this sort of, “You’re in Tier 2, but you’re going to get a Tier 1 rate”? What’s better for consumers, with respect to the options that were mentioned?

MR. GOLDMAN: Generally what happens is that if the obligation was not being honored, the Department gets complaints from consumers and opens an investigation. And so if that were to -- if the obligation wasn’t being honored on a broad enough basis -- I mean, anything can happen in a one-off type situation; a mistake, or whatever -- but if it were to be a pattern, you’d normally get consumer complaints. And when you got consumer complaints, the Department would normally investigate them. And if it found that there was a pattern to the behavior, it would take appropriate remedial action.

ASSEMBLYMAN CONAWAY: One of the things you mentioned -- and I will stop here, because I think I will accept questions -- but you raised a question of transparency. And one of the things that I thought was really noteworthy in the Senate hearings, that was raised by Senator Gill -- talking about how the New York Attorney General discharged his responsibilities with respect to tiered plans that were being introduced there.

And I’ll quote her, quoting him, in believing that, “More and complete information provided to the consumer better educates all parties. However, because measuring physician performance,” in this case, and it goes to hospitals as well, in my view, “is relatively new, complex, and rapidly evolving, the need for transparency, accuracy, and oversight” is even greater than it otherwise would be.

“When the sponsor is an insurer, the profit motive may affect its program of physician measurement,” and I would say, hospital measurement as well, “or reporting.” And there is “a potential conflict of interest,” that comes into play because of the profit motive of the insurance company -- again, you know, raising the demand for as much disclosure as possible, and as much oversight and transparency in their process as possible.

Going on, “When making important health decisions, such as choosing a primary care physician or specialist, consumers are entitled to receive reliable and accurate information unclouded by potential conflicts of interest.” And we’re going to hear from physicians later, in-house, but this is one of the major concerns I have with this entire plan. When the OMNIA alliance was rolled out, they talked about a set of criteria that was involved in that case. Then they had to go before the Department and they found out, “Well, gee, we have to cover the whole state.” What was offered in the Senate -- and when health plans come up, we’re going to ask this question again -- what was stated by, I think, it was Mr. Conlin, “We had to change the criteria in order to make sure we had coverage across the state.” And that’s the problem.

We didn’t know the first set of criteria; we understand that criteria can change. And even now, under this OB situation, who knows if there is, yet, a third criteria used here? And all of that occurring -- all of that, sort of, flexibility on the part of Horizon I think is troubling and concerning, and really demands that the process be as transparent as can be.

And we haven’t even reached the physician thing, and we’re going to talk about that as well. Because the physician, of course, has even

less -- the individual physician has even less power, vis-à-vis insurance companies, and sits even more in the dark with respect to their own involvement in these tiers.

So I think this legislation needs to stand for, and the government in general needs to stand for as much as transparency as possible in these processes, because the consequences are great.

Mr. Goldman. (no response)

Oh, I thought you were going to say something.

MR. GOLDMAN: No, no, no. (laughter)

ASSEMBLYMAN CONAWAY: Well, if not, then I'm done.

MR. GOLDMAN: I was only going to say that--

ASSEMBLYMAN CONAWAY: Anybody else have--

Geez, I was (indiscernible) in here for a minute, there.

ASSEMBLYWOMAN MUNOZ: Yes, I just wanted to make a comment about the stressors -- the financial stressors on the hospitals that are in this Tier 2 system that go beyond this as well -- which is, under the Affordable Care Act, if you have a readmission within 30 days, that you don't get paid for that care. And this issue, for me, is troublesome for the same group of hospitals because they're dealing with *a*) sicker patients in many parts; but also less affluent patients who may not have access to children in the state who can come in and take care of them; home health aides, etc., etc.

So I think we also have to be mindful that the stressors within the Affordable Care Act -- i.e., we will not pay you if your 88-year-old mother gets readmitted within 30 days -- may be out of the control of the hospital.

MR. GOLDMAN: Yes.

ASSEMBLYWOMAN MUNOZ: And those stressors are going to fall more heavily on these Tier 2 hospitals by virtue of their clientele. And I think that that piece of information has to be considered as well. Because you've now taken these hospitals and said, "Okay, now you have this; and in addition, we're not going to pay you because, again, your grandmother can't afford Visiting Angels to come in every day." That's an unfair burden on these same hospitals. And I just wanted to have that on the record, because I think that that's not even being discussed here at all. And it's a burden on these urban hospitals serving this population.

MR. GOLDMAN: The problem -- if this is allowed to go forward and has the consequences that are potentially there -- is that it can't be fixed, you know? If a hospital is unable to continue because enough of its patient population has migrated from it to a Tier 1 hospital, and it's forced to either dramatically cut back its services or close, it is very unusual to see those hospitals be reopened. And the question becomes: How big a risk do you want to take about that happening without properly accounting for the safety net aspect of what many, many hospitals -- and particularly, the Catholic hospitals -- have historically provided to these populations in the State of New Jersey?

ASSEMBLYWOMAN MUNOZ: And if you look at--

ASSEMBLYMAN CONAWAY: Ms. Munoz.

ASSEMBLYWOMAN MUNOZ: I'm sorry; if you look at Plainfield which -- when they closed that hospital, that community had no access, suddenly. And you're right; even to try to -- the attempt to open up

some kind of a system to provide that health care within the City of Plainfield has failed.

MR. GOLDMAN: It's very, very hard to do.

ASSEMBLYWOMAN MUNOZ: And they can't get anywhere, because they have no access through transportation.

MR. GOLDMAN: A big part of what the Reinhardt Commission was attempting to accomplish in the *Rationalization of Health Care* was to make sure that, for those hospitals providing the most charity care, they got an appropriate share of charity care reimbursement. And I thought the Commission, as a whole, did a very good job of analyzing the kinds of issues that were presented, by reshuffling the deck on how charity care was allocated. It's still a difficult problem; there's still-- Even with a greater insured population, there's still a very large charity care component. I'm not sure that's still going to adequately address--

But these are the sorts of things that I think, when you're looking at a plan like OMNIA in the context of-- And that's what really distinguishes OMNIA. You know, it's been said that, well, there have been tiered plans before. That's true. But the tiered plans that came before were not designed to shift patient populations and market share, and that is the big difference here. It's a huge difference to say, "I'm going to offer a two-tier system," and that's fine. But it's a major ratcheting up of the consequence of the plan when you say, "My point, for those who are willing to give me the reduction in the reimbursement rate, is to give them more volume." Because there's only a limited pool of patients, and that means that somebody is losing those patients in order for those other hospitals to get those patients. That's the big difference here.

ASSEMBLYMAN CONAWAY: I know Assemblyman Gusciora wants to-- But isn't that typical of what insurance companies do? I mean, it is always, well, we're going to bring it-- You're going to accept -- you're going to come in network, and one of the reasons you go in network is to have access to patients. And those patients, you know, they are -- I guess they are a limited resource. You know, they are going to move, driven by their microeconomics, to that in-network provider. Our problem is -- and I've heard this at I don't know how many medical society meetings, and others, and meeting specialty societies -- but, "I decided, after years, to go in network. Now I'm working harder, I make less money, and I have less time to spend with patients" -- which is the outgrowth of that. But this mechanism -- that sort of moving patients to a preferred provider or hospital -- there's nothing new in that. I mean, indeed, I think insurance companies would argue that that's precisely the way we do business and that's precisely what we need to do to drive down costs for insurers.

MR. GOLDMAN: That's fine when you have a level playing field for participation, which you don't have here.

ASSEMBLYMAN CONAWAY: Yes, yes.

MR. GOLDMAN: You don't have a level playing field--

ASSEMBLYMAN CONAWAY: That is the key difference.

MR. GOLDMAN: --for people to have -- for institutions to have the opportunity to participate; and you don't have transparent and objective measures to figure out who's entitled to participate. If you look at the outcome, and you look at some of the hospitals that are part of systems -- whose ratings, from a quality standpoint, are inferior -- the conclusion you reach is because they're part of a system, they were included -- because

that was the deal that was made with the system. That's not necessarily the way to put a sustainable cost reduction for healthcare costs in place. Because ultimately, if you drive other hospitals out of business, what happens in the marketplace? I mean, you don't have to be an economist to figure out what comes next.

ASSEMBLYMAN CONAWAY: You don't have to be a rocket scientist to figure that out.

MR. GOLDMAN: So it seems to me the goal is right; it should be undertaken in an appropriate way. And I think it can be undertaken in an appropriate way, and I think that's what ought to happen. But to allow this present configuration of OMNIA to go forward, in our view, is a mistake.

ASSEMBLYMAN CONAWAY: Well, studies are already showing that -- Harvard just came out with one showing that, indeed, patients do shift the locus of their care. If you look at the contracts -- the way they're written, and the process -- the way it's written -- it is designed to move patients from one venue to another. And, indeed, objective studies have shown that, in fact, that will happen.

Now, if you are a hospital -- and we're going to hear from some hospitals on this point -- and you look at your book of business; and we know there's cost shifting across -- if you have a lot of Medicaid, or cost-shifting across the various insurance lines. If your viability is dependent upon that commercial business from Horizon that, over time, goes away -- and as they said, "we expect to see linear growth" in the uptick of the OMNIA plan -- are these CEOs just, sort of, having a bad dream? They ate an underdone potato, or something, and they are having a nightmare? Isn't

it reasonable for them to expect that, with this linear growth in OMNIA, that their financial viability is going to be significantly impacted by the--

MR. GOLDMAN: Are you talking about Tier 2 hospitals?

ASSEMBLYMAN CONAWAY: I'm talking about Tier 2 hospitals, yes.

MR. GOLDMAN: Well, it's a question of the payer mix. I mean, if you have urban hospitals that are -- you know, the only part of their payer mix that pays a rate that's satisfactory is the commercial insurance piece of it, and if you have a lot of charity care, and a lot of Medicaid patients -- as was mentioned earlier -- you know, you have a problem.

ASSEMBLYMAN CONAWAY: But take it to its logical--

MR. GOLDMAN: If you take out of that mix the best payers, and you're left with only the worst payers, or no payers, you have a bigger problem.

ASSEMBLYMAN CONAWAY: So taken to its logical conclusion -- because I think you mentioned it -- so OMNIA continues to grow. Hospitals that have payer mix issues or other issues in the marketplace -- perhaps they are bought; although Horizon testified in the hearing before the Senate that the sort of contracts are designed to mitigate against mergers. So you might be bought, or you might find that you can't continue on as a going concern. There are jobs-- You're now out of the marketplace. If I'm in the-- You know, these contracts have a limited period of time. So I now have been the recipient of this largesse -- these patients -- and might I decide, "You know what? I really don't like this deal, this discount, that I've been offering here under the terms of this

contract these past three years.” And now the contract’s up and perhaps the competitor down the road is no longer there, or I bought that competitor, and maybe shifted them to another line of work; maybe make them turn into an in-patient hospice or a rehab or whatever -- not necessarily providing hospital care. Would it be surprising that some large Tier I hospital, well financed, could say to Horizon or other insurers, “You know what? I’m not going to accept these rates; I’m out. And I now don’t have to worry about competition, because they’re now gone.” Isn’t that something that could happen? And wouldn’t that then affect the cost of care for people down the road?

MR. GOLDMAN: It could; but, I mean, I think it depends on the economics of how this plays out. I mean, I think if the hospitals that are participating are finding it economically beneficial to continue to participate, they’ll continue to participate. The systems that are in the OMNIA plan are the largest systems in the state. They have the most power over Horizon because they’re providing Horizon with a big subscriber base by putting their patients into this system.

So it’s not like Horizon sits at the leverage of power and these institutions are powerless; far from it. There’s a lot of power that’s flowing in the other direction. And so there’s an opportunity to renegotiate those contracts; there’s an opportunity to change the reimbursement rates; there’s an opportunity to do a lot of things. I think it will depend on what happens as this thing unfolds, if it unfolds.

ASSEMBLYMAN CONAWAY: Well, I think it seems like big competition decreases costs for consumers. And if competition is lessened, generally, the cost of service goes up.

MR. GOLDMAN: Oh, there's no doubt about that; yes.

ASSEMBLYMAN CONAWAY: Reed, did you have something?

ASSEMBLYMAN GUSCIORA: Commissioner, thanks for coming.

I wonder if you could just brief us on the Public Interest Rule, and how the present DOBI could have implemented it and protected the collateral damage.

MR. GOLDMAN: Yes, well, it depends on the heading of *public interest*. I mean, it's a question of, if you see something that has potentially dramatic consequences, it's like anything else in the world -- you want to examine it more closely. And so whether that meant that you met separately with affected constituents, or whether you held a public hearing, or some combination of the two -- it requires a careful look. How you implemented that careful look is a discretionary matter. You don't have to do anything, except if you sense that this has these potential consequences you want to be very careful before you sign off on it so that you understand what you're signing off on.

ASSEMBLYMAN GUSCIORA: But could it have been in the ambit of the Commissioner's authority to look into the Public Interest Rule when it came to the working poor being left on the cutting-room floor?

MR. GOLDMAN: Well, listen. During the time that I--

ASSEMBLYMAN GUSCIORA: Or do we need to--

MR. GOLDMAN: During the time that I was Commissioner, I had hospitals call me because they were having difficulty negotiating contracts with Horizon; that was not within my purview as Commissioner,

as such. And I had Horizon call me when they were having difficulty negotiating contracts with hospitals. That was also not within my exact purview. But it's part of the job. And so you work with the community you're regulating to try to get an outcome that works for everybody and works for the State as a whole.

So I don't know that, as the Commissioner, you point to public interest and say, "This means that you have to do such-and-so," but it does mean that you look at the totality of the proposal before you say it's okay. And I think that, in this context, given the potential consequences here for the designation of hospitals as Tier 2 versus Tier 1, and a lack of transparency, and a lack of objectivity, and the potential consequences for the safety net hospitals in urban areas -- yes, it required a closer look.

ASSEMBLYMAN GUSCIORA: Can the same thing be said for the adequacy rule?

MR. GOLDMAN: Well, the adequacy rule -- I think, it was sort of patched together to meet the requirement. I don't think it met the requirement as originally proposed. It was acknowledged that it didn't meet the requirement as it was originally proposed. And it was acknowledged that there weren't signed agreements. Now, you can -- the Department's taken the position in their decision with respect to the stay that signed contracts aren't necessarily required. Chairman Conaway referred to a three-year contract. Well, if you don't have a signed contract, there's too much -- and particularly a contract with this sort of consequence, both in terms of the reimbursement to the provider and the consequence in the broader healthcare delivery system -- those contracts were being negotiated because you needed contracts in a circumstance like this.

So I don't think that it was -- the network was adequate or in a posture where it should have been approved without having it be complete. What the driver was to put it under that kind of time pressure, I don't know. I mean, maybe it was that there was a CMS deadline coming up for purposes of pricing things in the exchange; I don't know. But something put a lot of time pressure on this to make it happen in this hasty way.

ASSEMBLYMAN GUSCIORA: I also understand that there was a tiered network offered in New York, and there was some push-back by the government. If you could--

MR. GOLDMAN: The network in New York was a tiered network for physicians, not for hospitals. And what happened in New York was that then-Attorney General Cuomo stepped in, wrote cease-and-desist letters to the insurance companies, and said, "Not so fast." A number of similar problems: lack of transparency, lack of objective criteria, there was no ability on the part of consumers-- And ultimately, the job of the Department is to protect consumers. And so, for consumers to make intelligent choices, they need to know what the factors that go into their choice are.

So in New York, what they did was, they basically reached a settlement with the insurance companies that required that they have objective criteria; that the affected physicians would have the opportunity to review how they were scored, so that if there were errors in the way they were scored they would have an opportunity to contact the insurance company and correct it. All of that information was posted on each insurance company's website. So if I was a subscriber of that insurance company and I wanted to see how Doctor One stacked up in his field

against Doctor Two, I could look at the website; I could look at all the criteria; I could see how the scoring came out; and I could decide which one I wanted to use. They put a monitor in place, I think, for a five-year period to make sure it got implemented, as was agreed. And you had a fair system.

So there's no problem with tiering. I mean, I think Linda Schwimmer is right. I think this is likely to be the future, but it needs to be done in the appropriate way.

ASSEMBLYMAN GUSCIORA: And, in your opinion, could our Acting Attorney General or our Acting DOBI Commissioner take similar steps as New York?

MR. GOLDMAN: Well, I think the Attorney General's Office could. I think DOBI's already stated its position. But I think the Attorney General could, yes.

ASSEMBLYMAN GUSCIORA: Great, thanks.

Any other questions from the members? (no response)

Thank you very much, Commissioner.

MR. GOLDMAN: Thank you.

ASSEMBLYMAN CONAWAY: Next, we'll bring up Vincent Costantino, Saint Francis Medical System. I don't know -- I see Alex Hatala of Trinity Health Systems as well. I see Chairman Youngblood in the audience; I don't know if you are planning on testifying today, Joe? No? Fine.

Mr. Costantino.

ALEXANDER J. HATALA: Good morning.

ASSEMBLYMAN CONAWAY: Who's first?

MR. HATALA: We're together; I just wanted to introduce myself.

ASSEMBLYMAN CONAWAY: His light was on, and I thought--

MR. HATALA: Alexander Hatala; I'm President of Trinity New Jersey, and also President of Lourdes Health System.

And Vincent Costantino, our Chief Administrative Officer for Saint Francis in Trenton, will be presenting our testimony here this morning.

**V I N C E N T C O S T A N T I N O:** So thank you, Chairman Gusciora and Chairman Conaway, and Joint members of the Assembly. I want to 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 issue.

As an organization with century-old roots in our community, Saint Francis Medical Center is committed to being a people-centered healthcare provider that enables better health, better care, and lower costs. That is the triple aim. Our organization embraces value-based agreements and the goals that a tiered network aims to provide.

As a faith-based system, ethics and social responsibility are central and core to our culture and mission. We recognize the sensitivities and access barriers that our community may face, and have always had the utmost commitment to provide convenient and 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 on 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.

So here's what we know about, and what Horizon has revealed about, their criteria.

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

And it's important to note that the Tier 1 hospital in the region, in Mercer County, earned a *C* on that same score on the 2015 Leapfrog standards.

Second, 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: Saint Francis, as well as our hospital partner, Lourdes Medical Center, in the region, were the first two hospitals in the state to establish PACE programs. These are programs for the all-inclusive care of the elderly, whereby we are both the provider of care and the payer.

Because we support and embrace different pay structures, we agreed to a monthly capitated fee -- so, a fixed fee from Medicare and Medicaid. We embrace payment reform and pay-for-performance structures, as well as support the growing need for population health models. Clearly, that wasn't considered. Our organizations have made significant investments in the whole fee-for-value proposition, in terms of care managers, in terms of the PACE program, as well as our commitment to the ACO and our participation in the ACO.

Lastly, and most importantly in our case, Horizon has stated that hospitals were chosen based on their location. Yet the OMNIA 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 services. For OB services, the distance would be even further. The alternative for Trenton residents would be to visit their local hospital, but face much higher out-of-pocket costs. And clearly, patients are going to make decisions based on price. The evidence is clear about that.

Despite these gaps, DOBI determined that the OMNIA network was adequate to meet the healthcare needs of Horizon members. It's impossible to imagine how a healthcare network can be considered adequate when it would require an expecting mother or, for that matter, someone who is having a heart attack, to travel upwards of an hour to access a Tier 1 hospital or face greater out-of-pocket costs.

Based on Horizon's own criteria, we feel that Saint Francis and Lourdes, as well as many of the other hospitals that they chose to exclude,

are 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 Saint Francis has serious financial ramifications for us and other 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 then 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 -- and particularly, the Certificate of Need that was extended to Saint Francis to provide advanced cardiac care.

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 services.

Both the DOBI and Horizon claim that the OMNIA network will not shift much business -- and that business, for Saint Francis in particular here in Trenton, is \$14 million a year. But we cannot rely on that assumption-- And the variables such as the rising cost of health care and new healthcare reform regulations are causing to shift more of the financial responsibility to employees. And plans like the one approved by DOBI will cause employers and consumers to switch providers. Employers, in particular -- it's understood there's about a 15 percent discount in

premium. That's real money for a small business that's shopping on the exchange. That's specifically why OMNIA was created; otherwise, they would not have put 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. These principles recognize the need to reduce healthcare costs, while also maintaining access to health care. 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 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 the network adequacy from the Department of Health -- which has a better understanding of healthcare providers in New Jersey -- so that access to care is maintained for all New Jerseyans.

Saint Francis and Lourdes are an essential part of the access that our state's poorest residents have to health care. We are a safety net for those who cannot afford care or are uninsured. Yet, we cannot provide that essential service to our community if we are not financially sound, and our bottom lines are already financially stretched. As a result, anything that restricts our ability to serve commercially insured patients will impact our financial viability. This is a very serious matter for us, one that could have significant impacts on our ability to serve our patients and our communities. Despite our pleas and the grassroots outpouring of concern

from local faith-based organizations, residents, the legislators, and the news media, neither DOBI nor Horizon have addressed the major flaws in the OMNIA network, or the serious ramifications it can have for hospitals that are excluded from Tier 1.

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

And, at this time, I'm happy to answer any questions that you may have. Thank you for your time and consideration.

ASSEMBLYMAN CONAWAY: Mr. Hatala, any comments before we go to questions?

MR. HATALA: Yes. Let me just amplify a couple of points.

And again, I would say, with our hospitals in Camden, in Willingboro, and also in Trenton, that we are one of the state's major urban healthcare providers and partners. And we are threatened, really, by this OMNIA network. And I think as the testimony has already shown, that the shift of patients from hospitals that already have 80 percent governmental payers to other providers really puts our urban hospitals at risk -- which, in the end, I think really does threaten access for the citizens that we do serve in the urban areas.

But also, in the long run, I think we'll increase the cost of care for the State if we do go out of existence -- if we are no longer there. You know, I would say, also -- amplify the fact that you should not let a commercial entity like Horizon step in the shoes of the Department of

Health in terms of public policy and the regulatory process. An organization -- and in the Senate hearings there was testimony that the number of commercially insured people in the state is 5 million; Horizon controls, basically, 3.9 million of those 5 million. Of that 3.9 million, 1.8 million are under the State workers' health plan; you know, under the ERISA plan -- but 2.1 million are basically commercially insured. When we've met with Horizon ourselves, I asked the question, because I think their position is, "This is a small product; it's not going to get legs underneath it. You still have access to 94 percent of our book of commercial business." But when asked, "What is your target for this product over a three-year period?" it's one-third of the commercial book of business -- so, 100,000 members. That would have a tremendous impact on urban providers.

The other thing that I would like to amplify also is, we are one of the shared savings -- we're in the shared savings program with Horizon and have been since 2013. In year one of that program, and going through, now, the first six months of 2015 that has been reconciled, we have earned shared savings in that program that are significant -- in the seven-figure number -- but we also have seen our quality metrics, our level of quality provided to those patients, increase from Level 1 to Level 3.

So, you know, again, I think that we're a great value partner, but it is not being recognized by the way this network was being constructed, which really leads you to question the criteria: How was it constructed, what are the criteria, what were the measures that were being used?

And finally, I would just say, at the eleventh hour, before Horizon was going to announce this network in September, I sent a letter to the Horizon leadership and I, in the letter, stated that we were “willing to meet your value proposition to be in that network.” That letter was never answered, and this was after multiple meetings since February -- I would say, month-to-month -- meetings or calls with Horizon about this product.

So, you know, again, what I would just reiterate is that the transparency wasn't there, the criteria wasn't there, the network was really put together in a flawed manner. It does have a great impact on the public policy of the State of New Jersey. It really threatens urban providers. And for those reasons, we would ask you to really, seriously consider putting this program in abeyance until some of the issues are corrected to make it a viable product.

Finally, we would just say we are not against value-based payments, as Vincent has said here today. We participate in value-based payments for Medicare, for Horizon, with Aetna, with our PACE program. It really is how this program was approved and constructed -- constructed, and then approved by DOBI.

Thank you.

ASSEMBLYMAN CONAWAY: Ms. Muoio.

ASSEMBLYWOMAN MUOIO: This is a question for both of you.

According to the criteria that Horizon later released, the first criteria was -- the leadership that they evaluated was, “Leadership mindset/commitment to transform the delivery of health care with a focus on patient-centered population-based health care.” So this was, sort of, a

subjective criteria, but it goes to leadership's mindset and commitment to transforming delivery of health care. You just mentioned that you had numerous conversations. Were either of you-- Because we've heard from some hospitals that they were not engaged at all in this discussion, their *mindset* was not something they were asked about. Were you approached, on that basis, as to whether you would be willing to participate? It sounds like you're saying -- at least, at the end of the process -- you were indicating that you were willing to meet their value-based service.

MR. HATALA: We were willing to meet their value proposition; but also, during the many months leading up to this, I had numerous meetings with the leadership of Horizon. In fact, I also had our President of the Trinity Health System, which is a national system in 21 states-- And Dr. Gilfillan, who is the President, was the author of some of the Accountable Care legislation -- specifically, the ACO component of that legislation. And so we came to the table and said, "Look, as an organization nationally, we are committed to basically value-based payments and also to a population health system -- improving the health of communities." And I think we could back that up with what we're doing nationally, as well as what we're doing locally, here, as evidenced really by our performance in Horizon's shared savings program itself, where we have been one of the more successful shared savings sites for Horizon. And also, as Vincent said, the PACE programs -- we're the largest PACE provider in the state. That's a program that's completely at-risk, based on value-based payments.

ASSEMBLYWOMAN MUOIO: Thank you.

ASSEMBLYMAN CONAWAY: So as I understand it, you -- the hospital has been awarded as a top-performing hospital providing high-

quality, low-cost care. You had been meeting with them on a regular basis, and offered to accept the payment structure that they outlined. You have been involved with them, over time, with respect to these alternative payment models that are designed to bring down the cost of care, and demonstrated that you can thrive in that environment. And yet, after all that's been said and demonstrated, you were left out -- one of the hospitals left out of the network. Why do you suppose that happened?

MR. HATALA: Well, we're not going to guess at that. But, you know, I think that, again, the criteria -- there was no transparency in the process, you know. And I think the criteria were flawed.

ASSEMBLYMAN CONAWAY: That seems to be coming through here today.

Any other questions for these gentlemen?

Mr. Benson.

ASSEMBLYMAN BENSON: As someone who was born at Saint Francis, and whose family has used it on a number of occasions, I can attest to the high quality; and their leadership, especially in many of these -- with the ACO and in many of the -- the Trenton Health Team; and just really trying to work with a lot of these collaborations as we move to a value-based model. I really do share the concern -- especially since Saint Francis had been working with Horizon very much -- that lack of transparency.

One of the big concerns I have is also this concept of mobility within the tiers. You know, without knowing what the criteria is, how do you set up a system that incents hospitals that may not meet some of the quality criteria -- and I think Saint Francis already does, based on

everything that's been testified to here -- but those other hospitals, if you want to have a system that's trying to move towards an ACA model of quality and paying for outcomes, you want to have a system where you're incenting others to come in. You have transparent metrics, and you have the ability to move in if somebody is not meeting it and moves out.

And so I do have a concern, based on some of these independent quality metrics that have been out there. And I don't think it's about pitting one hospital versus another. I think it's about looking at the hospital system as a whole -- especially because the ACO model's about getting hospitals to work together, as well, on very high, expensive patients.

Can you address, kind of, that in terms of not only are you working with other providers, but some of the ACO models where you're working with other hospitals to try to reduce those patients who are either frequent emergency room flyers or (indiscernible). How does this affect that, now that you have this Tier 1 and Tier 2, and some of those concerns?

MR. HATALA: Well, we would say -- our position would be, more access is better. So we're not-- I think that does make sense, if you can meet the value proposition.

However, you know, in terms of both Trenton, and also in Camden -- we work with the Trenton Health Team; it basically is focused really on reducing recidivism in the emergency departments, and also managing of chronic illnesses. And that is the same thing in Camden, with the Camden Coalition of Health Care Providers. So the same kind of objectives. And again, I think that the focus there is on managing the health and improving the health of the community through working with other providers. We do that in Trenton with--

Go ahead.

MR. COSTANTINO: Yes, with the Trenton Health Team, in particular, it's not just participation on a board or in a committee structure. It's also financial participation, with several thousand dollars committed to IT systems that are really geared to promote health and keep patients out of the high-cost setting; ensure that there isn't overutilization of things like CAT scans. So the emergency departments in the area, in the Trenton community, have access to that information so we're not repeating CAT scans. And so the ED physician has that information, really, to promote the health of the community.

MR. HATALA: And in Camden, we participate in the Coalition with Cooper, with Lourdes, and with Virtua in the City of Camden; and it's the same objectives. And we have all made tremendous investments in it -- the HIE, the Health Information Exchange. We are all invested in it, both in Trenton and Camden -- it's the same system, CareEvolution -- that gives us the ability, really, to use the data that's available to us and collaborate, as providers, to lower the cost of care, but improve the quality of the residents who we serve.

ASSEMBLYMAN BENSON: And do you feel the way this tiering system had been rolled out, and the lack of transparency that you've brought forward -- do you think that hurts that collaboration of that system?

MR. COSTANTINO: Well, I think that if we're not there, there's not going to be any collaboration, because there will be no providers.  
(laughter)

MR. HATALA: I also want to echo Commissioner Goldman's point about the confusion that this creates in the market. Last week, I had a 71-year-old woman call me; she was born in Saint Francis. And while she has Medicare and, obviously, the OMNIA plan doesn't affect that, she had a secondary insurance through Horizon. And she was concerned, because she had heard in the marketplace there was a problem with Saint Francis, but she wanted to continue to use Saint Francis.

So I think what that illustrates is that the damage and the impact goes well beyond just the 700,000-plus who are anticipated, in terms of enrollment. It goes deeper than that, in the community, because it does create that uncertainty in the marketplace

ASSEMBLYMAN CONAWAY: Ms. Muoio.

ASSEMBLYWOMAN MUOIO: Sorry, just on point.

I would agree; we're saying that more is better -- the more participants you would think in this system would be better. But if it's a system that clearly seems to depend on protecting or guaranteeing a certain level of market share, we can't have more is better, unfortunately. So that's where we -- that's the rub in this whole system.

ASSEMBLYMAN CONAWAY: You are correct.

Tell me, Saint Francis has the approved cardiac thoracic program. Now, I have -- you have Tier 1 physicians taking care of patients who might need to have cardiathoracic services. And the services there are Tier 2, correct?

MR. COSTANTINO: That's correct. The hospital is Tier 2, the physicians and the cardiologists who may be referring those cases are Tier 1.

ASSEMBLYMAN CONAWAY: They're Tier 1.

So I'm taking care of a patient; I have a long relationship with them; maybe it's not long. I will expect if they have some need for cardiac services, bypass surgery, they have to come in and get a stent. If I, as a cardiologist or a primary care provider-- And patients have an expectation they will be able to use their hospital. What's the value proposition for them? Here you have a highly rated cardiothoracic surgery program where their physician, their cardiologist works. I now need to have an intervention. What do I do? Aren't I going to experience higher out-of-pocket costs? And how does that impact -- it has to negatively impact the cardiothoracic surgery program. And for that product line in the hospitals, whether you have a CT program or not, they are generally very important for the financial viability of the hospital.

Now, my patients have to, sort of -- weigh whether or not I can afford to go there because my out-of-pocket costs suddenly are going to be very much greater if I decide to use the hospital I have always gone to; where my cardiologist practices, where my primary doctor practices. It has to have a detrimental impact on Saint Francis -- this cross-tiering that's occurring, physicians who are providing the care and the institutions that are providing care.

MR. HATALA: Yes, there's no question about it. And, you know, I think that we could point to cardiac services that would affect Saint Francis in Trenton. But, you know, if you really think what's the alternative here -- is you pay more out-of-pocket, or you get on a bus and go to New Brunswick or go to Camden. And for a cardiac patient, that's really not a great alternative, I would just say.

ASSEMBLYMAN CONAWAY: Ms. Jones.

ASSEMBLYWOMAN EGAN JONES: Thank you, Mr. Chairman.

I just want to say thanks for being here; I'm sorry you have to be here speaking to this issue.

I wasn't born at Our Lady of Lourdes, but I have two children who sure were. (laughter) So I have great affection for your institution, clearly.

But I think I'm hearing you say that the three hospitals -- the three locations you mentioned, you really fear that they will be gone if this system persists.

MR. HATALA: I think it will have a major impact on the financial viability of all three, right? And I do fear that with this tiered system, and the fact that Horizon has a monopoly in the state because of their market share, they have the ability, now, to basically create public policy and decide the winners and losers in the state. And the last time I looked, that responsibility, really, was the Department of Health's responsibility -- to ensure that there is adequate access for all citizens in the State of New Jersey; and also that there were Centers of Excellence created within the state to ensure a high level of quality specialty services. It appears that this system that is being put into place undermines that public policy in a big way.

ASSEMBLYWOMAN EGAN JONES: So I'm hearing oversight.

ASSEMBLYMAN CONAWAY: There you go. (laughter)

ASSEMBLYWOMAN EGAN JONES: Thank you.

ASSEMBLYMAN CONAWAY: There's the word of the day.

We need to move on.

Thank you, gentlemen.

MR. HATALA: Thank you.

ASSEMBLYMAN CONAWAY: Next, we'll bring up Mishael Azam with the Medical Society; Dr. Steve Orland, practicing physician in Mercer County; Laurie Clark with the Association of Osteopathic Physicians and Surgeons; and Dr. Robert Pedowitz, President of said Association.

**M I S H A E L A Z A M, Esq.:** Do you want me to go first? (laughter)

ASSEMBLYMAN CONAWAY: Steve -- he put his hand up first. Mishael is supposed to do -- these guys in the middle are supposed to do the, sort of, announcements and the presentation.

Steve-- Mishael, go.

MS. AZAM: Okay.

Good morning -- good afternoon, Chairmen and Committees. Thank you so much for taking up this issue. It's very, very complicated and there are very interrelated issues, so I appreciate your trying to get your arms around them.

The focus thus far at this hearing and in the press has been on the hospitals. But this is very much an access-to-care for physicians issue as well.

You have written testimony from one of our ophthalmologists; every specialty is affected by this plan. The main issue for us is both transparency and delivery of what's promised, both to the consumers and to the physicians.

So on the consumer side, one of the things that complicates this model is that it's both a high deductible plan and a tiered network. As it is, high deductible plans are confusing for consumers. They're new; consumers don't understand their liability when they go to the doctor's office. They don't understand that the insurance company doesn't pay that doctor a cent until the deductible is met. The patient has to pay the doctor that amount.

So the Platinum Plan, for example, of OMNIA -- it says it's the highest premium, but the lowest out-of-pocket. Now, as a high deductible plan, that could be true, except that this is also a tiered plan. So if you go on the website, you'll see that the individual deductible for Tier 1 is zero, but for Tier 2 it's \$1,000. So it's still a high deductible and a high premium; that's what's confusing here if a patient makes the mistake of going to a Tier 2 provider. So that's kind of the transparency issue on the consumer side -- that we're still seeing a frustration that plans and carriers are not explaining what's covered, what's not covered, what out-of-pocket costs are, what doctors are Tier 1 and Tier 2. It's going to be really hard to figure that out when you're in a hospital, or when you're in a facility that's kind of chopped up.

On the physician side, it's an issue that we've been talking about for years now. We've been talking about the lack of fairness in contracting, the lack of network adequacy. If contracts were more fair and had better payments, you would have more doctors willing to come into network. The essence here is that Tier 2 doctors-- And we don't really know what the contracts are going to look like; as far as we know, it's existing contracts that are being turned into these OMNIA products. The

essence of a contract is taking lower payment for increased volume -- for having predictability and a promise of volume. A Tier 2 doc is having that volume taken away. So the essence of the contract has been made moot here. You're getting a lower payment and lower volume.

But again, we haven't seen any contracts; our members aren't sure what the contract terms are. They're not sure what payment they're going to get. The patients know what their liability will be if they're able to check the website and figure out which tier they're in, but we don't know what kind of payments are going to be out there for the docs. So that's really our issue -- is that we've always argued for better contracts.

And I just want to touch on legislation really quickly. Linda Schwimmer actually mentioned the NAIC model. We actually have concerns with the NAIC model. There are other legislative solutions to protect consumers. There are bills that have been around for years, actually, predating this plan, in anticipation of plans like this. There are bills that require any willing provider, who meets criteria to be able to get in. There are bills that require carriers to make the profiling that they do of physicians public, which gets to the criteria issue here. It gets to, "Why am I in, why am I out, why have you given me a 3-star, 4-star, Tier 1, Tier 2" -- whatever you want to call it. And there are also bills about network adequacy. To this day, the Association of Health Plans opposes a bill that requires self-audits of plans. And to us, at this point in time, it's very brazen, as far as we're concerned, to oppose a bill that requires a self-audit when we know DOBI doesn't necessarily have the capacity to audit and to keep track of what's in and what's out. That large hole in Burlington

County should be reason enough, alone, to have legislation that requires audits of adequacy.

With that, I guess I'll turn it over to Dr. Orland. He is the President of The Mercer County Medical Society and a practicing urologist.

**S T E V E N M. O R L A N D, M.D.:** Thank you very much, Mishael.

And I would like to thank Chairman Conaway and, of course, Chairman Gusciora -- who's currently not here, but I'm sure he will be returning -- and the rest of the Committee members who allowed me this opportunity to address you on these important issues.

Now, it's always nice to start with a little story -- or, as I like to say, bring a little memory to our memories.

**ASSEMBLYMAN CONAWAY:** I'm going to steal that.

**DR. ORLAND:** Okay. When I came to the area in 1987 to establish myself in the private practice of urology, I, of course, wanted to get to participate with all the appropriate health plans in the area so I could see the widest variety of patients. So I started participating-- Back then, most physicians were naïve about health plans. You just signed a contract; you didn't really read it. I don't think we understood a concept called *hold harmless*, or anything like that back then. And anyway, you just signed to be able to see the patients.

And then, when I started here in Mercer County, the main hospital on which I got on staff with was Helene Fuld Medical Center, which is now called Capital Health Regional Medical Center. And once I got on staff there, my colleagues -- some of whom were also on staff at Mercer Medical Center -- said, "Hey, why don't you get on staff at Mercer,

then you can see a different group of patients? But there is one plan you can't get into." And I said, "Well, what's that?" And they said, "Well, there's closed panel HMO at Mercer called *HMO Blue*, and you can't get into it." And I said, "Gee, why can't I participate with it?" And they said, "Well, it's closed; that's it." So I'm thinking to myself, "Well, gee, can't I present my credentials, show my wares to Horizon?" who was running HMO Blue. "No, you can't. That's it, you're out. You can't apply."

Hmm, okay. Well, that, in a sense, got me involved in *any willing and able provider* legislation 27 years ago -- just to know that that one has been going on for a while. So I kind of minded my own business; I couldn't get into that restricted plan, but participated with other Horizon plans.

And then we get into the mid-1990s, and it's the early 2000s. Horizon had a plan for State employees; I believe it was called *NJ PLUS*. Now, NJ PLUS was basically an HMO masquerading as a PPO. In other words, patients can go to people who were in the book, but you needed a referral; and you could only go to certain hospitals to have things done. So again, being primarily at Helene Fuld Medical Center -- that wasn't in their network. I had to take them to Mercer; I had to take them to Hamilton. So again, a restrictive plan by Horizon.

And now we come to the current situation that we have with OMNIA. And again, as we've heard all morning about transparency issues, and we've heard about network adequacy issues -- the issues that apply to hospitals, they also apply to doctors. So when OMNIA was announced, did I get a personal letter from Horizon telling me that, "Dr. Orland, here are you, as a surgical specialist; you are, by definition, a Tier 2. And, by the

way, here is a list of hospitals you're on staff at in New Jersey, and here's the list of which hospitals are Tier 1 and Tier 2." Did I get a *personal* letter like that? No. Did I get anything telling me about my metrics or my quality of how I stacked up? No. It used to be, up until about 10 years ago, I got something in the mail every year from Horizon telling me how I was doing in relation to my peers -- that is, other urologists who are actually also in Horizon plans -- on various urologic conditions: microscopic blood in the urine, kidney stones -- in other words, how I evaluated the patients and whether I was in line with what were considered current norms.

And I always did okay; I was in the middle of the bell curve; there was no problem with that.

Now, about 10 years ago, those mailings stopped. And you figure, in the digital age, well, maybe Horizon would just switch that to e-mails or something like that. Nope; I haven't gotten any of those in the past 10 years.

So I'm being told -- again, by definition of *surgical specialist* -- that I'm Tier 2; yet I haven't been informed of the criteria, the metrics that were being used to tell me if I'm good at what I'm doing or not -- i.e., quality. I haven't been told why I'm being evaluated or how I'm being evaluated. And even with Horizon coming out last week about these six different criteria that they used -- which are very general, and most of them apply to hospitals -- oh, how are they evaluating things? Well, if they're not telling us anything, and there is no transparency, there's only one way they're doing it -- by the money. Cost. That's it. They haven't told me anything to the contrary; there's no transparency, that's all I can assume.

And that's what they've done all along, going back 27 years or more.

So all I'm saying is the more things change, the more things stay the same. A tiger doesn't change its stripes. Horizon was doing it then to us, and they're doing it now to us.

And in terms of access, the whole key -- everybody, going all the way back to the Mayors who started this hearing -- has to do with access for the patients. Patients need to be able to continue to see the doctors who they have trust in, to be able to have services done at the hospitals that they've trusted for many, many years. And those relationships are going to be destroyed by giving the patients economic disincentives to continue to see their doctors and use the hospitals that they trust.

And like the former Commissioner, who spoke a few people before, I think the plan should be suspended. And even if DOBI says they're not going to reevaluate what they're doing, there is still an Attorney General investigation going on. And that should continue, and the Attorney General should have the capability of suspending this plan before it starts January 1 and getting a much deeper look at everything that went on.

Thank you.

ASSEMBLYMAN CONAWAY: Great; thank you.

Ms. Clark.

**L A U R I E A. C L A R K:** Thank you, Mr. Chairman; and thank you to everyone -- Chairman Gusciora isn't here, of course -- but all the members, for listening today

I just want to echo my colleague Mishael Azam's comments. We agree; she did a very good job of summarizing.

I just want to say that we did talk about the hospital issue extensively; but this is a key issue for physicians, especially those who are in private practice. Because this type of a plan shows a mentality to drive private practice physicians into an employed service. And that's not really what you want; you want to have a mix of physicians.

As I travel throughout New Jersey, meeting with various physician groups, I'm very distressed to see the atmosphere amongst our physicians. There's clearly an element of fear that they do not know what is going to happen. And I think a lot of times legislators think that doctors have a lot of control over what is going on. They actually don't. This is a very prime example of the power that this insurer has, especially since they are the largest.

And there is no doubt that whether OMNIA goes forward with modifications or as is, it will change the healthcare landscape. And we are in a precarious environment -- where you saw the recent New Jersey Business and Industry survey that 95 percent of all physicians are concerned. Reimbursement prior to OMNIA is already on the decline, because when it stays -- in a state like New Jersey, when it stays level, and because we have the highest taxation rates and everything else, it's declining. And it's a concern.

If you were, prior to-- Let's just say you were participating in the New Jersey State Health Benefits plan under Horizon, and you have State employees -- like in Mercer County. Physicians in Mercer County have a lot of State employees coming to them. Those physicians--

Chairman, you came back at a great time, because you have your little chart with the co-payments. When physicians-- So prior to OMNIA, those patients going to our physicians in Mercer County had a low -- maybe a \$5 or a \$10 co-payment; now you're going to a \$50 or a \$60. So that's a big deal when you're on a certain income. They may love their doctors, but they're not going to be -- they're going to have to say, "Sorry, Dr. Conaway, I can't go to you because this is going to strain my income even further."

So there are a lot of considerations. And just so that you know -- so Horizon, when they spoke to the doctors who were Tier 2 who had concerns, they said, "Doc, don't worry. Your income will be the-- We're not going to reduce your reimbursement." But, guess what? It will be zero because the patients are not going to be able to come to you.

So these are just the commonsense concerns that, quite frankly -- I'm going to turn it over to our President, Dr. Pedowitz, because he is a practicing Tier 1 physician in a Tier 2 hospital. But the fact is, that you -- those of you who are here are elected officials; you are the only ones who can help. This is the one situation that your influence is going to help so much. The physicians of New Jersey are looking to Trenton for leadership, both from our medical organizations and from you. And we are going to look forward to working with you in the days and weeks ahead to try to resolve this.

Thank you very much.

ASSEMBLYMAN CONAWAY: Thank you, Ms. Clark.

Dr. Pedowitz.

**ROBERT PEDOWITZ, D.O.:** Chairman Conaway, Chairman Gusciora, members of the Committees, thank you for the opportunity to

speaking today. I did, also, testify in the Senate hearing, and I appreciate the opportunity to testify today. And I look forward to a little bit more of a discussion and conversation regarding this serious issue.

As stated before, I am the President of the New Jersey Association of Osteopathic Physicians and Surgeons. I'm also the Medical Director for Family Practice of CentraState. CentraState is a parent organization to my group, where we practice family medicine and primary care. We have over six offices in several counties. I personally practice in Hightstown, Mercer County; and Freehold Borough. So I take care of a large portion of State employees, as well as Medicaid -- and underserved populations comprise the majority of my patients.

We are a Level 3 Patient-Centered Medical Home, which means that we have been recognized nationally and by Horizon, as well as other insurers, as being at the top tier to providing quality health care at lower cost.

When I got a letter from Horizon that said, "Congratulations; you're a Tier 1 physician," I said, "I don't know what this means, but it sounds good." (laughter)

ASSEMBLYMAN CONAWAY: Better than Tier 2. It has to be better than Tier 2. (laughter)

DR. PEDOWITZ: So I said, "Yes, Tier 1; it's better than stepping in number two, I guess." (laughter) But I said, "You know, look. This is great." It was actually great news for me, but I didn't know what it meant. So we asked around, and I was told, "Well, your patients have a Medical Home, so you're Tier 1. Congratulations."

So as President, I travel around the state; I asked a lot of my colleagues -- some are in Medical Homes, some were not. There was no rhyme or reasons. Doctors who were in Medical Homes were dropped; and some doctors were not in Patient-Centered Medical Homes and they were Tier 1.

One of my colleagues, who is in the room today -- Jesse Stawicki, D.O., who practices at Saint Francis -- and he is also in Mercer County -- he's a Tier 2 physician. He asked his contact at Horizon for some criteria. And after several e-mails and communications back and forth, he was given this e-mail that stated -- and he has given me permission to read this -- just the highlights of this that "specialties were evaluated based on one or more of the following criteria. Number one -- cost efficiency metrics. Risk adjusted cost efficiency at the group practice level using Episode Treatment Group data. To qualify for the ETG analysis, practices were required to have a minimum of 50 episodes of care between July 2013 and July 2014, processed no later than September 2014." Most of us have no idea what Episode Treatment Group data means.

"Number two: Admission privileges and referral patterns to OMNIA Tier 1 hospitals where applicable.

"Three: Geographic access and coverage standards.

"Your office must meet all the criteria above to be OMNIA Tier 1."

And then it goes on to say that even if you are a Tier 2 physician practicing in a Tier 1 hospital, you'll be reimbursed only at your Tier 2 rates.

I read this e-mail, and said, “That’s interesting; because I don’t meet all three of those criteria, but I’m a Tier 1 physician. So why is my colleague, Dr. Stawicki, not a Tier 1 physician?”

A further problem is, I practice in a hospital system and I am an employed physician at CentraState Medical Center, a Tier 2 hospital. I see patients in the hospital; one of my office locations is adjacent to the hospital system. I have patient who I take care of in the hospital; I’m seeing them in my practice. I’m a Tier 1 physician and I say, “I have to admit you to the hospital, unfortunately.” And they know what’s going on. If they have an OMNIA plan, these discussions have now been happening.

To give a few patient examples and see what it’s like in the trenches, because we’ve heard -- people have said, “Hey, there’s jumping around and people are going to change practices and hospitals,” and there’s a lot of theory on that. I’m here to tell you it’s fact. I had a patient two weeks ago -- well, several weeks ago, who I saw, who needed physical therapy. He has Federal Blue Cross/Blue Shield -- not an OMNIA product. I sent him to my hospital to see a specific therapist who I knew could help him with a sports-related injury. I saw him in my office a couple of days ago and he said he was not better. And I said, “Well, I don’t understand. The therapist I sent you to is really good, and I have never seen anyone come back not feeling better.” He said, “Well, I didn’t go to your hospital; I went to a different place.” I said, “Why?” He goes, “Because you’re a Tier 2 hospital, and that’s going to affect me, and I didn’t want to pay for it.” And I said, “Well, hold on a second. First of all, you don’t even have OMNIA. (laughter) Second of all, I don’t understand; you’ve been going to this hospital for everything for your entire life. Why did you chose now?”

“I got a letter from Horizon, and the way I read it was if I have Horizon and I use your hospital, I’m going to pay more. So I figured I might as well start now using different systems and different services.”

ASSEMBLYMAN CONAWAY: I just have to-- (laughter)

Because, I tell you, this kind of thing is absolutely outrageous. And we’ve seen this in other contexts -- out of network and other things -- these letters go out-- And I don’t know if that is -- if that is actionable or not. I guess it didn’t affect you directly. But these kinds of missives that cause confusion to patients, it seems to me that somebody in the government ought to have responsibility about that.

And here’s a patient who made a decision based on something that probably didn’t affect him. And now his care has been compromised by that. There are issues now with communication between providers. You had an expectation about what kind of care he was supposed to receive, and his outcome as well. These are the kinds of things that are happening. And I tell you, we need to take cognizance of that in this Legislature, in this government, because what you’re describing is not at all unusual. It happens with great regularity to the detriment of patients, and it really needs to stop.

Go ahead.

DR. PEDOWITZ: So my fear is not only patients like this being swayed by marketing techniques; and whether it’s fact or fiction or misunderstanding, it really happens.

I’ve had several other patients who are now coming to me as new patients saying, “I looked you up on the network; you’re Tier 1. I’m switching from my provider, who is a Tier 2, or not in network at all.” And

likewise, I've had other patients who say, "I'm switching out of your practice because your hospital where I want to get care is not Tier 1. And I'm sorry, Doc; I love you, but I have to go where I can save money." And I've had other patients who say, "I'm going to use you as my doctor because you're Tier 1 and I like you, but I'm going to go to a different hospital system any time I need services." And I put my hands up, and say, "I don't know what to tell you. I'm going to take care of it the best I can; I'm going to fight the fight." I told them I'm going to Trenton this week and see what I could do.

ASSEMBLYMAN CONAWAY: Where's your pitchfork?  
(laughter)

DR. PEDOWITZ: So my fear is, when you have insurance companies like Horizon, maybe with the assistance of DOBI or the lack of *oversight* -- that word has been used quite a bit today -- deciding who is in, who is out, who is quality, who is not -- this is a very, very dangerous precedent. And I think if we go down this slope, we will see the demise of quality health care for all of our citizens in the state. And I really can't stomach that, and I hope that everybody in this room could work together.

I think quality, saving money -- I agree with Horizon's efforts in this case. But I think the plan needs to be halted. We need to look at this and make this affordable quality care for everybody involved. And any physician, any hospital should have the same right, the same ability to meet those standards, and those standards need to be published, and not erroneous as this e-mail might have indicated.

Thank you.

ASSEMBLYMAN CONAWAY: Well, that does seem to be a theme here of late from folks who have offered information to this Committee -- their concern about standards, about their application -- that they should be fair; and that ideally, everybody who can meet them ought to be in.

Now, insurance companies will say, "Well, if everybody's in, then I can't go and offer someone volume and get a discount from them to steer patients to them." "But, wait a minute. I had good outcomes. I'm a Tier 1 provider, and they go to my hospital. I have access to labs in the hospital; I can easily access their discharge summaries. The continuity of care situation is very much improved." How is that not best for patients? "And, oh, by the way, with all that's going on, relationships that I've had with patients, years in the making -- decades, in some cases -- now they're severing, they're broken." How is that good for patients? This is what this tiering process means. And everybody on this Committee and in this Legislature needs to be aware of this -- where the physicians concern the patients.

You're talking about severing relationships that patients have with their physician. And all of this talk about getting increasing care, improving outcomes -- a lot of it is centered where? In the physician's office, with long-term preventative care being handled by someone who knows you, who follows you through the arc of your life, and is providing the kind of care you need to extend your life and enhance your life as it goes forward. Being broken by this tiering system that's going to be applied to physicians, it is-- We're not going to achieve the hope and the promise of these cost savings if patients are going to be ripped from their physicians

-- driven, as they will be, as the expectation is, by these out-of-pocket cost considerations that are part of this plan.

We need to think about it.

Ms. Azam.

MS. AZAM: Sorry, Chairman. If I could just add one more thing -- just to kind of emphasize the issue of this squeeze that the physicians and the hospitals are facing.

So, you know, I've said already that if you're in Tier 2, you've sort of -- that the point of having a contract is negated. The problem is, instead of legislation that improves that landscape, and levels the playing field, and acknowledges that the contracts are unilateral contracts of cohesion, what we're seeing instead is legislation move forward that would punish doctors for going out of network. And those two things combined are going to be detrimental to patient care.

ASSEMBLYMAN CONAWAY: Well, there are a lot of people in and around this policy space who think that all physicians ought to be employed. Now, how to achieve that goal? And everyone ought to be in network. I mean, there are actually people who propose bills and processes that would drive everybody into a network, whether you think it's in your financial interest to be there or not. Now, I'm not sure what that's called; I've used the word *slavery*. I think if you are forced to give of your labor against your will, I sort of think that sounds like slavery to me.

Now, you have this idea out there that the independent practicing physician is sort of a dinosaur and really needs to be sort of wrapped up in a hospital system or some other large organization. Now, how do you achieve that? Well, one way to achieve it would be to enforce

this tiering process, begin to break apart the relationships between doctors and their patients. Because, as you have already mentioned, Jesse Stawicki who is here -- Dr. Stawicki -- we had this conversation the other day. Long-term patient, looking into the future, as people do -- "Can I stay with you? I'm healthy now but, you know, I'm up in years. I could need to use hospital services. The hospital-- If you follow me in the hospital, as I expect you to do -- you're my doctor -- I'm going to have to pay a lot more for your care because you're a Tier 2 doctor handling that episode of care. I don't know that I can stay with you."

Or if I'm with a Tier 1 doctor and I go to a Tier 2 hospital, then I'm out of pocket for in-hospital care; so I have to change." The relationships then change.

And so, hmmm -- now, if I'm a Tier 2 doctor, what might I do? When the hospital comes calling and says I want to buy your practice-- Now, one, what is the value of my practice now? The landscape has changed such that my practice has been devalued. I'm a Tier 2 doctor; I'm negotiating with a hospital over-- If I decide I want to go there, what's my negotiating position now that I'm a Tier 2 doctor vis-à-vis the insurer with the largest footprint in the state? What happens to the value of my practice in that situation? What happens-- And, as I said--

So this whole process is one that needs very close scrutiny by this Legislature -- what this means. Do we, as a policy, think that all physicians ought to be employed? Because that's where it seems that we're heading, and that's what this program seems to suggest to me. And I tell you, I'm an internist; I've had long-term relationships with patients. And it is one of the things that we in primary care cherish when we do that. And

not only internists, but people who are in surgical practice and the like have patients who they've known for years, and years, and years. And it's part of -- the enriching part of being in practice.

This process -- you know, you talk about quality of life and medicine -- very detrimental. And then you get down to the nitty-gritty facts of the dollars and cents. And, again, it is a detriment to physicians. And this tiering-- And worse, it's in a black box; you don't even know--

I looked up this Episode Treatment Group, and I'm going to read what it says here. And see if you can figure it out; I haven't quite got it yet -- I'm going to have to read it a few more times, I think (laughter) -- "--is an episode grouper for medical and pharmacy claims. It provides a condition classification methodology that combines related services into medically relevant and distinct units describing the complete and severity-adjusted episodes of care and associated costs." Now, anybody out there who can explain that -- and I'm a person, I think, of reasonable intelligence -- what that means and how I stack up against that, I'm all ears. I'm ready to be taken to school.

But I tell you, we need to look at this process. We need to think about patients and the doctor-patient relationship and decide-- We're going to have to make some policy decisions whether or not there's a role for the independent practicing physician in this landscape, because this set-up is designed to mitigate against that very -- mitigate against that, and I think it's bad for patients and it's certainly bad for physicians as well.

Questions?

Ms. Sumter.

ASSEMBLYWOMAN SUMTER: Thank you, Mr. Chairman.  
And I felt your passion over here. (laughter)

ASSEMBLYMAN CONAWAY: We don't tell a story necessarily, but hopefully something memorable anyway.

ASSEMBLYWOMAN SUMTER: Absolutely.

But to my physicians here -- if you don't mind-- Because I have spoken to a number of physicians as well, and their concern is that their patient population, who they have built these relationships with over the years, have received these notices from their insurance company without any input from them. And if their patients-- Or once they got back in network, there was no notification sent back to the patient that said, "Okay, now they're affiliated with a Tier I hospital." So they had to then chase those patients again.

So are you communicating -- any type of correspondence with your patients about these changes in the system? Or is it just solely the insurance companies communicating with the patient populations?

DR. PEDOWITZ: Yes, I can answer at least from our perspective. And also, just to address some comments by Chairman Conaway -- if I can handle both.

First of all, it is -- I believe the same way, but it is my goal as President of NJAOPS, and I'm sure the goal of MSNJ, to protect our independent physicians. And whereas many physicians, including myself, are employed, it certainly would be my goal and our goal to protect the rights of physicians to be individual business owners, like any other business, like any other ability to self-manage; and take care of their patients and not disrupt the physician-patient relationship.

With regards to communicating with our patients, as you asked, I can speak for our hospital system. We proactively -- our CEO proactively sent out letters to our patients, everyone, about proposed changes at the time, what it meant, what our hospital was doing about it, highlighting the benefits that our hospital provides. And we have certainly been having that communication with our patients on a day-to-day basis when they come into the office. We do have Community Outreach Coordinators, Nurse Navigators, who are having conversations with patients, counseling them about which insurance plans to choose, why they would make certain choices, benefits. So we're trying, but can you reach everybody on an individual level? It's difficult. Are we losing people to this particular issue? Absolutely.

ASSEMBLYWOMAN SUMTER: Thank you.

ASSEMBLYMAN CONAWAY: Ms. Pinkin.

DR. ORLAND: Just to comment on your question and response -- I certainly agree with Rob about the potential for that to be going on. Now, obviously, OMNIA is relatively new; it was just introduced October 1, but I guess the big hit is going to come December 26 for State employees, and January 1 for everybody else with commercial Horizon plans. So too, at my main hospital here in Mercer County, Capital Health, the CEO has sent out a letter to all providers on staff, as well as patients -- who have brought it into the office and shown me -- that the tone of the letter is basically, "With all of the foregoing, regrettably, if you do continue to use our hospital for services after January 1, then you will have higher out-of-pocket expenses." That's the bottom line. Unfortunately, you have

to state that, and state that explicitly to the patients so they do understand. I haven't had any patients leave yet because of that, but I think it's so new.

But when you talk about the State employees -- which, as we heard earlier, is not part of the 25 percent of the commercial market that Horizon has, but of course, State employees are a big chunk of Horizon's insured in the State of New Jersey. And again, you look at that map that Assemblyman Conaway put up, with that big hole in Burlington County where there is no full-service Tier 1 hospital in Burlington County. Well, so too, there's no full-service Tier 1 hospital in Mercer County either -- right where we're sitting, the capital county, where thousands and thousands of State employees work. Again, Robert Wood at Hamilton is Tier 1, but it doesn't have OB. And just recently, as we heard today, Horizon is going to rent the OB -- which is not just OB; we're talking high-risk pregnancies, we're talking about neonatal ICU, we're talking about all the specialized services that go along with OB -- at Capital Health. So again, because of network inadequacy that was glossed over by DOBI, we now have this patchwork system in various counties to try to fix the problem, which wouldn't have been a problem in the first place if DOBI had done its homework in the first place.

ASSEMBLYWOMAN SUMTER: Thank you.

ASSEMBLYMAN CONAWAY: Ms. Pinkin.

ASSEMBLYWOMAN PINKIN: Well, two things: One, you mentioned, Assemblyman Conaway, the issue of the value of your practice if you're Tier 1 or Tier 2, and how does that affect it. But I think that same concern would apply to hospitals that might be Tier 2, as opposed to Tier 1

-- as far as whether that is forcing or changing the value of the system overall. I think that's an important consideration.

But I have one question. I think you mentioned, from the letter that the physicians received from Blue Cross, about whether -- if they were Tier 1 and the hospital was Tier 2. Did you not say that?

DR. PEDOWITZ: In this case, it's stated that as a Tier 2 physician, if he was to see patients in a Tier 1 hospital, he'd still be paid at Tier 2 rates. And then, as a Tier 1 physician, if I was to see patients in a Tier 2 hospital, it would be at Tier 2 rates. So it's like (indiscernible).

ASSEMBLYWOMAN PINKIN: Well, that seems to be somewhat problematic. And I think it's unclear, because I think that people have had differing answers to those questions on that scenario; and I think that needs to be clarified with Horizon.

Thank you.

ASSEMBLYMAN CONAWAY: Perhaps we'll hear about that a little bit later.

And just lastly, the contract-- The contracting issues, and how these contracts can change. Is it anticipated that you'll just get a letter that says, "We're amending your contract," and that's it? And aren't there issues around the existing contracts the physician and/or the hospitals may have with Horizon and their other -- I guess they would call them *broad-based products*? Aren't there important contracting issues and fairness issues around the contracting that we should discuss as well?

DR. ORLAND: I certainly think that that's true. And what I didn't mention earlier is that I -- or at least my large urology group, has valid contracts with Horizon for all of its products, even its managed

Medicaid product, Horizon NJ Health. And the contract is the contract; it was negotiated, and usually there can be an amendment to a plan, or something like that, where Horizon, let's say -- "Here's an amendment; if we don't hear back from you in 30 days we'll assume that it's okay for this amendment to your plan. But however, if you do decide to protest it, then we have the right to kick you out." That's usually how those things work. And it kind of shows how one-sided these contracts are with health insurers. And I think it was even noted at the Senate hearing, when the -- I guess it was the Association of Health Plans also testified to that effect.

This is different, though. Because this is basically changing real contract terms -- in terms of your reimbursement, that you're a Tier 2 doctor, that if you go to a Tier 2 hospital this is going to be the rates you get. That kind of thing. That's a real key point of any contract that doctors have with insurers. And did I get something from Horizon that specifically stated changes in reimbursement and changes if you go to a Tier 2? I didn't; I don't know if Rob did.

DR. PEDOWITZ: No.

DR. ORLAND: But I certainly think, therefore, this falls under contract law. Again, I'm not a lawyer myself, but I know a number of them, and I've talked to them. (laughter) And this is under contract law. This is breach of contract; this is a violation of contract.

In the state of Washington, something similar happened with the main Blue Cross/Blue Shield insurer, called *Regence Blue Cross/Blue Shield*. They came out with a plan like this; a subnetwork of select hospitals. They even called it *Select*; that was the name by definition -- a subnetwork of doctor groups. And there was so much negative publicity about it that they

pulled out of it, but said that, “We have the right to reinstitute it at any time we want.” Well, the Washington State Medical Society sued them in court, and one week after the AMA joined the suit, Regence caved. And because of that, the State Medical Society in Washington has the ability to see what criteria are going to be used to profile doctors. They’re also going to be able to allow doctors to see their own profile before any new plan like that comes out. That’s what we really need here in New Jersey.

The point is that one of the reasons they sued, and one of the legal bases they were sued about, was breach of contract, violation of contract.

DR. PEDOWITZ: Yes, I just wanted to echo that. I have not received any contract or amendment information. All I got was a letter that says, “You’re Tier 1,” and that’s it.

So I get surprised whenever I read literature that says, “The physician community has agreed to take a lower co-pay, but will still be reimbursed at the same rates.” I’ve seen that language in publications, but I have not personally received any information talking about contract changes whatsoever.

ASSEMBLYMAN CONAWAY: Well, I think we need some kind of Commission or something to look at the contract. And we have, in years past, looked at this; and I think there -- I have had, for years, a concern about the fairness of these contracts and how they can be changed, sort of, willy-nilly. And I think in this environment, with this particular sort of market strategy and the relative powerlessness of physicians, vis-à-vis insurance companies, that this contracting process needs further review.

Thank you.

DR. ORLAND: Thank you.

ASSEMBLYMAN CONAWAY: Next, we'll bring up Matt Zuino, with Virtua. And along with Mr. Zuino, let's bring up Kristen Silberstein, with the Valley Health System; and Ron Rak with Saint Peter's University Hospital.

Mr. Zuino. Am I saying that right, Zuino? (indicating pronunciation)

**MATTHEW A. ZUINO:** Zuino; I appreciate it.

And I appreciate the opportunity to present today. I want to thank both the Chairmen and the Committees.

First, I do want to say much of what I was prepared to speak to today has been brought to the Committee -- which I think is really-- I want to thank everyone for taking the time. I think that the time today was well spent. A lot of the issues were brought forward.

I do want to start off by saying that I am a resident of Burlington County. So for me, personally, when I look over at that map and see a big gaping hole in terms of access, it really does strike me, for my neighbors.

With that, I'll shift into my role as the Senior Vice President for Hospital Services at Virtua. I do want to hit a couple things, that were referenced today, in terms of Virtua and how we fit in this discussion.

Virtua is recognized, from both Leapfrog and the Joint Commission perspective, in terms of a high-quality facility. We do serve Burlington, Camden, and Gloucester counties. When you talk about the OB components, our Virtua Mount Holly facility is the only OB provider in

Burlington County; and we are not a Tier 1 facility, so I do want hit that point.

ASSEMBLYMAN CONAWAY: Now, it's been represented to the Legislature that that situation has been rectified. So I'll ask before you-- Do you have a contract, now, with Horizon for the provision of OB services at a Tier 1 level, either by imputing Tier 1 co-pays for services there, or a direct contract to be a Tier 1 provider for Horizon under OMNIA?

MR. ZUINO: We have neither a contract, nor am I aware of discussions we've had with regard to that. I am-- Like many, we were made aware, on November 25, when Horizon/OMNIA made an announcement that individuals who would come to a Tier 2 facility for OB, in both Mercer and Burlington counties, would be treated -- and I believe the words were -- as a *benefit exception*. So at that point, as a benefit exception, they would then be subjected to Tier 1 pricing.

As it was brought up earlier, the concern as a hospital operator - my role is COO of our three facilities -- there are concerns I have in terms of things that were brought up earlier. So if we do have a patient who is an OB patient, what happens if they then have a medical issue and are transferred off of the maternity floor? We also have concern -- when you think about the number of births we have between our two facilities -- 8,000 births -- and you think about times that patients could be transferred out. For us, our partner is Children's Hospital of Pennsylvania. So you think of our partner as CHOP, which is not in the network either. If I go through just numbers in my head, of our 8,000 births, typically we see about 15 percent that would go to our special care nursery, or our NICU. Of that number, we could see upwards to 5 to 6 percent that are transferred

to CHOP. So when you think of OB coverage in terms of that benefit exception, those mothers could be, and equally -- if not more important -- the babies as well, could be transferred out of our facilities. And I'm not sure they fall under that exception.

ASSEMBLYMAN CONAWAY: Well, I want to review it. I'll have staff do it while you're here. But I thought that representatives from Horizon testified that, in the event that a child was transferred to CHOP, that there would be some kind of negotiated rate; and I think it would be at that lowest tier. But I want to at least confirm what they said in the Senate. They're not here; and perhaps when the Health Plans testify, they will know that off the top of their head.

That's, obviously, an important thing for people to know. And then, following that, is there going to be a difference between the treatment that that patient receives if they go to CHOP, as opposed to a NICU that's in-state; and what's going to be their co-pay in that situation.

MR. ZUINO: And that would be our concern for our NICU patients.

ASSEMBLYMAN CONAWAY: And no one has talked to you about that to explain how that works so you can, at least, be a point of information for patients, right?

MR. ZUINO: Correct. We have not had those conversations.

I do want to point out a few other quick things, recognizing the time.

When the discussion about OB coverage and-- When the percentages were put out there about a shortfall of about 2 percent in Burlington County, when Virtua dug into that number -- we believe that is

not an accurate number. In fact, according to an analysis that we did with available data, we see that OMNIA fails to meet network adequacy requirements for about one-third of Burlington County -- particularly, we're looking at 15 of Burlington County's zip codes, of the 46 within our County, which fall outside of that. So when you think about the 2 percent that has been spoken to, when we really drilled down into our County, we think it's much greater. And we would want that taken into consideration.

ASSEMBLYMAN CONAWAY: So I just-- I mean, Ms. Munoz said this, and I'm going to let her go after I ask this question. My understanding is -- and this is one of the things I wanted to raise, but since you raised it, I'll go now. That sort of GeoAccess data, as I understand it, was a submission made by Horizon to the Department for review. So they presented numbers to the Department, and they applied, then, their -- I don't know if you want to use the word geotracking; they drew a line or however it was -- but they looked at the numbers, and I guess locations of perspective insured under that plan, and then applied their sort of time and distance regulations to that.

You were able to review that same submission, or had access to that submission, and then apply these DOBI regulations. And you came up with a different view of what the coverages were. Is that what happened?

MR. ZUINO: So the methodology we followed is, we took publicly available data -- basically a zip code analysis -- placed the zip codes within our county; did a proximity -- and I believe we went more conservative, going 25 miles out, and just matched up zip codes to the two available Tier 1 facilities. So this goes even beyond the OB component; it really does look at the overall network itself. And in doing that -- and as I

said, we went more conservative with 25 miles -- we came up with one-third, or 15 of the zip codes falling out. In fact, I believe if we had gone down to the 20, we saw that number increasing upwards to 35 to 40 percent when we drilled out.

ASSEMBLYMAN CONAWAY: Now, this is not the Horizon-- You used publicly available data, but you did not review the Horizon submission on that point to the Department.

MR. ZUINO: Correct. And the reason for us, and the reason we took the approach of using the publicly available data-- And it's no different when I look at Burlington and Camden counties; in total, you're talking about a million residents. And although Horizon is calculating based off of the data they have -- basically the Alliance product, and who's participating in that -- from my perspective, and as a community member, they are heavily marketing this product. So I do think there is a potential for a greater number of enrollees.

In fact, if you step back, I think of just this past weekend in the Cherry Hill Mall, a regional mall, there was a large Horizon desk prominently displayed right outside of Macy's. So the idea of just focusing on its current book -- I do believe there could be potentially more. And when we look at it that way, that's when we take into consideration, "Is that access even greater?"

ASSEMBLYMAN CONAWAY: Ms. Munoz.

ASSEMBLYWOMAN MUNOZ: Well, my question, or comment, is about EMTALA. And so is this creating EMTALA violations that you're not -- that a woman in labor doesn't have access-- Because we know that that's Federal law. So how is that interfacing with what we've

done here? I mean, you can't transfer a woman actively in labor or deny her access to a hospital. So--

ASSEMBLYMAN CONAWAY: No, EMTALA is only going to apply if you're actually transferred out.

ASSEMBLYWOMAN MUNOZ: That's part of it; yes.

ASSEMBLYMAN CONAWAY: And the Department doesn't have--

ASSEMBLYWOMAN MUNOZ: But it's also denying them entry into--

ASSEMBLYMAN CONAWAY: Well, the Department doesn't look at-- I mean, if I understand their testimony, and what I know about it, is that if you get to a hospital -- whether it's Tier 1 or Tier 2 -- their regulatory review is sort of satisfied. So they're, sort of, not looking at that cost issue. And as long as one is not, sort of, transferring -- and the hospital is very careful about this in a lot of studies, not just OB -- not sort of willy-nilly transferring without taking the appropriate steps and they're going to be subject to an EMTALA violation. But this plan doesn't necessarily mean that that's going to happen.

ASSEMBLYWOMAN MUNOZ: Well, I just wanted to make sure that that is part of the discussion.

MR. ZUINO: So related to the OB component-- As I mentioned, it is a benefit exception. So we will be providing that care; it will be provided at the Tier 1 pricing. But the concern is, once that patient is in our facility, if there are complications, then how does that flow? And we think of complications outside of OB; complications going to a med-

surge floor; or, as I said, the concern is for mom and baby -- is there exposure to that Tier 2 pricing -- the concern there?

And again, we look at the larger scope, because we take into consideration that this could -- this product could be larger than its current offering.

Just two other quick points, and I do just want to reference our relationship with Horizon. Because we do feel Virtua -- we are very disappointed we weren't given an opportunity, because we do have a very good relationship with Horizon, in the sense that we have been a participant of Horizon's Patient-Centered Medical Home. So if you think of the PCMH program-- In fact, we believe we are Horizon's largest PCMH partner in Burlington and Camden counties. In fact, we have over 13,000 Horizon members, both adults and children, who are cared for by our Virtua Medical Group physicians in our Medical Homes. The concern is, with this going through, if those individuals elect OMNIA they will no longer have access at that Tier 1; they will have higher co-pays, higher deductibles -- that were discussed today -- for doctors who are caring for them. So another concern -- when we look at the long-standing relationship, we're going to subject patients to potentially higher costs.

In addition to that, in this past July, Horizon executives did present Virtua with quality awards for the performance of our three acute care hospitals. And they were awards in Patient Safety, Quality, and Cost-to-Care measures. So for Virtua, the real concern is why we weren't given an opportunity -- like many have brought up today -- and the potential impact it has on the patients and the communities we serve.

So with that, I don't want to take any more time. I do appreciate the opportunity to share Virtua's position.

ASSEMBLYMAN CONAWAY: Ms. Silberstein.

**KRISTEN SILBERSTEIN:** Thank you very much. I'd like to thank both Chairmen, as well as members of the Committee, for holding this important hearing today. And Valley Health System certainly appreciates the opportunity to testify on this issue.

My name is Kristen Silberstein; I'm the Assistant Vice President for Managed Care for Valley Health System. I've been in Managed Care my entire career.

Ironically, I started my career at what was then Blue Cross and Blue Shield of New Jersey, where I was asked to write a white paper and subsequently contract and select Horizon's first select hospital network back in 1993.

ASSEMBLYMAN CONAWAY: Ahhh. (laughter)

MS. SILBERSTEIN: And I wish I still had my white paper, because they've done the exact opposite of what we did way back then.

So, again, we know that Horizon is the dominant insurer in the New Jersey market; they control over 42 percent of the HMO market, and over 60 percent of the individual market. And we don't believe a dominant insurer should be picking winners and losers, and we certainly don't believe a dominant insurer should come between a patient and their physician.

As part of Valley Health System, we have a large multispecialty medical group. And Horizon decided to exclude Valley Hospital from its Tier 1 network, yet included is the large multispecialty group as a Tier 1 provider. So this is clear evidence of the fact that Horizon's selection

process had very little to do with care coordination or population health management, 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. And, in fact, this past spring we achieved NCQA Level 3 Designation for Patient-Centered Medical Home, which is essentially the national "Good Housekeeping Seal of Approval" for Patient-Centered Medical Homes.

So what doesn't make sense to us is why this highly-regarded physician group, and physicians with only privileges at Valley -- that Horizon has put our physicians in this untenable position of having to either hand off their patients to an unknown physician at a Tier 1 facility, or put our physicians in the position of having to explain to patients why they should incur greater out-of-pocket expense so that physician can care for them at Valley Hospital.

So which option should a patient choose? Be cared for by a stranger at an unfamiliar hospital, or stay with their physician and be financially penalized? We don't think the answer is either; that's a bad choice.

No insurer should be allowed to force a consumer to make this decision. And the OMNIA health plans do just that, and potentially to our 15,000 Horizon patients in our Patient-Centered Medical Home. The disconnect is clearly contrary to the concept of population health; it jeopardizes the long-standing relationships that patients have with their

physicians. And if Horizon were 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 that care and doing it in a high-quality, efficient manner, in accordance with Horizon's Patient-Centered Medical Home standards? It makes no sense. They are not concerned about population health or better care; they're merely concerned about deep discounts.

So just in closing, it's disconcerting to us that the Department of Banking and Insurance has not stayed this product. With two full months to go on the exchanges in terms of open enrollment, we do think that there is plenty of time to pull the product back and allow consumers the opportunity to select something else. But at the very least, we are looking for some sort of legislative action to prevent this from happening in the future. We need clear, concise, transparent criteria; and a process that is open to those who do meet that criteria to at least negotiate with the insurance companies to be part of these select hospital networks.

Thank you.

ASSEMBLYMAN CONAWAY: Great; thank you.

Mr. Rak.

**R O N A L D C. R A K, Esq.:** Yes, thank you, Mr. Chairman, members of the Committee, for having us here today.

My name is Ron Rak, and I'm Chief Executive Officer of Saint Peter's Healthcare System in New Brunswick. With me is my Chief Clinical Officer, Dr. Michael Hochberg.

A little bit of background. Saint Peter's is part of Saint Peter's Healthcare System; and our hospital has served the healthcare needs of

New Jersey for over 108 years. From our humble beginnings as a parish hospital, we have grown into a technologically advanced, 478-bed teaching hospital now affiliated with Rutgers Biomedical and Health Sciences. We train 118 residents and 50 medical students. We treat 23,000 inpatients and more than 245,000 outpatients annually.

We employ over 3,000 healthcare professionals and support personnel. More than 1,000 physicians and dentists have privileges at Saint Peter's. Our new state-of-the-art emergency room treats some 67,000 patients, of which 23,000 are pediatric admissions. Our recent emergency department renovation is a \$15 million investment on our part in infrastructure, and a reaffirmation of our commitment to improving health outcomes.

Our annual revenue exceeds \$400 million. Our catchment area includes not only Middlesex and Somerset counties; but when we look at subspecialties in obstetrics and pediatrics, we cover eight New Jersey counties, namely Middlesex, Somerset, Hunterdon, Monmouth, Warren, Mercer, Hudson, and Union counties.

Our How Lane clinic is the largest outpatient clinic in central New Jersey. We treat over 50,000 people each year, the vast majority of which are underprivileged who rely on charity care or Medicaid. We have subspecialists in obstetrics and pediatrics at that facility, unlike any other outpatient clinic in central New Jersey.

We are committed to the healthcare ministry of the Roman Catholic Church. We are sponsored by the Most Reverend Paul Gregory Bootkoski, who is the Bishop of Metuchen, New Jersey; and his Diocese

serves over one million Catholics in Middlesex, Somerset, Hunterdon, and Warren counties.

Do not misconstrue our objection to the OMNIA program. We believe -- and other hospitals, as well, excluded from Tier 1 status in the OMNIA plan -- we do not shy away from competition. And we agree that as society looks towards improved health care for our citizens, dramatic changes are called for on the State and public levels. But how we come about to make those changes is so important, and as important, as making change itself.

What happened here should disturb every one of us. The state's largest insurer designs a new insurance product that gives its insured incentives to seek care at hospitals that the insurer alone considers more qualified than others, based on criteria it selects and does not vet in any public forum. It works with State officials on the executive level to sell this program and roll it out, and has the State's blessing to offer that program as the insurance product of choice to all of our State employees. Municipalities are approached, and they are asked to sign on to this program as well.

The product is unveiled; and only then do non-participating hospitals, like Saint Peter's, learn, for the first time, of the program and the fact that we're excluded from it. Overnight, the insurer's website features a new home page; billboards go up along our major thoroughfares -- all suggesting that only participating hospitals can qualify and deliver quality care to patients. Therefore, with one sweeping program, our state's hospitals are divided into the *haves* and the *have-nots*.

As the program is rolled out and questions arise as to its genesis, Horizon gives mixed signals to all of us as to the criteria it used to rate its hospitals. We were told, at one point, that there were six criteria; and those criteria were clinical quality, service offering across the continuum of care, consumer preference data from publicly available sources, value-based care capabilities, scale of the organization, and commitment to value.

Horizon never explained how it weighed these criteria, and never explained the details of these criteria. Nevertheless, as we demonstrated in our written submission to this Committee, Saint Peter's is qualified to be a Tier 1 OMNIA member, every which way you look at those criteria. However, we're not designated as such.

Well, our position is that quality of care is key to the healthcare consumer in the State of New Jersey. So with that in mind, consider my hospital -- and I am only able to speak to my hospital.

We are one of six hospitals in the world to be ranked as a magnet hospital for nursing excellence by the American Nurses Association, for four consecutive four-year terms. That's 16 years in a row. The Joint Commission -- America's leading accreditor of healthcare organizations -- rates us as one of the nation's top performers on key quality measures of positive patient outcomes in the areas of heart attack, heart failure, pneumonia, and surgical care.

We are the lone New Jersey hospital to be commended by the Joint Commission for the quality of care of childhood asthma. Our neonatal intensive care unit is one of the largest in the country, and part of our state designation as a Regional Perinatal Center. And we are the only

such unit in New Jersey to receive a Beacon Award for critical care excellence in the delivery of neonatal intensive care nursing. Our intensive care unit is the only ICU in the State of New Jersey to receive a Beacon Award for critical care excellence on five separate occasions.

And our Hospital Consumers Assessment of Healthcare Providers and Systems -- or HCAHPS -- scores show that patients place Saint Peter's in the 99 percentile -- or number one in New Jersey in environment of care, pain management, use of medicine, discharge instructions, and care transitions; while we rank in the 98 percentile in the responsiveness of medical and support staff.

ASSEMBLYMAN CONAWAY: I'm blown away. (laughter)

MR. RAK: Now, at one point, Horizon said, "Well, our only criteria, quite frankly, is your ability to move on from a fee-for-service to a fee-for-value model of care." Well, for example, we're well along that path. We're actively engaged in building and growing a 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 we deliver and embrace every day. This five-year, \$20.5 million program performs early diabetes screening of all patients who arrive in our emergency department, our inpatient units, and our ambulatory network. And we also screen patients via our mobile health van, which travels weekly to scores of communities to promote healthy lifestyles. Hundreds of patients have been enrolled in this program over the last year, and we already are experiencing fewer emergency department visits and fewer hospital admissions because of diabetes-related concerns.

I can go on and on. But let me tell you this. The value of Saint Peter's services is reflected by our status as a go-to provider for a wide range of services, including specialty care difficult to find elsewhere in this state. With 54 bassinets, we operate the largest neonatal intensive care unit in New Jersey, and one of the largest in the Mid-Atlantic states. We are a designated children's hospital, and a Regional Perinatal Center that operates one of the largest maternity services in the country. In 2014, we delivered 5,579 babies, the most of any single hospital in central New Jersey. Our Department of Medical Genetics and Genomic Medicine is among the largest in the Northeast United States. Our Regional Center for Newborn Screening and Genetic Services offers comprehensive programs providing confirmatory diagnostic testing, management, treatment, education, research, and counseling for all genetic disorders currently screened for in the State of New Jersey.

Our Dorothy Hersh Child Protection Center, established to counsel and protect abused children, is one of four such centers in New Jersey, and serves eight counties in New Jersey. Board-certified child abuse pediatricians, psychologists, and social workers staff it.

And finally, according to the most recent available data, for year 2013, Saint Peter's is a volume leader in this state in the following areas: we are number one in obstetric discharges; we are number two in NICU admissions; we are number three in epilepsy discharges; and we are number five in the total number of inpatient pediatric cases.

Notwithstanding all of this, notwithstanding the cost involved, we also provide to our community. Last year we treated 16,889 uninsured patients as charity care. And State subsidy does not cover the full cost of

that care. In 2014, our unreimbursed portion of charity care was \$18.4 million. In addition to that loss, we spent nearly \$10 million to cover the cost of treating the indigent not covered by charity care; and an additional \$11.5 million was spent on community health and education programs.

What financial impact will OMNIA have on us? In 2014, we treated more than 16,500 individuals covered by Horizon health insurance; 6,500 of them will potentially switch to OMNIA because they are enrolled in either Horizon's HMO or point-of-service products which, we understand and are told, OMNIA will replace. OMNIA, therefore, could result in \$36 million of lost revenue to Saint Peter's.

ASSEMBLYMAN CONAWAY: You said \$36 million?

MR. RAK: Yes, \$36 million.

Now, may I also just go off on that -- in a sense that we keep hearing publicly that in year one, OMNIA may have, on average, a financial impact on hospitals of, say, \$1.1 million; and that, maybe, 250,000 individuals will switch over from one product into the OMNIA program and, therefore, leave a Tier 2 and go to a Tier 1.

But the projections that we're now told by Horizon as to how you're going to have that transference of population from a Tier 2 to a Tier 1 -- we understand that their projection is, by year three, at least a quarter of all of their insureds will have left the Tier 2 hospital and gone to a Tier 1 hospital. So to minimize the impact of this program and to simply focus on its impact in year one doesn't do a justice to anyone. Because we have to believe, quite frankly, that an insurer as sophisticated as Horizon would not have made such an investment in what they have made here unless there

was a true business plan that showed a seismic shift in population going from Tier 2 to Tier 1.

MS. SILBERSTEIN: And if I could also -- I'm sorry -- add to that, too.

It's not just the existing Horizon membership. Horizon has priced this product on the exchange significantly below all of the other players on that exchange. They're not stupid; they are trying to wrest market share from our better commercial payers -- from Aetna, from AmeriHealth, from Cigna, from Oxford -- so the financial impact isn't just the conversion of Horizon volume from Tier 2s over to Tier 1s, and that revenue loss -- it's the revenue loss because now your Aetna members have selected an OMNIA plan, and those Aetna members are no longer coming to your hospital either.

MR. RAK: And let's not forget that -- and again, I can only speak to Saint Peter's -- but if there are other hospitals similarly situated to mine-- I mean, we have contractual relationships with Horizon that give us the right to be notified ahead of time of new networks or subnetworks that they may create. And we are given a legal right to participate in those programs. And if not that, at least, certainly, apply for those programs.

So, you know, it came as a total shock to us when we found out-- And the only time we found out was after September 10 when, in the mail, we got a letter from Horizon telling us that we are not a part of the program. And, you know, I think it's very instructive also to recognize that this program was announced, and we were told of that fact, days before some official approval came from the Department of Banking and Insurance. Because what we can tell is that the letter showed that -- that

was dated on September 18, approving of the program as of September 15; but this program was rolled out on September 10.

So members of the Committee, on behalf of Saint Peter's and the people we serve, I ask you, first, to compel Horizon to suspend this program while the necessary facts are gathered. Second, implement a process by which all stakeholders can determine how best to create a fair and equitable healthcare marketplace that aids providers; but, most importantly, protects our consumers. Third, if we should decide, or it should be decided in a public forum, that a two-tiered insurance system best suits the needs of our citizens -- and we think it does -- then I would urge the Legislature to introduce legislation mandating safeguards designed to ensure that the creation and monitoring of that system is open, fair, and consumer-driven. And in our written submission, we did provide an example of how then-Attorney General Cuomo handled the physician-tiered networks in New York state; and that is very much analogous to what should and can be done here.

And then, finally, I do ask this Joint Committee and members of the Assembly for leadership in recognizing that while the delivery of health care in our state should be rationalized, it must not be done by "destined dialogue" and action among the few -- which clearly occurred here.

Thank you.

ASSEMBLYMAN CONAWAY: Well, I would say the testimony of all of you is impressive and has had, I guess, the expected impact on this chair, I can tell you; and I suspect other members of this Committee as well.

Mr. Rak, I know that you are independent of the group that's been established; but a lawsuit is-- Is one of the bases of the lawsuit that Horizon had an obligation to inform you of these new product rollouts, and didn't?

MR. RAK: You're talking about the individual lawsuit involving Saint Peter's and Horizon?

ASSEMBLYMAN CONAWAY: That's right.

MR. RAK: Yes, we had many allegations, in that part of that lawsuit is directed towards the language of our contract with Horizon. And our argument is that contractually, they were obligated to inform us of this product as they developed it; they were obligated to allow us to apply to be part of that product. But the lawsuit also goes into--

ASSEMBLYMAN CONAWAY: Other details as well.

MR. RAK: --other requests for relief; yes.

ASSEMBLYMAN CONAWAY: Now, we've heard from some hospital executives. Were you involved with Horizon in the earlier part of this year, as this plan was being put together -- in negotiations with them around this product, with the idea that you might be able to be in that first tier, maybe?

MR. RAK: Absolutely not. The first time that I or anyone at Saint Peter's ever heard of a program called *OMNIA*, ever learned of a tiered system that they were planning to roll out, was when we got our letter post-September 10 telling us that we were not part of that program.

ASSEMBLYMAN CONAWAY: And for Ms. Silberstein and Mr. Zuino, both of you have large Patient-Centered Medical Homes, where

your physicians are Tier 1. Horizon has told us that their patient Medical Home physicians are Tier 1 also.

MR. ZUINO: Now, if I could-- For Virtua, both our physicians and hospital are not Tier 1. So in the instance of our Medical Homes, we could have OMNIA patients who will now be faced with Tier 2 pricing to continue their relationships. So our physicians and hospitals are not in the Tier 1 network.

MS. SILBERSTEIN: Our physicians are Tier 1, and the hospital is Tier 2.

ASSEMBLYMAN CONAWAY: Okay, so now are you-- Is Virtua involved in a Patient-Centered Medical Home arrangement not associated with Horizon? Is that why you're not Tier 1? Because I had met with Horizon folks; I read the testimony that they gave before the Senate. My impression was that employed physicians of Tier 1 hospitals, hospitals and physician groups involved in Horizon ACOs -- or Accountable Care Organizations -- and physician involved in Horizon PCMH programs were going to be Tier 1. That's what was said on the record, and said to me personally by Horizon executives. Is that-- Are you not-- Is your Patient-Centered Medical Home not Horizon's, or something?

MR. ZUINO: So we are participants in Horizon's Patient-Centered Medical Home. But our physician, our VMG physicians are not in the Tier 1 network.

ASSEMBLYMAN CONAWAY: Well, that's not what I was told. I mean, I have a very good memory for that. That is not what I was told.

MS. SILBERSTEIN: And that's-- What you were told was consistent with what we were told, because we question it. We said, "Well, how does this make sense? These are our employed physicians; it's our multispecialty group. How are they going to admit their patients if they're Tier 1?" And Horizon just kind of blew it off and said, "Well, they're a Patient-Centered Medical Home, that's why they have Tier 1 status."

ASSEMBLYMAN CONAWAY: Okay. And so you're a Patient-Centered Medical Home, and you don't want-- Why? At Virtua, what's going on? Why are you not Tier 1, at least, there; and then the follow-on question is, why do you suppose that-- You know, there must be some point to having Tier 1 physicians -- having them in the first place; but then having the hospitals where these Tier 1 physicians were not in the network-- I mean, I'm going to ask you to speculate, and I'm going to ask when the insurance health plans come up, why would that be? Because that seems just not to make any sense to me. It doesn't make any sense to me. So why do you suppose that is?

MR. ZUINO: So, if I may-- For us, when you look at the Horizon Medical Home that we participate in, for our patients who are current participants that then elect OMNIA -- then, yes, they are going to be in that situation that we are not in that network and they are going to be subjected to Tier 2 pricing. As far as--

ASSEMBLYMAN CONAWAY: For physicians as well as the hospital care?

MR. ZUINO: For physicians and our hospitals. And as I said, as the only maternal child health provider in Burlington County, we have two of our facilities in Burlington County and one in Camden County.

ASSEMBLYMAN CONAWAY: All right, are you guys not demonstrating any savings there, or did something go wrong? Did you--

MR. ZUINO: As I opened up, when you look at Virtua, like those at the table as well, we have been recognized as a Leapfrog A facility; we are Joint Commission-recognized as well. We have had, as I mentioned, long-term relationships with Horizon -- not only the Medical Home, but most recently where we received recognition from Horizon for our three facilities.

To your question, we are just as confused as to why we weren't spoken to; why we didn't have that discussion. And that's why I brought up the fact that it was even more confusing, because we do have a relationship in the Medical Home, and have been recognized in our facilities.

ASSEMBLYMAN CONAWAY: This is--

MS. SILBERSTEIN: It makes no sense.

ASSEMBLYMAN CONAWAY: Please.

MS. SILBERSTEIN: And clearly, there is contradictory information coming out of Horizon. Because, again, we were told -- when we questioned it -- "Because of the virtue of the fact that you're a Patient-Centered Medical Home, and we're concerned about population health management, and care coordination -- of course we would make our Patient-Centered Medical Home Tier 1." And to that point, I said, "Well, then, how is it that they can coordinate those patients' care if their hospital is Tier 2?" It doesn't make any sense.

MR. RAK: Well, I think it would be interesting to know of those systems that are in Tier 1, how are they normally reimbursed,

currently, by Horizon? Because it very well may be that what you have here was an attempt to save money and cut costs on the corporate level and, therefore, worked deals with those who are your most expensive providers. And so you get them to agree to a steep discount, and your reimbursement -- and you, in return, therefore, agree to steer patients away from a Tier 2 hospital like mine, etc. I mean, you can look at the Senate testimony -- and I do think that at least one of my colleagues testified that, in his part of the state, his competitor may get at least three times the amount of money from Horizon as reimbursement for the same procedure that he receives from them at his hospital.

ASSEMBLYMAN CONAWAY: Yes, that was Mike Maron; I read that last night.

MR. RAK: Yes, so, you know, it could very well be that if one of them wants to cut costs, you make deals with your most expensive customers. You steer patients away from those who are least expensive. But, at the end, you have a savings because you're now increasing their book of business.

ASSEMBLYMAN CONAWAY: Ms. Sumter.

ASSEMBLYWOMAN SUMTER: Sure.

Sir, was any of that mentioned in your lawsuit that you have pending -- if you don't mind?

MR. RAK: No, no. That is something that will come out, maybe, but--

ASSEMBLYWOMAN SUMTER: Thank you.

ASSEMBLYMAN CONAWAY: Ms. Munoz.

ASSEMBLYWOMAN MUOIO: Muoio; that's all right.

ASSEMBLYMAN CONAWAY: Muoio; excuse me. (laughter)  
See, I did it myself. Darn it.

ASSEMBLYWOMAN MUOIO: You'll get it straight eventually.

Thank you, *Mr. Gusciora*. (laughter)

ASSEMBLYMAN CONAWAY: See, I haven't had anything to eat today, which is-- My carbohydrate's low.

ASSEMBLYWOMAN MUOIO: Mr. Rak, you brought up an interesting point about Saint Peter's; you mentioned that there were two existing Horizon programs that would be ended and the people who had the coverage -- 6,000, roughly, last year -- 2014 -- who had those plans. It would now roll into OMNIA.

MR. RAK: Yes.

ASSEMBLYWOMAN MUOIO: When OMNIA made the prediction of the 250,000 new commercial insureds who would be signing up, I'm just wondering if that includes -- these would not be, technically, new commercial insureds.

ASSEMBLYMAN CONAWAY: I don't think they said *new*. They didn't say they were all new. They made a statement that they expected 40,000 new, previously uninsured persons would come in. And they also made, in the hearing-- I was reading the testimony last night that a number of those -- of that 40,000 -- were made up of minorities -- black, Hispanic, and other -- was what they proffered in their testimony on October 5.

ASSEMBLYWOMAN MUOIO: But these are the new commercial insureds; these are people who signed up, I assume-- I'm just wondering if--

ASSEMBLYMAN CONAWAY: Well, they might be new to Horizon in a switchover. They might be picking that plan. I think that's what -- a migration from, perhaps, their broader -- I think they call it the broader plan; what is the term they use? -- to this OMNIA plan. And then they're marketing to small business -- small employers and individuals.

ASSEMBLYWOMAN MUOIO: Right. I mean, this was just an interview with Kevin Conlin. And he said -- in *NJ Business*, it said that they feel sure that the insured will pick up very few new commercial customers in-state. The prediction is about 250,000.

If people who currently have coverage under Horizon -- not OMNIA, now -- are switching, that's a whole other group of people who would be added to this 250,000. If Saint Peter's percentages are reflective around the state -- and I am assuming they are -- that's a whole other crop of people who will now be considered part of that number

ASSEMBLYMAN CONAWAY: And Horizon would say just to-- In the interest of fairness, they would say that people are going to make selections based on what is best for them in their particular circumstances. So if you are in an area where I have used Doctor A, and I've gone to Hospital A; and my expenses are not going to change very much, as Horizon posits -- that they put forward -- then for me, wanting to maintain my relationships, the OMNIA plan doesn't work for me. Or I want to seek care out-of-state. And if you're in OMNIA, you're not going to be able to seek care out-of-state, unless it's one of these special

circumstances where you need a transfer over to CHOP because they are the only ones that can take care of you, and there's no one-- Or, you know, for cancer care in New York because you have a unique situation that requires you to get care there. That's what I understand.

MR. RAK: But Mr. Chairman, just to that point, though. Let's just take the State Health Care Benefits Program. You know, that is, arguably, the largest customer of Horizon; and those individuals, as I understand it, were automatically enrolled in that program. So if you were a State employee, I don't believe anyone actually came and sat down with you and said, "Well, I mean, this is what this new program looks like. This is what -- you have the ability to make a choice." I mean, we were told that that was just an automatic default, that if you wanted -- you had a choice, but if wanted to go out of the OMNIA program, then you had to take certain steps on your individual behalf to get to that point. That's what we were told.

ASSEMBLYWOMAN MUNOZ: I don't think that's true. I think we defaulted to the ones that we had from the previous year -- unless we chose otherwise.

ASSEMBLYMAN CONAWAY: I didn't change. (laughter)

ASSEMBLYWOMAN MUNOZ: Because I didn't choose OMNIA; I stayed with-- We defaulted to the one we had last year.

MR. RAK: Well, that might be refreshing to hear, because that's not what the understanding is.

ASSEMBLYWOMAN MUNOZ: Yes, well, that's what we were told. I mean, I did nothing, so I defaulted to NJ Direct 15, or whatever.

MR. RAK: Okay, all right.

ASSEMBLYWOMAN MUNOZ: Yes, we would have had to opt -- we would have had to change that.

MR. RAK: Well, that would be helpful to know, because we're getting mixed signals.

ASSEMBLYWOMAN MUNOZ: Yes, well, that's we did, in my office and everywhere--

ASSEMBLYMAN CONAWAY: All right; so anyone else for these witnesses, please?

Any other comments?

Please.

MR. ZUINO: If I could, just one last comment around our Medical Home.

Because of time, I did not get into Virtua's position with what we've done with population health, and our ACO, and our efforts around that. But I should comment, as part of those efforts, in our contract with Horizon we did place language that ensured that all parts of our system would be on the same tier. So by Horizon electing not to put us in the Tier 1, we will not break -- our language will not allow our system to be broken up. So that is why we're in a position that our Medical Home and our system are one in the same tiers. Horizon does not have the ability in our current contract language to place our medical group in one tier, and our hospitals in another.

ASSEMBLYMAN CONAWAY: I see.

MR. ZUINO: And that was honestly tied to our efforts to ensure that we would have that coordination care around population health.

So that is why we are in the situation, with our hospitals being deemed as a Tier 2, that our medical group is in the Tier 2 as well.

MR. RAK: And if I could just make one final point.

ASSEMBLYMAN CONAWAY: Thank you for that clarification.

MR. RAK: By the way, I was corrected. It's those individuals who had no insurance -- they automatically went into the OMNIA program unless they made an election. That's what I'm told.

ASSEMBLYMAN CONAWAY: I see.

MR. RAK: So I apologize.

But my final point, though -- and I think if you look at the testimony of Ms. Schwimmer who, I understand, testified earlier today -- I think she made a very good point in front of the Senate, which was that in other states where the state employee program was the largest customer of an insurer who was creating a tiered product, the state actually found it appropriate to set the standards for how you tiered those hospitals. So given the--

ASSEMBLYMAN CONAWAY: That might be very instructive, actually.

MR. RAK: Yes. So given the fact that the State employee program here is the largest customer of Horizon, and also recognizing that Horizon is a quasi-public entity-- We're not talking about a for-profit insurer here; we're talking about a creature of the Legislature. I think it would be entirely appropriate for the Legislature to call for the creation of certain standards in how you tier products, particularly if they're going to be part of any State benefit program.

ASSEMBLYMAN CONAWAY: Great; thank you.

ASSEMBLYWOMAN MUOIO: Wait; can I--

ASSEMBLYMAN CONAWAY: Oh.

ASSEMBLYWOMAN MUOIO: I'm sorry.

ASSEMBLYMAN CONAWAY: Ms. Muoio; I got it right.

ASSEMBLYWOMAN MUOIO: Muoio, yes. (laughter)

So Virtua is a PCMH, currently -- or was.

MR. ZUINO: Currently, correct.

ASSEMBLYWOMAN MUOIO: All right.

MR. ZUINO: We serve over 13,000 Horizon patients in our Medical Home.

ASSEMBLYWOMAN MUOIO: Okay. Because in the testimony -- I guess it was the Senate testimony, or the documents given from their meeting with -- from Horizon's meeting with the State Health Benefit plan, they were asked, "Will all current PCMHs in the Horizon network automatically be part of the Tier 1 network?" And the answer was, "Yes."

MR. ZUINO: Well, again, with us, because of our language in the contract, we will not allow our medical group and hospitals to be broken apart. So, as a result, our medical home patients -- our physicians who serve those Medical Home patients are not in the Tier 1 status.

ASSEMBLYWOMAN MUOIO: Because they're not technically your PCMH, is what you're saying.

MR. ZUINO: They are the--

ASSEMBLYWOMAN MUOIO: They are?

MR. ZUINO: So the Horizon patients who are enrolled in our Medical Home and cared for by our VMG primary care physicians, if they elect the OMNIA product and they continue to seek service with our VMG physicians, they would now be paying Tier 2 pricing.

ASSEMBLYWOMAN MUOIO: Okay, thanks.

ASSEMBLYMAN CONAWAY: Thank you.

ASSEMBLYMAN GUSCIORA: Thank you very much.

ASSEMBLYMAN CONAWAY: I'm going to say, lastly -- we're going to see, obviously, if that holds -- we'll bring up Mr. Slattery and Ms. Waltman with the New Jersey Association of Health Underwriters; and Sarah Adelman, with the New Jersey Association of Health Plans.

Who wants to go first?

**JESSICA WALTMAN:** I will.

ASSEMBLYMAN CONAWAY: Speak and dash. (referring to PA microphone)

MS. WALTMAN: Sorry.

ASSEMBLYMAN GUSCIORA: Push it again.

MS. WALTMAN: Can you hear me?

ASSEMBLYMAN GUSCIORA: Once more.

ASSEMBLYMAN CONAWAY: There you go.

MS. WALTMAN: Okay. I know more about health insurance than I do about microphones. (laughter)

ASSEMBLYMAN CONAWAY: About pushing buttons -- yes.

MS. WALTMAN: So my name is Jessica Waltman, and I'm a principal at Forward Health Consulting. And I am here representing the New Jersey Association of Health Underwriters. Unfortunately, my

colleague, Mr. Slattery, had to leave. He may be coming back; I'm not 100 percent sure. But I will do my best, in his absence.

So, as you may know, the New Jersey Association of Health Underwriters represents about several thousand health insurance agents and brokers in the State of New Jersey. And our national organization represents about 100,000 health insurance agents and brokers nationally.

Personally, I spent the last 16 years working in public policy for the National Association; but now I operate my firm, Forward Health Consulting; and the goal of my firm is to help employers and brokers navigate and communicate the intersect between health policy and the employer marketplace, and to help them prepare for where the market is going.

Which is why I think I was the one who was tapped to talk today -- not specifically about the OMNIA plan, but about tiered networks and why, on a national level, they are growing in importance, and why employers and individual consumers like them, use them, their place in the marketplace. And then, also, what regulators are doing in other states and nationally to encourage and appropriately regulate network adequacy -- so just to give you a basis of information, as you move forward with this.

So, obviously, health insurance benefits, for both employers and individuals, are very expensive; and the reason why is the overwhelming cost of medical care. And there's not a lot an individual employer or an individual person can do about the cost to treat a broken leg or to treat heart disease; and there's not even really that much that they can do to prevent these things from happening to themselves or their families.

What they can do is control the health care that they receive --

the quality of care that they get, whether or not the care is necessary, and whether or not the care they receive is of good value.

Now, obviously, there's a great cost to providing good medical care. But we know that price isn't necessarily the only indicator of quality; and we also know that, even within a very small geographic region, there can be a wide range in terms of both prices and quality.

So we feel that today's consumers, both on the individual and an employer level, do not necessarily have the time or resources or wherewithal to decipher the cost, and value, and quality problem when it comes to day-to-day medical care decision making. And that's why it's very critical that they have tools that they can rely on and adequately use to get the best medical care out there at the best possible price. And the design of health insurance networks is a really key way that employers, and health insurance agents, and brokers, and health insurance providers have to make sure the consumers have access to both high quality and cost-effective medical care.

Networks that are designed using tiers based not only on cost, but specific quality measures, can help hold down the bottom line for all; and, most importantly, they do give consumers a framework that they can trust and rely on with making care decisions.

It's been talked a lot about the fully insured marketplace here in New Jersey, and then the large employer marketplace. In most states, the proportion of employers who utilize self-funded health plan arrangements is kind of switched. So nationally, about one-third of Americans are in a self-funded health plan, and the rest are in fully insured group arrangements.

But in New Jersey, that's just, for whatever reason -- there's a different dynamic there.

ASSEMBLYMAN CONAWAY: Do you want to speculate as to why? (laughter)

MS. WALTMAN: Yes. There are some reasons why. But that's not really the point. But the point is -- the reason why I mention that, is that the Department of Banking and Insurance regulates the fully insured products. And in self-funded plans, there is a greater ability to design flexible networks and use value-based design principles when designing their healthcare networks. Because those plans bear the risks themselves, and they can then -- they have that ability, the flexibility to kind of design what they want.

ASSEMBLYMAN CONAWAY: So the answer to the question -- So we're 30-70, or something like that; the rest of the country is 70-30. It's because we have a Department that regulates and forces people into the self-- Is that what--

MS. WALTMAN: No, no, no, no, no. I mean, self-funded plans are not State regulated.

ASSEMBLYMAN CONAWAY: I mean, New Jersey is always peculiar; we're always-- We're special.

MS. WALTMAN: I think it has to do more with the cost in the state, and mandates, and other reasons why the fully insured marketplace is smaller here. But I think your goal is to make it more competitive, not less competitive.

And so, anyway, getting back to the large employer plans, though -- have been using value-based design principles for some time. In

fact, state governments -- it's been noted many times, here, that the State of New Jersey is perhaps the biggest purchaser of health insurance benefits in the state; it's one of the largest plans. State governments across the nation are leading the way in value-based insurance design principles because they have this great pool of employees. It was earlier pointed out by Linda Schwimmer -- they have this great pool of data that they can use.

ASSEMBLYMAN CONAWAY: That they were not using, apparently. (laughter)

MS. WALTMAN: They were not using -- New Jersey is not. But there are other states, and there are people out there who can help you design plans that can better take advantage of that

But the point is, the value-based design, which incorporates oftentimes tiered networks -- it's yielding significantly lower costs and better health outcomes for large employers, nationwide. And there is a significant trend for smaller employers; and also larger employers that can't, for whatever reason, self-fund -- and there are reasons why you can or should or should not. They want to have this ability too, and they have to rely now

But these employers need, and deserve, and want access to value-based and tiered networks as well, and there are a number of reasons why. There's a 2013 study published in *Health Affairs* which shows that the majority of small employers want to have health plan options that include tiered networks and high-value networks for quality purposes; 57 percent were interested generally, and 82 percent were interested if they could yield them up to 20 percent lower costs. And looking at the large employer

experience on a national basis, that's not necessarily an unrealistic potential outcome.

Currently, our National Association is--

ASSEMBLYMAN CONAWAY: Go ahead.

MS. WALTMAN: Oh; I'm sorry.

ASSEMBLYMAN CONAWAY: Your partner is arriving. I'm waving him onto the tarmac.

MS. WALTMAN: Our National Association has partnered with the Robert Wood Johnson Foundation on a project with small employers, brokers, and consumers about the impact high-value plans and value-based design can have, including tiered networks. And the support has been overwhelming, and we're about to release data about it in mid-2016.

But the point is that nationally we see this call for expanded flexibility with networks amongst employers, including smaller employers that are in the fully insured space.

Someone earlier mentioned also one of the reasons why -- maybe the looming Federal excise tax -- and it was cited as this problem for both the State of New Jersey, the counties, and the various municipalities. I want to stress that the looming excise tax is not just a problem for these large, and municipal, and State employers by any stretch. There is a huge focus on its impact on unions and other large employers. But it affects all employers, down to two employees. Anybody who offers a group benefit plan is going to be affected by the excise tax.

ASSEMBLYMAN CONAWAY: But that really depends on cost -- so on the richness of those plans and the value. It's a cost basis,

because there was some testimony in the Senate, which I think was not accurate-- So it's really the amount that you spend on that individual group plan; it's \$10,000-and-change for that individual, and it's \$27,000 for families, I think.

MS. WALTMAN: Right. There are thresholds, and then there's going to be regulations to come on how you read those thresholds. There is some concerns that even plans that do everything that they can do to control costs, because of the age of their employees and other factors really have no means to control those pricings. And particularly in the small-group market, that's the case. So what my point is, is that now is not the time to limit fully insured plans access to control costs, or any means available to them, particularly when they may be having to scale back other benefits, like wellness programs and other things that provide value and quality to meet those thresholds. Impeding them on a value-based network design tool is really, I think -- this is not the time to do that because employers and their fully insured health plans are going to be looking to any means available to avoid paying-- And please keep in mind too that the employer is going to have to pay the tax, and it's fully allowable and expected to be pushed down to the individual employees. So we talk a lot about union employees being affected by this, but I want to stress that it's every employer is potentially affected. And small employers, because they have so much less ability to control their costs, and plan designs, and their workforce, could be really particularly hampered by it and crushed.

ASSEMBLYMAN CONAWAY: I hear you.

Now, tell me, have you heard today -- just in case; I don't think I have -- but have you heard today anyone say that they want to limit these tiered plans?

MS. WALTMAN: I have not. And this hearing was supposed to be about tiered networks--

ASSEMBLYMAN CONAWAY: Yes.

MS. WALTMAN: --and so I wanted to provide information about why they're-- I mean, because there was a lot of back-and-forth about-- We're not here to talk about a particular product. I'm here to talk about a competitive marketplace and making sure no options are closed off for employers, and down the road.

The other thing I wanted to bring up is that you're not the only state grappling with this, by any means. I just spent months, and months, and months of my life -- many, many (indiscernible) -- with hundreds of other state regulators, and interested parties, and stakeholders -- representing everyone from insurers to every kind of provider -- working with the National Association of Insurance Commissioners to help develop a model law on network adequacy which addresses, amongst other things, tiered network standards, and transparency -- all of the issues that you've been grappling with and have been presented with today.

It was noted that the network adequacy regulations in New Jersey are fairly old; and it's reasonable, I would think, after all this testimony that you, as legislators, may be wanting to look into what you can do to make changes in the future. And what I wanted to make sure was that you knew that this resource was available to you. It was designed --

very, very much so -- to not be a one-size-fits-all component, and it is just a model, so you can take and look at the components of it--

ASSEMBLYMAN GUSCIORA: Is that model a finished product?

MS. WALTMAN: It is; it's finished. It's available online. I just actually got an e-mail, because they were getting so many e-mails today about the availability of it.

ASSEMBLYMAN GUSCIORA: So could you forward that e-mail to us?

MS. WALTMAN: And I think some of them may have been coming from this room, so we can certainly forward it to you. (laughter)

ASSEMBLYMAN CONAWAY: New Jersey is the tail wagging the country on--

MS. WALTMAN: But also the Department of Health and Human Services has issued its 2017 *Notice of Benefit Payment Parameters*, and that, too, has network adequacy protections in it. That's not finalized; it won't be until the first quarter of the new year. But I think it is important to be mindful of the Federal regulators; and then, also, the Insurance Commissioners nationwide are looking at this. And there are a number of states that have also done work on network adequacy in the last few years that you might want to take a look at.

So I'm really happy to hear you say, Chairman Conaway, that you're not looking at making any restrictions on tiered networks, generally; or that is the sentiment. Because our message here today really is to say that they do have a value -- they need to be transparent, and there needs to be consumer protections, but they have a very big value and place in the

future of health insurance products. And we need a competitive marketplace; we need things employers and small business owners can use to keep costs down, and employees can use to ensure that when they're making medical care decisions that they can rely on a quality network. The idea that you're paying lower prices for the best possible doctors who are providing you the highest value care is a really important one that should be nurtured and encouraged. But we should use transparency means and consumer protections to allow that to remain an option for consumers -- so that they have a wide range of choices in the marketplace so they can buy a health plan that best fits their needs and budget.

ASSEMBLYMAN CONAWAY: Well, you know, one of the themes here has certainly been -- as you mentioned transparency for at least five times -- and that certainly has been a big theme. And I think if I've heard my colleagues, a big concern for -- in our review of what's going on with the OMNIA plan, I guess I'll say. And I would say the other -- we don't know what's happening with that as yet. We're going to find out what they're doing, and we want to know what Republic is doing, and we want to know what United Health Care is doing with their tiering, and how transparent they are. Clearly, the Legislature takes action in this area, and I believe we should, quite frankly, on the transparency side. It's going to apply broadly, not just to Horizon.

So we hear you, and we look forward to your supporting our efforts to bring transparency to this process.

You mentioned competition -- because it's been suggested over these past several years that we really need to look to -- across state lines to bring more choices to the marketplace as a means of bringing competition

and driving down costs. Speak about that, if you can -- about out-of-state insurers offering insurance here in the State of New Jersey.

MS. WALTMAN: Well, coverage over state lines-- I will give you-- I can give you my personal opinion about it, but I don't know that I'm speaking necessarily for the New Jersey Association. I'm not sure if they do, or what their position might be.

ASSEMBLYMAN CONAWAY: Which Association? (laughter)

MS. WALTMAN: But my personal opinion is -- I will tell you a little story. A few years ago, the state of Georgia enacted legislation to allow coverage across state lines to have insurers come in to Georgia. And if you talked to the Georgia Insurance Commissioner, you will learn that no one has come into the state of Georgia because you can't take a medical plan in Iowa and offer it in Georgia very easily. You would have to set up networks, you would have to meet-- It's not as easy as it sounds.

And so I think that you can build it, but that doesn't mean that they're going to come. I think that you could -- maybe a better focus would be to make the New Jersey market itself more competitive and attractive to insurers, and that would include not limiting their actions in terms of developing tiered networks, and market innovation, and value-based design; I mean, in just regulating it appropriately so that there is transparency -- consumers know what they're buying, health plans know what the criteria is that they're measured against -- and allowing that in the marketplace.

So that's my opinion.

ASSEMBLYMAN CONAWAY: Now, value-based design-- Now, one of the things-- And you're right; building these networks would be difficult with new entrants. And I've heard from-- Let's see, I've heard

from some insurers -- how can I say this -- that they had had some difficulty expanding their markets in New Jersey because one other insurer recognizes their presence, and prices their product in such a way as to basically drive them out of the market; and, actually, in ways that decrease competition. Some might use the word *anti-competitive*; I think that's probably the term of art there. And so, as you can imagine, it might be very difficult for someone who doesn't even have a footprint to come in from out of state and get established, given, as I understand, the market-based strategies, the tactics that have been used to even deal with large players like -- large national players who want to be in this marketplace.

As I read through the Senate testimony last night, I heard or read -- and, I guess, I sort of knew this but it just still sort of hit me at 2 o'clock in the morning -- that Horizon, I believe, has all insureds under the network -- oh, what's the word? -- ACA. Under the--

ASSEMBLYWOMAN MUNOZ: The Affordable Care Act?

ASSEMBLYMAN CONAWAY: It's under the Affordable Care Act, but the-- Gosh; see, I need to eat. (laughter)

ASSEMBLYWOMAN SUMTER: The exchange?

ASSEMBLYMAN CONAWAY: Under the exchange; excuse me. That they have all of the insureds under the exchange, and I think that's right. And I remember talking to Aetna, and I asked them, "Well, why aren't you guys getting in? They haven't played everywhere." But surely one of the problems -- one of the reasons they haven't gotten in is because of the competitive environment; not so much the regulatory environment, but the competitive environment with *Mr. H*.

And so it is -- I think we need to look at that and figure out whether that's best for consumers or not. And then, of course -- and I'm going to end here. And I am sorry for the ramble but, again, I haven't eaten (laughter) -- and then we were signing up people in the hospital. And the only way that you could sign up electronically-- There was only one plan that you could choose. It was-- The only way to easily get insurance was to come in through the -- and sign up for FamilyCare, which is a Horizon product. And that seemed to me to be-- I just thought that was an interesting structural and systemic issue that affected how people signed up for that plan.

And I just say that for the record, but it's something that, perhaps, bears some attention.

ASSEMBLYWOMAN SUMTER: Mr. Chairman, was this last year?

ASSEMBLYMAN CONAWAY: This was in the run-up to getting started in the exchange and the ACA. I mean, they were right there in my waiting rooms--

ASSEMBLYWOMAN SUMTER: So they were coming through your emergency room and signing up?

ASSEMBLYMAN CONAWAY: Yes, there were folks-- We had the assistors, and I went out to talk to them, as you might expect that I would do, and I talked to them about the process in signing up. And I had somebody in the office who tried to sign up on their cell phone, which I thought was interesting. But I talked to the assistors about what they were doing, and the only plan that they were able to put people in, or suggest to,

was the Horizon plan. And I thought, “Wow, that’s Horizon NJ Health.” I thought that was interesting; let’s put it that way.

Mr. Slattery, you’re more than a potted plant.

ASSEMBLYMAN GUSCIORA: I just have a question for Jessica.

Jessica, in your discussions with state commissioners around the country -- and you said months of work -- was there ever any discussion about making sure that access would be fair, both to urban and suburban customers?

ASSEMBLYMAN CONAWAY: There’s a question.

MS. WALTMAN: Yes. I mean, I wouldn’t say it was as specific as it has been today. But there was the acknowledgement that there were different states with very geographic regions, because you have urban-suburban here; but you can imagine in more rural states-- I mean, geography plays a part as well. So I think the focus really is-- The model act on network adequacy -- it’s really exhaustive; it expands a lot of issues that aren’t even covered here today. But that is one of them that was addressed.

ASSEMBLYMAN GUSCIORA: Can you put protections in place of regulations to make sure that there isn’t any discrimination between urban and suburban plans?

MS. WALTMAN: I think that that’s something that bears more thought. I would have to take a little bit more thought about how you could do that. I think that that’s what you really want to have, is an open discussion about New Jersey specifics so that you can have an adequate network that best fits your specific marketplace.

ASSEMBLYMAN GUSCIORA: Thanks.

**D E S M O N D X. S L A T T E R Y:** Good afternoon, Assemblymen Conaway and Gusciora, and other Committee members. I'd like to thank you for letting me speak.

My name is Desmond Slattery; I'm the Legislative Chairperson for the New Jersey Association of Health Underwriters. I actually wish I had gone before Jess, because she's tough to follow. (laughter)

The New Jersey Association of Health Underwriters is a statewide consumer advocacy organization of health insurance professionals who work to improve our members' ability to provide affordable and accessible health insurance to all New Jerseyans through education, legislative advocacy, and professional development. We are staunch advocates for individual and small business consumers, dedicated to educating employers and individuals about plan choices best suited for their needs; along with the marketplace, legislative, and regulatory issues affecting them.

As you all know, New Jersey has some of the highest healthcare costs in the country. Deductibles, co-pays, co-insurance premiums, and out-of-pockets continue to increase at a level that's unsustainable. This is a national problem, but just more acute here in New Jersey.

NJAHU welcomes any insurance carrier initiative to address these concerns. Many of the carriers have tiered their provider networks in the past, in a network to offer lower cost to healthcare alternatives. And those products either succeeded or not on their own merit. We embrace these efforts.

Recently, Horizon Blue Cross Blue Shield of New Jersey announced that they have created the OMNIA Health Alliance, which is a statewide network of high-value providers within their entire current network. Consumers and businesses that choose this optional plan will have the opportunity to have lower premiums and out-of-pocket costs, while still being able to utilize the entire network of Blue Cross Blue Shield providers. In addition to this option, consumers and small businesses can continue to offer other Blue Cross Blue Shield plans currently available.

NJAHU members and the entire broker community work closely with consumers and small business owners to make sure that the plans being offered address the clients' needs in terms of plan design, networks, and cost. This is whether it's a Blue Cross plan or from a competing carrier, such as Aetna, Oxford, United Health Care, Cigna, AmeriHealth, Health Republic, Qualicare, or anyone else that I might have inadvertently left off.

So New Jersey Association of Health Underwriters -- we applaud Horizon, as you would with any aforementioned carriers, on this initiative and hope that this new program succeeds in lowering costs while increasing quality.

Just a couple of-- So much of this was covered; a lot of different comments today. The small group marketplace -- the 2 to 50 business -- has shrunk in 2014, due to a lot of different reasons. The number of covered members decreased 25 percent. A lot went to the individual exchanges; some went other places where they couldn't be tracked. For 2015, the marketplace is going to shrink about another 10 percent. So the cry out there from our clients -- which are the end

consumers -- is another option to control cost and deliver quality care. So, I mean, that's really what we're pushing for, and we applaud this initiative.

A lot of different comments today about a lot of other concerns -- geographic, etc. -- and we hope that those things can get worked out. But the consumers who we represent are really calling out for some sort of solutions.

So thank you, folks.

ASSEMBLYMAN GUSCIORA: Any questions?

ASSEMBLYWOMAN SUMTER: Good afternoon.

MR. SLATTERY: Hi.

ASSEMBLYWOMAN SUMTER: Thank you for the testimony.

So I'm not sure how much of the testimony you were here for, but while I believe all consumers, including providers, would love to see the cost savings, value-based practice is what we're moving towards in the healthcare system; that's understood. Did any of the consumers who you surveyed express any concern with access, or their facilities not being included in a network based on the changes in this system?

MR. SLATTERY: Yes, well, in the-- Assemblywoman, in the course of our-- So we represent-- So I'm an insurance broker, and we represent the health (indiscernible) -- a group of insurance brokers. So when we sit down with somebody -- John Smith or Mary Jones -- and we talk to them about their business, their being an individual, where they're located -- we go into all that in terms of matching hospitals, doctors, and that sort of thing. So it would come up--

I mean, so there are issues, obviously, today with the OMNIA plan and the different coverage. A number of years ago, when AmeriHealth first got into New Jersey-- AmeriHealth is a subsidiary of Independence Blue Cross. They're very strong down south; they weren't as strong up north, so you really wouldn't talk to somebody in Passaic about an AmeriHealth plan 20 years ago. They've since become quite the -- they have a tremendous statewide network.

The same with Oxford. When they first started out of New York, they pushed down to North Jersey, and then Central Jersey. You weren't selling an Oxford plan down in Cherry Hill. So we have those sort of discussions; I mean, that's what brokers do, so that's -- we get into that sort of conversation. So you match people up with the different networks and plans that are available out there.

ASSEMBLYWOMAN SUMTER: So with their express concern, you match them up with networks. Because my concern is, even for our system, when you're negotiating a contract you're making sure that -- again, if you're in North Jersey -- there are providers in North Jersey that are available for your insured population. If not, what's the point of having the plan and you're spending 25 or 30 percent of your dollar on that plan?

So my curiosity point is making sure that even the purchasers, if you will, that you're working with as a broker, understand, one, the value that they're getting, and the adequacy of the networks that they're opting into as they're changing plans for cost-saving measures.

MR. SLATTERY: Correct. I mean, that's part of our whole consultative job. If we don't do it, somebody else -- the next fellow or

woman down the road is going to do -- broker is going to do a better job for them.

The fellow from Warren County was talking about the issue up in the northwest corner. It's interesting because that whole PA-Pocono area, it's a tough-- Once you get over there, it's not a vibrant market.

ASSEMBLYWOMAN SUMTER: Right.

MR. SLATTERY: So it's just a different sort of thing. So that's a whole different conversation. I understand exactly his challenge -- what he was saying. But that's a tough play up there anyway.

ASSEMBLYWOMAN SUMTER: Thank you.

ASSEMBLYMAN GUSCIORA: My concern in all this is that, say, for instance, First Baptist Church in Trenton was looking for an insurance plan. Would you be comfortable selling them the OMNIA plan?

MR. SLATTERY: Well, we'd sit down with them and we'd find out -- we would speak to their HR Department. I'm not sure what sort of HR Department a church has, but we'd find out where their employees live by zip code; there are different systems you could match up. So there could be challenges with the OMNIA plan. So the OMNIA plan can be a base plan, and there could be several buy-ups to other Horizon plans. Or whenever you say Central or South Jersey, AmeriHealth happens to be particularly strong with their networks, so that might be a better fit. So we represent all the carriers; we work very closely with all of them.

ASSEMBLYMAN GUSCIORA: That's my concern. Because OMNIA is doing this advertising, but it's not telling people that, particularly if you live in the urban areas, you'd better think twice about getting an OMNIA plan; and that there may be unscrupulous people selling

OMNIA to urban customers. It would be a shame if there's a Trenton-based company and an underwriter comes in and says, "You want to save money? Buy OMNIA." And then, lo and behold, they have to go to the hospital, and they find out they can't go to the hospital in the city. And I think that's a concern.

So I'm not applauding OMNIA or Horizon. And I think it's disingenuous of them to sell a plan but not really have too much fine print. There should be a lot more transparency.

MR. SLATTERY: Well, let me-- So the health underwriters-- I mean, it's our job to represent -- I mean, we represent the end user, the clients, whether it's individuals, small or large employers. So we're there to do the best job for them and to make sure that you don't get the call to say that there are some of the issues -- the aforementioned issues.

ASSEMBLYMAN CONAWAY: The employers for whom you consult -- what's going on with them with respect to the use of the tax credits? I understand that there are cost pressures. But under ACA, and where we are now in terms of how big you have to be to take advantage of the credits, what's going on with the tax credits and these insurance costs for small employers?

MR. SLATTERY: I've personally-- I could have Jessica jump in here, if you like. But we've personally seen very few employer groups eligible for that -- for the tax credits.

MS. WALTMAN: There's a wide range of reasons why small employers have been unable to take advantage of them, particularly in an area like New Jersey. I mean, one of the issues is the average income of employees, and it's not really realistic for a New Jersey business owner. I

mean, it might be in a more rural or a different area of the country. But the average income that you have to maintain-- Like, employees, I think it's \$25,000; it's not really realistic in New Jersey. Also, the small size, the relative value versus the premium -- there are a lot of obstacles. You have to buy it through the shop exchange which, in and of itself, is approved, but initially it really had a lot of hurdles and it can expire. There are many reasons.

And our national Association has supported legislation -- bipartisan legislation to clear up those hurdles with the tax credit, because it really would be wonderful if more businesses could take advantage of it. But there is a cost to that, because more businesses being able to take advantage of it does take Federal tax dollar, and those are in short supply. So the legislation hasn't necessarily moved quickly forward, but there's bipartisan legislation in both the House and the Senate to make those improvements to the tax credit. We'd love to see them move forward.

ASSEMBLYMAN CONAWAY: Okay; thank you.

Okay; Sarah.

**S A R A H M. A D E L M A N:** Thank you, Chairman Conaway and Chairman Gusciora.

ASSEMBLYMAN CONAWAY: Thank you both.

MS. ADELMAN: Thank you for sticking with us, now, into hour five. I appreciate your--

ASSEMBLYMAN CONAWAY: I didn't think we did quite that long. (laughter)

MS. ADELMAN: I am Sarah Adelman with the New Jersey Association of Health Plans. We represent the state's leading health

insurance companies, so we have Aetna, AmeriGroup, AmeriHealth, Cigna, Health Republic, Horizon Blue Cross Blue Shield, Oscar, United, and WellCare.

And I would just note, I'm not entirely sure, Chairman -- the point you were making earlier about enrolling into Medicaid -- but there are five Medicaid health plans in New Jersey that offer FamilyCare, so it should be that there is opportunity to enroll in all five of those.

ASSEMBLYMAN CONAWAY: I was just reading the testimony offered by the Horizon representative, I think -- or somebody who was testifying before the Senate. I can find it-- But be that as it may, I'll stipulate or accept that there are other people offering plans on the exchange.

MS. ADELMAN: Very good; thank you.

As an initial matter, New Jersey Health Plans works diligently on behalf of consumers and purchasers to ensure that every individual has access to high-quality, high-volume healthcare services from a robust network of healthcare providers and facilities across the state. New Jersey's Health Plans also hears from their members that healthcare costs are unsustainable. Consumers and purchasers are demanding more affordable options -- I think you've all recognize that here today -- and especially in light of the Affordable Care Act's mandate for coverage and the impending Cadillac Tax on high-cost plans. And I would just note that it may be a Cadillac Tax in some states; but in New Jersey, our health premiums are so high that we come very close and exceed those thresholds. So we may not truly have Cadillac plans, but we do have such high cost plans that they're meeting those thresholds.

And to that end, tiered health plans can be an attractive option and solution to help reduce healthcare costs. Tiered health plans offer individuals and employers a new choice as they shop for coverage; they create new opportunities for competition across health plans; and they serve as an affordable alternative for individuals who currently are enrolled in high-deductible plans and those who currently go uninsured.

I wanted to talk about the difference between *narrow networks* and *tiered health plans*. They should not be used synonymously. Both narrow networks and tiered health plans can help reduce cost and premiums, but narrow networks are typically products that are less expensive in exchange for a limited, narrow network of providers. Tiered health plans are preferred provider arrangements which maintain broad network access for all healthcare services and provider types, while offering lower cost sharing when a consumer selects a preferred tier provider.

So, Chairman Gusciora, you've talked a few times about people in Trenton not being able to access Tier 2 providers. I just want to clarify that Tier 2 providers are in-network providers, and that every individual has access to in-network providers--

ASSEMBLYMAN GUSCIORA: Absolutely. And I think that that was the rationale of DOBI for approving the plan -- that you could still go to a Tier 2 hospital. But they didn't delve into the bill at the end. And you or I may be able to absorb that deduction and that higher cost, but for the working poor and people who take a bus to get to the State House, I doubt very much that they would be able to put up with a Tier 2 bill.

MS. ADELMAN: And I promise I will talk more about that in a moment.

I just would note that those health plans are in-network, and that also in the context of an emergency, I just wanted to make sure it was clear that if you access an emergency room, health plans are required to ensure that you are protected at an in-network rate in the emergency, no matter what hospital you're at, even if they are out-of-network. So I wanted to be clear about that point as well.

I think you've heard that there is demand for tiered products in the market. New Jersey is home to some of the highest healthcare costs in the nation, and hospital costs represent about half of our medical spend in New Jersey; while pharmacy costs are growing at the highest rate.

If your annual individual premium exceeds \$10,200 annually, or if your family plan exceeds \$27,500 annually, your plan will be subject to a 40 percent excise tax beginning in 2018. The excise tax also applies to government health benefits. We've talked some about the purchasing power that the State has through the pension and health benefits review. And their study commission did look at the Cadillac Tax impact on New Jersey and estimated that it will cost \$58 million in 2018 to the State, and rising to \$284 million by 2022. So for that reason, and I think other demands -- including that now some State employees are beginning to pay more for their own coverage -- the plan design committee did take up the issue of tiered networks and asked for the State Benefits Health plan providers to begin to offer a tiered product.

Tiered products in New Jersey are common, as are they throughout the nation. Ten tiered networks have been approved in New Jersey over the past five years in the regulated market. There are very likely many more tiered products available in the non-regulated market where it doesn't require DOBI approval, so it's more difficult to measure.

New Jersey's tiered health plans must meet network adequacy requirements, and many exceed those requirements. In fact, New Jersey's Department of Insurance has instructed Health Plans that the top or preferred tier providers must meet network adequacy requirements if it were to stand alone -- even though Tier 2 or second tier providers are still in-network. Additionally, the Maximum Out-of-Pocket -- the MOOP -- is a consumer protection set by law to protect the individual and family--

ASSEMBLYMAN GUSCIORA: Sarah, could I back up?

MS. ADELMAN: Sure.

ASSEMBLYMAN GUSCIORA: Before, you said that if you had an emergency you still could go to whatever hospital will accept you. But my understanding is, if I have a heart attack and I get sent to Saint Francis, and I have an OMNIA plan -- the ambulance is free, but once I get to Saint Francis I'll be charged the OMNIA Tier 2 rates. Isn't that true?

MS. ADELMAN: Well, I'm not in a position to talk about specific plan details, but I can say--

ASSEMBLYMAN GUSCIORA: Well, you're defending the OMNIA plan. But my understanding is that -- and another reason why Horizon should be here -- but from my discussions with Horizon, if you have an emergency, and you have a heart attack and you go to a cardiac care unit and it's Tier 2, you'll be charged Tier 2 rates.

MS. ADELMAN: Well, the consumer protection rule that applies in that case is that the consumer must be protected with in-network rates. And in that case, a Tier 2 arrangement is an in-network rate.

ASSEMBLYMAN CONAWAY: *Is in-network?*

MS. ADELMAN: Yes.

ASSEMBLYMAN CONAWAY: *Is.*

But I just want to-- Did you say you're not here to talk about any particular plan?

MS. ADELMAN: I'm just not in a position to talk about particular plan details.

ASSEMBLYMAN CONAWAY: So I can't ask you about the OB situation in Burlington County? You can't speak to that?

MS. ADELMAN: You can ask me. (laughter) I'm not in a position to talk about specific--

ASSEMBLYMAN GUSCIORA: You can ask, but she won't answer. She'll deny it.

ASSEMBLYMAN CONAWAY: Good answer.

ASSEMBLYMAN GUSCIORA: You're not a lawyer, are you?

MS. ADELMAN: I'm sorry?

ASSEMBLYMAN GUSCIORA: You're not a lawyer, are you?

MS. ADELMAN: I am not a lawyer. I am also not in a position to-- (laughter)

ASSEMBLYMAN CONAWAY: Very nice; very nicely done.

ASSEMBLYMAN GUSCIORA: She should be a lawyer.

MS. ADELMAN: So just getting back to the Maximum--

ASSEMBLYMAN CONAWAY: She's had a snack today.

ASSEMBLYMAN GUSCIORA: She should be a lawyer.

MS. ADELMAN: Getting back to the Maximum Out-of-Pocket amounts -- the Federal law, through the Affordable Care Act, sets up a protection for consumers, individuals, and families, where they are not -- they cannot be held to pay anything out of pocket more than the Maximum Out-of-Pocket amount. And under the Federal law, the maximum out-of-pocket for an individual is \$6,850; and for a family, it's \$13,700.

I did want to talk about-- Assemblyman Benson, you raised this question on point earlier -- I think it's a really important one -- about if a specific tiered product goes away completely and people are left to the options they had before -- perhaps they're uninsured, perhaps they're in a high-deductible product -- what does that mean, in terms of their out of-pocket spending? So I wanted to use that State Health Benefits plan chart that you were showing before as an example.

So for SHBP members, in the Direct 15 and the Freedom 15 products, the individual maximum out-of-pocket -- so this is the old product, the pre-tier product that's still available to consumers today -- that individual out-of-pocket maximum is \$5,400, and the family maximum out-of-pocket is \$9,000. Those are still below the national threshold, but they are more than even the Tier 2 maximum out-of-pockets in the tiered product. So in the Tier 2 products, the maximum out-of-pocket for the individual is \$4,500. That is \$900 less than the Direct product.

So I just want to be clear that, as you think about what the costs are, the Tier 1 costs may represent an incentive or a reduction in out-of-pocket expenses and in premium for the consumer; but they also actually

represent a reduction in out-of-pocket expenses compared to the alternative -- if a tiered product didn't exist.

ASSEMBLYMAN CONAWAY: I would just caution that we talk about apples and apples.

ASSEMBLYWOMAN SUMTER: Right.

ASSEMBLYMAN CONAWAY: It's very likely that there are differences in the benefit structures of those plans which account for those costs. We don't have them before us, but I appreciate the point you are trying to make. But I'm not sure you quite hit it. (laughter)

ASSEMBLYMAN BENSON: And again, when I brought it up, it was about a very specific case -- it was about hospitalization comparison. It wasn't about the whole plan. But the example that kept being bandied around was someone giving birth. In that very specific case, you would pay more if you were left in the State Health Benefits plan, with the remaining options there. And that's the reason why I brought that up at the time.

MS. ADELMAN: Yes, I hear you.

ASSEMBLYMAN BENSON: And it doesn't speak to the others.

But the question I wanted to follow up on that is, though, the concern I have -- and it's been brought up a number of times -- is that this is what the price is today. And we've seen this a number of times from Horizon; they work in the marketplace to price something very competitive, move the market to a different location; and then, at that point, once you have everybody moved over to this OMNIA plan, and they hit their target, does the price now move up to a point because of being able to control that market by having that large portion of that? And I think that's probably a

concern some of your other members may have as well, being the smaller fish in the market.

So talk to-- From someone who has members from all the parties that are trying to compete with this, are there concerns about competition -- not only just among insurance plans, but again, some of the competition is among providers. You know, having a large provider pool helps your other members have competition and try to figure out who's going to be in their networks.

MS. ADELMAN: And just to be clear, the numbers I was quoting are from the SHBP Plan Design Committee, not from OMNIA.

ASSEMBLYMAN BENSON: Right, okay.

MS. ADELMAN: So that they are -- they exist for Horizon and for Aetna, the same figures.

ASSEMBLYMAN BENSON: Okay.

ASSEMBLYMAN CONAWAY: Ms. Sumter.

ASSEMBLYWOMAN PINKIN: That was per year?

ASSEMBLYMAN BENSON: Yes, per year.

ASSEMBLYWOMAN PINKIN: Okay.

ASSEMBLYMAN CONAWAY: Ms. Sumter.

ASSEMBLYWOMAN SUMTER: Yes; two points.

For the Direct plan -- when we're looking at plans, and just quoting that, I just wanted to be sure -- back to your point, Mr. Chairman -- that you've changed what hospitals are now in-network; whereas, you can go to any hospital system. So you're Tier 1 now; and you're Tier 2 and you're in OMNIA, versus Direct, or traditional, or any of the other plans-- So I don't think we can put that comparison in this context.

ASSEMBLYMAN CONAWAY: Another good point.

MS. ADELMAN: Well, I think it's actually -- it's actually still the same, because Tier 1 and Tier 2, whether it's the Horizon product or the Aetna product or any health plans' tiered products -- both tiers are in-network.

ASSEMBLYWOMAN SUMTER: I'm still not agreeing with you, but okay.

MS. ADELMAN: Both tiers are in-network. So the majority of health plans and the majority of hospitals are in-network together. There are very few cases where there are out-of-network hospitals with health plans -- where there aren't contract arrangements for payments. And most of those hospitals, frankly, exist in Hudson County and are part of our out-of-network bill discussions.

ASSEMBLYMAN CONAWAY: Moving on.

ASSEMBLYWOMAN SUMTER: Yes; thank you.

MS. ADELMAN: So I also wanted to just mention that when we talk about-- As you all consider the factors for tiering -- and I think that's something that, from a health policy perspective, you've been discussing today -- are what should health plans look to as factors for tiering-- There's no mandatory criteria for developing tiers, and nor should there be from a health policy perspective. To prescribe specific criteria would be to dictate that all health plans use the same factors, and thus design identical tiers -- essentially creating two classes of providers. And I think that's the thing that, as policy makers, as you consider this, you have to be careful to avoid.

So I see--

ASSEMBLYMAN CONAWAY: Now, now, now-- (laughter)

To create two classes of providers -- now--

ASSEMBLYWOMAN MUNOZ: Isn't that what we're talking about? (laughter)

ASSEMBLYMAN CONAWAY: I think that's what we've been talking about for the last-- You mentioned five hours--

ASSEMBLYWOMAN MUNOZ: For the last five hours.

MS. ADELMAN: If I-- And so--

ASSEMBLYMAN CONAWAY: I think we've been on that topic for the last five hours: two classes of hospitals, two classes of physicians--

ASSEMBLYWOMAN MUNOZ: Right, right.

MS. ADELMAN: But to underscore the point: This is where greater health plan competition comes into play. If you dictate--

ASSEMBLYMAN GUSCIORA: How do you get greater competition if you're going to put the hospitals out of business, by your own business model, and you're not going to have--

MS. ADELMAN: I disagree with that contention.

ASSEMBLYMAN GUSCIORA: Well, well, Horizon already said that they're going to say to Tier 1 hospitals, "We're going to pay you less, but you're going to have a greater market share because we're going to drive patients--

ASSEMBLYMAN CONAWAY: You were doing so well. (laughter)

MS. ADELMAN: Let me get back to it.

So that's -- I can't talk about-- I am unable to talk about specific plans.

ASSEMBLYMAN GUSCIORA: Well, OMNIA is paying most of your salary, so-- (laughter)

MS. ADELMAN: Well, that's not the case.

ASSEMBLYMAN CONAWAY: All right; hold on.

MS. ADELMAN: But I'm unable to talk about specific plans, but I think what we're seeing in the market already is that when one health plan designates one provider in a preferred tier, it becomes attractive for another competing health plan to bring, perhaps, Tier 2 providers into their preferred tier. You're already seeing that; that's what was played out in SHBP with the two products that are there. So now you have health plans competing against each other. And if you think about it -- for example, I'm your constituent in Burlington County, and if I were on the SHBP, I would look at which hospitals are my preferred hospitals in my area. And when I was choosing a product, I would choose the products, perhaps, where those providers were in the top tier. So the health plans are not competing against each other for that market share, and this is really how tiered products can help reduce costs. And this is the experience that you're seeing across the country.

ASSEMBLYMAN CONAWAY: But, you know, now-- I just want to make this little-- You said competing with each other. So if I'm Tier 1 over here (indicates), in say County A; but over here, in County B, Carrier B is -- I'm Tier 1 with them -- are they competing, or have they just carved up geographic areas in which they've made preferential arrangements with a different set of hospital providers? I mean, I'm not sure that's

competition. And the issue, as I think has been pointed out quite properly by the Attorney General in New York -- and I think it ought to be instructive to us, and when we're seen and understand the implications for physicians as individuals and hospitals who are-- I was blown away, quite frankly, listening to Mr. Rak from Saint Peter's about how well their hospital is doing and how they are leaders in all of these categories. And to find out that they're not involved as a Tier 1 hospital, I have to tell you, is shocking to me. And so, when we look at that -- and I'll speak for myself -- when I look at that and say, "Hmm, something doesn't sound right here. There is a rotten fish there in the basket of fish that somebody is selling; it doesn't make any sense to me."

And so when we say -- and I think it's been intimated, and I'll just say it more clearly if I haven't already done so -- is that these criteria need to be open and transparent. And I would like to see all of our hospitals and our physicians are being able to graduate -- move up, take the actions they need to take to be in the top tier; and that should be open to everybody. And so I'm in favor of it, and I think, quite frankly, that we -- as just has been mentioned -- that some states that have gone into this area have involved themselves in plan design and have set the table to make sure there's fair competition. I think that's exactly what the State ought to be doing.

Now, we ought to be looking to make sure that everybody has a fair shake in this thing. And the way to do that is to demand transparency, to demand and have a say in what the standards are, and to make sure everybody, wherever they're coming from, follows it. That's how we get fairness; that's how we don't have issues with conflicts of interest; and

that's how we protect the ability of the private physician to stay in business; and as a private physician that's how we protect hospitals that need to-- In the case of the out hospitals, 5,500 jobs in the state, and an important driver of our economy.

So I don't accept that these networks should remain in the dark and should remain opaque. And we shouldn't drive this standard across the landscape.

Go on.

MS. ADELMAN: Thank you.

You know, since speaking on behalf of myself has gone on the decline for you, (laughter) I would just say I read in the press recently, Kathy Hempstead from the Robert Wood Johnson Foundation said you can't make an omelet without eggs, and you can't make a tiered network without excluding providers. So it's no mystery why some perfectly good hospitals are not likely to be part of the health plans network. And I say that simply because all of New Jersey's health plans believe that all of their in-network hospitals are quality providers.

ASSEMBLYMAN CONAWAY: They just can't be Tier 1.  
(laughter)

MS. ADELMAN: And in order to offer--

ASSEMBLYMAN CONAWAY: So they're good, but they're not so good.

MS. ADELMAN: --one choice, and one new product in the marketplace, they're creating some of these tiered arrangements. This is, again, one option; it's an alternative to high deductible plans. It's a new option for the currently uninsured. And the other existing -- you know,

PPO, and POS, and HMO products that everyone is accustomed to are still options in the market. And for people who wish to purchase broad networks of provider products, they can continue to do so. But for some consumers, they are asking for and they are saying that they're willing to have a smaller network of providers where they can spend less money. And so where there's consumer demand for these kinds of new options and choices, that's why you see these tiered products come into play. And health plans will design these tiered products differently from one to the next so that you do see competition; so that consumers and employers can shop around for the tiered product that's best for them, if that's the product that they choose to purchase.

And I will stop there. Thank you.

ASSEMBLYMAN BENSON: Mr. Chairman, could I--

ASSEMBLYMAN CONAWAY: Who is that? Mr. Benson; please.

ASSEMBLYMAN BENSON: So when we talk about shopping around, that requires a certain level of sophistication on the basis of the consumer. You've heard all of us have confusion over how different things work in-tier, out-of-tier, emergency, non-emergency, renting a maternity ward, making sure there's adequacy, things changing -- obviously, even yourself said you can't speak to a specific plan.

MS. ADELMAN: Right.

ASSEMBLYMAN BENSON: How does one shop around? And even with all the products still being here -- especially when there's the level of advertising that you've seen out there on a plan to try to get people to move to it, because they're saying this is the best -- why isn't there the

same advertising on the other plans as well so people can choose, as opposed to being kind of pushed towards a product that clearly Horizon is favoring at the moment? You know, instead of having advertising saying one is great, a nonprofit should be talking about all their products, and saying, "Please choose the one that's right for you." Not having that in the fine print; that should be the main part of the advertisements.

So I think there's a really great opportunity here for Horizon to educate all consumers about all the products that are out there and what the risks and benefits are. Instead, I think we've gotten kind of advertising that's here about something that's new without talking about the risk. And that seems different from what I've seen other insurance companies have done in the past.

So can you talk to that kind of advertising piece of it, and the ethics of what should be explained to the consumer?

MS. ADELMAN: Well, to the first part of your question about helping consumers understand their purchasing decisions I would note that this Committee is taking up a number of issues other than the moment of purchase. But for the employer and consumer who are looking at their options, I think Desmond and Jess talked about their role in that process for employers; and that is really the service that they provide to employers -- is to help look at their -- where they're located geographically; where the employees are located; and what options are best for them. And brokers really do a terrific job of providing that service for the employer community. And at the individual level, on the exchange and through assistors who help people with purchasing coverage through the ACA, there are similar kinds of opportunities available. Assisors can serve the same function for--

ASSEMBLYMAN BENSON: But are they advertising at the same level that has been going on about this one?

MS. ADELMAN: Well, I apologize. I was kind of separating the two questions.

ASSEMBLYMAN BENSON: Oh, okay.

MS. ADELMAN: But just for that moment of purchasing--

ASSEMBLYMAN BENSON: Right.

MS. ADELMAN: --the other thing I would note is that on the exchange, which for most individuals -- especially because, like, 85 percent of New Jersey individuals get subsidies -- they're purchasing their insurance through the exchange. And on the exchange you can look at that specific level of detail, and you can look up your provider, you can look up your hospital when you're choosing your plan. So those kinds of education tools are there, I think.

To the question of advertising -- I mentioned before that I am not as aware of the tiered products that are available in the self-funded groups today. But I know that there are two AmeriHealth products, two Aetna products, one Health Republic product; there was a Horizon tiered product, and now there's this new one. And I believe it's replacing the old one. And some of these products are more geared towards a certain geographic region, so there may be advertising in those areas where the consumers will be most impacted. But as a matter of practice, I'm not as familiar with the advertising practices that are used at the health plans. It's regulated in the Medicaid space, and I think in the commercial space as well. I'm just not as familiar with that.

ASSEMBLYMAN BENSON: That's something we should look at.

ASSEMBLYMAN CONAWAY: Well--

ASSEMBLYWOMAN MUNOZ: What a day.

ASSEMBLYMAN CONAWAY: Are we at the end? (laughter)

MS. ADELMAN: Thank you, sir.

ASSEMBLYMAN CONAWAY: Thank you, Sarah.

Well, I think I want to thank the Committee for their attention. This has been, I think-- Certainly, it's been a long hearing. But I think it's a hearing that has brought a number of very important issues to the attention of the Assembly, and the Legislature, and the public at large.

I'll just comment, in closing. I want to make a few points.

We all share in the desire to make sure that our citizens have access to low-cost health care and to outcomes which are appropriate to their particular situations; that is, good outcomes that help their health and extend their life.

There are always going to be differences in how we get to that goal. We have to recognize -- and I hope we do, and there were some allusions to it today -- but I do think we need to spend some time on data gathering, on making sure that we have the information that we need in order to make good decisions about what networks to join, how to make assessments -- particularly of quality; we've heard that time and time again. But quality is rather elusive when you are dealing with a dearth of information. And you're dealing, most importantly, with patients who, when they leave your office, they may or may not follow the plan. I don't care how often you explain it to them. They don't come to the lab; they're

embarrassed about that. If I send a patient out of the hospital-- I'll just give you an example. I send somebody out of the hospital and they have Horizon, or they have United Healthcare. I can't send them upstairs to my hospital. This patient has a history of not doing their labs; and they'll come back to the office; they have medicines and other health conditions where I need to know what's going on. They take up a visit that's somebody else might use, and I can't use the stratagem that I had used: I don't give people prescriptions; I don't let them leave until they go to the lab. Now, if they can't use my hospital lab -- and this really bothers me -- that patient gets lost and there is a compliance issue; and there's an outcome impact to the system around how people get care that needs to be addressed.

So we're talking about systemic issues here. And I would say for myself, in the wake of this hearing that there are a couple of things that I think really require the attention of this Legislature. How we determine access to care, how that's to be measured, how we do that in an urban setting versus a suburban one; how we are going to tier hospitals. In my view -- and I'm interested to hear from my colleagues on this -- I believe that that tiering should be open and transparent. I think it is the best way to ensure for the public that there's a process; that it's fair to hospitals, that it is fair to physicians; that minimizes the risks and possibilities of conflicts of interest having a detrimental impact on their hospitals or physicians. I think those are important public policy goals.

And I think we can achieve that while still being able to benefit from the cost-saving measures that are offered by tiered networks.

So I'm in favor of those cost savings, but we have a responsibility -- we have other, larger responsibilities, as well: fairness,

ensuring that there's access in urban areas, ensuring that we have a regulatory environment that's appropriate to the challenge -- the challenges we face today.

I look forward to working with all of you here. I think everyone here is returning in this next Legislature. There's some action we might be able to take, even before we're done with this one. But that's what I take from this hearing. And I thank you all, again, for your attention and focus on this very important issue.

Mr. Chairman.

ASSEMBLYMAN GUSCIORA: I wanted to thank my colleagues for sticking it out. And I think that each of you had your own expertise and experiences with regard to health care.

I wanted to especially thank my Co-Chair, who is probably the most knowledgeable in the Legislature on healthcare issues.

I get it; I know that everybody wants affordable health care and that there are a lot of unknowns out there. The thing was -- the thing I learned today, and I guess I knew all along, was that DOBI was completely asleep at the switch, and stood by and allowed a private entity to dictate public health care in the state. And I don't think it's wise when our job in government is supposed to be to protect the public interest, and left off at the cutting-room floor were people -- largely the working poor in urban areas -- that I think have really gotten the short shrift in all of this.

And I also do get the sense that Horizon met in secret with other hospitals and came up with their own plan. We still don't know what the criteria they used was; we still don't know what fairness was in place to ensure that they would really be looking out for the consumers. And I don't

think that they were looking out for consumers; I think they were chasing the dollars, and that's troubling to me.

I think we may need legislation to ensure that DOBI looks -- takes seriously the adequacy rule, and DOBI takes seriously the rule for protecting the public interest. This is also troubling to me -- that the Administration has too many Acting Commissioners; and having an Acting Commissioner in DOBI -- we need somebody who is going to do their job and really concentrate on protecting the public interest.

So I look forward to working with you, Mr. Chair; but I hope that Horizon rethinks what they did to the Tier 2 hospitals. I think you heard it before, that "who wants to go to a Tier 2 anything," and that there's a psychological effect that has been lost upon the insurance industry -- that it is really going to hurt the urban hospitals and those that have been designated as Tier 2 status. I think we should all be Tier 1 status, and we should all strive to get the best possible health care that we can get for everyone, regardless of your stature or income capacity.

ASSEMBLYMAN CONAWAY: Other comments? (no response)

With that, thank you. We're adjourned.

**(MEETING CONCLUDED)**