
Joint Committee Meeting

of

SENATE HEALTH, HUMAN SERVICES AND
SENIOR CITIZENS COMMITTEE

SENATE COMMERCE COMMITTEE

“The Committees will hear testimony from invited guests regarding the recently announced OMNIA Health Alliance formed by Horizon Blue Cross Blue Shield of New Jersey”

LOCATION: Committee Room 4
State House Annex
Trenton, New Jersey

DATE: October 5, 2015
10:00 a.m.

MEMBERS OF COMMITTEES PRESENT:

Senator Nia H. Gill, Chair
Senator Joseph F. Vitale, Chair
Senator Raymond J. Lesniak, Vice Chair
Senator Fred H. Madden, Vice Chair
Senator Richard J. Codey
Senator Robert M. Gordon
Senator Ronald L. Rice
Senator Jim Whelan
Senator Dawn Marie Addiego
Senator Diane B. Allen
Senator Gerald Cardinale
Senator Thomas H. Kean Jr.
Senator Robert W. Singer



ALSO PRESENT:

David Drescher
Philip R. Gennace
Adaline B. Kaser
Todd W. Moore
*Office of Legislative Services
Committee Aides*

Alison Accettola
Marcela Maziarz
*Senate Majority
Committee Aides*

John Gorman
Laurine Purolo
Lisa Torres
*Senate 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***



NIA H. GILL
Chair

RAYMOND J. LESNIAK
Vice-Chair

JAMES BEACH
NICHOLAS P. SCUTARI
GERALD CARDINALE
THOMAS H. KEAN, JR.

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JOINT COMMITTEE NOTICE

TO: MEMBERS OF THE SENATE COMMERCE COMMITTEE
FROM: SENATOR NIA H. GILL, ESQ., CHAIR
SUBJECT: **JOINT COMMITTEE MEETING - OCTOBER 5, 2015**

The public may address comments and questions to Philip R. Gennace, Todd W. Moore, Committee Aides, or make bill status and scheduling inquiries to Joanne W. Gillespie, Secretary, at (609)847-3845, fax (609)777-2998, or e-mail: OLSAideSCM@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.

The Senate Commerce Committee will meet jointly with the Senate Health, Human Services and Senior Citizens Committee on Monday, October 5, 2015 at 10:00 AM in Committee Room 4, First Floor, State House Annex, Trenton, New Jersey.

The committees will hear testimony from invited guests regarding the recently announced OMNIA Health Alliance formed by Horizon Blue Cross Blue Shield of New Jersey.

Issued 9/28/15

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RICHARD J. CODEY
ROBERT M. GORDON
RONALD L. RICE
JIM WHELAN
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JOINT COMMITTEE NOTICE

**TO: MEMBERS OF THE SENATE HEALTH, HUMAN SERVICES AND SENIOR
CITIZENS COMMITTEE**

FROM: SENATOR JOSEPH F. VITALE, CHAIRMAN

SUBJECT: JOINT COMMITTEE MEETING - OCTOBER 5, 2015

The public may address comments and questions to David Drescher, Adaline B. Kaser, Committee Aides, or make bill status and scheduling inquiries to Chantal C. Bailey, Secretary, at (609)847-3860, fax (609)943-5996, or e-mail: OLSAide.SHH@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.

The Senate Health, Human Services and Senior Citizens Committee and the Senate Commerce Committee will meet jointly on Monday, October 5, 2015 at 10:00 AM in Committee Room 4, 1st Floor, State House Annex, Trenton, New Jersey.

The Senate Health, Human Services & Senior Citizens and the Senate Commerce Committees will meet jointly to hear testimony from invited guests regarding the recently announced OMNIA Health Alliance formed by Horizon Blue Cross Blue Shield of New Jersey.

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TABLE OF CONTENTS

	<u>Page</u>
Robert A. Marino Chairman, President, and CEO Horizon Blue Cross Blue Shield of New Jersey	3
Kevin P. Conlin Executive Vice President Healthcare Management Horizon Blue Cross Blue Shield of New Jersey	9
Minalkumar Patel, M.D. Senior Vice President, and Chief Strategy Officer Horizon Blue Cross Blue Shield of New Jersey	11
Linda Willett, Esq. Senior Vice President, and General Counsel Horizon Blue Cross Blue Shield of New Jersey	21
Jeffrey D. LeBenger, M.D. Chairman and CEO Summit Medical Group	129
Rebecca Levy, Esq. Chief Legal Officer Summit Medical Group	133
Peter L. Hartt Director Division of Insurance New Jersey Department of Banking and Insurance	139
Kristine Maurer Assistant Director Division of Insurance New Jersey Department of Banking and Insurance	158

TABLE OF CONTENTS (continued)

	<u>Page</u>
Linda J. Schwimmer, Esq. President and CEO New Jersey Healthcare Quality Institute	192
Joel C. Cantor, Sc.D. Director Center for State Health Policy Rutgers, The State University of New Jersey	202
Ronald C. Rak, Esq. President and CEO Saint Peter's Health Care System	208
Michael A. Maron President and CEO Holy Name Medical Center, and Chairman Catholic HealthCare Partnership of New Jersey	208
Alexander J. Hatala President and CEO Lourdes Health System	220
Robert Pedowitz, D.O. Medical Director Family Practice of CentraState Healthcare System, and President New Jersey Association of Osteopathic Physicians and Surgeons	242
Adam Beder Vice President Government Affairs JFK Health	242
Richard P. Miller President and CEO Virtua Health	242

TABLE OF CONTENTS (continued)

APPENDIX (continued)

	<u>Page</u>
APPENDIX:	
Letter, addressed to Senator Nia Gill and Senator Joseph Vitale from John Leyman Director Government and Regulatory Affairs Horizon Blue Cross and Blue Shield, and Horizon Blue Cross Blue Shield Tier 1 Hospital Map submitted by Robert A. Marino	1x
Testimony submitted by Brian A. Gragnolati President and CEO Atlantic Health System	20x
Testimony submitted by David Bollard, D.O. President Premier Health Associates	21x
Testimony submitted by Desmond Slattery Legislative Chairperson New Jersey Association of Health Underwriters	22x
Testimony submitted by Eric Brezina, D.O. Comprehensive Family Medicine, PA	24x

TABLE OF CONTENTS (continued)

APPENDIX (continued)

	<u>Page</u>
Testimony submitted by Jeffrey Scheininger President Flexline Inc.	25x
Testimony submitted by James Hercek Human Resource Manager Piscataway Township	27x
Testimony submitted by John DiAngelo President and CEO Inspira Health Network	28x
Testimony submitted by Marc Feingold, M.D. Private Citizen	30x
Testimony submitted by Marc Mayer, D.O. Owner Avenel Iselin Medical Group, PA	31x
Testimony submitted by Sloan A. Robinson, M.D. Ronaldo deGuzman, D.O. Farah Roomi, M.D. Meetinghouse Family Physicians	35x

TABLE OF CONTENTS (continued)

APPENDIX (continued)

	<u>Page</u>
Testimony submitted by Michael J. Vostenak Senior Director Radwell Human Resources Radwell International, Inc.	35x
Testimony submitted by Robert C. Garrett President and CEO Hackensack University Health Network	37x
Testimony submitted by Robert Goodman Private Citizen	38x
Testimony submitted by Sarah Charrier Private Citizen	39x
Testimony submitted by Steve Kalafer Private Citizen	40x
Testimony submitted by Tara Cambria Private Citizen	42x
Testimony submitted by Tracy Martin President and CEO Martin Insurance Group	44x

TABLE OF CONTENTS (continued)

APPENDIX (continued)

	<u>Page</u>
Testimony submitted by Wendy Ebner Private Citizen	45x
Testimony submitted by Jeffrey D. LeBenger, M.D.	46x
Testimony submitted by Linda J. Schwimmer, Esq.	48x
Testimony submitted by Joel C. Cantor, Sc.D.	52x
Testimony submitted by Ronald C. Rak, Esq.	59x
Letter, addressed to Kevin Conlin from Kevin Sears Senior Vice President Payer Strategy and Product Development Trinity Health	115x
Testimony submitted by Alexander J. Hatala	117x
Testimony submitted by John T. Gribbin President and CEO CentraState Healthcare System	121x

TABLE OF CONTENTS (continued)

APPENDIX (continued)

	<u>Page</u>
Testimony submitted by Adam Beder	126x
Testimony submitted by Michellene Davis, Esq. Executive Vice President Corporate Affairs Barnabas Health	128x
Testimony submitted by Assemblyman Thomas P. Giblin District 34 Deputy Majority Leader New Jersey General Assembly	129x
Testimony submitted by Audrey Meyers President and CEO Valley Health System	130x
Testimony submitted by Robert P. Wise President and CEO Hunterdon Healthcare	132x
Testimony submitted by Richard P. Miller	133x

TABLE OF CONTENTS (continued)

APPENDIX (continued)

	<u>Page</u>
Testimony submitted by Al Maghazehe, Ph.D. President and CEO Capital Health	138x
Letter, addressed to New Jersey State Legislator submitted by New Jersey Health Care Providers	141x
Resolution submitted by Trenton Municipal Democratic Committee	143x
Testimony submitted by Assemblyman Reed Gusciora District 15 Deputy Majority Leader New Jersey General Assembly	144x
Testimony submitted by Assemblywoman Elizabeth Maher Muoio District 15 New Jersey General Assembly	147x
Map Horizon Blue Cross Blue Shield Tier 1 Hospitals and Testimony submitted by Peter L. Hartt	151x

TABLE OF CONTENTS (continued)

APPENDIX (continued)

	<u>Page</u>
Horizon Tier 1 Professional Data	
Horizon Tier 1 Provider Data	
New Jersey Department of Banking and Insurance Practitioner Detail	
pnf: 1-254	

SENATOR JOSEPH F. VITALE (Chair): The hearing will come to order.

Would you call the roll, please?

MR. DRESCHER (Committee Aide): Before roll call, I would just make an announcement that Committee Room 1 is serving as an overflow room. So if this room is too crowded, there will be an audio feed playing in Committee Room 1.

For roll call, Senator Singer.

SENATOR SINGER: Here.

MR. DRESCHER: Senator Cardinale.

SENATOR CARDINALE: Here.

MR. DRESCHER: Senator Rice.

SENATOR RICE: Here.

MR. DRESCHER: Senator Whelan.

SENATOR WHELAN: Here.

MR. DRESCHER: Senator Gordon.

SENATOR GORDON: Here.

MR. DRESCHER: Senator Codey.

SENATOR CODEY: Here.

MR. DRESCHER: Vice Chair Madden is not in the room; he is in the Labor Committee at the moment.

Vice Chair Lesniak.

SENATOR RAYMOND J. LESNIAK (Vice Chair): Here.

MR. DRESCHER: Chairwoman Gill.

SENATOR NIA H. GILL (Chair): Here.

MR. DRESCHER: Chairman Vitale.

SENATOR VITALE: Here.

MR. DRESCHER: You have a quorum.

SENATOR VITALE: Let's just remind everyone--

SENATOR GILL: Senator Kean is here. (laughter)

MR. DRESCHER: I'm sorry, Senator Kean; I didn't see you there.

SENATOR KEAN: Senator Kean and Senator Cardinale.

I was going to say -- here.

Although Ray is going to go over to Committee Room 1, in case anybody is focused on that. (laughter)

SENATOR LESNIAK: Very funny, Senator.

I do have a question, if I may. Are we acting on any legislation today?

SENATOR VITALE: No.

SENATOR GILL: No.

SENATOR LESNIAK: So we don't need a quorum.

SENATOR VITALE: No; just for the record, we were just seeing who was here.

Just to remind everyone to turn off any electronic devices, please -- phones; pagers, if you still have pagers. (laughter)

So today's Joint hearing -- I want to thank Senator Gill and all the members of both the Health, Human Services and Senior Citizens Committee and the Commerce Committee for taking time to come here today, and to ask the questions and understand what it is we're going to talk about today. You know, just recently, Horizon Blue Cross Blue Shield

announced a new product for the market. And as everyone on this Committee is aware, it has created quite a controversy and a stir.

There are a great many questions that I know that my colleagues have -- on this Committee, , including Horizon Blue Cross Blue Shield, the Department of Banking and Insurance, hospital representation, some healthcare experts, and other providers as well.

And with that, I'd like to ask representatives from Horizon Blue Cross Blue Shield to come forward and offer their testimony.

And if you would, as you speak, please introduce yourself for the record.

ROBERT A. MARINO: Good morning, Senator Vitale. Let me introduce myself. I'm Bob Marino, Chairman and Chief Executive Officer of Horizon Blue Cross Blue Shield.

Sitting next to me, at my immediate right, is Dr. Minal Patel, Senior Vice President and Chief Strategy Officer of the corporation. Sitting next to his immediate right is Linda Willett, Senior Vice President and General Counsel of the corporation. And to my immediate left is Kevin Conlin, Executive Vice President, Healthcare Management.

Thank you, Senator Vitale and Senator Gill, for your invitation today. First, let me applaud both of you and members of your respective Committees for all you do to improve New Jersey's healthcare system. I'm grateful for this opportunity to explain the new products we are introducing, as well as provide an overview of how the OMNIA Health Alliance furthers the goals of improving quality of care, enhancing patients' experience, and lowering costs for New Jersey's healthcare consumers.

We all agree that healthcare costs in New Jersey are too high. Working families are struggling every day to keep up with ever-increasing costs of health care. Many individuals make decisions about their care based upon financial, rather than medical, considerations. One consumer told us that they had stopped playing sports because, "I'm afraid if I get hurt, I can't afford to go the doctor." Another told us that, "It's been six months since I haven't been insured, and I'm scared. I might get sick, and I'll have to pay out-of-pocket if it happens." These are real stories, not mere statistics.

The status quo of rising healthcare costs is not acceptable for the single mother with young children, or the dad working multiple jobs to support his family. Healthcare experts agree the current fee-for-service system continues to drive up costs without improving the quality of care. It's time for change.

Beginning in 2010, Horizon began a collaborate effort with hospitals and doctors to change how we pay for and deliver health care. Our patient-centered care program began to pay hospitals and doctors for meeting high standards of quality care, improving patient satisfaction, and lowering total cost. Patient-centered care is not a novelty; the Affordable Care Act, President Obama, and states across the nation have pushed for this change, and we applaud legislators here in New Jersey -- including members of these Committees -- who have embraced moving away from fee-for-service to value-based, patient-centered health care.

Patient-centered care has been tested, and it works. Today our patient-centered programs have more than 6,500 doctors serving more than

750,000 Horizon members. Our members are being cared for by patient-centered physicians, and are receiving more effective and lower-cost care.

Our success with patient-centered care drove our decision to create the OMNIA Health Alliance. The OMNIA Health Alliance, at its core, is an agreement between Horizon and each of our partners on a new way to pay for health care. Instead of paying for the amount of services provided, our goal is to pay for keeping our members healthy, improving the quality of life, enhancing patient satisfaction, and lowering total cost of care.

Two years ago we began a thoughtful, deliberate, internal evaluation of all network health systems to determine which systems we could partner with to move toward new payment and delivery models. Each of you have a detailed overview of criteria we used for our determining of our Alliance partners, and I will be happy to answer any questions on them.

Separate from the Alliance, we will introduce new lower-cost plans for customers in 2016. We'll continue to offer all of our standard, broad-network products that provide coverage for millions of New Jerseyans. In 2016, consumers will have more, not fewer choices for affordable coverage. Consumers in the individual exchange will have 10 plan choices, five of which are new OMNIA health plans. These plans replace our four tiered plans we introduced last year. The OMNIA health plans have expanded benefits and more access to specialists than the old tiered plans. We're adding five OMNIA plans -- to 11 standard, broad-network plans -- to the small group market. And all of our plans -- both the

current plans and our new plans -- all of Horizon's current network doctors and hospitals will remain available for our customers.

Our members are not losing access to care; they are gaining more options to save money on health care. In fact, the new plans provide members with the choice of more than 24,000 doctors and health professionals, including 6,500 patient-centered physician practices. Monthly premiums will be 15 percent lower than our standard plans. Members can also choose to seek care at certain Tier 1 doctors and hospitals to save additional out-of-pocket costs on co-payments, co-insurance, and deductibles.

Unfortunately, two very important points have been lost in the public discussion regarding our new plans. First, the new plans offer members a wide selection of Tier 1 doctors and healthcare professionals, in addition to hospitals. For example, in Trenton, 57 percent of the doctors and healthcare professionals are in Tier 1; and as you know, individuals seek care from doctors more frequently than at hospitals. Consumers, therefore, will have significant opportunities to save money on the care they receive.

In 2016, we project approximately 250,000 of our more than 3.8 million customers will decide to choose these new, lower-cost plans. More than 70 percent of these new customers will be in the individual and small-group markets, which are much more sensitive to high healthcare costs. More importantly, we project 40,000 currently uninsured individuals will be able to afford the new lower premium OMNIA health plans. Let me repeat: 40,000 men and women in New Jersey who, as we sit here right

now, are not insured will be insured because we are offering new, lower-cost premium health insurance options for them.

The OMNIA health plans, because of their lower premiums, will also help employers, including the State Health Benefits plan, avoid the Cadillac tax. This will save employers and taxpayers millions of dollars.

Our customers are the real story behind the OMNIA Health Alliance and our new health plans. We heard and we responded to their demands to work with hospitals and doctors to improve the quality of care and create new options for more affordable health insurance. More importantly, offering new lower-cost health plans impacts the lives of real people. Our OMNIA health plans will allow more hardworking individuals, including 40,000 currently uninsured, to experience the peace of mind that comes from having health insurance.

After understanding that our new OMNIA plans will allow 40,000 currently uninsured men and women to get coverage, how could we not act? Failing to act would be protecting the status quo; and for us, protecting the status quo is not an option.

I thank you for your time. I will be happy to answer your questions.

SENATOR VITALE: Thank you, Mr. Marino. Are there questions from members?

Senator Codey.

SENATOR CODEY: Yes. Bob, as you know, you came in my office not too long ago. And what I said to you was -- when I saw the paper that day, and I saw the breakdown of hospitals, it looked like the day after an election -- when politicians were either winners or losers. And it was

clear to me that the other hospitals that weren't Tier 1 were stigmatized by your announcement -- clearly. And the reaction that I've seen so far is just that. How can you and your company appease their fears that this will not hurt them, moving forward, in the healthcare business and the services they provide?

MR. MARINO: Senator, thank you for your question.

Perhaps I should start out with explaining the criteria, and how the decisions were made. We used a very deliberate internal process to evaluate potential partners for the OMNIA Health Alliance; 75 percent of the metrics that we considered in this internal evaluation were objective metrics; 55 percent of them are publicly available. The categories that we considered in selecting the OMNIA partners -- there were six broad categories including clinical quality of care; the service offerings provided by the potential partner across all service lines; consumer preference; the value-based capabilities; the scale of the organization; and then, importantly, the commitment to transform the healthcare system to a fee-for-value system.

I would ask Kevin to expand on that, and I believe Dr. Patel will expand on the clinical standards.

SENATOR CODEY: But to get to my question, though, in terms of the hospitals that are not in Tier 1 having the fear that I expressed to you. Can you answer that?

MR. MARINO: Well, Senator, let me explain, perhaps, the product configuration.

The OMNIA product is a tiered network product. We are still offering all of our broad network-based products that we have in the marketplace today. We chose a tiered network construct to provide our

members with choice. Basically, there are only incentives for a member to use a Tier 1 provider; there are no penalties for a member who opts to use a Tier 2 provider. As a matter of fact, there are only incentives for them to avail themselves of lower out-of-pocket costs if they use a Tier 1 provider.

SENATOR CODEY: But again, Bob, put yourself in their position, okay? And how do you address their fears?

MR. MARINO: Senator, again, 250,000 members are forecasted to be in the product in the first year -- that's out of 3.8 million members who we serve. Of that number, a significant number of them are individual consumers and small employers who are, indeed, most burdened with healthcare costs.

SENATOR CODEY: But again, you haven't answered my question, respectfully.

KEVIN P. CONLIN: Senator, if I may jump in and add a perspective to what Bob has said.

It is certainly not our intent to stigmatize any hospital organization, any set of providers. I think you know we have virtually all of the hospitals in the state in our managed care network; in fact, all but three of our hospitals are in that position. We go through a process of credentialing those organizations to ensure that they perform well, provide high-quality services, and are responsive to the communities that they serve. And we are offering a new product -- essentially, a choice to our customers in the event that they wanted to do that. So it was not our intent to stigmatize; and in fact, the selection criteria that we used was not intended to essentially comment on or evaluate their performance as a stand-alone hospital. Rather, our intent was to evaluate healthcare organizations on the

basis of their being able to provide more of a population health management-oriented approach.

SENATOR CODEY: Okay, two responses to that. One, the question still hasn't been answered; and I don't know if I'll get a direct answer. But if I'm Tier 1, I'm going to advertise that, as opposed to if I were Tier 2. And in the demographics of our state, if someone has a heart attack say, in the inner city, they're more likely to have other conditions such as diabetes, hypertension, so forth and so on -- as opposed to say, Morristown Memorial, up in a different demographic. And how did you take that into consideration, and how can you do that, moving forward?

MR. CONLIN: Senator, if I may. Let's talk a little bit about the quality of the institutions that are in our entire network.

SENATOR CODEY: Yes, but can you please answer my question?

MR. CONLIN: It's a directly-- What I will tell you is that we are very proud of every hospital that is in network, including the ones that are not part of the OMNIA Health Alliance. Why? Because the objective metrics we used, in terms of determining clinical quality across our network, stand. We have over 3.8 million members today who use these hospitals -- that we can look those members in the eye and say, "Every hospital that's in our network today, we're proud of." And we looked at the objective criteria for the OMNIA Health Alliance -- one of the biggest inputs was clinical quality. And we used CMS data for that, which is the most widely used and publicly available information, etc. How do you perform on 30-day readmissions? How do you perform on certain process scores? Someone is going to the operating room for a hip fracture, as an example. Are you

making sure that they're taking their medications from a blood clot? Are you making sure they have their antibiotics? All of those were metrics that went in.

But the critical factor here, Senator, is that for the OMNIA Health Alliance, and for our system to work, prevention and keeping patients healthy really is the way that we have to move forward. So the question we have to ask is--

SENATOR CODEY: Yes, but you have to judge each hospital individually, in terms of their mix of patients, before they enter that hospital, sir.

M I N A L K U M A R P A T E L, M. D.: All the criteria are risk adjusted, yes. So in other words, if there were more complicated patients with clinical conditions -- as you mentioned, in some of the inner cities versus suburban hospitals -- a lot of that -- all those were inputs that were taken care of.

The question we have to ask is, was it whether the patient was taken care of in the operating room and the hospital did a great job on that particular episode? The question we have to ask is, what did the hospital do with its physicians and its community to prevent that fracture, as an example, from happening to begin with? What are the protocols and processes in place that women, for example, are getting their screenings for osteoporosis? And if they are osteoporotic, are they on the appropriate medications to prevent that fracture? If the person has a fall risk, is someone doing a home safety evaluation? Those were much more comprehensive in terms of questioning; and unfortunately, today, there is no specific clinical metric that one could point to that can define the

success of a system with that regard. This really is where we need to go into the future of health care, which is why the criteria had not just to be around the specific quality of what an institution can do; but more broadly, what are the systems and processes it has to have to care for an overall population.

SENATOR CODEY: All right. Mr. Marino, does Medicare presently do something like this?

MR. MARINO: Senator, the OMNIA product is only available in the commercial marketplace.

SENATOR CODEY: No, I'm talking about the government.

MR. MARINO: Yes. As a matter of fact, the Center for Medicaid Services recently announced that it's their intention -- I believe it's by 2018 -- to have 50 percent of their reimbursements to hospitals; and CMS represents probably 40 percent of all hospital reimbursements in some type of value-based arrangement. And further, they ultimately hope to have 90 percent of all of the payments that they make to hospitals related to value-based payments.

SENATOR CODEY: And how about Medicaid?

MR. MARINO: I am not certain about Medicaid. I don't know if one of my colleagues could respond to that.

SENATOR CODEY: Can somebody answer?

MR. CONLIN: Senator, Medicaid also has similar expectations with regard to quality measurements, such as what are referenced in Medicare -- as well as what we're doing in the OMNIA product, yes.

SENATOR CODEY: Okay. I'll come back to some questions.

But I also want to congratulate you for bringing about full-time employment to lobbying efforts here in Trenton. (laughter) We are all very appreciative.

SENATOR GILL: Thank you for coming today and appearing before this Committee.

And I'd like -- I think we all agree that New Jersey residents deserve affordable, quality health care and access to providers they believe best meet their needs.

So today's hearing is just about that. How are the people of this state going to receive health care under the new OMNIA -- and I'd like to indicate that the last part of the initials spell *Nia* (laughter) -- OMNIA Alliance, that will change the delivery and the financing of health care? And not necessarily tomorrow or next year -- but years to come.

So before I begin my questioning, I want to lay out what we requested Horizon to provide for us today, for this hearing, as part of the Committee's fact-finding process.

We asked for, but did not receive, the entire list of criteria and scoring for how Horizon chooses the hospitals and providers in the OMNIA Alliance, as well as the Tier 1 hospitals not in the Alliance.

We asked for, but did not receive, the list of hospitals and providers that have signed contracts with Horizon to be part of OMNIA Health Alliance, and a list of Tier 1 hospitals and providers not in the Alliance that have signed contracts with Horizon.

Transparency in Horizon's selection process is critical to ensuring that the consumer knows what type of product they are purchasing. Unfortunately, Horizon failed to provide the Committee and

the public with the scoring or the weighting of the criteria used to select which hospitals and providers are included in the Alliance or tiered network. In addition, it is my understanding that Horizon did not provide the scoring or weighting of the criteria to DOBI, or even physicians, or hospitals -- despite their request to Horizon. It is my further understanding that, in fact, Horizon's letter to the Committee states that Horizon's discretion was 25 percent of the factors of who would be chosen to be in the Alliance.

Now, there are reasons transparency is important and necessary in the tiering process. And New York's Attorney General -- who at that time was Attorney General Cuomo, who is now the Governor -- had set a national precedent for applying oversight and transparency in tiering programs by insurance companies, and in the rating of provider performance. And in the Attorney General's settlement agreement with five of New York's health insurance companies -- and this is towards a national standard -- the New York Attorney General states that he "believes that more and complete information provided to the consumer better educates all parties. However, because measuring physician performance is relatively new, complex, and rapidly evolving, the need for transparency, accuracy, and oversight in the process is great."

In addition, he continues, "When the sponsor is an insurer, the profit motive may affect its program of physician measurement or reporting. This is a potential conflict of interest and therefore requires scrutiny, disclosure, and oversight by appropriate authorities.

"When making important health decisions," he continues, "such as choosing a primary care physician or specialist, consumers are

entitled to receive reliable and accurate information unclouded by potential conflicts of interest. The independence, integrity, and verifiable nature of the rating process are paramount.”

And in that discussion, the Attorney General and five of the leading -- Cigna and others -- signed a settlement agreement to do just that.

So the questions -- and that's framing where I'm-- We're not talking about if 25 people did a poll and they all said they wanted affordable health care. We understand that. We're here talking about how it is supposed to be delivered, or how it was constructed.

Now, when you say you began to create the Alliance almost two years ago, you created an Alliance OMNIA partnership, correct?

MR. MARINO: That is correct, Senator.

SENATOR GILL: And you decided -- and we don't know how, because we don't have the matrix or the scoring -- you decided who you would allow to be part of this partnership.

MR. MARINO: We identified the ultimate partners that were chosen for the OMNIA Health Alliance; that is correct.

SENATOR GILL: And have you made those metrics or requirements public to anyone who may want to join that Alliance?

MR. MARINO: Senator, we chose a deliberative process, it was an internal process; it was not a public process. It is a process that is widely used in the industry by not only us, but all of our national competitors when they are building tiered network products.

We've attempted to share as much information and response to your request and Senator Vitale's request regarding the six broad categories that we spoke of -- the actual individual clinical metrics that were there.

We also brought in an independent third party, a management consulting firm, to assist us to assure that in our internal--

SENATOR GILL: My question to you is this. You did not make those requirements public.

MR. MARINO: That is correct, Senator.

SENATOR GILL: Okay.

MR. MARINO: That is correct.

SENATOR GILL: And for these systems or hospitals that you chose, only one is a provider for physicians, correct? That would be Summit?

MR. MARINO: That is correct, Senator.

SENATOR GILL: And when you chose these particular systems to participate, they had been competitors, right? Weren't they competitors with each other?

MR. MARINO: To my knowledge, they are not competitors.

SENATOR GILL: Okay. And in this Alliance, you define certain things broadly that OMNIA health care partners have -- they have to agree to cut rates, correct?

MR. MARINO: I'm sorry, Senator? Would you-- I didn't--

SENATOR GILL: The partners have to agree to cut rates.

MR. MARINO: That is correct. There was a rate discussion.

SENATOR GILL: The partners have an understanding that there would be an increase in volume of patients to offset the cut.

MR. MARINO: That is correct.

SENATOR GILL: And finally, each partner in the Alliance participates in the shared savings or profits at the end of the year.

MR. MARINO: That is correct.

SENATOR GILL: So this Alliance creates a partnership with the providers where now they become part of the risk pool or risk dynamic in the insurance end -- shared risk.

Let me rephrase that. Now they become part of the shared risk. They benefit if you get a lot of volume, or if people do well -- they participate in the profits. And if not, they don't. Is that correct?

MR. CONLIN: Senator, if I may respond to that.

In the hospital-based systems -- and you correctly identified that Summit Medical Group is also one of the partners -- but specifically for the six hospital-based systems that we designated as an OMNIA partner, in four-- The formula is not exactly the same in every case, but in four -- I'm doing this from memory -- in four of them, actually, it's a shared savings approach, which really does not provide, if you will, downside risk to those organizations at first. If they achieve quality measurements and also achieve a reduction in the total cost of care, there is some sharing in the savings associated with that. I think that was your question.

SENATOR GILL: Yes. And these are certain groups, certain people, certain entities that you have picked.

MR. CONLIN: I'm sorry--

SENATOR GILL: You have only invited people -- you only invite the entities to become part of this Alliance OMNIA partnership.

MR. MARINO: That is correct, Senator.

SENATOR GILL: Okay.

Now, on September 10 you rolled out an extensive ad campaign.

And before I get to that, I'd like to ask you: Have you before, in New Jersey, had this kind of partnership with providers to share in the risk?

MR. MARINO: Yes, Senator, we have. It was actually approximately five years ago the company began developing what we called *innovative payment arrangements*. And those types of arrangements include concepts such as patient-centered medical care, global payments of care, and Accountable Care Organizations. All of those payment innovation models that we created five years ago do have an element of shared savings in those models. And those models are, indeed, the foundation of the OMNIA Alliance that we built.

SENATOR GILL: And shared savings and shared risk. I want to make sure that they're not two exclusive terms.

MR. MARINO: I'll defer to Kevin; but my sense is, on the patient-centered medical home, it is a shared savings model; and I believe it is the same on the episodes of care.

MR. CONLIN: It is a shared savings model on each of those three innovative payment arrangements.

SENATOR GILL: And is that different from a shared risk?

MR. CONLIN: I said that they are shared savings--

SENATOR GILL: Okay, I didn't get that.

MR. CONLIN: --but not -- they are not shared risk, which would suggest that there is a downside risk to the providers.

SENATOR GILL: So there's no downside for whomever is in the OMNIA Alliance?

MR. CONLIN: I was answering on behalf of the three arrangements that Bob just described.

SENATOR GILL: And I'm asking you, on behalf of-- And I think this is important, because this is extremely important for explaining and understanding for the consumers; I'll take a few minutes with this OMNIA Alliance partnership.

In the OMNIA Alliance partnership, are all partners equal or do they share in savings at a different rate?

MR. CONLIN: No, the rate at which they would share in it would be the same.

SENATOR GILL: It would be the same, correct?

MR. CONLIN: Correct.

SENATOR GILL: Okay. And in the OMNIA partnership, there is no downside, you said, because they don't share the risk.

MR. CONLIN: That is correct, yes.

SENATOR GILL: Okay. So whoever's there, they share the profits, but not the risk. And that's an entity that's a partnership.

And these questions, now, still continue to go to this partnership.

On September 10, you rolled out an extensive ad campaign with billboards, Internet -- pretty much a full PR blitz -- to announce the creation of the OMNIA Health Alliance, which is the partnership we were just talking about, correct? And you stated it was composed of the following: Atlantic Health System, Barnabas Health, Hackensack, Hunterdon Medical Center, Inspira Health Center, Robert Wood Johnson Health Center, and Summit Medical Group, correct?

MR. MARINO: That is correct.

SENATOR GILL: Okay. At the time you rolled out this product, were all of the entities that you listed -- had they signed contracts, and in fact were part of the OMNIA Alliance?

MR. MARINO: What we have are the contractual documents from these selected partners that have permitted us to be into the market with the products as of January.

SENATOR GILL: I didn't-- I'm sorry. You said--

MR. MARINO: We have contractual documents signed with the OMNIA partners that permit us to be in the marketplace, offering the OMNIA product, as of January 1.

SENATOR GILL: I'm not talking about the OMNIA product here. I'm asking you directly if the entities named had in fact signed a contract to become part of the OMNIA Alliance partnership.

MR. CONLIN: Senator, each of the hospitals in the OMNIA Health Alliance, as well as the Tier 1 hospitals that are not otherwise partners in the OMNIA Health Alliance, executed rate agreements in order to permit us to have the product in the market, effective January 1.

SENATOR GILL: And you're mixing--

MR. CONLIN: I'm sorry?

SENATOR GILL: You're mixing apples with oranges here. I'm not asking you about the tiers; I'm asking you about the OMNIA partnership. I understand the difference between signing a contract for the product; I'm not asking you that. I'm asking you if all of the entities you named as being part of the OMNIA partnership in fact had signed contracts to be part of the OMNIA partnership alliance.

MR. CONLIN: Each of the organizations that are OMNIA health partners had signed letters of intent with us, and we are in the process of finalizing what we're calling *strategic alliance agreements* with those organizations that deal more with the governance of the relationship -- such things as how we're going to transfer clinical information between one another. And we have, again, conceptual agreements, and we're in the process of finalizing those agreements now.

SENATOR GILL: Because-- You have to get closer-- We know, as lawyers, there's a difference between a contract -- a binding contract, and a letter of intent, correct?

L I N D A W I L L E T T, Esq.: Senator, the short answer to your original question is "yes." We have signed contracts with each and every one of those hospitals.

SENATOR GILL: Letters of intent for OMNIA--

MS. WILLETT: Beyond that, Senator.

SENATOR GILL: No, not beyond that -- because you're going to answer my question, because it is important, okay? Did you have a signed contract with Atlantic Health System?

MS. WILLETT: Senator, we have several contracts with each of the partners.

SENATOR RICE: Excuse me, Madam Chair.

Could we make sure when the speaker-- We are being transcribed, is that correct?

SENATOR VITALE: Yes.

SENATOR RICE: Can we make sure when people -- that they state their name and position on the record? I believe you are corporate counsel; is that correct?

MS. WILLETT: Yes, Senator.

SENATOR RICE: I think that's important so that when we look at these transcripts, we'll know -- in case there's litigation, we'll know who's who--

SENATOR GILL: Okay.

SENATOR RICE: --and who is saying what, so we can subpoena them.

SENATOR GILL: Did you have-- Since you are corporate counsel, did you have a binding contract with the entities that you named as being part of and constituting the Alliance partnership on September 10, when you advertised as such?

MS. WILLETT: Yes, Senator, we did and we do. The OMNIA Health Alliance is the result of many months -- in fact, probably more than a year-and-a-half of work.

SENATOR GILL: I understand.

MS. WILLETT: And we have several contracts with each and every one of the entities.

SENATOR GILL: Are they letters of intent, or are there contracts?

MS. WILLETT: It started with letters of intent, which are contracts. We then moved to rate agreements, which are contracts.

SENATOR GILL: No, are you--

MS. WILLETT: Rate agreements, which are contracts.

SENATOR GILL: Are they letters of intent-- On September 10, did you have, simply, letters of intent?

MS. WILLETT: No, Senator. We had beyond letters of intent. The letters of intent had been signed much earlier.

SENATOR GILL: Did you have binding contracts?

MS. WILLETT: We did have contracts; we do have contracts.

SENATOR GILL: Okay. Because -- and this is why I think it's important about transparency, oversight in regulation. We invited Saint Barnabas to appear here today. And we know, on September 10, you advertised that Saint Barnabas was part of -- and you can look at your advertisement -- part of the OMNIA Alliance partnership. You even have their logo.

We asked them to appear here today. And this was in response to my letter, along with Senator Vitale. On October 1, we received a letter from Saint Barnabas signed by Michellene Davis, Esq., and the last paragraph says-- And I will read the whole paragraph, because it's the last sentence, so we'll have it in context.

“Barnabas is one of several network contracted providers in the OMNIA Health Plan and cannot comment upon the specifics of the Horizon product design or its network. We are currently in negotiations with Horizon, a component of which is participating in the OMNIA Health Alliance. Consequently, we are unable to participate and provide testimony regarding the OMNIA Health Alliance at this time.”

So that in fact Saint Barnabas, at least, had not and has not yet signed a binding contract for the Alliance, because they say, “We cannot appear because we are still in negotiations.”

MS. WILLETT: Senator--

SENATOR GILL: That is--

MS. WILLETT: As Kevin mentioned before, and as you noted yourself, we do have a contract with Barnabas; their logo is on our advertising because we have a joint marketing agreement with them.

SENATOR GILL: I don't know anything myself.

MS. WILLETT: We have a rate agreement with them; we have a letter of intent--

SENATOR GILL: You have a rate agreement. And I won't beat this, and I will move-- You have a rate agreement; you don't have a binding contract as the Alliance. But you advertised as if they are part of the Alliance. You come here today to testify as if they are a part of the Alliance. And you are still in negotiations. So I don't know, out of-- And that's why we have to have transparency and oversight.

I don't know if any of the other hospitals are also, simply, in negotiations, have letters of agreement -- but you advertised to the public and consumers as if it was, in fact, a *fait accompli*.

And I will move on.

Now, there are-- All healthcare providers -- and they used to be competitors; you say "no," but, okay. So here again, we don't know how you chose the hospitals to be in this Alliance. And Tier 1 hospitals are different kinds, correct?

MR. MARINO: That is correct, Senator.

SENATOR GILL: So you have a Tier 1 OMNIA that represents this partnership, correct?

MR. MARINO: That is correct.

SENATOR GILL: And then you have a different Tier 1 that are those hospitals that you've chosen, but you have not provided to us either the metrics or the weighting of the reason they were chosen by you. The weighting and the metrics -- you didn't provide that.

MR. MARINO: Senator, they were chosen based on geographic access.

SENATOR GILL: Did you-- This is my question.

MR. MARINO: Yes.

SENATOR GILL: Did you provide the weighting and the metrics as to how you chose these hospitals? And once chosen, how did you then eliminate or include others?

MR. CONLIN: Senator, in response to the letter that you and Senator Vitale sent to us, we provided you with the six categories of criteria-

SENATOR GILL: And you did not provide the metrics, and you did not provide the weighting. How did you score-- What value did you give -- to Senator Codey's question -- to mixed populations and what that means. I'm not asking-- You papered the file, but you did not give the metrics or the weighting.

So we had that Tier 1; and then there's a different Tier 1. Then we have a non-OMNIA Tier 1, correct?

MR. CONLIN: Yes, that's correct.

SENATOR GILL: And you did not provide us with any of that information either, with respect to metrics, so we'll understand in the questioning and in the-- Why is there a different Tier 1 that's the OMNIA Tier 1? Why did you have to create two Tier 1's, almost three? What was

the purpose? And first we'll say OMNIA is Tier 1; then there's Tier 1. Why did you create Tier 1?

MR. MARINO: Senator, you're correct. The Tier 1 hospitals consist of the six that are OMNIA Health Alliance partners. And I believe there are seven other Tier 1 hospital systems that were identified as Tier 1 in order to satisfy and provide the membership with statewide geographic coverage.

SENATOR GILL: Because if you didn't have this other Tier 1, you couldn't have the OMNIA partnership with just their Tier 1's, because it didn't have the requisite geographic locations so that you could in fact get the product okayed, right?

MR. MARINO: Senator, what we chose to do with the OMNIA product is build a tiered network product, as opposed to a narrow network product.

SENATOR GILL: Okay.

MR. MARINO: We could have conceivably built a narrow network with just the partners, but we chose a tiered product design so that all of our members will continue to have access to the broad network, as well as provide stabilized geographic coverage.

SENATOR GILL: Okay. And I have three more questions.

Part of all of the tiers has to have an increase in volume of patients, or participants, correct? You said, "Look, cut the rates," but I'm sure there's going to be an increase in the volume of *consumers*, shall we say, as opposed to simply *patients*? Consumers.

MR. CONLIN: Senator, if I could jump in here for a minute.

If all we do is shift volume from Tier 2 to Tier 1, our Alliance will have failed. This is about keeping patients healthy, not in the hospitals. In fact, we are expecting that the Tier 1 hospitals that are part of the Alliance will actually have a bigger decrease -- if I can use the double negative there -- bigger decrease in their admissions than even the Tier 2s. That's really the objective of the Alliance.

SENATOR GILL: And this is the way it appears that the business model is. In order for the hospitals in Tier 1 and the OMNIA to make sure they get that profit, you have to increase the volume. That's one of your issues -- you said we have an understanding that there will be an increase in volume of patients to offset the rate cost, correct?

MR. CONLIN: Senator, that is correct; but there is another factor, which is that-- Back to the shared savings that you were asking us about previously. In order for the OMNIA Health Alliance partners to actually achieve any benefit from this relationship, not only must there be some volume transfer into them -- that is correct -- but they must also perform on the quality measurements, the member experience measurements, as well as being able to manage the total cost of care down. It's the sum of that, plus--

SENATOR GILL: But part of that sum is that you have to increase the volume of patients.

MR. CONLIN: Part of that -- that's correct.

SENATOR GILL: Right?

MR. CONLIN: Yes.

SENATOR GILL: And it would appear that in this business model you can increase the value of patients if people decide, "I'm not

going to a Tier 2 hospital, I'm not going to a Tier 2 doctor because it will cost me more. So even though I like Doctor Brown, Doctor Brown is not Tier 1." I am then forced to go to a Tier 1, and the Tier 2 hospitals -- then you begin to constrict the market, and you begin to constrict access. Because if I have insurance under Obamacare, but a hospital in my -- and I am on your product -- the hospital in my district may well not be in any tier -- like Newark, with United -- or it's in a Tier 2. So you have to get Tier 1 volume, and that volume, it seems, by this business model-- And I have just-- Because you're talking about a business model going forward for the future; you didn't do this for next year, or the year out. You've made calculations for how you would change the market in health care and financing. That's the whole part of this.

So you drive them from Tier 2; you constrict the market from 2, because the hospitals cannot survive. And they go to Tier 1, and you do it with both physicians and hospitals. And so there is a disincentive here for consumers to use Tier 2 hospitals. And that disincentive then forcibly constricts the market to Tier 1.

And that may be the unintended consequences. But you can't just say, "We want lower cost health care." The issue is how are you going to deliver it, and what is its unintended consequences?

Last question: Is there a-- If you're in Tier 1, as a hospital -- if you are in an OMNIA partnership, and you want to withdraw or opt out, are you permitted to opt out of the OMNIA partnership?

MR. MARINO: Senator, if I understand your question correctly, you're asking if a Tier 1 OMNIA partner is a partner and decides to opt out -- did I get that correctly?

SENATOR GILL: Yes.

MR. MARINO: There are provisions under which the partnership could be dissolved. The answer is “yes.”

SENATOR GILL: Are there penalties?

MR. MARINO: There are performance criteria that need to be satisfied on both sides of the partnership. And if one party believes the other party isn't satisfying those requirements, there's an ability to opt out. I don't want to profess to be an attorney, but I believe that's--

SENATOR GILL: Well, you do have an attorney here, so I'll ask her.

Are there penalties?

MS. WILLETT: Yes, there are.

SENATOR GILL: Okay.

MS. WILLETT: Within the contracts that we are forming with each partner, there are penalties.

SENATOR GILL: And in the contracts you are engaging in with the partnership, is there a time limitation -- that you cannot exercise the option for three years, or two years?

MS. WILLETT: Senator, I believe -- and Kevin, maybe you can help me with this -- that it's the standard kind of contract term where either party can give notice to opt out of the contract. And I think it's a period of days -- 60 days, 90 days -- that we give notice; it might be longer.

SENATOR GILL: I didn't ask-- No, my question is not to notice. My question is, are you required to stay in the partnership for a particular term; and if you opt out before that term is up, there are

penalties? I'm not talking about notice; I'm talking about the contractual relationship.

MR. CONLIN: Senator, I understand your question better. Let me jump in, if I could, Linda.

There are penalties and disincentives, if you will, for either party to depart the partnership. First is, if you will, a breakup fee -- monetary fee -- that each side is committing to each other, in the event that there is a breakup and performance is going as expected. Secondly, there are agreements between each of the parties with regard to activity and moving forward -- commitments to one another not to replicate this type of a relationship for short periods of time.

SENATOR GILL: In that contract, there is a non-compete clause, right? When you say *activities* -- that is, you leave, but for a certain period of time you cannot compete in a relationship like the OMNIA partnership.

MR. CONLIN: There's a provision in the agreement that essentially restricts, for a limited period of time, participation in an exact type of relationship as ours -- which, I think you'll agree, would be quite unusual.

SENATOR GILL: Well, no -- it may be very usual, because this is something that you are saying is the future of health care. So we know-- While they are in the partnership, can they also be in a partnership with some other health entity that's similar to Horizon?

MR. CONLIN: Senator--

MR. MARINO: Kevin, if I may, please.

They will be allowed to be in models that could be similar to the OMNIA construct, with the agreement that they can not exactly replicate the OMNIA construct.

SENATOR GILL: So while they're in OMNIA, they could be in another construct as long as it is not exactly like the OMNIA construct.

MR. MARINO: That is very possible. As a matter of fact, that construct with another party -- if it moves the delivery system in New Jersey towards value-based care over volume-based care, we would actually welcome that relationship.

SENATOR GILL: As long as it's not the relationship duplicated by Horizon.

MR. MARINO: To the exact extent that we've constructed the relationship; that's correct, Senator.

SENATOR GILL: Is there any prohibition by time-- Let's say I'm a Tier 1 hospital -- OMNIA or not; OMNIA partnership or not. During that time I buy a Tier 2 hospital, because that Tier 2 hospital is losing patients to Tier 1 hospitals. So I look around and I say, "I want to buy this Tier 2 hospital." Would the Tier 2 hospital that was purchased by the Tier 1 hospital automatically become a Tier 1 hospital by virtue of the purchaser?

MR. CONLIN: No.

SENATOR GILL: So that constricts-- Well, I'll withdraw that and rephrase it. That was clearly editorializing, I believe.

So now, is there a time limitation, or will you never be able to be a Tier 1 from Tier 2, even if you are purchased by a Tier 1?

MR. CONLIN: And your question, Senator, is there a time limitation?

SENATOR GILL: Yes. Are you going to let my hospital -- my Tier 2 hospital into Tier 1 in three years, or four years?

MR. CONLIN: What we've committed to in the partnership agreements that we're discussing with the partners is that that evaluation would occur no earlier than three years.

SENATOR GILL: And why did you pick three years?

MR. CONLIN: Simply to deal with not providing an incentive for a hospital-based organization to make acquisitions, with the expectation that they would automatically become a part of Tier 1.

SENATOR GILL: So it's for three years.

MR. CONLIN: Yes; there's, if you will, a three-year period of time that must be served before we evaluate that particular facility for inclusion.

SENATOR GILL: And this, you think, is a disincentive for Tier 1 hospital to purchase a Tier 2?

MR. CONLIN: If that Tier 2 hospital were thinking along those lines, I think it would have that effect, yes.

SENATOR GILL: Is there an application process? I want to be a Tier 1 hospital; I want to be a Tier 1 doctor. Do you have an application that I could fill out so I would know what the qualifications are, or I would know if I qualify or not?

MR. CONLIN: The answer to that, Senator, is no. The process that we followed was to evaluate each of the hospital organizations and large physician groups in the state.

SENATOR GILL: Okay.

Interns -- because I'm always concerned about expansion of doctors. If I'm an intern or I decide to be a resident, but I'm going to be a resident in a Tier 2 hospital, do you think that, in the long run, this will constrict the market for physicians? I spent all this money becoming a doctor, why would I intern or become a resident in a Tier 2 hospital that does not -- and this goes back to Senator Codey's question -- that sort of has a stigma because it's not a Tier 1? I might as well go out-of-state and practice and intern someplace that would not so detrimentally affect my future.

DR. PATEL: Senator, if I may.

We come back to the comment that every hospital that's in our network, from a quality standpoint, is in our network because we believe they can provide the kind of care that we're proud of in front of all 3.8 million members today. We don't anticipate that to change; and frankly, we think that is motivation for a physician to come and actually do their training, either in a Tier 1 or a Tier 2 facility.

SENATOR GILL: I have-- And the reason I -- and I have no more questions; but the reason I have-- I think this is a real serious issue. I think unintentionally an unintended consequence -- so we really need to examine -- is that it constricts the market; that it-- You're the largest provider; that it potentially is a monopoly that has-- And I'm not saying it is; but the fact that we don't have information -- you haven't given information to even DOBI or others -- that this could be, and it has the earmarks of, being a potential monopoly; as well as -- and I'm not saying it is -- as well as serious consumer protection issues.

And so we don't want to go down the road where it's raised later, and it disrupts the whole marketplace. But without oversight, without transparency-- And my understanding is, this morning you have a new product and you may have new people in the hospital -- Tier 1 or Tier 2. And that speaks more to the ability to unintentionally manipulate both who gets in, and thus constrict the market in the way that can be viewed as antitrust. I'm not saying you are; I'm saying there's a potential here that that is the unintended consequence, and that this needs more scrutiny, and transparency, and oversight.

But I thank you very much for your testimony today.

Thank you.

SENATOR VITALE: Thank you.

Senator Allen.

SENATOR ALLEN: Thank you.

Thank you very much for being here. I've had an opportunity to receive some information from you folks in my office a week ago, but I still have some questions.

And I guess, just right off, the first one is, would you please give to us just your basic spreadsheet -- you know, the things you looked for: Here are the hospitals -- all the hospitals -- so we can see how all of that worked? Is that a possibility -- even if we kept it just to the Committee?
(laughter)

SENATOR CODEY: Who would believe that?

SENATOR LESNIAK: Good luck.

SENATOR CODEY: Are you new here?

SENATOR LESNIAK: Good luck with that.

SENATOR KEAN: That would last about an hour.

MR. MARINO: Senator, we've shared as much as we believe we can possibly share. It is my knowledge and my experience that the amount of data that we've supplied in response to Senator Vitale and Senator Gill's request, in our written response to them, is probably more than I'm aware that any of our competitors -- locally or nationally -- have provided in their building of a tiered network.

What we cannot provide -- and I believe this is what you're asking for -- is the actual, if you will, document that we used for every hospital in the state. We consider that proprietary, and I have been advised from counsel that that is something that, because we consider it proprietary, we could not supply.

SENATOR ALLEN: Well, that saddens me, because you've said a number of things that I just don't understand. And the only way I could understand it, I think, is by seeing such a document.

For instance, you said that hospitals were chosen based on geographic access. Well, come on; we live in Burlington County, and that's not true. There is no Tier 1 in Burlington County, and there's only one Tier 1 in Burlington and Camden counties. And basically, as you look over the state, if you divide the number of hospitals by the number of residents it comes out, on average, 235,000 -- something in that neighborhood -- per hospital. We're a million people in Burlington and Camden counties; you have one, and it wasn't even in your first OMNIA thing; it was kind of a late add -- sort of an *oops* add.

A million people -- one Tier 1 hospital. So geographic access really probably isn't one of your criteria.

MR. CONLIN: Senator, if I may respond to that with regards specifically to the access of Tier 1's in Burlington County.

We built the network of hospitals looking at the entire state. We didn't consider actual city limits; we don't consider county considerations. What we did was attempt to plot -- and I think we did this successfully -- the time of travel and the distance of travel for our members to not only a hospital in Tier 1, but also with regard to primary care and specialist physicians. And in Burlington County specifically, the point -- and really, throughout the state -- it's important to note that access to a primary care physician and physicians in general is something that's sought much, much more frequently than access to a facility. Eighty percent of our members, in any given year, will see a physician; only 7 percent will actually need to be admitted to a hospital.

Having said that, 58 percent of all the physicians in Burlington County -- it's over 1,300 physicians -- are in Tier 1. The average distance of our members to one of those physicians is less than two miles. The travel time is obviously less than 10 minutes.

On the hospital side -- even though you're correct that up until recently there had been no Burlington County hospital in Tier 1, the average distance is 14.7 miles to a Tier 1 facility. Further, to my last point--

SENATOR ADDIEGO: From where?

SENATOR ALLEN: From where? Because Burlington County, as you know, is the largest county geographically; and I am sorry to disagree with you, but as I look at the little dots on your map, perhaps you don't realize the size of Burlington County. But I don't think 14 miles is accurate.

MR. CONLIN: Well, I respect your disagreement. This was based off of where the membership, that we have currently in Burlington County, resides in terms of the distance to the Tier 1 facilities surrounding Burlington County.

SENATOR ALLEN: So you don't have anybody in Shamong, for instance, or--

SENATOR ADDIEGO: Southampton.

SENATOR ALLEN: --towns in that area -- Southampton.

Well, anyway -- go on; 14 miles I don't think is--

SENATOR ADDIEGO: It's 32 miles.

MR. CONLIN: Further, we've attempted to listen to feedback that we have received. We also have been interacting with a key stakeholder, and that's the Department of Banking and Insurance. They've recently asked if we would change our position with regard to a Tier 1 facility for OB services in Burlington County, and we have agreed to do that. This is something that's happened recently, so we will be getting about the business of getting one of the Burlington-based hospitals that provide OB services designated as a Tier 1 facility.

SENATOR ALLEN: This happened in the last week?

MR. MARINO: Yes.

MR. CONLIN: Yes, approximately within the last week.

SENATOR ALLEN: So that's a positive move.

What happens if someone goes and has a baby in this Burlington County hospital, and the child has many issues when she is born and perhaps is then put into another part of the hospital. Will that also be considered Tier 1, or does that become Tier 2?

MR. CONLIN: That would be considered Tier 1 during the entire duration of the stay and the care, actually.

SENATOR ALLEN: And if the child was really, really ill and had to be taken immediately to CHOP in Philadelphia -- is CHOP going to be Tier 1?

MR. CONLIN: CHOP, on a stand-alone basis, is not Tier 1, no. However, using the scenario that you just outlined, to the extent that there are services available at CHOP that aren't available elsewhere in the state -- so if it's uniquely qualified to provide those services, then we will administer the benefit as if it's in Tier 1, yes.

SENATOR ALLEN: And that would happen not just if the child needed the services right then, but any child who needed particular services that are only available at CHOP?

MR. CONLIN: Senator, that is correct.

SENATOR ALLEN: Well, then, what about the CHOP physicians who exist in South-- Well, I mean, children go to CHOP from every county, as you probably know.

MR. CONLIN: Yes.

SENATOR ALLEN: It's considered the best children's hospital in the country, I think.

What about those physicians -- the CHOP physicians, I believe are called Tier 2.

MR. CONLIN: In this circumstance, they will be treated as if they are Tier 1.

SENATOR ALLEN: How about the circumstance that -- there's somebody who's a constituent of mine -- we've heard from a number

-- who goes to CHOP physicians with their kids. They feel that that is their best opportunity to get the best care. Now, that would be Tier 2?

MR. CONLIN: That is correct, and that Tier 2 benefit -- with regard to the out-of-pocket expense to that family -- is approximately the same as what they have in the broad access product.

SENATOR ALLEN: So the co-pay and the amount that they have to accumulate before they start paying would not change?

MR. MARINO: That's correct.

SENATOR ALLEN: You talked about a commitment-- The Tier 1 hospitals indicated a commitment to transform the system. Did you talk to every hospital to see if they would make that commitment?

MR. MARINO: No, Senator. Again, it was an internal process. We identified those ultimate partners that we thought would be best positioned to share the vision that we have -- which is to move the system from fee-for-service to fee-for-volume. It was only after we identified those potential partners that discussions began. There was discussion with any facility -- including the ones that were ultimately selected -- during the process.

SENATOR ALLEN: So you have some hospitals that don't fare well on a metric that you folks have always used -- the Leapfrog metric. And they don't fare so well, but they've made your Tier 1. And other hospitals that fare very high on that, have not. It leads me-- Well, go ahead. Please explain how that could happen.

DR. PATEL: So Leapfrog is a very reputable organization focusing on patient safety, primarily. Safety and quality are two sides of the same coin, but they are two sides. And so we chose to use the CMS

metrics primarily because they're objective, they're third party, they are used ubiquitously throughout the country; 50 percent of most inpatient revenue comes from CMS and so we chose to use those metrics.

There is no right or wrong there; it is a judgment that we made as far as the metrics that we decided. But again, it's--

SENATOR ALLEN: I guess, as I listened to everything you've had to say, you seem to be making your decisions -- and you're an insurance company; you're making decisions based on money and those sorts of things. And I applaud the fact that you're looking to cut costs. I mean, we do want to see that.

But I have a feeling that quality has taken a hit, just based on a number of things that you've said. And it really worries me. But even beyond that, people have come, again to my office -- I'm sure we all have experienced this -- saying, "Oh, my gosh. My hospital is a Tier 2 hospital. I want better care, so I'm going to have to switch to a Tier 1 hospital."

I don't think that this has been something in people's heads before, based on the way insurance has been rated into tiers, because it hasn't been put out there so fast and so strongly -- about Tier 1 and Tier 2. I mean, people absolutely have the opinion, based on what you folks have put out there, that Tier 1 hospitals are better. Not because of what it costs, but because of the quality of the care. I believe that that is a message that has gotten to them. It may not have been a message you meant, but it is a message they have received, and it is something that you need to address.

MR. MARINO: Indeed, it was not the message that we intended. We believe that every hospital in our network is a quality institution. Candidly, we have very rigorous credentialing standards for all

of the hospitals in our network, whether they're Tier 1 or Tier 2. And, yes, if that is the impression, we do not intend to correct that (*sic*). We don't believe that quality has gotten lost in this. Our ultimate goal is to actually improve the quality of healthcare delivery in the state by moving the system to a system that rewards value; value being defined as better patient outcomes, better patient quality, more engagement of the patient in the care that's being delivered -- and finally, and lastly, lowering the total cost of care.

You know, there's some interesting statistics out there; I believe you all know them. New Jersey is the second-most-expensive state in the United States for healthcare costs. We are the fourth most expensive state in terms of health insurance premiums. The current system is simply not sustainable, and the only way that we're going to address it is basically to change the model -- to move the system into more of a value-based system, which actually rewards quality.

So Senator, we believe that our intentions are very much aligned with actually trying to improve the quality of care delivered in the state, while lowering total cost of care.

SENATOR RICE: Could you put your name on the record for that long statement you gave, please -- the person making the last statement?

MR. MARINO: Yes, I am Robert Marino, Chairman and CEO of Horizon Blue Cross Blue Shield.

SENATOR ALLEN: I think you misspoke. You said you have no intention of correcting this. I don't think that's what you meant.

MR. MARINO: I honestly misspoke. (laughter)

SENATOR ALLEN: So how are you going to correct the idea that people have gotten? How will you deal with this -- both for them, and for the Tier 2 hospitals?

MR. MARINO: Well, obviously, as members elect the OMNIA product -- if they elect to choose the product-- And again, this is about choices, this is about options. OMNIA will be one of several products that Horizon continues to place in the market; we will still have all of our broad-based products in the market as well.

But for members who choose the OMNIA product, we hope that they have a different experience with us. There's going to be significant outreach to the member at the point of enrollment to explain the benefits, to explain the concept of what it is we're trying to do; explain that they still have choice and that they can continue to use that very fine quality Tier 2 hospital. It's just about choice, and it's just about incentives.

We are making a very strong commitment to be as proactive with members who elect the OMNIA product -- again, they can choose the product -- to ensure that they are adequately educated. As a matter of fact, I'm very proud to announce that we are actually adding 200 new positions at Horizon that will be dedicated to the members who select the OMNIA product.

SENATOR ALLEN: I think it is a good thing that you will be telling people who are electing a product. But what about folks now who may or may not be insured by you, but who are saying, "Oh, my gosh. This hospital is isn't as good. It's Tier 2; I want to go to a Tier 1." And I understand that part of what you're doing requires more people to go to Tier 1's, but this isn't the right way to get them to do it. So it would seem

to me that you somehow need to let people know now -- whether they're in your system or not -- that Tier 1 and Tier 2 are both good hospitals. But because you're called *Tier 2* doesn't mean that you aren't as good as Tier 1 -- unless you don't believe that.

MR. MARINO: Senator, I do share your thinking on that, and we're not suggesting by using the label *Tier 2* that one hospital's qualities are inferior to another. It was never our intent.

SENATOR ALLEN: I understand it's not your intent, but it is what has happened.

MR. MARINO: I understand that.

SENATOR ALLEN: And it's my belief that you need to fix that. And I would hope that you would come up with a plan very quickly to let people know that that's not the case -- that the impression that they have gotten from your information was incorrect.

MR. MARINO: I appreciate the concern. And as I said, we will do all we can for those members who choose the OMNIA product to properly explain to them exactly what the benefits are--

SENATOR ALLEN: So that really doesn't help those people who I'm looking to have helped. The information that is out there is-- I mean, we're trying to tell people what I believe you meant to say -- which was that it's all about an insurance, and it's not meaning anything about the hospital's care and so on.

MR. MARINO: Right.

SENATOR ALLEN: But people are getting the wrong idea. It needs to be fixed.

MR. MARINO: Senator, I appreciate the concern. Obviously, that's something that we're going to have to think about, and figure out a more effective way to explain it.

SENATOR ALLEN: I appreciate that.

MR. MARINO: So thank you for that concern.

SENATOR ALLEN: I appreciate that.

Now, when you made your original decision on your OMNIA network, there was -- was it 22? Is that the number? How many hospitals were in your original OMNIA--

MR. CONLIN: I believe the number was-- Yes, I believe that's correct -- 22.

SENATOR ALLEN: Twenty-two.

MR. CONLIN: That's correct.

SENATOR ALLEN: And so for most of the time, it was 22; and then, near the end of your process, there were quite a number that got added on.

MR. CONLIN: That's correct, yes.

SENATOR ALLEN: So why were they added on? Was it that you discovered the geographical issues were not well? Was it because hospital CEOs called you and said, "We need to be part of this, or else?" How did those in the last group come in?

MR. CONLIN: It was really a two-step process. The first was the process of developing these alliances -- what we're calling the *OMNIA Health Alliance partnerships*. We didn't expect, when we began the process, that we were going to have full geographic coverage across the entire state of the organizations that met the criteria, or scored highly on those criteria.

So as we got far enough along in our conversations with those partners, we then needed to consider how to make sure that we had Tier 1 facilities throughout the state to meet the geographic access requirements that DOBI and CMS have of an insurance company, if you're going to market a product across the entire state.

And once we considered that, that's when we went -- we identified those facilities and went back and approached them about their coming in as a Tier 1.

SENATOR ALLEN: So there were no hospitals whose initial contact wasn't you speaking to them about joining, but about them saying, "We want to be part of this."

MR. CONLIN: My recollection is, that we approached each of those also -- that they did not approach us. That was your question, wasn't it, Senator?

SENATOR ALLEN: It really is, because that was not my understanding. My understanding was that near the very end, there were a number of hospitals that heard about this coming, and had not been contacted, and were concerned and wanted to be part of it. But that's not your understanding?

MR. CONLIN: That is not--

SENATOR ALLEN: Nobody contacted you and said, "We need to be part of this?"

MR. CONLIN: Well, Senator, we did have organizations contact us -- so let me be clear about that. But I was answering your first question -- at least what I understood was your first question -- which was, was our process to contact the non-OMNIA Alliance partners who were in

Tier 1? And that is in fact how we proceeded. We contacted them. Along the way, we were contacted by others asking if they could be in Tier 1.

SENATOR ALLEN: And some were turned down?

MR. CONLIN: I believe all -- I believe all were turned down.

SENATOR ALLEN: How late in the process did you bring those other 12 into this plan?

MR. CONLIN: I'm going to have to give you an approximate date. It seems like we started that process in the late spring of this year.

SENATOR ALLEN: I would like you to go back and just speak one more time on the care issue again, because it is a concern of mine. The care does not seem to be the number one-- In particular, when you are saying to me that you're going to have-- Well, let's just go back to that for a moment. How important was the care that each hospital gives?

DR. PATEL: So as part of the process, quality was one of the most important inputs into the process. And again, looking at objective measures that CMS has provided -- both for hospitals and some on the physicians' side -- to determine what was the level of performance for each institution. And I can tell you the hardest part of this is that, as I said earlier, most of the institutions in the state provide quality care. So the decision making around what goes on in an acute care facility -- in the walls of an acute care facility -- which today, unfortunately, is how quality is measured, was in fact something that served as an input but not, frankly, the differentiator.

The question, then, we had to ask is, if we go back to the objective of the Alliance, the objective of the whole program -- which is how to get the best quality care at the lowest cost of care, with the best member

experience consistent with the Triple Aim -- we had to look at prevention, keeping patients healthy. And that involved looking at not a hospital by itself, but how it integrated within a system, how it integrated with its physicians, how it integrated with other aspects of the overall care continuum.

So really, that really was the focus of deciding who the OMNIA Alliance partners were.

SENATOR RICE: Did you put your name on the record?

DR. PATEL: Sure. Dr. Patel.

SENATOR RICE: Through the Chair, this is a legislative Committee. This is not local government. And you seem to be making a lot of money, because you're very intelligent people. So we shouldn't have to repeat ourselves: When you speak, please start off by identifying who you are, okay? And I'm not trying to be arrogant; I'm just trying to keep (indiscernible).

MR. CONLIN: We respect that.

SENATOR ALLEN: All right. I have another question.

It was said earlier that when a hospital came into the partnership, they had to agree to cut rates and then, in return, they would get an increase in volume. And then later it was said, we expect that they will have a bigger decrease in volume than the Tier 2. Help me understand how they can exist together.

DR. PATEL: Let me clarify. So the volume of membership is taken care of by a system; it would go up in this type of relationship. But ultimately we would expect the inpatient volume for our OMNIA Alliance partners actually to go down if we're successful in meeting our objectives

of taking care of patients and keeping them healthy. Then the impacts to the volume that goes to Tier I facilities needs to go down, and we expect it to go down.

SENATOR ALLEN: So it's the number of people who are seeing their doctors that increases.

DR. PATEL: We would expect that to be the case.

MR. MARINO: Yes, that's exactly right, Senator.

SENATOR ALLEN: I have other questions, but I don't want to take everybody's time forever.

SENATOR VITALE: We can come back and forth, Senator.

SENATOR ALLEN: Let me pass it on.

SENATOR VITALE: Senator Lesniak.

SENATOR LESNIAK: Thank you, Mr. Chairman.

I have some very, very serious concerns about what you're proposing. First of all, I strongly support what you are attempting to do with regard to value-based care. But it's pretty apparent that your definition of *value* is discriminatory. It's discriminatory against communities like Elizabeth that have a high percentage of low-income families, of minority families, of families whose first language is not English -- which make it more difficult. Oh, and as Senator Codey pointed out, most importantly, who have infirmities attached to other injuries, or treatment that's necessary; that adds to the difficulty and the cost in serving those communities.

Now, Senator Gill pointed out -- we don't know what those factors were. But I'm certain you do not factor that into it; I'd bet on it. So that's a real concern of mine that your definition of value discriminates

against the fourth-largest city in the state; and there are others similarly situated that have large percentages of low-income and minority families.

The other problem I have is that I don't believe your unintended consequences are unintended at all. There's no doubt that this is-- Oh, and by the way, even the prevention aspect -- the cost of prevention is more difficult in minority, low-income families. You cannot use the same criteria for higher income folks and better educated folks. We know that; that's what-- Our hospitals have a high percentage of charity care that we have to deal with. To put an additional squeeze on them by taking volume from them-- And your model will not succeed unless you do take volume from them. Sure, you say, well, you're going to decrease the volume in other ways; but you're still taking volume out of hospitals that are struggling to begin with because of their charity care, because of their increased costs.

I would suggest -- and I'm just going to make a statement, I don't have a question -- certainly that we see the criteria for your definition of how you evaluated what value is. But secondly, that you scrap what you're doing and have another value-based system that does not discriminate against low-income communities, high percentage of minority communities -- for factors that I just outlined.

That's all I have to say, Chairman.

SENATOR VITALE: Thank you.

Senator Singer.

SENATOR SINGER: Thank you, Mr. Chairman.

First of all, help me understand some things to make sure it's totally clear. Medicaid and Medicare are not affected by this whatsoever, correct?

MR. MARINO: That is correct, Senator. This is a commercial product only.

SENATOR SINGER: And help me understand: Presently, right now, with all your over 3 million patients, not every doctor in the state is part of your network, correct?

MR. MARINO: That is correct.

SENATOR SINGER: And that, therefore -- and I know, because I've had doctors call and say they can't get in the network -- that you limit that because to get the price you want to get from doctors, you limit that network and say, "Listen, we're going to give you more volume; we want a better price." Is that not something that's done by insurance companies all around the state and around the country?

MR. CONLIN: Senator, yes -- but we have 86 percent of all the practicing physicians in the state who've agreed--

SENATOR SINGER: Correct, but not 100 percent. And correct me if I'm wrong, because I get other insurance carriers that don't have as many as you have. And people call me and say, "How can I get in that network?" and they tell me the network is closed. Is that not happening in certain cases? If you have, in an area, enough orthopedic people, you don't put more orthopedic people in. Is that not correct?

MR. CONLIN: It is correct. I will tell you that that occurrence is relatively rare.

SENATOR SINGER: And let me help understand something. This is a product -- not your major product; this is just a product of many products, correct?

MR. MARINO: Senator, we offer a broad portfolio of products. We continue and will continue to offer those products. This is just one new product, one additional choice.

SENATOR SINGER: So in essence, most of the people we're talking about, unless they work for a small employer, might never see this product.

MR. MARINO: That is correct. As a matter of fact, we're estimating that of the 250,000 members who will select the product next year, 72 percent are individual consumers who pay their monthly premium; and the other is the small employer who, if you're a small employer, probably you're employees are paying 50 percent of the premium and then they're paying a high deductible on top of that.

SENATOR SINGER: The other question I wanted to understand is, Senator Vitale-- A little bit of a statement: Senator Vitale, a couple of years ago we had seen a study about hospitals in the state -- it was touted as an excellent study -- that really looked at safety in hospitals and the fact that we are over-bedded in the state. And of course, that study, like most studies, went on the shelf. But the realization is, with less beds being needed there is going to be cutbacks in the physical necessity for large hospitals in the state. Is that not a perspective that you see also, as someone involved in this issue?

MR. MARINO: Well, certainly if you were to look back over time, there's clearly a migration of what was formerly inpatient services, to an outpatient setting, to an ambulatory setting, to a doctor's office setting.

My own observation and my own opinion is that as technology improves and as technology advances, we're going to continue to see a migration outward, of inpatient services, to ambulatory, doctor's office and, ultimately, the home. For example, one of the latest technologies advents in healthcare delivery is the virtual doctor office visit. And that is something that we think will continue to grow.

SENATOR SINGER: Just one more statement, and then I'll be finished, Mr. Chairman. I appreciate your indulgence.

You know, I'm on the Advisory Board of a hospital that does rehab -- a rehab facility. Right now, we're involved in a study with Medicare; and the study is both with doctors and nursing homes. And the Federal government limited the nursing homes we could use in that criteria by a certain criteria they had. And they said, "These are the only nursing homes in the area we'll allow you to partner with because they meet our criteria."

So right now, the Federal government is doing, really, what you're talking about doing now. They limited who can be done, they want to see partnerships, and the ultimate goal is the better care of the patient. Is that not the overall goal we're talking about?

MR. CONLIN: You're absolutely correct. In fact, an announcement earlier this year from CMS -- which oversees the Medicare and Medicaid program -- indicated by the year 2018, 50 percent of all their

payments will be based on a model very similar to what we're attempting to build with OMNIA.

SENATOR SINGER: Thank you, Mr. Chairman.

SENATOR GILL: Thank you.

Senator Gordon.

SENATOR GORDON: Yes; thank you, Madam Chair.

Many of the comments I wanted to make have already been made. But let me just make a couple of observations.

Like the rest of my colleagues, I'm very concerned about the way this process unfolded and the lack of transparency. All of us, I'm sure, being -- are hearing from hospitals in our districts or nearby that did not make the Tier 1 cut, and have serious questions about the criteria that were used. Some of the metrics that have been mentioned today -- the first time I certainly heard anything. Cynical people might think that Horizon decided on who was going to be on the team, and then reverse-engineered their way through their set of criteria to get there.

I want to echo the comments by a number of colleagues about the reputational damage done to some really fine institutions that did not make the Tier 1 list. In my local papers, I'm seeing full-page ads being taken out by one of the institutions in my area pointing out that they're a quality institution. I'm sure they're not doing that because that was part of a planned advertising campaign.

I have concerns about whether this program is anti-competitive. I don't profess to have a legal knowledge of what Federal antitrust and price-fixing laws are about, but this certainly does not seem to be promoting competition.

I would point out that there is serious potential impact on the state, and hence, I think it is -- we're very justified in having this hearing. The Tier 2 hospitals represent 55,000 jobs in this state. They have issued \$3 billion in tax-exempt debt through the Health Care Financing Authority (*sic*). And if those institutions should fail, I'm concerned that the state taxpayers are going to be on the hook, as they were when Saint Michael's Hospital was not able to service its \$230 million in debt.

What troubles me most is just the way this process unfolded. We're hearing from those who are arguing about the quality criteria that were used. As Senator Allen mentioned, the Leapfrog safety data -- I understand that that's only one component of quality. But if you look at those data, in the Tier 2's, 60 percent are graded *A*; and in the Tier 1's, two-thirds are graded *B* or below.

You cite the CMS data that you're using. I just think we should have had this conversation months ago. We should have agreed on a set of criteria -- at least discussed it, debated it in an open fashion -- and then you can start putting the numbers in the spreadsheets and reaching some conclusions. I think there would've been a lot more confidence in the process, had you done that.

I just want to add my voice about the troublesome way this was implemented and the potential impact it will have.

Thank you, Mr. Chair.

SENATOR VITALE: Thank you, Senator. That was well put.

Senator Cardinale.

SENATOR CARDINALE: Thank you, Mr. Chairman.

I believe in the beginning of your testimony, you indicated that your plan is not unlike the plans of some of your competitors. Did I hear that correctly? Are there competitors in New Jersey who have similar plans?

MR. MARINO: Yes, Senator, you did hear that correctly. We do have competitors in New Jersey who currently have products similar to OMNIA in a tiered network structure in the market.

SENATOR CARDINALE: Could you tell me if, in those tiered plans, there are any hospitals which you have rated as Tier 2, who are rated as Tier 1 in some of those other plans?

MR. CONLIN: Yes, in fact many of the hospitals that we have in the Tier 2 category are in Tier 1 in the tiered products of a couple of our competitors.

SENATOR CARDINALE: And do you have any rated as Tier 1 who are, in any of your competitor's plan's, Tier 2 hospitals?

MR. CONLIN: Senator, your question is, are any of our (*sic*) Tier 2 in our competitor's--

SENATOR CARDINALE: Yes.

MR. CONLIN: Yes, that is the case.

SENATOR CARDINALE: So this is like -- we deal with auto insurance a lot in our Committee. And the auto insurers in New Jersey have been permitted, since the McGreevey Administration, to have their own rating criteria, which has provided a degree of competition. It appears to me that this kind of rating competition -- developing your own criteria -- is an introduction of some degree of additional competition into our system.

And I would applaud the objective of bringing additional competition. Because what it has done for auto insurance has been very beneficial in New Jersey. It has made access and affordability much greater options for our residents.

It appears to me that this arrangement is a typical managed care arrangement. It's an arrangement where you've tried to develop criteria where you can offer a product at lower cost; and as we've all heard, around the table, that's a very desirable outcome for New Jersey if it can be achieved over a long period of time.

In formulating these plans, I believe there are a number of administrative agencies with whom you have had to consult or review -- reviewed what you intend to do. Did that process go on? When did it begin, and how long did it go on?

MR. MARINO: Yes, Senator. There is a regulatory process which we are required to follow with respect to the federally facilitated marketplace. The OMNIA product had to be approved by the Centers for Medicaid (*sic*) and Medicaid Services. And I am not certain of the timeframe on that; perhaps one of my colleagues can answer that.

And then, secondarily, the product also had to be approved from a network adequacy perspective by the Department of Banking and Insurance.

SENATOR CARDINALE: And you submitted all of those? And in the course of those submissions, were there material changes to your plan that were made as a result of the recommendation of those administrative agencies?

MR. MARINO: I believe as a result of the Department of Banking and Insurance review, as we indicated, there were adjustments made for obstetrical services in Burlington County.

SENATOR CARDINALE: And--

MR. MARINO: And, excuse me -- and Mercer County as well.

SENATOR CARDINALE: And you made those changes?

MR. MARINO: Yes, we have agreed to make those changes.

SENATOR CARDINALE: And did you uniformly apply the criteria that you used to the various hospitals in particular that you were evaluating as Tier 1? In other words, did you maybe get a little lax in one area, and a little more strict in another area?

MR. MARINO: Senator, the criteria that we used -- we uniformly applied them to every hospital in which we made an evaluation and determination. To ensure our objectivity, we also brought in an independent, third-party management consulting firm to work with us in the development of the criteria and in the administration of the evaluation.

SENATOR CARDINALE: Then that gives rise to another question. Originally, you had 22 -- I believe that was in testimony here -- that were coming in; and then you added some more. What was the motivation -- what induced you to add some additional, beyond the 22?

MR. CONLIN: What induced us was the fact that there were geographic areas of the state where we did not have a Tier 1 facility. We wanted to actually -- and our whole goal of this was to respond to the needs of our commercial members. And we realized that we did not have adequate coverage in certain parts of the state. That was the driving force for our going back and contracting in those areas.

SENATOR CARDINALE: So would it be fair to say that you loosened up a little bit on your evaluation of categorizing hospitals as Tier I because of some geographic considerations?

MR. CONLIN: I would say it differently. I don't know that there was a *loosening up*, as much as the fact that we were not attempting to use the same evaluative criteria for the partnerships that we did for the build-out of the rest of our network. In that case, we did look at geography; we looked at range of services provided; and we looked at what our customers were telling us with regard to their preference for facilities in those areas. So it was on those three bases that we made determinations on the non-partner Tier I hospitals.

SENATOR CARDINALE: Well, I want to thank you for coming here and helping to clarify this. I want to echo the comments, that I've heard from so many of my colleagues, that it's unfortunate that there has been an aura around this that has come up, to where many people feel that there was something done with less public transparencies than there should have been. And I hope that this hearing will help to clarify some of that.

And I want to also thank you for having attempted to clarify that, at least to me, by having some of your folks come to my office and explain this plan in a good deal of detail. Doctor, I thank you very much for having been there.

DR. PATEL: It's my pleasure.

SENATOR CARDINALE: I have no further questions, Mr. Chairman.

SENATOR VITALE: Thank you, Senator Cardinale.

Senator Whelan -- or Rice.

SENATOR GILL: Senator Rice.

SENATOR WHELAN: Thank you, Mr. Chairman, Madam Chairman.

Like all my colleagues here, we're concerned about this Tier 1, Tier 2 issue. And following what Senator Cardinale talked about -- models elsewhere -- I mean, there are models elsewhere -- they're not just in New Jersey, but around the country -- that are similar to this.

MR. MARINO: That is correct, Senator. The concept of *tiered* or *narrow* networks is not a new concept; it's a concept that got further fuel, if you will, when the Affordable Care Act was introduced in order to respond to consumer needs.

DR. PATEL: To also build on Bob's comment is that, really, every hospital in the state provides a tiered network as part of its own benefit plan for its own employees. And that's been going on for decades, at this point.

SENATOR WHELAN: Let me ask, the current Tier 2 hospitals-- Well, let's back up. The Tier 1 hospitals -- or your agreements are with Tier 1 or Tier 2 -- I assume they have a term: three years, five years, whatever it may be.

MR. CONLIN: Yes, it's different, depending on whether it's an Alliance partner versus a non-Alliance partner that's, nonetheless, in Tier 1.

SENATOR WHELAN: So as that term comes to an end for a particular group of hospitals -- whether it's the partners or just the Tier 1's -- is that when the opportunity might be there for a Tier 2 to move into Tier 1, or to expand the number, or how would that work?

MR. MARINO: Senator, as we always do, we always evaluate, on an ongoing basis, the competitive environment, what our customers are telling us, the changing landscape of healthcare delivery. And as we always do, we will make adjustments -- whether it's in the product or the network -- based on what is going on in the external environment.

SENATOR WHELAN: Okay. So just so we're clear. When we say *make adjustments*, the possibility is there that a Tier 2 could become a Tier 1.

MR. MARINO: The possibility is there.

SENATOR WHELAN: Okay. Now, let me switch my focus here a little bit, because we've spent a lot of time, collectively, on this Tier 1, Tier 2. And I think what has certainly been glossed over -- it hasn't been completely forgotten -- is the potential cost-savings to consumers. So if a small business owner is out there, how much does he save, how much-- Let's start with the small business. What happens when a small business owner with 100 employees, providing health care through Horizon, switches over to OMNIA?

MR. MARINO: On average, that employer could expect to see a 15 percent reduction in their annual premium -- and that's the first thing that they'll see. The second thing that that employer will see, or their employees of that small employer will see, is the opportunity, if they chose, to have lower out-of-pocket payments in the form of a deductible, co-insurance, or co-payment if they select -- if they chose a Tier 1 provider.

If they don't choose a Tier 1 provider and continue to access the broad network of Horizon, their deductible, their co-insurance, and their co-pays will look pretty much like they look today. So there's no

added level of deductible, co-pay, or co-insurance if one chooses to use a Tier 2 provider.

SENATOR WHELAN: So from the individual patient's perspective, the employer signs up for OMNIA, but he, or she, or the group, the family -- they like the Tier 2 hospital. If they stay at that, their costs are going to be about the same?

MR. MARINO: Well, they're going to-- The first thing that that employee's family -- or that small employer would realize is that the employee contribution that the employee makes towards the health care will be less, because the overall premium being charged to the group is 15 percent less.

SENATOR WHELAN: Okay.

MR. MARINO: So the payroll deduction for the employee should be less; that's number one. And then number two, if the employee chooses to use a Tier 1 provider, they have an opportunity to save out-of-pocket because the deductibles, co-insurance, etc. will be less.

SENATOR WHELAN: But let's assume they choose the Tier 2 provider. They still get a low payment on the premium, and their co-pays, if you will, will be approximately what they are now?

MR. MARINO: That's correct, Senator.

DR. PATEL: Let me just clarify, Senator. The co-pay is just slightly higher than what they are in Tier 1; net-net, based upon the reduction in premium and their co-pays -- they're the same as they would be in a broad-access product that they have today.

SENATOR WHELAN: Okay. Thank you, Madam Chair -- I guess Co-Chairs -- whoever. (laughter)

This is obviously a tough issue and, you know, again I can only echo what some others have said -- starting with Senator Codey -- about the impression that the Tier 2s are somehow losers in this, or lesser hospitals, and so on. So whatever we can do, collectively, obviously -- Horizon primarily -- to change that would be helpful. But again, I think that we need -- we shouldn't just gloss over the fact that there are significant savings for potential customers, including small business operators who complain all the time about the cost of doing business in New Jersey -- whether it's taxes, or healthcare costs, etc. So if you can save them 15 percent, it's something that certainly has to be part of the discussion.

Thank you.

SENATOR VITALE: Senator Addiego.

SENATOR ADDIEGO: Thank you, Chair.

First of all, I'm just going to echo the fact that we all agree that we need to lower healthcare costs in the State of New Jersey. I don't think that's a question.

However, I'm one of the representatives for this big, empty spot here (indicates map). And my concern is adequate access to care, which includes cost. So I want to go back to just -- real quickly, because some of the terms I'm just learning -- like *Leapfrog*. Is that a national organization?

DR. PATEL: Yes, it is.

SENATOR ADDIEGO: Is it respected?

DR. PATEL: Yes, it is.

SENATOR ADDIEGO: Okay. And I think somebody testified that it primarily addresses safety.

DR. PATEL: Yes, it does.

SENATOR ADDIEGO: So when you were going through the criteria early on -- when your CEO was going through the criteria, I didn't get them all down, but I got some of them down. And I would think, certainly, safety talks to quality. I would also think that safety would also speak to clinical standards. And I would also think that consumers would prefer a high safety rating.

So that being said, I would think that, certainly, that could be taken in consideration. Thank God for smart friends, huh? I was able to get some information about the standard you did use -- or the matrix, I guess you did use. I'm sorry if I'm not using the correct term -- CMS?

DR. PATEL: Correct.

SENATOR ADDIEGO: Okay. Now, again, I'm talking about-- Because I have to be concerned about my District, which doesn't only include Burlington County, but most of it -- or a lot of it, along with Senator Allen. And my understanding is that a couple of my systems in my District and in Burlington County actually scored significantly higher than anyone else in South Jersey on the outcome measures under CMS.

DR. PATEL: So again, I come back to the comment I made earlier -- that when you look at the quality metrics on any institution stand-alone, we have great hospitals in the state, including those that we've not included as part of OMNIA Alliance. And if that were the only metric we used, then we would have the network that we have today in all of our broad-access products.

I come back to the notion that this is not about the quality of care in a given institution; it's about, again, consistently being able to deliver on the value of the Triple Aim in health care -- which is quality, cost,

and member experience. And there is no metric today that we can define that's objective on those three dimensions, which is part of the challenge. In fact, one of the things that I would ask Leapfrog, and what I would ask the New Jersey Health Care Quality Institute and other policy organizations, is to develop that metric so that other organizations don't have to be in front of a Committee like this.

So directly to your point, again, every hospital in our network has a level of quality that we're proud of -- including the ones that you're referencing today -- on the CMS metrics that we used.

SENATOR ADDIEGO: So keeping what my concern is in mind -- number one, access -- you've testified that my residents would be within 14 miles of, I believe it was, a Tier 1 hospital. However, you obviously haven't been to Shamong (laughter), which is 32 miles from any -- 32 to 35 miles, depending on the three closest systems in Tier 1.

DR. PATEL: So Senator, if I can clarify.

So the average is 14.7 miles; which means there is a range that you're referencing to, which is part of that as well. So low and up.

SENATOR ADDIEGO: Don't you think 32 miles, 35 miles is unfair to the residents of Burlington County and the 8th District?

DR. PATEL: I've answered this question in two ways: First, because it's a choice that we're offering in the marketplace, if they're really satisfied with their care they're getting in their Tier 2 facilities, we have lots of products they can purchase from us that will continue to give them access to those facilities -- just like they have today. So that doesn't change.

SENATOR ADDIEGO: So if you're in Tier 2, you're still in network, is that correct?

DR. PATEL: Absolutely.

SENATOR ADDIEGO: So when somebody is faced with all these choices -- which, again, is my concern; that you have a consumer who is being faced-- We get these books with all this-- It's very confusing. So they're going to see that the sixth-largest system in the state is in network; however, it's in Tier 2. Do they understand what *Tier 2* means? Does that-- Now, I thank you for expanding obstetrics to Burlington County, but what about a cancer patient?

DR. PATEL: If I could expand on what Bob said earlier. Number one, if they decide that they want to continue at the Tier 2 facility, they have the broad-access product they can purchase. If they decide to join the OMNIA health plans, one, they're going to pay lower out-of-pocket in their monthly premium. And then if they continue to use the Tier 2 provider, because that's the hospital or the physician that they want to go to, they are no worse off than they are today in that broad-access product. So what we have actually done is introduced a cheaper -- or a less expensive option if they decide to go to Tier 1, and taking nothing away for the individual who purchases OMNIA who still wants to use Tier 2.

SENATOR ADDIEGO: So I am somebody who has cancer, and just put me as a resident of Burlington County who has chosen this. And my doctors are in one of the systems that's in Tier 2. And the hospital that is closest to my home and my family is in Tier 2. My understanding is, if I choose to go to the Tier 2 hospital, I'm going to be paying a 20 percent co-insurance -- but I wouldn't be paying if I went to a Tier 1 hospital -- to a maximum, as a single person, of \$4,500, or family-- And that means if I'm

in the family plan, whether it's just me getting treatment, I'm on the hook for \$9,000.

DR. PATEL: Senator, you're referencing the benefits that are available to the State Health Benefits Plan, which is not reflective of the benefits that we are launching in our insured products. We are not yet releasing those details for reasons that -- based on CMS' requirements. Over the next, I would say, handful of days we'll be releasing those benefits that will become transparent.

So strictly speaking, on the State Health Benefits, they decide what the benefit differentials they want as part of the plan. It is not a reflection of what the overall product offering is for the broader market.

SENATOR ADDIEGO: Okay. Just so you understand, my concern here is, number one, access and the financial impact of working, middle-class families. And what is this-- Again, if I have to make the choice between driving 32-- Do I have to make that choice between driving 32 miles, and my family, to go to a Tier 1 hospital? Which again, I do agree with Senator Allen -- it creates a stigma on the Tier 2 hospitals and doctors. In order to save money, I may be forced to do that in order to financially not be harmed.

So again, I'm going to go back to the fact that I appreciate the fact that you've extend obstetrics into Burlington County -- which tells me that you are willing to make changes to this, to what you have out there. So what I'm going to ask you is, are you willing to make further changes?

MR. MARINO: Senator, we certainly will evaluate not only the product, but the network adequacy-- We will certainly evaluate as the

market conditions change, and make changes accordingly -- as well as what our customers are telling us.

SENATOR ADDIEGO: So do I have to wait three years for that?

MR. MARINO: Senator, no.

SENATOR ADDIEGO: Can you make change-- Because obviously you can make change right now; you said you could. I mean, you have done it, and again I appreciate that. I just want you to-- Again, looking at this big blank spot, and understanding that I have constituents who are 32 to 35 miles away from the nearest Tier I hospital. So again, I thank you for the obstetrics. I mean, if I'm having a baby I really don't want to have to drive 35 miles to get to the hospital. But a cancer patient -- I'm asking you on behalf of my residents to please talk to the fine-- I have some fine systems that are in Burlington County and the 8th District that service them. I'm asking you to please reach out to them. Because I believe, in all honesty, that they fulfill your criteria. Or perhaps you should, maybe, take another look at that.

Thank you.

SENATOR VITALE: Senator Rice.

Thank you for your patience, Senator.

SENATOR RICE: Thank you, Mr. Chairman

SENATOR GORDON: Could you identify yourself, please?

(laughter)

SENATOR RICE: Yes, I was going to do just that. I take that seriously when we have transcripts. You never know when we're going to need them. Many of you don't like to identify yourselves; I've noticed that.

First of all, Mr. Marino, thanks for coming down.

I think a lot was said, and asked, and talked about; and I too have the same concerns. And I think being how the corporate headquarters is in the City of Newark, you know my hue and cry never changes.

Unfortunately, you know, we receive all this information from various entities and organizations, labor unions, etc.; even my colleagues. I'm in a union, and they talk about the apple pie and motherhood stuff. I don't think there's a member here or anyone in the state who doesn't recognize the need to reduce health care costs -- particularly for those who are poor and don't make the kinds of incomes that union workers make, etc.

And so I think that's very important. So I'm glad Senator Lesniak raised the issue and began to raise it, and I'm glad Senator Turner came in to talk about Trenton. Because there are some of us who represent the wealthiest people in the State of New Jersey, and the poor simultaneously, and the middle class. That's what we represent. Many of those individuals are members of the New Jersey Legislative Black Caucus. So we kind of get it.

But we also know that every time, regardless of what party it is, when it comes down to the State, and it comes down to arguing a case, there's this whole articulation publicly about the middle class. And it annoys me because it seems as though no one talks for those who are not middle class anymore. Maybe when they go into an election, as an elected official, or in the community with the poor people, then there's no shame in using the words *those who have the least*.

But when it comes to this kind of thing, it seems like when the media is around, everybody -- Republicans, Democrats, corporate America, organized labor -- talk about the middle class; how we have to grow it, how we have to protect it.

I concur with that. But someone has to be a voice for the voiceless. And that's the role of some of us in here -- and particularly myself as Chairman of the Legislative Black Caucus, who represents a very diverse community, economically diverse as well as racially.

And so this whole talk about the incredibly high cost -- we get that. A lot of people here don't get it, because if that was the case -- we were concerned about high cost, then we would have passed, and the Governor would have signed, the health care exchange for the Affordable Care Act. Now, I'm not even sure if there's a relationship between what you're trying to do and the Affordable Care Act; and whether there is a relationship, whether it is going to hurt or help us long-term -- because it appears as though you are experimenting as well.

But in all these conversations, and all the hospitals that have closed -- and I think Senator Addiego is moving in the right direction. Because I'm told, also, that when it comes to poor people -- those who are not middle class wage earners or wage earners like the unions have, who most of them are middle class, particularly in certain areas -- and the non-union workers, the question is, what happens on the front end? Because there's this talk about how the Alliance is attempting to lower costs by working with hospitals and doctors to improve the quality of care we receive. And we need to collaborate on this type of relationship. And that's coming from a union person, okay? But they don't talk about poor people

and who's collaborate on behalf of poor people. Some doctors may very well collaborate on behalf of poor people; but they wouldn't collaborate on how they're going to pay their college tuition, and bills, and stuff like that. They keep coming up with more money or better reimbursement rates. Corporate America -- you're sure not going to argue that case; your stockholders are not going to allow you to do it.

And so the question is, where are we at the table on this? When there was conversation before-- This Alliance goes back at least two years of conversations, if I heard you correctly. Then it means that you had to reach out to some of these folks. Everybody forgets, though -- we did a merger on hospitals and institutions in this state. And some of those are directly related and indirectly related to this whole concept of Alliance. The Barnabas system is part of the Alliance. I don't see University Hospital at all on the paper. I don't even know what it is. It's a Trauma I hospital. And my understanding -- and this goes back to Senator Addiego's issue -- is that some folks are going to be pushed into Beth Israel, which is going to do harm to University Hospital in many ways, as well as other healthcare components.

And then some people who are going to University on the front end may wind up having to pay more, but they can't pay -- substantially more, depending on what it is they are going there for.

Can you address that? Were there any conversations about University Hospital? And if so, what were those conversations about the issues that may impact that institution and the people who work there, and the people who get services there?

MR. CONLIN: Several points of response to your question.

We share your concern about the working class. I will tell you that that was one of the main drivers in the development of this product. Bob mentioned, in his opening comments, that at the very beginning of this whole process we were very engaged in listening to our members. And our members include those who are the working class -- the working poor, if you will -- many of whom are in urban environments.

And as we did our focus groups to understand what their perspective was with regard to health insurance coverage in the state, and the affordability of that, their voice was very definitely included in that process.

Secondly, because of the cost that we've been able to reduce through this activity, there will be 40,000 New Jerseyans, effective January 1 of this coming year, who will be able to afford coverage through the exchange -- usually with subsidies -- that today cannot afford it. So we believe that that's a significant step in the direction of addressing the affordability for working families as we do move forward.

To your question, sir, about University Hospital -- and have we had conversations with them. Again, during the process itself, we did not have conversations with any organizations prior to our finishing our evaluation process. Once we did, we did have conversations with those organizations. University Hospital was not one that we found necessary to speak with; as you stated, Newark Beth Israel is a Tier 1 facility that we think provides solid coverage and access for the residents of Newark.

SENATOR RICE: Through the Chair. So what you are saying to me is because of the *destrip*, if you will, in reputation of the Barnabas system, with Newark Beth Israel; and the recent collaboration and coming

together of Robert Wood Johnson -- that the State institutions, they had a real problem when we did this merger. I knew this was coming this way. And the people who will still be using that facility -- if it stays in existence the way that it is going right now -- they were non-players. You don't care about that. And that's the problem I'm having, because you don't care about Trauma I institutions, such as University, so you feel you don't need to talk to them.

That's real problematic with me. That's like saying that you don't need to talk to some legislators, because we can't talk to others because we're not Committee chairs, or we're not the Speaker, or the President. I have a real problem with that scenario, and that kind of mindset and thinking of any corporation, not just yours. And that's how poor people and the low-income people, number one, get harmed and, in many cases, get discriminated against. Because you mentioned that there was some conversation about the working poor and the poor people. Well, who was our spokesperson inside there? Tell me, who raised that, who dissected that, who analyzed that on behalf of working people, poor people, immigrants, people of color in these urban cities? Tell me, who was the voice? I'd like to know who was that voice at the table. Because according to Assemblyman Giblin -- because he's not just an Assemblyman -- of Local 68, is that doctors and hospitals need to come together. He didn't say anything about doctors, and hospitals, and elected officials who represent the poor; or some organization, nonprofit that represents the poor people. Tell me, who represented us?

MR. MARINO: Senator, as Kevin was indicating, we've done extensive market research on the OMNIA product and who the potential customers would be. And we've identified--

SENATOR RICE: Excuse me, I don't mean to be rude. I'm like Senator Gill now; I want my question answered. (laughter)

See, research doesn't speak to me, because research is man-made, and I know how to do research, and I've done research, and I know how to analyze it. And some of the data is faulty. So I need to know who had verbal, at-the-table, conversations representing-- Let me put another perspective for you -- black people who look like me, Latinos, women, and other immigrants and ethnic populations who live in rural communities, who live in urban cities like mine, like Trenton -- there is no Tier 1 in Trenton. So I would like to know who those people are.

And I don't-- I get passionate about this stuff, and that's why it's difficult sometimes, at my age, to sit in some of these committee meetings. Because I want to be professional, but I'm starting to get pissed and angry, etc, because you feel you're going to do what you want to do anyway. And that may be problematic because it may not go to where you think.

So can you tell me, who was at the table?

SENATOR LESNIAK: Senator, there is no Tier 1 in Elizabeth either. I just want to point that out.

SENATOR RICE: I beg your pardon?

SENATOR LESNIAK: There is no Tier 1 in Elizabeth, the fourth-largest city.

SENATOR RICE: I know; we raised that before. Yes -- and a couple of other places.

DR. PATEL: At the risk of sounding passionate myself, I was brought to this country with my parents -- at the age of 7 -- who were also poor immigrants. My father worked and scraped barnacles off of ships in Hoboken--

SENATOR RICE: Did you speak for us? You're the one who spoke for us?

DR. PATEL: I am part of the team here, as part of an organization that is committed to the State of New Jersey. We have 5,000 employees who look like us -- look like the plethora of people sitting around this table.

SENATOR RICE: Mr. Chair.

Excuse me, I didn't mean to cut off.

Through the Chair, I want an answer to my question. I want to know who were our spokespersons at the table. Give me names, give me organizational names, give me leadership names. I know that you spoke to Barnabas -- you had to speak to somebody at the top. You spoke to the other Alliance people -- you had to speak to somebody at the top. You spoke to the doctors -- you had to speak directly to the doctors, not the subordinates. Who spoke for everyday people who we represent? Just tell me no one, if it was just concluded from the data; I'll accept that. Because it's clear to me when you talk transparency and accountability, the issue is not saving money. It's about accountability, transparency, equitable opportunities, if you will, okay? And the thing is, to have input you don't have a monopoly on brains. I know probably more about my people, along

with other people from my ethnic group and my city, than most people here. And they know more about most people in the rural community than I do, etc. So we have to have voices there. Do you understand where I'm coming from? You can't rely on simple data.

So just tell me no one did.

DR. PATEL: Senator, we live in the communities that we serve. It's one of our advantages of being in this marketplace. We understand not just our neighbors and friends, but people who we go to church and temple with, what their needs are. And that goes into our decision making.

And frankly, I would say that that is somewhat different than some of the for-profit competitors that we compete with that are not based in the state. So I respect your question wholeheartedly as a person who grew up in this great state, in an urban environment. Advocating for the underserved is a core part of who we are.

SENATOR RICE: You mentioned the fact that 40,000 people-- There are actually more people out there who are uninsured -- we know that -- just trying to get health care exchanges. But there are 40,000 who you allege will be able -- it doesn't say they will get it -- but they will be able to get coverage that's cheaper, if you will. And I guess the question, number one, is, at what cost? And number two, how did you identify these 40,000, and do you have a breakdown from an ethnic and gender perspective, as well as a geographic perspective?

MR. MARINO: Senator, the 40,000 were identified from extensive consumer research focus groups talking to people throughout the state. With respect to the demographic breakdown: 65 percent of those

40,000 who we expect to become insured through the OMNIA product are African American; 20 percent are Hispanic; 85 percent come from urban areas; 98 percent of them have family incomes below \$40,000 a year. So we really think, with the OMNIA product, we are being responsive to the consumer segment and being responsive to many of the concerns that you've raised, sir.

SENATOR RICE: Okay. Can you share that information? Do we have that, through the Chair?

MR. MARINO: I would be happy to share the market research that we did, and share these demographics.

SENATOR RICE: And don't forget the research. And yes, the demographics are important, because we need to look at that because we may want to go back and redo that market research for you. That's why you need to slow this thing down -- so that we can take a better look, since you don't have the transparency and accountability. We might have to take it, that's for sure, okay?

I'm going to-- There are a couple of more questions, and then I'm going to leave this alone for now.

Number one, there seems to be a transportation issue involved with this -- contrary to what you say about someone running down the street in a couple of minutes, and someone going here. How does that get addressed if in fact that's the case? You want to pay? Who's going to pay? Is it going to be out-of-pocket costs? I mean, how does that get addressed?

MR. MARINO: Well, the access standards were based upon travel time and geographic distance. And correct me if I'm wrong, Kevin, but I believe we have met -- 99 percent of our members have access.

MR. CONLIN: It is 99.9.

SENATOR RICE: I'm sorry; say that again. Could you repeat that, please?

MR. CONLIN: Bob just made the point that 99.9 percent of all of our members in the State of New Jersey meet geographic access requirements and travel distance requirements.

I will add to that, that for our members who live in urban settings, 100 percent of our members meet the geographic time and distance standards.

SENATOR RICE: Okay. My final question, through the Chair, to you, is something that Senator Turner is very much concerned about, and rightfully so. How do we get a Tier I in Trenton, the State capital? It doesn't make any sense, just like Elizabeth, to have this situation. And I know this is also on your map; I don't know what it means, maybe my colleagues can answer it. I see a lot of space and blanks in Warren County. What does that mean? Does it mean that there's no tier there? Do they have to go to Sussex County? Can you just respond to those two things?

MR. MARINO: Senator, Kevin Conlin and I met with the Mayor of Trenton and we met with Senator Turner, in their respective offices. We heard the concern; we heard the concern that you're raising here.

The commitment that we made is that we understand the concern. We are going to go back and reevaluate the concern, and then come up with a solution that works. I'm not prepared to say what that is

right now; but she has my commitment that I heard the concern, and that we are willing to look at that and address that issue.

MR. CONLIN: Senator, if I may add to that.

This was something we indirectly referenced-- We have also committed, to the Department of Banking and Insurance, for Mercer County to add a Tier 1 hospital for obstetric services; and we will be doing that over the next -- attempting to get that settled over the next couple of weeks.

SENATOR RICE: We need to have some conversations about University, because it's still not clear, even from the record, as to how University is going to play in this. And if you know something I don't know, we need to know. Because I'm not going to allow -- not without a fight, okay? And I will do all I can to crucify you, (indiscernible) or not. I believe in demonstrations, but I think it's going to do harm to the workers and the people there. I'm being honest about that; that's for the record. That's not a threat, that's a promise, primarily because University continues to get harmed. And I don't know-- And Barnabas needs to talk to me as well, because I don't know what that means as it relates to Beth Israel, the Barnabas system, University. And my colleagues need to be supportive of whatever comes out of those conversations. And I'll be asking the Essex County delegation to join me in those conversations. I'm not even sure what it means for East Orange and some of the other areas that are going into the private side, etc. So there are some conversations you can have, and I just don't really believe we should roll this thing out in January. You need to buy some time with this stuff so we can get the kind of accountability--

Does the Board have to approve this stuff -- your Board? You have a Board over there, right? What's the role of the Board? Do they understand what you're doing? Do you have to prove it? Did they sanction this stuff?

MR. MARINO: Senator, we, indeed, have a Board of Directors. The Board of Directors is responsible for execution of company strategy. The Board of Directors is fully supportive of the OMNIA Alliance and the company strategy to move towards value-based healthcare reimbursement.

SENATOR RICE: Are those the people who we appoint from down here -- some of those people?

MR. MARINO: The Governor appoints four people to Horizon's Board of Directors. There is a total of 15 Directors on the Board -- four are appointed by the Governor, and 11 are independently elected.

SENATOR RICE: So did the Department of Health have any input in this over the last two years? Did the Department of Insurance (*sic*) have any input over the last two years?

MR. MARINO: The regulatory body is the Department of Banking and Insurance.

SENATOR RICE: Okay, so if I'm looking at the list correctly, there are some conflicting relationships, depending on how they line up behind doors there.

Okay, thank you, Mr. Chairman.

SENATOR VITALE: Senator Kean.

SENATOR KEAN: Thank you, Mr. Chairman.

If I may, just by way of context, how many lives are covered commercially in New Jersey today, overall? Not within your network, necessarily -- but overall?

MR. MARINO: Senator, do you mean Horizon's commercial membership, or the entire commercial market?

SENATOR KEAN: The entire commercial market.

MR. MARINO: I'm going to make an approximation on that. I just got five fingers (gesture from Mr. Conlin); does that mean 5 million? (laughter) Approximately 5 million, Senator.

SENATOR KEAN: Okay, 5 million individuals are covered. Obviously, there are far more individuals than that in the State of New Jersey.

MR. MARINO: Yes.

SENATOR KEAN: Where are a number of other places that individuals would get coverage through insurance -- or other metrics when they go in for care? Medicaid, Medicare -- can you walk through that? What percentage of the State of New Jersey residents, versus--

MR. MARINO: Yes.

SENATOR KEAN: Those vehicles.

MR. MARINO: Yes, let me see. I'll try to address the question, Senator.

Medicaid -- I believe there are over 1 million -- 1.1 million, Kevin?

MR. CONLIN: Actually, about 1.5 million.

MR. MARINO: About 1.5 million Medicaid members in the State of New Jersey. There are probably -- we have an estimate on the senior Medicare population--

MR. CONLIN: About (indiscernible).

MR. MARINO: Medicaid-eligible, I would say--

MR. CONLIN: No, Medicare.

MR. MARINO: Medicare? About 1.5 million.

SENATOR KEAN: Okay. And then to the extent--

MR. CONLIN: The rest would be commercial market.

SENATOR KEAN: Right. And of the 5 million -- you are talking impact in the first year -- how many people-- Of that 5 million market, how many people would be impacted the first year?

MR. MARINO: Let me clarify, Senator. So it's 5 million, overall, in the State of New Jersey, who are in the commercial market. Horizon's book of business is 3.8 million members. If you take out the Medicaid, Medicare, and Medicaid (*sic*), I believe our commercial book is somewhere around 2.1 million members. And of the 2.1 million members, we're estimating about 250,000 would select the OMNIA product in year one.

SENATOR KEAN: Okay; and through you, the OMNIA product is geared towards individuals at what percent of the poverty index, poverty line?

MR. MARINO: The data that we have suggests, again, 250,000 members will sign up; of that, 146,000 are individual consumers who buy that health insurance directly with Horizon. There is another 37,000 who are members of small employer groups. So those two together

represent 72 percent of the 250,000 who we estimate will enroll. Further, of the 147,000 individual consumers, 40,000 of them we estimate are currently uninsured and will now have access to an affordable health insurance product.

SENATOR KEAN: There was a great deal of hospital aggregation within the State of New Jersey -- and actually, in fact, nationwide -- as a result of the Affordable Care Act. And they said that was because it was compliance costs, and a variety of other factors. Did those Federal regulations play any role in the generation of this type of-- I mean, how has that impacted the insurance market, in your view?

MR. MARINO: Well, the Affordable Care Act obviously, as you know, Senator, made several structural changes in health insurance and how health insurance is sold and delivered in the United States. What we're trying to do with the OMNIA product is respond, in our view, to one of the things that the Affordable Care Act did not necessarily address. In terms of access, the Affordable Care Act certainly was a success. We have 11 million more people in the United States who are getting health insurance coverage as a result of the Affordable Care Act. But what the Affordable Care Act, in our view, did not fundamentally do -- it did not get out the reasons why healthcare costs go up year over year. And that's because we operate in this fee-for-service system that you heard us speak about, and what we're committed to doing is moving the system to a fee-for-value.

So while the Affordable Care Act did a great job in providing access, it really hasn't addressed why healthcare costs go up 10, 15 percent, year over year.

SENATOR KEAN: So besides being misnamed, the Act includes a Cadillac tax provision.

MR. MARINO: It does.

SENATOR KEAN: And to the extent that many employers -- including the State of New Jersey -- will be impacted to the tune of hundreds of millions of dollars, over time, as a result of the Cadillac tax, can you talk to that facet within the context of this plan, or others?

MR. MARINO: Indeed. The first comment I'll make is that the OMNIA product is not subject to the Cadillac tax; and I believe, Kevin, you may have some statistics on this for the State Health Benefits Program.

MR. CONLIN: Actually, in the State Health Benefits plan the savings to the individual families that will be parties to that is about \$1,200 per family per year. To the State, the savings turn out to be -- for every 21,000 members that we have in the OMNIA product, there's a \$5 million expense reduction. That's separate and apart from a concern with regard to the Cadillac tax.

SENATOR KEAN: And the question, if I may, through the Chair-- On the issue of -- I know you talked about some changes recently in Burlington County. And I believe it was Senator Allen or Senator Addiego who brought up the issue of the infant being born within a facility, having to be transported to other places within that system or beyond the state. And if you could just walk us through-- If it wasn't created-- If it wasn't that instance, but an individual came -- whether through cancer, or whatever, through facilities in-state or out-of-state-- I'm concerned about cost. Whether it be Sloan Kettering, whether it be CHOP, whether it be any one of these individuals -- that could be listed on a Tier 2 hospital.

How do we reassure parents, siblings, kids -- within this context -- that their loved ones are going to get the access to care at an affordable rate?

MR. CONLIN: Senator, as I understand your question -- and I want to make sure I do -- what I understand you're asking is that you want some assurance that an individual member, if they're in an OMNIA plan, will have access to an appropriate setting for care.

SENATOR KEAN: An OMNIA plan-- Yes, start with an OMNIA plan, yes. Start with an OMNIA plan.

MR. CONLIN: Yes, the way that the OMNIA plan will work is that there will be financial incentives for Tier 1; I think you understand that.

SENATOR KEAN: Yes.

MR. CONLIN: And we believe -- we feel strongly, in fact, that a very high percentage of the medical needs of those individuals will be able to be handled by the excellent hospitals that are in New Jersey -- both Tier 1 as well as Tier 2. In the rare event -- and we believe that that's the case -- that someone cannot get the level of the care that they need in a Tier 1 or a Tier 2 hospital in New Jersey, we will provide Tier 1-level benefits to an out-of-state provider.

So I trust that responds to your question.

SENATOR KEAN: I believe so; thank you.

Through the Chair, thank you.

SENATOR VITALE: Senator Madden, did you want to go?

SENATOR FRED H. MADDEN (Vice Chair): Thank you, Chairman.

Good afternoon.

So if we could stay with the conversations that Senator Kean was having for a second. I'll give you, by way of example-- Tell me what would happen here. A senior, 80 years old, described by his cardiologist that he has the need for heart surgery. What happens? They're in an OMNIA health plan, doctor and hospital. Where would that individual be able to have the heart work done? What boundaries-- Is it just within the State of New Jersey? Quick eval; take something pretty common.

MR. MARINO: Senator, just for a point of clarification. I understand the question, but a point of clarification: An 80-year-old member would not be enrolled in the OMNIA plan; more often--

SENATOR MADDEN: Because he'd be on Medicare.

MR. MARINO: He would be on Medicare, sir.

SENATOR MADDEN: Okay, so now he's 50. (laughter)

MR. MARINO: Okay. I got the spirit of your question.

SENATOR KEAN: How about 47? Can we do 47?

MR. MARINO: So obviously a patient, who is in the OMNIA plan, who is 47 years old and has a need for cardiac surgery -- we believe that there would be sufficient access in the Tier 1 hospitals to provide that surgery. And as Kevin indicated earlier, if for some reason that was a service that could not be performed anywhere within the State of New Jersey, and that person needed some specialized care out of the State of New Jersey, provisions would be made on a clinical basis to achieve that.

SENATOR MADDEN: Okay. And if the individual is in a Tier 2 -- I'll just use the word *network* -- experience -- his doctor and his hospital -- where would he-- Would he still be limited to just New Jersey?

MR. MARINO: A Tier 2 member-- The entire broad Horizon network is available as part of Tier 2. So the member would have a choice of not only the Tier 1 providers, but the entire network of Horizon providers.

SENATOR MADDEN: Does that permit the Tier 2 individual to go outside of New Jersey for the work that could commonly also be done within New Jersey?

MR. MARINO: If the question is, if the service was not able to be performed in New Jersey, and there was a need for a specialized hospital out-of-state; using appropriate clinical protocol, Horizon would make that accommodation and that member would be considered in Tier 1.

SENATOR MADDEN: And Chairman, I understand that. I get that piece. You can't perform the surgery in New Jersey--

MR. MARINO: Right.

SENATOR MADDEN: --so if it's only offered someplace else, you're going to cover that.

MR. MARINO: Yes.

SENATOR MADDEN: But my question is a little bit more simple.

MR. MARINO: I think I understand it.

SENATOR MADDEN: Does the patient have a choice here?

MR. MARINO: I believe I understand the question. Let me see if I can give a fuller response, or a better response.

So for the group employer who buys an OMNIA product, the group employer will have the option to continue what's called, in Blue Cross Blue Shield, the *BlueCard Program*, which enables a member to go

anywhere in the United States and have services rendered by a participating provider in the entire network of Blue Cross Blue Shield organizations. So employers will continue to have that option in addition to buying the OMNIA product.

I believe what you might be asking is for the individual consumer -- the 140,000 that I referenced who will buy the OMNIA product. There are no out-of-state benefits, other than emergency services or, as explained by Kevin, if there is a clinical need for a member to be treated by an out-of-state facility -- that will be granted on a clinical basis.

SENATOR MADDEN: In today's day and age, it's not uncommon for a physician to say to the patient, "We have two ways we can move with the procedure here," and explain the pros and cons of each step -- and maybe there's even a third. But it's not uncommon for the physician to turn and say, "Which would you like to do?" And often, or at times, the patient will look and say, "Doc, if it was your father, what would you do? If it was your son, what would you do?" And some doctors are very honest in their response. And to be quite honest, quite frankly, sometimes they recommend a special team -- whether it's in the world of transplant or oncology, or these more unique diseases -- and they may often recommend and say, "Well, if it was my family member, I would go to," and you heard the word *CHOP*, or some place in New York. And now the insurer is sitting there saying -- could they possibly be sitting there saying, "I'm in this scenario, and my insurance company isn't letting me go. They're making me go to one of these other three hospitals in New Jersey where they may do 20 procedures year. But this other facility does 300 procedures a year."

Could you elaborate on that scenario, because that's the--

DR. PATEL: It's a great question, and a question that does come up from time to time when it comes to physicians making recommendations and options for their patients.

As long as those recommendations are based on sound evidence, and there are clinical protocols and evidence to suggest that a team at Colombia, or a team at Brigham and Women's, or MD Anderson can do a better job, and it is the best option for the patient, then absolutely that is part of the consideration in making the decision and to offer that in Tier 1.

The real issue, though, comes up at when we look at the statistics of the number one reason why our members leave the state for health care -- if you look at New York City, for example -- it's actually normal vaginal deliveries. It's people electing to go to a New York City hospital or a Philadelphia hospital to have a child, when I would submit to you that nearly every hospital in this state that offers OB services can do just a great job at that.

So part of this is choice, in terms of offering that as an option; and part of this is in the real, rare circumstances where there are options that are evidence-based. Clearly we would evaluate that and make that available to a beneficiary.

SENATOR MADDEN: I think I already know this answer.

If the individual decided to go out-of-state for the service anyhow, would they be on the hook for the entire bill?

MR. MARINO: Senator, it depends upon the benefit structure that the member has. If they access nationally, through the BlueCard Program, and they elect to go out-of-state, and that particular facility is a

member, or is a participating member with the local Blue Cross plan, they would be considered in-network. If the facility is out-of-network, they would be considered out-of-network.

SENATOR MADDEN: Okay, thank you.

And Chairman, just one final question.

Am I to understand that with the OMNIA plan, for those who are in the Tier 1 OMNIA group, the insured will see a decrease in their premium? And the ones who are not in the Tier 1 group, or the OMNIA plan, they will see no increase in their premium? Am I saying-- In other words, the people who are currently insured, the 147,000 that you referenced that are individuals; or 37,000--

MR. MARINO: Small employer.

SENATOR MADDEN: --small employer. So, like, here they are now, just rolling along through life, making their payments -- are they going to see any increase or decrease -- not the OMNIA people, just the non-OMNIA people?

MR. MARINO: The non-OMNIA members will only see whatever normal premium increase would be associated with that policy. There will be no subsidization for the OMNIA product. That product will be rated and will stand on its own.

I think that's what you were attempting to ask.

SENATOR MADDEN: Yes, I'm just trying-- I basically have it in my mind that there's going to be potentially two categories: non-OMNIA and OMNIA. If you're a non-OMNIA, you're paying -- there's no increase. If you're in the OMNIA network, you will see a decrease of upwards of 15 percent.

MR. MARINO: That's essentially correct. But let me caution you-- Let me back up. The OMNIA product, if you elect to buy that product, on average your premium will be 15 percent less. So those are the people who choose OMNIA.

If you choose not to buy the OMNIA product, your premium is a function of medical inflation. So I don't want to create the impression that you would never see a rate increase. Your increase would be a function of the medical inflation.

SENATOR MADDEN: I understand. Thank you.

Thank you, Chairman.

SENATOR VITALE: Good afternoon, gentlemen. Thank you for spending all this time with us.

SENATOR CODEY: Joe, real quick--

Is there any way that Tier 1 could drop to a lower tier, and the lower tier come up to the higher tier?

MR. CONLIN: Senator, the answer to both questions is "yes." In the case of a current Tier 1 dropping-- To the extent that there are -- that they don't achieve some of the goals established for improving quality, members' experience, and getting total cost of care down, we do reserve the right to have them drop out of that category.

And then we will evaluate, on a regular basis -- annually, in fact -- based on business conditions, demands from our customers, and the like, with regard to the inclusion of what's currently in Tier 1.

SENATOR CODEY: Do your competitors have any kind of plans similar to the OMNIA plan?

MR. MARINO: Yes, Senator, they do.

SENATOR CODEY: Which ones are those?

MR. MARINO: Aetna, Health Republic, and AmeriHealth have tiered products in a network, currently.

SENATOR CODEY: How long have they had those?

MR. MARINO: I believe, since the Affordable Care Act they have had those products in the market,

SENATOR CODEY: Okay. I don't think anybody, obviously, doesn't want lower premiums. We all do for health care; and lower costs. I just think, as I said to you, Mr. Marino, you have to somehow tweak this program so we don't have those so-called *winners* and the so-called *losers*.

Thank you.

SENATOR VITALE: Thank you for spending so much time with us today, Mr. Marino, and Mr. Conlin, and Dr. Patel; and to the members who have stayed, and came early to ask their questions.

And I'd like to just address -- go back to some of the comments that you made, some of the questions that were asked earlier, just so that, in my mind -- sort of tie up some of the loose ends and try to understand from that perspective.

Well, first, let me say thank you for saving us from the Affordable Care Act; I didn't want to forget to mention that.

It's a joke; I just wanted to loosen you up a little bit. (laughter)

But in all seriousness, I want to go back and just talk about, sort of, the basic premise of this product, as I understand it. And correct me if I'm wrong.

So there is the OMNIA plan member -- the Alliance member -- then there's the non-OMNIA Tier 1 provider, and then there are the Tier

2s. So the OMNIA member gets to have their rate reduced with the promise of increased volume; and then, at the end of the year, there is shared savings.

The non-OMNIA Tier 1 hospitals really only get -- they get the rate cut, and they get a promise of volume without any real shared savings based on this quality metrics, right? Is that about right?

MR. CONLIN: Your comment with regard to the non-OMNIA Tier 1-- Did you suggest that they would be eligible for shared savings?

SENATOR VITALE: No. No, I'm-- So their only benefit to being at that table -- to be a non-OMNIA Tier 1 -- is that they get the promise of increased volume for the rate cut that they-- Right? That they--

MR. CONLIN: Yes. That part is correct, yes.

SENATOR VITALE: The Tier 2's are what they are.

So I find it sort of fascinating that-- Now, economics wasn't my major; but this is sort of logic. So the promise of-- If I'm a Tier 1 hospital -- whether I'm OMNIA or otherwise -- and I am promised additional volume, that volume has to come from somewhere. We're not growing new patients, right? It's the same, basic patient base that we have already. And because of the lower cost at the Tier 1's, in terms of co-insurance -- not premium, co-insurance -- and the threat of higher co-insurance payments at the Tier 2, those patients-- Over time, you're hoping -- at least 250,000 in the first year, and a portion of that is ACA, but whatever -- over time a large group, you're hoping, of members -- of existing members will move over and utilize Tier 1 providers and not the Tier 2. That's the way it has to happen, right, for it to be successful? For you to meet the promise of those providers that you've contracted with?

MR. CONLIN: Senator, yes, that's part of the answer -- particularly over time. The bigger part of the answer is -- and this is what we're banking on -- is the fact that as we work more closely with the Alliance partners, that we'll together be able to provide a total cost of care that is lower through our collaborative efforts. We think that's actually going to yield a larger reduction in total cost than some of the hydraulics of moving patient volume.

SENATOR VITALE: Sure.

So I want to get really past the infomercials and the-- (laughter) I'm not trying to be disrespectful -- just the ads, and the marketing, and the postcards that we're getting in our homes saying that this is the greatest thing since health care was invented.

So I want to get past all that and talk about some of the substance. Because I think we're losing this in some of the catchphrases and the words that we're all using -- about the quality that we know we should have, and the low cost that we know we should have. And no one disagrees on any of those measures, on any of those points.

But for me it's what it means to the others, right? So there's the adult table where the OMNIA members are, and the Tier 1's are. And then there are the Tier 2's. And they are, by your own admission, going to suffer patient loss because those patients will attrit over, based on cost.

Now, you're saying that that's the patient's choice. They still have choices -- they can go to a Tier 1, or they can go to a Tier 2. But certainly if they go to a Tier 2, their risk of higher co-insurance, based on what they generally have today -- particularly in the State Health Benefits plan -- would be much greater for a single or family member. Because that's

the only reason that they're going to the Tier 1 is the threat -- not overt threat -- but the threat of additional financial cost. So they're going to Tier 1. We're going to say that's pretty much the way it looks, right? That's pretty much true. That's their incentive to go to the Tier 1, in addition to that you're going to promise higher quality by trying to enforce and work with those members in terms of better outcomes, inappropriate readmissions, infections -- all those things -- post-op -- all the things that OMNIA members promised to do a better a job with.

It also suggests to me -- and I read the *Star-Ledger* this morning, and there was a comment by Dr. Patel, who said that, "Whereas a Tier 2 hospital may provide excellent care to the patient who fell and broke a hip, the OMNIA facilities will work to prevent the hip fracture and make sure that the patient had osteoporosis screening," and all that.

Well, that's nice. Don't you think that the existing Tier 1 hospitals -- as you've defined them -- already have policies in place? I remember sponsoring the Patient Safety Act, and the law that requires us to reduce the possible facility-acquired infections; and the collaboration between the Hospital Association, and the Department, and patients to reduce medical errors, to reduce facility-acquired infections. So as a State, and as policy makers, and as facilities -- we're all already going in that direction in some ways. We can certainly do a better job.

As you know, Medicare won't reimburse you for certain never events -- meaning hospitals; not you, but hospitals -- so there's a huge incentive for all hospitals -- Tier 1 or otherwise -- to do a better job with the decubitus ulcers, and urinary tract infections, and leaving a sponge in someone after surgery, cutting off the wrong leg -- those are all bad things

that should never happen. And Medicare will not pay for that, right? It won't pay to fix what the hospitals did wrong.

So there has been, for several years now, a movement on quality. So to suggest that these-- And I think there's an inference here -- that the Tier 2 hospitals are not wanting to be branded with this scarlet letter. Because, you know, number one is number one,. You know, everybody wants their favorite team to be number one. And so number one is what it is. And number 2 -- Tier 2 -- will suggest to patients that it will connote quality and it will connote cost. And on the cost side, it's probably true. On the quality side, I'm not so sure.

So when I look at your quality metrics that you used to decide part of this, and part of your selection process -- you used the CMS data and *U.S. News and World Report*; but you didn't use Leapfrog. And I'm really shocked. And I have to ask, was that intentional? Because if-- Did you want to back into a result on quality by using different metrics or leaving out Leapfrog? Because when I-- Leapfrog is the gold standard, and they don't just talk about quality -- it's healthcare safety, quality, consumer value; and they're the gold standard nationally. And to say that, "Well, you know, there was the Leapfrog thing, but we went with CMS and *U.S. News and World Report* instead," suggests to me -- and tell me if I'm wrong -- that you didn't want to use Leapfrog numbers. Because if we look at the Leapfrog numbers -- I haven't identified the hospitals, out of respect to them -- there are several hospitals in the OMNIA program, in the OMNIA Tier 1 that are not rated *A* by Leapfrog. So the greater percentage of higher-ranked -- by Leapfrog standards -- hospitals are in Tier 2.

So if quality -- in my view at least, from where I sit on this Committee, and with my members who, probably, the same thing -- quality and cost go hand-and-glove -- right? -- or should. And quality is always -- should be always paramount for patient safety and patient care. Because we're all in the patient business -- in different ways, but we're in the patient business.

So can you respond to that, and tell me how it is that there are hospitals, by Horizon's own admission, that are the lowest cost, best quality hospitals in the state, yet are not in the top tier; and that hospitals that are ranked *B* or *C* are in the top tier? If you're driving people toward quality-- Now, you may say -- and I'll let you answer the question, because you may say that we're trying to get these very expensive hospitals, Hackensack, Robert Wood, and others -- not a criticism, but they're expensive hospitals -- to do a better job, lower their cost, cut their rate, do a better job on quality, and everybody wins. That's a great thing. No one disagrees that we should be doing all of those things, all those measures -- but in every hospital.

You're punishing hospitals -- we are -- not *we*, *you* are punishing hospitals that, through no fault of their own, even though they're ranked with great quality, and great outcomes, and patient satisfaction, and they have CNs who are providing any variety of a number of services -- they're at the kid's table. And make no mistake, that's what it is. I mean, you can fluff it up and talk about how it's not that way and that, "They're all the same; we love all our children," but really, we don't. (laughter)

So could you respond to any number of those rants? (laughter)

DR. PATEL: Senator, I really appreciate the question, and the complexity of that question. Because, again, as we stated earlier -- as I stated earlier, when it comes to measurement of quality of an individual institution, there are a number of factors that can come into this. And there is no one gold standard -- whether it's Leapfrog, which is primarily a safety-oriented organization. And again, I was part of Horizon a decade ago when we put the Leapfrog report card programs out. So I know it well, and I feel very passionate about it.

But the CMS quality scores, again, come back to measuring activities that include a lot of patient safety parameters. Prophylaxis against blood clots, surgical infection rates -- all those things that you mentioned. And I would submit to you -- again, going back to the earlier comment -- that many, if not most, if not all the hospitals in our network across all those dimensions, or most of those dimensions, do very well, whether it's a Tier 1 or a Tier 2 facility.

But I come back to the comment that, for the future of where we need to go with health care, that's not enough. It's not enough to say, "I've got my surgical infection rate down; I've got my never events to zero." Frankly, never events should never happen without CMS requiring a penalty and payment, is what I am submitting to you.

The future of health care is, we can't allow someone to be admitted for a hip fracture. We need to get that before it even happens. And those dimensions-- I will also submit to you that there's, one, no metric; and secondly, even of our Tier 1 Alliance partners, we have a lot of work to do with them. I can't tell you any one of the seven Alliance partners that we have that, slam dunk, have figured this out. This is a long-

term collaboration between a payer and these seven partners in order to try to figure out how do we get to the point where Mrs. Jones doesn't get admitted with a hip fracture, so the metrics of quality by which we measure institutions today become obsolete in the future. That's really where we're driving to.

So again, we accept the critique that we didn't use Leapfrog; there's no perfect answer to that. We didn't reverse engineer the process. *U.S. News and World Report*, for example, were not used as part of quality; it was used as part of consumer preference, and primarily because we wanted a third party definition of consumer preference -- not our definition of consumer preference -- so that, again, we could point to that from an external point of view.

So I hope I've answered your question.

SENATOR VITALE: Well, you only answered one of them. So you did talk to me about the risk that we're putting Tier 2 hospitals in.

So New Jersey has spent, over the last several years, about \$55 million of the Health Care Financing Authority to buttress hospitals that have been in trouble. Most of them are safety-net hospitals. And so when we think about simple economics, we're going to see, over time, patients attriting over to the Tier 1 product from Tier 2 hospitals, and the downward effect that that will have on them. So you look at medically underserved communities within urban centers mostly -- not completely, but mostly -- that have a pretty lousy payer mix. And it's Medicare, Medicaid, uninsured -- meaning *undocumented*, not just -- uninsurable; and Medicare, Medicaid, and some level of commercial, and maybe some State health benefits. We begin -- you begin to take -- I keep saying *we*. Horizon

begins to take those members away -- meaning move them, incentivize them, whatever -- to another program, to the Tier 1's. There has to be -- and there will be -- an effect on their outcome, on their bottom line, on their own well-being. As much as they try to be the best hospital they can be -- Saint Francis, for example, by your own admission best quality, lowest cost hospital in the state -- they're on the outside looking in.

So we all want to get there. But in my view, I think it is that we have to provide-- And I can tell you, I echo what Senator Lesniak had said earlier -- that I really think you ought to stop this right now, in that we're already in open enrollment in the State Health Benefits plan; and let that be the canary in the coal mine, let that be the pilot.

But to foist this product on the unsuspecting public, and legislators, and policy makers who have had very little time to digest what it is that you're doing-- We tried to do this on the fly in the last seven days, or more. So what's the plan? So my concern is that you're going to roll this out; you're saying 250,000 -- I think it's going to be more. And your brokers are ready to go -- ready to go after your existing client base, they're ready to go after Aetna's customers, and to United's customers. And that's what I would do, right? I would say, "Look, you're paying this. This is your plan; if you come over to the OMNIA plan we'll save you 20 percent -- 15 percent of your policy." I think some business owners who are customers of other plans will say, "Where's your pen?" And that's their choice.

And so, I don't want to argue that there is this -- or get in the way of someone's business model. But it's really more than that, for me -- and for us, I think. We have a responsibility to say, "For all of our state's

hospitals, for all of our state's consumers, what will this plan mean to them? And how will they be educated about it?"

You know, doing the push-pull is offensive and a waste of your money. Sending out postcards that say that this is the best thing since sliced bread doesn't do anything other than try to put into the heads of consumers, "This must be a great thing," without any knowledge of the details of the plan.

So I wanted to really-- We've spent a lot of time on this. And I don't think that the Legislature and other policy makers have been given the opportunity to really talk to everyone about this and to make -- form our own opinions and offer them to you. You're the state's largest health insurer; you have Medicaid; you're the gorilla in the market -- the commercial market, right? The State Health Benefits plan -- you're the big player. It wouldn't matter if you were some obscure insurance company that had a small piece of the market. It matters when Horizon does something.

You know, as a medical services corporation, you have certain responsibilities to the rest of us and to the people who you serve. You've been given significant tax breaks over the years as a not-for-profit. You have the Foundation, and you do good work. But you have been given significant tax breaks, and you're different than the others. And I'm not saying that you want to act differently, that you don't want to be a good steward of our money. But I think in this particular case -- and this is no small thing for me -- I think you got this wrong. I think that you could be better, much better.

I think that you shouldn't be punishing hospitals, through no fault of their own, that are on the outside looking in. They weren't even asked to the dance. You never had a conversation with them. It's not fair. It's not just about fairness; it's about survivability. It's about access. When people are now-- If those hospitals suffer, what does it mean to our Medicaid program? Are we going to step up and pump millions more dollars into our state's inner city hospitals that can't survive the cost shift for the loss of customers? The answer is, I don't think we have the money. And do we want those hospitals to close? Do you care?

You know, someone suggested to me that Horizon really doesn't care. They don't care if this extraneous hospital closes, or this one closes, or that one closes. No one listened to the Reinhart report, no one paid attention to the Navigant report. And so, we're going to do this on our own. Because when you boil all this down, the consequences are going to be that hospitals will suffer because of this -- and that's not your job. It's not anyone's job. It's our job to make them all whole.

There may have been a question in there, somewhere, Kevin.
(laughter)

MR. CONLIN: Senator, if I may.

I think at the base of what I understood of what you just said, was a statement that our proceeding with this OMNIA Health Alliance and tiered products built around it is going to have a very harmful effect on the hospital infrastructure in the state -- if I understood your point correctly.

We've modeled that out, and I recognize what you said earlier, Senator, which is, "Yes, but it's only 250,000 at first," and you expect that that will be a bigger number. Even at that, I think it's important to keep in

focus that this is a tiered product, and although we project that more members will utilize the Tier 1 facilities over time, our experience to date has been, in the exchange products that we have that are built off a similar chassis, that 40 percent of the members who choose this continue to access, if you will, the Tier 2 organizations. In addition, even with that taken into consideration, as we've modeled this out, the impact next year -- assuming it goes right to the point that we're -- 250,000 members on the nose -- the impact on the average Tier 2 hospital will be a reduction in an average daily census of one, literally one. And that's very consistent with every assumption that we've made as we built all of our pricing assumptions that we have filed for approval. So that can work backwards from that point.

That average daily census of one -- and again, all I have to work off of is the average Tier 2 hospital in the state, which is what we've used -- that will have an impact on revenue of about \$1.1 million. Again, nothing to sneeze at, I will concede. But in the context of the budget of a typical Tier 2 hospital, it's not that significant of an undertaking.

As our volume in this grows -- if it does, we don't know that it will -- but as our volume in this grows, the impact would be, we think, linear. So the more members we have, the more of an impact that would have.

One other point that I think is important to keep -- two other points, in fact, that are important to keep in focus -- and I'm going to back to my previous two-plus decades of running hospitals. When that member does not show up -- a patient does not show up in that one particular facility, about 50 percent of that cost is not incurred. So the net impact to

the organization can be cut in about half. So it's not quite as dramatic as it looks.

And then, lastly, I think it's important to keep in focus that even though we will attempt to market a tiered type of a product around this OMNIA Alliance, our competitors are going to be doing the same. So whereas I would like to sit here and think that we will be the only beneficiary, as an insurer, of picking up market shares as a result of this, or converting our own members into this product, I expect that our competitors are working diligently to come up with something that's going to be very attractive. And that will have an impact on reducing the amount of volume that will shift into what we consider our Tier 1 facilities, and will go into what they consider their Tier 1 facilities -- which are, for the most part, our Tier 2.

SENATOR VITALE: Sure.

So let's talk about just the uptake. So if it is that there's a lower-than-expected anticipated enrollment in the OMNIA plans in 2016, what happens to-- So you've negotiated a rate decrease -- a rate reduction with the provider community, so the OMNIA hospitals and Tier 1's have seen a reduction. And what happens if it is that there is a-- And you've-- Let me ask you this. Did you calculate the rate cut based on the anticipated volume that these hospitals should receive as a trade-off? Forget about the shared savings at the end of the year. I'm just talking about -- just in terms of volume versus rate cut trade-off. Is there a calculus--

MR. CONLIN: Yes, that was part of the criteria that resulted in the requested rate reduction.

Part of what we were also shooting for was the amount that our customer base told us they needed to obtain in order to consider making a transition over to this type of a product -- which, as we've discussed, is that 15 percent number. So between those two considerations, that's how we arrived at that.

SENATOR VITALE: So what would happen, then, if the uptake -- I mean, you aren't as successful as you had hoped to be in the first year, or the second year, and your numbers are half of what you hoped that they would be. And you've made this rate-cut calculation with your provider partners. Would you have to raise rates, then? Would they have to raise-- I mean, to make them whole, because they've now taken a rate cut based on a promise of X. There's a calculation in there somewhere, right? They're not just going to take your word for it.

MR. CONLIN: Yes.

SENATOR VITALE: So what happens?

MR. CONLIN: What happens in that scenario is that we've invited these organizations in as partners. They have some risk in that; that's part of the risk that they're taking on -- is that, together, we're not successful at getting the level of membership that we anticipated.

SENATOR VITALE: So they're willing to take this gamble? Is that what you're saying?

MR. MARINO: I believe that's true, Senator. I think what Kevin is saying is, in the spirit of the partnership they realize that there is some risk.

DR. PATEL: I just also want to --

SENATOR GILL: Excuse me.

DR. PATEL: I just want to clarify--

SENATOR GILL: Excuse me.

We had a long discussion, and you stated there was no risk for the partners in the OMNIA. Now you're saying there--

MR. MARINO: Senator.

SENATOR GILL: Who's calling me? (no response)

And now you're saying there is a risk.

MR. MARINO: Senator, let me clarify. The *risk* reference I was making was a risk reference on how strong our projection of enrollment is. It was not a risk reference to the financial arrangement that ends at the end of the contractual period.

SENATOR GILL: Well, it was obviously tied to the financial issue, because the testimony just then was, what happens if you don't get the amount of volume. And the rate cut is, in fact, pegged to the amount of volume increase, and would you have to raise rates.

And then I'll turn it back over to my Co-Chair.

MR. CONLIN: Senator, when you asked me that previously, my understanding of what -- I mean, earlier this morning -- I understood that what you were asking was are our arrangements with these health alliance partners -- OMNIA Health Alliance partners -- did they include, if you will, downside risk? And my response was it was really only what we call *upside only*. So to the extent that they exceed the budget, they get to share in some of that. That's what I was responding to.

I understood Senator Vitale had asked the question, "Is there is a risk to the partner if the enrollment in the first year does not meet what we projected that it would be; and upon which they relied to make a

concession on their rates?” And that is a different type of risk that I was responding to in trying to describe. And that’s what I’m saying -- that the Alliance members do hold some risk for that.

SENATOR GILL: So risk is risk, and there may be different kinds of risk -- but it is risk.

And I will let you answer-- And this shows why we need a transparency; this shows why we need oversight more than anything.

But I will go back to Senator Vitale.

SENATOR VITALE: Thank you, Senator.

Earlier you talked about the savings to the health benefits plan. And I think it was Mr. Conlin who suggested that -- or stated that a family would save about \$1,200 in premiums for the family plan, right?

That’s accurate. But what I think you failed to share with us is that the same family exposed themselves to a \$3,000 deductible and a 20 percent co-insurance if they use a Tier 2 provider -- up to \$9,000 in the State Health Benefits plan. Now, I know that-- How do you respond to that? Because there still is some risk; now we get back to everyone’s earlier comments about that there is really seamlessness here. That it’s just about the costs are the same, but the quality will be better here, and your out-of-pocket will be less. That’s not really so much true in the State Health Benefits plan. The card that I have -- NJ Direct 15 -- if I stayed where I am today, I wouldn’t go anywhere near this product because I can go where I want, and my deductibles and my co-insurances are ridiculously low. I mean, it actually should be higher. But to-- How will you--

So those are, sort of, the facts about how that works. So how are you going to-- And again, that is going to affect some of the inner-city

hospitals -- like Trenton, for example -- where there are a great number of State employees who live in this general area, who may have Saint Francis in their network, who won't go there now. But if they have to go there for whatever the reason is -- for an elective procedure -- and they need to go, they're exposing themselves to great risk. Instead of having to drive, they would rather stay locally.

So there is a great deal of exposure for members of the State Health Benefits plan if they choose to go to a Tier 2 hospital -- even though they may save \$1,200 a year as a family, or \$450 in premium for an individual. The State picks up the other piece of that.

So how are you-- Earlier you described this process whereby it is that you're going to roll this out and educate the public. So tell me how-- Who's educating the State Health Benefits-- Open enrollment is now; it's taking place -- October 1, it started. So who has the responsibility to educate the consumer in terms of what their risk is and their benefit is to this plan?

MR. MARINO: Senator, it's my understanding that Horizon will conduct approximately 100 open enrollment meetings with State employees at various locations throughout the state during the term of the open enrollment period -- which I believe concludes on November 1. So we've made a pretty strong commitment to hold 100 different meetings with State employees in various locations to educate them -- not only on the OMNIA plan, but also on all of the-- I believe there are nine benefit offerings for members to choose from.

One further comment: Just for clarification -- I believe the Committee understands this.

The plan design and the structure of the OMNIA product for the State Health Benefits Program were decided by the State Health Benefits Commission. That is not the typical, commercial OMNIA product design that Horizon will have in the market for the individual and small employer segments.

SENATOR VITALE: Tell me about the process you're going to--

SENATOR WHELAN: Mr. Chairman.

SENATOR VITALE: I'm sorry?

Senator Whelan.

SENATOR WHELAN: I just want to apologize. I have a 2 o'clock Committee meeting; so I apologize to you, and our Co-Chair, and the other members, and this panel, and others who are going to testify. We will get a copy of that testimony from the others who are testifying on this.

And again, my apologies.

SENATOR VITALE: Thank you, Senator.

Mr. Marino, you were saying.

MR. MARINO: I was just trying to make a point of clarification that the benefit design that you referenced for the State Health employees with respect to the Tier 2 deductible -- that was a decision of the benefits Commission, if you will. That is not the typical commercial OMNIA product design that we will have in the marketplace for individuals and small employers.

SENATOR VITALE: Right; I understand that. But there will be -- there are financial disincentives to go to a Tier 2 hospital. Otherwise, there wouldn't be the volume shift to a Tier 1. So I know earlier, either Dr.

Patel or Mr. Marino said that, "Well, you know, the numbers are virtually the same, or close to the same, give or take--" Well, can you tell me what those numbers look like and what a patient would be -- a plan member would be exposed to? Take your average plan; what is their co-insurance? What is their out-of-pocket? And what's their (indiscernible)?

MR. MARINO: Senator, unfortunately, the plan designs -- correct me if I'm wrong here, Kevin -- we're required by CMS not to make those -- not to release them until the open enrollment period starts -- which I believe is November 1 on the Federal exchange.

SENATOR VITALE: Well, you're having-- You said the other day that you were having a preview with brokers -- is that the small group market and the individual market -- some time in mid-October.

MR. MARINO: I'm not sure.

SENATOR VITALE: You're having like a--

MR. MARINO: Senator, I'm not certain. I could be wrong, but the impression I'm under is that the products become available on the Federal exchange for all carriers, with benefits and rates, effective November 1.

SENATOR VITALE: But you will be having conversations with your brokers and your sales teams in advance of that, right? I mean, it may not be a-- Are you restricted in terms of what you can tell them, or are you restricted in terms of talking to them at all?

MR. MARINO: I'm not certain we're--

MR. CONLIN: Senator, we have spoken with the broker community. We have described the products. We've not given, at least to the best of my information -- it's not something that I'm directly involved

with -- but the best of my information is we have not provided them with the specific pricing.

SENATOR VITALE: Not specific pricing. And would the -- whoever it is who is responsible for marketing this to the State Health Benefits people -- is it the State? Is it Horizon? Who has the discussion about what their exposure could be? Is that Horizon? Is it the State?

MR. MARINO: Senator, we -- as we do with every open enrollment period -- conduct open enrollment meetings with all State employees. And we're available to answer all q, on the nine options that are available to State employees -- which the OMNIA is one.

SENATOR VITALE: Right.

So let me just understand how that works. Do you all get in a room like an auditorium and have -- do you give a presentation? Do they ask questions? Do you give them all the information they need to ask questions? Would you tell them that this could be a risk -- these could be the numbers if they choose to go to a Tier 2 hospital, if they enroll in the OMNIA plan? Would you proactively tell them that, or would you hope they ask the question?

MR. MARINO: It's our intent, if the member is interested in the OMNIA product, that they get a full explanation of how it works, how the Tier 1 works, how the Tier 2 works, and to specifically advise them of what their exposure would be.

SENATOR VITALE: Can you tell me how long it took the Department to sign off on your submission? From the time you submitted it to the time they approved? CMS aside; just talking about DOBI.

MR. CONLIN: Senator, speaking just to the network side of this, specifically from the time we submitted it until the time they signed off, I'm going to say was somewhere in the ballpark of 60 days.

SENATOR VITALE: So when you submitted your proposal to the Department, did you time it so that it coincided with open enrollment -- so that once it was approved, you could go right to market with the product?

I know it's taken you a long time to design this and get acceptance from your partners; but was this timed so that you could go right into enrollment?

MR. MARINO: We were in discussions with the Department of Banking and Insurance, and the filing-- When we submitted it, we thought we were giving sufficient time for them to be able to review it, approve it, and for us to be able to be in the open enrollment this fall.

SENATOR VITALE: Okay, so the timing was good for you, then. Could you have submitted this in April or May, or was it not ready?

MR. MARINO: I think it's the latter, Senator. We were not ready in April or May.

SENATOR VITALE: I just have one other-- Just a different subject all together, and something I've been meaning to ask.

If someone is an OMNIA member, so they have options, right -- three options? If they suffer a stroke and they're admitted to John F. Kennedy Hospital in Edison -- which is a comprehensive stroke center, by the way, and in Tier 2 -- and they've stabilized him, and maybe there's a procedure, they're cleaned up, they're good -- but they have to be admitted for two or three days. What happens to them? Now, I know they've got to

use emergency, and emergencies don't count. But if they're admitted through the emergency room -- not just to take care of them as an emergency patient -- they're admitted and they're given a bed, do the Tier 2 benefits kick in, or do they get Tier 1 protection?

MR. CONLIN: In that scenario, that would be covered at a Tier 2 benefit level.

SENATOR VITALE: Wow, really.

SENATOR GILL: Wow.

SENATOR VITALE: So in the case of JFK-- And this reminds me of something that I was told. Governor Christie cut parents out of family care, between 133 and 200 percent. I was concerned about what would happen to the people who were already under care -- cancer patients, whatever. What would happen to them? Would they be cut off? And they were given a short period of time to find another a doctor and be made somewhat whole.

This is pretty interesting news; it's kind of stunning news. So someone suffers a stroke, heart attack, and they can go anywhere. I mean, under the current rules now, we can go anywhere we want and get taken care of.

But for admitted -- because we need to have some continuity of care -- that patient will be then treated as a Tier 2 because they're in a Tier 2 facility. So the emergency, they don't have-- So they don't have to break up the cost on this. So maybe for the emergency, they're treated as a Tier 1; but anything after that, in terms of admission, they would be treated as a Tier 2.

So this stroke patient who is now at a comprehensive stroke -- designated stroke center -- and many of us here today voted for that legislation to create that law to give money to those hospitals to create these dynamic centers for stroke care -- they now need to go to rehab. JFK -- they're here today, and they'll speak for themselves -- but they have a very special rehab program for stroke patients, and it's Tier 2. So where does that patient-- Well, first of all, how can you expect that patient to be charged as a Tier 2 patient? Do we expect them to be transported to a Tier I hospital to protect themselves?

So if I have a stroke -- God forbid -- and I'm conscious a couple of days later, and I'm like, "Get me the heck out of here; take me to Robert Wood," because the clock is ticking, and so is the meter --that doesn't seem fair to the patient who's laying in the bed, more worried about their recovery than they are about the cost (*sic*). And the cost of transportation, by the way-- It ain't cheap to go from wherever to wherever in an ambulance.

MR. MARINO: Senator, perhaps I can clarify.

Yes, they would be treated as Tier 2; but their financial exposure, in terms of deductible and co-insurance, will be essentially the same exposure they have today when accessing the broad Horizon network. There is no additional exposure, if you will.

SENATOR VITALE: But they're not in a traditional plan in this scenario. They're in the OMNIA plan.

MR. MARINO: And we are building the OMNIA plan in the commercial market to -- for Tier 2, for the deductibles and co-insurances, generally speaking -- to look like the deductibles and co-insurances that a

member has today. So therefore, if they choose to go to a Tier 1 -- again, their choice -- they have an opportunity to reduce their out-of-pocket expense. But we are not penalizing them in the form of higher deductibles, higher co-insurances than they would normally have today.

SENATOR VITALE: Today, meaning today under--

MR. MARINO: Today in a normal, standard commercial product.

SENATOR VITALE: Right. But if they-- We're going circular here.

They're in the hospital, and they have your product. And there's going to be a cost consideration for them. When you say, "Close to what it might be if it's a commercial--" Well, they're not in that anymore; they're in your plan. And through no fault of their own they had a stroke. And they wind up at a Tier 2 hospital that's a stroke-designated center -- stroke designation for that hospital. They're going to get whacked for money that they shouldn't have to pay for.

We get that if they made the choice to go to a Tier 2, that's just like going out of network. This is sort of like out of network *light*. It's like going out of network -- you know if you go out and made that decision to go to a hospital that's not in your network, or a doctor, you'll get hit with a higher cost of co-insurance and cost sharing. You know that. But you had an emergency, you went to the hospital, they saved' going to get hit with additional costs.

It would be different if they said, "Hey, I think I'm having a stroke. Take me to JFK." Like you would do that; that sounds kind of silly. But do you know what I'm saying? It's like, why is it that you will now be

penalizing that person? Again, it would be one thing if they decided to go to a Tier 2; and I don't agree with the policy. But if it does happen, and they do make their own decision to go to a Tier 2, regardless of cost -- "I love the hospital, I love the doctors, I love the grass, I want to go there." This is different. Why are we treating them as if they did something wrong?

MR. MARINO: What I attempted to articulate, and perhaps I didn't do it well, is that in our standard commercial OMNIA offering, if a member chooses to go to a Tier 2 facility, whatever deductible or co-insurance they have today in a standard product -- if that product is to be replaced by a standard OMNIA product, that the cost sharing in the OMNIA product for the Tier 2 will look essentially like it looks today. There's no greater cost share, generally speaking, than what the member has today. It is only incentive if they choose to use Tier 1.

So in the example that you've been describing about the patient who has a stroke, goes to a Tier 2 hospital, the exposure they have -- from an out-of-pocket perspective -- for a standard commercial product relative to a comparable standard OMNIA product, would look pretty much like it looks today. There is no greater financial exposure.

SENATOR GILL: For how long? Let's assume that's true, and we're now in OMNIA. We used to have another insurance, but we're now in OMNIA. For how long would that practice be in effect -- that if they were in a Tier 2 hospital, it would look the same?

MR. MARINO: Senator, what I'm describing is a function of the benefit design. And it will be that way for as long as the benefit design remains that way.

SENATOR GILL: And how long would the benefit design remain that way? You're making it sound as if -- and I could be-- So this is where I need clarification.

MR. MARINO: Benefit design--

SENATOR GILL: It sounds as if--

MR. MARINO: Benefit designs typically are concurrent with the rate, which is basically a one-year--

SENATOR GILL: So this is for one year. So that if that same patient had that same experience the year after, their benefit design would be different.

MR. MARINO: Potentially, or it could be exactly the same.

SENATOR GILL: But potentially it could be different, correct?

MR. MARINO: It could be exactly the same, it could be greater--

SENATOR GILL: Or potentially it could be greater, because the benefit design that you referenced would have been for one year. And if that patient had the same experience the next -- their benefit design could be different. They could be paying more in out-of-pocket expense than they paid the year before. It's just shifting, I'm just asking you-- I'm not-- This is not-- Not that any questions are trick questions, but this is a practical question. Since you think that is a feature, it would only last a year. Am I--

MR. MARINO: Benefit designs, Senator, for the majority of Horizon's businesses are sold on a group employer basis. And it is the group employer that generally decides, on renewal, whether or not they're going to keep the same plan design or they're going to change it. So I just want to be clear that, generally speaking, for the majority -- the vast

majority of Horizon's business, the benefit design is a function of what the employer chooses, and the employer annually evaluates their benefit design.

SENATOR GILL: And that benefit design can have a financial impact on the same scenario a year later.

MR. MARINO: That's correct, Senator.

SENATOR GILL: Okay.

MR. MARINO: That would be up to the employer. But that is correct.

SENATOR GILL: Thank you.

SENATOR VITALE: So I want to do a little bit more research. Would you provide us with some information about the differential on co-insurance between what is an average standard plan today and the Tier 2 product -- on average. I know things will change a little bit.

You should also know, though, that since that stroke designation, you have the comprehensive stroke centers, and you have the other lower-grade. But they're all good; I forget what they're called. EMS is required to take patients with strokes, if they can, to the comprehensive stroke center, if at all possible. So we're taking patients who may have gone to a Tier 1, but now they're going to a Tier 2 -- like JFK, for example. And I think there are three or four other comprehensive stroke centers in New Jersey that are not Tier 1. And did you give any consideration for that -- to the hospitals with a Certificate of Need. Saint Francis has a CN for heart -- for cardiac surgery. These hospitals have the stroke designation -- comprehensive stroke designation -- which is really where they should go; stabilize at the others, possibly, and then be brought over to the comprehensive stroke centers. Was there any consideration to the

specialized service that those hospitals provide when you were picking your partners?

MR. CONLIN: The answer is yes. As I think I've mentioned on a few other occasions, but not in this context -- the concept of geographic access. And we did concern ourselves with the geographic access of clinical programs to the location of our members. So in effect, yes we did take that into consideration.

SENATOR VITALE: And just lastly, and then members may have a follow-up question or two.

But if you would get us members of the Committee -- maybe if you go through the Chairs -- get us some data; get us a data sheet that describes what those costs look like. So for the patient who is admitted in a Tier 1 hospital through the emergency room, or Tier 2 hospital room, what will the differential cost look like on some of your average plans? And give me a few different examples, okay?

Thank you.

We're going to call the next panel. Before we break, I just--

Oh, Senator Allen, I'm sorry.

SENATOR ALLEN: I have just a couple of follow-ups, if I may.

SENATOR VITALE: Sure.

SENATOR ALLEN: Thank you.

SENATOR VITALE: We're not going to break, right?

SENATOR ALLEN: You've been really good to sit there without food and not much to drink -- and I'll be very quick.

I continue to have the concern about winners and losers. And while some of it was built into what you're doing, some of it was not. You

said you would look at the problem of people assuming what Tier 1 and Tier 2 mean. And I would ask that you not just look at it, but you make some decisions on how to deal with it, and get back to us on that -- one way or another -- in a fairly short period of time so we can know-- I mean, call them *blue* and *green* instead of *1* and *2*, and talk about how they're all wonderful. Just find a way to mitigate that issue.

Winners and losers, though, continue when it comes to Burlington County. I've looked at this map, where everything is. While my protractor is at home, I nonetheless have been able to look at 14.5 miles. And more than half of Burlington County is not covered within 14.5 miles -- more than half. That is unacceptable, and I need for you to have a Tier 1 hospital in Burlington County.

Now, I'm thankful that you're looking at, now, putting maternity in. And I will tell you that Dawn and I spoke to DOBI last week about that specific issue. And I'm thankful that that seems to have rippled over to some change. We need to go, though, beyond just that one particular issue. It's important that we take care of that, but just doing one piece and not the rest -- I think that hospital needs to be within your system so that we can cover everything. Again, unacceptable that it's more than 20 miles for a good portion of Burlington County.

There's no other area in the state that is dealt with in this way. You talk about access a lot, and I'm thankful that you do. And you seem to have some areas where you really meet your criteria, but we are not one of them. And we need for you to look at that very closely and come up with a plan for us so that Burlington County isn't the stepchild for the entire state when it comes to what your offerings are.

I also want to ask a question on how you determine whether you're going to cover Tier I benefits for a hospital that is out-of-state. If you have been going to Sloan Kettering for something, and you have a doctor, and you have everybody who's already organized with whatever your particular problem is, there may be a possibility that there's another hospital in the State of New Jersey that reaches those things -- and it could be 110 miles away -- as opposed to you living near Sloan Kettering. How do you determine whether you will move forward with Tier I benefits?

MR. CONLIN: It's a two-part response.

There are currently some regulations that are known as *continuity of care* considerations. And in certain clinical conditions, it's required that we cover the continuation of that care for a defined period of time. You mentioned oncology, for instance, Senator. That's one of the situations in which -- and I'm sorry, I can't quote the exact duration of time from memory; I want to say it's nine months, but please don't hold me to that. But we would be required to continue to cover that once the care -- long-term care had been established with the provider. So that's the first part of the response.

The second -- and I think you were really asking this more in the context of outside of the relatively few situations in which the continuity of care provisions apply. And in that scenario, this is something, actually, that we do fairly routinely. We have a team of physicians on our staff who interact with the treating physicians to make sure that they understand the situation with the individual member, understand the clinical conditions of that member, understand where they find themselves in the treatment process, and interact with the physician to make a

determination -- and this is usually something done jointly between our medical directors with the treating physician -- to determine if, without harming the treatment of the patient, if there could be a transition made to another provider.

So that process is the same process that we would use, moving forward.

SENATOR ALLEN: So how much does it count if, for instance, your doctor at Sloan Kettering is considered one of the top three in the country? Now, could you find somebody else if the other two are in two other states, but not New Jersey?

I guess I'm concerned that we are surrounded-- Let me quickly say we have some great hospitals in New Jersey, and we've all been treated well and appropriately in New Jersey. But if you have those particular things where you need to go to Children's Hospital, you need to go to Jeff or Penn, you need to go to Sloan Kettering or some of the others because it's the best doctor, the chance of the best outcome, and those sorts of things -- how much of a fight is it going to be for somebody, who's fighting so many other things already, to get that kind of coverage?

MR. CONLIN: Senator, that's a difficult question for me to answer simply. As I mentioned, the determination is going to be the result of a process that would take place between two physicians who would be interacting with one another. Our physicians are attempting to understand the needs of the member and the needs of the members' family as they're making a determination about that. You asked the question directly, "How much of the idea that someone might be considered to be the best in the world of something -- how much would that factor into it? I'm confident it

would factor in significantly. But for me to quantify more than that -- it's just difficult for me to do, and I don't want to leave a misrepresentation.

SENATOR ALLEN: All right. I appreciate that.

And I will leave you just with this, one more time. Unacceptable -- Burlington County not having Tier 1. And while maternity is great, we need the whole enchilada. I really would appreciate it if you would re-look at things for us in Burlington County and consider that we have hundreds of thousands of people who are very far from coverage.

Thank you.

SENATOR VITALE: I'm sorry that you have to plead those cases, Senator.

Senator Rice.

SENATOR RICE: Yes.

I'm sorry, Mr. Chairman. I just want to read something into the record because I'm not sure-- You're a Doctor Patel, is that right?

DR. PATEL: Correct.

SENATOR RICE: Okay. I'm not sure if you received a communication or not -- or if this is something that's going to be on the record if the participants are here -- that was directed to you, Dr. Patel. And it came from Dr. Raj Patel. And it says, "Good morning, my name is Dr. Rajesh Patel. I am a family practice physician with an office in Plainfield." Now, you know where Plainfield is, right?

DR. PATEL: I do, sir.

SENATOR RICE: You understand the demographics of Plainfield?

DR. PATEL: I'm sorry?

SENATOR RICE: You understand the demographics of Plainfield?

DR. PATEL: I do, sir.

SENATOR RICE: Okay.

“I participate in the JFK ACO” -- which is the Accountable Care Organization, which you are aware of -- “where I receive incentive payments for meeting established quality and cost goals with my patients. I believe in the ACO care model, which helps to compensate my practice for taking the extra steps necessary to improve patient care that were previously unreimbursed under the traditional fee-for-service care model.

“Today I work with other ACO physicians, JFK Medical Center, its care managers, and after-hours call centers to reduce readmissions to the hospital, avoid unnecessary ED visits, and identify patients’ medical issues before they become serious enough to require expensive inpatient admissions. Although it is too soon to declare this model a success, I have seen early anecdotal evidence that the ACO model is having a positive impact on the health of many of my patients.

“I have been informed by Horizon that my practice would be placed in Tier 1 of the OMNIA network, but my hospital of choice to admit most of my Horizon patients -- JFK Medical Center -- is in Tier 2. I am very concerned that Horizon’s decision not to include JFK Medical Center in Tier 1 of OMNIA could have a detrimental impact on the JFK ACO and my ACO patients as long as the plan grows in market share. Moreover, I believe that it will be impossible for JFK to be held accountable for the care only of patients in their ACO, yet they are incentivized to seek care at other hospitals through significant discounts in their cost-sharing obligations.

“I support JFK’s recommendations to require tiered network transparency and to allow any willing provider that can meet health plans’ minimal qualifications for Tier 1 participation to join that tier. This would provide qualified doctors and hospitals immediate access to Tier 1, and would give others clear goals to work towards to join the tier in the future. This will allow all providers to work towards improving health care in New Jersey through innovative care and payment models. “

Was that something that you received there, by chance? Did you receive that communication, by chance?

DR. PATEL: Not personally; no, Senator.

SENATOR RICE: Okay, well, can you respond to that? Because the more I thought about-- When I asked the question about where was our voice, and you kept implying that you were that voice because you come from the same community -- but I have a real big problem with you saying that you are that voice. But I’m going to accept that for now; I have problems given my history, for a lot of reasons. So I’m going to be on the record with that, okay?

But can you respond to this, if you understood it?

DR. PATEL: Sure. And again, it wasn’t my voice; it was a collective voice that our members of the community that I was referencing -- including my voice, just to clarify.

So for Dr. Patel’s patients -- if they were to enroll in OMNIA, they would benefit two-fold: One, they are going to pay less monthly premium; secondly, if they continue to see Dr. Patel, their out-of-pocket will be lower than it is today. So they are going to benefit two-fold.

If they decide to continue to use JFK for their inpatient testing or inpatient admissions if they need it, they'll be no worse off than they are today. And these are the details that Senator Vitale has asked us to provide. So net-net, for an individual who joins OMNIA, for this particular situation, and this particular Dr. Patel's practice, the patient is actually better off -- even if they continue to use JFK as Tier 2.

SENATOR RICE: Do you know how many physicians are similarly situated as Dr. Patel -- as this Dr. Patel, Dr. Raj Patel?

MR. CONLIN: Your question is, how many physicians are there who practice primarily at a hospital that's Tier 2, and they themselves have been designated as Tier 1? Is that your question?

SENATOR RICE: Yes.

MR. CONLIN: I don't have that number off the top of my head. We have just about 24,000 physicians in the state in Tier 1. Most of them, meaning at least half, are in the category of being tightly aligned with one of the hospital organizations that are in Tier 1.

I know we have 6,500 practices that are patient-centered medical homes, whether aligned with the Tier 1 or not. That's another big group of physician as well. But I can't respond off the top of my head to your direct question.

SENATOR RICE: Could you respond, through the Chair, in writing, a breakdown on that and where they're located -- basically geographically, the practices, the doctors -- whatever you can--

Thank you, Mr. Chairman and Madam Chair.

SENATOR VITALE: Thank you, Senator Rice.

Senator Addiego, for a final comment.

SENATOR ADDIEGO: Thank you.

I'm just going to follow up on what Senator Allen had said. And I'm thankful that you agreed -- at least by shaking your head -- to look into the Burlington County situation. But I'm going to assume that you have been misled by the averages with regard to distance for our constituents, and that perhaps it was a mistake.

As you know, as Senator Allen said, more than 50 percent of Burlington County does not fit into your average. So we're looking at, on average, 30 miles for our constituents to have to travel -- which is more than double what your average is. So I am going to ask for a commitment from you to address this issue before 2016. We know that you can, because you've addressed it with regard to obstetrics. So can I have a commitment from you to address this issue in 2016?

MR. MARINO: Senator, we understand the issue. We will go back and evaluate the issue. If you're asking me to make a commitment right here and now as to whether or not there will be an additional hospital in Burlington County, I'm not prepared to do that until we go back and assess the situation that you described.

SENATOR ADDIEGO: But you can make that-- If you find that what Senator Allen has said is, in fact, correct, would you make the commitment in that case?

MR. MARINO: If, indeed, there is new data brought to us that we need to reevaluate, we will certainly consider that.

SENATOR ADDIEGO: For 2016?

MR. MARINO: We will consider that for 2016.

SENATOR ADDIEGO: Thank you.

SENATOR GILL: Is it the particular data, or new data? Because the Senators are saying our position is with respect to the distance.

MR. MARINO: Yes.

SENATOR GILL: And if you go back and you find that the distance is as the Senators indicated, will you in fact add another Tier 1 to Burlington County? Not any other data -- but what they're talking about.

MR. MARINO: Senator, I understand the issue that they presented. We're willing to go back and look at it; we'll go back and test our access standards, and we'll see where that results. I am not prepared to make a commitment right now without--

SENATOR GILL: Okay. So if your access standards disagree with their position, you're not prone to comply with their request.

MR. MARINO: Senator, I'm not prepared to make a commitment until we've researched the data and look at it again.

SENATOR GILL: Okay, thank you.

MR. MARINO: Thank you.

SENATOR VITALE: Mr. Marino and Mr. Conlin, thank you for spending so much time. I know that we still have a lot of questions that are just going to evolve out of this hearing, and questions that we have not asked yet that we would like to ask today. So we may very well come back at another time soon to have an additional hearing.

But I wanted to, lastly, ask you about physician panels -- the State Health Benefits Program.

MR. MARINO: Sure.

SENATOR VITALE: And in order to achieve one of the criteria that's created for Tier 1 providers under the State Health Benefits

Program, which is to offer preferred scheduling-- That was Horizon working with the physician community to ensure that their panels reserve adequate space for the increased volume in their panels. Because we know, not just anecdotally, but there are lots of physicians -- whether they are ob-gyns or pediatricians -- who are booked up. So how do you account for this panel issue?

MR. CONLIN: Senator, your question was, how are we working with them to achieve that? Is that what you're getting at?

SENATOR VITALE: Yes. The State Health Benefits Program requires you to have adequate space in the panels to achieve coverage for new members. So if you're looking at an influx of X amount of new members you have to account for them in the physicians panels.

MR. CONLIN: Yes, what we rely on with regard to that is, in our base contract with the physicians, they represent -- and we rely upon that representation -- that they will make their panels available for our members. To the extent that that's not happening, we encourage our members to get in touch with us so we can communicate with the physicians who are indicating they don't have such access.

SENATOR VITALE: Well, that's sort of -- that's kind of like network adequacy, right? So are you relying on the patient to call you to tell you that, "I can't get an appointment with an ob-gyn in my area," or a cardiologist, or whatever, "in my area;" and not have your people surveying physicians to see-- I mean, because-- You're shaking your head "yes," so you do that, but you said patients do it. So who's going to do it? You want patients to call, or do the plans have to do follow-up on a regular basis to

ensure network adequacy and that the panels account for, pursuant to law, that there's enough space.

MR. CONLIN: Actually, Senator, the approach that we take is a combination of the two. We do rely on patients to give us feedback, just as I mentioned to you. We also routinely and systematically check on the availability of physician access. Some of that we do internally by placing calls into physicians' offices randomly. We also work with an outside vendor who actually does this type of work on our behalf. So we have a set of processes in place that we take responsibility for internally, to make sure that that's the case.

SENATOR VITALE: All right, thank you. Thank you very much.

Yes, we're going to ask some of the other groups to testify next.

SENATOR CODEY: Do you want me to show them where the bathrooms are? (laughter)

SENATOR VITALE: If you wouldn't mind, if you can stay with us for a period because we may want to ask you to come back and clean up some questions, if that's possible.

Thank you.

Dr. Jeff LeBenger, Chairman and CEO of Summit Medical Group.

J E F F R E Y D. L e B E N G E R, M. D.: Dr. Jeffrey LeBenger, yes.

I want to thank the Committee for having us testify today. My name is Dr. Jeffrey LeBenger; I'm the Chairman and CEO of Summit Medical Group and Summit Health Management. To my right is Rebecca Levy, my Chief of Legal Counsel.

The Summit Medical Group started in 1919 and followed the Mayo model. We incorporated in 1929. We have 600 providers. We take care of over 300,000 active patients in six counties in New Jersey. And our mission is to deliver high-quality, cost-effective care through a comprehensive, integrated, multi-specialty group of practitioners.

I came to Summit Medical Group in 1989, and to me it's all about the patient. It's about the New Jersey resident, the patient of New Jersey, and how to take care of that patient. I don't know how to practice in a one- or a two-doctor physician group; I only know multi-specialty. It is a way of an integrated model that we take care of the patient as a whole. We have an integrated healthcare record that everybody gets to see. We have a model in which we have *hub and spoke* -- where we have primary care in the communities; we have centralized urgent care, which is high acuity urgent care; we own our own hospitalists and intensivists who take care of the patients in the hospitals. And what we have shown over the years is that, in an integrated model we've shown that we have been able to meet, in the highest quartile, all quality metrics that the insurers have.

Three years ago, we entered into a pilot program with Horizon; we're calling it *Accountable Care Program*. And we went in full-network with them two years ago. As we proceeded with this product we were able to meet every quality metric with good patient satisfaction, and we were able to lower the healthcare costs 8 percent two years ago and another 5 percent this year.

So when we look at a model of health care and reducing costs, for us it is all about integration, having all aspects of medical care under one roof, and being able to afford quality medicine to New Jersey residents.

One of the ways that we provide good service to the residents of New Jersey and the population is that we try to manage out of the hospital. The hospital is the high-cost center, and people do need hospitals to go in for surgery and other aspects. But, for example, we have four urgent care centers, high acuity, where a patient might come in who has an infection -- diverticulitis, infection of the colon, or they have Lyme disease -- something happens to them and they need IV antibiotics. Normally, that patient would have to be admitted into a hospital for one, two, or three days. But what we do in our institution is that we will see them in our urgent care centers; we will start to instill IV antibiotics, and then we will send them home to take care of -- by our care managers or a navigator, to take care of them at home at a lower cost point.

With that, what we have shown -- and as I stated -- is that we are able to meet all quality metrics in the state and lower the cost by 8 percent; and then by another 5 percent, moving forward.

That's our model; that's what we see. And when Horizon came to speak to us about entering into their OMNIA product, we already showed how we do lower the costs. We felt it beneficial for us, at that point, to be part of their Tier 1 network.

So thank you.

SENATOR GILL: Thank you.

Any questions?

Senator.

SENATOR ALLEN: Were there lengthy discussions, or did they just come to you and say, "We want you to be part of our network?"

DR. LeBENGER: We've had-- Four years ago we started out our discussions with Horizon to go in-network with Horizon in the pilot program. I would say they were very lengthy; they took -- our discussion and our contract took approximately six months to a year to sign.

SENATOR ALLEN: For OMNIA?

DR. LeBENGER: No, no.

SENATOR ALLEN: I'm asking about OMNIA.

DR. LeBENGER: For Horizon, not for OMNIA.

SENATOR ALLEN: I'm asking--

DR. LeBENGER: We were already in a value-based product with them. And we showed how we saved dollars for them and for the employers -- for the beneficiaries. So for us-- It was simple for us to go into their Tier 1 network because, if they are lowering costs to the hospital systems in the state, it would be beneficial for our patients.

SENATOR ALLEN: So they came to you and said, "We have this new thing, and we want you to be part of it."

DR. LeBENGER: Yes.

SENATOR ALLEN: And that was when?

DR. LeBENGER: I think it was approximately about nine months ago or so.

SENATOR ALLEN: Thank you.

SENATOR GILL: With respect to the OMNIA partnership, did you receive from Horizon any requirements or qualifications in order to become part of the OMNIA partnership?

DR. LeBENGER: No. We already had aa, we'll call it, *accountable care product* or a *shared savings product* with them. And we've

already met, in the top quartile, every quality metric; and beat the market by 8 percent two years ago, 5 percent this year. So for us it was simple to enter into that tiered product, because we lowered the cost in the hospitals that we do send our patients to.

SENATOR GILL: And my question was not, “Was it simple for you to do it?” but did they present you with any requirements, any metrics, any indication of how they would weigh certain things, or did weigh certain things, in order to invite you into the partnership?

DR. LeBENGER: As I stated, we already had our shared savings product with them, so we just placed it within.

SENATOR GILL: I understand that. But you weren’t in -- you were not in a partnership at that point that--

DR. LeBENGER: No.

SENATOR GILL: Okay. So we know you did particular things that would make you be an attractive ask. I’m asking you, did Horizon provide you with any kind of metrics, any kind of requirements that you would have to meet or they were looking for in order to invite you into the partnership?

R E B E C C A L E V Y, Esq.: It’s our understanding that the criteria--

SENATOR GILL: Now, who are you?

MS. LEVY: I’m Rebecca Levy; I’m the General Counsel for Summit Medical Group.

SENATOR GILL: Okay, so you don’t want-- Doctor, you’re not going to answer this?

DR. LeBENGER: I can answer.

MS. LEVY: Okay.

DR. LeBENGER: I'll answer.

MS. LEVY: I'll answer. It's our understanding that the criteria for the OMNIA partnership were very similar or the same as to what we had entered into when we did, initially, a pilot.

SENATOR GILL: Did they give you the qualifications? Did they give it to you?

MS. LEVY: Yes.

SENATOR GILL: Not what you assumed--

MS. LEVY: Yes.

SENATOR GILL: They gave-- Okay. So they gave you a piece of paper, a contract or something that said, "These are the qualifications, these are the metrics. But this is what we're looking for in a partner."

MS. LEVY: It wasn't a checkbox with criteria, but it was-- In the contract, we have very specific criteria that we have to meet in terms of quality metrics and costs.

SENATOR GILL: Before you signed the contract-- I understand the contract, okay? I'm asking about the invitation. When you were invited into OMNIA-- And we can make this even "yes" or "no," I'm not trying to-- If they didn't give it to you, fine. If they did, then I want to know what it said. Did Horizon give you, before you signed a contract to be in the partnership, any kind of requirement, metrics that they were looking for that you possessed that made you an entity to become a partner with them?

DR. LeBENGER: I would say they asked us to continue the metrics and the requirements that we already had in our product. They did not come back with new metrics.

SENATOR GILL: Did they give you any written document with respect to that?

DR. LeBENGER: No. It was a continuation of our contract.

SENATOR GILL: And so this is an oral conversation?

MS. LEVY: No, it's very detailed in our original contract. I understand--

SENATOR GILL: And you want to go to the contract. I understand that, because that avoids the question.

MS. LEVY: No, no.

SENATOR GILL: But my question is with respect to the invitation to be in the partnership. And the doctor has answered it, which is okay. It was oral: "Come in to the partnership, I like what you're doing." I can understand that, but it was oral. I'm looking for a document to see if they showed you a document, did they show Saint Barnabas a document, or was this a discretionary function totally without metrics, or really without any kind of memorialized process? That's all I'm asking you and-- Okay, so we'll move on. It was oral.

The other thing is, when did you sign the contract to be in the OMNIA Alliance?

MS. LEVY: So we signed an amendment to our population health agreement. We have a lot of contracts with Horizon -- we have the rate letters, we have the amendment. We were given the OMNIA contract; we were negotiating. This obviously has slowed down a little bit. We have a few business items that we're working out because it's part of a big alliance with governance decisions, so--

SENATOR GILL: I understand that. So you have not yet signed the partnership agreement -- for whatever reasons -- with Horizon.

MS. LEVY: Correct. We signed the amendment to make us Tier 1, but have not executed--

SENATOR GILL: And we know that Tier 1 is not the partnership agreement, okay?

MS. LEVY: Yes.

SENATOR GILL: So Tier 1 is over here (indicates); that's the product. I am focused on the partnership agreement because, here again, Horizon advertised and said in their advertisement that you were -- that is Summit Medical Group; that we might add does excellent work. So we're not here talking about the quality of the care that you give. I'm here talking about the issue of the partnership and what Horizon has done. Horizon -- they have your logo all over, leading the public to believe that you have already signed on as a partner. Now, you may have done significant legal steps in that direction, but my understanding is that you are still in negotiations.

MS. LEVY: Yes.

SENATOR GILL: Okay.

MS. LEVY: As a lawyer, I'm sure you understand there are many different phases of the contracts.

SENATOR GILL: As a lawyer, I understand negotiations.

MS. LEVY: Right.

SENATOR GILL: And I understand advertising as if you're already in the partnership. You don't even need to be a lawyer to do that. We're just talking about, what is Horizon saying to the consumer? Horizon

is saying to the consumer -- and this goes back to why we need oversight and transparency -- Horizon is saying to the consumer in every infomercial, anything on the Internet, "Look who we have. Look who's in our partnership." So for instance, I may think, "Hmmm, you know -- I think Barnabas is excellent. That's in that partnership. I think that's some place I'd like to go. You know why I'd like to go there and why I want to participate in that? It's because this partnership includes Summit Medical. And every time we've gone to Summit Medical, it has been excellent. So if Summit Medical and their logo are here, that partners in it, I want to be partners too."

So I'm not -- and this does not reflect on you; you do excellent work. And so Horizon-- And I don't know how many others that are said to be in their partnership; really, they may be working towards a partnership. But it's clear that we have issues of how they advanced in advertising and what they did.

I have no further questions for you.

Any other Senators?

And thank you--

Senator Cardinale.

SENATOR CARDINALE: Just a follow-up so that I can understand this.

If an OMNIA patient phoned your office tomorrow morning and said, "I have Horizon OMNIA. I want to come in as an OMNIA patient. Do you accept OMNIA patients?" What would the response be?

DR. LeBENGER: If I understand the question -- if a patient calls, and they are an OMNIA patient, and they have an issue, what would

we say? Open enrollment has not occurred yet, so I don't think the product is on the market just yet. But we do take calls prior--

SENATOR CARDINALE: It's on the market in a couple of days, I understand.

DR. LeBENGER: I'm sorry?

SENATOR CARDINALE: It's only a few days, but I understand what--

DR. LeBENGER: Right. So if this was in a few days from now, and we are part of OMNIA, and the patient calls, we do tell them that we accept their Horizon benefit and the OMNIA benefit, and they could see us in our offices.

SENATOR CARDINALE: So you would see the patient.

DR. LeBENGER: Yes.

SENATOR CARDINALE: Thank you.

SENATOR GILL: And there's a difference between the OMNIA product -- the tier -- and the OMNIA partnership.

DR. LeBENGER: Excuse me?

SENATOR GILL: There's a difference between the partnership and the products.

DR. LeBENGER: Right.

SENATOR GILL: So you could sell the product and not be in the partnership.

DR. LeBENGER: Correct.

SENATOR GILL: Or could sell the product, and be working to be in the partnership that you're still negotiating -- but you are identified as if you are a partner in the roll-out by Horizon.

DR. LeBENGER: Yes.

SENATOR GILL: Okay, thank you.

I have no further questions.

I see your light on. I know you're the attorney; we always want to get the last word. (laughter) Is there something else you'd like to say?

MS. LEVY: No, thank you.

SENATOR GILL: Okay. Thank you very much for your testimony.

DR. LeBENGER: Thank you.

SENATOR GILL: We have representatives from the Department of Banking and Insurance. I think we have the Director of Insurance and the Assistant Director. I guess we don't have -- although it is very good to see you -- we don't have the Commissioner of Banking -- the Acting Commissioner of Banking and Insurance.

P E T E R L. H A R T T: That's correct, Senator.

SENATOR GILL: Was his schedule too crowded?

MR. HARTT: I understand he had another commitment.

SENATOR GILL: Okay. Well, it's nice to see both of you. And I'm quite sure you are well equipped to answer the questions.

MR. HARTT: Thank you, Senator.

SENATOR GILL: Would you like to make a statement, and then be questioned?

MR. HARTT: Yes, please, if I may.

SENATOR GILL: Oh, sure.

MR. HARTT: Thank you so much.

SENATOR GILL: And Senator Rice isn't here, but you better still identify yourself. (laughter)

MR. HARTT: Good afternoon, Chairwoman Gill -- and also, I guess, Chairman Vitale is not here at the moment, but I send my greetings to Chairman Vitale as well -- and members of the Senate Commerce Committee and the Senate Health, Human Services and Senior Citizens Committee.

My name is Peter Hartt; I am the Director of Insurance for the Department of Banking and Insurance. And I am joined today by Assistant Director Kristine Maurer. Thank you for inviting the Department to testify today.

While I have provided you with a more comprehensive overview of the regulatory responsibilities in the Department -- including citations to our key statutes and regulations -- in the interest of time, I'll shorten my opening statement to just briefly highlight a few key elements.

So to begin: The mission of the Department of Banking and Insurance is to regulate the banking, insurance, and real estate industries in a professional manner so as to protect and educate consumers; and to promote the growth, financial stability, and efficiencies of those industries in this state.

Specific to health insurance, the Department, in conjunction with the individual health coverage and small employer health program boards, has been granted statutory authority to regulate fully insured health benefit plans sold in the commercial markets in this state. Fully insured plans are health plans where the insurance carrier bears the costs of the claims generated by the plans' members, in return for payment of the

insurance premium. Only about 25 percent of health plans in the state are fully insured, and thus regulated by our Department.

Most citizens obtain their health coverage through self-funded plans offered by their employers. In these plans, the employers bear the financial responsibility for payment of the healthcare costs, and the insurance carrier simply administers the plan in return for the payment of a fee.

Now, the Department has the sole authority to license insurers to transact health insurance business in the state, after determining that they meet the standards set forth in our laws. We conduct continuous risk-focused monitoring and examinations of health insurers' financial condition to ensure that the companies have sufficient funds to provide health insurance coverage to our consumers, and to pay claims to healthcare providers. We review insurers proposed premium rates to ensure that the rates being charged are not inadequate, or excessive, or unfairly discriminatory; and are in compliance with all other State and Federal requirements.

Additionally, the Department has an entire unit dedicated to consumer protection, and that's called the Office of Consumer Protection Services. This unit accepts complaints and inquiries from consumers, from providers, and from others; and it provides assistance and guidance. It reviews any actions by Department licensees -- that would be both insurers and producers or agents -- that are of concern or that have been the subject of complaints; and we look at those for violations of our laws. And then we institute enforcement actions against licensees whenever necessary.

Most relevant to this Joint Committee hearing is the Department's role in reviewing the adequacy of provider networks created by insurers and sold to New Jersey employers and residents, in order to ensure that there's adequate access to care for consumers. New Jersey is a national leader in network adequacy requirements. For example, the national agency charged with accrediting each state's insurance department -- known as the National Association of Insurance Commissioners -- is developing a national network adequacy model law right now that, if adopted, still would contain standards less specific and not as protective of consumer access as we currently have in place in our state.

While the testimony I provided you with includes a lengthy history of our network adequacy rules and a detailed description of those standards, I would like to just mention that the Department continuously monitors and updates our regulations to keep pace with industry trends. Our regulations require all carriers offering managed care plans in this state to maintain an adequate network of primary care physicians, certain specialists, and ancillary providers.

The Department reviews all networks to be used by insurers for fully insured health plans sold on the commercial market, and by Medicaid HMOs to ensure that these standards are, in fact, met. The Department's network adequacy standards do not apply to self-funded plans like the State Health Benefits plan, or to Medicare plans.

Over the past few years, and coinciding with the advent of changes caused by the Federal Affordable Care Act, and continuing upward pressure on the costs of health care and insurance, health insurers have been looking for ways to lower the cost of insured health products and to offer

consumers more choice. As has been reported in the media, insurers throughout the nation have used limited or narrow networks and/or tiered network product offerings to provide consumers with lower costs and more choices. To clear up any ambiguity here, I must stress that both tiers include all in-network providers the consumers may select from, albeit with different in-network cost-sharing rates. Therefore, tiering in this context bears no relation to the out-of-network, in which consumers are subject to much greater cost exposure when receiving--

SENATOR GILL: Sir.

MR. HARTT: Yes?

SENATOR GILL: I don't mean to interrupt. And I'm quite sure we kind of have a working understanding of tiers and tiering. And, in fact, although we sent a letter to the Acting Commissioner on September 25, 2015, asking him for information -- specific information, we didn't even get your statement until 10 o'clock this morning, after we were scheduled to begin.

So we don't need a broad-ranging discussion on the theoretical implications. We don't need a history. We need to talk about, specifically, Horizon and this particular product. So maybe we can get to that -- either we can get to that through questioning, if that gets it to be more focused with your reply; or if there's something in your written testimony that would go specifically to this discussion.

And to help you do that, I would just like to read into the record as to what we asked you for -- you meaning the Commissioner, Acting Commissioner, in the letter.

“As part of the regulatory duty, the Department of Banking is required to approve all new insurance plans sold to residents of our state, as well as its rate increases on existing plans.” And then it goes on to talk about the tiers, “We have requested that Horizon suspend, for 30 days, their release; and a moratorium will allow consumers for Horizon to hear about the cost.”

We sent a further letter. Keeping track of papers is not my forte, so-- (pause for memo search)

While we look for that document-- So if you can narrow your testimony to Horizon and this issue. Thank you.

MR. HARTT: Yes, Senator. I absolutely will do so. I apologize.

So I'll jump ahead. Horizon previously obtained approval of and sold a tiered network product known as *Advance* -- and that was in the 2015 individual health insurance market. However, reflecting consumers' cautious approach to purchasing plans comprised of tiered networks, Horizon *Advance* tiered products represented less than 3 percent of the company's total statewide enrollment in fully insured health benefits plans.

Now, Horizon has publicly stated that it intends the OMNIA network to *a*) replace its *Advance* tiered network offerings in the fully insured market, and *b*) to supplement the continuation of all of its full network -- that would be non-tiered offerings -- also in the fully insured market.

Now, upon filing of the OMNIA tiered network, Department staff -- over the course of a number of months, actually -- undertook a diligent review of the data submitted by Horizon in support of the network

that included multiple tables of primary care physicians, specialists, hospitals, and enrollment projections by geographic location.

SENATOR GILL: And this is where I'd like to stop you. Because we asked in the letter of September 25, to the Acting Commissioner, "Given the Department's review of the OMNIA Alliance and its new tiered network plan, we ask that you provide the Committee, by October 1, 2015, with all documents you received from Horizon," -- and clearly you must have received some, because you're talking about what a diligent job it has done -- "relating to OMNIA Alliance and the new tiered network plans that were used in DOBI's network adequacy review."

We did not receive any of that requested information that obviously you reviewed -- because you're talking about information you reviewed. We received nothing from the Department until 10 o'clock this morning. And, quite frankly, that statement -- a treatise on the tiered system and the function of DOBI -- absolutely does not address this letter at all.

And the reason I sent you the letter -- Senator Vitale and I -- in advance was so that whatever documents you have -- we're not here trying to play trial by ambush -- that the Senators on the Committee would have an opportunity to review so that we could ask you questions that are both productive and informative for the consumers and the public. That's why I requested the material.

There was no response except this response at 10 o'clock, and your response there. So now, do you have with you these documents, so that when we begin to question you on specifics you have the information before you?

MR. HARTT: So first of all, I appreciate your concerns about the timing, and I apologize that it was not--

SENATOR GILL: But that's okay; it's not-- You're not the Acting Commissioner; you're just the one he sent. (laughter) So I never -- I'm not here trying to kill the messenger. So you don't have to worry about me on that. I just want to know if you have those documents that we requested before you now so we could ask specific questions.

MR. HARTT: Right. I do not.

SENATOR GILL: Okay.

MR. HARTT: And the main reason for that, Senator, is that it's more than 700 pages -- the documents that were requested, that were produced, as you noted, just at the start of the hearing. They are in excess of 700 pages. But we have a good understanding of them at a high level, and we'll certainly try our best to answer your questions.

SENATOR GILL: Well, if the State of New Jersey can't reproduce 700 pages from the Department of Banking and Finance (*sic*) to the Chair of the Commerce Committee and to the Chair of the Health Committee, then we have a real issue.

Senator Gordon wanted to make a comment.

SENATOR GORDON: Yes, I don't need a review of the 700 pages, but I wondered -- and I'm sure my colleagues on the Committee share this question -- could you review the process that the Department undertook to evaluate the network adequacy, and the ability of the Horizon OMNIA plan to satisfy the requirements set forth by the Health Care Quality Act and the regulations that you're supposed to implement? Could

you take us through the process -- how did you establish the adequacy by specialty and by geographical coverage?

MR. HARTT: Right.

SENATOR GORDON: For starters, I think that would be very helpful.

MR. HARTT: Sure.

SENATOR GILL: And Senator Rice may -- we'll come back to have you answer that.

SENATOR RICE: Yes, for the record -- I want the 700 pages. See, the assumption is that we don't read. The assumption is that we don't have folks who work with us who-- And I always tell people, "You don't have a monopoly on brains." We know what we're reading. To get a summary of what you think is good, but when you put the totality of the documents together, there are questions that give rise to kind of offset some of the things that appear to be positive or valid on the surface -- that raise additional questions.

And so I agree with the Chair. For the Administration to say that we can't get 700 pages -- to be quite frank, we should be able to get as many pages as we want. We pay for this stuff, okay? That's where your budget's coming from. So I think that should be done right away. And I know you're just the messenger, as the Assistant, but I kill messengers.

You see, my attitude is that if they're going to send you, then you take it back.

MR. HARTT: Right.

SENATOR RICE: You know, so the thing is, take it back and let them know that we need the 700 pages, through the Chair. I mean, it's

just that simple. Because I guess what's bothering me is for over a year now -- a couple of years, it seems like, on the Administration's side -- it's almost as though we're not legislators under the Constitution. It's almost like we're just placeholders. We ask people to come before us; they can't come because they're acting. We ask for documents, we can't get them until people want to give them to us. And I've been here long enough to know we don't function that way. And eventually, the Legislature, in its totality, needs to take on the Administration and make it very clear that if we're going to budget for the records and the commissioners, they are going to respond to us. We can't tell them what to do, but to disrespect these houses-- I'm up to here with that.

So I want the 700 pages, Madam Chair.

SENATOR GILL: I'm quite sure--

SENATOR RICE: You can get the summary, because maybe you don't read as well as I do.

SENATOR GILL: I'm quite sure that we will--

SENATOR GORDON: I'm working on my reading.

SENATOR GILL: I'm quite sure, gentlemen, that we--

MR. HARTT: If I--

SENATOR GILL: I'm quite sure. We have made the request; we know it's 700 pages.

MR. HARTT: So if I may, on this, because I want to make sure that it's clear. Perhaps I misspoke.

First off, I want to assure you -- there was no assumption whatsoever that members would not read 700 pages. The 700 pages--

SENATOR GILL: That was rhetorical.

MR. HARTT: Okay.

SENATOR RICE: No, it wasn't.

SENATOR GILL: You will-- We understand. We asked for the 700 pages; you don't have it. Now, if we could get--

MR. HARTT: Well, I just want to be clear. It was produced to the Committee. My point -- and this is where I, perhaps, misspoke, so I apologize -- my point is I do not have the 700 pages in front of me, and I guess that was--

SENATOR GILL: It was produced to the Committee?

MR. HARTT: There was concern-- I didn't think I had-- There was a lot of utility in me being able to go through 700 pages in the Committee hearing setting.

SENATOR GILL: Okay.

MR. HARTT: But 700 pages were provided to the Committee--

SENATOR GILL: At 10 o'clock this morning.

MR. HARTT: Yes.

SENATOR GILL: Okay.

MR. HARTT: Exactly; okay?

SENATOR CARDINALE: Madam Chair.

SENATOR GILL: But we have-- Yes?

SENATOR CARDINALE: May I add to your request?

SENATOR GILL: Yes.

SENATOR GORDON: May I get my question answered?

SENATOR GILL: Yes, we're going to do that, Senator.

SENATOR CARDINALE: On this point of the request, may I request that the Minority Office be copied with those 700 pages as well?

SENATOR GILL: Yes, you know me. I'm for full disclosure and transparency.

Now we will get back to Senator Gordon's question.

MR. HARTT: Right, thank you.

SENATOR GORDON: And if I could just amend that, because Senator Rice wasn't here at the time.

We're particularly concerned about what we've heard about the network inadequacy in urban areas and in areas populated by low-income households.

MR. HARTT: Right. So thank you, and certainly a very pertinent question, and certainly very valid concerns.

So to begin with, the standards that we applied for a review of the OMNIA proposals were the same standards that we've applied to all of the other tiered network offerings that exist in the state, and that came to us, that were subject to our review and networks in general. They're the same set of standards; they're spelled out by regulation.

To be specific, there are a few different standards depending on the type of service that we're talking about. For PCPs -- for primary care physicians, there's a 10-mile or 30-minute driving time standard. For specialists, there's a 45-mile or 1 hour driving time standard. For acute care hospitals and surgical facilities there's a 20-mile and 30-minute driving time standard. And then for a series of other types of services, there's also a 20-mile and 30-minute driving time standard.

So when the files come in-- And, again, they're lengthy -- right? -- because there's a list of all of the providers in all of these different areas. We're looking at that, and we're also looking at the enrollment that is expected to take advantage of this network -- to be used in or having to use this network if the consumers in that pool of enrollees have decided to take advantage of this offering. And so then what we do is we compare all of those providers in whatever category to the base of the enrollees who are projected for the plan, and we apply those time-and-distance standards in each case to make sure that the regulatory requirements are met. And so we did that here in the case of OMNIA.

SENATOR GORDON: And if I could just follow up.

Do you do any kind of audit to verify the accuracy of the data? And I ask that in the context of what we've learned about the adequacy of networks in the behavioral health area -- where we're told that an insurer is providing adequate coverage in the area of behavioral health, and then when we do an analysis, we find there are only 30 psychiatrists in the state taking new patients. And on further analysis, you find that the practitioners are no longer at a particular address, or they're not accepting patients.

MR. HARTT: Right.

SENATOR GORDON: And so is there some kind of audit of the data presented by an insurer like Horizon to make sure that it is accurate and up-to-date?

MR. HARTT: Yes; thank you, Senator. Good question.

So we do an ongoing review of this. Also, the insurer is obligated to provide us with updates if the situation changes. But we can

get information from elsewhere as well. So if we receive other information that indicates that something might have changed in that network, we can go back in and look at it to make sure the accuracy is still met. And if it is not met, then we go to the insurer and require that they meet it.

I would also say that if an insurer -- and, fortunately, this hasn't been a problem to date -- but if an insurer was somehow trying to pull a fast one and not provide the adequacy that they claim they are providing, then we would take enforcement action in those instances.

The one caveat, though -- and you mentioned behavioral health; it's a good example -- it is important to realize there are some instances where there aren't actually enough providers in a given geographic location to meet adequacy. But we have a safety net for that situation, which is that if you can't get the in-network provider, then you are entitled to use an out-of-network provider at the same cost-sharing level that you would be paying if that provider was in-network. So there is a safety net, or safety valve in those situations.

SENATOR GILL: Senator, before we get to you--

Senator Allen, out of the 700 pages that they dropped on us this morning -- some of which they claim they can't produce because Horizon has represented it as proprietary -- there is this memo that was just produced that I think maybe you may want to also read.

SENATOR VITALE: Somewhat redacted.

SENATOR GILL: It's redacted; part of it's redacted. But it's about Burlington County.

And so you can continue with your questioning, but I want you to have it.

SENATOR ALLEN: Thank you.

So we're talking about adequacy. And I am thankful that the change has been made for ob/gyn in Burlington County. It is an issue, without question, and clearly that decision was made to make a change.

You're talking about a 20-mile standard; is that what I'm understanding?

MR. HARTT: For acute care hospitals and surgical facilities, that's correct.

SENATOR ALLEN: So we have some large parts of Burlington County that are not covered--

MR. HARTT: Right.

SENATOR ALLEN: --by that 20-mile standard. And we have hospitals that could fill that. So why are we not moving towards having another hospital in that tier?

MR. HARTT: Yes, so a very good question that really illustrates an area that I think there's been some confusion about -- in terms of what the network adequacy standards do.

So the standard is not in relation to a set of borders -- okay? -- municipal borders or county borders. The standard is in relation to the consumers who are going to be using the plan.

SENATOR ALLEN: Right, which is exactly what I said. The 20-mile standard -- and we know that if you live in Tabernacle, it's 30 miles to Cooper, 32 miles to RWJ Hamilton, and 27 to SOCH.

MR. HARTT: Right. So we would look -- and I appreciate that, and that's an important point. So we would look at the pool of customers who would be in this plan. The standards are applied to that

pool of customers; not everybody in a given geographic area, but the people in that plan. In addition, the standard is, under the rule -- the standard is 90 percent of that pool. So the time-and-distance requirements are applied to at least 90 percent -- that's a minimum -- 90 percent of the people in the pool who are actually going to be using this plan. So that, of course, does mean that there are situations where there is somebody in a certain part of a county who is farther away. But again, the standard is for 90 percent of the people who are in that plan.

SENATOR ALLEN: Right. But if you look at this map with the dots of where everybody is, almost everyone is within 20 miles, for sure. There's one small part of Warren, there's one really big part of Burlington, small parts of Camden and Atlantic. So there's one area where there's a big part of our state that isn't covered. And you clearly recognize that, based on your decision to push ob/gyn.

MR. HARTT: Well, thank you, Senator. I appreciate you acknowledging that, because I think there has been some confusion here.

You know, when Horizon submitted this OMNIA plan, and we looked at what it meant for residents of Burlington County, we identified -- proactively, ourselves -- identified that the plan was not meeting the network adequacy group requirements for OB for those residents. So we insisted that Horizon make the changes necessary to meet those adequacy requirements. So this was not sort of a voluntary thing on their part. I just want to make sure that that's understood.

SENATOR ALLEN: Yes, I appreciate that. And certainly Senator Addiego and I, in talking with DOBI, reinforced that point for ob/gyn. But we reinforced it for other things as well.

MR. HARTT: Right.

SENATOR ALLEN: Whether it be getting chemo, or whatever the issues are, it's really unfair to ask a large portion of Burlington County residents to be the ones who have to travel the longest. If it was just a couple of residents in this county, and a couple in that county, and a couple in another -- that would maybe be a different thing. But we're talking about a large hole in the center of Burlington County. And we need to make sure that we have a hospital that handles everything, not just ob/gyn. And I would ask -- I would firmly ask that you take a look at that another time, that you make sure that you feel that Burlington County is adequately covered. Because I can tell you, the two Senators who represent Burlington County do not.

MR. HARTT: Okay. So thank you, Senator.

So first off, when we did the initial review, we certainly were confident in that initial review that the standards under the rules were met. When the issue was raised, we took another look at it, okay? And we continued to be confident the standards under the rule were met. I completely appreciate that there may be some concern that maybe those standards are not addressing all of the issues or all of the concerns that folks may have. But our job as regulators is to enforce rules; we expect companies to follow our rules, while we expect that we ourselves will follow our rules as well; and that's what we did here.

SENATOR ALLEN: If it turns out that you do not believe that we have our residents -- a large portion of our residents covered, that you feel that us being on the outside looking in is something that's acceptable, I

would like to see all of your notes on that to understand how you arrived at putting our county outside of the norm to that extent.

MR. HARTT: Okay. So we would be appy to provide an analysis of that, through the Chairs, of the review that we did and how we arrived at the various decisions. It doesn't have to be just limited to Burlington County. We can talk about how we got there, and I hope that would be helpful.

But I do want to clarify that acceptable -- what is acceptable, what's not acceptable really depends on sort of where you're sitting. For us, acceptable is, does it meet the rule? And I realize that that doesn't result necessarily in something that is acceptable for everybody else who has other sets of concerns. But for us, who are rule makers and enforcers of rules, and follow our own rules, that's what's acceptable for us-- is that it, in fact, complied.

SENATOR ALLEN: Just one further point.

I mean, everybody talks about access. Our people in the middle of Burlington County aren't getting that. You're talking about adequacy. This is not adequate, in our estimation. And the people who are living in this part of Burlington County, in particular, are lower income. So once again, we're looking at those folks as the ones who aren't being covered, who aren't being given consideration, who are just outsiders, who are losers in all of this. I don't think that's right, and I again reemphasize our wish that you would look at this very closely.

MR. HARTT: Thank you, Senator.

SENATOR GILL: Senator Vitale has a question.

SENATOR VITALE: Thank you. Thanks for appearing today.

I have a question about -- to follow-up on the issues raised by Senators Addiego and Allen regarding the network adequacy in their county.

So I have in front of me some of the data, and at least one med/surg be OB and critical care in any county or service area greater than 20 miles or a 30-minute drive for 90 percent of covered lives. Am I reading that -- this rule doesn't necessarily require Horizon to provide anything more than they are already providing, pursuant to what you require them to do? Or can you also require them to provide some additional services? I mean, do you have the latitude -- do you have the regulatory latitude to do that, or-- I'm sorry; my last question -- or do the OB rules -- are they different than everything else?

MR. HARTT: Right. They are not. So first off, we do not believe that we have the latitude to require Horizon, with the OMNIA network or their prior existing network, or any other company with any of their networks or tiered networks, to do more than what is specified in the rule. We do not believe we have the authority to compel them to do anything more than what is required by the regulation. And we believe, again, in having looked at it more than once -- we believe that what they are doing does in fact abide by the rule.

SENATOR VITALE: So how were you able to compel them to provide OB? Are they doing this out of the kindness of their heart, or are you putting the squeeze on them? How are you getting this done?

MR. HARTT: Yes, thank you. That's such a great question.

It was simply the fact that their initial proposal did not meet the requirements of the rule with respect to OB.

SENATOR VITALE: So, to OB.

MR. HARTT: Yes, it did not. And so that's why we told them, "You're going to have to fix that," and that's why they came back and added two hospitals at Tier 1 for OB.

SENATOR VITALE: But it's my understanding that OB-- Are you saying that OB has separate rules for network adequacy than every other--

MR. HARTT: No. Well, there's a list here--

SENATOR VITALE: Right. Peds, med/surg, OB, critical care -- aren't they all co-equal?

MR. HARTT: Well, there are different standards depending on what type of service we're talking about. So a primary care physician has a standard, the hospital-- I mean, if we're talking about OB as obstetrics in the hospital, that would be the hospital standard.

SENATOR VITALE: Yes, but I'm talking about acute care, though. So acute care -- don't the same rules apply? I may be missing the point here.

K R I S T I N E M A U R E R: Senator, if I may, really quickly.

The standard is the same; you're correct. So it's the 20-minute or 30-mile driving time -- or 20-mile, 30-minute driving time within 90 percent. And that's the same for acute care hospitals and hospitals that provide obstetrics.

With regard to Burlington County, as Director Hartt indicated, we originally saw that there could be some concerns because there was a lack of a Tier 1 within the county. So our staff looked at it a bit closer and they got GeoAccess reports from Horizon with regard to acute Tier 1

hospitals, and then also drilled down with the specifics of looking at the surrounding Tier 1 available hospital, it met the network adequacy standards in the rule, but there was -- it was 2 percent short with regard to obstetric services. Thus is why we required, under the rule, them to add two additional hospitals for Tier 1 in Burlington County.

MR. HARTT: And when Assistant Director Maurer mentions the 2 percent short -- in other words, they were close; they were at 88 percent; they satisfied for 88 percent of the enrollee base, but not 90 percent. And that's when we said, "Well, 88 is-- You may think its close, but it's not good enough. It has to be 90."

SENATOR VITALE: So what about they never get us with respect to trauma -- so with Tier 1 and Tier 2's? Sorry -- the Level 1 and Level 2. So Capital is a Level 2 Trauma Center in Trenton; and University is a Level 1 Trauma Center in Newark. Where are the-- It says that they must have a contract to cover all medically necessary trauma services, right? So how will you apply, or how will they apply, or how will you allow them to apply the payment schedule for--

So earlier I had a question or two, to them, and put a question to them that if someone was admitted through the emergency room at a Tier 2 facility-- And while the emergency services were covered normally, without any additional expense, once they were admitted -- because they had to be -- the Tier 2 costs kicked in. Will the same thing apply in trauma facilities as well? Is this something that you can allow or disallow to have happen, or is that just contractual? Because it seems to me that you require it-- If you're going to a trauma center, you're going there for a reason, whether it's a 1 or a 2. And you're directed by the ALS or by the

paramedics. Then you're going to get stuck with a higher bill. I mean, how does that -- what can the Department do to intervene on its policy?

MR. HARTT: Right.

SENATOR VITALE: And just lastly, does Horizon's plan meet network adequacy with respect to trauma facilities?

MR. HARTT: Yes, it does. But I appreciate your concern. I mean, there are situations where somebody ends up in a facility; they didn't have the opportunity to choose which facility they were going to go to; and that facility turns out to be a Tier 2 facility instead of a Tier 1 facility. And in that case, under the current proposal or the current plan, that person would be paying the Tier 2 cost-sharing level -- which is basically a standard cost-sharing level -- instead of the discounted cost-sharing level that was in Tier 1. That is absolutely the case.

SENATOR VITALE: Right. So at the very least, they should pay the Tier 1 cost share because they're there through no fault of their own; meaning that they were taken to the emergency department by a rig, because either they were unconscious or that's where they had to go -- for example, they had a stroke or something, and they are going to take them to the comprehensive stroke center that is closest. A gunshot wound to wherever -- to University or, for that matter -- because they were Level 2 as well. But you are going to be treated differently.

I dispute that. The cost for that person who was admitted at a Tier 2 will be the same as it is if they had some other ordinary HMO. I dispute that. In the State Health Benefits plan, of course, they will see an enormous cost, the co-insurance -- upwards of 20 percent. And in the

private market, I think a commercial policy, I think -- the folks at Horizon said that it's basically the same. I think that's a pretty subjective word.

MR. HARTT: Right.

SENATOR VITALE: So I guess my point is, it seems unfair to the patient who presents -- finds themselves at a Level 1 or Level 2 trauma center. And they're stuck with a higher co-insurance than if they had been lucky enough to go to Robert Wood -- their Level 1 trauma center.

So what can the Department do about that?

MR. HARTT: Well, first, I appreciate the concern. But we do not have a basis to compel a different result, because the rule does not provide for us the authority to compel a different result.

SENATOR VITALE: You're talking about the network adequacy rules as they exist today?

MR. HARTT: Yes, sir.

SENATOR VITALE: Thank you very much. Thank you.

SENATOR GILL: Now I understand why you would like to give us 700 documents at 10 o'clock. But having a good staff, I did find some documents that I'd like to question you on.

It would appear that on September 15, Horizon was aware that the Tier 1 hospital in Burlington County did not meet network adequacy. And in fact it was at 88 percent. Are you aware of this?

MR. HARTT: Yes. So--

SENATOR GILL: No, I didn't want "so, um." I asked you, are you aware of it?

MR. HARTT: I am aware that they did not meet network adequacy.

SENATOR GILL: Okay. So they didn't meet network adequacy for Burlington County.

MR. HARTT: For OB, yes.

SENATOR GILL: And they asked to be allowed to work out a solution, correct?

MR. HARTT: Yes.

SENATOR GILL: And that solution was not with respect to the rules and regulations you say that you had to enforce as regulators, because they had not met the adequacy rule for Burlington, correct?

MR. HARTT: Well, I have to disagree.

SENATOR GILL: Well, I'm sure I have -- all I have is an e-mail here that you supplied at 10 o'clock among the 700 pages, okay?

And it's that -- it was aware that Burlington -- Tier 1 -- only met 88 percent, right?

MR. HARTT: For OB, correct.

SENATOR GILL: Yes. And in fact Horizon asked you -- meaning the Department -- "At this time, we would like the latitude to conduct one of two options." And of course, we received this e-mail, and those options are redacted. So we don't even know what options Horizon presented, knowing full well they did not meet the adequacy rule. And is it when I saw your -- you know, I mean the Department's -- is it the Department's position that the options redacted, but put forth by Horizon-- Why did you redact?

MR. HARTT: Because the options were business proprietary. Those were decisions -- those were business decisions that Horizon was weighing in order to ultimately meet the requirements of the reg. And so

the discussion was basically, “You have to meet the requirements of the reg.” There are different ways to meet the requirements of the reg; you can make a decision about which way you’re going to choose. But at the end of the day, you have to meet the requirements of the reg.

SENATOR GILL: And it was clear that at the end of the day on September 15, they didn’t meet the requirements of the reg. This is the e-mail you provided to me (gestures) and it says, “Due to timing, we received this information pertaining to Burlington; we would like the latitude to determine which solution works best. We are confident that the above approach addresses any access concerns. We will follow up shortly to go over questions you have.”

So when the Department sent out this September 18 letter approving the OMNIA network, the Commissioner -- or the Department was aware that on September 18 Horizon had not met the adequacy standards for Burlington hospitals. Correct?

MR. HARTT: Not exactly, Senator.

They had committed to meet the requirement in one of a number of ways.

SENATOR GILL: They had committed, but it had not been done.

MR. HARTT: Well, they had committed to do so.

SENATOR GILL: They had committed to do, but it had not been done.

On September 18, when the Department of Banking and Insurance -- and we might add, Consumer Protection -- when they sent out

the letter saying the approval of OMNIA network, the Department of Banking and Insurance knew that Horizon had not met the adequacy standards for Burlington hospitals.

MR. HARTT: The Department was confident that--

SENATOR GILL: I'm not asking if the Department was confident.

MR. HARTT: Well, the Department--

SENATOR GILL: I'm not asking if you're confident.

MR. HARTT: Right.

SENATOR GILL: On September 18, when you sent out the letter that approved the OMNIA network, the Department of Banking and Insurance knew that Horizon had not met the adequacy standard for Burlington County.

MR. HARTT: Well, Horizon demonstrated to us that they were going to meet the standards--

SENATOR GILL: Going to, going to.

MR. HARTT: Right.

SENATOR GILL: *Going to* is future. But on September 18, they had not met the standard.

MR. HARTT: (Indiscernible).

SENATOR GILL: Look, I took 10 minutes to go through your 700 pages. Now I see why you wanted to send them at 10 o'clock.

This is an e-mail (gestures) that you provided in the 700 pages -- and the letter. I'm asking you one question, and I'm asking it to you directly. On September 18 when the Department of Banking if Insurance

approved OMNIA network, they knew that Burlington County -- that Horizon had not met the adequacy requirements for Burlington County.

MR. HARTT: Senator, all I can say is I would not characterize it in that way.

SENATOR GILL: Well, what-- I'm asking you, did they know? I'm not asking you to characterize. I'm asking you to give me a straight answer to a fact. And that fact is predicated upon the e-mail that we got at 10 o'clock.

MS. MAURER: Senator, if I may.

On September 15, Horizon made the commitment to do one of two -- to do--

SENATOR GILL: I understand commitment.

MS. MAURER: But by making--

SENATOR GILL: I'm not talking about commitment. You cannot get an approval based on something I may do in the future at some other time. That's why we have rules and regulations; that's why we have a regulatory department, and that's why we have oversight to protect the public, the participants, and the consumers.

Now, I'm asking you not what they were going to do -- because we know the road is always paved with good intentions. I am asking you: On September 18, when the Department issued the approval letter for OMNIA network, the Department knew that Horizon had not fulfilled the adequacy requirements for Burlington County.

MS. MAURER: Senator, I would say that that's not accurate.

SENATOR GILL: What is not accurate about it?

MS. MAURER: They made a commitment to -- can I? -- they made a commitment to satisfy in one of two ways. Either way-- One way, if they chose to contract with another hospital for Tier 1 in Burlington County--

SENATOR GILL: Are you now giving--

MS. MAURER: No, no. They could do that; they could choose to just provide Tier 1 cost-sharing at those hospitals for obstetric services. They could choose to satisfy it in a number of ways.

SENATOR GILL: Did they, before--

MS. MAURER: Yes.

SENATOR GILL: --September 18?

MS. MAURER: Some of those--

SENATOR GILL: On September 18, when you issued it, had they made a determination of how they were going to satisfy the adequacy issues with respect to Burlington? Had they presented it to you, and had you okayed it?

MS. MAURER: The Department was fine with any of the options.

SENATOR GILL: I didn't ask what they were *fine* with. I asked if they presented to you an option, and that that particular option was okayed by the Department before September 18.

MS. MAURER: Yes, Senator.

SENATOR GILL: And when?

MS. MAURER: On September 15, the Department approved either of the options presented by Horizon to satisfy-- They could have gone either direction, and it would be satisfied, and it was fine.

SENATOR GILL: Now, since you are going to talk about those options, you clearly have waived the proprietary issue here. Because the options are contained in the memo of September 15 that has been redacted on the basis of proprietary interest. But now that you have chosen to disclose part of them, then we're going to discuss all of them.

What options did they present, and how was it going to be effectuated? Let's talk about-- There were two options, correct?

MS. MAURER: There were two options, Senator, and as Horizon discussed earlier today--

SENATOR GILL: And now I'm asking-- Two options -- I want you to explain in detail what those two options were.

MS. MAURER: The options would be to contract at a Tier 1 level; or to do cost-sharing at Tier 2 hospitals at a Tier 1 level for obstetrics. Those are the primary options that were available.

SENATOR GILL: And are those the options that are in this memo?

MS. MAURER: I don't have the unredacted memo in front of me.

SENATOR GILL: Well, if you are talking about options, were there more than the two options that you indicated?

MS. MAURER: I cannot-- Potentially, there could be.

SENATOR GILL: I didn't ask you -- I'm not asking you about potentially; and I'm not playing a game, and we're not going to play a game of words, because the messengers may have a problem with it.

On what date did the Banking -- that the Commission determine that Horizon had met the adequacy for Burlington -- on what date?

MS. MAURER: September 15.

SENATOR GILL: And you have documentation to indicate that, on September 15-- And what was the way that the Department had agreed that Horizon could fulfill the adequacy issue? What was it?

MS. MAURER: Senator, the Department does not dictate the decisions of Horizon.

SENATOR GILL: I didn't ask if you--

MS. MAURER: Horizon presented to--

SENATOR GILL: And which one?

MS. MAURER: They presented two equally acceptable options, and they wanted time to decide which direction to go. But either direction made them meet network adequacy for obstetrics, and therefore the network was approved on that day.

SENATOR GILL: That's the way you did this regulatory scheme? Okay.

Now, Horizon testified this morning that it was last week DOBI informed Horizon that additional hospitals needed to be included in the OMNIA tiered plan. So if on September 20 your Department stated, "DOBI has reviewed the OMNIA tiered plan and found that it satisfies access requirements," what has changed from this last to last week?

MR. HARTT: There have been no additional requirements on Horizon with respect to the OMNIA network since those communications regarding Burlington County.

SENATOR GILL: Did you ever indicate-- You were not given the metrics or the weighing of the weight given to the requirements by Horizon, were you?

MR. HARTT: That's correct, Senator.

SENATOR GILL: So you, as you sit here today, have no idea what the requirements were that Horizon advanced, correct?

MR. HARTT: That's correct.

SENATOR GILL: You have no idea how they weighted any requirements that they thought were necessary?

MR. HARTT: We do not know anything more than what they have publicly stated with respect to those decisions -- those business decisions of theirs.

SENATOR GILL: And you have no idea -- do you? -- that, based on whatever metrics they used, there's only one Catholic hospital in the State of New Jersey in Tier 1?

MR. HARTT: That is correct. Because those metrics are not metrics that are provided for in the regulation. A review of those metrics are not provided for in the regulation.

SENATOR GILL: So when you talk about having reviewed Horizon, your review is limited to adequacy -- pretty much, right? -- and on that adequacy, you let them go forward for them to choose whatever they may have decided with respect to Burlington County.

MR. HARTT: That's right, because that's the regime that's put forth by the regulations, yes.

SENATOR GILL: That they can give you anything, and the insurance company can pick later as to what they'd like to do?

MR. HARTT: Well, as Kristine has said, I mean, once it was clear that they were going to meet the network adequacy requirements, and approve one of a number of acceptable measures, then the proposal was approvable. And they subsequently did meet one of those measures.

And let me just say that if they had decided not to -- if they had reversed course for some reason and not lived up to their commitment, then we would have certainly withdrawn approval.

SENATOR GILL: So we'll-- I'm quite sure that you'll provide me with the documents that shows on what date this actually happened, okay?

Now, you also -- and this is just two questions. You're the State's regulatory agency. Do you consider it a slippery slope to go down when the hospital is tiered and you have no information on the requirements within the tiering?

MR. HARTT: Well, I appreciate the concerns that have been raised. There are a number of significant public policy concerns surrounding this issue: the use of these kinds of networks; networks in general; and tiered networks, specifically. I mean, there are issues of: What is the cost of the policy to consumers? How much are providers being reimbursed? What choice of hospitals or other kinds of providers do people have? Even issues such as the fate of given hospitals -- that's a legitimate public policy concern. Clearly, the important role that hospitals play in our communities -- those are obviously very significant public policy concerns. They just happen to be outside of the purview of the Department.

SENATOR GILL: And the policy concerns about if a particular business plan may raise issues of being monopoly, correct?

MR. HARTT: Conceivably.

SENATOR GILL: Constricting-- Yes, constricting the market and being a monopoly. Those are legitimate policy concerns.

MR. HARTT: That would be another one of several legitimate policy concerns, clearly. Yes, Senator.

SENATOR GILL: And I would guess, under the scheme of things, if you say that even though you're the consumer protection, you have no -- *you*, meaning the Department -- has no regulatory authority with respect to that, I then would suspect that the person who has oversight -- or can have oversight, like they did in New York -- is the Attorney General, on this civil part.

Are you aware of the settlement by the Attorney General in New York?

MR. HARTT: I am not, Senator. That's outside of my purview.

SENATOR GILL: So whatever is in your purview, that's only-- Okay.

All right, I have no further questions. Thank you both very much.

Senator Rice has a question.

SENATOR RICE: Yes. Madam Chair, you did an excellent job. If everybody was paying attention, and those who are viewing this, they need to be very much concerned.

Let me also say to those who are here, things that you may not like to hear -- is that Bridgegate, from my perspective and all I know, was this sort of redaction and failing to answer valid questions, and being

evasive. Those were some of the elements that caused what we thought was a simple thing to get out of hand, and a lot of good people have gotten hurt and are being hurt.

So I just want to go on the record with that.

The issue I have and the question I have is that-- And this is not for the messengers; this is for you, to try to get some perspective; and you may not -- and it's for the Chairs also -- anybody can put perspective on it. The issue that we are dealing with is the cost of a product -- insurance product. The problem is the impact has on health care. So we have product over here, and everybody is looking at cost. But the impact of this particular product that needs to be looked at objectively and thoroughly impacts health care. And the question is, is it looked at from your Department from a perspective of the intent? Because if the intent is to reduce healthcare costs, then reduce it for whom? And it comes down to those who are being serviced, right?

So when you look at your regs, regardless of what the regs say now and what the rules are saying now, do you coordinate and collaborate with the other entities? I mean, are you so narrow-minded that we're only talking cost and our rules and regs, and the statute said this; we don't care what impact it has on real people as long as they follow what it says here? Or do you go over and say, "Look, we have to look at the cost of things, and the rules and regulations that determine impact. We certainly understand that maybe we may have to change these regs and rules, either by legislation or in-house?" And you may have to take a look at this from your Department, where we can justify the change before we move forward, where we can raise some additional pressures in terms of the entity -- in this

case it's Horizon -- making the kind of necessary changes that are going to protect the consumer over here (gestures).

Is that part of your process? Or are you just narrowly focused on what your rules and regulations are, which you wrote? Not you personally -- the Department wrote. We write the statutes, other regs, right?

MR. HARTT: Right.

SENATOR RICE: And they can be changed, by the way, any time we so see fit or need, right?

MR. HARTT: Within the statutory constraints, yes, sir.

SENATOR RICE: I understand statutory constraints; but they can be changed.

MR. HARTT: Yes.

SENATOR RICE: So just respond to that piece for me.

MR. HARTT: Yes.

SENATOR RICE: And I don't know if the Chair heard it, but maybe she could answer also.

MR. HARTT: Yes, thank you, Senator. A great question, and a great set of observations.

So naturally when Horizon approached us -- and other carriers have approached us with their tiered network proposals -- we are aware that part of the purpose there is to reduce the cost of health insurance for consumers. But that is not a metric or a standard under the rule that is applied for determining network adequacy. So we may see what we're doing when we approve or disapprove as having a positive or other kind of effect in some other area -- such as cost -- but we can't factor that into the

decision. The decision is really confined by the words in the regulations -- it stands in the regulation.

Now, having said that, we deal with some other issues in other areas of the Department -- cost is a good example. So we do rigorous rate review and we enforce what's called the *medical loss ratio requirement*, which is to make sure that the health insurers are giving to doctors, giving to providers at least 80 cents of every premium dollar that they receive from consumers. And if they do not meet that standard, they have to issue refunds to those consumers in order to meet the standard. So that's an example where we act, and we act vigorously on the cost side. But the network adequacy piece stands alone and just follows the standards that we've talked about.

SENATOR RICE: So you don't go to the Department of Health in this situation and say, "Look, we're going to follow the rules and the regs. We need to find out what kind of impact you see on health care as it relates to the consumers, because we may have to change the rules and regs." Even if it's not now -- in the future. There's no-- You're just narrow-minded on what you have before you. And that's the problem with government, I found. There is no collaboration or coordination with agencies.

What I raised, Madam Chair, when you were out--

SENATOR GILL: Oh, I did hear you.

SENATOR RICE: Okay. The impact on what it is all related to. And so the question then becomes, do we get the Health Department in here? Does the Health Department have any role or any say-so in this whole fiasco? Because I'm still concerned about not only the distance and

the transportation piece, and a place that lacks the Tier 1 hospitals, I'm still concerned about what role, or what impact, or effect that it's going to have on University Hospital -- which is still a State institution, which is still a Trauma 1 hospital -- and that population that's not middle class or upper middle class, or have the kinds of incomes that you and your workers have.

And so that's why I raised it. And I think we're going to have to go back and take a look at regs, but also legislation. And I think that, hopefully, all of this is aboveboard. Because there are some of us who are probably going to dig a little deeper to make sure it's aboveboard. Because I see a lot of good people being hurt -- not only those being provided services, but those who have to provide those services too.

So I just wanted to say that, Madam Chair, to you.

SENATOR GILL: For the record, we did invite -- we invited the Department of Health, because, clearly, the Department of Health is involved in this endeavor. However, the Department of Health sent us a letter on October 3 declining to appear before us -- maintaining that "We do not regulate-- As you may know, the DOH does not regulate the sale or purchase of health insurance or physicians' practices." Now, we know that the result is the Department of Health is involved. But it seems like every department that we have asked to come here maintains they have no regulatory authority -- even in the broad sense.

So again, they have declined the invitation on the theory that they are not involved in this process at this time.

So Senator Rice, we-- And we also -- I also -- Senator Vitale and I invited the Department of Human Services. And on October 2, the Department of Human Services writes us back -- they decline to come

because they said, “The Department of Human Services has no role in the oversight or operation of this private insurance product.”

So we-- I understand the narrative that the Executive Branch is advancing here. And that is why we need oversight, transparency, so that consumers can know what’s happening. Because it’s clear the Executive Branch -- nobody is involved in the broader implications of this. So we tried to invite everyone to do that.

And there’s one last question, and then we’re going to go to Senator Madden and Senator Addiego.

I have a question. Did DOBI require additional network adequacy standards on Horizon for maternity care in Mercer County?

MR. HARTT: No, Senator, we did not.

SENATOR GILL: So that if Mercer County is, at least their maternity care, is now included as Tier 1, would that designation have been done outside of DOBI’s review?

MR. HARTT: Yes. So Horizon apparently made a number of business decisions regarding contracts with Tier 1 hospitals that were not required in order to meet our network adequacy standards. That’s correct.

SENATOR GILL: Okay. So when they didn’t meet the standards, they went out and contracted with particular hospitals for the area in which they did not meet the adequacy standard for the particular location?

MR. HARTT: I hope this is helpful -- so there were two basic scenarios. There was a scenario where they didn’t meet the standard; we identified that they didn’t meet the standard, and they fixed it. And there are scenarios where, for their own business decisions -- whatever those may

be -- they decided to increase the number of Tier 1 hospitals under contract in excess of what the network adequacy requirements would have held to.

SENATOR GILL: And those Tier 1's increased in areas where they were deficient in terms of adequacy?

MR. HARTT: I'm sorry; I apologize. The distinction I'm trying to make is that in Burlington County they were deficient, and so they made a change to meet the standards. I think there are others--

SENATOR GILL: And that standard change they met in Burlington County was to make maternity Tier 1 in a hospital that's Tier 2.

MR. HARTT: That's correct. I believe in two hospitals; correct.

SENATOR GILL: And in Mercer County, how did they meet the deficiency?

MR. HARTT: I believe they met it in the initial filing; they met it through the OB services provided at Princeton.

SENATOR GILL: In Mercer, OB provided by Princeton.

MR. HARTT: That's correct.

SENATOR GILL: In Mercer, is there any Tier 1 hospital?

MS. MAURER: Yes, Senator, Robert Wood Johnson in Hamilton is the Tier 1 provider.

SENATOR GILL: And so that we know who we're talking about in terms of-- So Robert Wood Johnson is the designated Tier 1 in Mercer.

MS. MAURER: Yes, Senator.

SENATOR GILL: They did not fit the adequacy -- they could not fulfill the adequacy requirements, so they then went to Princeton and said, "For your maternity, we will put you in Tier 1."

MR. HARTT: I believe actually that the decision to have RWJ as a Tier 1 in the county and Princeton as Tier 1 for OBVIOUSLY, across the border, were made at the same time. I believe those were presented to us at the same time and those met network adequacy.

MS. MAURER: Yes.

MR. HARTT: Because, again-- And I know this is an area of confusion because this stuff is complicated.

SENATOR GILL: That's why we need our documents ahead of time -- because it is complicated.

MR. HARTT: I understand, Senator.

Because the standard is not really a county border standard; it's an access that's determined by distance and time of travel. So there are plenty of instances where somebody lives right next to a county border, and the most convenient location is on the other side of the border with the neighboring county instead of someplace else that may be farther away but within the same county. So it's a really consumer-centric standard around how quickly somebody can access the service.

SENATOR GILL: Okay.

Senator.

Thank you very much.

Senator Madden

SENATOR MADDEN: Thank you, Madam Chair.

Director Hartt, so can we just get back to this 90 percent for adequacy; and it was 88 percent in Burlington County. And then Horizon came up with options for a way to cover the 2 additional percent. And then they were conditionally approved -- or they were approved, actually, under the belief that they would do something.

So is it 90 percent for all illnesses, or just ob/gyn?

MR. HARTT: The 90 percent standard applies across the board. It's 90 percent of the enrollees in the plan, and that applies regardless of the service that we're talking about.

SENATOR MADDEN: So if you cover -- if there's a mechanism in place now to cover the ob/gyn concerns, if someone had a heart attack or the baby is 6 months old and started having serious respiratory problems -- convulsions -- what happens then? Does that qualify as ob/gyn or-- Do you see what I'm saying? If it's strong or good enough for a Department of Banking and Insurance-- And, I mean, you're a Division Director, so you're at a pretty significant level in that Department. So when the Department or the Division would say it's acceptable, we're doing all this review and we find -- we've identified that there's a shortage in the adequacy for ob/gyn. What I'm trying to figure out is, why wouldn't you just say, "It's across the border," for all care, or all critical care. Why just that particular service?

MR. HARTT: Thank you, Senator.

Because the initial filing, that was inadequate with respect to OB, was adequate in the other areas. So they had already met adequacy with respect to the other services. It was just with OB that they were not adequate.

SENATOR MADDEN: Okay. I'm just missing something.

Let's just take the mother who is carrying a child. And the services were now met, according to these other two options. But there was a shortage when the woman was carrying the baby. Now, the baby is born, and a year later the mother has a heart attack. She's covered -- is that what you're saying?

MR. HARTT: Yes, sir.

SENATOR MADDEN: And could you explain how that is that it's just ob/gyn that was not covered, but any other of these emergencies or scenarios were all covered?

MR. HARTT: Yes, sir, it's a good question, because there's a whole list of services that are in the regulation that need to meet these adequacy -- these time-and-distance standards. And so having a heart attack or any number of other types of emergencies are covered by the standards in the reg and, as indicated, the initial filing from Horizon did meet all of these requirements. Where they had the gap was just in the OB area.

SENATOR MADDEN: When you talk about time-and-distance -- I keep hearing that -- what exactly does that mean? It may sound like a little bit of a foolish question at times, but you're sitting here, you're (indiscernible) under a reg, and you're establishing or authorizing licenses or permits. I can travel this 20 miles in 20 minutes in some venues, and then I can travel 20 miles in the middle of the winter and it's going to take me an hour, an hour-and-a-half to make that trip. How do you make those distinctions? And in a rural, such wide-open area in Burlington County, you can really be in a world of hurt, especially if it's during

snowfalls and ice storms and things. So could you elaborate on time-and-distance and how you figure that this meets the need that you're looking for, in terms of access?

MR. HARTT: So thank you.

The reg sets out, as I indicated, that it's sort of 10 miles or 30 minutes, 45 miles or 1 hour -- again, depending on the type of services provided.

So what we do is, when we get the list of providers that are proposed for this network, we know where they are; we have the addresses, and we make sure those are correct. We look, then, at the enrollment -- expected enrollment for the consumers who will be in this plan and where they live. And then we apply a map into that to determine what those distances are.

Now, your question is, could there be a situation where, because of a blizzard or some other factor, that somebody ended up actually traveling a farther distance in a specific situation? I'm sure we could not rule out that possibility.

SENATOR MADDEN: I'm just having a hard time figuring how you can sit in an office or sit in an entity here, and equate what travel distance is like in all the various counties. I mean, you have to have some -- I guess in your mind, or in the Division's mind -- acceptable travel mode, so many miles.

We're going to leave here, depending on what time -- it could take us literally 10 minutes to get to 195; or it could take us, on average, if we leave at rush hour -- it's going to take us 20. And if it's snowing, and it's

the beginning of the snow and everybody jumped out at once, it's going to take upwards of an hour.

So the travel time piece, at least from my perspective, shouldn't even fall into the mode, because you don't know when people are going to be on the highway.

But if I may, it sounds as though you are making these calls based on Horizon's membership pool in these areas. And you are trying to judge 90 percent of their membership pool must be within the travel -- or the miles of these Tier 1 hospitals. And the numbers that you are receiving now -- and we've heard the Chairman of Horizon and his team testify that they're anticipating upwards of 250,000 OMNIA patients in the first year.

There's a firm belief among the Senators who are sitting here that that number has the potential to grow significantly. I hear numbers from Horizon of about 5 million; we have 2.1 million people who we insure now. So as that number continues to grow, what, if anything, are they required to do in terms of coming back to the Department of Banking and Insurance for a modified plan? You see, so all of a sudden -- Burlington County may have a low number and the people don't -- they're hitting 90; now, all of sudden, there are more people jumping in because they're trying to save money -- whatever the piece is. Is this endorsement good now, and Horizon's on its way? Or what do you require of them?

MR. HARTT: Yes, thank you, Senator. That's a great question and that's a great observation.

And we're going to be monitoring this on an ongoing basis. So we track enrollments. We would like that information anyway; we need that information for financial reasons, in addition to network adequacy.

So if there are changes in the landscape -- either with enrollments or with the providers that are available -- then Horizon is going to have to change accordingly to continue to meet the standards in the reg. So that's a living process; that's an ongoing process.

SENATOR MADDEN: If I may shift over to the Deputy Director (*sic*) Maurer.

The two solutions you spoke about -- I listened, but I was trying to scribble. What were the two -- at least, that you can recall; you indicated that there may have been more.

MS. MAURER: Senator, as Horizon indicated earlier today, one of the solutions was the one that they selected -- which was that they would provide Tier 1 cost-sharing for obstetrics in Burlington County at the two hospitals that provide obstetric services. There are three hospitals in Burlington County; they are all Tier 2. Only two of those three provide obstetric services, so those are the ones where there would be Tier 1 cost-sharing available.

Another option that they could have chosen to do, for example, would be to pick one of those two hospitals with obstetrics and contract at a Tier 1 rate for obstetrics only. Or they could have gone -- decided to go broader and contracted Tier 1 across the board. I mean, there was various different ways they could have gone about doing it, any of which the Department would have been satisfied with. We wanted to make sure they got to that standard; it didn't matter which way they did it.

MR. HARTT: Under the rule--

MS. MAURER: Under the rule, it didn't matter. It's a business decision, from the Department's perspective. It's not something we dictate to them or have the ability to dictate to them.

SENATOR MADDEN: Okay. And then my last question, Chairman -- could you just jump back onto the monitoring that you're talking about. If this was the forge ahead, what happens now? What role does the Division have, or the Department of Banking and Insurance?

MR. HARTT: So if we see changes in the landscape -- again, whether it's enrollment or changes in providers -- it may be a hospital deciding to provide different services, to remove a service it's currently providing, or PCPs, or specialists -- whatever those changes are, we would require that Horizon submit a new filing to demonstrate that network adequacy continues to be met. And if it is not met, then we would force changes. And again, they would have latitude in how they met -- ultimately satisfied the standard. But we would make sure that they did satisfy those standards.

SENATOR MADDEN: So am I of the understanding -- say one of the hospitals that are in the OMNIA network has a stroke center, and for whatever reason it goes out of the stroke center business. You are a part of that notification? I know Health is; but are you telling me that the Division of Insurance receives that notification also?

MR. HARTT: Right. Well, first off, Horizon would be obligated to provide that information to us if it had any material impact on them. But we also would be monitoring what's happening in the marketplace, and if we have any concerns because we see that a hospital has changed or, again, enrollment's changed -- we would go to Horizon and say,

“You have to go and resubmit your information to make sure you still meet adequacy.”

SENATOR MADDEN: And just out of curiosity, I mean, you're a Division, the ranks are pretty thin, how do you know that? Here's a Division of Insurance; how do you know these changes are taking place? Or if you see an increase in enrollment -- in your operations, how do you know it? Is there an operational unit with 1 person in it, 20 people? You don't have a 20-person unit; not in today's environment, right? What's the real skinny behind it here, in terms of-- You testified eloquently on the correct answers, and what would be ideal. But in the real world, how do you really know what we have in terms of compliance?

MR. HARTT: Yes, thank you, Senator. It's a great question.

So we have multiple units within the Department that may touch on this in one way or the other. I mean, for example, the solvency monitoring may collect information that would be relevant. Our Life and Health Bureau that is looking, or the Individual and Small Employer Program Boards -- they collect information that may be relevant. The staff that does network adequacy specifically -- they may be collecting information that would be relevant. And we -- one of our jobs there is to make sure that we are all communicating with one another; and we do do that.

SENATOR MADDEN: Thank you.

Thank you, Mr. Chairman.

MR. HARTT: Thank you, Senator.

SENATOR VITALE: Senator, did you have a question?

SENATOR ADDIEGO: Yes.

SENATOR VITALE: Okay, Senator Addiego.

SENATOR ADDIEGO: Thank you, Chairman.

First of all, thank you for being on the hot seat and being willing to come here.

So as you are aware, Senator Allen and I, and a lot of the Senators here are very much concerned about Burlington County -- a large part of which Senator Allen and I -- pretty much all of it -- represent.

I need to understand something -- I may not be using the terms correctly -- 90 percent of adequacy is based on a 20-mile-- Is that what the--

MR. HARTT: Right. So it depends on what the service is that we're talking about. But let's just talk about acute care hospitals, for example, and surgical facilities. So the distance and time requirement there is 20 miles, 30 minutes. So a 30-minute drive, 20 miles in distance. Then that is overlaid on the customers that the carrier has. So it's not overlaid on the entire county; it's overlaid on the customers that they have. It is important, I think, to point out that this is one product from one carrier; the carrier has other products. And there are other insurers competing with this insurer to try to get customers as well. They're all competing to try and grow and get more and more customers.

So there will be other carriers that will have other hospitals in different tiers, in different areas. And in those cases, we would also be doing the same thing. We'd be applying this 90 percent of their enrollees, 90 percent of their customers against what they're proposing in terms of which hospitals they're going to use. But that's what the 90 percent means.

SENATOR ADDIEGO: Okay. So I'm going to ask for your help here, because as Senator Rice has pointed out we're recording everything here. And Horizon testified earlier that the adequacy -- correct me if I'm wrong -- the adequacy mileage they were using was 14. Am I correct?

MR. HARTT: I think they said--

SENATOR ADDIEGO: But we all heard 14. So I'm asking for your help here, because they made a commitment to re-look at -- to see if Senator Allen and I were right -- that that number, in Burlington County, for 50 percent of Burlington County, at least, was probably close to double that, if not more. So they were going to re-look at this in light of the fact that maybe we might be right.

So I'm going to ask for your help. Because I'm going to guess that you could tell me -- now, correct me if I'm wrong -- that as you both sit here today that they would not meet that 14 mile adequacy. Am I correct?

MR. HARTT: Well, actually, I don't know. I did hear them--

SENATOR ADDIEGO: But if that's true, could you provide them-- Because they said they would like the data.

MR. HARTT: Right.

SENATOR ADDIEGO: Would you have that kind of data to show that, perhaps, the 14 mile was not met in Burlington County?

MR. HARTT: Yes, that is an interesting question. I'd have to think about that. I did hear them assert-- The way I heard it was that they were asserting that they were above and beyond the requirement in the reg.

SENATOR ADDIEGO: Right.

MR. HARTT: That they were doing better than the requirement in the reg.

Clearly, you have to do at least a little bit better, or you're not really meeting it. But I don't know if we have the data to determine that or not. But we can look into that.

SENATOR ADDIEGO: I would appreciate that.

MR. HARTT: Okay.

SENATOR ADDIEGO: And I would appreciate if you would, through the Chair, let them have that information as well as Horizon. Because I think you might be the key here to help Burlington County, and to help Senator Allen and I to make sure that our residents have adequate access to a Tier I hospital.

With regard to the maternity, do you know which two hospitals they were talking about?

MR. HARTT: It is Lourdes and Virtua Memorial.

SENATOR ADDIEGO: Okay. The only other concern I do have -- and I just want to throw that out -- is the fact that when we're making these -- when we're looking at these, that we're segregating ob/gyn, and acute care, I guess, or hard or-- I'm not quite sure what all those stand-- It kind of is confusing if you're going to allow-- I think once they don't meet the adequacy in one area, it should be blanket that you need a Tier I -- only because it becomes confusing to the consumer. And then the question is, what if you have a pregnant woman who has some other condition. You know, you have to figure out, does she go to this hospital or that hospital? I'm just saying that I think we need to re-look at it; that if they don't make it in one area, they shouldn't make it -- you need a Tier I

hospital in all-- Because, again, it's-- I want to make sure we're providing adequate -- not only adequate access, but a cost-effective product for the people who are choosing this so that they're not confused. I'm concerned that we're going to confuse the consumer.

So I would thank you for providing, if you would, and helping us here in Burlington County -- making sure our residents have adequate access by providing any information that you may have that would show that, one again, Horizon is not meeting their own standard of a 14-mile access.

MR. HARTT: I understand. Thank you, Senator.

SENATOR ADDIEGO: Thank you.

MR. HARTT: Thank you.

SENATOR RICE: Senator Addiego, through the Chair -- yes, I'm confused because you're asking for data. And the messenger is saying they're not sure if they have the data. But I thought someplace under "these rules and regs or statutes" that there are some statutes or regs that talk about the distance. So if that's true -- is that correct?

MR. HARTT: Yes, Senator.

SENATOR RICE: Okay. The "yes" is good enough.

So if that's true, Senator, it seems to me that in order for them to do an evaluation, an analysis -- a thorough one -- that that would have been looked at, which means that they have the data. Do you understand what I'm saying? In other words, you say you're playing by the rules. If I'm correct, he told Senator Gill that they're playing strictly by the rules and the regs. And if the rules and the regs say *A*, *B*, *C*, then they just sanction that, etc.

The rule says something about this distance. I know the rules or the statutes say something about the distance -- which means they had to lay that down next to the plan. And you know, as an attorney, that's what they have to do -- they have to lay this next to this, next to this, right? Which means they have the data, I would think. There's no guess to it. You're going to have to have it in order to make a decision whether geographically you're proving these things -- where the Tier 1's are, where you lack, and this and that. Is that not correct?

MR. HARTT: Senator, what you're saying sounds completely logical. My only caution was, I need to go back and talk with the team just to make sure that there's not something there that I'm missing in terms of the ability to drill down to that level to determine whether or not 14 is actually the correct number. That's what I'm saying; I just have some caution about that.

SENATOR RICE: Well--

MR. HARTT: But you're absolutely right -- that you would think you'd be able to get a bigger picture.

SENATOR RICE: Well, if you can't bring it down to their level-- Because they said 14 versus 35--

SENATOR ADDIEGO: Twenty.

SENATOR RICE: Twenty, or whatever, then I'm not going to accept if you can't bring us to that level; that in a city like Newark or a town like Essex -- then it's too many. You understand? I won't accept that. The technology should be able to break it down.

I would like, through the Chair, to see all of those breakdowns, if that's the case. Because if you're not sure if you can identify it or not,

that means you were taking somebody's word for it -- do you see what I'm saying? And we can't afford to take people's word for it if we are "regulatory agencies" and enforce-- That's what I'm saying.

So please take a look at that; and not just send that county; maybe we should look at all the counties. Because maybe if you can't bring it down that-- You may have to go back so you guys at Horizon hold up. We have to figure out to make sure that all these counties -- the travel distance is accurate within our rules and regulations that we're laying down next to.

MR. HARTT: I appreciate that.

SENATOR ADDIEGO: Sure.

I just want to-- If I may, through the Chair, I just want to remind you that that was the number Horizon came up with -- not whether it was correct or not correct. That was the number they said up here over and over again, correct?

MR. HARTT: Yes, Senator.

SENATOR ADDIEGO: Okay. Just so you know.

MR. HARTT: I appreciate the comment.

SENATOR GILL: And I think we finished questioning.

This is a statement. And I just can't wrap my mind around -- do you wrap your mind, or your hands? I can't wrap my mind around this.

That DOBI will permit an adequacy requirement where three floors of a Tier 2 hospital can be considered a Tier 1 hospital for the purpose of adequacy. If the whole hospital isn't Tier 1, then how can one tier of the Tier 2 hospital turn into Tier 1? It makes no regulatory sense, and it absolutely is -- it has an internal conflict.

So maternity is on floors 3 and 4; that's Tier 1. But if you go upstairs to get a pill because you have a fever, that's a Tier 2. So if we are here about the quality of the care, it only depends on what Horizon needs to fill its adequacy requirement -- where DOBI permits two floors in a Tier 2 hospital to be considered as a Tier 1 hospital so that Horizon can meet its adequacy requirements. From a regulatory scheme, from a public policy scheme -- it's almost like, can somebody please tell me where the Mad Hatter is because I don't understand the public policy logic.

Not that Horizon wouldn't want to do it; but the tragedy is, that DOBI permits it.

But thank you very much for appearing, and we look forward to working with you.

MR. HARTT: All right, thank you.

SENATOR GILL: Linda Schwimmer, please.

SENATOR VITALE: Good afternoon, Linda, and thank you for -- Ms. Schwimmer, thank you for waiting and for your testimony. We're looking forward to it.

L I N D A J. S C H W I M M E R, Esq.: Good afternoon, Chairman Vitale and Chairwoman Gill, and the rest of the Committee. Thank you for inviting me here today.

I am the President and CEO of the New Jersey Health Care Institute. The New Jersey Health Care Institute is a multi-stakeholder, nonprofit, nonpartisan organization that is focused on health care quality, safety, transparency, and controlling costs.

We also are the regional rollout entity for Leapfrog. Leapfrog is a safety score and safety survey, which has been mentioned several times today. And I would be happy to answer questions about Leapfrog as well.

I'm not going to read my testimony; I did supply you with my comments in advance. And I appreciate you inviting me here today.

I have three main points that I think have come up as well. But I want to just refocus on those and reiterate them.

I think that, first, one of the things, as you move forward, to look at -- and this is something that Senator Rice and, I believe, Chairwoman Gill were just discussing -- the State is the largest purchaser of insurance or health benefits in the state. And as such, you have significant market power. There is 1.7 (*sic*) individuals who are covered by Medicaid now due to the Medicaid expansion under the Affordable Care Act. And there are over 800,000 individuals who are covered under the State's State Health Benefits Program. So what that means is that you have a lot of market power. And rather than listening to another entity decide what they would like to see the products look like, you, as a large purchaser, can exert that market power and dictate what you, as the State, would like to see a product look like; and would like to see your State healthcare system look like.

And this is a discussion that I think would be important to have with many different sectors of the Executive Branch -- including Treasury, which is the purchaser under the State Health Benefits Program.

I would submit that in making those purchasing decisions, you want to make sure that what you're doing is going to have a positive impact on the state at large -- particularly with respect to quality, safety, and

transparency. And earlier today there were some comments about there not being disparities around quality or safety. And I would submit that that certainly isn't the case; and, in fact, later this month you're going to be -- Leapfrog is going to be releasing information on C-sections and C-section rates among the hospitals across the state. And you're going to see a lot of disparity. And C-sections -- I think it's a good example, because with C-sections-- Actually, vaginal births are less expensive than C-sections, and they're much better for the safety and the health care of the mother and the child -- if it's medically appropriate, and can be done.

So that's an instance where there are quality measures, there are safety measures; they also relate to cost and efficiency, and they're available. As these plans are designed, you have the ability -- as the largest purchaser in the state -- to insist that quality and safety measures be built into these plan designs, and that these measures be fully transparent -- 100 percent transparent.

Let me give you an example of an active purchaser -- the state of South Carolina. The state of South Carolina Medicaid Department no longer pays for early elective deliveries. And in doing so, the early elective deliveries in the state of South Carolina have plummeted. They are a success story -- where you can take quality, you can take safety, you can build it into your purchasing, and you can drive real change for your population.

Another success story is the state of Washington. The state of Washington has a purchasing authority. So they purchase, for the state, a health benefit program, as well as Medicaid, all together. The state defines

what they want their value-based products to look like and then they move forward from there as an active purchaser.

Another success story is the state of Maine. The state of Maine uses Leapfrog and builds in incentives to their state workers. And they say, if you go to an *A* Level safety hospital for procedures, your cost-sharing will be less than if you go to a lower-rated hospital for those procedures. Again, rewarding for quality, driving people to quality -- and that changes the system. Because then, when a patient has a conversation with their physician, and says, "Why do I have to pay more to go the hospital that you practice at? Why can't you practice at an *A*-scored quality hospital, as opposed to a *C*-scored?" And then those physicians go and talk to the Quality Improvement Officers within those hospital systems, and then those hospital systems improve.

So I laid out a lot more in my testimony here for you today. But really, my point -- and I want to be succinct, since you've been here all day -- is that the State has a lot of power; that's 2.5 million lives. And the State should be using its market power to demand quality, to demand safety, to demand transparency so as these products are being designed -- whether it's for the State Health Benefits plan, or other products -- you know what's going on.

One of the problems is that we don't have a lot of data. We don't have an All-Payer Claims Database, for instance, in New Jersey. If we had more data, or if the State publicly reported the data from the State Health Benefits Program, we could also make more data-driven quality decisions.

So I'll stop there to see if you have an questions. But, again, I'm not here today to criticize value-based plans. Value-based plans are here to stay; you're seeing them across the country. They save money; they're very attractive to consumers. But we can make them also built on quality. They're not mutually exclusive and, in fact, as I laid out with the C-section example, quality usually goes hand-in-hand with cost-savings -- particularly if you're avoiding complications, etc.

Thank you.

SENATOR VITALE: Ms. Schwimmer, thank you for your testimony.

Why don't I ask you two questions, and then I know other members have a couple of questions as well.

The issue of quality-- So earlier my comment-- The testimony from Horizon -- they discussed their quality measures and how was it that they, in part, selected their OMNIA partners. And it was, in part, driven by quality and, in part, driven by other factors.

And when I asked them to describe what those quality measures looked like and how they were scored -- based on what? -- and they said, "Well, CMS, *U.S. News and World Report* on patient experience; CMS on outcomes and quality" whatever. And when I mentioned Leapfrog, their Dr. Patel was rather dismissive. And I found that shocking, knowing how thoughtful Leapfrog is, and how much experience that those members have, and how independent, and nonpartisan, and agnostic they are in terms of politics; and it's all about the quality metrics.

Can you describe your experience with Leapfrog?

MS. SCHWIMMER: Sure. Thank you for that question, Senator.

So Leapfrog is going to be celebrating its 15th anniversary this year. Horizon has actually used Leapfrog for its Hospital Reward Program for the past 10 years. And actually, due to its leadership, New Jersey has some of the highest quality hospitals in the country -- certainly, much higher quality than any of the other states in our region. We also have some of the highest participation rates. All but 9 of the 72 eligible hospitals in New Jersey report to Leapfrog. By reporting to Leapfrog, all of their quality measures are available transparently on the website so you can see the quality measures.

The measures that Horizon -- at least in the testimony that they submitted to the Committee, which is what I've seen -- the measures that Horizon is using for quality -- they're using 13 or 14 CMS measures; 8 of those measures, frankly, are being retired by CMS this year because they're topped out. And basically what that means is that they've become somewhat obsolete; they're-- Most of the hospitals across the country are at 95 percent of those measures. So CMS is not going to be collecting additional information on those measures, and they're not going to be reporting on those measures, going forward. Those measures are expiring this year. So those aren't going to be particularly meaningful measures. And that's why on those particular measures you really don't see much disparity, because those are being phased out.

But that doesn't mean that quality measures, or safety measures are obsolete; in fact, I would argue the opposite. Quality will never be obsolete, and safety will never be obsolete. And the minute we stop

measuring on those things, that's when we're going to fall back. We have to keep going on those things. We're just continually raising the bar so that we improve quality. We still have a long way to go, but New Jersey's doing well and, in large part, that's due to Horizon's prior -- and, hopefully it will continue -- but up to now, Horizon's commitment to actually using Leapfrog measures for its Hospital Reward Program.

SENATOR VITALE: So I guess I will conclude my comments by asking you if you think that another institute has really been working on the cutting edge in policy initiatives, and advocacy. And so I guess my only question to you, Linda, would be, you know, what you know about Horizon, and what their product does, and what your experience -- your knowledge of their programs in the past and their performance. You had talked a little bit about the Medicaid population in these underserved communities and the (indiscernible) of hospitals, and what this initiative might mean to them. And so I think I remember reading something recently where you were quoted as saying that while value-based health care is a great idea, great goal, great initiative done the right way, there are certain shortfalls or loopholes that you think exist in this plan. Can you articulate that a little bit?

MS. SCHWIMMER: Yes. Thank you, Senator.

So going back to my opening comment, where the State should really be thinking of itself as an active purchaser. When you have such a large market player designing a product, there are going to be marketplace ramifications, there's going to be an impact. If this was one of the small niche players in the individual market, I think it would be a very different

story. And those insurance companies have been designing these tiered or narrow products for a while.

But when you're talking about an insurance company that has 49 percent or more of the marketplace across the state, when they design a product there's going to be implications. And so across the state there are, particularly in our cities, there are essential hospitals. And I'm using that term as it was used in that Reinhardt Commission report. So these are essential hospitals that take care of our most vulnerable residents. And many of those hospitals predominantly have -- their patients are on Medicaid, they also have individuals who are undocumented who receive their care there, and then they have -- a very small slice of their business is commercial pay. And if they are not included in Tier 1, they are at risk of losing those commercial pay patients. And those commercial pay patients really help to make their hospital financially sustainable.

And so going back to what was discussed in the Reinhardt report -- or Reinhardt Commission, if you start to have your essential hospitals -- again, the ones who are really taking care of the people who need to be taken care of, who don't have many alternative choices -- and if marketplace factors start to come into play, and there's a shift and they start to lose that commercial revenue, what's going to happen to those hospitals? Again, that's something that the State has to look at, wearing that big picture system hat. And it might mean that you might need to reallocate charity care payments, you might need to think about how you're going to reimburse for Medicaid, and whether you're reimbursing for Medicaid appropriately and whether those rates need to be adjusted. When you're talking about a market player that has such a large market share,

these are the types of policy issues that come into play that need to be considered by somebody as these products, in such a global way, are being designed.

So hopefully, I answered your question.

SENATOR VITALE: You did very well. Thank you.

Senator Gordon.

SENATOR GORDON: Thank you, Mr. Chairman.

Let me begin by congratulating you on your new position.

MS. SCHWIMMER: Thank you, Senator.

SENATOR GORDON: Your comments about C-sections actually triggered a memory deep in the recesses of my mind. Twenty years ago I had access to the data tapes of a major insurer, as a management consultant, and analyzed utilization rates for a number of procedures across, probably, 30 hospitals in the New York Metropolitan Area. And I just remember a huge disparity, even then, in C-section rates attributable, as I remember, to practice patterns and the fact that C-sections are easier to schedule than the alternative.

My question is this. You say we have a lot of market power. How can we get access to the data we need and analyze it in a way that gives us meaningful information for policymaking purposes? I'm a little -- I'm not sure that asking a State agency to analyze a huge amount of data is going to give us the guidance that we need.

Do you have some ideas on what we can do if we wanted to exercise that market power we have?

MS. SCHWIMMER: Absolutely. Thank you for that question, Senator Gordon.

The State, again, has over 800,000 lives -- and that is the State's data. The Quality Institute actually is conducting a project right now with an outside consultant that would make all of that information 100 percent transparent, and we're actually looking at the quality of different procedures within different hospitals.

That's one way it could be done, but if the State had an All-Payer Claims Database and it allowed researchers to do -- to utilize that research, that's another way.

There are other databases that are out there -- that one, in particular, is called Health Care Cost Index (*sic*), I think, HCCI -- where if the State required all of the data be submitted to that, they make their data available to researchers for that type of quality research, as well as cost comparison.

So there are available avenues to take. The State hasn't taken those avenues yet. But, frankly, I think that that's a lost opportunity, because it's really hard for you and other policymakers to make informed decisions without having the data before you and just having to rely on various contractors and vendors. You're really making decisions in the dark, which is -- as you said from your consulting days, if you have the data in front you, you see the disparities and see opportunities to drive change.

SENATOR GORDON: Right. I'm reminded of something that Peter Drucker said, "If you can measure it, you can manage it; and if you you're not measuring it, you're not going to be managing it, obviously."

MS. SCHWIMMER: Right, right.

SENATOR GORDON: So are you suggesting that, through a legislative remedy, we could require the provision of data which we could have analyzed by an appropriate organization or in-house agency?

MS. SCHWIMMER: Absolutely.

SENATOR GORDON: Okay. Thank you.

Thank you, Mr. Chairman.

SENATOR VITALE: Any other questions? (no response)

All right. Thank you very much for your testimony, Linda.

MS. SCHWIMMER: Thank you.

SENATOR VITALE: You get the gold star for the shortest time. (laughter)

Joel Cantor, representative for the Center for State Health Policy.

Thank you, Joel. How are you doing?

JOEL C. CANTOR, Sc.D.: Good.

Thank you, Chairpersons Gill, Vitale -- thank you very much for inviting me to speak with you today. Distinguished members of the Committees, I'm very pleased to be here.

I'm Joel Cantor, Director of Rutgers University's Center for State Health Policy; and I'm a Professor of Public Policy at Rutgers. The mission of the Center is to inform and support State health policy in New Jersey and around the country. The views I'll express today are mine, and not those of the University or the funding agencies and organizations of our work at the Center.

I'll also be -- like Linda, I'll be abbreviated in my remarks; it's been a long day. The first thing I'll do is change my opening statement from "good morning" to "good afternoon." (laughter)

SENATOR VITALE: You better hurry up; it might be "good evening." (laughter)

DR. CANTOR: Good evening -- almost.

I just want to make a few points; and you do have -- at least the staff has my full remarks. But I'll be very brief here.

I'd like to start with a few comments about why we are really here at the table, and to look at the problem we're trying to solve here. And then I'll comment specifically on the OMNIA plan -- both what I see as the potential benefits and also the potential downsides, which have been talked about extensively so, again, I'll be brief.

Recently, the Commonwealth Fund Scorecard on State Health System Performance, along with measures from other organizations, has shown what I think are pretty serious gaps in the performance of the New Jersey healthcare system. My written testimony has a lot of data in there; I'll just cite a few statistics. New Jersey ranks 44th in our Medicare 30-day readmission rate; we rank 49th among hospitalized patients who report that they don't get the information they need in order to transition successfully to home after discharge; 35th in pediatric asthma rates -- and I could go on.

These are serious markers of a system which has avoidable, and preventable, and very expensive utilization of hospital services, both inpatient and in the emergency department. These are statics that have improved somewhat in New Jersey, but we still are ranked as stubbornly low relative to other states.

Turning to OMNIA: Traditionally, as you know, private health plans have paid on a fee-for-service basis, rewarding volume rather than quality of care or outcomes. This has led to a dynamic of mistrust and acrimony between providers and payers, and it has failed to deliver optimal care. New models, such as patient-centered medical homes and Accountable Care Organizations, have begun to move the needle away from those incentives, but they still rely fundamentally on fee-for-service payment and are not moving us quickly enough toward better performance.

I do believe that OMNIA moves in a different direction. It is a total-cost-of-care model, which is the way I think we need to go as a system -- where providers have incentives to share in the savings they can produce, as opposed to working hard to fill every bed, every day. Of course, that's subject to quality metrics and achieving high quality of care, which of course, is challenging.

There is a growing belief that healthcare delivery enterprises that integrate care across settings -- from outpatient to inpatient, and then home care and rehab -- can do a better job. A lot of the statistics I cited earlier reflect failures in transitions; failure to prevent the admission in the first place with strong, high performing care in the physician's office; failure to keep patients from coming back to the hospital by moving them into effective home care after discharge.

I think OMNIA aligns the incentives to improve those metrics. But as I said at the outset, it also brings with it some potential, unintended consequences, as we've discussed throughout the day -- or as you've discussed throughout the day. Of course, the most controversial element is the tiering -- the Tier 1, Tier 2 -- the two-tier model. The benefits structure

is designed to entice hospitals into the program to be willing to accept lower rates; and those lower rates, in turn, are in part what allows Horizon to lower premiums and waive a lot of the cost-sharing. Over time, the hope is that the incentives will align in those facilities, and that they will work with their community physicians and others to make care better and reduce the levels of avoidable inpatient, emergency department use and, therefore, induce more savings.

I think it's very likely that a lot of those things will happen. I think there's a lot of question about how quickly they can happen. These things are not easy to do.

In short, the partner providers will have to think differently than they have in recent history. They'll have to invest in high-value, often low-tech and underutilized services, including preventative care, patient coaching and education, and other population health measures, and pivot away from the culture of maximizing admissions.

From a consumer perspective, obviously, for those who have access to the Tier 1 network, they can save quite a lot of money in deductibles and other cost-sharing. And that really reverses a trend in our markets recently, where cost-sharing has only gone up, and premiums have only gone up.

Turning to the potential unintended consequences -- I think there will be a shift in volume to the Tier 1 facilities from Tier 2, depending on the total enrollment they're able to achieve. And I think that there are probably four specific things to be watchful of.

First of all, as has been said, the Tier 2 facilities will experience lower commercial volume. And while there are regions of the state that are

still overbedded, there are other regions of the state that are not. And to the extent that Tier 2 hospitals lose commercial volume in those areas, they could be significantly disadvantaged. Money-losing hospitals have difficulty in investing in care improvement; they may end up closing less profitable services that are still needed in the community. It is important to watch for those potential outcomes.

The second risk, I think, is that the OMNIA partners may not succeed in their goal of improving care and saving money. History tells us that health systems that have taken on too much financial risk too quickly don't always succeed. They will strive for the sweet spot of better care and lower cost, but if they have trouble achieving that, the other next-best way to save money is to stint on necessary care. And I think we need to be mindful that that could happen as well. And again, close monitoring for potential underdelivery of services is important.

Third, for the first time in a very long time, really, with the implementation of the Affordable Care Act, we see much more vigorous competition in our health insurance market -- particularly the individual market. With the two new plans entering the market, market share is becoming a lot less concentrated than it has been in the past. And given the premium differentials that it looks like we'll be seeing in the marketplace, I worry that that could reverse the trend toward a more competitive individual market and shift us back to a less-competitive market.

And finally, the last concern has to do with concentration of markets in the hospital sector. There is now a very substantial body of research that shows that hospital market consolidation mergers among

hospitals lead to higher costs and higher prices. And while there's lots of consolidation going on for all kinds of reasons -- nationally and in New Jersey -- I think that aligns incentives for further hospital consolidation, which could then give those hospitals stronger bargaining leverage in price negotiations; not just with Horizon, but with other commercial payers as well.

So in conclusion, we have seriously lagging health system performance in this state. It's a persistent problem that does need to be addressed. I do think that OMNIA is a serious attempt to address and create the paradigm shift we need in the delivery system -- moving away from fee-for-service toward value-based care. But at the same time, I think there are concerns about the potential for growing disparities in access to services in the hospital markets and in insurance markets, as this rolls out over time. I agree with other folks who have spoken to you today that there's a need for transparency and regulatory oversight as we watch for these potential, unintended consequences.

Thank you.

SENATOR GILL: Thank you.

Any questions?

SENATOR VITALE: Any questions from the members? (no response)

Thank you, Joel, very much. Thanks for waiting today, too, with your testimony.

DR. CANTOR: Sure; thank you.

SENATOR VITALE: Do you have written testimony?

SENATOR GILL: He has already supplied it.

SENATOR VITALE: You have? Thank you.

We're going to bring up -- we have five witnesses from the hospital community. And we're going to ask them to come up in panels.

So we'll do Saint Francis, Saint Peter's, and Holy Name.

I thought because you all speak the same language, I thought it would be good that you--

And the next panel will consist of John F. Kennedy Hospital and CentraState.

SENATOR GILL: Before we start, I would just like to indicate that we invited Saint Barnabas -- they declined; we invited Hackensack Medical -- they declined; we invited Meridian -- they declined; we invited Atlantic. So all of the OMNIA partners, and a significant part of Tier 1 declined to testify today.

So thank you very much for coming.

RONALD C. RAK, Esq.: Thank you.

MICHAEL A. MARON: Thank you for having us.

SENATOR RICE: Excuse me, Madam Chair -- just a question to the Chair.

We received information as to why Barnabas wasn't here; but was there any explanation given for the others, in writing?

SENATOR GILL: Hackensack submitted written testimony, but would not appear.

SENATOR VITALE: They are not here to answer questions, obviously.

SENATOR GILL: And they, of course, are in support of the plan, but would not come to testify. And we received nothing else from any of the other hospitals.

MR. MARON: So Senator, how would you like us to proceed in this format?

SENATOR VITALE: Ron, go ahead.

MR. RAK: Thank you, Senator. Thank you, Senator Gill, as well. Thank you, members of the Committee for having us here today.

I am Ron Rak, CEO of Saint Peter's Health Care System. We have served the healthcare needs of New Jersey for over 108 years. From our humble beginning as a parish hospital, we have grown into a technologically advanced, 478-bed teaching hospital affiliated, today, with Rutgers University. We train 118 residents and 50 medical students.

Last year, we treated 23,000 inpatients, and more than 245,000 outpatients; and 46 percent of that population was Roman Catholic. We employ over 3,000 healthcare professionals and support personnel. More than 1,000 community doctors and dentists have privileges at Saint Peter's. On an annual basis, our new state-of-the-art emergency room treats some 67,000 patients, of which over 23,000 are pediatric admissions. Our annual revenue exceeds \$400 million.

Our catchment area includes Middlesex and Somerset counties; however, our catchment area for subspecialties in obstetrics and pediatrics covers eight New Jersey counties -- Middlesex, Somerset, Hunterdon, Monmouth, Warren, Mercer, Hudson, and Union.

Our How Lane clinic is the largest outpatient clinic in New Brunswick, treating over 50,000 people each year -- the vast majority of which are underprivileged, who rely on charity care and Medicaid.

We are committed to the healthcare ministry of the Catholic Church. We are one of less than 10 Catholic hospitals in this country today sponsored by a Bishop. Our current sponsor is Bishop Paul Bootkoski of the Diocese of Metuchen, and his Diocese serves over one million Catholics in the state.

Many years ago, Middlesex General Hospital -- now named Robert Wood Johnson University Hospital -- was bankrupt. My predecessor at Saint Peter's, the late Sister Marie de Pazzi, instructed my hospital to give Middlesex General \$500,000 to cover their immediate expenses so that they could remain open -- and we did.

I share this bit of history with the Committee to make one very instructive point. Sister Marie did what she did because she believed that the healthcare consumer in our community deserved a choice. The OMNIA program takes away that choice. In part of the state, and so many places elsewhere, this plan deprives the consumer of the ability to seek treatment in a faith-based facility. Do not underestimate the importance to so many Roman Catholics, and people of different faiths and no faith whatsoever, that they receive care in a setting that nurtures compassion and a respect for life at every stage.

Saint Peter's and other hospitals excluded from Tier 1 do not shy away from competition. We agree that as society looks towards improved health care for our citizens, dramatic changes are called for. But

how we come about to make those changes is as much important as making change itself.

And what happened here today -- and particularly what we heard here today -- should disturb all of us, but most especially the consumers of New Jersey. With one sweeping program, the state's largest insurer has divided us -- the hospitals -- into the *haves* and the *have-nots*. And given the nature of this new insurance plan, the viability of non-preferred hospitals is threatened, and because of that fact, consumer choice as well.

Such a dramatic change in the delivery of health care should not have been the subject of secret discussions in executive suites, perched high above Newark, New Jersey. It should have been a matter of public discourse.

This seismic shift in our Catholic marketplace was decided not in our public forum in this state, but rather in a Roman coliseum where the Emperor allows the beast -- the company -- devouring everything in his sight to prevail, and spares but a few brave warriors because they happen to serve his ultimate purpose.

OMNIA's Tier 2 designation implies, in the public eye, that those hospitals receiving the designation are not providers of quality care. Without question, it misrepresents the quality of care my hospital delivers every single day. As noted in my written testimony to this Committee, beyond quality, Horizon has said there were other methods of selecting Tier 1 hospitals. Well, I even heard them today, when they talked about cost and consumer preference, experience and quality. And as we demonstrated

in our written testimony before this Committee, Saint Peter's qualifies to be a Tier 1 hospital.

Quality of care is key to our healthcare consumer. Regulators, judges across the country asked to adjudicate challenges to tiered insurance products agree, always ruling that whatever an insurer's criteria for Tier 1 status, quality has to trump every other criteria.

So with that in mind, very briefly, consider my hospital. We are one of six in the world to be ranked as a magnet hospital for nursing excellence. The Joint Commission rates us as one of the nation's top performers on key quality measures. We are the lone New Jersey hospital to be commended for quality care of childhood asthma. Our NICU is one of the largest in the country, and is the only unit in New Jersey to receive the Beacon Award for critical care excellence. Our intensive care unit is the only ICU in the state to receive a Beacon Award for critical care excellence on five different occasions. Our HCAP scores show that patients place our hospital in the 99 percentile -- or number one in New Jersey in several key categories of care -- while we rank in the 98 percentile in the responsiveness of medical and support staff.

We are moving along that path, including DSRIP program for diabetes, which proves that we are on the path to managing population health. We are the go-to provider for a wide range of services, including specialty care -- often difficult to find in any other hospital in New Jersey. We operate the largest Neonatal Intensive Care Unit in New Jersey, and one of the largest in all of the Middle Atlantic states.

We operate one of the largest maternity services in the country. In 2014, we delivered 5,600 babies -- more than any other single hospital in

the Garden State. Our Department of Medical Genetics and Genomic Medicine is one of the largest in the Northeast United States. Our Dorothy B. Hersh Child Protection Center, established to counsel and protect abused children, is only one of four such centers in New Jersey.

We are, today, number one in the state in obstetric discharges; number 2 in NICU admissions; number 3 in epilepsy discharges; and number 5 in the total number of in-hospital pediatric patients. Besides all of this -- and this all costs a lot of money -- we are very charitable. Last year we treated 16,889 uninsured patients as charity care.

What financial impact will have OMNIA have on my Catholic hospital? As explained in detail in my written testimony, we face the prospect of a loss of revenue of some \$36 million.

Members of this Joint Committee, beyond what Horizon has testified to today, I urge you to delve into the motivation -- further delve into the motivation behind the analysis employed, the players involved, and the discussions that company had with hospital representatives, as well as State and municipal elected officials or employees -- even if that takes you to the highest levels of the Executive Branch -- as the OMNIA program was conceived, designed, and rolled out.

And I also ask this Committee, first, to compel Horizon to suspend the OMNIA program while the necessary facts are gathered; second, to implement a process by which all stakeholders in this state can determine how best to create a fair and equitable healthcare marketplace that aids providers -- but most importantly, protects consumers; third, if it should be decided that a two-tiered insurance product is what is best for New Jersey, then I ask this Committee to ask this Legislature to introduce

legislation mandating safeguards designed to ensure -- just like they've done in other places in this country -- that the creation and monitoring of that system is open, fair, and consumer-driven. And we can take notice of, as Senator Gill said earlier today, what was done by then-Attorney General Cuomo in the state of New York.

And fourth, I ask you for the leadership in recognizing that while the delivery of health care in New Jersey should be rationalized, it must not be done by clandestine dialogue and actions among a few.

We are here because of a poorly executed insurance product that is now dividing our state's healthcare providers. Forever an optimist, however disturbing to me and many others why we meet here this afternoon, I hope today marks the dawn of a long overdue constructive and inclusive public dialogue about how best we can improve upon the delivery of health care, particularly to our most vulnerable brothers and sisters. And this is not impossible, not even in the State of New Jersey.

For such an endeavor to be a success, however, we just have to agree to the following: that insider politics has no role in healthcare delivery; quality of care trumps the bottom line; and what's best for the people of New Jersey may not be what's best for a self-interested few.

Thank you for listening.

SENATOR GILL: Any questions? (no response)

Thank you very much.

MR. RAK: Thank you.

SENATOR VITALE: What we'll do is, we'll listen to -- we'll take testimony from all three, and then we'll ask questions all at once -- sort of a common denominator for all of you.

Thank you.

MR. MARON: Good evening. Thank you for having us, Madam Chairwoman, Mr. Chairman. I appreciate being here.

I speak, sitting here today, not just as the President and CEO of Holy Name Medical Center, but also as the Chairman of the Catholic HealthCare Partnership. And I think it's important to know, Senator Gill -- you pointed it out a number of times today -- that the Catholic hospitals in this state have clearly been disenfranchised in this decision making. That has us greatly concerned because we think we all bring value.

I had submitted written comments; and what I would prefer to do-- And I encourage you to please read them; I think there is some very different points in there that you will get a chance to see and I can comment at some other time.

What I would like to do is use my time just to talk a little bit about what I heard today, and to sort of sum up some of the things and the challenges that we're facing.

No one here -- I don't think any of my colleagues would disagree -- Tier 1, Tier 2 -- that New Jersey's healthcare system is in a transformational change. It is a very, very imperfect market. The concern that we have -- and that Ron articulated as well -- is that all markets, especially in the grossly inefficient ones like New Jersey's healthcare market, become subject to deceptive manipulation, as transformation evolves. Existing market leverage -- either by a payer or a provider -- should not be allowed to interfere with the free and fair operation of the market and create artificial, false, and misleading appearances with respect to the price and delivery of these services.

What you heard today was a number of conflicting testimonies, even within the representatives themselves of Horizon, on the intent of OMNIA. We have a system that's going from this fee-for-service, transactional, very fragmented, volume-rewarded system to a value-based system. We have one-and-a-half feet in the fee-for-service, and we have a big toe in the value system, right? What's happened here is that we are confusing the incentives of the old system. Senator Gill, this morning you very appropriately pointed out that those Tier 1 hospitals took rate reductions that are going to be rewarded by volume. Tiers in this -- a narrow network in this in this immature market in New Jersey, at this level, have no basis, right? It is all about market manipulation and steerage -- and that's what's going on. And they're going to steer at the expense of somebody else.

You should also know that the rates negotiated by Blue Cross amongst the providers in the state can vary by as much as 300 percent. So you have to ask yourself: If we're really, really concerned about bringing value to the consumer, if we're really, really concerned about lowering those premiums, then why did you align yourself with the most expensive, costliest, highest-reimbursed hospitals in the State of New Jersey? A 15 percent reduction off of their rates? Nothing, right? Take it from all of us who have operated at a third of those costs for so many years and managed to do it so well.

I'll give you another little tidbit on the quality. Six hospitals in this state signed up for Horizon's ACO experiment -- only six: Holy Name, Lourdes, JFK, Hackensack, Barnabas, and Atlantic. They recently just concluded those six -- three are out as Tier 1, three are in -- all clearly

demonstrated a commitment to transformational care. Only one performed well enough to get an incentive reimbursement back from Horizon in that experiment -- Holy Name. And I will, quite frankly, tell you it was without trying. And those are also artificial benchmarks, because those benchmarks were set against ourselves -- not an industry norm. So all I had to do was out-perform our previous years' experience. If I could outperform the market, it would have been a whole other level. Take that and roll that into an insurance product; you probably could have cut premiums an additional 15 percent, for a total of 30 percent, had you designed this thing properly and steered it to the low-cost, efficient hospitals and allowed the high-end hospitals to start to conform. The most expensive health care should be a commodity in the system. We talk about prevention and wellness. So hospitals like Holy Name and CentraState that invested heavily in fitness and wellness programs have been excluded.

If you go to Horizon's website, they lay out 11 criteria. I don't disagree with any of them as to what's wrong and what's driving costs in the State of New Jersey. And in fact, I will add a 12th, and it is a big one, and it is one where New Jersey scores dead last -- and this is accurate data -- in the country, and that's end-of-life care. So we are ranked by Dartmouth Atlas consistently as the worst state in the nation when it comes to end-of-life care. It is a major, major driver. Holy Name has participated in -- we have our own Medicare ACO, we have participated in Medicare bundled payments, and Horizon's ACO. One of the common factors we have found in all the data is that, as someone raised earlier, we have not had access to data. So this is the first time, I think, Senator Gordon, that we actually ourselves can see data across the spectrum and make intelligent decisions

about what we need to modify care. We've been blinded to it; so imagine our frustration.

We know that the community wants value-based, and we know they want lower costs. We're trying to deliver that. So here, we know that end-of-life care is the single-biggest driver in those costs, across the board. So you have an organization, again, like Holy Name that goes out and invests substantially in homecare, in hospice, and in inpatient hospice in a very unique program up in northern New Jersey; the only one -- because there's no money. But it's the right thing to do. There isn't a margin in end-of-life care today, because it's not reimbursed; and what is, is very, very poorly reimbursed, but we did it. We're moving the needle on it; it's making a big, big change -- yet we were excluded.

So when you look at criteria that are out there, you have to be very careful to say, "What really is available, and what should those criteria be?" As DOBI sat here and argued about network adequacy, those rules and regulations are 20 years old. That's not the paradigm of today. That's not this transformational system. You should absolutely demand today a contemporary definition of what network adequacy is; it should be transparent, and everybody should be allowed to perform to that level. That is the only way -- through this kind of open, transparent, competitive market -- that we're really going to lower premiums.

If this is allowed to go through, the reputational damage, in the manner in which this is being rolled out to us, the more -- the lower, the cost-efficient hospitals in the state -- it's going to be detrimental. They minimize the impact; they minimize the fact, saying, "Maybe 200,000 people in total." There are 8.9 million people in New Jersey; Horizon

insures 3.8 million of them. When you do the math, and you take out all the numbers that were thrown around today -- those who are in traditional Medicare, and those who are in traditional Medicaid -- that is an enormous, enormous market share. It is a nonprofit; they operate by different rules. All the hospitals that are participating are nonprofits; they operate by different rules. Would any of them turn around and bail out a hospital today, the way Saint Peter's did years ago, in this environment? I think not. That's the tragedy of where this system has evolved to, and that's what really needs to be changed.

So I implore you that, as you go through this and you look at the solutions, that you absolutely demand DOBI to rescind what seems to be -- through very accurate and extensive grilling -- inappropriate issuance of an approval for this product; that Horizon withdraw, because they're already marketing aggressively in the market. That open public criteria, like Leapfrog, like Magnet, like so many others -- that you also be very careful that quality data is both subjective and objective. And even on the objective, some of the -- it changes over time. And I don't want to belabor this, but we had a lot of discussion about C-section rates, and we talked about readmission rates. By the way, Holy Name has the third-lowest readmission rate in the state -- but we're not in. And that is somewhat objective.

I will tell you, if you came to Holy Name, or Saint Peter's, or Lourdes, and you had services done and you left; and you were in a motor vehicle accident and had to be readmitted -- is that really-- That's how CMS calculates. So it's an admission for any reason. So even readmission

rates, you have to be careful as to how they are quantified. So just a word of caution as we roll out and we go in -- it needs to be measured.

We will absolutely respond to the Hawthorne effect; that has been proven. But everybody should be given the opportunity to respond.

So call on DOBI, call on the AG. I would rescind this product; I would call for a much more transparent and open enterprise. And I would absolutely insist that the total public-- So that you know and most people don't (indiscernible) -- it's not what we charge. There's been a lot of media attention to prices. What prices are, are those rates that have been negotiated by the payers to the providers. And market leverage has allowed that 300 percent differential to occur over the last 20 years. It needs to stop.

And so what you have here is a crossroads where fear in this transformation are all going to -- it's a market grab -- to grab land share, to get rid of those highly competitive organizations that are really going to define the market. Now, the Camden County-- In Burlington County and Mercer -- those are legitimate access issues. I can't argue access up in the north, right? There are a bunch of us. But they are highly competitive; they are highly well-organized organizations, all with a commitment to delivering care.

So I applaud you all for taking the time today. I know it has been a long, long day and you have been barraged with stuff. So I leave myself open to questions.

SENATOR VITALE: Alex.

ALEXANDER J. HATALA: My name is Alexander Hatala. I serve as President for Trinity Health in New Jersey. I have responsibility

for Saint Francis Medical Center in Trenton, New Jersey; for Lourdes Medical Center of Burlington County in Willingboro, New Jersey; and Our Lady of Lourdes Medical Center in Camden, New Jersey. We are the state's urban healthcare partner, and we have been for a long time.

You know, as I listened to the testimony today, one of the things that I really wanted to come back to is really value-based payments, and also support of tiered networks. And we would say, as an organization, that there is a place for that, and we do stand up really for the choices that consumers make, and also the positive impact it can make on the communities.

However, when you look at, as has been said many times today, how this product has been created -- the OMNIA health product -- how it was rolled out, the lack of transparency, the lack of objective criteria, the lack of objective quality, the lack of inclusion -- it really should not move forward from today. It is misguided and misaligned with the State's health policy.

Also, as Linda Schwimmer said earlier today, and as was said by Mike here, when you look at Horizon and you look at whether it is a monopoly or not -- it acts as a monopoly. And it is leveraging all of us, specifically the urban healthcare provider, in a manner that is really not in the public's best interest or the State's public policy. To allow an insurer to step in the role of the Department of Health and obviate its regulatory responsibility to create access for all -- specifically, the most marginalized of our citizens-- To obviate the centers of excellence that have been created over years through the Certificate of Need process, and allowing a

commercial insurer -- through using financial mechanism -- incentives to step in the role of the State policy, is completely inappropriate.

I think that what happens with the roll-out of a product like this -- it really does financial harm to the communities we're trying to serve in the urban centers of the State of New Jersey. It also will create irreparable harm financially to the institutions that I represent. And it will ultimately eliminate access for the marginalized of our citizens.

Some of the things that I would like to point out, from our perspective, that just need further illustration are, first of all, quality. You can see that I put a trophy up here in front of me. This trophy was given to Saint Francis Medical Center just a few weeks ago because they were one of Horizon's own high-performing hospitals awarded for its score on Leapfrog. So Saint Francis Medical Center received an *A*; Our Lady of Lourdes Medical Center in Camden received an *A*; yet, for some reason, we don't meet the quality metrics to be in this network. But we do have the trophy to show it. It doesn't say *Tier 2* on the trophy, either. (laughter)

As has been said before, if you look at the hospitals that are in Tier 2, they have a higher percentage of Leapfrog *A* scores than the ones included as Tier 1's. Another thing that I would like to come back to -- if you look at our three hospitals and our Catholic health providers -- but our three hospitals in the urban areas -- we have been a proponent of value-based payments. Trinity Health is the largest provider of PACE Program, a program for the all-inclusive care of the elderly in the State of New Jersey, which specifically is designed by the Federal government to treat seniors with chronic illnesses. And we get paid a capitated rate, one payment per month, per recipient, to manage all the care -- the total care of each of the

recipients. We've been doing that for years. And so if those recipients need hospital care, we pay for the hospital care. We'll pay for the physician care, we'll pay for the nursing care; we even go in the house and fix the houses when it's needed, if it's going to create a health risk.

So we've been providing value-based care for a long time. I don't know how we didn't meet that criteria.

We also are in Medicare bundle payments programs. We are also in our ACO; in our shared savings program we have 70,000 attributed lives, either through Horizon, Aetna, the Medicare program. Most recently, we were named as one of the 19 pilots for the Next Generation ACO-wide Medicare -- which does allow 80 percent upside and downside risk. And we were selected as the only organization in the State of New Jersey by Medicare to participate in that program.

So if you think about, again, some of the reasons that we oppose Horizon moving forward, and the impact to our urban population-- Let's just take Trenton again, which was said, over and over. Saint Francis in Trenton, as , because a small movement of commercially insured patients will undermine the financial viability of that institution, and then this city loses a Catholic healthcare provider that has served that mission for 140 years. And we're letting a commercial entity make that decision to get rid of a 140-year history of serving the poor. We don't think that that's appropriate.

Also, what I would like to point out to you -- in the packet that we distribute, there's a letter that I sent -- or that we sent to Horizon prior to their announcement. And if you look in your packet, that letter basically said that we would meet any of their value requirements in terms of cost,

quality, patient experience. We never received a response to that letter. We were never invited to the dance.

I had numerous discussions with Kevin Conlin, with the team from Horizon, from February through September, asking about the criteria that were being used, asking about what was the value proposition that was necessary -- never any response to that. And finally, at the last minute, sent a letter, saying, "Look, we'll meet your value proposition because we are always in the top 5 percent of all hospitals in terms of cost; we also have an exemplary quality record for all three of our organizations," as I said before. But not a response on that from Horizon -- going back to the transparency and the dialogue.

The other thing that I would like to point out with Horizon itself -- and this comes from my meeting individually with the Department of Banking and Insurance, asking about how they approved this product. And again, you heard the line of testimony from Banking and Insurance: it's all about network adequacy. And I don't know how that does serve the public interest the way it's designed today. And it does really need to be updated.

But when asked, "Whose projections are the 250,000 individuals who are going to enroll in the product?" Well, it's Horizon's. What is it based on? It's based on Horizon's experience on the healthcare exchange last year. When asking the Department of Banking and Insurance, "Is the benefit design the same?" "We don't know, we don't look at that." When asked, "Are the financial incentives the same?" "We don't know; we don't look at it; we just look at network adequacy," and you

could see the response we get on network adequacy -- it's inadequate, totally.

So with that, again I would just say, from our perspective, I think that the concept is a good concept. But this is a misguided experiment and direction, and we would ask you to put a halt to Horizon's implementation of the OMNIA health network because it will have dire consequences in our cities -- in Trenton, in Camden, in Willingboro -- because you will not have institutions like ours -- value-based, Catholic institutions that have been serving the poor for 140 years -- n existence.

SENATOR VITALE: I do have one question, I guess for, maybe, all three hospitals.

You've all, in your own way, talked about your willingness to participate--

Is there another person who wants to testify?

UNIDENTIFIED MEMBER OF PANEL: No.

SENATOR VITALE: Okay.

--your willingness to participate in the OMNIA program. And I think we made some points earlier, and some of the members did. And I asked, if it is that, why is it, from Horizon's perspective, that they can't apply this value-based idea throughout the entirety of the hospital system and the state -- well, the systems, rather, instead of having favorite hospitals?

Because it seems to me that, in some ways, there are arbitrary decisions made in terms of who gets selected and who doesn't get selected. Sometimes it's about the quality, sometimes it isn't -- or the quality measures are a little cloudy. When we talked about Leapfrog, they

dismissed Leapfrog as sort of this -- I don't even know; they just dismissed it in favor of CMS and *U.S. News and World Report*. And they acknowledged that the only way for the Tier 1 hospitals and the OMNIA partners to accept this is because there will be a shift in volume, right? It's only for the Tier 1; non-OMNIA hospitals, where they're not getting any of the shared-savings (indiscernible) people, it's just about volume shift.

So it's going to have to be an aggressive-- So for a Tier 1 that's non-OMNIA, there is going to have to be an aggressive shift on behalf of the plan to move people over, because I don't think that the hospitals are going to tolerate a loss of revenue without seeing a stream of new patients coming in.

If we were to include all hospitals, and some value-based metric, where everyone was encouraged and incentivized to do better work, you wouldn't see the shift; you would just see hospitals succeed or not succeed, based on the kind of quality they provide. You do think that's a workable system, or is that -- or do you have to have winners and losers?

MR. HATALA: Well, I think it is more in line with the State health policies. So when would more access be bad? If we could all meet the value proposition, more access is good, I think. And that has been the Department of Health's position.

And I think it is fairly workable. And again, why would you want to exclude low-cost, high-quality institutions like ours? Mike Maron said it earlier: some of the institutions that are in that Tier 1 are the highest cost institutions in the state, and have rate structures 200 to 300 percent higher than ours.

MR. MARON: Yes, and Senator, I wouldn't actually say that the solution for us here is to be part of OMNIA -- at least, not for me, at this stage, because-- And I don't think this just applies to Blue Cross. This applies, now, to all payers. Now, Blue Cross, by far, is the dominant payer. But Aetna, who has a smaller share right behind-- Our market is not mature enough in its transparency, in its communication of data to the consumer to support this kind of steerage. And that's what opens you up to manipulation.

So I think the call, from my perspective, would be: consistent, equitable criteria -- the same for all of us. Same payment, same performance. And if we can operate in that, then we need to adapt to do that. That's fair, that's equitable, and at the end the consumer benefits. No one loses access, and everybody is able to participate. That process, I think, is absolutely doable; it has been done in other states; and I think it is something that New Jersey -- that has participated in leading the country in the past in reimbursement models -- should, once again, step up and say, "We can design a system, given where we are, to effectively manage this transformation from fragmented, fee-for-service medicine all the way through to this model."

And the volume-- I mean, you heard it here today -- again, conflicting -- Summit Medical, part of the Alliance. Their incentive is to keep everybody out of the hospital. The incentive is prevention, wellness, and health. So even with the steerage, as this matures, if that-- And I actually believe that's true; I've seen what Alex and others have done around the country with the PACE model. It can work. And you can

absolutely change behaviors and the health patterns of the population at large. But you need to give everybody a chance to participate.

So if Summit Medical really succeeds in their model, all utilization rates in the acute setting are going to drop. So you go through this temporary period of, “We’re going to steer away from others so I can maintain my market dominance and my position; hopefully, artificially inflate premiums, artificially inflate what I’m reimbursed -- because now I’m the only player left in the market. And I get to dictate terms, and maybe I can take a much more gradual transition to this future state.”

So there is an urgency, and I absolutely think it can be done, and needs to be done right away.

MR. RAK: Sir, I think the simple answer is-- I mean, if you start with the premise that quality is key to the consumer--

SENATOR RICE: Could you put your names on the record?

MR. RAK: Yes, I’m sorry.

SENATOR RICE: Everybody is talking, and I want to read the transcripts and I want to know who’s talking.

MR. RAK: Ron Rak, from Saint Peter’s.

SENATOR RICE: I’m sorry, through the Chair.

MR. RAK: If you start with the basic premise that quality is key to the consumer, I think, then, you have to start with basically a blank slate. And I don’t think we should try to take what Horizon is proposing and try to transform it to meet the needs of a few who may object to it, including myself.

I think what this is calling for, on a State level, is a very serious discussion on what is best for the consumer, how do we best construct a

medical model in New Jersey that makes sense? But quality, again, always has to be number one. You know, I was very much taken aback today, because, first of all, for the first time, I heard there were three criteria. Because when my hospital called Horizon and asked what the criteria was, we were given one criteria. And then I think when Al, or someone, called someone else--

MR. HATALA: And they said we had six.

MR. RAK: Six criteria.

MR. HATALA: Yes.

MR. RAK: So actually, I was working on a presentation that focused on Al's six criteria. Now, today we hear three criteria. But what did they say when they talked about the criteria? When it came to the issue of quality, when this Committee raised the issue of quality, their response was, "Yes, we admit many of those we admitted into Tier 1 are not of the quality that we would, basically, prefer. But we will work with them on that." My contention is that there are enough of us around the table -- his trophy is proof of that -- who can help Horizon, help their Tier 1 hospitals, and teach them all a little bit about quality.

But again, to your point, I firmly believe that we've got to have a real dialogue in this state; we have to depoliticize our healthcare system; and I think we have to seriously bring all the stakeholders together, representatives from each constituency, and have a true discussion on what's best for New Jersey.

I submitted in my testimony how Tier 1, in a physician level, started lawsuits across the country. But how, yet, when New York was faced with all of the issues that they were facing with Tier 1 physician

networks, and all the major players there tried to squeeze the small players out -- the Attorney General stepped in, the Department of Health stepped in, and they came out with a rationalization on how we can handle this marketplace. The State can't necessarily tell an insurer how to run their business, but the State has the authority to set down rules and regulations by which all the players have to play.

MR. MARON: I would just add that we need to be careful about this monopolistic behavior that's going on. Because the only, really, evidential behavior that exists today, that we can conclude as to why you're Tier 2 or out of this network, is either you're Catholic-sponsored or you are a stand-alone organization. And those are bad criteria for the ultimate market performance that you want to achieve.

Because you can hurt-- We'll all be able to argue on the fine points of quality and performance. But because we're standalone-- And you look at Bergen County: dynamic market, two standalone hospitals -- both excluded. Everybody else -- a hospital that closed and is struggling to reopen gets included as Tier 1, because they're aligned to one of the major players in the Alliance partnership. That is a tell-tale sign of where this whole program is flawed, and where the consumer ultimately is going to be penalized.

MR. RAK: Can I just make one point, following that? And I'm sorry.

But let's take obstetrics.

SENATOR RICE: Name.

MR. RAK: Ron Rak, from Saint Peter's. Thank you, Senator.

MR. MARON: Senator Rice remembers me. (laughter)

MR. RAK: Yes. Okay, all right.

Obstetrics -- we just heard from the Department of Banking and Insurance that some adjustments had to be made because there was not sufficient coverage for obstetrics cases in my part of the state. And if you read between the lines, that meant that there was not enough coverage at Robert Wood Johnson Hamilton -- although I have the coverage; I just gave you nine counties I cover, including Mercer -- and so how was that problem fixed? No one came to Saint Peter's to talk to me about possibly helping them out with Tier 1 obstetric cases. No -- they had to take out -- Princeton out of Tier 2, move it into Tier 1 just for those types of cases -- and somehow you got your magical number that satisfied the Department of Banking and Insurance.

My response to that is, there is a reason why I'm number one. Because I do it all the time, because I do it very well. Why wasn't anyone-- If Horizon chose not to call me, where was someone from the State calling me to say, "This concerns us. Maybe you should be part of this dialogue." It didn't happen.

MR. HATALA: One other comment that I would also make-- And so we have focused on Trenton, but also Burlington County extensively today. We have a hospital in Burlington County. But one of the comments made by the Horizon folks earlier today, when the question was asked about whether a hospital that was being acquired would become part of the Tier 1 network -- and the answer was "no."

Well, the other thing that we should be concerned about is Atlantic County, because we have a hospital there that is a Tier 1 provider,

that is being acquired. And so presumably Atlantic County also would not have any coverage either with this OMNIA health network.

So again, I think that the rules of engagement here are very flawed.

SENATOR VITALE: Any other questions from members?

I'm sorry -- Senator Addiego.

SENATOR ADDIEGO: This is directed to Lourdes.

On September 15, we have a copy of the e-mail wherein Horizon was coming up with a solution for the inadequacy of access. And I believe there was testimony that Lourdes was one of the hospitals that would be providing the ob/gyn services.

Was Lourdes contacted in the last 20 days?

MR. HATALA: No, they were not. And just to give you some insight on the flawed information and the market intelligence related to Burlington County -- Lourdes Medical Center, Burlington County, does not have an OB service.

SENATOR ADDIEGO: Oh, I know that.

MR. HATALA: Right.

SENATOR ADDIEGO: I knew that.

MR. HATALA: Right.

SENATOR ADDIEGO: I just wanted to see if you were even contacted.

MR. HATALA: No, we were not contacted, and I think that our peers at Horizon were not that familiar with that.

SENATOR ADDIEGO: Thank you.

SENATOR CARDINALE: Mr. Chairman.

SENATOR VITALE: Senator Cardinale.

SENATOR CARDINALE: If you could change something in this plan that would allow greater participation by hospitals, but still result in the kind of cost-saving that is promised under this proposal -- or actual fact, I guess it is now -- what would that be?

MR. RAK: Transparency. There has been nothing transparent about this plan

SENATOR CARDINALE: Well, transparency in what respect?

MR. RAK: Transparency in terms of the criteria. I mean, first of all, you have, by Horizon's own admission -- you have across the State of New Jersey, in their words this morning, very high-quality hospitals. They actually tried to make some of us in Tier 2 feel very good today by saying, "I think you have some good quality Tier 2 hospitals." (laughter) So my response to that, Senator, is if we are all of such good quality, then allow us all to come to the field and try out for the game. It hasn't happened.

Also, let us be very clear about where they stand in terms of how they weight their criteria. Because they could talk about how, maybe, we want a quality system of health care for the State of New Jersey. But they're not telling us -- and I didn't hear anything this morning that suggested that they're willing to share with any one of you, let alone us, how they weighted those criteria. I think the word was *proprietary*. "We're not going to share that with you." I found that quite offensive, not only as a CEO of a hospital, but as a healthcare consumer in New Jersey. I would like to know how the company, that happens to be my insurer, rates quality with regard to other criteria for inclusion in some plan.

MR. MARON: So, Senator, I would agree with that. I think really what you want to say is, from my perspective-- What they should do is pull it back; there shouldn't be tiers. There should be a set standard that says, "Here's what we're willing to pay," or share in the premiums. A better way to do it -- take it to the next generation of maturity in this market.

What they're telling you -- and we'll use the only public data we have right now, because they haven't released everything -- is the State Health Benefits plan design that is out there. So that's targeted for this.

If a family coverage went from \$27,000 annually -- and these are real numbers -- went from \$27,000 annual premium to \$22,340, that's the new premium under the OMNIA Alliance; then that's the reduction they're talking about. Take that premium and say "We're willing to share the savings on that premium if you can help us control the spend on those lives." So it's how the ACOs are working -- "We're going to attribute lives to you, and if you help us manage that and we come in less than the \$22,000, our medical loss ratio goes down." Right? You heard that earlier today. They have to hit -- they have to spend 80 percent, is where there's contradiction in the regulations. I charge a premium, and yet I'm held by DOBI rules that I have to spend 80 percent on MLR. Well, that premium is so high, I might as well give it to the providers, right? That's not an incentive; that doesn't help actually lower premiums down.

So set that where you're going to turn around and say, "I'm going to allow a set standard so that a Holy Name and a Valley can compete against a Hackensack in our market fair and square, up above board. And if Hackensack can lower their operating costs, God bless them,

they should do it, if they can match my rate-- But it shouldn't be an impediment to me being able to perform.

So set that -- define the market. Every market has to have rules. This one doesn't. The participants are defining the rules. And it is one of the responsibilities of this body to say, "Time out. There has to be rules." DOBI's rules are old; the Department of Health rules are old. It's time to reset the rules. And that's a good, healthy dialogue that should take place.

SENATOR CARDINALE: But it's quite obvious that DOBI's rules don't really cover the questions that are being raised by this Committee. I mean, DOBI's rules are DOBI's rules, but they're irrelevant to this problem.

MR. MARON: Not really, because if they had relevant rules they wouldn't have approved this product in the first place.

SENATOR CARDINALE: Right.

MR. HATALA: Right. And I think they do have a responsibility to act in the public interest.

SENATOR CARDINALE: Well, they dispute that. They don't consider themselves a policy-making group.

But what has been presented to us is that the savings that are projected are only possible because they are limiting the network and, therefore, giving an incentive that more patients are going to go certain places; and therefore these places, in return for getting more patients, are going to lower the costs.

Okay, and I can understand that as -- Well, what you seem to be saying is that it isn't necessary to redirect patients. You can lower costs without redirecting patients. Do I understand you correctly?

MR. MARON: Correct; that is correct, Senator.

SENATOR CARDINALE: So what I think you would like to see is some sort of system where -- and I think you said it, but I just want to be sure that I heard you correctly -- that there are-- Everyone gets the same rates; that all hospitals are reimbursed similarly. Perhaps you might have some regional differences; I don't know. But that if we could, by law, say everybody gets the same rates, everybody who's willing to match those rates is part of the system, and Horizon doesn't have a choice -- they have to take you if you can match the rates at a level of quality.

MR. MARON: That's right.

SENATOR CARDINALE: Who would determine whether that level of quality was, in fact, the same level of quality? Because that's, to some degree, a subjective assessment.

MR. HATALA: Well, I would just say they have a measure of quality already -- it's Leapfrog; they've used it for 10 years. And I would just say that's probably the best we have at this point.

But it deserves further dialogue, that's all. You know, this thing, the way it was rolled out in a matter of weeks, not allowing any dialogue on the validity of those quality criteria, I think is inappropriate. But I agree with your basic premise that any willing provider be allowed to come to the table if they meet the value proposition.

MR. MARON: But then that should be the same value proposition for all -- not unique for Lourdes versus Holy Name, versus Robert Wood Johnson. They should be the same.

SENATOR CARDINALE: Thank you.

SENATOR VITALE: Senator Rice.

SENATOR RICE: Yes, a couple of things.

If I heard correctly, when you asked about the measure of quality -- who measures that, how that was measured now-- But the little network they have, you're saying that has to be measured in there too, or you don't stay in the process. So if you measure-- If you have a way of measuring those and the Alliance, then that's your (indiscernible) outside. They come up with something now.

But the question I have for those who are here is, what happens if the Legislature does nothing, or the Legislature does something and can't stop the implementation of Horizon's plan in January? What happens after that, from your perspective? What's going on?

MR. RAK: First, what happens now is that there will be a slew of litigation.

SENATOR RICE: That's what I thought; okay. So--

MR. RAK: This matter will go to the courts.

SENATOR RICE: That's what I thought. I knew it -- litigation.

First of all, I don't like tier systems because I come from a different kind of history. I just never (indiscernible) my mind, people of my history. Tiers, to me, are discriminatory. Maybe I never felt it intentionally, in some cases. But at the end of the day, it's the little people

who get harmed in the tier system. That's why they have -- whether it's this insurance, whether it's auto insurance -- and they we have to do credit checks that have nothing to do with driving. You know, stupid stuff that we agreed to, as Legislators, and our Majority -- which I think is insane. And I'm going to keep fighting against them, and eventually I have enough legislators on both sides who agree with me, and I won't be in the minority.

But I'm going to suggest that-- Because I smelled litigation, I'm going to suggest to this Committee that we do have some real firm conversations, collectively, with Horizon to slow this thing down and get everybody to the table. Because once again, the apple pie-motherhood piece -- we're not against that; we get that. Everybody gets that, nationally. And we're not sure what actually works, at the end of the day, to get it down.

Because if we don't do something, then I'm going to suggest a couple of things. I'm going to suggest that someone go to court and get a stay on this thing -- and I think that's going to happen. But I also suggest that the Legislature -- and I hate to keep doing subpoena stuff, but we do have a constitutional fiduciary responsibility to oversight any Administration -- not just this one. Just as we did Bridgegate, we may have to subpoena information -- whether we get it or not -- for the record. Because it's obvious to me that there's information that we are entitled to that we're not getting. Yes, maybe some of it we're not entitled to, but we have enough legal minds and enough common sense to determine whether we can legally have that or not, or whether we shouldn't get it.

And so I'm suggesting that to the Chairs -- both Chairs. I mean, if we can ask for a Committee to go after one thing, then we should be able to ask for a Committee to go and protect the consumers, etc.

That's my perspective on it, and I'm willing to support that. Hopefully, it doesn't have to go that far; hopefully, Horizon will see that the Legislature and this majority of their peers-- Because I read the articles from Hudson County -- I know they're not here -- and others in the state. Apparently there is a great concern.

So if you don't have-- Because if you're so business-minded, and so willing to just suck up the dollars that you're not going to respect the Legislature, the voice of the people, to come to the table and rethink this thing, and bring everybody to the table -- then we can eliminate people there, to do that; then they can tell us how big that entity is and how they think that they run the government.

I just don't want any of our houses to be subordinate to anyone, when we're the people's voice. I always argue that. Some of my colleagues say, "Well, there's nothing we can do." I just disagree. The Constitution is very clear that we can shut people down, etc. Sometimes we need the Governor, and sometimes we don't. But we can spend money and litigate too. We can be friends of the court, or we can bring it to litigation.

And I tried to get the Senate President to see that -- not in the other house -- but I told him, I said, "Some of this stuff, you're going to have to start stepping up," and we, as the legislative department, have to lead the court action; not on your politics, but on the people's concerns.

MR. RAK: Senator, just one other point with that.

You could also, today, just to make a statement, urge -- I believe it's Treasury's responsibility to rescind the 2016 State Health Benefits plan design that they put out there. Because while they may be looking at what is a fictitious short-term savings, the long-term impact is detrimental. And as to what Linda Schwimmer said earlier, you have large purchasing power. You should let the market know that you're not accepting this -- by the largest employer pulling back that plan, putting it on hold until there's a better design and a better position in place. So I think that would send a very powerful statement to the market.

And you also have -- it was only mentioned once today. There is \$3 billion of New Jersey Health Care Facilities Financing-issued debt at risk here. The State has already suffered nine downgrades; I don't think you really want to get the rating agencies and the debt markets to pile on on this, as far as the overall detriment it's going to have within the community.

SENATOR MADDEN: Joe?

SENATOR VITALE: Senator Madden.

SENATOR MADDEN: My question is for Alex. How are you doing?

MR. HATALA: Good.

SENATOR MADDEN: So Alex, were you in the room when the Department of Banking and Insurance were here -- particularly the Director of the Division of Insurance and the Deputy Director?

MR. HATALA: Yes.

SENATOR MADDEN: During their testimony?

MR. HATALA: Yes.

SENATOR MADDEN: And the latter part, in the waning minutes of their testimony, I asked Deputy Director Maurer about the two options that Horizon had put on the table that would fulfill the gap of the 2 extra percent -- to get that to 90 percent. Do you follow me?

MR. HATALA: Yes.

SENATOR MADDEN: And she laid out that there were two points -- one, Horizon was looking to contract -- doing a Tier 1 contract with a hospital in Burlington -- or Newark, with two hospitals. And that closed my questions, and we moved on to Senator Addiego. And Senator Addiego's question of the Deputy Director was, simply, "Could you tell me who those two hospitals are?" And her response was that it was Lourdes and Virtua. Now, I believe you're testifying that you don't know anything about this.

MR. HATALA: I do not.

SENATOR MADDEN: Why do you believe -- what reason do you think a Deputy Director from the Division of Insurance would testify in a manner like that -- as though she knew for sure when she was posed that question by Senator Addiego? Any idea?

MR. HATALA: Perhaps she was misinformed.

SENATOR MADDEN: Did you take it that she was affirming that you are the hospital, and that Virtua was the other, when you were sitting here and heard the Q and A?

MR. HATALA: That's the way I heard it, yes. But I have no knowledge of that.

SENATOR MADDEN: Thank you; thanks.

Thank you, Chair.

SENATOR GILL: Thank you.

Any other questions? (no response)

Thank you, gentlemen, for your testimony.

MR. MARON: Thank you.

MR. RAK: Thank you very much.

SENATOR GILL: Thank you.

We'll have panel two, please. CentraState-- We're going to get you some company. JFK and CentraState.

Thank you, gentlemen. Please identify yourselves for the record.

R O B E R T P E D O W I T Z, D. O.: Rob Pedowitz, D.O., family physician, Medical Director of CentraState Family Practice. And thank you for the opportunity to testify here today.

And Senator Gill -- and I know Senator Vitale is not here -- and the rest of the Senator Committee, thank you for your hard work on this issue. I know it's been a long day, and hopefully my comments will not be too long today.

A D A M B E D E R: Adam Beder with JFK Health.

And Senator, if it is okay with you, I know the CEO from Virtua Health is also here today, and I believe he would like to join us if that's okay -- Rich Miller.

SENATOR GILL: Sure. Please come forward. And can you identify yourself for the record, sir?

R I C H A R D P. M I L L E R: Rich Miller, Virtua CEO.

SENATOR GILL: Who would like to go first?

MR. MILLER: Me? Okay, great.

First of all, thanks for hearing the testimony today. I know it's been a long day -- and good evening, everybody.

Thank you, Chairwoman Gill, for your support and long day today and, obviously, Chairman Vitale as well -- as well as the rest of the Committee. And Senator Addiego, who represents us in Burlington County -- we appreciate her representation as well.

First of all, let me comment that it's important to understand we are a for-value network. We think value is important; we think measuring quality, safety, and cost is very important. And New Jersey is preparing itself for that. Any hospital in New Jersey that's not preparing to take on value will not be here in the long run. So every New Jersey hospital understands that if they're going to play in the new world of health care, that they have to work with value.

Also, let me comment that we've been a good partner with Horizon in southern New Jersey. Virtua represents the three counties in southern New Jersey -- Burlington, Camden, and Gloucester. We have 9,000 employees and we're the largest employer. We have three hospitals, all are Leapfrog A hospitals. We received the Hospital Distinction Award at Voorhees, which only 100 hospitals in the country receive. So we are-- the trophy that Alex had -- we have three of them. So we didn't bring them, either. (laughter)

But we work with Horizon directly. Here's the concern, from Virtua's perspective. The coverage in our community-- And Chairwoman Gill, let me make it clear -- and I think Senator Addiego was getting to this. There is only one hospital in Burlington County that provides maternity services -- Virtua Memorial in Mount Holly -- not two. So when the people

were here from DOBI they suggested that there were two choices. There is one choice in Burlington County -- it's Virtua Memorial. We're the only provider of maternity in Burlington County. So I have some concerns about that.

And your other comment, frankly, about offering Tier 1 services in a Tier 2 provider -- that could easily be Virtua for maternity services. Because if you consider Burlington County and Mercer County, there are no Tier 1 providers for maternity in either one of those counties.

So let me give you an example. A pregnant woman who has a Tier 1 product has to travel to Cooper in Camden or to Princeton to deliver their baby. And I would submit to you -- that is a pretty long haul. And if it's during rush hour, that's over an hour to get to those providers. That's a problem of access in Burlington County.

So that was an important comment. And I think that has to be clear, at this Committee level, that there weren't choices in Burlington County when OMNIA was presented. There's only one choice in Burlington County for maternity.

The last thing-- And I will also tell you that we were never informed by Horizon; we were never asked to participate by Horizon. I'm hopeful that they're not offering Tier 1 community members -- potential Tier 1 community members Tier 1 status at Virtua Memorial without telling us. Because they have not told us that, or have not informed us of that. That's an important comment to make here, because nobody has told us anything about it.

So at this point, we're a Tier 2 provider across the board for Horizon. A very important comment.

I just want to also comment that Virtua is Horizon's largest patient-centered medical home care product in southern New Jersey. We have 13,000 Horizon lives that we manage with our care coordinators. We were told we were one of the best providers of care in the medical home service across the State of New Jersey. So we are doing value in southern New Jersey with Horizon, with 13,000 members. Why would we be excluded from providing services now in their OMNIA Tier 1 product?

I want to clear something else up. The cost issue with Tier 1 is basically Horizon coming to the providers and saying, "We're going to pay you less in your rates in a Tier 1 scenario." So every one of those providers that are Tier 1 had to take a rate cut -- or some form of rate cut. For Virtua, we were never approached to even consider taking a Tier 1 rate cut. So we meet all the quality -- or meet or exceed all the quality parameters for quality and safety for the Horizon network, and I would challenge Horizon to put us in their quality forum to see how we do with quality and safety. We'll exceed most of their parameters and, frankly, we'll exceed a lot of the Tier 1 providers in South Jersey that are already being considered.

So the key is transparency to the consumer. And Horizon hasn't been transparent in advertising the product to the consumer. They're basically advertising the product. And when you say *Tier 1*, *Tier 2* to a consumer, the automatic recognition is, "Tier 1 must be better." And if you're talking about quality and safety -- that we chose quality and safety providers, what you're referencing there is that, "Tier 2 doesn't have the highest quality -- that their quality is lower than Tier 1." So the perception of the consumer, right away, is, "Boy, Horizon put a high-quality network, low-cost network together. I need to join that." And that's not fair to the

Tier 2 providers because, frankly, when you take Leapfrog scores across Tier 1 and Tier 2, there's more Leapfrog A in Tier 2 than there are in Tier 1. That's an important fact to note as well.

So I just want to say here, on quality, value, cost -- Virtua is one of the leaders in the state, and one of the leaders in the country. We're prepared to move in that direction. You have to ask the question, then, why the sixth-leading provider in revenue in the state-- We're sixth in line of total revenue of all the providers in the state; we have the best coverage in South Jersey for covered lives, given our locations. We do health and wellness, we have three hospitals, four outpatient centers, 2,000 physicians, 350 employed physicians -- all high quality. Why would you leave out Virtua, or not even ask them to participate in this network? And why would you include and ask Cooper Health System to participate, who is an owner of a competitor health insurance -- AmeriHealth, who competes directly with Horizon in South Jersey? I have to ask the question, because they're not a logical choice when you're bringing your competitor into the fold. I don't get that; I don't understand why that was done; and frankly, there's a real gap in South Jersey in coverage.

So there's a lot of questions to be answered, and I think a lot of questions remain for this Committee -- and actually, for Virtua as well.

Thank you.

SENATOR GILL: Any questions? (no response)

Next, sir.

DR. PEDOWITZ: So I would like to address everyone as somebody who has not had an opportunity to speak today -- that's with a physician's voice. We've heard from administrators and executives -- we

haven't heard from physicians and, by the way, we're all patients. So I think I speak for the patient, and I speak for the physician.

First of all, for full disclosure, my group, Family Practice of CentraState, is one of the original patient-centered medical homes in the State of New Jersey. We've had a long-standing partnership with Horizon, and we've been recognized, and we are a patient-centered medical home Level 3, NCQA certified -- so we have achieved the highest level of certification there is.

I've enjoyed my partnership with Horizon and meeting with them, and we have a lot of great discussions on improving quality and saving costs.

Everyone, today, has agreed on the same goal: Let's lower costs and improve quality. But it is very confusing for the consumer, I agree. As a physician-- And I have practiced my career in the inner city; I've been in Burlington County most of my career, and in Trenton, and I have been in Monmouth County -- western Monmouth County for the last three years. Western Monmouth County, also, has a big donut there; there's nothing there. CentraState is the only hospital in western Monmouth County. We service a very large geographical area, very diverse. We see patients of all backgrounds, ethnicity, and certainly of socioeconomic status.

We're one of only three systems in the entire state that offers a high level of care for MS patients. We are the only hospital in western Monmouth County to offer inpatient psychiatric services -- and this was mentioned earlier about, really, the lack of a lot of insurance coverage for mental health in the state. We are the only inpatient service for obstetrics

and gynecology in western Monmouth County. Therefore, we are also experiencing the same problems here.

What's interesting is, I'm Tier 1, my practice is Tier 1 -- my hospital is not. I have an office that's, literally, attached to my hospital, and I have patients who have MS who are brought in to me in wheelchairs. And a lot of them have Blue Cross -- Horizon Blue Cross products. And I say to them, "Well, yes, of course I want you to go down the hall for services." They tell me -- this is real -- "Doc, I just can't do it; I can't afford it. I don't know what I'm going to do, but I have to go somewhere else."

That's really sticking a dagger in the heart of what I try to do every day -- and that's take care of people. We can't do it when there's a division there. And I understand that there's choice; we have choice. Well, my patients had choice of taking Horizon -- the Advantage EPO Plan over the last two years. I was in-network; they said, "Great, we're going to join with you." I saved them money, provided high quality. I then get a letter at the beginning of this year, "Sorry, CentraState is no longer a provider in our EPO plan." My patients were forced -- not choice -- forced to leave my hospital system because I take what my hospital takes. I'm employed; so if I'm an employed physician-- By the way, 50 percent of doctors in the state are now employed, and that's growing. So we're going to have a huge chasm between physician and hospital; and more importantly, between our patients and our physicians. We strive to practice quality. We care so much about our patients. The margin in family medicine is so small; one patient per day -- that could be \$100 a day, extrapolated over 365 days a year; the margin just isn't there. That's an employee or two that I'd have to fire because I can't make up the difference. And this is real; this is real

information, this is in the trenches. I'm not saying this for any reason but we've got to look at it.

So I propose-- I liked comments before about taking this back to the Committee and looking at this. To me, if everyone had the same bar -- you know, for me, it would be NCQA-certified. I have a bar that I have to achieve. I have 100 point-scale that I have to be graded on. And to hit that grade is not easy; believe me, it is not easy. It costs us a lot of money just to get there. Everyone should have the same access, the same ability to hit that score. You know, if this is any willing provider -- and that's what we're talking about -- if any doctor in any hospital had the chance to do this, let them have that chance. And whether it be Horizon's product, or anyone's product, give them the chance to achieve the same level.

Oh, and by the way, to your comments: I am Tier 1, but no one approached me. No one asked me. I've talked to many of my colleagues up and down the state, "Hey, you're Tier 1; that's great. What did you do to get it?" "I don't know." (laughter)

So I'm privileged, I'm happy. Unfortunately, I can't send my patients to my hospital. And I'm on staff, so I can't manage them. By the way, when we send patients to other hospitals that are not in our system, that causes a decrease in communication. You're looking at duplication of testing that may not have needed to be done. You're looking at a decrease in quality of care when the patients come back -- if they come back from going to the competing hospital system; if they come back. We don't get that communication. We may be looking at hospitalization rates in under 30 days -- re-hospitalization rates go up because we have not received the

proper communication with them. So this is a potential problem that I know we could avoid. Again, these are unintended consequences.

But I will close my comments there, because I know it's getting late. If anyone has any questions, I appreciate your time.

SENATOR GILL: Any questions?

I have a question.

DR. PEDOWITZ: Sure.

SENATOR GILL: It appears to me by the-- And you may not be able to answer this. By the model -- Horizon's model, and with this Tier 1 doctor, Tier 2 doctor -- I guess you could advertise that you're Tier 1, right?

DR. PEDOWITZ: Sure.

SENATOR GILL: So you can bet that's a leg up, so to speak, that you can advertise that way.

But it seems to me that if you actually follow it out, and Summit Medical practice -- the only physician service that's in the OMNIA partnership-- So that you -- by designating a doctor Tier 2, that's a disincentive for patients to come; for designating a doctor Tier 1, but the hospital he's associated with is a disincentive to go to the Tier 1 doctor, because he's in a Tier 2 hospital. And so you can force mergers with Summit in order for doctors to be able to continue to practice. And so-- And I say Summit because they're the ones that are the partner, and the only-- So you can see that you weaken the market for physicians if they're Tier 1 or Tier 2. You can't sustain your practice. You have to pay your bills. Somebody comes along and says, "I'll buy you," or, "You merge with

me.” And that person could be Summit. So that they have constricted the market for physicians, and they forcibly drive it to a particular entity.

It’s hard enough, as you said. With the margin of profit, and with this added disincentive so that the doctors will be weakened, it drives that to either a merger or buy-out, or “I have to go work with this group, because I can’t survive on the way this system is tiered.”

I find that to be very troubling because I think it is part of the business plan. And it’s part of the business plan that we may see happen in four years or five years.

So thank you for your testimony.

Sir.

MR. BEDER: Senator Gill, thank you. Adam Beder, Vice President of Government Affairs with JFK Health.

I’m going to be brief today. I think most of the points that I was going to cover on behalf of our CEO, Ray Fredericks -- who left earlier -- have already been covered.

I do want to start by thanking you, Senator Cardinale, Senator Rice, and the rest of the Committee for your work here today. It’s been wonderful to see all these details come out about Horizon’s OMNIA product. We knew so little going into this hearing, and I think we feel more informed.

I would like to highlight just a couple of points and recommendations that I think have been brought up today, but I would be remiss if I didn’t highlight them.

On behalf of JFK Health, we’re not opposed to tiered plans; in fact, we have a tiered health plan for our employee health plan. The issue

with the OMNIA plan is its lack of transparency about the qualifications to be in Tier 1, and its exclusivity. There does not seem to be a pathway for -- whether it's a hospital, a physician, or other provider -- to get into Tier 1 under, really, any circumstances. And if there is, that is opaque to us. We can't determine what that is.

Several individuals earlier brought up the correlation between this program and what Medicare does -- the Medicare shared-savings program and bundled payment programs. The big difference between OMNIA and many of those Medicare programs is the fact that Medicare is transparent about the criteria to participate, and any provider is permitted to participate -- and they take on risk in doing so.

We think, frankly, that that is an appropriate model and is something that the Committee should consider exploring with OMNIA and with other similar products. And it's not just because of the situation we find ourselves in with OMNIA; but also because when you create a program that is designed to incentivize quality and value, and you make it transparent, and you allow anyone to join-- The providers who qualify initially, who would get into Tier 1 initially, are already high-quality providers, and that's a good thing; but by making those criteria transparent and allowing anyone that can meet those criteria to join, you will incentivize hospitals and doctors that don't meet those criteria today to improve. And that way all of us in the healthcare field are working to achieve the Triple Aim of health care -- to improve quality, reduce costs, and improve patient experience.

If we're not all working together to do so, that means some of us are not working to that aim. And that, I think, would be troubling for policymakers like yourselves.

So I'm going to leave it there; I think everyone else has covered all the other salient points that I was going to make. But I can't underscore enough how important it is to provide that transparency and make all of these value-based programs accessible to providers that meet the basic criteria.

Thank you.

SENATOR GILL: Thank you.

MR. MILLER: Senator Gill, if I could make one comment on your point you made a few minutes ago about the physician marketplace. I also think it's important, when you consider this business transaction of these large providers and Horizon coming together-- The truth is, you can economically incent your Tier 1 physicians in a way that that will allow volume to go to Tier 1 hospitals. So the more primary care physicians you gather at a Tier 1 level, the better chance you have of doing that and consolidating the market. And then, down the road, frankly, when Tier 2 hospitals can't compete, where do they go? They're either going to join a Tier 1 network, hospital, marketplace; or they're going to close.

So the longer-term issue here is the survival of the Tier 2 hospitals; and also, the marketplace of physicians that will join either a large medical group or join a Tier 1 hospital network so that they can survive -- especially in the primary care space.

I mean, that's the scary part of this. I think you've said it well; and that's the concern, as a hospital system, we have as well.

SENATOR GILL: Thank you.

Anything else? (no response)

Thank you very much for your testimony.

ALL: Thank you.

SENATOR VITALE: I think that concludes our day.

I want to thank everyone who testified, but I also want to thank the staff -- partisan staff and OLS for their great work in helping to prepare us, the members.

SENATOR GILL: We stand adjourned.

(MEETING CONCLUDED)