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"With a New Year and New Administration, Patients Need to Come First to Improve Health in New Jersey"

Submitted by: Access to Care Coalition

In Response to "Moving New Jersey to Affordable Quality Care" report from Better Choices, Better Care NJ:

"Recently, Better Choices, Better Care NJ (BCBC) released a report, entitled 'Moving New Jersey to Affordable Quality Health Care.' The report was sent to Governor-Elect Phil Murphy for consideration, and highlights issues related to the state of health care in New Jersey.

The members of the Access to Care Coalition find that the report misses the mark in one major aspect – it focuses more on business costs, rather than patient care. We have identified six issues presented in the report and offer the following patient-centric solutions we believe will benefit the health of New Jersey for the long-term more than those offered in the BCBC report:

- **Issue 1:** ***Ensure greater transparency and more fair pricing for out-of-network billing.***
  We agree with the recommendation for network participation transparency, but further support legislation that improves patients' health insurance literacy (see S3299/A4956) and encourage network adequacy and a reduction of administrative burdens and costs.

- **Issue 2:** ***Ending the practice of self-policing at health care-related state boards.***
  Boards are only inefficient or mismanaged when they are not fully appointed. We should ensure that all boards and governmental bodies are fully appointed.

- **Issue 3:** ***Reduce health care costs by allowing nurses and clinicians to perform the services they are qualified to perform.***
  Rather than silo care, which increases cost and decreases liability to patients, we must ensure that we make New Jersey a positive practice environment for physicians, especially primary care physicians, by increasing incentives. We must also encourage team-based care and direct care models.

- **Issue 4:** ***Preventing fraud and combating the opioid crisis through greater access to prescription drug data.***
  The State should facilitate PMP integration into patient records to increase the efficiency of the tool as a means to reduce abuse and diversion and implement the Governor's Task Force recommendation to increase insurance coverage of alternative therapies for pain.

- **Issue 5:** ***Save Medicaid dollars by enforcing existing laws meant to reduce waste.***
  Patient access to quality care produces long-term savings. We need to increase deference to medical treatment plans in order to expedite care and reduce administrative costs.

- **Issue 6:** ***Providing incentives for health insurers to pay for quality of services instead of quantity.***
  The BCBC proposed solution does not consider what is best for the patient. We recommend holding health insurance companies and third-party administrators accountable by increasing transparency on their profits and spending, while also further enforcing MLR standards. Profits should cover patient care.

Expanded commentary on each issue and solution is further outlined in the attached white paper, compiled by the Access to Care Coalition."

About the Access to Care Coalition:
The Access to Care Coalition is comprised of 21 patient-focused groups representing more than 10,000 physicians with an aim to improve health literacy and access to quality care. To learn more, please visit: http://accesstocarecoalition.com/.

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ACCESS TO CARE COALITION
RESPONSE TO BETTER CHOICES, BETTER CARE NJ 2017 REPORT

This paper serves as an analysis of recommendations made by Better Choices, Better Care NJ (BCBC). The BCBC report is heavily focused on business costs, rather than patient care. This paper will provide information on the issues, as well as alternative solutions that put patients first, in the order of the BCBC paper. This paper only addresses issues in the BCBC paper for which the provider community has alternative solutions that are more patient-friendly and better for the long-term health of New Jersey.

Issue: Ensure greater transparency and more fair pricing for out-of-network billing

According to the BCBC white paper, "New Jersey should adopt a standard that imposes a numerical cap on payments that represents a reasonable multiple of Centers for Medicare & Medicaid Services (CMS) fees" and a requirement that providers offering services at hospitals participate in the same networks as such hospitals.

The proposal to statutorily benchmark physician payments at government rates is misguided. Government rates could change and government programs could end. Further, Medicare and Medicaid rates are low. New Jersey physicians receive among the lowest Medicaid payments in the country, despite bearing among the highest costs.

More importantly, if the desire is a cap on payments, New Jersey law already provides them. Statutes already limit out of network payments for the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP). See NJSA 52:14-17.29 and NJSA 52:14-17.46.7. The Department of Banking and Insurance (DOBI) arbitration program also has a cap. The caps used by all three programs are models because they use market rates, rather than precarious government rates, as benchmarks. The national Fair Health database is award-winning, uncompromised and fair. The New Jersey PIP program also uses Fair Health. Arguments have been made that Fair Health is too generous and that physicians abuse market-based systems in order to stay out of network. But, SHBP and SEHBP have very robust networks, arguably the best in the State, so such arguments are meritless.

Regarding the recommendation requiring insurance network participation, there is again, a shallow understanding of the way physicians are paid. They rely on third party payers to keep their practices open for patients, whether in network or out. In hospitals, physicians treat and heal patients regardless of insurance status. However, they must make decisions based on patient demographics and other criteria, including private practice costs, when deciding which networks to join. There are hundreds of plans, but not all allow physicians to cover their costs. In fact, physicians are getting kicked out of contracts as insurers focus more and more on cost over quality, using narrow and tiered networks. Contract negotiation is only getting harder for physicians, resulting in decreased patient access.

A government forcing a physician to sign a contract with any insurance company is a restraint of trade. Further, it will jeopardize access to care. When planning its reforms, the New York State Department of Financial Services stated: "New rules aimed at addressing these issues should recognize the right of providers to remain out-of-network, and should avoid placing undue burdens that could interfere with patient care or deter specialists from providing emergency care or other needed services." 2012 Report by New York State Department of Financial Services

Specifically, if an insurance company knows a physician is required to participate in the same plan as a hospital at which she sees patients, the insurer will have all of the contract negotiation leverage. The company will be able to pay the lowest possible rates without any discussion. This is already happening with physicians who were placed in Tier 2 of Horizon's Omnia plan. This pattern is not good for reliable patient access to highly trained physicians. Why would qualified physicians stay in New Jersey?

Only a small handful of hospital physicians are out of network. And, the fact is, physician payments make up a small percentage of total health care costs. On the other hand, American health insurers spent more than twice as much as any other developed country per person on administrative costs (about 20% of premiums) and their profits are at record-setting levels.

We wholeheartedly agree with the recommendation for network participation transparency and further support improved health insurance literacy from insurance companies, so that patients understand cost sharing, maximum allowable payments and other benefit design features. Further, the BCBC proposal that New Jersey should examine ways to ensure there is "transparency across all divisions of health care, with a specific focus on how consumer products are priced," should be extended to insurance products, not just drugs.

Alternative solution: Support legislation improving patients' health insurance literacy. See S3299/A4956. Strenuously enforce network adequacy rules so that patients have access to in-network physicians.

Issue: Ending the practice of self-policing at health care related state boards

This issue is sorely misstated, as if regulatory bodies in New Jersey are without oversight or are inherently self-serving. First, the example provided, the Board of Medical Examiners (BME), in fact has three seats for public members. Most boards deliberately include this kind of diversity. The issue with most boards is actually getting seats filled; we need Administrations to make appointments.

For example, it was only when a physician member slot on the Small Employer Health Board was vacant that the board allowed carriers to decrease out of network benefits for members who already paid high premiums for such benefits. Plans immediately reduced these benefits. The regulatory change was a blow to patients and small businesses, and to physicians who rely on fair payments in order to be able to see Medicaid and Medicare patients. The action engendered ongoing litigation.

On the issue of BME disciplinary actions, it is incorrect to say the board protects the profession it regulates. The BME exists to protect patients. A search of disciplinary actions will reveal a very aggressive board, monitoring not only fees, but record-keeping, prescribing and other issues. There were more than twenty actions taken just in the last two months of 2017. State Board of Medical Examiners Disciplinary Actions

Further, on the specific issues of physician fees, DOBI also addresses cases of patient charges. They respond to patient complaints and often see repeated bad behavior by insurers, not providers, despite previous sanctions. In 2015, Oxford Health Insurance Inc., Oxford Health Plans (NJ) Inc. and UnitedHealthcare Insurance Co. used a pattern of underpayments, failing to provide coverage for their members. They deliberately misrepresented patient cost sharing and underpaid doctors, forcing patients to pay the bills instead. It took action from DOBI to stop the behavior, with a $300,000 fine.

Moreover, health insurers had been caught in these schemes before. For example, in 2007, Aetna was assessed almost $10 million for underpaying physicians; $530,000 for failure to limit a covered person's liability for services rendered by non-participating providers; $530,000 for failing to keep members free from balance bills, $650,000 for misrepresenting their obligation to pay out-of-network claims; and almost $8 million for failing to pay claims fairly, promptly and in good faith. Though the final settlement amount was less, these multi-million dollar settlement costs are much higher than sporadic payments that must be made for complicated out-of-network surgeries.

Along with high administrative costs (again, the U.S. is highest in the world) and bloated executive salaries, these health insurance industry practices of collecting premiums without covering care are what truly cost consumers.

Alternative solution: Ensure all boards and governmental bodies are fully appointed.

Issue: Reduce health care costs by allowing nurses and clinicians to perform services they are qualified to perform

Patient should always have access to a highly trained physician with a plenary education. That is what network adequacy is all about. New Jersey's budget every year funds medical education at New Jersey's teaching hospitals, only to send those millions of dollars out of state when graduates choose to practice elsewhere. The answer is not to increase the number of medical schools or even residency programs, necessarily. It is about making New Jersey a positive work environment for physicians, especially primary care physicians, to practice. Each year, New Jersey ranks among the lowest as a physician-friendly state, due to high practice costs (taxes and malpractice) and insurance monopolies.

The BCBC paper proposes to eliminate requirements that nurses and physician assistants work in collaboration with physicians. But, in states that allow independent practice, APNs choose the same specialties as physicians, due to practice costs. Primary care gaps still remain. Of those who do choose primary care, most do not practice in underserved areas, due the same cost concerns. Moving New Jersey away from physician-led team based care will result in various professionals with varied levels of training working in practice silos, which increases costs (referrals), lowers quality and decreases affordability. The BCBC paper purports to support "patient centered care models." As such, it should not support fragmenting care by breaking up healthcare teams. Team care that is physician-led is proven to be the model to maximize patient access to high quality, low cost care.

Once independent, APNs face the same practice costs as physicians. It is actually a priority for them to be paid on par with physicians, according to their state association. Additionally, if they are also held to the same malpractice standards (this should be mandated for patient protection), savings will be hard to find.

A State program offers $120,000 in student loan redemption for qualified primary care physicians practicing in underserved communities over a four year period. However, it is underutilized by primary care physicians as a result of statutory requirements and regulatory interpretations that limit practices from qualifying, reducing the State's ability to retain primary care physicians and make it hard for physicians to provide care in medically-underserved communities. This program requires an overhaul with a focus on retention of physicians, establishing functional application criteria for hiring sites and applicants that will encourage primary care physicians to be hired in private medical practices in underserved communities.

Additionally, the Direct Care (DC) model provides businesses and government with an alternative to fee-for-service insurance plans and provides patients a solution to high deductible plan obligations. DC typically works by charging employers or patients a fixed periodic fee that offsets service costs. DC is designed to remove the middle man and remove the financial barriers patients encounter in accessing routine primary care; including preventive, wellness, and chronic care services. New Jersey is already looking into this model under Senate President Sweeney's leadership. Unfortunately, in New Jersey, a DC practice can exist only if the physician is exclusively in a DC model, with no insurance participation at all. This is a key barrier that requires a legislative change.

Alternative solution: Increase primary care physician incentives and encourage team care and direct care models.

Issue: Preventing fraud and combating the opioid crisis through greater access to prescription drug data

Allowing insurance companies to access data beyond coverage periods violates federal health privacy laws. The proposal also seriously jeopardizes coverage options, especially if state or federal governments fail to require coverage for preexisting conditions.

New Jersey already has among the lowest rates of opioid prescriptions and our rate consistently goes down each year. The US Drug Enforcement Administration and New Jersey have restricted access to opioids with caps. We are already seeing collateral damage for pain patients. The collateral damage of health record privacy violations will be much greater. Allowing insurance companies to access to records outside of their coverage, such as mental health treatment, cannot be undone easily. The New Jersey Prescription Monitoring Program (PMP) includes many other medications, including those for mental health conditions, like anxiety or depression. Patients have a right to privacy for treatment of those conditions, especially while these conditions are still so stigmatized.

Privacy breaches cannot be undone. The more information put in the hands of insurers, the more breaches become likely. Here are examples of New Jersey privacy breaches, including insurers and private health information:

Two Essex County men who take HIV medications have filed a lawsuit against Aetna, alleging breach of privacy and negligence on the part of Aetna relating to recent mailings by the company to over 12,000 Aetna customers Read more here.

Over 650 data breaches were reported in New Jersey last year, according to a release sent out by the office of New Jersey's Attorney General Christopher Porrino. Read more here.

The state's largest insurance carrier will pay a $1.1 million penalty for failing to protect the private information of 690,000 policy holders whose information was contained on two laptops stolen from the company's Newark headquarters in 2013. Read more here.

The American Civil Liberties Union of New Jersey has expressed concerns about opening up patient records to third parties. We urge great caution about using cost savings as a reason to allow privacy breaches. Physicians do not even have PMP information integrated into patient health records due to technological barriers. Insurers and employers certainly should not have this clinical information unfettered.

Other states have assisted and funded efforts for integration of PMP data into patients' electronic medical records (EMRs). This is an imperative step in making the PMP a useful tool for prescribers.

Finally, the real solution to reducing opioids, while still providing compassionate patient care is to adequately make alternatives available. The State has finally recognized this need in the 2017 Report of the Governor's Task Force on Drug Abuse Control: "Health care is no longer what it used to be and is driven more and more not by what is necessarily best for the patient, but what health coverage, whether fully insured, self-funded, or government programs, will support. Thus, those who provide health coverage need to be encouraged to support non-opioid therapies and new and additional pathways for the treatment of pain." Report recommendation: "All those who provide health coverage should be encouraged to support non-opioid therapies and new and additional pathways to treatment for the treatment of pain." Report of the Governor's Task Force on Drug Abuse Control

Alternative solution: Encourage PMP integration into EMRs to increase the efficiency of the tool as a means to reduce abuse and diversion. Increase reporting tools and treatment options so that information gleaned from the PMP can be properly used to decrease criminal activity and increase access to addiction treatment. Implement the recommendation of the Governor's Task Force regarding insurance coverage of alternative treatments for pain.

Issue: Save Medicaid dollars by enforcing existing laws meant to reduce waste

The BCBC report states that "IUROs are not consistently using protocols and guidelines established by the NJ Medicaid Program, as approved by the New Jersey Drug Utilization Review Board and as adopted by the Medicaid Managed Care plans. There are several examples, with the most noteworthy being the IURO consistently overturning clinical decisions related to the appropriate use medications used to treat Hepatitis C (e.g., Harvoni, Epclusa and Zepatier). Horizon Blue Cross Blue Shield of New Jersey estimates that this misapplication of the clinical protocols for Hepatitis C treatment alone has cost the state over $6.7 million in 2017."

Though Independent Utilization Review Organizations control immediate costs, denials create long-term costs. Patients with Hepatitis C were likely glad their direct-acting antiviral (DAA) medications were covered. The federal Centers for Medicare & Medicaid Services recommend this coverage. From a letter to state Medicaid programs: "CMS reminds states that the drugs under the approved state plan must be available to individuals enrolled in Medicaid managed care arrangements" and "…limitations should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments using DAA drugs for beneficiaries with chronic HCV infections." Assuring Medicaid Beneficiaries Access To Hepatitis C (HCV) Drugs, Release No. 172

Insurers have developed a range of interventionist strategies and tools to reduce their cost and increase revenue, "such as selective contracting with networks of providers (PPOs or IPAs); utilization review - for example, prior authorization of non-emergent hospital admissions and aggressive review of lengths of hospital stay; pharmaceutical benefits management; introduction of practice guidelines and physician profiling; and outright acquisition or formation of health maintenance organizations (HMOs) and point-of-service plans (POS)." The Rise of Managed Care in the United States: Lessons for French Health Policy

According to the American Medical Association, "Health insurers frequently require prior authorization for pharmaceuticals, durable medical equipment and medical services. The inefficiency and lack of transparency associated with prior authorization cost physician practices time and money. The lengthy processes may also have negative consequences for patient outcomes when treatment is delayed." The AMA believes that prior authorization is overused and that existing processes are too difficult. Though this is a national problem, New Jersey has the power to reign in arbitrary questioning of medical recommendations by ensuring (1) clinical validity of authorization (2) continuity of care (while waiting for authorization) (3) transparency and fairness of the review process (4) administrative efficiency and (5) alternatives and exemptions. AMA Prior Authorization and Utilization Management Reform Principles

The Medical Society of New Jersey is conducting a study on prior authorization requirements, including an examination of approval rates and services subject to such requirements. Preliminary findings show that most authorizations are in fact granted, despite delays and appeals. As such, they cause patient stress, interrupt care and cost physicians' offices time and money for no clinical reason.

According to a recently released survey conducted by New Jersey law firm, Brach Eichler, most New Jersey physicians (95.31%, up from 89.89% in 2014) believe that the changing healthcare environment has negatively impacted them. More than 39% said that they felt an increased administrative burden (e.g. insurance paperwork), while 26.5% said reduced reimbursement and 15.6% reported reduced time spent with patients were among the most harmful changes. The Brach Eichler 2017 New Jersey Health Care Monitor

Healthy outcomes produce long term savings; focusing on short-term savings is cruel and actually increases costs for patients and payors. Coverage hurdles are dangerous for patient health. They negatively impact patient access to quality care. Deference to true clinical protocols is best for patients and payors.

Alternative solution: Increase deference to medical treatment plans in order to expedite care and reduce administrative burden and cost.

Issue: Providing incentives for health insurers to pay for quality of services instead of quantity

Though the issue as stated has merit, the proposed solution is extremely anti-patient. The report recommends that the State revise "MLR rules to allow insurers to include expenditures made towards quality improvement programs, patient centered care initiatives, and fraud, waste and abuse detection and deterrence efforts as medical costs in their MLR calculations. New Jersey law should also allow for MLR calculations over a three-year period, instead of the current one-year limitation."

Medical loss ratio (MLR) is a formula that determines how much of an insurer's profit must be spent on covering members' care. Diluting the formula means that less dollars will actually be spent covering patients' medications, treatments, procedures and healthcare. New Jersey had medical loss ratio requirements before the Affordable Care Act. We should pride ourselves on requiring our insurers to provide the coverage their members pay for.

Further, MLR requirements do not even address the level of the premium increase, only the percentage used for claims and quality activities; and they do not directly address non-price dimensions of health insurer competition such as product design, provider networks, and customer service. We should strengthen MLR, not dilute it.

For example, Quality Improvement Activities (QAI) are exempt from the formula, but in a list of activities that insurers may already be counting as QIA, there are many that are of questionable validity. This includes: claiming QIA expenses for undefined activities such as "services provided by sources outside the company;" "prior authorization;" "overhead allocation;" "Explanation of Benefit notices;" undefined "internationalization review of all new services;" "utilization management;" "prescriber detailing;" "high performance network designation;" and other activities that may or may not qualify, but the lack of specificity limits the ability for regulators to reject them. Without proper MLR enforcement, patients and payment for their care are not prioritized.

In addition, when insurance companies act as third party health plan administrators (TPA), they increase cost. Administrators of employee benefit plans have an obligation to disclose their charges in a truthful manner, consistent with their administrative services contracts. In *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, 751, F.3d 740 (6th Cir. 2014), cert. denied, ___ U.S. ___ (2014), the Court affirmed a $6 million judgment for charging undisclosed fees to employee benefit plans and calling them medical costs. Blue Cross Blue Shield of Michigan was held liable for violating its fiduciary duties. Third party administrators, including managed care companies like the Blue Cross and Blue Shield entities, have an obligation to disclose and charge only fees that are permitted under their administrative services contracts. Sponsors of employee benefit plans, including employers and trustees of Taft-Hartley benefit plans, should be vigilant to make sure that administrators are not over-charging for their services. Sponsors should consider periodic audits to uncover and recover over-charges. The experience of Hi-Lex Controls demonstrates that third party administrators can and do over-charge for their services, and it is very unlikely that the over-charges are limited to Blue Cross Blue Shield of Michigan. Employers, including state and local governments, should ensure that third parties are working for them. This issue can seriously impact a government, union, or company's bottom line and the health of its employee/members. Costs for healthcare administration should be both legitimate and transparent.

The percentage of premium revenue allocated to administrative costs and profit continues to rise. Health insurance companies are doing very well across the nation. The State, and businesses, should analyze third party health benefit administrator contracts and audit activity regularly.

Alternative solution: Hold health insurance companies and third party administrators accountable by increasing transparency on their profits and spending, and enforce MLR standards.