IN NOVEMBER 2016, Better Choices, Better Care NJ launched as a public education project advocating for innovative ways to improve health, transform care and lower health care costs. Our goals and priorities were clear: we wanted to help consumers, employers and elected representatives examine, understand and harness the changing health care landscape to create the best outcomes possible for New Jersey.

One year later, our goal remains one of advocating and educating about ways to lower health care costs, while enhancing the quality of health care for all New Jerseyans. We still believe moving health care in New Jersey further towards patient centered care will prove the best way to lower costs and boost the quality of care. Moreover, health care has been a topic of intense national debate; but that debate has not yielded any significant positive policy changes or done much to lower the cost of care. To the contrary, uncertainty from our nation’s capital means New Jerseyans – like many people across the country – will see dramatically higher insurance premiums in 2018.

While remaining true to our mission statement, Better Choices, Better Care NJ did sound an alarm this past summer regarding Washington chaos. We warned that if our elected representatives were unable to stop the uncertainty and piecemeal approach to health care reform, there was the potential for disastrous consequences. Those predictions have, unfortunately, come to fruition.

Before creating this organization, Better Choices, Better Care NJ did extensive research to see what issues were of most concern to New Jersey residents when it came to health care. Through our qualitative and quantitative consumer research, we saw that two-thirds of New Jerseyans were concerned about the cost of care and more than half did not have a favorable view of health care in our state. Throughout our first year, we then engaged directly with consumers through a variety of means. What we saw and heard on a constant basis was that these themes of cost and quality of care held up. We repeatedly received feedback from those worried about how they would pay for their health care, or upset that a family member could not find the kind of care they needed.

This barrage of feedback, coupled with the whirlwind of events in 2017, has shown us that it is not merely enough to discuss broader health care themes. Nor is it enough to sit back and sound the
alarm. Rather, we as an organization believe it is imperative to actively advocate for measures that will have an actual, real-world positive impact on consumers. To that end, Better Choices, Better Care NJ set out to examine and define a series of measures that – through executive or legislative action – can not only help reduce the cost of care, but also enhance the quality of health care in New Jersey.

We examined various ways and means to meet these goals. After extensive discussion, input and research, we narrowed it down to 15 measures. We strongly believe these actions will make health care in New Jersey less costly, of higher quality, and more accessible.

**These measures fall under four categories:**

1. **Increasing Access to Affordable, Quality Health Care**
2. **Keeping Health Insurance Costs From Skyrocketing**
3. **Reforming Medicaid**
4. **Promoting Patient Centered Care**

In this report, Better Choices, Better Care NJ lays out why we have selected these issues, how leaving them unresolved negatively impacts New Jerseyans and what specific remedies we see as needed to fix them.

As we head into 2018 and beyond, Better Choices, Better Care NJ will be actively engaged in ensuring the ideas outlined in this document are discussed, acted upon and implemented. Moreover, while we firmly believe these steps will vastly improve health care in the state, we will also stay focused on our goal of moving New Jersey closer to patient centered care. Our efforts to conduct consumer-driven engagement as well as consumer education will not cease. But the quickly evolving health care landscape means we all must play a more proactive part in protecting the future of health care in New Jersey.
I. Increasing Access to Affordable, Quality Health Care

Promoting enrollment in the ACA exchange to keep insurance affordable

Background: New Jersey’s Individual Health Coverage Program was created to provide people without health insurance – either through their employer or a government sponsored program - access to coverage for themselves and their families through private health insurers. People obtaining insurance through this program may purchase coverage on the “individual market,” and are guaranteed coverage regardless of their age or health status. Historically speaking, however, the individual market has had the greatest difficulty of all health insurance programs in terms of sustainability. It tends to have highly imbalanced risk pools, meaning there is a large difference between those with low to minimum need for health care services versus those who require significant health care services.

This discrepancy is due to a variety of factors, including: the inability to predict how many people will purchase insurance on the individual market; not enough insurance companies participating or offering enough plans; and changes in regulations impacting the individual market. Due to these factors, premiums in this marketplace have spiked.

The recent national debate over “repeal and replace” of the Affordable Care Act (ACA, also known as “Obamacare”), has only served to make the problem worse. The ACA established a health insurance exchange to make it easier for people to purchase health insurance plans that meet minimum standards of coverage and affordability. The Trump administration’s efforts to limit advertising and public awareness about the exchange, coupled with efforts to eliminate subsidies for low-income individuals and families accessing health insurance through the exchange, has threatened the viability of the individual market.

All of these conditions combined could serve to weaken the individual market. Whether there is agreement or disagreement on the ACA as it currently exists, the individual market remains a critically important part of New Jersey’s current health care system. Declining enrollment in the individual market will adversely impact those who purchase coverage through the individual market through increased premiums, less attractive health plans and fewer coverage options.

States across the country have taken steps to prevent a disastrous collapse of the individual market. California, after establishing their own state run health insurance exchange, (New Jersey did not create its own exchange, opting instead to default to the federal exchange), created an agency called Covered California to oversee it. The agency has spent millions of dollars in advertising to boost enrollment in the exchange. As a result, “two factors – bigger enrollment numbers and healthier people signing up for insurance – have lowered the cost of premiums 6 to 8 percent in 2015 and
Concern about lack of funding from Washington has resulted in the agency increasing its advertising budget from $100 million last year to $111 million this year.²

Washington State established a public-private partnership to form the Washington Health Benefit Exchange. The Exchange is separate from the state and governed by an independent 11-member bipartisan board.³ Until the middle of 2015, insured individuals paid their premiums to the Washington Health Benefit Exchange. Since then, payments are made directly to the insurance company. Through the exchange, the Washington State uninsured rate has dropped from 19% to 5.8% in four years.⁴ In 2016, “Washington health plans did not see the large spike in premium costs other states did...While so-called ‘silver’ plans saw premium increases of 25 percent in some states, comparable plans (in Washington) rose 8 percent in cost.”⁵ But, like other states, Washington is anticipating substantial premium increases next year due to the aforementioned factors.

Proposal: To counteract the erosion of membership in this market segment, New Jersey should undertake its own efforts to promote, market and facilitate enrollment in the individual market. This could include:

- State-contracted health care facilitators to link consumers with health insurance plans
- State-sponsored advertising and marketing
- Formation of a public/private partnership for the promotion of the individual market

New Jersey may also want to consider creating its own exchange. Previous attempts to do so were vetoed by the governor. With a new administration entering the State House in January, renewed attempts may be successful. Any attempts at creating an exchange, however, should include looking at existing government infrastructure to assist with implementation and oversight, versus automatically creating new bureaucracy.

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² http://www.capradio.org/articles/2017/11/03/covered-californias-outreach-budget-is-huge-despite-federal-cuts/
To keep costs from skyrocketing, require the uninsured in New Jersey to purchase health care insurance

Background: As part of the ACA, individuals are required to obtain health insurance coverage, whether it be through their employer, a government sponsored program such as Medicaid, or by purchasing a plan on the individual market. Those who fail to obtain coverage are subject to a penalty. Known as the “individual mandate,” this requirement is one of the key elements of the law.

While no doubt controversial and the subject of much national debate, the intention of the individual mandate was to broaden the pool of insured individuals and to attract healthier individuals into the health insurance system, thereby creating a more balanced risk pool. The inclusion of more healthy people in the risk pool translates into lower premiums which means more people can afford coverage. As more people get covered, health care costs are reduced through a reduction of the use of the emergency room for treatment (especially in non-emergency situations), less need for charity care, and more access to care for those who traditionally could not afford coverage.

The future of the individual mandate is in doubt. The Trump Administration has expressed little desire to enforce it and has advocated for its repeal. While the latest proposed repeal of the individual mandate was not put up for a vote for lack of support, it is not unreasonable to think that another effort at repeal and replace will occur. Though it would depend on the contents of any new proposal, repealing this measure would likely have damaging impacts to New Jersey. This could include (note: some figures are based on the last proposed repeal and replace bill):

**Nearly 900,000 previously uninsured New Jersey residents that have obtained health care coverage would lose it.**

The 1.8 million New Jersey residents that are covered by Medicaid or through the individual market (including 1 in every 3 children in the state) risk losing their coverage as well.

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**Estimated Loss Of 86,000 Jobs.**

The state would also be responsible for paying an additional $1 billion in Medicaid costs to continue to pay for those who remain covered.

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11 https://www.njpp.org/healthcare/acarepeal2017
The health insurance market would become incredibly unstable, as most likely only those with the greatest need for insurance would opt for health insurance. This has many destabilizing effects on the health insurance market including:

Significant increases in premiums

New Jersey businesses moving to high deductible plans, increase premium sharing, or simply not offering plans at all.  

Specifically, when it comes to the individual mandate:  

The uncertainty over repeal prompted Horizon Blue Cross Blue Shield of New Jersey to request a 22% average increase in rates, and it attributes at least 8.5% of that increase to the Trump administration’s indifference to the individual mandate.  

“A weakened individual mandate, the potential loss of cost-sharing reductions, and the reinstatement of the health insurance tax are going to produce premium increases in New Jersey that are substantially higher than they would otherwise have been,”  

WARD SANDERS,  
President of the New Jersey Association of Health Plans.

Currently, California and Washington, D.C. are proposing to create individual mandates in their jurisdictions. But only Massachusetts has officially implemented such a mandate. In 2006, then-Governor Mitt Romney signed the bipartisan Massachusetts universal care coverage plan, and the individual mandate was a key provision in the legislation. Massachusetts was the first state in the nation to require the individual mandate, and even in 2006, it was being lauded as a national model. The individual mandate was the key provision in the health care plan.

How does it work?

• **INDIVIDUALS:** “As of July 1, 2007, all individuals had to have coverage.” (The numbers below are based on the Federal Poverty Level [FPL] in 2006)  
  - Those below 300 percent of the FPL (about $38,500 for a family of three), but not eligible for Medicaid, had their private insurance plans subsidized at a sliding-scale rate.  
  - Children whose families earn below 300 percent of the FPL were given free coverage through Medicaid.  
  - Individuals with incomes below the FPL ($9,600) had premiums waived on private insurance.  
  - Those who could afford insurance were increasingly penalized for not buying coverage. In the first year, they lost their state personal income tax exemption.
    - In 2013, the tax penalty was $1,272.

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17 http://www.bmj.com/content/350/bmj.h1480
Family coverage was extended to cover young adults up to the age of 25.

Allowed the use of "health savings accounts" with cheaper high-deductible "catastrophic" coverage plans. HSAs allow consumers to invest money and withdraw it "tax free" to cover health-care costs.

**BUSINESS:** All employers who have more than 10 employees must contribute to employee health-care costs.

- Employers who don't provide insurance pay an annual fee of $295 per full-time employee.
- Encouraged private insurers to offer more low-cost options.
- Created a "health insurance connector" to help individuals and businesses find affordable private coverage.

**What were the results?**

*(note: these results do not take into account how recent actions by Washington D.C. may have impacted the state)*

- By 2010, 98.1% of Massachusetts residents were insured
- Between 2006 and June 2010, 401,000 people gained insurance:
  - 83,000 bought their own insurance
  - 164,000 gained insurance through MassHealth (Medicaid and CHIP recipient)
  - 154,000 purchased subsidized plans through the state exchange
- The cost of insurance dropped dramatically, from $8,567 in 2006 to $5,143 the year after the Massachusetts law took effect.
- The law had one clearly negative impact on small businesses who bought coverage in the "small group" market. Their premiums rose faster than before, a major disappointment because small businesses had been hoping for a decrease.

**Proposal:** Should Congress pass and the president sign a repeal of the ACA and replace it with a law that does not include the individual mandate, or, should the administration continue a policy of not enforcing the mandate, the state of New Jersey should create its own mandate or work on ways to incentivize the business community to fill that void. As noted above, a properly thought out coverage mandate would draw healthy individuals into the health insurance system, thereby driving down costs for all, increasing access to care and improving health outcomes for all New Jerseyans. Before a mandate is implemented, however, an impact study should be conducted to see what such a mandate would do to small businesses. If a negative impact is found, ways to alleviate that impact should be discussed and, based on feasibility, implemented.

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II. Keeping Health Insurance Costs From Skyrocketing

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

Background: Surprise medical billing is when a patient seeking medical care under their insurance plan is billed an incredibly large amount of money because the care they received was performed by an out-of-network provider. Surprise bills happen when the amount an insurer pays a provider (hospital, health care facility, doctor, etc.) that does not participate in the insurer’s network does not match up with what the provider actually charges.

Under some circumstances, patients are protected from surprise bills, but if patients seek out-of-network care, these protections may not apply. In typical managed care settings, providers that contract with an insurance company agree to accept a predetermined amount for the delivery of specific health care services and are prohibited from billing the patient for anything other than the patient’s cost-sharing requirements (deductibles, coinsurance or copays). However, out-of-network providers are not bound by these restrictions and may bill as much as they want. Depending upon the situation, even if the health plan pays a portion of the bill, the patient may be stuck paying the out-of-network cost sharing obligation and any amount that is over and above the plan’s “allowed amount.” Moreover, in emergency situations, patients are shielded from balance billing by out-of-network providers and insurers are generally required to pay the entirety of the provider’s charges, even if such charges are excessive. These high costs are spread out among all health insurance consumers and serve to drive up premiums for all those who purchase health plans.

New Jersey Policy Perspective estimates that surprise billing is a $1 billion problem that drives up premium costs for all policyholders in New Jersey. While drawing some attention to it, Better Choices, Better Care NJ has mostly stayed away from this issue in the past, largely because it appeared that progress was being made and the issue would be resolved. But competing bills have only partially advanced through the Legislature during this current session, and nothing has emerged as a final bill ready for the governor’s signature. Every day that there is a failure to act leaves open the possibility that one more person will fall victim to this practice. Reform is a straightforward matter of saving millions of dollars per year in unnecessary billing to consumers.

Proposal: The Centers for Medicare and Medicaid Services (CMS) has established a set schedule of fees for the reimbursement of providers who treat Medicare and Medicaid recipients. To help offset the costs imposed by surprise medical billing, 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, a requirement that providers offering services at hospitals participate in the same networks as such hospitals, and a requirement that providers and facilities publicly disclose the networks in which they participate.

Make transparency guidelines equal across all divisions of health care

Background: The pharmaceutical industry (PhRMA) is a vital part of New Jersey. It provides life saving medications for millions of residents, while at the same time employing countless New Jerseyans. No one can deny the positive impact PhRMA has on our state. However, as noted last year in *Time Magazine*, “The high cost of prescription drugs has been causing pain and hardships for millions of Americans for years. And that situation appears to only be getting worse: Drug prices have risen an average of nearly 10% over the 12-month period ending in May 2016 – a time when the overall inflation rate was just 1% in the US.” The *Wall Street Journal* also noted that while food and alcohol prices rose 2.8% and clothing and accessories rose 5.7% during that time, pharmaceutical prices increased 9.8%.

While other divisions of health care are subject to government review whenever they seek to raise prices, PhRMA can increase costs with no stated reason or substantiation needed. This discrepancy in transparency guidelines has a clear negative impact on consumers. Other states have taken a variety of measures to ensure greater transparency in PhRMA drug pricing. In California, the legislature has introduced a series of measures, including one that would require 60-day notice of any increase of a drug’s price if it costs more than $40. Maryland just recently established “price gouging” prohibitions in the setting of pharmaceutical prices. While the new law is presently the subject of litigation, the federal courts have allowed the law’s provisions to take effect while the litigation proceeds.

Specifically, the law prohibits drug manufacturers and wholesale distributors from engaging in “price gouging” in the sale of “essential” generic drugs. Under the law:

- “Price gouging” occurs when there is an “unconscionable” increase in the year over year cost of a specific drug. A price increase is deemed “unconscionable” when: 1) it is excessive and not justified by the drug’s production costs or the cost of expanding access to the drug for the promotion of the public health; and 2) it results in consumers having no meaningful choice because of the importance of the drug and insufficient competition in the marketplace.
- An “essential” drug subject to the Act’s provisions is any drug that is: 1) a generic or off-patent drug; 2) appears on the list of Essential Medicines by the World Health Organization or is designated by the Maryland Secretary of Health as an essential medicine; 3) is made by only 3 or fewer drug manufacturers in the U.S.; and 4) is available for sale in Maryland.
- Wholesalers are not subject to the bill’s prohibitions when the price increase of a drug is attributable to additional costs imposed by the manufacturer.

24 [https://www.wsj.com/articles/drugmakers-pricing-power-remains-strong-1468488601](https://www.wsj.com/articles/drugmakers-pricing-power-remains-strong-1468488601)
• The Maryland Medicaid program shall notify the Attorney General when the price of a drug covered under the law increases by 50% or more in one year and the price of the drug exceeds $80 for a 30-day supply.
• The Maryland Attorney General may order a drug manufacturer to submit documents, records, and other information concerning the increase in their prices.
• Under the law, and upon petition of the Attorney General, for the purposes of enforcing the prohibition on price gouging, a Maryland state court may: 1) order the production of records by a drug manufacturer; 2) issue a restraining order against a drug manufacturer thereby prohibiting the sale of the drug at the unlawful price; 3) order the restoration of funds to a consumer who has been gouged; 4) require a drug manufacturer to reduce an unlawful price to the price for which the drug was sold in the prior year; and 5) impose a civil penalty of up to $10,000 for each violation.26 27

Proposal: 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.

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

**Background:** New Jersey currently has no law that prevents any of its health care related state boards from being self-governed. While these boards should certainly have members that represent the industry or profession they are overseeing, this failure to prevent self-governance means boards can be made up entirely of members who will push for regulations and standards that are favorable solely to their respective industry. This leaves New Jersey consumers with little to no protection.

One example of this is the State Board of Medical Examiners (BME). This board is made up of medical doctors whose decisions on the board directly or indirectly impact their profession. This can have negative consequences as it relates to health care costs. There is no current New Jersey law that provides for limitations on the amount health care providers can charge. While there is a prohibition against “excessive fees,” there is no strict definition of what that means, outside of vague language that is subject to individual interpretation. Moreover, the BME has not taken steps to actively enforce this rule.

This lack of a strict definition of “excessive fees”, coupled with lax enforcement of the regulation, means higher health care costs for New Jerseyans. To keep pace with ever increasing fees, insurers must continuously increase premium charges. As a result, New Jerseyans end up paying higher premiums and shouldering the burden of any excessive costs.

This example is not meant solely to single out the BME. Rather, it is meant to show the consequences, especially as it relates to health care costs, of continuing to allow these kinds of state boards to self-govern.

**Proposal:** Amend state law so that health care related state boards are not self-governed. Instead, require that at least half of any of these individual board’s memberships be comprised of individuals whose professions are not directly regulated by that board, and who would be representative of consumers that utilize the services overseen by the board. In addition, the state should examine and issue a report on best practices utilized by other states for health care related state boards.
Reduce health care costs by allowing nurses and clinicians to perform services they are qualified to perform

Background: New Jersey currently has various laws, rules and regulations that severely limit the kinds of health care services that nurses, physician assistants or therapists can perform, and in instances where they can perform certain services, they must be supervised by a doctor. These professionals, however, tend to bill at a lower rate than doctors. This means that, even though they are capable of performing various services that, by law, they are not allowed to perform, New Jerseyans are charged higher health care costs. As anyone who has spent time in an emergency room or doctor’s office can tell you, these services can often be performed without the doctor present.

This is wasteful spending that can be easily saved. Many states, including Alaska, Arizona, Colorado, Maine, Oregon, Rhode Island, Vermont, and Washington, have adopted laws that allow advanced practice nurses (nurses with master’s degrees who often can provide primary care) to perform more services.

Proposal: New Jersey law and regulations – through the Division of Consumer Affairs - should be amended to expand the kinds of services nurses, physician assistants or therapists can perform without supervision and in general. This will create less costly, equally safe and effective health care service delivery.
Ensure small businesses are not taken advantage of by bad neighbor insurance companies

**Background:** The Small Employer Health Benefits Program, established in 1994, was created to help ensure that small businesses had a stable place to buy insurance plans for their employees. The program provides access to health care coverage regardless of the health status of the employees being covered. It also is intended to prevent the lapse of coverage from year to year by guaranteeing renewal of a group’s health benefits plan.

Certain carriers operating in New Jersey have looked to lure away small businesses with a history of low insurance claims from this program. Instead, they offer a self-insured model with a stop-loss insurance policy to protect against an uptick in claims. State law, however, does not protect these small businesses from having their stop-loss insurance policy dropped should they see an increase in claims. If a small business does have their insurance cancelled, they then have to reenter the Small Employer Health Benefits Program, but this time at a much higher cost of coverage because of their increased claims. This kind of action impacts the entire program by raising premiums for all participants.

**Proposal:** State law should be revised to prohibit and eliminate self-funded arrangements in the small employer market. This, in turn, will reduce costs for small business owners and their employees. Reforms, however, should ensure that small employers’ ability to join a MEWA or other alternative health insurance coverage model would not be impeded.
Preventing fraud and combating the opioid crisis through greater access to prescription drug data

Background: The New Jersey Prescription Monitoring Program (NJ PMP) was established in 2007 as a statewide database for the collection of prescription data on controlled dangerous substances and human growth hormones dispensed both in New Jersey and by out-of-state pharmacies dispensing into New Jersey. Under the law, pharmacies are required to provide this data to the NJPMP. Generally, this data has been accessible only to law enforcement agencies and certain officials.

In a September 2016 report, the Office of the State Auditor recommended that Medicaid organizations and commercial insurers be authorized to access data in the NJPMP. According to the report, “New Jersey Medicaid officials, as well as other prescription plans, would benefit by having a more complete prescription record for its patients from the NJPMP, as the program data also includes a prescription history with multiple payments types, including Medicaid, other insurance, and cash.”28

Proposal: Provide Medicaid organizations and commercial insurers access to the NJPMP. This will help in the battle against substance abuse and can save health care dollars by limiting the number of opioids and other such drugs that are used for nefarious purposes.

28 http://www.njleg.state.nj.us/legislativepub/Auditor/661014.pdf
Bring laws into the 21st Century by eliminating unnecessary and costly paper material requirements

Background: New Jersey laws, rules and regulations force health insurers to provide countless amounts of paper materials to consumers. These tedious paper requirements range from ID cards to contracts to notices. Horizon Blue Cross Blue Shield of New Jersey, just one of the state’s many health insurers, estimates that they print more than 300 million pages of paper a year. Not only is this environmentally detrimental, but it wastes millions of dollars that could be saved through using online services. The millions of dollars it costs for all this paper is ultimately paid for by consumers through increased premiums.

Many states, including Wisconsin, South Dakota and Indiana, have begun moving towards paperless delivery of required insurance documents. In Wisconsin, for example, the electronic delivery of notices and documents by insurers is allowed by law. The Department of Banking and Insurance permits insurance carriers to use electronic delivery options if the recipient agrees to it and only for certain member documents. Clearly, there is room for greater use of electronic delivery.

Proposal: New Jersey should revise state law to allow for the electronic delivery of insurance materials and should provide for such delivery as the default method, while allowing consumers to opt in to the delivery of paper materials if they wish. Such changes can result in millions of dollars in savings for consumers.
III. Reforming Medicaid

Lower Medicaid costs by putting mental health and drug addiction services under one roof

**Background:** New Jersey has been a leader in facilitating the delivery of comprehensive services to Medicaid enrollees. Comprehensive services is where health care for an individual is organized, coordinated and managed within their health care plan. This type of managed care coordination can lead to more cost effective and time efficient health care, and most importantly, to better outcomes. It can be something as basic as doctors talking to one another about a single, shared patient, to ensuring someone is taking their prescribed medications. Although 95 percent of New Jersey’s Medicaid population is enrolled in this kind of managed care, with limited exceptions, behavioral health and substance abuse disorder treatment services remain unmanaged, splintered and scarce.

The Centers for Medicare & Medicaid Services, the federal Substance Abuse and Mental Health Services Administration and New Jersey’s own Rutgers Biomedical and Health Sciences Center have documented that 50 percent of Medicaid recipients have a mental health diagnosis. Of those, the one percent highest cost members almost universally have a behavioral health or substance use disorder diagnosis. Between 2000 and 2014, opioid-related inpatient stays increased by 64 percent, and opioid-related emergency room visits increased by 99 percent.

Using managed care principles can increase access to behavioral health services and reduced medical costs. Moreover, there is nationwide precedent for merging oversight of these services – thus better ensuring there is coordination of care - under one agency:

**Arizona:** In 2015, Arizona merged its Medicaid agency, called the Arizona Health Care Cost Containment System (AHCCCS), and its Department of Health Services’ Division of Behavioral Health Services (DBHS), giving the state’s Medicaid director responsibility for both physical and behavioral health services. Arizona’s experience offers lessons to policymakers as they consider how best to integrate physical and behavioral health services and ensure that Medicaid is an efficient and effective purchaser of health care services.29

**California: Agency Consolidation** – In 2012 and 2013, California eliminated its existing mental health and Substance Use Disorders (SUD) agencies, transitioning most their responsibilities to the state’s Medicaid agency, in order to integrate financing and improve patient outcomes.

**Kansas: Consolidated Contract Oversight** – In 2013, Kansas implemented a new Medicaid managed care program called KanCare, under which Medicaid managed care organizations (MCOs) cover both physical and behavioral health services. To support this shift, Kansas consolidated all Medicaid fiscal and contract management functions in the Kansas Department of Health and Environment (the Medicaid agency) and maintained responsibility for behavioral

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New York – New York is transitioning its rate-setting responsibility for behavioral health agencies into its Department of Health, which serves as the state’s Medicaid agency.

Proposal: Increase access to care and reduce Medicaid costs by transitioning behavioral health and substance use disorder services to the Medicaid Managed Care Program. This will also provide greater opportunity to implement coordination of health care services for consumers.
Streamline Medicare and Medicaid services to save money and lower costs

In 2015, there were 11.4 million people enrolled in both Medicare and Medicaid. These “dual-eligible” beneficiaries experience high rates of chronic illnesses, with many having multiple chronic conditions and/or long-term care needs. 41 percent of dual-eligibles have at least one mental health diagnosis, while 60 percent have three or more chronic conditions. In 2012, dual-eligible enrollees accounted for 20 percent of Medicare enrollees, yet 34 percent of Medicare spending. The same individuals comprised only 15 percent of Medicaid enrollees but represented 33 percent of Medicaid spending.

Through the Centers for Medicare & Medicaid Services (CMS), states are conducting financial alignment demonstrations to test models of integration as well as refine existing mechanisms to better integrate Medicare and Medicaid. Currently, 12 states are pursuing demonstrations to align Medicare and Medicaid financing and integrate primary and acute care, behavioral health services and long-term services and supports (LTSS). While New Jersey Medicaid currently has a Dual-Eligible Special Needs Program (DSNP), there are much better options available to maximize the savings potential. Recent results from Massachusetts, Minnesota, and Washington show trends suggesting lower rates of hospital admissions, high rates of beneficiary satisfaction and Medicare savings for Washington’s managed fee-for-service demonstration.

Proposal: While our understanding is that CMS is no longer approving new demonstration projects, New Jersey should work closely with CMS to request flexibility to implement a comprehensive blending of Medicare and Medicaid funding and aligned program administration.
New Jersey must have a backup plan to protect Medicaid from Washington

Analysis: On September 13, 2017, the U.S. Census Bureau released its most recent analysis on health care coverage and it showed that the percentage of New Jersey residents without health insurance dropped to 8 percent in 2016, a 0.7 percent decrease from 2015. This is widely attributed to the ACA and New Jersey’s acceptance of Medicaid expansion funding. Congress, however, may make wholesale financing or programmatic changes to Medicaid such as:

- Elimination, phase-out or freezing of optional Medicaid adult expansion
- Medicaid adult expansion
- Block grant, per capita cap or other growth limits
- Benefit package changes
- Eligibility changes
- Work requirements
- Lifetime limits
- Cost sharing
- Personal responsibility measures
- Delivery system reform

Proposal: New Jersey should prepare a contingency plan of New Jersey-based solutions should Washington lawmakers and the president mandate reductions in Medicaid coverage and funding.
Save Medicaid dollars by enforcing existing laws meant to reduce waste

**Background:** The Independent Health Care Appeals Program (IHCAP) is an external review program administered by the Department of Banking and Insurance (DOBI). The program is charged with reviewing what is known as utilization management (UM) determinations made by health plans.

**Utilization management is:**


In other words, UM determines if decisions being made about your health care are smart and cost effective. DOBI contracts with groups called Independent Utilization Review Organizations (IURO) to perform preliminary and full reviews of any cases presented to the IHCAP. Health plans bear the cost of the reviews. When performing its review, the IURO is required to use all information submitted by the provider and the health insurer including: pertinent medical records, consulting physician reports, generally-accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed or used by the insurance company.

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.

**Proposal:** DOBI should more strictly enforce measures already in place to ensure IURO’s are complying with the terms of their contract. Moreover, they must ensure that IURO’s are using applicable clinical protocols and/or practice guidelines developed or used by the Division of Medical Assistance and Health Services and carriers. Doing so will reduce waste and mismanagement and save consumer dollars.
IV. Promoting Patient Centered Care

Save money by moving Medicaid away from paying for quantity of services to paying for the quality of services

Background: More and more, states are moving away from the traditional fee-for-service model of health care payment to fee-for-value. This change moves health care systems away from incentivizing doctors for the amount of care they provide and towards incentivizing them for the quality of the care they provide. Under fee-for-value, also known as patient centered care, the focus is on keeping patients healthy, not on testing and procedures.

Historically, Medicaid has operated under the fee-for-service model. There is, however, the potential for significant improvements in quality of care and cost savings if Medicaid moves more quickly towards patient centered care.

Proposal: The State should pursue appropriate federal waivers and State legislative and regulatory activities in order to accelerate the implementation of innovation service delivery and patient centered care models. These can then be applied to hospital systems, community-based providers and federally qualified health centers (FQHCs).
Providing incentives for health insurers to pay for quality of services instead of quantity

Medical Loss Ratios (MLR) are established under both federal and State law and generally require insurance carriers to spend a minimum amount of funds collected through premiums on direct health care costs, such as payments to physicians and hospitals and the purchase of pharmaceuticals and medical equipment. 

MLR’s are meant to ensure that if you have insurance, your premium costs are resulting in direct value for you as a policyholder. Insurance companies must spend a certain percentage of their revenue on items that will directly benefit you before spending money on things like administrative costs, taxes, etc.

In the individual and small employer markets, the minimum medical loss ratio is 80 percent, meaning 80 percent of premium dollars that come in must be used for services provided to consumers. While medical loss ratio requirements are well-intended, New Jersey’s MLR rules are outdated and inconsistent with federal law and the laws of many other states. For example, under New Jersey State law, carriers are not permitted to count the following kinds of expenditures in their MLR calculations:

- quality improvement programs
- value-based or patient-centered care initiatives
- fraud and abuse detection and deterrence efforts

This restriction makes New Jersey greatly different from both other states and the federal government. It also disincentivizes carriers from making investments in these important initiatives because the costs of such investments will compete with other necessary costs, like administrative services and paying taxes. Insurers are more likely to accelerate patient centered care initiatives and other related programs if the costs of such investments are not crowded out by traditional business costs.

In addition, while many states allow carriers to average their minimum medical loss ratios over a three-year period, New Jersey requires the MLR to apply on an annual basis. This restriction erodes an insurers flexibility in managing its MLR requirements and restricts a plan’s ability to invest in long-term initiatives aimed at improving care and lowering costs for its customers. In addition, a more relaxed MLR requirement, such as the three-year average model used by many other states, including California, helps to avoid year-to-year spikes in premiums.

Proposal: Revise New Jersey 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. Before doing so, however, an economic impact study should be completed to look at the overall impact to consumers, businesses and insurers of making such changes.
About Better Choices, Better Care NJ

Better Choices, Better Care NJ is a 501(c)4 public education project advocating for innovative ways to improve health, transform care, and lower health care costs.

Our Steering Committee

Eric Boyce: Eric Boyce has spent over 35 years advocating for the rights of working people. He currently serves as the Assistant Administrator of the Plumbers and Pipefitters National Pension Plan, based in Alexandria, Virginia. Previously, Eric served as the Business Manager for Plumbers Local 24. He has also served as Co-Chairman of the New Jersey Alliance for Action in Hudson County, as a member of the New Jersey State Building Trades Council Executive Board, Treasurer and President of the Hudson County Building Trades Council, and a member of the Hudson County Workforce Investment Board. Eric is most proud of his work with public agencies, non-profits, and the public and private sectors to create workforce training programs and job opportunities for countless individuals. He is a widely respected voice among the organized labor community in New Jersey, especially with regard to how health care impacts the industry.

Tom Bracken: Veteran businessman Thomas A. Bracken is the Chairman of Forward New Jersey as well as President and CEO of the New Jersey Chamber of Commerce since February of 2011, when he took the reins of the state’s business advocacy organization as it celebrated its 100th year.

Bracken has had a long history with the Chamber and the business community. The Skillman resident served as chairman of the New Jersey Chamber of Commerce’s Board of Directors from 2005 to 2007, and has been involved with the Chamber for more than 30 years.

He has four decades of experience in the banking and financial services industry, serving previously as president of TriState Capital Bank’s New Jersey operation, based in Princeton.

Bracken joined TriState Capital Bank, which serves mid-market businesses in Pennsylvania, Ohio and New Jersey, in January 2008. Prior to that, he was president and CEO of Sun Bancorp, Inc. from 2001 to 2007. He also held executive positions with First Union Bank and Corestates Financial Corporation. He is a former chairman of the Economic Development Corporation of Trenton and a former chairman of the New Jersey Bankers Association.
Bracken, a Bucknell graduate, is currently chairman of the New Jersey Alliance for Action Foundation; a board member for Public Media NJ, the subsidiary of WNET that runs NJTV and a member of the Board of South Jersey Industries, Inc. and Solix, Inc.

Lizette Delgado-Polanco: Lizette Delgado-Polanco is the Political Director for the Northeast Regional Council of Carpenters (NRCC). The NRCC represents nearly 40,000 hardworking men and women in Delaware and New Jersey and portions of Maryland, New York, and Pennsylvania. NRCC is one of the largest trade unions on the East Coast.

Prior to joining the NRCC, Delago-Polanco was the Executive Director of the Service Employees International Union (SEIU) New Jersey State Council. The SEIU NJ Council coordinates the legislative and political agenda for over 40,000 members in NJ across four major industries. She has also served as a principal for D-Solutions, which is a government relations and business development firm. In 2001, Delgado-Polanco successfully led Governor McGreevey’s statewide Latino base voters program. In 2002, she was named the Assistant Secretary of State, becoming one of the highest ranking Hispanics in the state government. In this position, she managed a $41 million budget and directed the daily operations of 11 divisions. She has also served as the Director of Special Projects under Senator Jon Corzine.

Ms. Delgado-Polanco sits on several boards, including the NJ Working Families Alliance, Latino Action Network, NJ Citizen Action, Working Families United for NJ, LUPE PAC (Latinas United for Political Empowerment) and Planned Parenthood Action Fund of NJ. She received her Bachelor’s degree in Labor Studies from National Labor College in Maryland.

John E. Harmon, Sr.: John Harmon is the current President and CEO of the African American Chamber of Commerce of New Jersey. Harmon is also the founder of the organization. Previously, Harmon was employed at the Bowery Savings Bank in New York City and at Chemical Bank. Prior to his banking background, Mr. Harmon founded a transportation company in 1989, called Harmon Transfer, Corp.

John Harmon is the former President and CEO of the Metropolitan Trenton African American Chamber of Commerce (MTAACC). Under his guidance, MTAACC grew its membership substantially, established affiliations with the Mercer County Regional Chamber of Commerce, the National Black Chamber of Commerce and the U.S. Chamber of Commerce, and forged strategic partnerships in the public and private sectors to benefit African American businesses throughout New Jersey.

John Harmon also serves as the Regional Vice President of New York and New Jersey for the National Black Chamber of Commerce. Additionally, Mr. Harmon is a Board member of The National Black
Chamber of Commerce, and The American Chamber of Commerce Executives. Harmon earned his Associate Degree in Business Administration from Mercer County Community College in 1981, and then transferred to Fairleigh Dickinson University where he earned his Bachelor’s Degree in Business Management in 1983.

Dr. Joyce Nkwonta, MD: Dr. Joyce Nkwonta is a board certified internal medicine practitioner and has been active in clinical practice for over 18 years. She has been practicing in the Plainfield, NJ area since 2005 and is also on staff at the John F. Kennedy Medical Center in Edison, NJ. She is a fellow of the American College of Physicians.

Dr. Nkwonta completed her Internal Medicine Residency in 1997 from New York Methodist Hospital, which is associated with Cornell University’s Weill Medical College. Afterwards, she spent seven years working in a multi-specialty medical practice.

Dr. Minalkumar A. Patel, MD, MPH: Minal is a serial physician entrepreneur who recently founded ABACUS Insights to serve payer needs around data integration and insight generation. Prior to this he has held senior roles at payer organizations most recently serving as SVP and Chief Strategy Officer of Horizon BCBSNJ. His entrepreneurial experience includes founding Care Management International, a pioneer in leveraging offshore clinical talent to support payer clinical functions, which was successfully sold to iHealth Technologies (now Cotiviti) and Vayu Technologies, a telecommunication platform developed by Bell Labs and spun out and sold to SeniorLink. He holds a BA and an MD from Boston University and an MPH from Harvard School of Public Health and completed his residency training in Internal Medicine at Brigham and Women’s Hospital where he served as a staff physician and faculty at Harvard Medical School for nearly a decade. He has also served as an associate with McKinsey and Company.

Laurel Pickering: Laurel Pickering is the Chief Revenue Officer for WellDoc, which focuses on improving the lives of those living with chronic diseases. Previously, she was President and CEO of Northeast Business Group on Health (NEBGH). Pickering built and led an employer-led coalition of healthcare leaders and other stakeholders with the mission of empowering members to drive excellence and value in healthcare and patient experience. Pickering worked for Northeast Business Group on Health for nearly twenty-five years.

Ms. Pickering is also a board member and former chair of The Leapfrog Group, and served on the Board of National Quality Forum (NQF) and National Business Coalition on Health (NBCH). Regionally, she is Chair of the Board of Directors of the NEBGH subsidiary HealthPass, a health insurance exchange for small businesses. Ms. Pickering received her BA in Anthropology from SUNY Albany and MPH from Emory University.
Michele N. Siekerka, Esq.: Michele Siekerka is currently the President and CEO of the New Jersey Business and Industry Association (NJBJA), that represents 20,000 businesses comprising over 1-million employees in the state. Siekerka also sits on the Board of Directors of Investors Bank.

Siekerka was previously the Deputy Commissioner for the New Jersey Department of Environmental Protection. She also served as the assistant commissioner for economic growth and green energy and the assistant commissioner of water resources at the New Jersey Department of Environmental Protection.

Before her tenure at the Department of Environmental Protection, Siekerka was the President and CEO of the Mercer Regional Chamber of Commerce for six years. She was a practicing attorney for over 12 years in Mercer County and is former Senior Legal Counsel with AAA Mid Atlantic.

Siekerka obtained her J.D. from Temple University and holds a B.A. in Political Science and Government from Rutgers University.