NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Quality powered.

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

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

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

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

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

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

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

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

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

A tiered product is one where the in-network providers are divided into levels based usually on cost-share to the consumer. The consumer may access the plan's entire network but will pay differing amounts depending on what tier the

provider is in. Tiered networks differ from narrow networks in that tiered networks often include a larger sum of providers, ensuring network adequacy and sufficient access, but the providers fall within different tiers, with varying levels of consumer cost-share, and some tiers are more financially accessible than others.

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

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

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

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

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

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

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

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

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

NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Quality powered.

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

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

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