NEW JERSEY HEALTH CARE QUALITY INSTITUTE
Quality powered.

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Testimony of Linda Schwimmer, JD, President & CEO
New Jersey Health Care Quality Institute
Assembly Financial Institutions and Insurance Committee
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My name is Linda Schwimmer and I am the President & CEO of the New Jersey Health Care Quality Institute (Quality Institute). The Quality Institute is the only independent, nonpartisan, multi-stakeholder advocate for health care safety, quality and affordability in New Jersey.

Chair McKeon and committee members, thank you for the opportunity to present to you today on the topic of innovations in the health care services and technology market, such as those developed by CVS, Amazon, and Apple, and the effect of these innovations on the delivery of health care in the State. I will focus my remarks on how I see these industry leaders, and others, using data and technology to:

1) better understand and manage their employee health care costs;
2) develop new programs and contracts that move away from a fee for service reimbursement system that incentivize increased volume of services rather than outcomes; and,
3) connect consumers to higher value benefits that keep them well and lower costs.

The goal for New Jersey should be to ensure that these advancements bring better care, better health and lower costs to everyone in the Garden State.

New Jersey, thanks to the Affordable Care Act, achieved a record level of insurance coverage with only 8% of residents uninsured as of 2017. Unfortunately, our health care costs are high and spending on employer sponsored health care in New Jersey grew by 18% from 2012 – 2016, as compared to 16% nationally. If New Jersey's increase were closer to the national trend, we would have spent about $1.3 billion less, which could have been used to shore up state, company and family finances or increased capability for investments.

The first step to take as an employer, or state, is to know your data. All of the companies the committee is discussing here are data driven. They are building their business models around solutions to the problems they see in their data. In order to address our spending challenges, New Jersey leaders and employers must understand what is driving our health care spending. Once a purchaser has its data and understands what to solve for, it can design interventions that use new payment models, new technology, or better ways to engage consumers and employees.

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Here are some real-life examples of purchasers who did just that and serve as examples of what New Jersey could do:

After reviewing its claims data, **Walmart** knew that areas of concern for them were spinal surgery and joint replacements. They saw that they were paying for too many unnecessary surgeries plus readmissions and complications after surgery. Therefore, using their data and other data on quality, they created a Second Opinion program and a Center of Excellence program where they pay 100% of the costs for patients to receive an independent evaluation. In many instances, alternative treatment was recommended rather than surgery. When surgery is necessary, it is provided at centers of excellence leading to significant reductions in readmissions and enabling their associates to recovery more quickly and return to work and other activities.

CalPERS, which covers 1.3 million state and local government employees, retirees and their families in California, found more than a seven-fold difference in the price for hip and knee replacements, and implemented a payment strategy known as "reference-based prices" for these procedures in collaboration with Anthem Blue Cross. **Anthem** identified 46 hospitals which met volume and quality standards and were willing to perform hip or knee replacement surgery for $30,000 or less for the hospital stay and the prosthetic device. CalPERS expanded the program to include other procedures such as colonoscopy and cataracts surgery. Over the first two years of its pilot, according to CalPERS, it saw millions of dollars in savings from what they would have spent for those procedures due to a number of the higher priced hospitals renegotiating their contracts and lowering their fees to be included in the program and from moving lower risk patients and procedures to Ambulatory Surgery Centers.

The **States of South Carolina and Texas**, through their Medicaid programs, decided that they wanted to stop paying for care that was actually harmful to women and babies. They stopped paying for purely elective, non-medically indicated inductions of labor prior to 39 weeks (EEDs). They did this through two state-based programs. The South Carolina Medicaid's Birth Outcomes Initiative (SC BOI), in 2013, stopped paying hospitals and doctors for non-medically necessary EEDs, after two years of quality improvement activities. The initiative reduced EEDs by 51%, and elective inductions by 55%. In partnership with all 45 South Carolina birth hospitals, SC BOI realized savings of $6,076,000. As of 2016, the program's fifth year in operation, 76% of all South Carolina birthing hospitals had a 0% rate of non-medically necessary EEDs. Texas launched its Healthy Babies Initiative in 2011 within the Texas Medicaid program, denying payment to providers for EEDs prior to 39 weeks. EEDs fell by as much as 14% in Texas after this payment policy change and drove gains of almost five days in gestational age and six ounces in birthweight among births affected by the policy.

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In summary, New Jersey, just like these innovative purchasers, has the capacity to view its data, leverage its market size, and design payment and care delivery models that will result in higher quality care and save consumers, businesses, and the state significant money.

The Quality Institute looks forward to assisting you in this important mission.