Committee Meeting

of

SENATE COMMERCE COMMITTEE, AND SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

"The Committee will receive testimony on the status of Federal healthcare reform implementation in New Jersey"

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

DATE: March 3, 2011  
2:00 p.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Nia H. Gill, Co-Chair  
Senator Loretta Weinberg, Co-Chair  
Senator Robert M. Gordon  
Senator Fred H. Madden Jr.  
Senator Joseph F. Vitale  
Senator Jim Whelan  
Senator Dawn Marie Addiego  
Senator Diane B. Allen  
Senator Gerald Cardinale  
Senator Thomas H. Kean Jr.  
Senator Robert W. Singer

ALSO PRESENT:

Elizabeth J. Boyd  
Philip R. Gennace  
Eleanor H. Seel  
Committee Aides  
Office of Legislative Services

Sarah Lechner  
Jason Redd  
Senate Majority  
Committee Aides

Laurine Purola  
Christina Velazquez  
Senate Republican  
Committee Aides

Meeting Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,  
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey
COMMITTEE NOTICE

TO: MEMBERS OF THE SENATE COMMERCE COMMITTEE

FROM: SENATOR NIA H. GILL, ESQ., CHAIR

SUBJECT: COMMITTEE MEETING - MARCH 3, 2011

The public may address comments and questions to Philip R. Gennace, Committee Aide, or make bill status and scheduling inquiries to Joanne W. Gillespie, Secretary, at (609)984-0445, fax (609)777-2998, or e-mail: OLSAideSCM@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

The Senate Commerce Committee will hold a joint public hearing with the Senate Health, Human Services and Senior Citizens Committee on Thursday, March 3, 2011 at 2:00 PM in Committee Room 4, First Floor, State House Annex, Trenton, New Jersey.

The committees will receive testimony from invited guests and written testimony from the public on the status of federal healthcare reform implementation in New Jersey, including preparations for a health insurance exchange and measures to be taken for the required expansion of Medicaid.

Issued 2/24/11

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SENATOR NIA H. GILL (Co-Chair): Good afternoon. Welcome to the joint Committee of Commerce, and Health and Senior Services. This Committee will be chaired by myself and, of course, the distinguished Loretta Weinberg.

As we all know, the Federal healthcare reform is now law. So today we are not going to debate the merits of healthcare reform; we are going to discuss the implementation of this law and how the State should best proceed.

Today’s meeting will be divided into two aspects: the Federal health reform law, Medicaid expansion, and the creation of the statewide health insurance exchange. I want the Committee and the public to be aware that throughout today’s meeting, many of our invited guests will use the term consumer when referring to those who purchase insurance. I would like to clarify that, in this context, consumer means both individual and employers.

I turn the mike over to Senator Weinberg.

SENATOR LORETTA WEINBERG (Co-Chair): Well, I’m going to take advantage.

We did have a Health Committee meeting just preceding this, so obviously it’s the Health Committee that’s the most well attended. (laughter)

SENATOR GILL: That’s because the Commerce Committee was further away.

SENATOR WEINBERG: Yes, right, okay. Well, hopefully they’re traveling--
SENATOR GILL: Takes us a little time to find our way.
(laughter)

SENATOR VITALE: That's true. And as Vice Chairman, I want to welcome you.

SENATOR GILL: Thank you very much.

SENATOR WEINBERG: Just to add to what the Chair of the Commerce Committee, Senator Gill, said, the states are responsible for meeting the Federal requirements which are outlined in the law. And they include creating temporary high-risk pools; establishing a standard medical loss ratio; and the requirement that children remain covered on their parents' health plans until the age of 23 -- although I think in our state we already do that -- I think it's 26, actually; broader provisions of health reform, such as the Medicaid expansion insurance mandates -- even though we have not been following that right here in New Jersey -- and the health benefit exchanges.

So we hope to hear from our invited guests what is happening here so that we can't wake up early one morning and find out that New Jersey has not been responsive to what the Federal mandates are.

Does somebody have a list of the speakers available here?

SENATOR GILL: And while we get a list of the speakers, of course we would like the ranking -- so as not to say the senior -- most senior -- Republican to make an opening statement if he would like.

Senator Singer? You have none?

Is there anyone on the Republican side who would like to make an opening statement at all? (no response)

See how bipartisan we are in the Commerce Committee?
Okay, then we will start with the first witness, Mr. Dave Knowlton.

Thank you very much, sir.

DAVID L. KNOWLTON: Thank you, Senator, Madam Chair; Senator Weinberg.

Senator Gill asked me to do a presentation on an overview of the elements of reform, particularly surrounding the exchange; and that’s what I’m going to do. I have handed out my material to you so that you can follow on along if you’d like, because to take on the challenge of presenting all the information about an exchange would take a very long time to do that -- it’s very nuanced, it’s very complicated.

I’m not going to take a position on anything; I’m going to try to describe how it works at a very high level. I also understand from your staff, Senator, that the Department will be following me and they have some specifics about how New Jersey is specifically responding.

SENATOR GILL: Yes, they will.

MR. KNOWLTON: Okay.

So let’s get into it. What is an exchange? An exchange is really a virtual marketplace where the consumer can compare insurance costs and benefits side-by-side and make purchases of insurance. People will be subsidized; you will need to have information on what those subsidies look like. You may actually have something online so that people can actually see how their subsidies would play out within the exchange.

The exchange is the place that people who do not have insurance will be going to get insurance under the new law, if they don’t have it through other means.
There are four principles of exchanges; I like to call them the four As. And I would hope that legislators would keep in their mind these principles as they examine the exchange information that will come before you.

Availability. Is access granted geographically? Can people get the care they need? Is care available?

Is it adequate? Are there adequate numbers of networks, benefits, and providers?

Is it affordable? The fact that there may be subsidized premiums doesn’t mean that the there may not be cost shifting within the benefit itself. Is it affordable?

And finally, is it administratively simple? Is it able to be understood? Are people going to be able to make good decisions as they look at information and choices?

What the exchange requires is adherence to qualified health plan rules -- that certification, recertification, and decertification -- how would that work?

Essential health benefits -- meeting the Federal guidelines which includes all the things you would think: hospital emergency, prescription drugs, behavioral health, rehab, maternity, etc.

It requires a toll-free call center. It requires the maintenance of a website with plan information in a standardized format, and it's one of the first things that -- deliverables -- that you have to provide -- you have to provide people.

And it requires an online calculator to determine the actual cost of coverage. Now, this is actually a picture of an online calculator that the
Kaiser Family Foundation actually uses right now. You can get that online at their website. And to show you what a calculation looks like, showing not only the premium that you would pay if you were not on this income -- this is a premium unsubsidized; and this is what you'd pay subsidized, about 10 percent of that premium.

I think there's a lot of potential to a national insurance exchange. Though economies of scale can be gained, and some increase insurance market efficiency, it's also an opportunity for greater market oversight. This transparency -- getting some transparency into the system and new opportunities for insurance market competition, which has long been an objective of reform and of the exchange.

So let's go over some of the key issues. And I, again, apologize; you kind of need your seatbelts to go through this so quickly. Some key issues -- exchange functions and authority: Should there be active or passive oversight? Should you just say, "Okay, whatever plan wants to come in, can come in," or should you have strict rules of who can get into the exchange? Because remember: This is where consumers -- Senator Gill, you were correct -- consumers, being both employers and individuals, are going to be buying policies.

Who can participate in the exchange? Can everybody participate? Is this an all-comers can participate, or can only certain select people who meet certain select criteria participate? Are you going to set the rules governing insurance that's sold inside and outside of the exchange? Will company A, if they sell within the exchange, have to adhere to different rules in the products that they sell outside the exchange? There's
been debate in some states of making them the same; I don’t know anyone who does yet.

Concerns about risk selection -- and I’ll talk a little bit more about that later -- but if plans are subject to tremendous adverse selection because they’re in the exchange, they will follow the downward spiral of -- death spiral -- of insurance and they won’t survive. You have to be able to know that you can manage adverse selection and risk.

Should the exchange be the exclusive source for certain markets -- for the poor, for people transitioning from Medicaid -- so that they would be the only place to buy these services; or should they be just an alternative source for some markets?

The premise of why they put an exchange into the-- Well, the practical answer why they put an exchange in was because Massachusetts did, and it worked. But the reason that the exchange, in theory, is in is because health insurance markets haven’t worked very well. You go out and buy auto insurance, you can go see some basic coverages and say, “What’s it going to cost me?” and make a decision. Health care is a good deal more complicated, and whether you get the adequate coverage that you need is not quite as easy to figure out.

In addition, exchanges can really be designed to create oversight and structure to insurance markets that make some good determinations.

One of the most exciting areas of the exchange is its role in addressing the costs of care. They can be given the authority to negotiate with plans over price. Some states have chosen not to do that; and some states they might do that. They can look at standardized benefit packages to promote price comparisons by both the employers and consumers. They
can look at fixed employee contributions to promote lower cost -- requiring a fixed contribution. The public plan could catalyze private plans to become more cost efficient if the exchange has an alternative that’s a public plan or a quasi-public plan. The public plan would be something like Medicaid for everyone. A quasi-public plan might be something like access to the State health benefits program or something like it, administered externally to the State but sponsored by the State.

And finally, greater insurance transparency will promote more informed consumer choice and give incentives for efficiency because you would be able to track what’s happening. The exchange is intended to be very transparent.

Getting people into the exchange in enrollment is always a challenge. And the exchange is going to have to have ways to facilitate enrolling people. They’re going to need reliable information on options and all processes within the exchange. They’re going to need help centralizing how you would choose plans, and how to determine a subsidy. Let me explain: If someone is insured by their employer, they have a standard plan. Let’s say it’s a woman. She becomes pregnant; she decides she’s going to leave her job for a period of time, longer than just family leave. That alters her income. She is now eligible for a different level of subsidy than she was when she was in her employer’s plan. Then let’s say she’s been out for a couple of years; she goes back in again to the workplace. The subsidy equation shifts again. So if we don’t figure a way to make it very easy for people to understand, this is going to be a nightmare -- trying to figure out who’s entitled to what subsidy at what level, in terms of the program.
How are people going to make payments can be determined by the exchange. They can centralize that if they wish. Payments could go through the exchange if you thought it was the right way to go.

And tracking enrollment and disenrollment -- to minimize the coverage gaps that I talked about.

Exchanges don't have to just be about how they get people enrolled, they could also be involved in requiring people to report on quality, investigate complaints. They can be a gateway for Medicaid and SCHIP. And one of the things, as you can imagine -- people who have lower-end jobs may move in and out and need transition. The transition between the exchange and Medicaid, the exchange and SCHIP, is going to be a big issue.

They will allow participating plans to be evaluated, and they can establish and publish comparative standards so people can get comparative information, much as the Senate Health Committee pushed when they pushed for patient safety reporting, cardiac reporting, other levels of reporting in the state.

Now, all the comments I just made are what exchanges are doing generically. Frankly, New Jersey's way ahead of the game. If you look at the President's health reform, New Jersey is way ahead. We, for example, have no penalty for pre-existing conditions and we haven't had for a long time. We have guaranteed issue and guaranteed renewal. We have no medical underwriting permitted in our individual and small group markets. The Kids First (sic) law that was passed -- Senator Vitale's bill -- got all kids covered in New Jersey. We have medical loss standards right now that exceed the Federal standards, not only the level but a stricter
enforcement of what can be included in those standards; we have no benefit caps except in one program, the basic and essential policy which we have a Federal waiver for; and no rescission. If you followed what happened in California, rescission is when someone says, "Oh, I find out that you've got breast cancer, but you neglected to tell me that you were a cigarette smoker 20 years ago, so we're not going to cover you for your breast cancer." It's a moot point in New Jersey because of our guaranteed issue and renewal. So we don't have the problem that California had with rescission.

I would also add that we have-- I don't want to put this as -- ahead of the game; someone said behind the game. But we have 33, I think, 33 mandated benefits in New Jersey. Some of those are a problem and drive up the cost of health care, but some of those are benefits that other states are going to have to put in their policies when the Obama reforms come forward, because we already have them. One that comes to mind is an Ob/Gyn acting as a primary care physician. It is a New Jersey law; it will be mandated under Federal reform.

So let me talk briefly about process, and then I'll comment briefly on what I see as some of the concerns. Your initial decision point is, what really do you want to do? Do you want to form a State exchange? You don't have to. Do you want to form a State exchange and, if you do, if you want it to be a State-based exchange, do you want to run it? Or do you want it to be a not-for-profit company that's going to run this, some not-for-profit group? A for-profit cannot run it, but a not-for-profit can. Do you want to do it, or do you want somebody else to do it?

Or do you want to form a regional exchange? And if you want to do that, do you want to create your own, or do you want to join another
regional exchange? If you look at the way healthcare benefits are purchased in New Jersey, people live in New Jersey and work in New York; people live in Pennsylvania and work in New Jersey, and vice versa. So having-- There is certainly an argument that making it very easy for people to move across state lines and stay within easy coverage in their network, and so forth, makes some sense. It adds to the complexity of the insurance issue, and makes it a difficult decision.

The other alternative is to do nothing -- there’s no requirement that the State have an exchange. If the State did not have an exchange, the Feds would create one for you, and you’d be adhering to the Federal rules. If my-- One of the brief editorial comments I’ll make is I hope you won’t choose that option. New Jersey is already, as I mentioned earlier, far ahead in their regulation of insurance -- on many of the things that the Obama reforms intend to get at, New Jersey has already done. And the interface between Medicaid and this level of insurance in the individual and small group exchange markets will be important, and there needs to be a specific New Jersey flavor, in my judgment, to those markets.

So what’s the exchange responsible for? They’re responsible for marketing, network adequacy, quality improvement, and reporting uniform enrollment; provider directories including a significant amount of data in and out of network; and timely consumer data for cost sharing -- what’s involved in cost sharing. And that’s a very-- Having been involved a little bit in the out-of-network debate, that’s a very difficult thing to come up with: How can we get a consumer timely information on what that consumer’s out-of-pocket costs will be at a provider at a given point in
time? And now we’re talking about doing that determination when they’re trying to buy a policy. It’s pretty complicated.

An exchange has to have an expert board of directors, the ability to maintain transparency in some way, relationships with State agencies and private agencies -- probably less an issue in New Jersey -- and the ability to protect and promote health care delivery, health plans, and, most importantly, the consumer.

Now, let’s talk a little bit about the consumer issues, because that’s where the rubber hits the road a little bit. The exchange is -- as Senator Gill pointed out -- the exchange is a consumer vehicle in that consumers here are both small businesses and individuals. The consumer issue, as I see it, it really has to be independent from insurers in some capacity. It has to be sensitive to health literacy. We make a lot of determinations that people we think need to understand about their health and about their care, and we neglect the fact that some people don’t understand. The example of the diabetic who was taught to inject an orange to learn how to give himself insulin injections, comes back a week later and has been dutifully injecting his orange and not giving the injection to himself, is a real-life story. And so health literacy is a big issue.

Cultural sensitivity. People are going to want to know the cultural sensitivity of the plans that are within the exchange. Can we make that information available? Language: Cultural sensitivity is more than racial issues; it’s more than specific cultures; it’s also, can you go to the doctor at night? Can you go to the doctor on a Saturday? Do they speak your language? I believe that any state will have to have some ombudsman or ombudsman function to see this through in a meaningful way, and two
states have tried initial efforts with just using an ombudsman and, ultimately, had to engage local community navigators. These are local, usually advocacy groups who are helping people navigate through the exchange.

They need a subsidy algorithm or a calculator like I showed you earlier; and especially important in this state is Medicaid coordination -- Medicaid and SCHIP.

One thing I worry about with consumers is the quantifiables squeezing out the relevant -- that we report on a lot of data because we can gather that data, but it’s not data that’s especially meaningful to people. Some of our health reports recently reported everybody is sort of about the average -- everybody’s about average. It doesn’t give you -- yes, we can record it very carefully -- but it isn’t telling us information we can make decisions on.

And I think, ultimately, the exchange will fail if it doesn’t enable us to put a bright light on plans that are doing good -- that are doing good for consumers in making good choices.

There are a bunch of other decisions that need to be made -- I’m not going to go through these. You’re going to be having this debate again and again, I’m sure, and I’ll be glad to come back and answer the questions. But this gives you an idea of some of the other choices that are in your documents that I handed to you. There are a bunch of choices that you have to address in looking at this legislation.

So where do you start? Well, you’ve got a good start. You have enabling legislation already in the hopper, as I understand it. You have technical resources available to you that can help you with it. And let
me give you your bogey: There’s a deadline for the Federal Health and Human Services to evaluate your proposal by January 1 of 2013. Exchange has to be up and working by 2014. Drilling down a little bit, this is the timelines: the RFP in July 2011; have to submit by 2012; 2013, start selling health insurance through the exchange; fully operational by 2014; and the big, big, big problem, for most states: self-sustaining by 2015.

Now, are there current working models? Sure there are. Exchanges exist in Massachusetts, which actually did the first one called the Connector. And in Utah, most recently, one was created specifically in response to Federal reform in California. And I won’t go through all the details -- the Massachusetts program known as the Connector -- they have an individual mandate in Massachusetts; about 95 percent of Massachusetts citizens are covered now under their program. Cost remains a problem in Massachusetts -- cost is still very high. Plans cannot be sold through their Connector, as they call it, without approval by the state.

Utah is a much more open system, open to any plan that wants to participate. The state only defines the minimum benefits that have to be provided. And they have about 85 percent of their residents covered in the Utah program.

California is brand new. It was the first exchange in response to the Affordable Care Act. They have broad powers to negotiate on behalf of the public; we don’t quite know how that’s going to roll out because they’re too new. It is thought it’s going to look like the Connector in Massachusetts, and they have no individual mandate yet. The translation is, I think they may be going to rely on the Feds for their individual mandate.
So what I’d like to do in the remaining couple of minutes is talk about some concerns I have, and things that I think may be problematic that you ought to pay attention to in the Connector and in reform. The first, I mentioned earlier, is adverse selection. If people can move in and out, based on whether they’re sick, and the price depends on what happens as sicker people get in the plans, you’ll have the problem we have in the individual market: that people get sick, the price goes up, so people who are a little healthier leave; the price goes up some more, so more people who were not quite as sick, but still sick, leave, leaving only the real sick in the plan. That’s the downward spiral. So you really have to be able to address adverse selection, and that’s not an easy task, as I think the folks from DOBI who will follow me will be speaking about.

One of the big problems in adverse selection is pre-existing conditions. New Jersey -- another editorial comment -- I promised Senator Gill I’d identify my editorial comments -- another editorial comment is that I think the Obama reforms made a mistake with their pre-existing condition regulations, because I think New Jersey did it right. New Jersey has a waiting period for pre-existing conditions, which means that somebody will not casually go bare on insurance assuming, “Well, I’m not going to get sick.” Under the Obama reforms, you can sign up immediately -- it’s immediate issue by 2014 for adults, for kids now -- but kids don’t get sick as often as adults. So you could show up at-- Go bare, pay a minor penalty in the early years, up to two-and-a-half percent of your income in the later years, and if you’re young, and you’re healthy, you’re going to say, “I’ll pay the penalty.” At the maximum you’ll pay $2,500 at the real outside, and that’s not even, probably, in the individual market, four months’ premium -
- and it's $2,500 a year, so you can do the math. What they do instead, then, is they wait, and if they fall off a dock, or hit their head, or get sick, get cancer or something else, they show up and sign up immediately because there's no waiting period. That's going to be a big problem. It also will preempt, as I understand it -- I'll be interested in what the DOBI people say -- but as I understand it, New Jersey law would be preempted on that matter, and that's going to be a problem for us. So you're going to have to address that in some way.

I also believe, by the way, the Feds have got to address it because it will cause a downward spiral in insurance if they don't.

*Crowd out* is when people say, "I'm going to use the plan on the inside, in the exchange, rather than continue to provide a plan as an employer." So I say to my employee Catherine, "Let me give you a check for the amount of the premium," and I'm out of it from now on. That's called crowd out, and there is a fear that you'll crowd out good coverage that some people have now. How you protect against that is a big issue in health reform and in the design of the exchanges consistent with what's going on in Federal law.

Physician availability. You will not have enough primary care in New Jersey now if you were to implement this today. There is not enough primary care capacity now. Let me give you an anecdote: You're now sitting in Mercer County. In the past three months, seven doctors in Mercer County went to concierge medicine, where you pay an $X amount of money in order to get your care. Seven practices went to concierge medicine. So everybody says, "I don't know what your feelings are on that," but everybody kind of said, "Well, that's too bad; they shouldn't do
that.” The real reality is they move from covering about 1,600 people a year in their practice -- and that’s a pretty low estimate -- to covering 600 a year. So you have 7,000 people in Mercer County now without primary care, and seven fewer providers to provide that care. Huge problem -- huge problem in New Jersey, it was a huge problem in Massachusetts. It inundated the emergency rooms because they couldn’t -- people just getting routine care -- not because they wanted to, but because primary care was not available. It will become an even increased problem with Medicaid. So another problem that really needs to be addressed in New Jersey.

I mentioned-- I won’t reiterate the issue of literacy.

Interfacing the individual and small group market is going to be a challenge. You’re going to have to do it in a responsible way, or you may say, “Let’s just merge it.” That’s going to be a decision point you’re going to have to think through.

I can’t say too much about this next thing: the undocumented. New Jersey has a significant amount of undocumented. When we were doing the reform work with Senator Vitale, we were eighth in the nation in undocumented residents. President Obama has been very clear that no Federal dollars will be used to cover undocumented residents. I don’t know what will happen as we parse back charity care, because we’re now covering people with insurance cards instead. But I can tell you that hospitals, even though the Feds will not cover it, hospitals still have to provide care under the EMTALA Law. And New Jersey’s EMTALA law far exceeds the Federal EMTALA law. The Federal EMTALA law is a lot more lenient; New Jersey law is a lot more strict. So you’re going to have real challenges in dealing
with the undocumented, and I don’t see a clear solution to that immediately on the horizon.

Last issue I’ve seen concerns is an issue that the Legislature attempted to address in the Assembly; I understand it did pass a limited bill and it’s over here now for consideration in the Senate -- and that’s on out-of-network costs. It’s going to be impossible to maintain this system if people can charge people in the exchange out-of-network charges of eight, nine, or 10 times Medicare and get paid that; it will break the bank. I am a great fan of market forces working in health care, but if you don’t let them work and they’re unfettered in price, it will break the bank. So you have to pay attention to it. The out-of-network issue is a crisis with respect to health reform. You have to pay attention to it.

I also-- I trust that you are all a little more knowledgeable about this than I am, but just let me take my quick stab at it -- on the issue of politics here; and there are political issues here. The first most obvious is funding -- who’s going to pay for this? Are you going to have it subsidized by people playing in the exchange (indiscernible) with plans? Are you going to prevent them from passing that on? Are you going to allow it to be considered in a medical loss ratio? These are all very big issues. What is the base of exchange operations going to be, as I mentioned earlier? Is it going to be a not-for-profit? Is it going to be in the State? If it’s in the State, is it going to be a new entity like one of the authorities, or is it going to be in DOBI or Health or Human Services? The out-of-network issue, I don’t have to tell you, is a political issue. If you don’t think it is, wait until you take up your bill, coming soon.
And what participation requirements do you plan for providers? What requirements to participate? For example: If you’re in one plan in the exchange, do you have to be in all of them? What are the rules going to be? And what requirements for the plans? If you have an exchange offer, do you have to offer all the plans available in the exchange? If you have plans, and you have still maintained the individual and small group markets, do you have to continue to do that?

So if you want to look at it graphically, on one side you have really individual health underwriting, pre-existing condition limits allowed, high deductible plans, etc. -- much of which we’re going to do away with in health reform, but there will be things right at that edge. And on the other side you have government prescribed prices, benefits; it’s the only market; universally comprehensive benefit plan. And you have each side saying, “I don’t want to do it that way.” So politically, that’s where the challenge will be. Everybody’s going to be searching -- and I’m not going to walk through these individually -- but as you can see, it moves from less regulation to more regulation, and I’ll let you read the materials that are in front of you to see the particular issues there. But you move from having anybody play to only a few play.

So I’d like to leave you with a few points of just summarizing this -- a few reminders. Remember -- this is one of my favorite New Jerseyans -- remember, number one: Subsidies vary with personal circumstance. People will move in and out of subsidy. That is going to be an enormous problem, and I would suggest to you that it can’t be managed without computers. So this is going to have to be web-based solutions of some kind, because people will be moving too rapidly.
There is a strong foundation of insurance market reform and regulation in New Jersey. It’s something to be proud of, it’s something you should build upon. You should not try and reinvent the wheel. We already far exceed Federal standards in New Jersey.

Exclusivity enhances the value of the exchange. If you say -- if it’s the GUMs -- the great unwashed masses -- everybody can play, you will not play as well. You will not have the leverage that the exchange is meant to give.

Setting benefits standards is critical for adequate coverage and informed choice. New Jersey has a good record there; you should be proud of it, and I think you should be willing to step up to that plate.

The cost curve rules. If you can’t bend it, this won’t work. So it won’t work here, and it won’t work federally. Cost curve absolutely rules. It has to bend, and the treatment trap is right behind it. The treatment trap is that we overtreat -- that we’re overtreating, and in New Jersey, as you know, the real horror here is end-of-life care which we overtreat to the tune of being number one in the nation.

If there is no primary care, there is no access. There cannot be access without primary care. There is not an easy solution to primary care. It’s going to require outreach to nursing; it’s going to require outreach to other extenders to be able to maintain the primary care that your citizenry will need as this reform moves forward.

You’re going to have to create the exchange to be trusted in a meaningful way. And the price of success will be somebody staying on top of it. There will need to be oversight and vigilance.
And I’ll leave you with a comment that Hillary Rodham Clinton made, when she was doing her health reform, that always stuck with me, when she said, “Don’t forget the fear.” There’s a significant difference between the concerned, cost-conscious consumer and the panicked patient in pain. And so there is a need to be sensitive as we design these beautiful systems. There’s a need to be sensitive to the patient who’s looking at their computer screen and trying to make an informed choice about the options for he or she and their family. And I think the point was well made this morning in the release from the AARP, with health leading the number one concern of their constituency. What you’re dealing with is not, in this exchange issue and the reform issue, is not only approaching 18 percent of the domestic gross product; but it’s also something that everybody lives with that really matters to people.

So I thank you. I’m honored that you asked me to share this with you, Senator Gill. And I’ll be happy to answer any questions if I can.

SENATOR GILL: Thank you very much.

Any questions from anyone?

Senator Vitale.

SENATOR VITALE: Thank you, David. Thanks for that presentation, and I’m happy to hear that you’ll be back again, because we won’t fix this in two hours -- or learn all about it. It’s pretty extensive.

I do want to talk about three things: one is the most recent comment about primary care and access. I mean, it’s an issue now, and it’s going to be a greater issue with the 1.3 million uninsured New Jerseyans -- maybe a little bit less -- gaining access to health insurance and demanding care. We have done some things over the past few years to expand the

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ability for advanced practice nurses to practice not just independently, but also to increase the scope of their practice -- to diagnose and to prescribe drugs for their patients. So that’s a good step in the right direction. And it will take longer than 2014 for us, even if we were to start today, to aggressively recruit and retain, through any number of means, medical students in New Jersey. It will take at least 10 years to see the fruits of that labor. So you’re right. What are some of your -- what would be some of your ideas going forward -- starting today, even recognizing the reforms you’ve already put in place with loan forgiveness for nurses and for doctors, and for expanding the scope of practice for LPNs -- what else should we do?

MR. KNOWLTON: Well, there’s no question that you’re going to have to look to nursing in a big way; and you’re going to have to move-- It’s also a public relations problem. You’re going to have to move the public’s confidence in that care. The basis of it-- I can tell you, as a health quality person and a researcher, that the quality is excellent and there’s no reason to be worried about it, but it can’t become second-class care. If people perceive it as that, they won’t use it.

I foresee a lot more clinic use. What has been an anathema to many states -- of the retail clinics -- is going to become a reality, and I think one that should be embraced but managed; where Walgreens and Rite Aid and Walmart are looking at retail clinic environments in states. They’re going to become really needed because you can use one provider more efficiently in a clinic setting. Hospitals are going to be asked to step up. But we need to plan for this now. I think the big thing, Senator Vitale, is that we do the planning now -- that we don’t wait until this hits us in 2014;
2014 is a nanosecond away in terms of health planning. And in terms of implementation of regulations to do all this, it takes a long time.

SENATOR VITALE: True.

Next, I want to ask you a little bit about the Medicaid expansion and what has to take place -- what will happen in 2014? Currently, New Jersey has set up a 60-40 match in Medicaid, so it's 40 of the State dollars, 60 Federal dollars for match. And that's good; it used to be 50-50, and they've increased that a little bit over the past couple of years, but certainly a pretty significant burden on our treasury to support the cost -- the State-borne cost -- of Medicaid. What I've read is that by the first year the Federal government will cover the cost of all the Medicaid dollars up to 100 percent of those costs for a period of time, and then we'll gradually go back down to level off at around 88 percent of Federal dollars and 12 percent State -- which is now 40 percent, which is a big savings for our State. Of course, we have to consider that we're going to increase the number of people enrolled in Medicaid and so it might balance itself out.

If you could explain -- and I'm still trying to get my head around this equation -- that it will be-- Reimbursement will apply at certain levels for those who are already in Medicaid?

SENATOR GILL: Senator, we're trying to do this in two parts. But we do have a second segment -- is devoted directly to Medicaid.

SENATOR VITALE: Okay.

SENATOR GILL: So if you would be kind enough to reserve that question.

SENATOR VITALE: For the Medicaid folks?

SENATOR GILL: Yes.
SENATOR VITALE: Sure, no problem at all.

SENATOR GILL: Any other further questions from any Senators?

Senator Cardinale.

SENATOR CARDINALE: Thank you, Madam Chair. You addressed shortages of personnel, particularly of primary care physicians. Is New Jersey unique with respect to that shortage?

MR. KNOWLTON: No. Primary care shortages are a problem around the nation. New Jersey has a very high shortage, comparatively, but it is not unique at all.

SENATOR CARDINALE: To what do you attribute our being in a worse position than, perhaps, some other states?

MR. KNOWLTON: Yes, we are in a worse position than some other states. Primary care-- I hope I’m getting your question, Senator. The primary care crisis is a national crisis; it is not a New Jersey crisis, it’s a national crisis.

SENATOR CARDINALE: But I think you just told me that it’s worse in New Jersey than in some other states.

MR. KNOWLTON: It is, it is.

SENATOR CARDINALE: To what do you attribute that difference?

MR. KNOWLTON: It’s not exactly something that I’ve looked at carefully, so I’m just giving you my judgment. I think it’s population density, so that the amount of primary care that we need in our geographic confines, with the population density we have, has to be that much richer -- number one. And number two, a lot of our medical students that we train
here, leave -- they go elsewhere. And that would be my guess. But I haven’t looked at it rigorously, Senator, so I’m not an expert on it.

SENATOR CARDINALE: Is primary care the only area of physician shortages that we have?

MR. NOWLTON: No.

SENATOR CARDINALE: We have physician shortages in many areas?

MR. NOWLTON: Yes.

SENATOR CARDINALE: Obstetrics?

MR. NOWLTON: Again, not an expert. That’s my understanding -- yes.

SENATOR WEINBERG: The answer is yes to that.

SENATOR CARDINALE: Neurosurgery?

MR. NOWLTON: Neurology-- I could give you a list of a number of them.

SENATOR GILL: Senator, I know we’re talking about the time constraint, but he said he doesn’t have all the--

SENATOR CARDINALE: Yes, I--

SENATOR GILL: You can make the statement, and we’ll all agree.

SENATOR CARDINALE: No, I’m not interested in making a statement; I’m interested in developing some information--

SENATOR GILL: Okay.

SENATOR CARDINALE: --which I think could be useful for us.
In your presentation you suggested that we might have to rely on non-physician-trained personnel to do some of the functions that physicians today do -- I don't know if it was you or if it was Senator Vitale who talked about that -- as diagnostic functions. Do you believe that the population of New Jersey is receptive to having non-physicians do their diagnostic work-ups?

MR. KNOWLTON: I believe portions of them are, Senator. It's part of the issue I talked about -- that we're going to have to educate the public. But yes, I think so. I think portions are; I certainly am. And I think that it's been a factor in the military forever. So certain people are used to it, and certain people are not. But it is an absolute imperative under reform, because if you decided today you were going to fund whatever funding was available, and you were going to give long redemption and whatever to get everybody all re-enrolled and get your enrollments up in medical school, you still have a 10-year window. So it's a problem that's not going to go easily away. There has to be some sort of extenders to accomplish the result.

SENATOR CARDINALE: The question that occurs to me then is, if diagnostic procedures can be acceptably done by non-physicians, why should we have medical schools? Why don't we disband our medical schools and have an expansion of nursing facilities or some other kind of profession, whatever we might call it?

MR. KNOWLTON: Well, there's an awful lot, Senator, that -- a diagnosis that a nurse could do, and there's a lot of diagnoses that a nurse would not attempt that is outside the scope of the practice.
SENATOR CARDINALE: I would suggest to you that that's correct. The problem is when the patient is ill, we don't know which patient can be successfully diagnosed by a nurse, and which patient may really require a more professional diagnosis. So traditionally we have required that those diagnoses be done by a physician, because we know that the physician is in a better position, generally, than other personnel -- whether it be physicians assistants, nurses, or anyone else. I'll agree with you that many cases can be handled by lesser-educated personnel. But the problem is we don't know in advance which those are, and so people are going to be misdiagnosed if we denigrate the professional training of those who are going to do this procedure.

MR. KNOWLTON: I won't belabor it. I would just reply that I would love to talk to you about it. I think there is an opportunity to do both. I think it's a question of expanding responsibly. We've had this type of expansion in dentistry, optometry, podiatry, osteopathy in the history of the country, and I think we're ready for the next stage. But it has to be done, exactly as those professions were, in a responsible manner. But we need to address it or we'll have a problem.

SENATOR GILL: Thank you.

Senator Whelan.

SENATOR WHELAN: Thank you, Senator Gill.

You gave us some statistics: Massachusetts is 95 percent and Utah is 85 percent. Do you know what New Jersey is?

MR. KNOWLTON: No, I do not.
SENATOR WHELAN: Okay. When you talked about the RFP in July 2011 -- presumably that’s being put out by the State to start this process -- on your timeline sheets, July 2011, RFP.

MR. KNOWLTON: I have to-- I have to go back to what you’re referring to.

That’s the RFP for information technology of the web structure. We have to have an RFP out--

SENATOR WHELAN: Okay, who’s putting the RFP--

MR. KNOWLTON: We’re putting the RFP -- the State has to put out an RFP.

SENATOR WHELAN: The State.

MR. KNOWLTON: The State, yes.

SENATOR WHELAN: That’s what I’m saying.

MR. KNOWLTON: Yes, that’s--

SENATOR WHELAN: So the State--

MR. KNOWLTON: I didn’t know what you were looking at.

SENATOR WHELAN: Now-- Okay.

I’d like to ask: I have a sense, from your presentation, from the consumer’s point of view -- either individual or employer, group, whatever -- how it kind of works. From the insurance company’s point of view, what’s their incentive and why do they want to be part of the exchange instead of just being out there on their own, especially the larger ones? They say, “Why do I need this? I’m BlueCross BlueShield,” whatever.

MR. KNOWLTON: Senator, let me answer that two ways: One way to answer it is, the insurance industry has stepped up in the State in the past. Kids First never would have happened if insurers hadn’t
stepped up to participate on a very public purpose basis. But that being said, they were also getting access to a lot of covered lives. If the exchange is designed in a way that’s responsible and doesn’t hurt them, but is responsible also and doesn’t hurt the consumer so both sides--

You point out a very excellent point: It has to be a balance or it won’t work. Because the insurers can certainly say, “No, thank you.” The providers can say, “No, thank you.” And the consumers can say, “No, thank you.” So you’ve got to balance it so that it works. And that it will be a challenge -- exactly.

SENATOR WHELAN: But explain again-- If I’m one of the big guys, why do I want to go into an exchange where I’m laid side by side with other companies that may be undercutting me or whatever? Don’t I want to just use my bulk to say, “I’m the 800-pound gorilla, and I’m not going to be part of the exchange.”

MR. KNOWLTON: Well, I think they’d want to be for the reason I said: that they would gain access to covered lives. But let’s take, for point of argument, that they didn’t, and everybody stayed home. Well, then New Jersey may want to say that participation in an exchange is tied to providing insurance in the State of New Jersey, because we need the exchange to be covered. You can regulate it all-- As I started in my presentation, Senator, I said you can regulate it at any level here, and it is a balancing act. You’ve got to balance the interests of a variety of stakeholders that very often have different views. Your point is very well taken with the plans. But if everybody stays home then you’ve got a problem; you’ve got to tweak the exchange and change the rules.

SENATOR CARDINALE: Thank you.
SENATOR GILL: Senator Allen.

SENATOR ALLEN: My question is really a follow-up, talking about if everybody stays home. When we first got SCHIP, that's what everybody did -- they stayed home. And it took years and so many different trial balloons as to how we could bring them in, and so many different things that we tried. I worry that we're going to run up against the same sort of thing, and as you said if that's what happens, we're in big trouble.

MR. KNOWLTON: You're exactly right, Senator Allen. The enrollment issues challenges are significant. However, I would suggest that-- My personal belief is that New Jersey has learned from its SCHIP experiences. This recent Kids First work that we did really got enrollments rapidly, much more rapidly--

SENATOR ALLEN: Twelve years later--

MR. KNOWLTON: Yes, after a lot of experience, I admit.

And also the Department of Human Services now is much better oriented to getting enrollment. I don't know how that will work in the exchange; it may be that Human Services is better resourced to assist in enrollment and the crossover. When Human Services is up here later, you may want to ask about the interface between Medicaid and the exchange.

What happens when somebody is making beds at one of the casinos in Atlantic City, and covered by Local 54 HEREIU, suddenly loses their job in a layoff; now is subsidized and has to dump into the exchange with almost 100 percent subsidy; and then suddenly gets reemployed -- what happens with Medicaid and how are you going to interface those things? Those are big issues.
So it’s not only enrollment, it’s interface to make the system work.

SENATOR WEINBERG: It’s the infrastructure.
SENATOR ALLEN: Thank you.
SENATOR GILL: Any further questions?
One quick one.
SENATOR VITALE: Thank you, Chairwoman.

Dave, we-- As part of the Federal reform, obviously there’s the mandate that all shall have health insurance and purchase it. And, you know, just the work that we did over the years -- we met with lots of experts, and talked about that particular dynamic and how it relates to the cost of insurance when everyone is in, versus when everyone has the option of being in. That’s one of the main sticking points, of course, that a lot of the lawsuits are now based upon nationally -- by some of the governors who protest, and it’s about the mandate mostly. Can you explain, just in your opinion, why it is that it’s necessary to have the mandate?

MR. KNOWLTON: It doesn’t work without a mandate. Because insurance is about spread of risk, and you have to spread the risk. You have to have a bunch of homes that aren’t going to burn down to pay for the one that does. You have to have a bunch of drivers who never have an accident to pay for the people who do. And health insurance is one of the few places that everybody feels they don’t get their money’s worth if they didn’t use it. You don’t complain about your life insurance, “Gee, I didn’t get to make a life insurance claim this year.” So the problem is, if everybody isn’t in, it gets absolutely destroyed. I worry about that in the Obama reforms.
I -- editorial comment -- I think the reform you suggested, Senator, in your Phase 2, that would have allowed for automatic enrollment if you remained uninsured, was a more practical way than penalizing people -- minimum penalties that will cause people to adversely select out. You cannot pay for the sick -- you cannot pay for the sick without the help of the healthy. It's impossible.

SENATOR GILL: Thank you very much for your testimony today. Thank you very much.

MR. KNOWLTON: Thank you for the opportunity.

SENATOR GILL: And we will hear from the Department of Banking and Insurance, Neil Sullivan; a five-minute presentation.

ASS'T. COMMISSIONER NEIL SULLIVAN: Good afternoon. My name is Neil Sullivan; I'm Assistant Commissioner for Life and Health in the Department of Banking Insurance. And I have primary responsibility for the insurance reform aspects of the Affordable Care Act.

So a lot of ground to cover in five minutes -- that's a challenge; but let me give it my best shot.

The Department of Banking and Insurance-- The two major issues that the Department has been dealing with have been the Pre-Existing Condition program and the planning for the exchange. So a little bit of what's happened in the past, a little of what's been going forward.

We are part of an interagency task force working very closely with other agencies of the State that are affected by healthcare reform; working very closely with Valerie Harr, who you will be hearing testimony from. We have also been coordinating closely with other states and other
national associations to try to stay plugged into what's been going on, on a national level, with respect to healthcare reform.

The Department of Banking and Insurance has applied for and obtained from the Federal government grants for the implementation of the insurance reform aspects of the Affordable Care Act. We applied for and obtained a $1 million grant with respect to improving our rate review capabilities. We applied for and received a $1 million grant with respect to planning for the establishment of the exchanges. We applied for and received a grant that totaled approximately $900,000 to use for enhancement of consumer protection functions of the Department. We also entered into a contract through the Individual Health Coverage Program Board -- which is in, but not of the Department of Banking and Insurance -- to run what was originally called the High Risk Pool in the State of New Jersey -- what has come to be called the Pre-Existing Condition program.

And I'll spend a few minutes talking about that, because that's an important initiative. There's been made available $141 million in Federal funds under the Affordable Care Act, and we put a good deal of time and attention into looking at that and deciding how to implement that in the best interest of the residents of the State of New Jersey.

The rules established by the Federal government for eligibility are challenging for a state like New Jersey. To be eligible for the Pre-Existing Condition program, an individual has to have been uninsured for six months; an individual has to have a pre-existing condition; and an individual has to be here on a documented basis. The challenge for New Jersey is that we are one of only five states that already has guaranteed issue
in the individual insurance market, where it is already unlawful for insurers to reject an individual who applies for coverage on the basis of their health status, or to rate them up on the basis of their health status. Pre-existing condition programs, or high-risk rules, have traditionally been used in states where there is medical underwriting and, therefore, there are people who are shut out of the market because of their health status. That has not been true in the State of New Jersey. So a good part of the early implementation was in working with HHS to get them to accept some tweaks to the program that would make this work for the State of New Jersey. We have the option: We could either establish a plan for the state and in the state, or we could default to the Federal government and allow them to establish a high-risk pool in the State of New Jersey. And many states elected that option; close to half of the states elected that option. But we didn’t see that as the best option for the State of New Jersey. A key issue is our guaranteed issue status and how to make sure that this money is used to provide the most coverage to the most individuals in the state.

A lot of talk has been in the press about disappointing enrollment in the high-risk pools -- not just in New Jersey, but nationally. And so I’d really like to address that. We established, through the Individual Health Coverage Program, initially working with Horizon BlueCross BlueShield of New Jersey -- Horizon was the first carrier to step up to the plate to work with the State to use our individual insurance program to make these plans available.

We had to convince HHS that the requirement that the plans be offered at a standard rate don’t mean that the prevailing rates that apply in the State of New Jersey -- because we’re guaranteed issue, our individual
health coverage is already sold at a premium-- Because of that guaranteed issue there is adverse selection, as Dave Knowlton referred, so the prices are higher. So we need to track people in the State of New Jersey into a higher-risk pool. We need the ability to offer it at a lower rate.

Health status has not been the barrier to coverage in the individual market in New Jersey; affordability has been the barrier. And we work with HHS and they allowed us to establish these plans. Although they're richer benefits, they don't exclude pre-existing conditions from day one. They are 30 percent less expensive than the prevailing plans in the State of New Jersey.

As of the end of January, our enrollment in the Pre-Existing Condition program was 256 insured lives. And so there's been talk about the expectations for the plans, and the fact that the enrollment is low. There are five states that are guaranteed-issue in the United States. When HHS released data -- the most recent data on enrollment in the high-risk pool, on a national basis for every state, was released as of the end of December. Numbers were really skewed because they were as of the end of December for state-based high-risk pools; as of the end of January for the Federal. So they had an additional month in their enrollment figures. Nevertheless, New Jersey's enrollment was higher than the enrollment in 34 states and the District and Columbia. So we are, despite our guaranteed-issue status, and despite the fact that in many states this program could be more attractive to many more citizens, we are in that top tier. Among the five guaranteed-issue states in the State of New Jersey (*sic*), two of them, Vermont and Massachusetts, had no enrollment. So we're pretty proud
about the way that the high-risk pool, the Pre-Existing Condition program, has been implemented in the State of New Jersey.

Beginning in March, a second carrier will be available under this program. AmeriHealth has agreed and we have entered into a contract with HHS to bring in AmeriHealth, so their individual plans will also be made available to persons who qualify for the Pre-Existing Condition program. And we’re hopeful that that will further help to enhance enrollment in that program.

On September 23, many of the market reforms of the Affordable Care Act came into effect for plans with anniversaries on or after September 23. The Department, prior to that effective date, issued guidance to the industry on how to bring plans into conformance with the requirements of the Affordable Care Act. As Dave Knowlton mentioned, many of the requirements that are in the Affordable Care Act are already State law in the State of New Jersey, but others are not: the requirement that preventative services be offered without cost sharing; the prohibition on annual and lifetime limits, with the prohibition on annual limits coming in on a graduated basis between now and 2014.

One of the challenges for New Jersey is that we have a State law that establishes a basic and essential plan. That plan is the most popular plan in the individual insurance market. That plan covers 75,000 New Jersey residents. So under New Jersey State law, insurance carriers are required to offer several things: they’re required to offer three comprehensive plans that have no annual limits, that have no lifetime limits; and they’re required to offer a basic and essential plan which is a much less expensive plan, but does include internal annual limits on certain
services that could be considered to be essential benefits under the Affordable Care Act. They have limits on wellness benefits, on physician visits, on in-hospital diagnostic tests.

SENATOR GILL: Mr. Sullivan, I wondered: We could actually -- I know you have a wealth of information -- address this to the exchange.

ASSISTANT COMMISSIONER SULLIVAN: Okay; be happy to do that.

SENATOR GILL: Thank you.

ASSISTANT COMMISSIONER SULLIVAN: We applied for, as I mentioned, and received a $1 million planning grant for the establishment of an exchange in the State of New Jersey. Mr. Knowlton did, I thought, a very good job of describing many of the variables in the establishment of exchange, many of the challenges in the establishment of the exchange. So we have been using that planning grant money and intend to use it for several purposes. The most immediate purpose is stakeholder engagement. We have contracted with Rutgers Center for State Health Policy to run forums talking to different constituents that will be affected by the running of an exchange in 2014, to get their take, their opinions on many of those variable that are involved in establishing an exchange. So there have been forums that have been run under Rutgers with provider groups; there are forums that are planned throughout the month of March and into the middle of April with consumer groups, with employer groups, with health plans, and with brokers to get their input. That's the first part of the planning process -- is to find out what people think about those variables in the establishment of the exchange.
SENATOR WEINBERG: And how much of the $1 million was spent on that?

ASSISTANT COMMISSIONER SULLIVAN: That contract is for a little less than $250,000.

We also intend to use the planning grant to engage consultants to work on some of the issues, many of which Mr. Knowlton mentioned, that require some technical expertise: a lot of those issues with respect to adverse selection; a lot of those issues with respect to changes to the Medicaid program; a lot of those issues with respect to what are different options for-- Dave described some of the problems with people whose eligibility changes as you cross the magic threshold from 133 percent of Federal poverty level, and therefore the Federal responsibility -- threshold with respect to Medicaid eligibility, and move into the tax subsidy eligibility. To see how to coordinate the coverages between Medicaid and private plans in the best way.

So we have drafted a request for proposal; we are looking for consulting expertise on a lot of those design issues around those issues; around pros and cons of different governance models; around different financing models. As Dave mentioned, in 2015 there will no longer be Federal funds available for the establishment of the exchange and a New Jersey State-run exchange will have to be self-supporting.

SENATOR WEINBERG: Let me interrupt again for a moment, if I may.

Mr. Knowlton talked somewhat about the need for computers, or infrastructure, in order to be able to carry out any of these programs. Are you investing in that at all?
ASSISTANT COMMISSIONER SULLIVAN: Absolutely. So let me talk about the grants that have been accessed, the grants that are available in the future.

I mentioned the consulting services: One of the initial issues is an information technology gap analysis. We have certain capabilities in the State of New Jersey, primarily in the Medicaid operation, to perform eligibility and enrollment tasks. That will need to be built out to also have the exchange perform those tasks with respect to individuals who are not Medicaid eligible, but are subsidy eligible, and would be using the exchange. So the initial part is to scope out that gap analysis to determine exactly what are the additional software and hardware needs to perform those infrastructure functions, so that in future grant opportunity we can apply for the funds to execute on that and to have that information technology infrastructure out there.

There are a number of challenges around that, one of them being that HHS has not yet defined the technical specifications that will be required. So we can start the planning now, but we can’t finish it.

There are also expectations that there will be, sort of, developed through our Federal grants, some of the modules that may be necessary; and so that states will be able to access those modules -- as opposed to 50 different states building some of these pieces -- which will be, by definition, uniform throughout the United States.

SENATOR GILL: So to facilitate our time, please, if you have questions raise your hand and--

SENATOR WEINBERG: Go ahead.

SENATOR GILL: --we can participate.
Senator Cardinale.

SENATOR CARDINALE: Yes.

I think you said something that challenges my knowledge of what I thought we had in New Jersey with respect to pre-existing conditions. Did I hear you correctly? If Mr. X, who is uninsured, finds himself diagnosed as needing a heart transplant, can Mr. X go out and get a guaranteed issue policy in New Jersey?

ASSISTANT COMMISSIONER SULLIVAN: Under this Pre-Existing Condition program that I described, if Mr. X has been uninsured for a period of six months, and Mr. X has a pre-existing condition, he could buy a plan that will, from the first day, cover that pre-existing condition.

SENATOR CARDINALE: Is that what all of your 256 people in this plan have done? Are all of these folks people who have developed a serious illness?

ASSISTANT COMMISSIONER SULLIVAN: The requirement that was imposed by the Federal government is that they have a chronic condition. So not necessarily serious, but certainly serious would count.

SENATOR CARDINALE: Can it be an acute condition?

ASSISTANT COMMISSIONER SULLIVAN: We’ve been in discussions with HHS. They originally imposed the chronic condition upon us. We were looking to get the eligibility as broad as possible, and they required that we only apply this for chronic conditions. More recently we have seen HHS put out guidance, with respect to their own pools, that appear to be broader than that. So we are in discussions with HHS on that very issue.
SENATOR CARDINALE: The question occurs to me that you’re applying for grants and you’re spending certain funds based on the Federal law. I know, and I guess we all know, that a Federal judge has declared this law unconstitutional. Is it wise for us to be spending funds, making plans for something, which has already been declared by a Federal District Court to be unconstitutional?

SENATOR GILL: And I’m assuming that you can’t answer that (laughter). And the further question--

ASSISTANT COMMISSIONER SULLIVAN: Thank you, Madam Chair.

SENATOR GILL: That clearly is not within your expertise. Perhaps it could be a question proper to the Governor, or some other person.

But factually--

SENATOR CARDINALE: Madam Chair, let me rephrase my question.

SENATOR GILL: You know, Senator Cardinale, I always give you all of the time you need. But we do have other people to testify, and I think our more esoteric questions can’t be engaged here, because we have a whole list of people. So--

SENATOR CARDINALE: But I believe I can rephrase my question to overcome your objection to the question.

SENATOR GILL: Of it being esoteric, or the question itself? (laughter)

SENATOR CARDINALE: The question itself.

SENATOR GILL: We will--
SENATOR CARDINALE: Because I think it's an important question.

SENATOR GILL: You don't have to edit-- Ask the question, but in deference to the people who are here to testify, try to get that--

SENATOR CARDINALE: I realize I asked him--

SENATOR GILL: Ask your question, Senator.

SENATOR CARDINALE: --and you properly have corrected. I asked him to express an opinion with respect to something that he may not have the expertise to opine.

But let me ask you a different question: Are there any other areas where the Department is currently expending significant money gearing up for the implementation of any other law which has been declared unconstitutional by a Federal judge?

SENATOR GILL: That--

SENATOR CARDINALE: True or not?

SENATOR GILL: That-- We're trying to keep this so that we can get some information based--

SENATOR WEINBERG: And let me add, because I don't know what the Department is expending, so far it seems to me that they are expending money they're getting from the Federal government that is earmarked for this. Am I correct?

ASSISTANT COMMISSIONER SULLIVAN: That's absolutely true. None of these expenditures I have described have included State dollars.

SENATOR CARDINALE: But Senator--

SENATOR WEINBERG: Yes.
SENATOR CARDINALE: --the Federal government doesn’t have any money that it hasn’t first taken from taxpayers--

SENATOR WEINBERG: Wait a minute; you know--
SENATOR CARDINALE: And New Jersey taxpayers pay the most.

SENATOR GILL: Senator, in all--
SENATOR WEINBERG: Call your Congressman.
SENATOR GILL: --due deference, we’re going to move on.

Are there any other questions from any other Senator? Senator Vitale -- yes.

SENATOR VITALE: Thank you, Neil.

Can you describe -- and I may have missed this -- the number of grants that you have, that the Department has applied for, whether it’s DOBI or other departments in the State?

ASSISTANT COMMISSIONER SULLIVAN: I’m not aware of all of the grants outside of DOBI. We do have discussions with other agencies, but I wouldn’t be comfortable -- I really haven’t been tracking those. I can certainly describe the ones that the Department has applied for.

SENATOR VITALE: Just how many -- how many DOBI--

ASSISTANT COMMISSIONER SULLIVAN: Sure. Valerie can describe what-- So for the Department it was the $1 million Exchange Planning Grant; it was the $1 million Rate Review Grant; it was the $900,000 Consumer Assistance Grant.

SENATOR VITALE: For the high-risk pool.

Thank you very much.

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SENATOR GILL: Thank you.

Any further questions? (no response)

Thank you very much for your testimony.

ASSISTANT COMMISSIONER SULLIVAN: Thank you.

SENATOR GILL: Thank you.

SENATOR WEINBERG: Thank you. We would like to call Valerie Harr, the State Director of Medicaid.

VALERIE HARR: Good afternoon, Chairwoman Weinberg, Chairwoman Gill, and members of the Senate Health, Human Services, and Senior Services Committee, and Commerce Committee. My name is Valerie Harr; I’m the Director of the Division of Medical Assistance and Health Services in the Department of Human Services, and I have the responsibility of overseeing the CHIP, NJ FamilyCare, and Medicaid programs.

I will be speaking specifically today about the Affordable Care Act and the impact on the Medicaid and FamilyCare programs.

Since the Affordable Care Act has many provisions impacting Medicaid, we’ve been working over the past 11 months to assess the various provisions to begin responsible, appropriate implementation in compliance with those provisions.

The Division has built a tracking system for and management of the over 50 provisions of the Affordable Care Act that do impact the Medicaid program. That includes program integrity, Medicaid and CHIP eligibility, Medicaid and CHIP benefits, quality and access, long-term care, and demonstration projects.

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An example of the mandates associated with the Affordable Care Act: There was a change to the pharmaceutical and manufacturing rebates that are provided to the Medicaid program and retroactive to January 1, 2010. The Affordable Care Act increased the minimum rebate percentage from 15.1 percent to 23.1 percent of the average manufacture prices, and 11 percent to 13 percent for generic drugs. So we’ve been required to collect those rebates, as well as collect rebates on the pharmaceutical dispensing among our four participating HMOs. So we’re in compliance with that provision and are collecting those increased rebates.

We’re also in the process of establishing a recovery audit contractor to identify provider improper payments, overpayments, and underpayments. We submitted a State plan amendment in December 2010, and we anticipate having the recovery audit contractor in place by April 2011, which is another requirement under Affordable Care Act.

Additionally, we’ve applied to CMS to cover our 57,000 low-income general assistance adults to get Federal financial support for that program. We applied for a State plan amendment and, unfortunately, in the past few weeks, the Centers for Medicare and Medicaid Services did not approve that State plan amendment because, as you may know, this program does not include an inpatient or outpatient hospital benefit.

So we’re continuing to work--

SENATOR WEINBERG: I’m sorry, just-- If the program doesn’t-- What did you say?

MS. HARR: It does not include a hospital benefit for the general assistance population.
SENATOR WEINBERG: So therefore, what did we lose in Federal funding for that?

MS. HARR: It’s not-- We haven’t gained-- We don’t-- It’s currently a State-funded program. Historically, that’s what it’s been, and we’re trying to get Federal support -- Federal matching funds -- for that program. They disallowed the State plan amendment, but they’re continuing to work with us for us to seek another way to get Federal financial support for that program, probably through a waiver approach. So we’re in active conversations with them.

In 2014, the Affordable Care Act makes major changes to the Medicaid landscape. Currently, the Department of Human Services Division of Medical Assistance and Health Services covers approximately 1.3 million residents of New Jersey. Effective January 2014, Medicaid program eligibility will increase across the board to 133 percent of the poverty level. This will be for parents, childless adults, and children. New Jersey already covers parents and children up to that level, so the majority of the new enrollees in 2014 will be childless adults or adults without dependent children.

Using the census data, we estimate that an additional 380,000 people will become eligible for Medicaid. The enrollment expansion will be 100 percent federally funded for the first two years.

The Affordable Care Act also changes the way income is calculated for Medicaid eligibility. It will be modified to a calculation called modified adjusted gross income. It’s an IRS calculation. We are awaiting CMS regulations and guidance on exactly how that new calculation will work.
So with the anticipation of that new level of individuals entering the Medicaid program, we’re starting to think about and create the vision of what the Medicaid program should look like, in anticipation of 2014. We’re looking at making data-driven decision making, relying more heavily on health information technology, looking at patient-centered medical homes, health behavior incentives, and increased access to home- and community-based services -- all in anticipation of sort of that new Medicaid landscape.

The Affordable Care Act will require Medicaid payment rates to primary care physicians to be no less than 100 percent of Medicare starting in 2013 -- and I know you had some discussion about primary care access -- And so in 2013 and 2014, we will be required to increase primary care reimbursement to 100 percent of Medicare. The fact that this increase is only funded by the Federal government for two years is of concern to the State, and how to maintain an adequate network beginning in 2014, and then knowing that in 2015 the responsibility of that increased provider reimbursement will need to be shared by the State.

New Jersey, unfortunately, has the distinction of ranking among the bottom, nationally, in reimbursement rates for Medicaid, so it will be considerable cost for New Jersey to maintain that increased provider reimbursement rate.

With the expansion of Medicaid to the--

SENATOR WEINBERG: I’m sorry. Again, I’d just like to get this straight--

MS. HARR: Sure.
SENATOR WEINBERG: --in terms of the discussion we had a little earlier about the loss of primary care physicians.

We know that Medicare rates are pretty low now. So what percentage of Medicare rates does Medicaid pay to primary care physicians?

MS. HAAR: Medicaid’s primary care rates are currently about 34 percent of Medicare. So in 2013 and 2014, we will have to increase our Medicaid primary care rates from 34 percent of Medicare to 100 percent of Medicare.

SENATOR WEINBERG: Which might have answered the earlier question about one of the reasons we’re losing primary care physicians. Thank you; go on.

MS. HARR: So the Affordable Care Act provides enhanced funding for states to pursue medical homes, and New Jersey legislation had been enacted requiring the Medicaid programs begin a pilot demonstration around medical homes. So I’m pleased to let you know that we’re actively working with our contracted managed care organizations to implement a medical home pilot, and last week we issued memorandums of understanding with our four contracted HMOs to begin implementing that medical home demonstration.

We also have many technology initiatives underway that will help us get to 2014 and, again, I think as you heard some of the discussion about the IT requirements under the Affordable Care Act, I think the Medicaid program is-- We’re in a very good position. We’re in the midst of building a new eligibility system that would be utilized by all 21 county welfare agencies. The system could be used as a building block for a health insurance exchange. We’re also in the process of procuring a new fiscal
agent -- that’s our Medicaid Management Information System -- that processes all of the claims to our providers. And we recently submitted a Medicaid health information technology plan to CMS to promote the use of health information technology and electronic medical records. And under that, in the fall of 2011 we will be making incentive payments to providers that are adopting electronic medical records. That is 100 percent federally funded by CMS, but the funds will flow through the Medicaid agency.

SENATOR WEINBERG: Is there a limit on that Federal funding -- a limit of time?

MS. HARR: Yes, I think it’s through -- I could confirm this for you -- but I think it’s through 2016. There will be several stages -- several installments, of that funding. The providers need to show meaningful use and meet certain criteria to continue to receive those incentive payments.

SENATOR GILL: And with the medical records, does the State have to build an infrastructure to make sure that we have a high degree of privacy, where you can’t-- In other words, someone cannot hack into the medical records, and who can see the medical records, and things like that?

MS. HARR: Right, absolutely. There are privacy requirements. We are working in coordination with the Director of the State HIT office in the Governor’s Office, as well as the Office of the National Coordinator. And yes, there would be -- and we would make sure that we respect and meet those privacy requirements.

We continue to be mindful of the Affordable Care Act and the impact on Medicaid, making sure we’re in compliance with the enacted
provisions and regulations, while balancing the current challenges and opportunities for the Medicaid program.

So again, I thank you for the opportunity to speak, and I’d be happy to take any additional questions.

SENATOR GILL: Thank you very much.

Any questions? Oh, I cannot believe it.

Senator Cardinale. (laughter)

She doesn’t know anything about Federal law.

SENATOR CARDINALE: You’re planning to triple -- as I understand it -- your reimbursement in, is it two years from now?


SENATOR CARDINALE: Okay. Where are you going to get the money?

MS. HARR: Right. So in 2013 and 2014, because of the concern about all the people who would be newly eligible under the Affordable Care Act, that’s 100-- The difference between where we are now and where we would need to be is funded by the Federal government. But the problem is, after those two years, if the State wants to sustain that level of reimbursement, the State must share in the cost. So it is a very good question; it’s something we will all have to, I think, be challenged and decide.

SENATOR CARDINALE: So that absent a major Federal appropriation, that we can’t really rely on today because that appropriation hasn’t been voted on by the Congress for two or three years hence, this Affordable Care Act is going to triple New Jersey’s obligation under the Medicare program. Is that an appropriate assessment?
SENATOR GILL: I don't think that-- Are you qualified to answer that question?

MS. HARR: Correct. I don't know the long-term -- the financing -- of the Federal Act.

SENATOR GILL: Thank you.

SENATOR CARDINALE: Someone's going to have to pay for it.

SENATOR GILL: We'll find out for you, Senator Cardinale.

SENATOR CARDINALE: Thank you.

SENATOR GILL: That's one of those esoteric questions. Senator Vitale.

SENATOR VITALE: Thank you, Senator Gill.

Thank you, Valerie, for coming.

I want to stay on the Medicaid discussion for a moment, and there was a question I wanted to ask earlier that's more appropriate to ask you, and that's -- just help me out with this, because I'm not good with math; they threw me off the Budget Committee -- those who are currently in the Medicaid programs, when the Federal Act is fully implemented, those who are already in will maintain a certain rate of reimbursement to the State; those who are newly eligible after will get the higher match? Is that correct?

MS. HARR: Yes, correct.

SENATOR VITALE: So for example: There are how many people in Medicaid today?

MS. HARR: One-point-three million Medicaid and CHIP -- 1.3 million.
SENATOR VITALE: Right. And so in 2014, we continue to get this-- What do we have, 60-40 match with Medicaid?

MS. HARR: Medicaid, it’s 50-50 Medicaid--

SENATOR VITALE: Right.

MS. HARR: --after we lose the enhanced ARRA stimulus funding, it’s 50-50. It’s 35 percent State share, 65 percent Federal for CHIP.

SENATOR VITALE: So those numbers stay the same for those already enrolled in Medicaid, right? So then I guess the question is -- and it’s tricky, I guess. After 2014, those who become eligible -- not who are eligible for, but not yet enrolled -- those who become eligible after 2014 we will get 100 percent match for the first couple of years from the Feds.

MS. HARR: Right. That’s the newly eligible; that’s the 380,000 people who I’m talking about, yes.

SENATOR VITALE: Right. And after-- And in the third year, the match -- well, gradually goes down to where’s it’s 88 percent match Federal, 12 percent State.

MS. HARR: Correct.

SENATOR VITALE: As opposed to 50-50 today. So we don’t know what the-- We’ll have to do this study, we don’t know what the cost effect will be when we certainly go up in coverage -- go up in reimbursement, rather, from the Feds; which is a good thing, because we’re only paying 12 percent, not 50 percent. We’re also increasing the number of people who are in the program. So I don’t know how that’s going to balance out in terms of dollars and cents.
So there will be two populations that we will be reimbursed for, right? Those who are already in and should have been in before, and those who are newly eligible after.

MS. HARR: Right. Eligible but not enrolled, versus a new category of eligibility: childless adults are not categorically eligible for Medicaid today. They will be in 2014.

SENATOR VITALE: Right. And we’ll get the high max then.

MS. HARR: Yes. I did want to point out -- I heard your earlier comment that for those individuals -- the parents, over 133 percent of the poverty level -- the State would have an option to -- Those individuals could move into an exchange and be eligible for a subsidy, or State Medicaid program could offer a basic -- continue to cover them -- offer a basic health plan and take the Federal subsidy. I don’t know all the details. I think there are definite pros and cons to that, but really I think that what happens is you draw a line in the sand around -- at 133 percent of poverty -- going forward, in terms of the Medicaid program, and the sort of categorical eligibility goes away.

SENATOR VITALE: Setting aside -- last question -- setting aside the overall cost of all of this, if we were to incrementally expand eligibility in Medicaid now, today, starting next month and going forward to 2014, for childless adults and parents who were no longer eligible for FamilyCare, and began to enroll them in Medicaid, once 2014 came would we get a higher match for them?

MS. HARR: Correct. If we expanded coverage today, it would be 50 percent State share, 50 percent Federal share. But you would be held harmless in 2014 and get the full Federal funding.
SENATOR VITALE: So somebody who is better at math than me could sit down and figure out what it is that-- And I think that we will benefit if we make the investment now, because we'll see an enhanced investment or an enhanced match after 2014. Yes, we have to make a greater investment now in spending Medicaid, but once 2014 hits we get held harmless on those individuals, and then it gets a little bit lower at 88 percent; as opposed if we do nothing with them now, we don't expand now, and then we stay at 50-50 match, when 2014 comes they're going to remain at 50-50 because they were eligible but not enrolled -- is that right? Do they stay at 50-50?

MS. HARR: No. So the childless adults that we're talking about are not eligible today.

SENATOR VITALE: But I don't mean childless adults; I mean those who are not currently enrolled.

MS. HARR: So we have individuals eligible for Medicaid today; for whatever reason they have elected not to enroll. We would get 50 percent match on them today; we would get a 50 percent match on them in 2014.

SENATOR VITALE: What population will we get a higher match on -- if we enrolled them today -- in 2014, if we increased enrollment? Is there a population?

MS. HARR: That we would get a higher match now?

SENATOR VITALE: Later.

MS. HARR: That's the childless adult population. If we expanded today, we would get a regular Federal matching rate. So we
would have to have 50-- You know, half State, half Federal; but in 2014 it would be all Federal.

SENATOR VITALE: One hundred percent.
MS. HARR: Hundred percent.
SENATOR VITALE: Thank you.
SENATOR CARDINALE: Madam Chair, I have a point of order.

SENATOR GILL: Yes.
SENATOR CARDINALE: Senator Vitale has asked some very important questions. And he’s asked these very important questions about what’s going to happen in 2014. The witness has information which I think is good for us to generate. But when I ask questions about what’s going to happen in 2014, the Chair seems to feel that this witness does not have the information to answer my questions. I do not understand that procedure.

SENATOR GILL: Well, let me explain. The questions asked by Senator Vitale are based on the information and the numbers presented in her discussion and the laws as they exist. You asked a question based upon a hypothesis of information that was not presented here.

SENATOR CARDINALE: That’s not correct. Maybe you misunderstood my question.

SENATOR GILL: Well, we’re not-- I misunderstood your question, but what we will do is that we will come back to her at another point; we’ll finish these others. Would you be available to stay?
MS. HARR: Yes.

SENATOR ALLEN: Senator, if I could-- I think we would appreciate it if we could just deal with that question now while she’s here.
SENATOR GILL: What is the question?

SENATOR CARDINALE: It’s a very simple question. This witness told us--

SENATOR GILL: What’s the-- Okay.

SENATOR CARDINALE: This witness told us--

SENATOR GILL: What is the question?

SENATOR CARDINALE: She gave us information, and my question is based on information that she gave us.

SENATOR GILL: Ask the question.

SENATOR CARDINALE: You’ve told us-- It’s a repeat question; I think you know what the question is, but let me repeat it. You have told us that our 34 percent reimbursement rate is going to go to 100 percent reimbursement rate -- that’s tripling.

MS. HARR: Yes.

SENATOR CARDINALE: Roughly tripling of our reimbursement rate. Now, that is a tripling of New Jersey’s expenditure with respect to this program. My question was: How much is that going to cost New Jersey, and how is that proposed to be financed under this Act that is termed affordable health care?

MS. HARR: Okay--

SENATOR GILL: Which is a different question, but we’ll let this-- This one is better formed. Go ahead.

MS. HARR: Okay.

SENATOR CARDINALE: I understand--

SENATOR GILL: Listen, you could--
SENATOR CARDINALE: Well, I understand-- You have to understand, I'm not a lawyer so I don't-- I understand lawyers second-guessing my question.

SENATOR GILL: No, I understand doctors just want to get a second opinion.

MS. HARR: So right now, as the Affordable Care Act is written, is that in 2013 and 2014 we must triple our primary care Medicaid reimbursement rates up to the Medicare rate. That's estimated to cost us -- cost -- several hundred million dollars each year. Those first two years, as the Act is written now, is that the Federal government would pay for that increased reimbursement level. But after those two years, again as the Act is written today, if a state wants to maintain their reimbursement levels up to that level they have to provide the state matching funds. So I think that, just to restate, you said where-- We would have to address where would the State funds come from if the State chose to maintain that higher level of reimbursement after that enhanced Federal funding expires.

SENATOR CARDINALE: And let me opine, Madam Chair. It can't come from anywhere but the taxpayers of the State of New Jersey. And that's the point I am trying to get across.

SENATOR GILL: And you--

SENATOR CARDINALE: That affordable health care is a word that may not be very affordable for the taxpayers of the State of New Jersey, given the circumstances that this Act also brings with it. It's not affordable; it's probably breaking the bank.

SENATOR GILL: Thank you very much, Senator Cardinale.

And thank you.
I'm going to call a panel together: Ward Sanders from New Jersey Association of Health Plans; New Jersey Hospital Association; I don’t know if Fred Jacobs is here or -- you didn’t identify yourself; and the Employers Association of New Jersey -- John Sarno.

So you know we have some background, so we’d like you to zero in.

WARDELL SANDERS: Sure.

I’ll start. Ward Sanders with the New Jersey Association of Health Plans. My organization represents the major health plans in the state that insure or administer benefits for about 7 million New Jersey residents.

And we thank the Chairwomen for inviting us to testify today.

I will issue one little caveat, and that is: from the invitation yesterday I haven’t had a chance to really vet these comments with my plan members. I’ve done my best to sort of identify areas of common interest and common thought around exchanges and around Medicaid expansion.

First, on the exchanges: Just to be clear, Health Plans believes that -- the ultimate goal here, that we have, is really the same as the legislation -- is to make sure that residents have access to high quality and affordable coverage. The exchanges, we believe, are a mechanism or a tool to get to that and we’re supportive of the notion of an exchange.

It’s just important to remember that exchanges are really just one vehicle or mechanism of a distribution channel for accessing coverage. Health Plans does have the business and technical expertise to aid the State in creating a workable exchange, and we will clearly work with the State and
legislators to do our best to contribute to that process, and we want to partner with the State.

We do believe that states are best positioned to create -- and are advised to create -- local exchanges that are state-based. While there is an ability for the Federal government to step in, in the absence of State action, we don’t believe that it’s really in anyone’s interest to have the Federal government step in and create a solution from outside the state for what New Jersey should do. We feel very strongly that the State is best positioned to do that; and that the Federal government will be evaluating our progress on January 1, 2013, and that we will need to act with some alacrity to make sure that we meet the requirements of that to move forward the State-based program.

We will have -- as Mr. Knowlton and others have pointed out -- a number of key decision points. So I was going to mention, just at a very high level, some of the concerns or positions that we have, really, on the architecture of this exchange.

First, with respect to governance: We believe that the exchange needs to be independent and transparent, and largely devoid of political influences. We would recommend a broad constituency of stakeholders involved in the governance of this with consumers, employers, health plans, and other organizations and persons with experience in this area to help run this.

The second point is with respect to efficiency. We really -- this is a very important point to us -- we really want to make sure that there’s not overlapping regulatory responsibilities. So for example: Currently the New Jersey Department of Banking and Insurance reviews policy forms, and
rates, and solvency requirements. What we really don’t want to see happen is an exchange that has a separate regulatory responsibility in these areas, so that on one hand the exchange is telling us that we have to do X, but the Department of Banking and Insurance, meanwhile, is telling us we have to Y. There are plenty of roles for the exchange to play, but we do not want to see an overlapping responsibility with potentially conflicting regulatory requirements.

In a similar vein, there are elements that are going to be required of this regarding, for example, quality standards. We would really like to see national standards be used, rather than sort of home-grown standards. For example, the NCQA does a very nice job with national standards for national plans that have to, state-by-state, tailor 50 different mechanisms to measure metrics on quality -- it’s a little challenging. We don’t believe that there-- While there are substantial costs that are associated with that, the complexity and so forth -- and without an incremental value -- is an important point. So to the extent that there are national standards that can be used in some of these areas for measurement, we would request that they be used.

Third, on product offerings: We would like to ensure a broad range of consumer choices. The requirements of the Federal law are pretty strict. An issuer has to be licensed in good standing; has to offer at least one of the metallic plans -- a silver or gold plan; and charge the same premium whether it’s in or outside of the exchange; and they have to sell a qualified health plan that’s certified by the exchange. We believe that any plan that -- that there should be a vibrant market, and that the market should be competitive, and folks should be -- if they meet the requirements
-- be permitted to sell in the exchange without restriction. Also we believe the carrier should be able to offer products outside the exchange if necessary.

So I think that will be necessary for folks who are undocumented, as undocumented will not be permitted, I don’t think, to purchase through the exchange. You know, New Jersey has had a similar experience in the early ’90s with the reform--

SENATOR GILL: We’re not going to go back in history at 4:30, 5 o’clock. So we’ll keep it on--

MR. SANDERS: Okay.

And two other very quick points -- to make sure that I’m consistent with the timeframe here -- is that we would like to keep the individual in small group markets distinct and a large group market distinct from the exchange as well.

I had a number of points on Medicaid exchanges, but -- I’m sorry, on the Medicaid expansion, but the Medicaid Director did a really good job of explaining that. I will say that there’s clearly a chasm between the folks who are eligible for subsidies and those who can afford coverage. And we are ready to partner with the State to try and assist where subsidies are provided to help those folks be able to afford coverage.

And again, just on the undocumented: We will-- I think our uninsured rates -- someone was asking what that is -- it’s about 1.3 million to 1.4 million residents. It’s about, I think, about 15 percent of our population. We will continue to have an uninsured population because we have a fair number of undocumented--
SENATOR GILL: What is it that-- Okay. So we kind of get that.

Do you have any other points?

MR. SANDERS: No, I'll close with that.

SENATOR GILL: Okay, thank you very much. And thank you for your testimony.

Next, please -- identify yourself.

NEIL EICHER: Good afternoon. My name is Neil Eicher from the New Jersey Hospital Association. I promise I will be brief.

Like the Committee, we're trying to get our heads around the post-reform era. As such, the Association -- we created eight separate work groups to kind of handle the Affordable Care Act over the next few years, and, as such, we'll be producing policy papers. We produced one on health insurance exchanges last year and, through the Chairs, I would be happy to submit it to the Senate Commerce and to the Senate Health Committee.

We tried to bring in some national expertise for the Committee hearing, but on short notice we were unable. However, we remain available as a resource to bring in whatever representatives from the Federal government to speak on this issue in months and years to come.

Specifically on the exchanges: I just wanted to highlight two recommendations that we offer in our white paper. The first has to deal with enrollment. We believe that hospitals, as a point of service facility, should play an integral role in enrollment for Medicaid and the exchange -- either some form of direct enrollment, some automatic enrollment or, if that's not possible, at least some real-time connection through HIT mechanisms with the State -- to be able to do some sort of income
verification and automatically enroll these people in insurance so that we don’t send them out after treatment and they are uninsured, and then come back as uninsured. We want to do whatever we can to assist the State in the enrollment process.

And secondly, I will say with respect to adequate networks: We want to make sure that -- even though people have an insurance card, it’s not successful unless they have access to care. So we want to ensure that there are adequate primary care and specialty networks for these newly insured people.

Thank you.

SENATOR GILL: Thank you very much.

Next witness, please.

JOHN J. SARNO, ESQ.: Yes, John Sarno.

UNIDENTIFIED MEMBER OF AUDIENCE: (Indiscernible)

MR. SARNO: Okay, I’m going to move up.

SENATOR GILL: And as you move up, I’ll call Christine Stearns from the NJBIA.

MR. SARNO: John Sarno, Employers Association of New Jersey. I’ve e-mailed a statement, so I’ll just briefly comment on two related features in connection with the exchange.

One, Dave Knowlton mentioned-- He referred to it as crowding out -- that is, employers simply getting out of the game, getting out of the healthcare game. And related to that is purchasing power -- the type of purchasing power that the exchange may have.

So let’s talk about crowding out really quickly. There’s no requirement-- The Affordable Care Act does not require any employer to
provide insurance to any employee. In fact, when you look at the incentives, and you look at the subsidies, and some of the modest penalties in the bill, there's actually an incentive for employers not to sponsor health care. Why do I say that? Well, if you're an employer -- a small employer, 50 or less employees -- there's going to be no penalty for either discontinuing insurance or not providing it in the first instance. And that, of course, is our small market in New Jersey right now, which insures about 800,000 people, right? No penalty.

If you're over 50 employees -- employers over 50 -- then there's no penalty for-- There's no penalty either if you provide what's called a free choice voucher to your employee. And what that is, is basically what it sounds like: It's a voucher that -- the employee goes into the exchange and it helps that person purchase insurance. So if the employer decides to do that, no penalty. The only penalty, and it's modest, for an employer -- mid-size or larger -- that discontinues insurance or gets out of insurance entirely is if the employee gets a subsidy. Now, what does this mean? That means that conceivably we're going to have a market in New Jersey that migrates from a small group plan to an individual market, I should say. And that's going to have an enormous impact on the exchange, what it looks like, how it operates.

Now, David said that -- he implied -- that crowding out is a negative thing. Well, I-- It's not necessarily a negative thing, because employers and businesses generally will focus on what they do best: They can get out of the health and welfare business, focus on what they do best -- which is to be competitive. So we're looking at an exchange and a process which could have a tremendous competitive impact on business in the state.
I just want to be clear about that: This is not just regulation in health care and what’s affordable, what’s not. If we do this right, we can have a tremendous competitive business environment. We can decouple; in other words, we can have true portability in New Jersey, where an employee doesn’t have to worry about their employer providing the insurance. They’ll have it on their own, and they can take that insurance from -- wherever they go.

So that’s a tremendous positive, it’s a tremendous opportunity that, quite frankly, hasn’t been addressed in any statement thus far.

The other thing -- and I’ll end with this -- is the purchasing power. What is this exchange going to do? Right now, the small employer market in New Jersey has 800,000 people, right? We just said that. If I was a corporation with 800,000 employees, that gives me enormous, enormous bargaining power. And you know what? I’m going to self-insure, although the incentives for self-insurance will no longer be there in 2014. So let’s say I go to a carrier -- right? -- and I negotiate with that carrier. And that’s why the insurance premium for a large corporation is substantially smaller than what a small employer pays in New Jersey -- because they have bargaining power.

So the question, the decision point: is the insurance exchange going to be able to bargain directly with a carrier? Because they’re going to have 800,000, a million, 2 million lives. So is it going to be a passive exchange, a website where people just shop? Or will the State of New Jersey use that power to negotiate with a carrier to bring reductions to the small employer?
So those are the two comments that I'll leave you with, and if you have any questions I'll be happy to answer them.

SENATOR GILL: Ms. Stearns.

CHRISTINE A. STEARNS, ESQ.: Thank you, and thank you for giving me the opportunity to speak today. I will try to be brief.

You have written comments from me that I believe have been distributed to you. And I’m here to be a resource if you have any questions. I know this will be an ongoing dialogue that New Jersey will be engaged in as we go forward in the next couple of years.

There are just a couple of quick points I'd like to make. First, I would like to express my appreciation to Chairwoman Gill for her comments as she opened this, to say that when we say consumer we don’t just mean individuals, we also mean small business. Because I think that is a very important point that -- remembering that small businesses are very key to the discussion of how we put the exchange together and how it’s designed, and are a key component to their success in the future.

And I know that many of you have listened to me for many years talk about the importance of ensuring that health insurance remains affordable or within the reach of small businesses in New Jersey. In recent years, as the economy has taken a downturn and insurance premiums continue to climb, health insurance has become out of reach for many small employers and we’ve seen a significant drop in the number of people who are covered in the small employer market.

So for many of them, they look to the exchange not becoming a choice fast enough for them, and are really hoping it provides a meaningful alternative for something that is more affordable.
So that choices that the State is going to make -- in terms of what size employers are permitted initially into that marketplace; whether individuals and small employers are put altogether in terms of the pricing, and what impact that will have on cost; what the State does with adding on to the package of what is considered essential benefits, and whether we add what are currently mandates in New Jersey which will impact the cost of the benefits -- are all really sort of key decisions that we make, and I think something that we should all think about very carefully in terms what it will do to continue to put health insurance within reach for small employers.

So with that I will conclude my remarks, because I know the hour is getting late.

SENATOR GILL: Thank you very much, both of you.

Now we will have the next panel: New Jersey Citizen Action, Ev Lieberman; and New Jersey Policy Perspective, Ray Castro.

Oh, you can move up; we don’t bite -- just sounds like we do.

EVIE LIEBERMAN: Good afternoon, Chairwoman Gill, Chairwoman Weinberg, and members of the Committee. Thank you so much for holding this important hearing and giving us the opportunity to speak today; and for those of you who are still here, for being here still.

Citizen Action, as you may know, is the State’s largest independent citizen watchdog organization. And we also lead a large consumer healthcare coalition representing approximately 70 organizations that collectively represent around 2 million residents here in New Jersey. And it is on behalf of Citizen Action and that coalition that I’m here to speak today.
We believe that the establishment of New Jersey's health insurance exchange is of the utmost importance to New Jersey consumers -- healthcare consumers, patients -- and, in fact, many regard it as the heart of Federal health reform. And that mechanism, that at least holds the promise of bringing us the greatest benefits, particularly to low and moderate income families who by far will get the most benefits from the exchange -- both in terms of access to coverage and access to subsidies -- as well as small business owners, and really as to our State as a whole and to all taxpayers, in that it will be, if it's done well, a mechanism that can reduce costs.

But fundamentally -- and I'll go over some of the issues that you've heard about and give you our views on some of them, as well as expand on some of them -- we believe that an exchange must work for us as consumers and patients; that it must provide us the best coverage at the best price, and protect and negotiate on our behalf; be independent of conflicts or free of conflicts, whether those conflicts come from the industry or politics.

It's interesting and important that the establishment of the exchange is the only provision under the Affordable Care Act that requires states to include stakeholders in the planning process. We know that the State, as you've heard, has gotten a $1 million planning grant, in part to have that stakeholder process, and we are looking forward to being involved with that and hearing more from the State about their plan to solicit and incorporate our views.

So I think David Knowlton gave a really terrific overview of the myriad of issues that are involved; I won't go through all of them, but I do
want to highlight some of the ones that we think are most important to consumers.

The first is, is that we do believe New Jersey’s exchange, like in Massachusetts and in California, should be what we are referring to as an active purchaser. We will provide the Committee with more detailed written testimony, but one of the things I have provided today is a report that was released by the Robert Wood Johnson Foundation, along with the Urban Institute, just two days ago about health insurance exchanges and Medicaid, and how they will impact the State. In New Jersey what they tell us from that report is that--

SENATOR GILL: Do we have the report?

MS. LIEBMAN: You do have the report -- yes.

SENATOR GILL: Okay, so do you want to highlight what’s important in the report to you--

MS. LIEBMAN: Yes.

SENATOR GILL: --or do you want--

MS. LIEBMAN: I just want to point out a couple of statistics from the report--

SENATOR GILL: Okay, please do.

MS. LIEBMAN: --in terms of illustrating how large the exchange will be, and in the context of a market and the value to consumers.

Their estimate is that the exchange will serve almost 600,000 non-elderly healthcare consumers; 28 percent of these consumers will be under 200 percent of the Federal poverty level; 18 percent will be between 200 and 300 percent; 10 percent will be between 300 and 400 percent; and
43 percent will be above 400 percent. So what we are going to see in the exchange is a majority of consumers who are low- and moderate-income, and who will have access probably for the very first time to affordable coverage.

Those who access insurance through the exchange will also be accessing the subsidies through the exchange -- a major component of that affordability equation. The Robert Wood Johnson report estimates that for this population they will be able to access up to $700 million in subsidies to offset the cost and make insurance more affordable. So it gives you a sense of the size of this pool, the strength of its ability to use its purchasing power, to negotiate with carriers for the best possible products at the best possible price. And for that reason we believe that New Jersey’s exchange -- and we hope we will be here again to talk about various legislative proposals -- should designate our exchange in New Jersey as an active purchaser; that it uses our marketing power to our benefit as taxpayers and consumers to get the best possible product.

And what that does is it puts those of us who aren’t fortunate enough, necessarily, to work for a very large corporation or the State of New Jersey on a level playing field. Because those large, self-insured plans -- the State of New Jersey, right now, very much uses their purchasing power to negotiate the best health coverage and best health services for their employees. And that is what New Jersey taxpayers, New Jersey residents who can’t access insurance through that system, should have as well.

SENATOR WEINBERG: We’re--

MS. LIEBMAN: Yes?
SENIOR WEINBERG: If you could kind of get to the bottom line of your suggestions here, and move to Ray so we can hear from him, too.

MS. LIEBMAN: Sure, okay.

I just wanted to point out that that is the opposite of the Utah model or the take-all-comers, very passive approach, which some also dub the craig’slist approach to health insurance exchanges, where you just throw up a website and let anybody post anything and let the consumer fend for him or herself.

I want to just speak briefly about what David talked about in terms of adverse selection -- the idea that we--

SENIATOR GILL: We’ve heard about adverse selection. If you want to add--

MS. LIEBMAN: I just wanted to give you some examples of the types of market rules that we should be considering to prevent adverse--

SENIATOR GILL: Okay, but we don’t have to go through the whole explanation of adverse selection.

MS. LIEBMAN: No, no, no.

SENIATOR GILL: Okay.

MS. LIEBMAN: So some of the types of things that other states have considered, and that we think New Jersey needs to consider to prevent adverse selection or cherry-picking, are things like requiring insurers that sell insurance outside the exchange to comply with all the requirements applicable to plans sold inside the exchange; prohibiting insurers that participate in the exchange from establishing separate affiliates to sell only outside the exchange; prohibiting insurers from using marketing practices or
benefit structures intended to attract healthy applicants to plans outside the exchange, while discouraging unhealthy applicants; and prohibiting brokers from collecting higher commissions for plans that are sold outside the exchange, thereby discouraging them from directing consumers into the exchange.

We also believe that we need to give serious consideration to combining our individual and small group markets. We believe, and many health economists agree, that health insurance markets work best when risk is shared across large numbers of subscribers.

We also believe that at a minimum the Department of Banking and Insurance, which I think is the most likely agency, should be preparing and making public up-to-date actuarial analyses so we can make the best decision about how and if to merge these two pools, so that we get the best bang for our buck and better serve both small business owners and consumers.

We believe that we should have an independent public exchange, not a not-for-profit corporation. The main reason that we think it should be an independent public body is that the exchange should be open to open meeting laws, public disclosure laws, the Sunshine Act; that their agendas, their meeting notes, should be public; and that the public has an opportunity to also interact with the board.

We think that the board needs to be independent. We also think that healthcare consumers should have a seat at the board, but that any entity that has a financial interest in the exchange should not sit on that board; and we do not think that any appointed officials,
commissioners, other State regulators should sit on the board but should serve in an advisory capacity.

We also--

SENATOR WEINBERG: Excuse me, you-- We heard Neil Sullivan testify about the $250,000 grant that went to Rutgers to engage stakeholders. Have you been involved with that at all?

MS. LIEBMAN: I’m aware that they have been retained to conduct a process to get stakeholder input. Citizen Action has not yet been contacted in any way to participate in that process.

SENATOR WEINBERG: Okay. It is getting really late, so we have to wind this up. We would like to hear from Mr. Castro.

SENATOR CARDINALE: Madam Chair, I have one quick question for this witness.

SENATOR GILL: That’s not up to you; I’m not holding my hand up to you (referring to her raised hand); that was the sun (laughter).

SENATOR WEINBERG: The sun is coming right into-- (laughter)

SENATOR GILL: Of course.

SENATOR CARDINALE: I would never accuse you of violence.

MS. LIEBMAN: Just two more quick points--

SENATOR WEINBERG: Did you say you have a question?

SENATOR CARDINALE: I have a question.

SENATOR WEINBERG: Go ahead.

SENATOR GILL: The Senator has a question.
SENATOR CARDINALE: You tell us you want a public entity as this exchange. And we have had -- it's not recent -- but we have had a great deal of experience with a public entity in auto insurance called the JUA; it turned out to be a disaster. But you add an element to it. You say you want this public entity to have, essentially, no competition from entities which are outside. Do you really believe that monopoly leads to lower prices? America was built on competition, and competition leads to lower prices. Why is it, if you think this exchange is good, you are afraid to have private entities competing with it?

MS. LIEBMAN: Senator, perhaps I misspoke. When I was referring to a public agency, I was referring to that entity that would govern the exchange and manage the exchange. I wasn't speaking to the carriers that would operate within the exchange. What we anticipate is that there will be, hopefully, vibrant competition--

SENATOR CARDINALE: I understood that.

MS. LIEBMAN: Oh, I'm sorry.

SENATOR CARDINALE: If I appeared not to, I fully understand that you are referring not to the insurance companies being public entities.

MS. LIEBMAN: Well, I don't think it would serve New Jersey consumers or small businesses to have multiple exchanges run by multiple governing authorities.

SENATOR CARDINALE: But you suggested specifically that any company outside the exchange that was selling a similar product to what would be sold in the exchange, would have to be guided by all the rules and regulations that governed the companies in the exchange,
therefore eliminating any possibility of competition. Competition drives prices down. What happened to auto insurance in New Jersey when we allowed more competition? We no longer have a problem of affordability and availability for our constituents, because eight or nine years ago we got smart and we allowed competition. Why do you want, in health insurance, to prevent competition?

MS. LIEBMAN: My suggestion was that that was one type of market rule that could be examined in the context of avoiding adverse selection. It may not be a market rule that fits for New Jersey, based on our market and based on the level of competition, but these are the types of policy options or policy alternatives that should be examined. And we do believe there should be market rules, that work beyond those that are already in the Affordable Care Act, to manage adverse selection so that the exchange succeeds.

SENATOR CARDINALE: I don’t really understand your answer, but I’m not going to pursue it because the hour is late.

SENATOR WEINBERG: At 10 minutes to five you don’t ask to understand your answer.

SENATOR CARDINALE: I understand, I understand. I’ll stop.

MS. LIEBMAN: Just two quick points, and then I will turn it over to--

SENATOR WEINBERG: Okay, please -- we really have to finish this now and I would like to move to Mr. Castro. So we have a copy of the report that you referred to, so if you would just sum up now.

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MS. LIEBMAN: Just one other point -- expand a little bit on what David Knowlton raised in terms of cultural competency.

SENATOR GILL: We don’t need-- I’m not-- An expansion on what someone else said-- Is there anything else new you want to add?

MS. LIEBMAN: Yes. What I wanted to suggest is that, in the system of navigation, that New Jersey should encourage, if not mandate, a public-private partnership with community-based organizations who are often trusted and better able to help residents of their communities access the exchange, understand the insurance products, as opposed to a system that simply relies on the exchange itself or a system of brokers.

SENATOR GILL: Thank you very much.

As you begin to speak, sir, I will call our last witness -- and I’m sorry, my eyeglasses weren’t clean -- Independent Pharmacy Alliance, John Covello, can come up.

You can start your testimony, sir.

RAYMOND CASTRO: Oh, okay, thanks.

SENATOR GILL: Thank you very much for your testimony.

MR. CASTRO: Thanks. I’ll be very, very brief because that (indiscernible) did cover a number of my points.

We, as you know -- Medicaid is one of our nation’s most successful programs, and it’s not surprising that ACA built upon the success of Medicaid. My estimate is similar to the Department’s in terms of over 300,000 individuals who are going to be enrolled in Medicaid by 2019. I also estimate that in the first year alone about 62 percent of them will be enrolled -- that’s over 200,000 people. So you can understand the tremendous pressure that the exchange is going to be under, and Medicaid
is going to be in, in the first year. So we really have to be prepared this year in order to get to that level.

As also was pointed out, we're talking about childless adults. This is basically a new group for Medicaid. The only way that you can get -- if you're a childless adult, is if you apply for welfare in our state, General Assistance.

And so childless adults are very diverse: we're talking about people who are mentally ill and homeless; and we're also talking about people who have been middle class their entire life and may have a college degree, and who have become unemployed and suddenly are going to be going into Medicaid. It's a new group, and it's a much more mainstream group than we've had in the past. And that's an opportunity, I think, to mainstream Medicaid and to reduce the stigma in the program.

And then I think one of the other things that the Legislature could do is that we should really lump all these programs together in one name -- like New Jersey Cares. Instead of having a Medicaid program, a New Jersey FamilyCares Program, and exchange program, we should call it one program.

There are two things this year that I think are very important: one is the information technology. We're very happy with the progress the State is making in that area. We believe there are a lot of decisions that have to be made; I guess the question is how easy is the application process going to be? For example, in Wisconsin all you have to do is enter your Social Security number and it literally fills out the application for you, and then asks you if the information is correct. Also in Wisconsin, the same
application process determines eligibility for food stamps and other programs. Those are decisions that we'll have to make in our State as well.

The other area was the issue that was raised Senator Vitale in terms of what can we do now to expedite the process towards reform. We are allowed to expand eligibility starting this year at a 50 percent match. That will greatly reduce the demand for services starting in 2014.

SENATOR GILL: We've gone through that.

MR. CASTRO: Okay, all right.

The other issue is, with respect to the Federal funding that we will get for this program, I know there were a number of concerns with aid to taxpayers. I think it needs to be pointed out, as Valerie pointed out, they are applying for a waiver for General Assistance. Medical costs in GA cost about $190 million -- that's all State funded. For the first time we have an opportunity to draw down a lot of debt. That's going to be a windfall to New Jersey, to the taxpayer, before this program is even started. So I think that needs to be taken into account.

The other issue which is going to be important is the benefits that are going to be provided in Medicaid. This new-- Under the Federal rules for childless adults, you can set the benefits lower than the benefits that others in the Medicaid program would have. We would be very concerned about that; we think that would be very inequitable. These individuals are going to have the same incomes as anybody else in Medicaid. We believe that they should have the same benefits.

Thank you.

SENATOR GILL: Thank you.
SENATOR CARDINALE: I have a question for this witness, Madam Chair.

SENATOR GILL: I think you piqued his interest.

Senator Cardinale.

SENATOR CARDINALE: I just can’t let that stand.

(laughter)

You say this is a windfall for New Jersey because it’s going to be paid with Federal funds.

MR. CASTRO: Existing State benefits under the GA program would be paid with State (sic) funds.

SENATOR CARDINALE: Every state is covered by the Federal law. Every state is going to have to be treated somewhat equally by the Federal government. So this expansion of cost -- you think it’s a windfall for us because we’re going to get a grant from the Federal government? Have you ever looked at the numbers -- what we get in benefit for what we pay in taxes to the Federal government? New Jerseyans are going to pay a disproportionate share of this cost from other states. I think you are based on a totally and completely erroneous premise to say that this is a windfall. This is a disaster for New Jersey taxpayers.

MR. CASTRO: I’ll have-- Can I respond to that?

SENATOR GILL: I don’t think that that calls for--

SENATOR VITALE: I have a question.

SENATOR GILL: Is that a question? Is it a disaster or is it a windfall? The Senator thinks it’s a disaster.

SENATOR CARDINALE: I think it’s a disaster. I’m disagreeing with his statement.
SENATOR GILL: You say it’s a windfall, and I will say beauty is in the eye of the beholder. (laughter)
So if you have anything else to add other than that--
Thank you very much for your testimony -- thank you both.
And please move up, Mr.--
SENATOR WEINBERG: Covello.
SENATOR GILL: --Covello.
SENATOR WEINBERG: Just before--
SENATOR GILL: Oh, I’m sorry.
SENATOR WEINBERG: --you go ahead, John, I know Mr. Sullivan is still in the audience -- yes, from DOBI -- and Valerie Harr from Medicaid. I would like, on behalf of both Committees, to get from each of you a list of legislation that you think needs to be passed in this session of the Legislature, okay? Is that--
UNIDENTIFIED MEMBER OF AUDIENCE: (off mike) We will respond to the (indiscernible).
SENATOR WEINBERG: Yes, what you think we need to be addressing in terms of legislative initiatives during this particular legislative session.
SENATOR GILL: In this session -- before November.
SENATOR WEINBERG: Yes, the 2010 and 2011 legislative--
SENATOR GILL: We wouldn’t like it in January, because technically you would be complying with (indiscernible).
SENATOR WEINBERG: This year.
SENATOR GILL: But if you have a date--
SENATOR WEINBERG: Well, in time to get it passed if it needs to be passed this year. So it would be nice to have this by June -- by the end of the budget session.

SENATOR GILL: Mr. Covello, aren’t you glad you’re not responsible for that?

JOHN COVELLO: I certainly am, Madam Chair; as a former staffer I know the last witness should be brief and cover only what hasn’t been covered. And I will do both.

I want to thank both the Chairs for inviting me to testify as one of the provider groups in this, and recognition that-- Really, the main thing for the Committee-- Pharmacy services are going to be an important part of the development of this exchange, and our national group -- National Pharmacy Association -- has developed some basic principles for legislation to build on the model (indiscernible) that NAIC has done. And really it’s -- (indiscernible). I just want to draw attention to, as the process moves forward and legislation will have to be enacted, things that need to be added and covered in that.

As the two Chairs have sponsored bills at the State level, it’s important to recognize the Federal ACA act does provide for some level of pharmacy benefit manager with oversight and responsibility to the Federal government -- in terms of reports and information, and a lot of things that have been covered in the bills that the two Chairs have dealt with for over a decade in New Jersey. And obviously we’re going to look forward to working to make sure those provisions are covered in the bill.

Another important part is that the law requires that these qualified plans -- part of the requirement is-- An important thing is that it
will have to recognize and include a clear statement that our practices of any willing providers for pharmacy services be included, as this is developed, so that it’s open access, and it meets all the adequacy of standards, and accessibility, and quality of these plans. So that it would really have to reflect that in the practices act -- dealing at all providers’ levels and primarily insuring that there isn’t requirements of mandatory mail order. And also the treatment -- as we’ve dealt with and seen in other areas in the state -- who’s defining what’s considered specialty drugs, and make sure that it is still covered and provided at the pharmacy -- local -- for access.

The only other point that’s really important as it moves forward -- and I think this sort of builds on what Mr. Knowlton said -- is it’s going to change a lot of the paradigms -- and it’s been done iteratively. Additional services, that now we are licensed to allow pharmacies to provide -- like therapy management, and MTM, and other services -- are going to have to be defined in this and provided for this. A lot of this is, with the fact we’re going to have so many new people providing access to this care, it doesn’t always have to be done in a primary setting. And obviously that is something that State and other payment programs -- Medicaid is looking at, Medicare provides for this -- will have to be built upon that.

So really, we just welcome the opportunity as part of the end of the continuum, that I know oftentimes can get overlooked. And certainly by including us early and recognizing that we play an important role -- we wanted you to know that we’re ready to speak up through the process to make sure this component is also covered as to what’s going to be necessary for these individuals.
And I’d be happy to answer any questions you may have.

SENATOR GILL: There are no questions because Senator Cardinale had to leave. (laughter)

I would like to thank everyone for testifying. And this will be an ongoing -- not the testimony -- but the work will be ongoing. So that we want to make sure -- both Chairs -- that we get it right, and I know both Committees.

So although we have had abbreviated testimony, the Committee aide Sarah will take any further information and will be one of the point persons with respect to the exchange -- that’s my bill and Senator Vitale’s bill. And we hope to get Senator Cardinale on at one point. (laughter) And that will be in Commerce Committee. And Jay, of course, is for Health with Senator Weinberg, and that Committee will have jurisdiction over the Medicaid portion. So Commerce is the exchange -- that’s Sarah; Medicaid is the health -- Jay in Senator Weinberg’s--

SENATOR WEINBERG: Jay Redd.

SENATOR GILL: Jay Redd. I gave him--

SENATOR WEINBERG: We have a few Jasons.

SENATOR GILL: Oh, okay.

And so forward any suggestions, any ideas -- no complaints (laughter), they don’t take any complaints -- and we will work through this to make sure that it is what it should be.

And thank you all very much for your testimony and presence here today. Thank you.

(MEETING CONCLUDED)