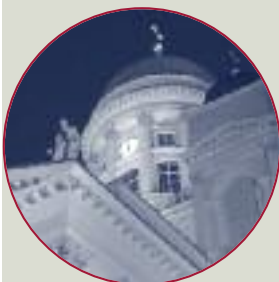
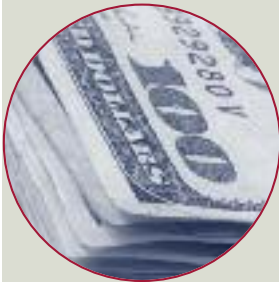




INSIDE

- Health Care “Reforms” Take Effect **Page 2**
- Mercer Study Outlines Conflicts **Page 3**
- Benefit Plans Adjust **Page 5**
- New 80% Spending Rule Enacted **Page 6**
- Legislative Update **Page 7**



HCPC ENTERS AGREEMENT WITH EXTEND HEALTH, INC.

The Health Care Payers Coalition has entered into an agreement with **Extend Health, Inc.**, to utilize the company's exchange services for the sale of Medicare retiree supplemental insurance and prescription programs to HCPC members.

Extend Health operates the nation's largest private Medicare insurance exchange and recently crossed the \$1 billion threshold in savings for employers that provide retiree health benefits. Since its inception in 2004, the insurance

exchange has served more than 300,000 retirees sponsored by some of the nation's largest companies, including the “Big Three” auto makers and a growing number of public sector employers.

“We're pleased to have reached this agreement with Extend Health,” said HCPC executive director Edward Geisler. *“It makes good sense for our members and their retirees who will save out-of-pocket costs, and it makes good sense for our coalition, which is able to offer another valuable service to our members.”*

CONTINUED ON PAGE 7

HCPC'S CASE MANAGEMENT SERVICES A COST SAVER

Despite its proven savings in the face of escalating medical costs, case management remains one of the least utilized services offered by the Health Care Payers Coalition.

The underutilization is perplexing, according to HCPC executive director Ed Geisler, given that that the average savings on disputed claims handled by the department over the past three years has exceeded 80 percent.

“With health care and prescription drug costs continuing to rise at alarming rates, many self insured and self administered plans are being forced to either eliminate or reduce benefits while asking their

members to shoulder higher co-pays and out-of-pocket expenses,” Geisler says. *“It only makes sense to use every weapon in your arsenal to protect this extremely valuable but endangered employee benefit.”*

The numbers verify the success of the coalition's case management department in holding the line against excessive billing practices by providers. Through the first nine months of 2010 the department saved member plans approximately 83% off charges through rigorous negotiations with surgi-centers and hospitals. This compares favorably with the case management savings compiled between 2007 and 2009,

which ranged from 80 percent to 87 percent off charges.

Diane Glancey, who has managed the department since 2001, says its mission is twofold: 1) to negotiate lower payments for members on charges that are clearly excessive for the health care services provided, and 2) to educate plan participants about the importance of using in-network providers and directing them to providers who offer the most cost effective services.

“People don't normally ask about costs or procedures prior to receiving treatment for a condition or ailment, either because they trust their provider's judgment, or they're too intimidated to ask the necessary questions,” Ms. Glancey states. *“Any time you can have an experienced third party reviewing a case and its outcome, you have a better chance of reducing abuse, especially when it comes to charges.”*

Ms. Glancey brings vast experience to her position as head of the HCPC's Case Management team, and her strong clinical background gives weight to her arguments and opinions regarding charges and treatment options. She is a registered nurse and has worked in both clinical

CONTINUED ON PAGE 8



Edward Geisler & Diane Glancey

HEALTH CARE "REFORMS" TAKE EFFECT

It's almost certain that passage of the health care "reform" bill will have a profound influence on the design, cost and eligibility standards of union and employer health benefit plans. However, the real impact of the Affordable Care Act on large and small businesses and multiemployer plans will not be fully understood until the final rules and regulations are developed and implemented by various federal agencies over the coming months and years.

PROVISIONS ALREADY IN EFFECT AS OF SEPTEMBER 23, 2010

- Small business tax credits to make employee coverage more affordable. Firms that choose to offer coverage will be able to take advantage of tax credits of up to 35% of premiums in 2010. (In 2014, tax credits will cover 50% of premiums).
- Medicare Part D "donut hole" begins to close. Medicare beneficiaries will receive a \$250 rebate in 2010 when they reach the "donut hole," which will be completely closed by 2020.
- The bill gives employers that provide health benefits for retirees ages 55 to 64 assistance in offsetting the costs of expensive health claims.
- Extends coverage for children up to their 26th birthday under their parents' health insurance policy, if they are not eligible for other employer-sponsored coverage.
- Bans health plans from dropping people from coverage when they get sick, and prohibits health plans from denying coverage to children under the age of 19 with preexisting conditions. (In 2014, that prohibition would extend to everyone.)
- Prohibits lifetime limits on coverage.
- Tightly restricts new plans' use of annual limits. U.S. Department of Health & Human Services will define those tight restrictions.

Numerous other changes are to take effect in 2011, 2014 and 2018.

THE AFFORDABLE CARE ACT'S IMPACT ON NEW JERSEY—BY THE NUMBERS

- **Small business tax credits.** 144,000 small businesses in New Jersey may be eligible for the small business tax credit that makes it easier for businesses to provide coverage to their workers and makes premiums more affordable.
- **Closing the Medicare Part D "donut hole."** Approximately 109,000 Medicare beneficiaries in New Jersey reached the "donut hole" in Part D coverage in 2009. As of early August 2010, some 34,600 New Jersey seniors had received a \$250 tax-free rebate check upon hitting the "donut hole."
- **Health coverage support for early retirees.** An estimated 117,000 people in New Jersey retired before they were eligible for Medicare and have health coverage through their former employers. In 2010 a \$5 Billion temporary early retiree reinsurance program was established to help employers continue to provide such coverage.
- **Extending coverage to young adults.** This provision will affect approximately 27,800 individuals in New Jersey who may be able to qualify for coverage through their parents.
- **Coverage for uninsured with pre-existing conditions.** Some \$141 Million in federal dollars are available to New Jersey, as of last July 1st, to provide coverage for uninsured residents with pre-existing medical conditions.

- **Free preventive services for seniors.** All 1.3 million Medicare enrollees in New Jersey will be eligible for preventive services, like colorectal cancer screenings, mammograms, and an annual wellness visit without copayments, coinsurance, or deductibles.

HEALTH CARE PAYERS COALITION OF NJ

OFFICERS

George R. Laufenberg *Co-Chair*

Christine Stearns *Co-Chair*

Charles "Tip" O'Neill *Treasurer*

Darlene Regina *Secretary*

Edward Geisler *Executive Director*

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David Knowlton *NJ Health Care Quality Institute*

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Fred J. Mihelic *Mihelic Associates*

Charles "Tip" O'Neill *Laborers Local #472/#172 Welfare Funds*

Darlene Regina *Building Contractors Association of NJ*

Kevin McCormick *Steamfitters Local #475*

Christine Stearns *NJ Business & Industry Association*



HCPC OFFICERS—Seated are co-chairs George R. Laufenberg and Christine Stearns. Standing (l to r): Edward Geisler (executive director), Darlene Regina (secretary), and David Knowlton (founding member). Treasurer "Tip" O'Neill was absent when photo was taken.

MERCER STUDY OUTLINES CONFLICTS WITHIN HEALTH CARE “REFORM” ACT

While the Affordable Care Act is expected to have a major impact on America’s health care system, the lack of realistic cost controls means it may not be all that beleaguered employers and consumers had hoped for.

In a somewhat critical review of the landmark legislation, the Mercer Consulting Group states: *“Health insurance reform puts the US on a path that increases consumer expectations of having comprehensive and affordable insurance coverage... (but) absent significant changes in health care cost, this expectation is unrealistic. And, the federal subsidies that are intended to make insurance coverage more affordable simply mask the cost problem rather than correct it.”*

The Mercer study, entitled **Health & Benefits Perspective**, says the new insurance reforms will place added pressures on employers to control costs, expand eligibility, comply with new coverage and contribution requirements, absorb new fees and try to avoid excise taxes for having a high-cost plan. Mercer estimates that in the near term employers will absorb an additional 4% to 6% increase above current health care costs due to various factors, including:

- Expanded eligibility for groups of employees who are not currently eligible and for dependent children up to age 26
- Higher contributions for low-income employees who are currently paying more than 9.5% of their income for coverage
- Expanded benefit coverage to eliminate any copayment or coinsurance on preventive care and to eliminate lifetime and annual plan maximums
- Industry fees on suppliers, manufacturers and health plans that add billions of dollars are likely to be passed through to employers as part of the cost of materials and administrative expense
- Per-participant fees for effectiveness research

In addition to these new costs, health insurance reform **did not** address the inequities between provider costs paid by government-sponsored plans and those paid by employer-sponsored plans. Medicare and Medicaid have negotiated extremely favorable payment rates, which may encourage providers to cost-shift their expenses to the private sector as a means of making-up any insufficiencies or profitability losses.

The legislation does assume that payment cuts will be made in both the basic Medicare program and in Medicare Advantage, but the proposed cuts pose several risks:

- If the cuts do not materialize (as has been the case with planned cuts in Medicare physician payments), the shortfall will increase the federal deficit and potentially increase taxes and fees for employers and individuals.
- If the cuts do occur, providers may turn to employer-sponsored plans and individuals to make-up the difference in their payments.
- Medicare payment reductions increase the risk that providers will limit the number of Medicare patients they accept.

The Mercer study does see some positive results from the new law, including increased health care coverage and accessibility, but it also warns of conflicting outcomes. For example, increased enrollment in Medicaid and individual and employer plans will reduce the uninsured population, saving employers from being charged for uncompensated care.

However, the cost of individual coverage is likely to increase in the short term, making it less attractive to new enrollees, unless they are eligible for significant subsidies. Also, new enrollees will include individuals who had previously been denied coverage due to pre-existing conditions. They come into coverage with health conditions that must be addressed. Thus, initial utilization for this group will be high and costly.

In addition, the low penalty for not having coverage increases the risk of adverse selection and provides an incentive for healthier individuals to opt in and out of coverage as needed.

Then again, because of the relatively low financial penalty to be assessed against employers who do not provide coverage, some employers may be inclined to replace the health care benefits they currently offer with some type of contribution to help their employees purchase coverage on their own.

Still another unintended outcome could stem from a provision of the law that forces some employers to absorb added costs because of shared responsibility requirements to cover new groups of employees. According to the study, *“These employers have to weigh all possible alternatives—increase their cost by adding new employees, pay a penalty or evaluate ways to restructure their workforce... (including) reduced work hours. Thus, rather than expanding access to coverage, the law may result in reducing the number of hours employees are eligible to work, thereby reducing employee income.”*

In summary, rather than encouraging employers to retain coverage, the new law may create incentives for them to reduce or drop it altogether, thereby further increasing the cost of coverage.

Mercer suggests that employers pursue advanced health care strategies that will enable them to retain health benefits that are compliant in terms of benefit design and eligibility, yet avoid an excise tax on high-cost plans. Key strategies include:

- Adopting plan designs that are structured to improve outcomes
- Selecting hospitals and physicians that consistently demonstrate compliance with standards of practice, optimal outcomes for their patients and cost-effective use of resources
- Adhering to medical guidelines and treatment recommendations
- Shifting to more cost-effective drug treatments
- Identifying personal health risks
- Participating in lifestyle management and management care programs
- Implementing high-quality solutions for individuals with high-cost, high-risk conditions



HCPC SPONSORS SEMINAR ON HEALTH CARE REFORM ACT

The HCPC co-sponsored a daylong seminar on the impact of the federal health care reform legislation in August at the NJ Carpenters Funds Building in Edison. Presented under the auspices of the International Foundation of Employee Benefit Plans (IFEBP), the seminar detailed various aspects of the complex legislation whose interim rules are being developed and implemented by several different government agencies.

Seminar speakers included: George McGregor, president of McGregor & Associates, Inc., San Diego, CA; Mark Nielsen, principal with Groom Law Group, Chartered, Washington, DC; Robert Projansky, partner with Proskauer Rose LLP, New York, and Aruna Vohra, senior consultant of Horizon Actuarial Services, LLC, Miami, FL.

Titled **Health Care Reform—What Plans Need To Do Now**, the seminar covered various topics of interest to benefit plan administrators and fiduciaries, including:

- A detailed discussion of mandates in the Affordable Care Act that apply to both “grandfathered” and “non-grandfathered” plans
- The Retiree Reinsurance Program, a temporary program created to reimburse plans offering health coverage to pre-Medicare retirees between ages 55 and 64
- An overview of fees, taxes, reporting disclosures, rebates and subsidies involved in the Act
- The employer “play or pay” mandate
- The exchange insurance and individual mandates established under the Act
- A brief timeline for implementation of the new rules, mandates, fees, taxes and subsidies to be enacted under the Act, most of which will be fully effective by 2014.

“We were delighted to be able to co-sponsor this seminar, along with several of our member-plans,” said Ed Geisler, HCPC executive director. *“The health care reform act will have a huge impact on every health care consumer and payer in our country, including both employer and union benefit plans. The more information we can disseminate on the act, the better our plan administrators and fiduciaries will be able to incorporate it into their programs.”*

“One of the main themes coming out of the seminar is that the Affordable Care Act is still a program in great flux. We probably won’t know the full impact of the act until its different jurisdictions finalize their rules and regulations. That will take at least until 2014.”

IRS ISSUES FINAL GUIDANCE ON HEALTH CARE TAX CREDITS

The Internal Revenue Service has released final guidance for small employers eligible to claim the new small business health care tax credit for the 2010 tax year. Included in the Affordable Care Act enacted last March, the small business health credit is designed to encourage both small businesses and small tax-exempt organizations to offer health insurance coverage to their employees for the first time or maintain coverage they already provide.

The new guidance clarifies that a wide range of employers meet the eligibility requirements, including religious institutions that provide coverage through denominational organizations, small employers that cover their workers through insured multi-employer health and welfare plans, and employers that subsidize their employees’ health care costs through various contribution arrangements.

In general, the credit is available to small employers that pay at least half of the premiums for single health insurance coverage for their employees. It is specifically targeted to help small businesses and tax-exempt organizations that primarily employ moderate and lower-income workers.

Small businesses can claim the credit for 2010 through 2013 and for any two years after that. For tax years 2010 to 2013, the maximum credit is 35% of premiums paid by eligible small businesses and 25% of premiums paid by eligible tax exempt organizations. Beginning in 2014, the maximum tax credit will increase to 50% of premiums paid by eligible small business employers and 35% of premiums paid by eligible tax-exempt organizations.

The maximum credit goes to smaller employers—those with 10 or fewer full-time equivalent (FTE) employees—paying annual average wages of \$25,000 or less. The credit is completely phased-out for employers who have 25 or more FTEs or who pay average wages of \$50,000 or more per year. Because the eligibility rules are based in part on the number of FTEs, not the number of employees, employers that use part-time workers may qualify even if they employ more than 25 individuals.

More information about the credit, including a step-by-step guide to claiming the credit, is available on the Affordable Care Act page on IRS.gov.



BENEFIT PLANS ADJUST TO RECESSION AND REFORM RULES

A survey by the International Foundation of Employee Benefit Plans examines the strategies that more than 1,000 employers, representing over seven million lives, are implementing in response to the enactment of health care reform legislation.

Only 20% of employers plan to immediately extend health care benefits to children up to age 26. The majority of employers (67%) report that they will not extend such coverage until required by law. About 5% of respondents' plans currently meet legal requirements and 9% are not sure.

Half of employers intend to apply for the Early Retiree Reinsurance Program. The survey found that 52% of employers who currently offer medical benefits to retirees plan to take advantage of the one-time federal reinsurance program established by the health care reform legislation. Many (35%) have not yet decided whether they will apply, and 13% have decided not to apply.

Approximately three in five employers (61%) who currently offer medical benefits to retirees, plan to review their health plan benefit strategies for early retirees (55-64 years old) in the next 12 months. Half of the respondents offering retiree coverage intend to examine their strategies relating to retirees who are 65 and older.

Other key findings in the survey include:

- 87% of employers agree that their organizations will continue to offer health care benefits because they are critical to employee recruitment, retention and remaining competitive.
- Of employers whose plans currently include lifetime maximum provisions on essential benefits, only 4% are removing lifetime maximums before they are required to do so; 86% are not making changes until required, and 10% are not sure.
- One in five employers is planning to add or increase emphasis on high-deductible health plans in the next 12 months. Close to 70% of these employers are likely to focus on account-based plans linked to health savings accounts.
- Close to half of all respondents (48%) are focusing on redesigning their health plans so that by 2018, their plans will avoid triggering the excise "Cadillac" tax for high value plans.

IMPACT OF RECESSION

One of the most disturbing aspects of the ongoing economic recession is the serious

impact it is having upon the fiscal stability of building trades health plans. The 40 to 50% unemployment rates among many building trades unions has led to a drastic cutback in contractor and member contributions to the benefit funds, placing many in a precarious position and endangering the pay-out of future health care benefits.

The drop-off in contractor/member contributions has forced many multi-employer plans to enact draconian measures to ensure the future availability of promised benefits, including in some cases, a) changes in eligibility standards and the design of funds, b) the reduction, suspension or elimination of certain benefits, c) an increase in deductibles and co-pays, and d) the establishment of restrictive rehabilitation programs.

In response, the NJ State Building & Construction Trades Council formed a standing committee of benefit plan administrators that has been meeting regularly to discuss and consider the various initiatives and options available to the plans in confronting this growing crisis. George R. Laufenberg, administrator of the NJ Carpenters Funds and co-chairman of the Health Care Payers Coalition, is chairing the

committee and moderating the sessions, which have been attended by representatives of many of the building and construction trades unions in the state.

"The financial strain that unemployment is placing on our union benefit plans is common to most of the trades and is having an equal impact on both our union members and signatory contractors," Laufenberg stated. *"Through these sessions, we are able to engage in an honest discussion of the problems facing all of us and present some of the strategies that our peers are implementing to keep their plans solvent."*

"The general consensus among the attendees is that the discussions to date have been fruitful, and that we should keep them ongoing and cooperate in whatever ways we can to ensure the fiscal integrity and survival of our benefit funds."

Bill Mullen, president of the State BCTC, said the council adopted a resolution at its annual convention in July, supporting the formation of the Benefit Plan Administrators Committee in order *"...to help keep the funds financially secure and ensure the future payout of all pension and health care obligations."*

EXPECTED COST IMPACT OF HEALTH CARE REFORM ACT

The Segel Co. recently surveyed major health insurers, HMOs and third party health plan administrators about the expected impact of the health reform bill—the Affordable Care Act of 2010—on plan-sponsored health benefit costs in 2011. These organizations cover approximately 80% of the employees enrolled in group health plans. Key findings include:

- More than half of respondents (56%) estimated the cost to comply with ACA will add between 1% and 2% to 2011 costs of plan-sponsored health benefits.
- Nearly a quarter (22%) said the cost of compliance will add more than 2% to medical cost trends next year.
- Three-quarters of respondents (76%) estimated that raising dependent child eligibility to age 26 will increase costs between 0.1% and 1% for 2011.
- No respondents estimated that the cost to comply with ACA will be zero.
- Nearly three-quarters (71%) said that cutbacks in payments by the Center for Medicare/Medicaid Services to Medicare providers will increase costs to private plan sponsors, but they could not quantify the impact on health plans.

According to Edward Kaplin, Segel's senior vice president and national health practice leader, *"We have priced-out several cases where raising the dependent age to 26 could add 3 to 4 percent in new costs in 2011, which suggests that the average forecast noted in our survey may not be appropriate in all cases,"* he said.

"Potential cost increases could vary dramatically among plan sponsors. As a result, plan sponsors should evaluate group-specific demographics and experience before relying solely on insurer estimates of future costs."

NEW 80% SPENDING RULE ENACTED FOR INSURERS

Under regulations released by the Department of Health & Human Services in November, health care insurers will be required to spend at least 80% of their revenue on direct medical care, or pay a rebate to subscribers. The government estimates that 45% of people who buy their own health care coverage are in plans that currently do not meet the new standard.

If the new regulation was currently in effect, it's estimated that about nine million people could be eligible for rebates, either directly, if they buy their own coverage, or through their employers, if they're in job-based coverage. Consumer advocates say insurers that cover one-fifth of Americans spend about 30% of their revenues on administrative costs, a percentage that will result in rebates unless those costs are reduced.

The 80% standard applies to individual and small group policies. Larger group policies—generally considered to be more than 50 people—must spend at least 85% of revenues on care. The new rule doesn't apply to employers who self-insure. There are some exemptions:

- Employers and insurers that offer "mini-med" policies, which are plans that limit coverage to \$250,000 a year or less, can calculate their medical spending in 2011 differently: they'll total the amount spent on doctors, hospitals and other medical and quality improvement expenses, then multiply that figure by two. That will allow them to meet the 80% ratio by spending as little as 40% on medical costs. HHS will revisit that provision after 2011.

- States may apply to have the requirement adjusted, if meeting the 80% spending requirement would destabilize their individual markets.
- Some small plans will not have to provide rebates, at least for the first year.

The new regulations allow insurers to include many quality improvement costs along with payments to doctors, nurses, hospitals and other providers in their medical expense calculations, but not the cost of broker commissions.



NJ BIZ LISTS LAUFENBERG & KNOWLTON AMONG "MOST POWERFUL" IN HEALTH CARE

A pair of HCPC founding members are listed among the state's 50 Most Powerful People in Health Care by New Jersey BIZ magazine.

According to the publication, George R. Laufenberg, co-chairman of the Payers Coalition and administrative manager of the NJ Carpenters Funds, *"...has a voice in shaping public health policy through his role as the negotiator of plans covering 17,000 New Jersey carpenters, retirees and their dependents. He urges his members to become better health care consumers and works with the Legislature, doctors and hospitals on creating a more rational system."*

Laufenberg is also a trustee and former chairman of the Monmouth Medical Center Board of Trustees and serves on the board of directors of the NJ Health Care Quality Institute.

Founding member and former HCPC executive director David L. Knowlton serves as president and CEO of the NJ Health Care Quality Institute. NJ BIZ says the Institute, also founded by Knowlton, *"...advocates for higher health outcomes in a state where high levels of spending have yet to translate into high marks on overall health quality. He (Knowlton) argues that employers who provide high levels of financial support to the health care system should insist on having a say in policy."*

Knowlton is a former deputy commissioner of the NJ Department of Health.

HCPC executive director Ed Geisler also serves on the board of directors of the Quality Institute.



HCPC co-chairman George R. Laufenberg (l) and HCQI president David L. Knowlton (r).

HCPC LEGISLATIVE REPORT

(A-3378/S-2583) Designated the "Health-care Transparency & Disclosure Act," this bill makes various changes to the administration of health benefits plans, regarding: 1) out-of-network payment collection responsibilities by physicians and health care facilities, 2) certain disclosures by physicians, health care facilities and health plan providers, and 3) eligibility for participation in health insurance plan networks. It would also establish an Office of Insurance Claims Ombudsman with the authority to conduct an investigation, hold a hearing and render a binding decision as to upholding or overturning a claims decision. Sponsored by Assemblyman Gary Schaer and State Senator Joseph Vitale, the bill was approved in the Assembly (41-28-8) on January 10th and referred to the Senate Commerce Committee.

(S-948) Requires health insurers and HMOs to provide insurance coverage for all eating disorders (anorexia, bulimia and binge-eating) under the same terms and conditions as provided for any other covered illness. Sponsored by Senators Joseph Vitale and Richard Codey, the measure is in the Senate Health Committee.

(S-796/A-968) Sponsored in the Senate by State Senators Joseph Vitale and Barbara Buono, and in the Assembly by Gordon Johnson, Valerie Vainieri Huttle and Linda Greenstein, this bill requires insurers to cover treatment for alcoholism and other substance abuse disorders under the same terms and conditions as other diseases or illnesses. Currently in the Senate and Assembly Health Committees.

(A-3222) This legislation would prohibit health insurance policies, health benefit plans and HMOs from excluding coverage for the treatment of illnesses, injuries, or conditions sustained by a covered person because that person was intoxicated or under the influence of a narcotic. It would repeal an existing statute that permits such exclusions. Sponsored by Assemblywoman

Connie Wagner and Assemblyman Charles Mainor, the bill is currently in the Assembly Financial Institutions & Insurance Committee.

(S-364/A-1070) Requires a hospital, which is a participating provider under a patient's health insurance plan, to notify the patient, or a representative, about physicians and other providers under contract to the hospital who are not participating providers under the patient's health insurance plan. Sponsored by Senator Loretta Weinberg and Assemblyman Reed Gusciora, the bill is currently in the Senate and Assembly Health Committees.

(S-1742 & A-2992) Two separate bills. **(S-1742)** requires a provider participating in a carrier network to give notice to the covered person when the patient is referred to an out-of-network provider. **(A-2992)** requires providers in managed care plans to give written notice to covered persons whenever they are referred to an out-of-network provider. Sponsored by Senators Joseph Vitale and Nia Gill and Assemblyman Reed Gusciora.

(A-1364/S-715) The NJ Healthcare Choice Act, this bill permits health insurers licensed in other states to provide coverage in New Jersey under certain circumstances. Sponsored by Assemblymen Jay Webber and Alex DeCroce and Senators Joseph Pennacchio and Anthony Bucco.

(A-1684) Establishes the NJ Rx Program to reduce the cost of prescription drugs. Under its provisions, the state would utilize manufacturer rebates and pharmacy discounts to reduce prices. The state would act as a pharmacy benefits manager (PBM) in establishing rebates and discounts on behalf of qualified residents. Sponsored by Assemblyman John Burzichelli, the measure is in the Assembly Health Committee.

(S-1844/A-1806) Legislation would establish limits on non-economic loss for damages received in a medical malpractice action.



Based on the severity and type of injuries incurred by the action, damages shall not exceed either \$100,000... \$500,000... or \$750,000, or three times the amount of non-economic loss, whichever is less, for any action in which the negligence of defendant(s) is found to be the proximate cause of an injury. Sponsored by State Senator Joseph Kyriillos and Assemblywoman Caroline Casagrande, the legislation is currently in the Senate Commerce and Assembly Financial Institutions & Insurance Committees.

(A-1997/S-937) This bill would allow persons covered by certain managed care plans to receive covered services from a network provider without obtaining a written referral from his primary care provider. Sponsored by Assemblyman Herb Conaway and Senator Loretta Weinberg, the bill passed in the Assembly (63-10-1) on December 13th and was referred to the Senate Commerce Committee.

(S-2553/A-1930), (A-3561/S-1288), (A-3733/S-2597) All 3 bills would establish a NJ Health Insurance Exchange as an independent public entity, with authority to facilitate the availability and choice of health benefit plans offered to employees of small employers and other eligible persons.

AGREEMENT WITH EXTEND HEALTH (continued from page 1)

A health care exchange can help reduce administrative costs and market inefficiencies in the health care system, while empowering consumers with choice. Employers leveraging the exchange continue to fund their health care benefits while the exchange will help their retirees choose plans that best suit their needs, guiding them through the enrollment process and administering the plans.

The average retiree couple who has purchased individual Medicare plans through

Extend Health have saved approximately \$500 a year in total out-of-pocket expenses.

Extend Health offers private Medicare plans from 67 national and regional carriers, offering a wide variety of insurance plans that cover a broad spectrum of Medicare Supplement (MediGap), Medicare Advantage, Part D, Vision and Dental plans. Participating insurance carriers include among others: AARP, Aetna, Cigna, Humana, regional Blue Cross/Blue Shield systems, and UnitedHealthcare. Annual cost

savings of 20% to 30% are not unusual for clients of the exchange.

"Our clients have reduced their cash spending by hundreds of millions of dollars and their OPEB liabilities by billions of dollars without reducing or eliminating benefit levels," said Rob Harkins, vice president of **Extend Health, Inc.** *"We've helped hundreds of thousands of retirees seamlessly transition from their post-65 group medical programs to guaranteed-issue individual health plans."*

HCPC NETWORK SAVINGS AMONG INDUSTRY'S BEST

The Health Care Payers Coalition continued its strong record of savings through November of 2010, saving members in its participating provider network an average 62% off actual charges in six key categories: 1) inpatient, 2) outpatient same day surgery, 3) physician network, 4) ancillary services, 5) other outpatient services, and 6) other negotiated savings.

HCPC members saved an average 68% on inpatient fees, 55% on outpatient SDS fees, 50% on ancillary service fees, and 38% on physician fees.

At the same time, HCPC's case management services saved participating members a staggering 83% off the actual charges of disputed claims through the first nine months of 2010. HCPC executive director Edward Geisler said the negotiated and case management savings ranked among the best for all preferred provider organizations and attributed the coalition's outstanding performance to the "commitment and dedication of our fine staff to ensure accountability within our provider population."

Geisler added that HCPC members who take advantage of the coalition's preferred provider network save an average \$30 for every \$1 in access fees—an extraordinary return on their investment.

CASE MANAGEMENT SERVICES (continued from page 1)

and corporate environments.

Along the way, Diane has established good working relationships with a host of health-care providers, including physicians, hospitals and surgi-centers. "We strive to create cooperative and amicable relationships with both in-network and out-of-network providers," she notes. "It helps to open doors when we contact them about a disputed claim and expedites the negotiating process. In some cases, we've actually been able to bring an out-of-network provider into the coalition's preferred provider network."

Most HCPC member-plans use the case management services for outlier or clearly excessive, out-of-network claims, instead of routinely for every claim. And, it appears that surgi-center charges are being red-flagged with increasing frequency. Most surgi-centers, or same day treatment facilities, refuse to join preferred provider networks and practice few if any cost controls. When it comes to charges, the sky is the limit and more often than not there is little push-back from an insurer or benefit plan.

"We handle claims for a single day use of a surgi-center that can easily exceed \$15,000, and that is over and above the physician's fee," Ms. Glancey says. "In one case we were presented with a \$25,000 charge for a simple knee arthroscopy performed in a surgi-center. When we were able to demonstrate the sheer unreasonableness of the charge, we were able to negotiate it down to \$1,260, resulting in a savings of \$23,740 or 95 percent."

Other examples of major surgi-center savings negotiated just this past September include an 89% discount on a shoulder arthroscopy when the case management department was able to reduce \$23,252 in

charges to \$2,548, and a 90% savings on a hernia repair billed at \$13,000 and later reduced to \$1,358. In addition, an inpatient hospitalization was reduced from \$33,000 to \$12,000.

Ms. Glancey says her department also instructs plan members about the importance of using free-standing facilities like Lab Corp or Quest for basic bloodwork, and free-standing radiology facilities for x-rays and other outpatient services. Hospitals often charge up to 10 times more for the same services. Plans can often negotiate less expensive flat rate fees with free-standing, in-network facilities than they can with hospitals that usually bill on a percentage of charges.

Yet, despite the savings and other benefits provided by HCPC's Case Management Department, it remains underutilized by the coalition's members. On average, the department receives fewer than 50 disputed claims a month from member-plans, even though evidence abounds that abusive billing practices have played a significant role in the continuing and alarming ascent in the cost of health care.

"Members are under no obligation to utilize our case management services. And, if they do, they certainly don't have to use them for every claim. They can pick and choose as the need arises," Geisler concludes.

"Costs will no doubt escalate for the foreseeable future and will continue to have a negative impact on the benefit plans that are part of our coalition. In such an environment, it only makes sense that every questionable claim is worth negotiating, and our case management department has been very successful at it."



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