

APPENDIX

Commissioner Marlene Caride
Department of Banking and Insurance
Senate Commerce Committee Hearing on the Out-of-network Consumer
Protection,
Transparency, Cost Containment and Accountability Act (A2039/S485)
Tuesday, April 30, 2019

Good afternoon Chairwoman Pou, Vice Chair Cryan and members of the Senate Commerce Committee. I am pleased to be here to provide an update on implementation of the out-of-network law.

As you know, the law enhances consumer protections from surprise bills for out-of-network health care services in addition to making changes to several elements of New Jersey's health care delivery system. The improvements include increased transparency and various consumer disclosures by carriers and providers, cost-containment for out-of-network services and the creation of an arbitration system.

Implementation of the law falls within the purview of the Departments of Banking and Insurance, Health, Treasury and the Division of Consumer Affairs.

Our department is responsible for the implementation of the arbitration system to resolve disputes related to out-of-network billing. When insurance carriers and providers cannot agree on an acceptable reimbursement for services, an arbitrator is required to choose between one of two final offers submitted by the parties.

This applies to fully insured plans, MEWAs, the state Health Benefits Program and the School Employees Health Benefits Program, and self-funded ERISA plans that opt into the arbitration provisions of the law. In the case of self-funded plans that have not opted in to the arbitration

provisions of the law, the arbitration system may resolve disputes between providers and plan members who choose to avail themselves of arbitration.

I am here to provide an update regarding the process to date, and to address concerns raised about the arbitration process.

The bill was signed into law on June 1, 2018 and took effect August 30th. On August 27th, the department began the advance notice process for issuance of a department bulletin to provide guidance to carriers and other interested parties to assist them in meeting their obligations under the law.

In the interest of transparency, and in keeping with my office's open-door policy, we met with numerous stakeholders, including doctors, specialists and hospital representatives, as well as carriers, to receive feedback that informed the process. The department is now finalizing regulations and continues its ongoing discussions with stakeholders.

As per the law, patients may not be billed beyond what they would pay for in-network services for inadvertent out-of-network services or emergency or urgent out-of-network services. If the carrier and provider cannot agree on a reimbursement rate for the services, the carrier, provider, or in certain cases a covered person, as applicable, may initiate binding arbitration.

The law provided for the current entity engaged with the department under the "Health Claims Authorization, Processing, and Payment Act," to be utilized for arbitration and provided that, after a period of one year from the effective date of the law, the selection of the arbitration entity shall be through the Request for Proposal process. The current company managing the process is Maximus.

Prior to enactment of the law, in preparation for its implementation, the department informed Maximus that the legislation provided for the company to be used for the process.

Once the law was signed, we had numerous conversations with the company about the need to get the arbitration process and website, through which parties initiate the arbitration process, deployed in a timely manner. It was not until January that Maximus got its website up and running. In February, the company reported to the department that 300 arbitration cases were pending.

The department indicated to the company that it should utilize all necessary resources to address the pending cases. By April 19, the company reported that all pending cases had been resolved.

Under the law, the arbitration determination is to be made based on a review of the parties' final offers, their written submissions, the circumstances presented therein, and the arbitrator's experience in health care pricing arbitration – which may factor in available data. The law does not set a standard benchmark of claims data to be used as the basis for the determination. It is silent in this regard. However, the arbitrator in their expertise and experience is permitted to take data into account when reviewing the file in its entirety and making the determination.

I would like to point out the department's role under the law.

The department is not authorized to interfere in the arbitration decision-making or in the determination of any benchmark data used in the process.

As of last week, 357 cases had been decided under the law – one hundred and fifty (150) decided in favor of the provider (15 awarded by default) and two hundred and seven (207) in favor of the carrier.

According to Maximus, as of April 26th, the total amount awarded to carriers was \$411,742. The total amount awarded to providers was \$1.8 million, with an additional \$224,932 awarded to providers by default.

As of April 26th, there were 318 cases pending. We have provided a breakdown of the pending cases to you, as well as a list of the decided cases which includes the practice specialty, the final offers submitted and the award amount for each case.

The department recognizes this process has real impacts on the parties involved and on those who are in this room, many of whom I expect you will hear from today.

We are committed to ensuring the arbitration process is operating effectively. With that said, we urge providers, carriers and other stakeholders to reach out to us with questions, concerns and feedback about the practical impact of the law.

This law is in its early stages, and as with the development of any program as complex as this one, we can expect some obstacles along the way. In order to ensure that we can quickly address any potential issues that arise, we need to hear from stakeholders.

If there is noncompliance with the law, we also encourage you to contact the department – so that we may investigate and act on complaints. Complaints are handled by our Consumer Protection division, which may be contacted through our consumer hotline: 1-800-446-7467.

As you know, this law was a decade in the making. New Jersey took significant action to address an issue that is now being looked at by other states and the federal government in order to protect patients from unexpected health care bills.

While it is too early to evaluate the long-term impacts of this law, we do know it is having a positive impact on our residents as the law prohibits balance billing for inadvertent or emergency out-of-network services.

We are committed to ensuring this law works effectively, and to working with you in this process.

Thank you.

April 30th, 2019

NJ STATE LEGISLATURE
Senate Commerce Committee
State House Annex
PO Box 068
Trenton, NJ 08625

Testimony of:
Stavros Christoudias MD, FACS
Chairman of the Board
The New Jersey Doctor-Patient Alliance

Dear members of the Commerce Committee,

I want to thank you for the opportunity to testify before you today. My name is Stavros Christoudias, board chair for the NJ doctor-patience alliance.

I would like to start this testimony by first acknowledging and publicly thanking Senator Vitale and Speaker Coughlin for having the bravery and forethought to write the Out of Network Bill. Our advocacy group has from its inception agreed with the position that patients have needed to be protected and advocated for. The fact that this debate is a centerpiece in Washington DC today goes to show you just how ubiquitous and pervasive the problem is. But it also shows how forward thinking our state can be in advocating for patients. And for this, Senator Vitale and Speaker Coughlin should absolutely be commended.

However, I am here today to highlight the fact that what are commonly known as "surprise bills"—are misnomers. Patients get sick, and physicians perform a service to heal them, often times in dire emergencies. Its not a surprise that we expect to be paid for our labor. What is the true surprise is that the insurers, who are more than happy to collect premiums when a patient is healthy, will go to any length to deny payment to the physicians who actually make the patients well. These "surprise bills" should be called what they really are—"surprise denials".

When I testified last year before committee about this bill, I was clear and steadfast about my support for the bill. However, my concerns about the bill were that there was no floor for the payments to physicians, of whom many are small business owners like me. Nor was there strict accountability for any shortcomings in the execution of the bill.

I am here now one year later to report that my worst fears have come true. The insurers have used this bill as an excuse to severely underpay and abuse thousands of small businesses like my own. The insurers paid me roughly 50 percent of my charges before this bill passed. Today, they pay me 7 cents for every dollar charged, well below any point where I can be profitable. They've aimed to cash starve us, and drive many of us

out of business. The process has been devious and methodical

They first devised language that was defamatory and put on every single explanation of benefits they sent to my patients. They stated in writing that my charges were "excessive", when they are actually less than the state health benefits plan consider to be the "usual and customary" fee. They then moved their call centers for negotiations to the Philippines where I was told by a call center representative that he had "absolutely no idea what he was supposed to do". They later outright refused to negotiate in good faith, sometimes outright stating after the first phone call on the first day of the 30-day negotiation period that they wanted me to arbitrate. This then forced us into a backlogged arbitration system which I was amongst the first physicians to enter, and now 6 months later, have yet to have even received a single decision of an arbitration. Then, and more recently, the unthinkable happened. The insurers have misapplied this law to thousands of elective surgeries amongst myself and our members—something expressly forbidden by the law.

In the meantime, my practice, which I was so proud of and sacrificed so much for, has been decimated. I have taken two paychecks in the last 6 months. I have had to fire an employee, an inner city single mother, whom I could no longer afford to pay. And in a twist of irony, am on the verge of not being able to afford health insurance for my employees or myself. Our financials have grown so pathetic, that we don't even have cable tv in our waiting room anymore. My wife has needed to make our mortgage payments since February. I no longer spend the majority of my time worrying about what nuance of surgery best suits my patient, but am losing sleep over how to slash costs, or whether I will have to shutter my doors soon.

The insurers have become emboldened in flouting the regulations of the law, because they know there is no penalty for abusing us. They've misapplied the law to federal erisa plans, and when these were rejected from arbitration, Dobi told our members that they didnt have jurisdiction and that complaints had to be made federally, leaving those claims in legal limbo, but still unpaid.

I want to be clear, I am working as hard as ever, busier than ever, at complete capacity, to the point where I have to turn away patients. I am absolutely working as hard as can be. Except now, I'm not being paid for any of it.

I've been honored to be nominated by my peers as a NJ "top doc" almost every year I've been eligible. And yet, here I am being faced with a choice—to weather the storm and have faith that this problem can be remedied by our legislators, or be forced to move to another state, which pays better and has a lower cost of living. In 2018 "Wallet hub" ranked NJ as the worst state in the US to practice medicine. At present, I'd have to agree with that ranking.

I am ultimately asking our legislature to consider amending the out of network bill by creating a floor for payments that are at a survivable level. Nobody is asking to be enriched here, but my practice, and thousands like it, are being destroyed and abused by the insurers. Please consider acting soon to help us.



Out of Network Testimony

Senate Commerce Committee

April 30, 2019

Chairwoman Pou and Honorable Members of the Committee:

My name is Neil Eicher, Vice President of Government Relations and Policy at the New Jersey Hospital Association. On behalf of NJHA's and the Fair Share Hospitals Collaborative members, thank you for the opportunity to provide testimony on the implementation of the new Consumer Protection, Transparency, Cost Containment and Accountability Act, commonly known as the Out-of-Network law.

NJHA and the Fair Share Hospitals Collaborative reiterate our support for protecting patients from surprise medical bills. Throughout the past 10 years we've taken the stance that patients should not receive a surprise out-of-network medical bill when they have done everything possible to ensure that the physician and hospital are in-network with their health insurance plan for an elective service. We maintain our support for these essential protections. Physicians, hospitals, insurance companies and employers should all come together to make sure these situations are prevented and eliminated.

We appreciate the opportunity to provide testimony on the early effects of the new OON law. We are constantly monitoring the impact of the new law and look forward to the opportunity to return later in the year with a more comprehensive assessment of the environment. Below is a list of concerns we have heard to date from our members.

Patients Losing Access

Since the bill was signed into law last June, some hospitals have seen some concerning actions by insurance companies. When we testified on this bill throughout the process, we warned about potential unintended consequences that could affect patient access to quality and affordable healthcare services. We've heard of a few specific examples of insurance companies attempting to use very aggressive contract negotiation tactics to force hospitals out-of-network. This has the potential to leave patients without access to their local hospital for necessary services. This aggressive stance is new to the relationship between providers and insurance companies and unfortunately can lead to patients being denied care at their local hospital or being faced with unexpected or costly medical bills.

Support for Physicians

Furthermore, we have heard from the physician community that they are also experiencing similar problems with insurance companies. Simply put: Hospitals do not exist without physicians. As you know, New Jersey's hospitals hold the top spot in the country in patient safety scores. Attracting and retaining highly skilled and experienced physicians and other healthcare professionals is critical to achieving that high level of quality.¹ We support the physician community as it continues to work through its concerns.

¹ <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/state-rankings>

Implementation Issues

In addition to contracting concerns, consumers are confused about the new law. Without complete proper guidance from the regulatory agencies responsible for implementation and from the insurance carriers that hold the information about a consumer's healthcare benefits, providers are providing the required disclosures to consumers based on information that is often incomplete. Please see the list of implementation concerns on Appendix 1.

Leveling the Playing Field

NJHA has reconvened its out-of-network task force to identify problems and present solutions to the Legislature that will ultimately protect consumers from surprise out-of-network medical bills. We've been actively monitoring negotiations as hospital contracts come up for renewal. As this continues, we will have more information as to the trends in the negotiating environment. Lastly, the task force is actively monitoring implementation of the transparency and disclosure requirements to ensure that consumers are being educated about the Act's protections.

Thank you once again for allowing us to testify on this important issue. We look forward to our continued work with the Legislature and the Murphy Administration to provide high level quality of care to the patients we serve.

Appendix 1

We believe that some of the guidance offered to date goes beyond the requirements of the law. Specifically:

Department of Health (DOH) instructions state that the hospitals must provide the patient with “the names of health care professionals reasonably anticipated to provide services.” The instructions further state that the facility must provide the information for which health plans the health care professionals are in-network. However, section 4(a)(2) of the law states that the facility must: “*advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is in-network or out-of-network with respect to the covered person’s health benefits plan and provide information about how to determine the health plans participated in by any physician who is reasonably anticipated to provide services to the covered person.*”

Later in the section the law states that hospitals must provide: “a statement that:

(3) as applicable, the name, mailing address, and telephone number of the hospital-based *physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, and radiology*; and

(4) as applicable, the name, mailing address, and telephone number of *physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.*” (4 b (c) (3) and (4))

There are essentially three categories of physicians that perform services at a hospital: employed physicians, hospital-based contracted physician groups and physicians with privileges. For the most part, employed physicians contract with the same insurance companies as their hospitals. Hospital-based provider groups (like anesthesiology, etc) perform services in conjunction with the scheduling of an elective procedure and physicians with privileges are often specialists who work at multiple hospitals and provide necessary services for the hospital. The law clearly states that hospitals must inform the patient about information concerning *employed and hospital-based physicians*, but does not require the hospital to inform the patient about physicians with privileges. In many instances, it is impossible to know which health insurance plan every single individual physician has a contract with. In this case, the DOH instructions go beyond the letter of the law.

In addition, The DOH instructions require multiple points of time when the disclosure must be given, including being sent to the consumer for signature prior to the date of their scheduled service, after providing the disclosure verbally. Generally, this would have to be done by US mail since not all consumers use email and there are concerns about sending these disclosures without encryption. Often times patient schedule appointments for within 24-72 hours, therefore anything put in the mail would not realistically get to the patient’s home prior to their service date. We believe this also goes beyond the letter of the law.

We also believe that the Department of Banking and Insurance (DOBI) shall issue some clarifying guidance that includes:

1. Self-funded and fully insured (issued in NJ) status of health benefit plans is not transparent to the consumer, hospital or physician's office on the health plan ID card in most instances, and is not always available to providers in an electronic portal. There is no way to tell when the information was last updated. Having this information electronically at the time of scheduling services is critical to ensuring that the consumer is given the correct disclosure information and understands how the Act protects them. Providers often do not see actual ID cards until the patient presents for services, if at all. In addition, services excluded from a person's coverage are not listed. Coverage levels are at a summary level, so again, trying to provide details on what the potential out-of-pocket cost for consumers might be is difficult.
2. Explanations of Benefits (EOB) from carriers are sometimes not compliant with the Act. As a result, the network status of doctors and hospitals is not clearly shown on the EOBs. It is also not clear how the claim has been processed (i.e. whether the cost sharing "owed" is the in-network level of cost sharing or the out of network level of cost sharing). Additionally, consumers are confused by the explanations being offered concerning network status of doctors and hospitals. Consumer confusion and declining satisfaction as a result of the disclosures and other information required to be provided would appear to run contrary to the intent of the law.
3. We have heard that the programming changes required to bring EOBs and ID cards into compliance as well as the suppression of additional patient cost sharing post-arbitration are significant. Increases in healthcare insurance premiums are one strategy that carriers have referenced for paying for the cost of the Act's implementation. Resources invested by carriers to comply with the Act should not be counted as part of the carriers' medical loss ratio.
4. Hospital and physician office staff are spending significantly more time on the phone with consumers when they call to schedule services or procedures due to the disclosure requirements and answering patient questions. This has resulted in the need to adjust staffing to meet consumer needs.

We ask that this committee work with the regulatory agencies to provide clear and concise regulations to providers so that consumers receive accurate information to make informed choices.

etc...sometimes we get a little back. I hire collection companies, listen to educational seminars, pay lawyers to interpret the current regulations, unsubsidized mandates and still...bottom line is, that if an insurance company can get away with not paying, they will TRY to do that.

I enrolled in the managed Medicaids for a few reasons. I am losing money on every surgery I do on a Medicaid patient. For Medicaid, we collect about 1 % of charges. For managed Medicaid, we collect about 3%. I am paying my staff more per hour than I get for an office visit. Now that private insurance payments are going away, and we are being forced to arbitrate every claim, this is 100 times worse. Could a restaurant run on 3% of collections? Did you ever eat at a dinner or get plumbing done in your house and hand over 3% of the bill?

I am the Chair of the Ethics Committee for the AANS. I am sure that you all know what the Sunshine rule is. If a drug company takes me out to a fancy dinner, it has to be reported on the CMS website, right? WHY? Because as a doctor, if I have a COI, that should be public information. But when patients sign up for their insurance plan, are they told how much ROI is given to the shareholders of that company? Or what the doctors' satisfaction rating is for that insurance company? Or how well that insurance company treats doctors? Or how many hours I have to spend on the phone for patients just trying to get a script for a MRI Brain authorized for a child with a brain tumor? NO, none of that is ever disclosed in lay people or any other terms.

NJ is losing many great pediatric surgeons, subspecialists and doctors in general. These doctors are being replaced with mid-level practitioners, foreign med grads and others. Maybe 99% of you don't need doctors. But when someone's child has a brain tumor, or if their school bus rolls over, you are all going to be missing us badly. I LOVE my patients and their families. Most of them understand what is going on in healthcare. It's hard to tell a child and their family, I am sorry, but I cannot afford to see you anymore. When I cannot negotiate in network, and I am not being paid out of network, and the parent cannot afford it, and I cannot provide FREE care, there are no other options. THAT IS THE REALITY OF WHAT IS HAPPENING. I have had to STOP SEEING AND CARING FOR KIDS WITH MEDICAID AND SOME MANAGED MEDICAID. And the recently enacted OON law has only exacerbated this problem.

My question for this committee: Where is the money going? How many BILLIONS OF DOLLARS ARE INVESTED IN HEALTHCARE INSURANCE COMPANIES? Who reaps the benefits? Patients are being denied services, treatments, scans and x-rays and doctors and hospitals are underpaid or

SENATE COMMERCE COMMITTEE TESTIMONY

April 30, 2019

Dear members of the Commerce Committee,

I want to thank you for the opportunity to testify before you this afternoon. I would also like to thank Senator Vitale and Speaker Coughlin for their concern for patients, their medical bills and fair reimbursement.

My name is Dr. Catherine Mazzola, board certified pediatric neurosurgeon. I have been practicing in NJ since 2002 as an attending or senior neurosurgeon. I care for thousands of children with birth defects and other neurological problems. My partner, Dr. Luke Tomyecz and I operated on three of the children from the Paramus bus accident on Route 80 last year.

I am very concerned about the delivery of critical healthcare. When I started in practice in 2002, about 10 % of my patients had managed Medicaid and 1 % had straight Medicaid. The private insurers were paying about 80-90% of our surgical charges, and we were able to hire staff, build our practices, and support the necessary to care for these kids and their families.

Now, in 2019, about 25% of my patients have private insurance and 74% have managed Medicaid and 1 % straight Medicaid. These are the poorest or the poor. Every year, I also provide FREE care to 3- 5 kids who have no insurance, and who are not citizens at all. For me, there is no reimbursement, no benefit but a HUGE MEDICAL LIABILITY. Every year my medical malpractice increases, and even by providing FREE care, there is no protection or lesser risk. Even if I do EVERYTHING PERFECTLY, if a child takes a turn for the worse, I am held responsible.

I started my practice in 2009. I employ 14 staff and one other pediatric neurosurgeon. In July, August and September 2018, I took no salary in order to keep the lights on at my practice. I couldn't sleep I was so stressed out. My husband wanted and still wants us to move to FL. I do not want to leave. I want to stay in NJ. I look at the faces of my patients, the kids on that school bus...and I know I should stay here. If our practice closes that would be a disaster. The other neurosurgery groups are feeling the same stressors as me. Frankly, we are at a tipping point in NJ.

I cannot FIX the healthcare problem. The ability of insurance companies to undercut doctors for their services is KILLING our practices. We are all small business owners and we are struggling to make ends meet. I have insurance companies paying the 10% NP/ assistant fee and denying the surgeon's fee. Years later after several appeals, letters to DOBI, ERISA

not paid at all. So where is all the money going?? Now we physicians have to hire lawyers to arbitrate payments for our services that maybe only five people in NJ can perform? Are you kidding? Lawyers charge 500/ hour. They don't get Medicaid rates. Not even managed Medicaid. I cannot AFFORD YOUR LEGISLATION.

I provide hundreds of thousands of dollars in free care every year. I get no tax break. I get nothing. ZERO. Not even a THANK YOU LETTER from the state, hospital or anyone except...my patients. And while I TRULY LOVE THEM, I CANNOT WORK FOR FREE. I have to pay my employees. I have to pay their healthcare benefits. I have to pay taxes. I have to pay rent. I have to pay my insurance. I am driving a 2013 FORD EXPLORER WITH about 100,000 miles on it. I have 3 biological sons, and 2 adopted daughters and I am the sole provider for my family. I am BEGGING YOU TO FIX THIS LAW AND MAKE THE INSURANCE COMPANIES PAY AT LEAST 75%-80% OF CHARGES OR FULL FAIR HEALTH WITHOUT ANY ARBITRATION AND TO DISCLOSE ANY AND ALL COI'S ON THEIR WEBSITES. I WANT PATIENTS TO KNOW WHAT THEY ARE BUYING. Right now, they think their insurance covers them and really what they get is a shell or an empty promise.

Thank you so much for listening to me and I'd be happy to answer any questions you may have.

SENATE COMMERCE COMMITTEE TESTIMONY

APRIL 30, 2019

Dear Chairwoman Pou and esteemed members of the Senate, I would like to thank you for the opportunity to testify before you. My name is Ciro Giuseppe Randazzo and I am a Board certified neurosurgeon and endovascular neurosurgeon, partner at IGEA Brain and Spine, Comprehensive Stroke Center Director at St. Joseph's Regional Medical Center in Paterson, board member of the New Jersey Doctor Patient Alliance, current Treasurer and President-Elect of the New Jersey Neurosurgical Society. Prior to my current positions, I was the Comprehensive Stroke Director at Atlanticare Regional Medical Center in Atlantic City.

After finishing medical school at UMDNJ, I began neurosurgical residency at Thomas Jefferson in Philadelphia. As a resident there, we received innumerable transfers from throughout New Jersey because there was a shortage of neurosurgeons willing to take cranial call in the Southern part of the state – malpractice was too high, reimbursement was too low and simply not enough neurosurgeons to cover all of the hospitals in South Jersey. After training, I accepted a job at Atlanticare and we were able to build a successful neurosurgical

service line. Within two years, we were doing over 500 cases, retaining significant neurosurgical volume in Southern New Jersey and saving lives. Many of the patients we were treating would have died had they been transferred - a situation I had seen many nights as a resident in Philadelphia. After two years of recruitment, I was able to bring on a partner and we doubled our volume. Due to poor provider contracts, with two neurosurgeons doing more than a thousand new cases a year and reducing transfers out of the state, the hospital was unable to continue to support entry level salaries and we were forced to leave the practice. It took over a year and a half to find a replacement. That replacement did not provide 24/7 coverage and patients once again suffered by having to be transferred out of New Jersey after regular business hours. This same situation is now beginning to develop throughout New Jersey.

Unfortunately, though the OON bill has excellent protections for patients, it is devastating our ability to continue to build neurosurgical practices in New Jersey. New Jersey is **NOT** in easy state to practice medicine in. Even before the OON law, NJ:

- Routinely ranked as the first or second **LEAST FRIENDLY** to practice medicine

- Is sandwiched between two of the largest cities in the country with spectacular, historical healthcare institutions
- has one of the highest costs of living.
- Continues to raise the taxes and limit deductions
- Has no protections for physicians from frivolous malpractice claims

As a result, my practice is now seeing offers turned down for new physicians as we can no longer offer a competitive starting salary or a favorable practice environment. There are currently fewer than 80 neurosurgeons in NJ. This includes pediatric neurosurgeons (9). Many of the adult neurosurgeons do NOT EVEN perform cranial surgery.

As a result of the OON bill, we have also had to outsource our billing to an out of state billing company and lay off five employees of our billing staff as collections have become increasingly difficult. In 2018, we performed the same amount of clinical work as 2017 and our reimbursements were reduced by 1/3. Our first quarter of 2019 appears even worse.

While we now have a very useful piece of well-thought out legislation in the out of network bill, it appears, the insurance companies continue to exploit this law, patients and physicians. Under this law, it took at least **9 MONTHS** before the first case was heard. These delays in reimbursement significantly disrupt our ability to run a small business successfully. There is a reason for prompt payment laws.

Furthermore, the OON law has emboldened insurance companies to sell ever higher priced plans which promise choice through false OON benefits all as they raise copays, coinsurance and deductibles to deter patients from obtaining care.

When a patient finally does seek out care, providers are then reimbursed as close to Medicare rates as possible by pegging those "OON benefits" to 85-120% of Medicare. When the charges settle out, patients are paying more than the insurance companies for treatments even as they are seeing IN-network doctors.

As physicians, it is often difficult to discuss the cost of care with patients. The OON bill requires us to inform patients of their financial responsibility. Though well intentioned, this is extremely distasteful and awkward, particularly in a life-threatening emergency. Should patients and their family members really have to decide, after physicians spend hours building a rapport and telling them that their loved one has a very high likelihood of imminent death, that they may want to

consider an in-network doctor? How should I tell a family member that there loved one needs to have his/her head sawed open immediately and then tell them they should seek out the lowest bidder to do that job? Assuming there is another neurosurgeon available, it is almost impossible in a reasonable amount of time in off hours, to know what a patient's costs will be for a procedure. Plan reimbursement varies even amongst in-network providers under the same Geozip. We need further guidance from DOBI on how to handle these situations.

Ultimately, the problem is low, arbitrary and capricious in-network provider reimbursement which leads to a need for providers to cost-shift. If we want to see the final effects of allowing insurance companies to dictate reimbursement without a standard or a floor, simply look at Medicaid Managed Care plans. An emergency life-saving craniectomy pays about \$500. In negotiations Horizon NJ Health, despite having NOT A SINGLE NEUROSURGEON WHO PARTICIPATES IN THEIR PLAN, will only offer to pay Medicare rates. They will tell you they are losing money under these plans which the federal and state government fully fund. Their financial statements however reveal otherwise as does Shelby Livingston in *Modern Healthcare* - Medicaid WellCare CEO Kenneth Burdick received a salary of \$12.7 million in 2018 – his realized pay SOARED 130.4%.”

We implore this Committee to establish a floor to provider reimbursement in NJ so we may continue to provide the excellent care that the citizens of this great state

deserve. If this Legislature does not restrict the unfair price setting practices of the insurance companies and the significant delays in the payment process, our practices and small businesses will not be able to survive. Many New Jerseyans will lose their doctors, their lives and their jobs. We cannot continue to operate below cost – which Medicare rates certainly are. The Neurosurgical Society of New Jersey and the Doctor Patient Alliance beseech this committee to adopt a reasonable standard as a basis for physician reimbursement under this law.

Thank you.

Good Afternoon,

My name is Darlene Prevocki. I have been in the medical billing industry for the last 40 years, when 'fee-for-service' billing was first introduced to hospital-based doctors. I was at the forefront of starting-up these practices for different doctors (namely, radiology and pathology).

I have been on both sides of the problem and I do understand the concerns and the need for this law. I have been both, a patient who has received surprise medical bills and an employee who works for doctors, fighting for every cent from the insurance carriers.

I believe that this Law was intended for patients who have out-of-network claims that exceed into the thousands of dollars. I never want to see any patient struggle with medical bills and have always prided myself to be more of a 'patient advocate' than a medical biller.

There are two types of hospital-based doctors that are being encompassed by this new Law.

The problem is not being caused by the smaller physician groups such as radiology, pathology, cardiology and emergency room physicians. These doctors' bills are usually under \$200 after the insurance pays.

The larger problem is those expenses that exceed into the thousands of dollars. These are the bills that patients cannot afford to pay. Bills of this magnitude are created by specialty doctors such as anesthesiologists, neonatal doctors, infectious disease physicians and alike.

Based on the structure of this Law, as it is written today however, the smaller groups of physicians will be forced out of business within the next 30-90 days.

Since 1985, I have been working for a group of 18 cardiologists who only bill for one, single service: the reading, interpretation and reporting of EKGs rendered on hospital-based patients. Our fee for this service is \$95 and 94% of our patients come into the hospital on an emergent basis.

Medicare, Medicaid and Horizon plans only approve between \$4 and \$9 for our service and, as we all know, 78% of self-pay and charity care patients are written off as bad debts. This only leaves us with a minimal source of revenue; the 11% of patients who are covered under self-insured plans. We simply cannot afford to participate with these carriers as they are our only source of revenue to keep us in business.

Most insurance companies have a Rider on their policies that cover out-of-network providers, rendering services at an in-network facility. However, since the onset of this new OON Law, they have eliminated the use of this benefit and are now refusing to pay balance-due claims or negotiate amounts.

Unfortunately, this new OON Law was written and implemented with and/or without the following parameters:

First - No fee schedule was attached to this Law that enforces an amount that the insurances must pay. Without this in place, they are now approving minimal amounts, forcing doctors to write-off the balances. These write-offs are now totaling into the thousands of dollars. The carriers are unwilling to negotiate, knowing that we cannot balance bill. We have absolutely no leverage to work with.

This is a vital component and I believe that this Law should have never been implemented without a fee schedule attached to it.

For the last five months, our practice has been struggling to pay our mandated business expenses and the doctors did not receive any salary last month and it appears that, going forward, this will continue. So now, they are essentially working for free.

The proposal being made here today is to adopt and mandate payments at the 85% percentile of the Fair Health Benchmark. I feel that this would be a great start.

Secondly, it appears that the Law was originally written to cover the NJ State Employees and patients covered under the Affordable Care Act. The Law describes (in section #3) that the 'carrier shall not include any other entity providing or administering self-funded benefits plan'.

This Law also outlines that the self-funded plans must elect to be entered into and be subject to the terms and conditions, (items #7-e, #9-d and #20).

In addition, once ERISA plans (self-pay carriers) enroll into the Surprise Bill Law, they must notify the members of this on their ID cards, (per #6-e). I have reviewed patient ID cards and there is no indication showing that they are enrolled.

Currently, many self-funded benefit plans (such as: AmeriHealth NJ, Oxford, and Aetna, to name a few) have adopted this policy wherein they are paying close to nothing and notifying their members that they are not responsible for payment of the balances. However, they do not provide any indication on the Explanation of Benefits that they have enrolled into or are paying under the OON Law, as described in item #6-d.

I have not been able to obtain a list of the enrolled carriers and am waiting for a response from the NJ Department of Banking and Insurance. This information should be readily available to both patients and physicians on their website.

Without this information being listed on the EOB or on the patient ID cards and not being able to access a list of the enrolled carriers, there is no way for us to determine which insurances can and/or cannot be mandated to pay the balances.

If this Law is being embraced by self-pay insurances, enabling them to pay less, then it should be mandated that they follow the terms and conditions of the Law by:

- a.) Notifying us of the effective date that they have enrolled
- b.) Specifying that a claim is being processed under the OON guidelines and
- c.) Provide ID cards to their policyholders that indicate this information.

If they are not following these terms and conditions, then they should not be allowed to pay these smaller amounts and notify their patients that we cannot balance bill them.

My third concern is the arbitration process set forth in this Law. This ONLY allows for arbitration on claims that exceed \$1000 on the *same* patient, for services rendered during the *same* encounter. This is not outlined in Item #10 of the Law but it is noted on the DOBI Bulletin No. 18-14.

With this guideline in place, every insurance carrier will want to opt-into the Law because this will benefit them.

The OON Law encompasses ALL hospital-based doctors (large specialists and small practices alike); however, the only appeals that they will receive will be those sent by the specialists, whose bills exceed \$1000.

The benefit that they will receive is that all small practices within the hospital will have to accept their allowable amount as payment in full and they will not have to arbitrate or negotiate on these claims.

Perhaps the Law can exempt these smaller groups of doctors and/or place a limit on how much they can bill per encounter (ex: \$300 maximum) so that they can maintain their business expenses.

The fourth area of concern is that the DOBI instructed that smaller practices should facilitate the option of the Program for Independent Claims Payment Arbitration (PICPA) process. They state that this would enable us to aggregate different claims to exceed \$1000 for each insurance carrier. However, the problem is that we would not be able to use this service because 94% of the EKG readings are performed on an emergent basis.

Per the DOBI correspondence that I received, PICPA handles only non-emergent claims and according to the website, they "will not consider claims arising from: self-funded health plans or contracts for the Federal Employees Health Benefits Program

and the State Health Benefits Program (whether self-funded or insured – *both programs have their own review systems*”.

So, between the two types of appeals available (arbitration and PICPA), neither one can be utilized by the smaller practices who perform services on different, emergent-care patients.

The recommendation I have is that one or both of these appeal modalities be modified to accommodate aggregated claims totaling over \$500, on emergent-care patients, processed by self-fund plans*

*However, please note: this would not be needed if the Law mandates notifications to physicians when self-funded carriers enroll into the Law, present this information on the EOB and ID cards and pay based on a fee schedule.

And lastly, despite the fact that our small practice is currently unable to appeal with either process currently provided, this Law was set-up with unobtainable time restrictions for the appeals and arbitration procedures.

a.) The Law states that the first appeal must be done by the doctor within 30 days of the date of payment (usually sent by mail, which cuts the office down to 3 weeks).

b.) The insurance carrier then has 30 days to respond and notify the office that they will not negotiate. This is rarely, if ever done. I know this because I have been submitting appeals since day one on these types of payments and only ONE self-pay carrier sends a response that they will not negotiate.

c.) And, within 30 days of this notice, doctors must then begin and submit an arbitration claim.

Being in a billing environment with limited staff, I am in agreeance with the proposals being set-forth today requesting that the time limitations be extended to, at the very least, a 90- to 150-day window, in order to accommodate the increased amount of work volume that must be performed by the staff.

In closing, if changes are not made to this Law, I am at a loss of how we can continue to conduct business. The doctors are not receiving salaries, the practice is unable to pay its monthly expenditures and, for the first time in 33 years, we have fallen behind in paying our bills. Insurances have been paying minimal amounts for the last six months, we have no way to know if they are enrolled and we have no appeals process available to us. Therefore, at this point, our practice will be forced to close within the next 60 days.

Putting our hospital-based doctors out of practice will have them leaving the State and will put hundreds (if not thousands) of employees out of a job.

My plea here today is that you consider the following:

#1.) The introduction and enforcement of a fee schedule at the 85% percentile of the Fair Health Benchmark. Please consider implementation of this to be done on a retroactive basis to assist offices recoup the losses that they have incurred over the last 4-6 months. Without that, the doctors will continue to work for free and will be forced to close.

#2.) Smaller practices such as radiology, pathology, cardiology and emergency room physicians are not the problem. They are not causing the large, out-of-control costs.

I am in hopes that these groups can either be exempt from this Law, which would enable the insurances to restore the Riders that cover these smaller claims or provide us with an appeals process that will allow us to aggregate claims, performed on an emergent basis that are processed by self-funded plans at a reduced cost that we can afford.

#3.) The Law must enforce an accessible list of enrolled insurance carriers and their effective dates through the DOBI website or other means. Insurances carriers must notify physicians that they have enrolled into this contract along with the effective date, via the Explanation of Benefits remittance and the members' ID cards to substantiate

this information. We should also be provided a list of insurance carriers who may terminate their enrollment.

#4.) The volume of work involved to appeal and/or arbitrate is going to be overwhelming for all parties involved, therefore, it there is an absolute need for time extensions to be modified on the current Law.

I thank you for your time and considerations in these matters and I will be happy to answer any questions you may have at this time:

Darlene Prevocki

Operating Officer
Plains Cardiopulmonary Associates

April 15, 2019

To whom it may concern:

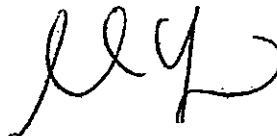
Please accept this letter of introduction in conjunction with our testimony before the committee. We are Michael Bilof and Basil Yurcisin bariatric surgeons practicing at 4 hospitals in New Jersey; St Barnabas in Livingston, Overlook in Summit, Monmouth in Long Branch and Deborah Heart and Lung in Browns Mills. Each of us are a Fellow in the American College of Surgeons (FACS) and a Fellow in the American Society of Metabolic and Bariatric Surgery (FASMBS). Dr Bilof is a past President of the NJ Chapter of the ASMBS and current section chief for bariatrics at Deborah Heart and Lung. Dr Yurcisin is the current section chief for bariatrics at St Barnabas.

Our practice is "Garden State Bariatrics & Wellness Center" which is a 100% bariatric surgical practice in the state since 2007. The issue we would like to discuss with the committee is the inappropriate application of the recently passed "Out of Network" bill to medical interventions to which it was not intended.

The law was designed to apply in situations that are deemed "inadvertent, emergent or involuntary". Bariatric Surgery is the complete antithesis of that. These surgeries are completely elective and pre-authorized with the insurance carrier. The typical patient will meet with a Physician, Registered Dietician, Psychologist and other affiliated staff on multiple occasions during a lengthy (typically 3-6 months) pre-operative process. The process is capped by a determination from the insurance company that the patient has the benefit and meets requirements to undergo the procedure.

Despite that, our practice has repeatedly received reduced payments from insurance that cite the Out of Network bill as the reason (see submitted EOB's). The insurance company further encourages us to begin an arbitration process that is not applicable.

Respectfully,



Michael Bilof, MD, FACS, FASMBS

Basil Yurcisin, MD, FACS, FASMBS

North Jersey Office
225 Millburn Avenue Suite 204 | Millburn, NJ 07041
P: 973.218.1990 | F: 973.629.1274

South Jersey Office
1430 Hooper Ave. Ste 203 | Toms River, NJ 08753
P: 732.269.6800 | F: 973.629.1274

Garden State Bariatric
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Date: /19/2019
PAGE 2 OF 4

JAN 24 2019

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PATIENT							SUBSCRIBER				SUB ID		CLAIM NO			PATIENT ACCT	
DOS	RNK	POS	TOS	QTY	PROC	MOD	BILLED	NOT ALLOWED	REAS	ALLOWED	CO-INS	COPAY	DEDUCTIBLE	CUST LIAB	REAS	OTHER CARR	PAID

NJ DIRECT - PROVIDER SERVICES: (800)624-1110

2/18/18 Z319 11 1 1 99213							0.00	189.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	189.00
Z632																
Y755																
Y751																
CLAIM TOTAL:							0.00	189.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	189.00

7532 PLEASE NOTE. CLAIMS MUST BE FILED WITHIN 15 MONTHS AFTER THE END OF THE CALENDAR YEAR IN WHICH THE CHARGES WERE INCURRED. FOR EXAMPLE, IF A SERVICE WAS PROVIDED IN 2011, YOU WOULD HAVE UNTIL MARCH 31, 2013 TO FILE A CLAIM.

755 HORIZON PROVIDES ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

751 THIS SERVICE IS PAID IN ACCORDANCE WITH THE MULTIPLAN DISCOUNT RATE AGREEMENT. MEMBER LIABILITY IS LIMITED TO APPLICABLE COPAYS, COINSURANCE AND DEDUCTIBLES.

319 YOU ARE NOT A PARTICIPATING PROVIDER WITH HORIZON BCBSNJ. THE CHARGE EXCEEDS THE MAXIMUM ALLOWED BY THE MEMBER'S HEALTH BENEFIT PLAN. THE AMOUNT THE MEMBER IS RESPONSIBLE FOR IS SHOWN ON THIS FORM.

0/22/18 G809 21 2 1 43775							0.00	2,214.47	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2,214.47
Z319																
0/22/18 G809 21 2 1 43235-59							0.00	252.67	0.00	0.00	0.00	0.00	0.00	0.00	0.00	252.67
Z319																
Z632																
Y755																
G807																
CLAIM TOTAL:							0.00	2,467.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2,467.14

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809 WE FIND THE CHARGES FOR THIS SERVICE TO BE EXCESSIVE, PURSUANT TO NJ ASSEMBLY BILL 2039, WE HAVE FINALIZED THIS CLAIM WITH A PAYMENT THAT WE CONSIDER TO BE FAIR REIMBURSEMENT FOR THE SERVICE RENDERED. UNDER THIS LAW GOVERNING THE PAYMENT OF INADVERTENT AND INVOLUNTARY SERVICES BILLED BY OUT-OF-NETWORK PROVIDERS, YOU HAVE 30 DAYS FROM THE DATE OF THIS NOTIFICATION TO NEGOTIATE WITH US BY CALLING US AT 1-800-624-1110.

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Date: 1/19/2019
PAGE 3 OF 4

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PATIENT							SUBSCRIBER				SUB ID		CLAIM NO.			PATIENT ACCT	
DOS	RMK	POS	TOS	QTY	PROC	MOD	BILLED	NOT ALLOWED	REAS	ALLOWED	CO-INS	COPAY	DEDUCTBLE	CUST LIAB	REAS	OTHER CARR	PAID
1/07/18	G809	21	8	1	43775-AS			0.00		301.18	0.00	0.00	0.00	0.00		0.00	301.18
	Z319									4							
	Z632																
	Y755																
	G807																
CLAIM TOTAL:								0.00		301.18	0.00	0.00	0.00	0.00		0.00	301.18

Z632 PLEASE NOTE: CLAIMS MUST BE FILED WITHIN 15 MONTHS AFTER THE END OF THE CALENDAR YEAR IN WHICH THE CHARGES WERE INCURRED. FOR EXAMPLE, IF A SERVICE WAS PROVIDED IN 2011, YOU WOULD HAVE UNTIL MARCH 31, 2013 TO FILE A CLAIM.

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									30				
1/26/18	G809	21	8	1	43775-AS	0.00	294.48	0.00	0.00	0.00	0.00	0.00	294.48
	Z319												
1/26/18	U715a	21	8	1	43281-AS	0.00	409.32	0.00	0.00	0.00	0.00	0.00	0.00
	Z632												
	Y755												
	G807												
CLAIM TOTAL:					52,387.00	0.00	703.80	0.00	0.00	0.00	0.00	0.00	294.48

Z632 PLEASE NOTE: CLAIMS MUST BE FILED WITHIN 15 MONTHS AFTER THE END OF THE CALENDAR YEAR IN WHICH THE CHARGES WERE INCURRED. FOR EXAMPLE, IF A SERVICE WAS PROVIDED IN 2011, YOU WOULD HAVE UNTIL MARCH 31, 2013 TO FILE A CLAIM.

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Y15a THIS SERVICE IS NOT PAID SEPARATELY. THIS SERVICE IS INCIDENTAL TO A PROCEDURE THAT HAS ALREADY BEEN PROCESSED FOR THIS DATE OF SERVICE UNDER CLAIM NUMBER 780261900834748 00.

Garden State Bariatric
& Wellness Center

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Date: 1/15/2019
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JAN 23 2019

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PATIENT							SUBSCRIBER				SUB ID		CLAIM NO			PATIENT ACCT	
DOS	RMK	POS	TOS	QTY	PROC	MOD	BILLED	NOT ALLOWED	REAS	ALLOWED	CO-INS	COPAY	DEDUCTIBLE	CUST LIAB	REAS	OTHER CARR	PAID
Z319 YOU ARE NOT A PARTICIPATING PROVIDER WITH HORIZON BCBSNJ. THE CHARGE EXCEEDS THE MAXIMUM ALLOWED BY THE MEMBER'S HEALTH BENEFIT PLAN. THE AMOUNT THE MEMBER IS RESPONSIBLE FOR IS SHOWN ON THIS FORM.																	
[REDACTED]							[REDACTED]				[REDACTED]						
10/08/18	G809	21	8	1	43775-1		0.00			301.18	0.00	0.00	0.00	0.00		0.00	301.18
	Z319																
	Z632																
	Y755																
	G807																
CLAIM TOTAL:							0.00			301.18	0.00	0.00	0.00	0.00		0.00	301.18

Z632 PLEASE NOTE, CLAIMS MUST BE FILED WITHIN 15 MONTHS AFTER THE END OF THE CALENDAR YEAR IN WHICH THE CHARGES WERE INCURRED. FOR EXAMPLE, IF A SERVICE WAS PROVIDED IN 2011, YOU WOULD HAVE UNTIL MARCH 31, 2013 TO FILE A CLAIM.

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Date: 1/09/2019
 PAGE 3 OF 9

Check No:
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PATIENT							SUBSCRIBER				SUB ID		CLAIM NO			PATIENT ACCT	
DOS	RMK	POS	TOS	QTY	PROC	MOD	BILLED	NOT ALLOWED	REAS	ALLOWED	CO-INS	COPAY	DEDUCTBLE	CUST LIAB	REAS	OTHER CARR	PAID

11/12/18	G809	21	8	1	43775-AS		0.00	301.18		0.00	0.00	0.00	0.00			0.00	301.18
	Z319																
	Z632																
	Y755																
	G807																
CLAIM TOTAL:							0.00	301.18		0.00	0.00	0.00	0.00			0.00	301.18

11/12/18	G809	21	2	1	43775		0.00	2,214.47		0.00	0.00	0.00	0.00			0.00	2,214.47
	Z319																
11/12/18	G809	21	2	1	43235-59		0.00	126.34		0.00	0.00	0.00	0.00			0.00	126.34
	Z319																
	Z632																
	Y755																
	G807																
CLAIM TOTAL:							0.00	2,340.81		0.00	0.00	0.00	0.00			0.00	2,340.81

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Y751 THIS SERVICE IS PAID IN ACCORDANCE WITH THE MULTIPLAN DISCOUNT RATE AGREEMENT. MEMBER LIABILITY IS LIMITED TO APPLICABLE COPAYS, COINSURANCE AND DEDUCTIBLES.

Z455a MEMBER COINSURANCE OF \$94.65 WAS APPLIED TO THIS CLAIM.



Date: 1/09/2019
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PATIENT							SUBSCRIBER				SUB ID		CLAIM NO			PATIENT ACCT	
DOS	RMK	POS	TOS	QTY	PROC	MOD	BILLED	NOT ALLOWED	REAS	ALLOWED	CO-INS	COPAY	DEDUCTIBLE	CUST LIAB	REAS	OTHER CARR	PAID

NJ DIRECT - PROVIDER SERVICES: (800)624-1110

0/29/18	G809	21	2	1	43775-58		0.00	1,062.24		0.00	0.00	0.00	0.00		0.00	1,062.24	
	Z319																
0/29/18	G809	21	2	1	43282-58		0.00	3,464.60		0.00	0.00	0.00	0.00		0.00	3,464.60	
	Z319																
0/29/18	G809	21	2	1	43235-58		0.00	126.33		0.00	0.00	0.00	0.00		0.00	126.33	
	Z319																
	Z632																
	Y755																
	G807																
CLAIM TOTAL:							0.00	4,653.17		0.00	0.00	0.00	0.00		0.00	4,653.17	
0/29/18	G809	21	8	1	43775-AS		0.00	150.59		0.00	0.00	0.00	0.00		0.00	150.59	
	Z319																
0/29/18	G809	21	8	1	43282-AS		0.00	471.19		0.00	0.00	0.00	0.00		0.00	471.19	
	Z319																
	Z632																
	Y755																
	G807																
CLAIM TOTAL:							0.00	621.78		0.00	0.00	0.00	0.00		0.00	621.78	

2632 PLEASE NOTE: CLAIMS MUST BE FILED WITHIN 15 MONTHS AFTER THE END OF THE CALENDAR YEAR IN WHICH THE CHARGES WERE INCURRED. FOR EXAMPLE, IF A SERVICE WAS PROVIDED IN 2011, YOU WOULD HAVE UNTIL MARCH 31, 2013 TO FILE A CLAIM.

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ate: 3/01/2019
AGE 2 OF 9

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MAR 08 2019

RECEIVED

PATIENT							SUBSCRIBER				SUB ID		CLAIM NO			PATIENT ACCT	
JS	RMC	POS	TOS	QTY	PROC	MOD	BILLED	NOT ALLOWED	REAS	ALLOWED	CO-INS	COPAY	DEDUCTBLE	CUST LIAB	REAS	OTHER CARR	PAID

15/18	21	8		1	43845-AS		0.00			433.26-	0.00	0.00	0.00	0.00		0.00	433.26-
15/18	21	8		1	44180-AS		0.00			1,494.11-	0.00	0.00	0.00	0.00		0.00	1,494.11-
CLAIM TOTAL:							0.00			1,927.37-	0.00	0.00	0.00	0.00		0.00	1,927.37-
15/18	21	8		1	43845-AS		0.00			1,203.50	0.00	0.00	0.00	0.00		0.00	1,203.50
15/18	21	8		1	44180-AS		0.00			564.45	0.00	0.00	0.00	0.00		0.00	564.45
CLAIM TOTAL:							0.00			1,767.95	0.00	0.00	0.00	0.00		0.00	1,767.95

2 PLEASE NOTE CLAIMS MUST BE FILED WITHIN 15 MONTHS AFTER THE END OF THE CALENDAR YEAR IN WHICH THE CHARGES WERE INCURRED. FOR EXAMPLE, IF A SERVICE WAS PROVIDED IN 2011, YOU WOULD HAVE UNTIL MARCH 31, 2013 TO FILE A CLAIM.

5 HORIZON PROVIDES ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

PURSUANT TO THE OUT-OF-NETWORK CONSUMER PROTECTION, TRANSPARENCY, COST CONTAINMENT AND ACCOUNTABILITY ACT, MEMBERS ARE NOT LIABLE FOR FULL PAYMENT OF INADVERTENT, EMERGENT OR INVOLUNTARY CHARGES FROM OUT-OF-NETWORK PROVIDERS, AND MEMBERS CANNOT BE BILLED FOR AMOUNTS ABOVE THEIR COSTS FOR IN-NETWORK SERVICES. IF YOU TREATED THIS PATIENT ON AN INADVERTENT, EMERGENT OR INVOLUNTARY BASIS BUT THE PAYMENT DOES NOT REFLECT THAT, CALL 1-800-624-1110. OUR NEGOTIATION ATTEMPTS TO SETTLE THE ALLOWED CHARGE FOR THESE INADVERTENT, EMERGENT OR INVOLUNTARY SERVICES WERE NOT SUCCESSFUL. THE INCREASE FROM THE ORIGINAL PAYMENT REPRESENTS OUR FINAL OFFER FOR REIMBURSEMENT OF THIS SERVICE. AS A RESULT OF THIS INCREASE, THE MEMBER'S ORIGINAL COST-SHARE MAY HAVE INCREASED. IF THE SERVICE IS ARBITRATED, THE MEMBER'S COST-SHARE WILL NOT INCREASE FURTHER REGARDLESS OF OUTCOME. THE MEMBER CANNOT BE BALANCED BILLED ABOVE THEIR NOTED COST-SHARING LIABILITY.

YOU ARE NOT A PARTICIPATING PROVIDER WITH HORIZON BCBSNJ. THE CHARGE EXCEEDS THE MAXIMUM ALLOWED BY THE MEMBER'S HEALTH BENEFIT PLAN. THE AMOUNT THE MEMBER IS RESPONSIBLE FOR IS SHOWN ON THIS FORM.

X G-code

34x



Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza
Newark, NJ 07105-2200
www.HorizonBlue.com

K131546C000480 002/003

April 22, 2019

Genova State Building
8 Wellness Center

APR 26 2019

RECEIVED

RE: Patient Name:
Member ID Number:
Reference Number:
Date(s) of Service:
Claim Number:
Patient Account Number:

Dear Health Care Professional:

Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) acknowledges receipt of your written inquiry on March 22, 2019.

After careful review, please be advised that the claim was processed correctly in accordance to the applicable allowance under this plan. The payment represents the maximum benefit allowance for the procedure(s) performed.

Our records indicate that you are not a participating doctor with this plan. The claim was processed and paid correctly per inquiry with members in network benefits based on the provider participating status with us. No adjustment is made to alter the payment.

This plan covers only reasonable and customary allowances, which are determined by the Prevailing Healthcare Charges System (PHCS) fee schedule. This schedule is based on actual charges by physicians in a specific geographic area for a specific service.

We value your partnership and your concerns are very important to us. Should you have further questions, please feel free to contact us at one of the numbers below:

- Physician/Healthcare Professional at 1-800-624-1110
- BlueCard Dedicated Unit at 1-888-435-4383
- Institutional/Facility at 1-888-666-2535

(Continues)





Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza
Newark, NJ 07105-2200
www.HorizonBlue.com



Did you know by accessing Horizon's website www.horizonblue.com or by using our automated Interactive Voice Response (IVR) system which is available 24/7 for your convenience, you can save time and minimize the need to contact us via a telephone call? These online services make it easy for you to access the important information you need to manage your patients such as *Claim Status; Eligibility/Benefits; Referral Submission; and other pertinent information*. Registration for the website is easy. If you encounter problems during registration, you can contact our eBusiness Helpdesk (Monday – Friday from 8:00 a.m. to 5:00 p.m. EST) at 1-888-777-5075.

Information on your appeal rights is available at <https://services5.horizon-bcbsnj.com/eprise/main/horizon/tsnj/tsweb/appeals.html>

Sincerely,

Shweta Khaitan

Shweta Khaitan
Service Request Correspondence
Provider Services Department

Garden State Building
& Wellness Center

APR 26 2013

RECEIVED





P.O. BOX 981106
EL PASO TX 79998-1106
USA

Payment Address:

Provider Address:

Explanation Of Benefits

Please Retain for Future Reference

Printed:
Page:

PIN:
TIN:
Trace Number:
Trace Amount:

Get paid faster sign up for EFT today!

With electronic funds transfer (EFT), we deposit your payments directly to your account. No more trips to the bank! Sign up through EnrollHub® at <https://solutions.caqh.org>. Or get a paper enrollment form. Medical providers go to www.aetnaeft.com. Dental providers go to www.aetnadentaleft.com.

Patient Name:

Claim ID

Recd:

Member ID:

Patient Account:

Member:

DIAG:

Group Name:

Group Number:

Product:

Network ID:

Aetna Life Insurance Company

Network Status: Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/28/18	21	4364482	1.0					1				384.80
12/28/18	21	4328182						2				0.00
		51										
TOTALS												384.80

ISSUED AMT:

\$384.80

Remarks:

- 1 - This appears to be an inadvertent or involuntary covered out of network service at an in-network facility, or a bill for emergency services. The patient does not owe the healthcare provider anything more than the plan's in-network copayment, coinsurance or deductible. New Jersey law prohibits a healthcare provider from billing the patient for any additional amount.

The patient has been informed to notify us if a provider bills the patient for any additional amount. We have paid this claim at an initial allowance that may be less than the billed charge. If you do not accept our allowance as payment in full, you have the right to negotiate with us for a 30 day period from the date you received this notice.

Please request the negotiation as soon as possible. It may be filed by email, fax, or certified mail:

Email: NJSurpriseBill@aetna.com

Certified Mail: Aetna
P.O. Box 981106
El Paso, TX 79998-1106

Fax: 1-859-455-8650

SPECIAL HANDLING - NJ NEGOTIATION FOR AN OUT-OF-NETWORK CLAIM.

If the request is not received within 30 days of receipt of this payment notice the provider will not be able to address the bill through the New Jersey arbitration process for inadvertent, involuntary and emergency claims. [NJ1]

- 2 - The member's plan provides coverage for charges that are reasonable and appropriate. This charge is for a service that is considered incidental to another procedure performed on the same date of service. [V31]

Continued on Next Page

37x

Testimony of Dudley Burdge
for the Communications Workers of America
before the New Jersey Senate Commerce Committee
concerning Out of Network Payments
April 30, 2019

Last year, after a decade of effort, the New Jersey legislature passed and Governor Murphy signed landmark legislation protecting New Jersey consumers from often unconscionable emergency and surprise out of network bills.

The legislation also played a small role in reducing health costs. Since the typical New Jersey family with commercial insurance typically pays 25% of premium cost (in addition to out of pocket expenses), any decrease in premiums or the premium equivalents of self-insured plans helps New Jersey families.

The Context of Out of Network Payments in New Jersey - the World's Highest Health Care Costs

Every year the Health Care Cost Institute, using data provided by Medicare and major health insurance carriers, produces a report on the comparative costs of health care in the United States. New Jersey has consistently had among the highest costs in the nation and by extension the world. For the last year available, 2017, New Jersey had the highest cost among states with similar or greater population. We were only behind the rural and low population states of Wyoming, South Dakota, West Virginia, New Hampshire and Alaska. Professional services were a particularly high healthcare cost area in New Jersey; growth in professional service costs in New Jersey continue to outpace the growth of other healthcare costs. Spending on professional services in New Jersey were 31% above the national average; only Alaska had higher professional services costs than New Jersey.

In previous years, we ran neck and neck with the formerly high cost state of Massachusetts and but now we significantly outpace it by 18%. . Massachusetts, unlike New Jersey, has taken effective action to restrain health care costs. Years ago we had similar health care costs to Maryland, now our healthcare costs are sharply higher (30%.)

The trend in health price increases is worsening. Between 2013 and 2017 healthcare prices in New Jersey rose 16.6% while utilization rose by a tiny .2% for the same

period. The rise in health price was well above the rise of the overall cost of living and sharply higher than the rise in wages.

Two decades ago the imminent New Jersey health economist, Ewe Reinhardt, said in reference to the high cost of healthcare in the US and New Jersey, "It's the prices Stupid."

The Communications Workers of America believes that any action concerning or impacting out of network payments must first ensure that those actions do not increase the already astronomical healthcare costs for New Jersey families.

Burden on New Jersey Families

The Kaiser Family Foundation has found that typically families in the US pay between 40 and 45% of healthcare costs between premium sharing arrangements and out-of-pocket expenses. These costs have significantly increased in recent years as typical premium sharing arrangements for families are now slightly above 25% of premiums while out-of-pocket costs have stayed high with the increasing popularity of high deductible plans.

With the average cost of family coverage in New Jersey in the \$25000 to \$30000 range typical costs for families are in the \$10,000 to \$13,000 range. Though this burden on middle and lower income New Jerseyans has not been the subject of academic discussion, policy forums, legislative action or political campaigning, it is very real, very large and deeply felt.

While it's not the subject of much public discussion in New Jersey, it is of the same magnitude as the constantly discussed property tax burden.

The New Jersey legislature first should do no harm and not increase the burden on working families solely to benefit medical specialists many of whom, frankly, have astounding incomes.

The CWA/State of New Jersey Collective Bargaining Agreement and Out of Network Reimbursement

The key aspect of healthcare cost savings achieved in the recently approved CWA/State of New Jersey contract was a switch from the failed Fair Health system of out-of-network reimbursement to a reference based system.

The move to a reference based system of out-of-network reimbursement for CWA represented state workers, all of whom are members of the State Health Benefit Plan, is expected to produce premium savings in the 10% range.

CWA is deeply concerned with any legislative effort that would undermine our collective bargaining agreement and the savings that agreement achieved. We are also concerned with the impact any change in out-of-network arrangements might have on the state budget.

Through painstaking negotiations, CWA and the Murphy administration came to an agreement to set out-of-network payments across the board at 175% of Medicare rates. The use of reference based pricing derived from Medicare rates has the advantages of being fair, well recognized, transparent, and equitable.

Medicare rates are easily accessible to insurance carriers, third party administrators, and providers, all of whom use these rates on a daily basis. They are consistent from year to year; any significant changes are part of a public administrative process. They do not change from month to month like the Fair Health system and the public can access accurate Medicare rates easily.

Referenced based payment systems based on Medicare also avoid the high level of provider manipulation that is inherent in "charges" based payment systems such as Fair Health. Fair Health rates are not based on actual payments made to providers but rather whatever amount a provider may choose to charge even if they never expect to receive payment anywhere close to their "charges." Nonetheless, the outlandish charges made by a minority of medical specialists exerts strong upward pressure on Fair Health rates and health care costs more generally.

Medicare reference rates provide an important measure of equity in the payment of providers. Though Medicare rates are usually seen as more beneficial to medical specialties than primary care providers, they are vastly more equitable than the wild variation of out-of-network rates that the current system of Fair Health and constant insurer/provider battle provide. For instance, with out-of-network rates set at 175% of Medicare rates, poorly paid and female dominated providers such as primary care physicians, mental health therapists, speech therapists, and other providers will see increases in out-of-network reimbursement while overall cost savings are achieved. This level of equity is achieved even with overall very significant savings to our plan and our members.

We strong urge you to ensure that the provisions of the CWA/State of New Jersey collective bargaining agreement concerning out-of-network payments using reference based pricing is fully implemented.

The Movement to Referenced Based Pricing

We believe that the current out-of-network law regulating emergency and surprise out-of-network situations is too new to adequately assess its impact. Certainly, the likelihood is that over time arbitrations will decrease as a system and amounts of out-of-network payments stabilize.

However, if the legislature believes changes are needed in the current law, strong consideration should be given to more broadly implementing a reference based pricing model similar to that which CWA negotiated.

A number of public employee health plans have moved in this direction including red, blue and purple states such as North Carolina, Oregon, and Montana. Interest is strong elsewhere.

There is broad and rising support for changes at the federal level such as Medicare for All, Medicare for America, and Medicare Buy-ins. All these proposals are undergirded with massive increases in the use of reference based pricing derived from the current Medicare system.

Most importantly, the broader use of Medicare derived reference based pricing in New Jersey holds the promise of relief for all those New Jersey families in the commercial insurance market.

NJ Provider Arbitration

MAXIMUS Federal is the largest provider of government-sponsored benefit appeal programs in the nation, working collaboratively with federal agencies and state governments in the development and implementation of independent benefit dispute resolution programs. We currently support more than 50 state and federal appeal programs with over 2,000 staff and associates. We focus on collaborating with our clients to identify non-inherently governmental portions of the appeals process to streamline operations and eliminate backlogs. MAXIMUS Federal specializes in implementing scalable solutions that utilize advanced forecasting models to anticipate volume fluctuations and adjust operational capacity as required. MAXIMUS Federal has provided independent review services for more than 25 years and has conducted more than 5 million reviews for over 50 federal and state agencies. Available legal advice and relevant subject matter expertise are indispensable parts of the appeals process support and transformation solution. We have a nationwide panel of more than 1,500 health care practitioners, and legal professionals that currently support our portfolio of over 50 appeals and review projects that span the country.

MAXIMUS Federal has been providing arbitration services to NJ DOBI since 2007. Specifically, MAXIMUS Federal arbitrated 23,469 claims under the Program for Independent Claims Payment Arbitration (PICPA). Presently, MAXIMUS Federal arbitrates both PICPA and Out of Network Claims (OON).

- 6/1/18 – Enacted Out-Of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act, P.L.2018, c.32
- 8/30/18 – Effective Out-Of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act, P.L.2018, c.32
- 11/21/18 – NJ DOBI publishes C.32 OON bulletin to NJ DOBI website
- 1/17/19 – MAXIMUS NJ Arbitration website updated to accommodate C.32 OON process

OON Arbitration Case Summary as of 4/26/19

Total # of OON Cases	1082
Pending Award Determination or Dismissal	318
Awaiting information/documentation from Carrier and/or Provider	217
Carrier Awarded	207
Provider Awarded	135
Withdrawn	99
Dismissed*	91
Default Awards Issued to Provider	15

*Dismissal Reasons	
Plan not issued in NJ	68
Self-funded plan did not opt-in to OON	16
Disputed amount is <\$1000	5
dispute concerns medical necessity	1
Out of scope for OON	1



OON Arbitration Process

N.J.S.A. 26:2SS-1 to -20 permits health care providers, carriers and, in certain instances, covered persons to apply for arbitration when they cannot agree on the appropriate reimbursement for health care services rendered by an out-of-network health care provider on an inadvertent, emergency or urgent basis. In other words, there is not a dispute with the quality of the service rendered, the complexity of the service, CPT codes and whether the service was medically necessary. The purpose of this document is to describe MAXIMUS process for arbitrating Out of Network (OON) arbitration cases. An OON arbitration is initiated through the MAXIMUS NJ Arbitration website. Typically the Provider or Provider's Representative initiates OON arbitration by completing the online form and uploading supporting documentation.

1. Initial Eligibility - MAXIMUS reviews the OON application and supporting documentation for completeness and eligibility within 7 business days.
 - If the application is deemed ineligible (e.g. disputed amount is less than \$1000, matter involves an insured plan issued outside of New Jersey or matter involves a self-funded plan that did not opt in), then MAXIMUS emails the Initiating Party (typically Provider) a Notice of Dismissal.
 - If there are deficiencies in the application (e.g. missing EOB or claim form), then MAXIMUS emails the Initiating Party a Notice of Deficiency. If MAXIMUS does not receive a response within 15 calendar days, then the case is dismissed.
 - If the application is complete and eligible, then MAXIMUS emails the Initiating Party a Notice of Application Acceptance. Concurrently, MAXIMUS emails the Responding Party (typically the Carrier) to inform the Carrier that the case has been accepted and that the Carrier must provide information/documentation within 15 calendar days.
 - If a Responding Party does not timely respond to MAXIMUS's Notice of Application Acceptance, MAXIMUS sends a follow up notice. If the Responding Party does not respond to the follow up notice within 72 hours, a decision is entered in favor of the Initiating Party.
2. Request for Information - Upon receiving information/documentation from a Provider or Carrier, MAXIMUS reviews the information within 5 business days. If additional information is still necessary, MAXIMUS contacts the Provider and/or Carrier and requests additional information be provided within 7-15 calendar days depending upon the nature of the requested information/documentation. If the additional information is not timely provided, a follow up notice is sent. If there is no response to the follow up notice, a decision is entered in favor of the other party (if the nonresponding party is the Provider, the arbitration may be dismissed and if the non-responding party is the Carrier, the arbitration award will be in favor of the Provider.)
3. Arbitration Full Review - Once MAXIMUS has complete information from the Parties, the MAXIMUS arbitration team (attorneys/arbitrators and certified coders) conducts a full review and issues a decision within 30 calendar days.
 - MAXIMUS certified coders review the health insurance claim form which indicates the diagnosis, date of service, location of rendered service, service rendered (CPT code), complexity of rendered service (modifier) and explanation of unusual circumstance. Each claim form and EOB is evaluated to determine appropriateness such as the application of modifiers for complicated procedures, multiple surgery reduction, assistant at surgery reduction, etc. Once the coding review is completed, the MAXIMUS certified coder runs a query in Fair Health to obtain allowed and billed UCR benchmarks for the payable codes while appending appropriate modifier adjustments. In addition, MAXIMUS coders review applicable Medicare data to determine the prevailing Medicare payments for the services at issue.



- Each arbitration is determined based upon the facts and circumstances of that individual case. MAXIMUS attorneys analyze all documentation and communication gathered from both parties in addition to the coding analysis conducted by the MAXIMUS coding team to determine which Party's final offer is closest to the amount that MAXIMUS has deemed fair and reasonable (e.g., an average Fair Health billed and Fair Health allowed – please note different fair and reasonable calculations may be applied to different cases). In cases where providers indicate patients and services were extraordinary in nature (e.g., with use of a modifier indicating that the service was complicated and requires additional reimbursement or if there is an assertion that a secondary procedure was separate and distinct from other services provided), MAXIMUS attorneys will take this information into consideration and work with appropriate MAXIMUS clinical experts to assist in determining if the records submitted contain evidence supporting the providers assertion that the services were extraordinary in nature.
- Once the prevailing party has been decided, MAXIMUS sends both Parties the OON Decision Notice. DOBI is provided a copy of each decision.

**ADDITIONAL APPENDIX MATERIALS
SUBMITTED TO THE**

SENATE COMMERCE COMMITTEE

for the

April 30, 2019 Meeting

Submitted by Michael L. Bilof, M.D. and Basil M. Yurcisin, M.D., Representing
Garden State Bariatrics and Wellness Center:

Medical Society of New Jersey, “Applicable Services,” November 29, 2018. © 2108
Medical Society of New Jersey.

Medical Society of New Jersey, “Claims/Arbitration Process,” November 29, 2018.
© 2108 Medical Society of New Jersey.

Medical Society of New Jersey, “Patient Arbitration Process,” November 29, 2018.
© 2108 Medical Society of New Jersey.

Medical Society of New Jersey, “Disclosure - Physicians,” November 29, 2018. © 2108
Medical Society of New Jersey.