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# *Committee Meeting*

of

## SENATE COMMERCE COMMITTEE

*“The Committee will receive testimony from invited guests concerning the implementation and operation of the recently enacted ‘Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act’”*

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**LOCATION:** Committee Room 6  
State House Annex  
Trenton, New Jersey

**DATE:** April 30, 2019  
2:00 p.m.

### **MEMBERS OF COMMITTEE PRESENT:**

Senator Nellie Pou, Chair  
Senator Joseph Cryan, Vice Chair  
Senator Joseph A. Lagana  
Senator Paul A. Sarlo  
Senator Joseph F. Vitale  
Senator Thomas H. Kean, Jr.



### **ALSO PRESENT:**

Todd W. Moore  
*Office of Legislative Services*  
*Committee Aide*

Kate Millsaps  
*Senate Majority*  
*Committee Aide*

Laurine Purola  
*Senate Republican*  
*Committee Aide*

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

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NELLIE POU  
Chair

JOSEPH CRYAN  
Vice-Chair

NICHOLAS P. SCUTARI  
GERALD CARDINALE  
THOMAS H. KEAN, JR.

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**New Jersey State Legislature**  
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**COMMITTEE NOTICE**

**TO: MEMBERS OF THE SENATE COMMERCE COMMITTEE**  
**FROM: SENATOR NELLIE POU, CHAIR**  
**SUBJECT: COMMITTEE MEETING - APRIL 30, 2019**

*The public may address comments and questions to Todd W. Moore, Committee Aide, or make bill status and scheduling inquiries to Joanne W. Gillespie, Secretary, at (609)847-3845, fax (609)777-2998, or e-mail: OLSAideSCM@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.*

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**The Senate Commerce Committee will meet on Tuesday, April 30, 2019 at 2:00 PM in Committee Room 4, First Floor, State House Annex, Trenton, New Jersey to receive testimony from invited guests concerning the implementation and operation of the recently enacted "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act."**

Issued 4/23/19

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**SENATOR NELLIE POU (Chair):** Commissioner, I know that you just got off of your testimony in front of the Budget Committee.

And thank you so very much for making it so -- being able to respond to the questions so rapidly, that we got you immediately.

I'm going to ask our OLS to take a roll call, and then immediately after that we'll be happy to hear your testimony.

Thank you, once again, for being here.

Ladies and gentlemen, once again, thank you very much.

I am going to -- while we're getting ready to do that, please know that we do have a long list of speakers. I'm going to ask every speaker to really take into account the person who is coming after them.

I also recognize that while everyone's schedules are important, we are going to try to do this in a manner in which we can make sure to cover, and hear, and listen to everyone.

So please bear in mind that we will call your name according to the information that we have in front of us. There may be just some minor changes that I will be doing.

However, that being said, please, if you come up as a group and you're part of a panel, I'm going to ask you to be very mindful of not repeating the same kind of information that's already been provided, so that we would have the benefit of all of the information and testimony that you're looking to provide.

With that being said, welcome once again to the Senate Commerce Committee.

We will now begin our meeting with a roll call.

Mr. Moore.

MR. MOORE (Committee Aide): Senator Kean.

SENATOR KEAN: Here.

MR. MOORE: Senator Lagana.

SENATOR LAGANA: Here.

MR. MOORE: Senator Vitale

SENATOR VITALE: Here.

MR. MOORE: Senator Sarlo.

SENATOR SARLO: Here.

MR. MOORE: Vice Chair Cryan.

**SENATOR JOSEPH CRYAN (Vice Chair):** Here.

MR. MOORE: Chair Pou.

SENATOR POU: Here.

Mr. Moore, what I'd like to also make mention to everyone -- I know that we have two additional Senate colleagues who will be sitting in the meeting. I just want to welcome both Senator Vitale and Senator Joe Lagana, who are here.

I know that our regular member, Senator Scutari, is unable to come to today's meeting; but I know that Senator Paul Sarlo will be sitting in for him as well.

So thank you; and welcome, gentlemen, to the Committee. I know it's no stranger to most of you.

Thank you very much.

With that, Commissioner, thank you so very much; you can begin your testimony.

**COMMISSIONER MARLENE CARIDE, Esq.:**

Thank you.

Good afternoon, Chairwoman Pou, Vice Chair Cryan, and the 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 healthcare 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 the 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 into the arbitration provision of the law, the arbitration system may resolve disputes between the providers and plan members who choose to avail themselves of the arbitration.

I'm 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 30. On August 27, the Department began the advance notice process for issuance of the 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 and provider -- or in certain cases, covered persons, 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 an 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 the 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; 150 decided in favor of the provider and 207 in favor of the carrier. According to MAXIMUS, as of April, 26, 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 the providers due to a default.

As of April 26, there are 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 the stakeholders. If there is noncompliance with the law, we also encourage you to contact the Department so that we may investigate and act on the complaints. The complaints are handled by our Consumer Protection Division, which may be contacted through our consumer hotline; and if I may, the number is 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.

SENATOR POU: Thank you very much, Commissioner.

Also, let me just mention I really appreciate having had the opportunity to meet with you and your Chief of Staff to go over a number of issues.

I know that we had an opportunity to go over some of what you've shared today in your testimony. I know that you've added some additional information.

So with that being said, that was helpful; and it allowed me to get a better understanding of some of those questions that were out there, that we really still were somewhat unsure of.

I do have another -- I have several questions for you. But in particular, I wanted to ask you-- Something we talked about yesterday; but because there's been a great deal of conversation with regards to this concern, I'd like you to go over how many-- Upon the implementation of MAXIMUS -- actually beginning the program early February, because their website didn't go up until January-- Although I understand what we talked about yesterday, and what you've mentioned -- that the guidelines were provided back in November of 2018.

But because the program didn't actually implement until -- get started until February, could you tell me how many out-of-network arbitrators were actually working on these cases? How was that process?

What impact or problems that you found? What were some of the solutions, or recommendations, or courses of action that were taken? There was some concern, with regards to a significant number of cases that had not yet been decided upon.

So if you can just begin with some of those particular questions.

COMMISSIONER CARIDE: Thank you, Senator, for the questions.

With regards to the questions -- as I had indicated in my statement, we had reached out to MAXIMUS to get the website and the process for arbitration up and running. Their website was up in January, and it was in February that we found out that there were 300 cases pending.

At that point, we instructed them to use all available resources to get those cases taken care of. At that point, they had six arbitrators -- six attorneys -- and then staff also working. So they were able to get through the 300 cases and decide them by -- I believe it was April 19.

Currently, there are four attorneys -- arbitrators -- and the rest are staff. So there are 12, all together, working on the New Jersey files. While some might wonder why they went from six attorneys to four attorneys, it has to do with the number of files that are pending. And they have indicated that if there are more files, than they would add more attorneys to the review of these pending cases. Less files -- then, of course, then they have fewer attorneys. But there are 12 individuals working on the New Jersey arbitration cases.

SENATOR POU: That was really good to hear.

However, what I what I found -- and I shared this with you, and I just want to share this with the members here -- what I found to be somewhat concerning was that we all knew that the law was being advanced, we knew that it was happening, it had been approved, it had been signed into law. You had already put out -- your Department had already put out an advanced -- the DOBI advance notice that was then, later-- They were aware that this was happening.

The fact that they actually were not properly staffed to cover some of these responsibilities, by virtue of only having one -- and I'm going to stick to that, unless you tell me otherwise -- by them having just only one arbitrator to really deal with all of the cases -- that was concerning to me, and I shared that with you.

So while I am happy to see that your Department intervened in making sure that they pulled additional resources to cover these particular issues, that to me -- for a company of this size, and for the size of our state and what we were looking to do -- that should have been something that could have been preplanned.

So I don't know, going forward. I take what you're indicating to us and sharing, that moving forward, should there be any kind of backlog, as it obviously occurred during -- leading up to this period, there should be some type of resolution to that.

I'm hopeful that we don't get to that point, because we should be prepared at this point. We know what the process is; we know what some of the guidelines are; we know that we're still waiting for those regulations. It's my understanding that your Department is working on that. Are you in the position to talk about that and just share with us--

When do you think that will be forthcoming, and how might that be that much different than what your current guidelines indicate, or your guidance -- because I think that's what you refer to it as?

COMMISSIONER CARIDE: Okay; thank you, Senator.

As you mentioned, we had gone out for advanced notice in August. And from the comments that we received from the public, we used that to put together our bulletin, which is the guidance that we gave to all the carriers and providers. And that's up on our website, and we shared it with the list of organizations and individuals on our advanced notice list.

At the same time, we started working on the regulations. It's complex; it's a complex law that requires a lot of time. And so we started working with the team right away, when we were working on the bulletin, to give the guidance.

The regulations -- I'm happy to say we're finalizing them; and I'm hoping to go out in advance notice of the regulations by May.

The process there, then, would be that we would go out for advanced notice, get comments. We'd go back and look at the comments, with regards to the regulations, which would basically mirror the bulletin that we have now. We would then, after looking at the comments, revisit our regulations; and at that point, if we make any changes, then we go out for notice with regards to the regulations for the adoption. We look back at comments at that point; and then at the end, then we can move for the adoption of those regs.

So we are closer to the end than we were at the-- We're not in the middle; we're closer to the end of getting the regulations out and about.

And as I said, we're hoping to be out on advanced notice by the month of May, which starts tomorrow.

SENATOR POU: Thank you very much; thank you.

I'm going to stop there and open it up to questions from some of my other colleagues.

Senator Sarlo.

SENATOR SARLO: I've talked enough this morning, I don't want to--

Just a quick question. So the volume appears to be 300 cases every couple of weeks or so since-- You had indicated there was 330; they were resolved. Now, as of April 26, there's another 318? In a report that was provided to our offices from MAXIMUS, they're saying 1,082, a total of out-of-network cases that they're dealing with; 1,082.

So it appears to be every couple weeks the volume is running about 300 or so? Am I correct on that?

COMMISSIONER CARIDE: Well, based on the information that we have been getting from MAXIMUS, there was a backlog of 300, which they've taken care of. The information that you had received from MAXIMUS -- I also have a copy of it -- and the total number of out-of-network cases that they have to date, including the backlog, was 1,082. So they have resolved those 300; according to their chart, they're telling us that they have 318 that are pending determination. And then they have another 217 that are awaiting information and documentation, either from the carrier or from the provider.

I wouldn't be able to tell you that; it's like every few weeks they have 300. It just -- these are the numbers that they have provided to me, to date, which--

SENATOR SARLO: It just seems, if you take the chunks of 300 and change, it gets you up to about the 1,100 mark.

Okay; so that's where we're at, the 1,082.

And then, just one final question I have. I'll do some follow-up, but--

Are you hearing from providers -- whether it's hospitals, or the doctors -- that it's carriers-- Instead of sitting down at a table, and sitting down and working out billing issues with the providers, that they're automatically just sending them out to the arbitrator? Are you hearing any of those concerns -- that it's, sort of, not sitting and trying to work through the billing issues, but just letting MAXIMUS deal with it? Is that a potential issue?

COMMISSIONER CARIDE: Senator, as I had mentioned in my statement -- and you know me very well; so you know that I always have that open door policy. So I've always had individuals in my office, and organizations, and I continue to speak with them. Throughout our conversations, have there been comments about providers not playing well? Yes. Have there been comments about carriers not playing well? Yes. But to say that the carriers are just going into arbitration -- no. As a matter of fact, the way the law was written, if the provider and the carrier cannot work out or negotiate within those 30 days after they get their initial payment, then it's the provider who will file the paperwork for arbitration.

SENATOR SARLO: Thank you; thank you, Commissioner.

SENATOR POU: Thank you.

Senator Kean.

SENATOR KEAN: Thank you; thank you, Madam Chair.

And thank you, Commissioner, for our time to talk yesterday, as well as throughout the course of last year, on a couple of different issues.

Obviously, you are starting to implement a piece of legislation that the Legislature passed -- over a number of people's, on this dais, objection -- that was signed into law.

It seems to me that the Bill is-- And you are mandated, therefore, to implement an extraordinarily complex, almost impossible to meet standard; and complex providing of information between providers, and carriers, and everything else.

I guess the question-- We talked a little bit about other states. And you are, potentially, doing a better job, having a much more transparent, much more equitable arbitration system. Have you done any research into what New York is doing well and not doing well?

COMMISSIONER CARIDE: Senator, following our conversation yesterday, I did ask my staff to look into it.

There are a couple of different things I'm looking into, with regards to New York City. But I don't have anything--

SENATOR KEAN: And New York state.

COMMISSIONER CARIDE: I'm sorry, New York state.

SENATOR KEAN: New York state.

COMMISSIONER CARIDE: For New York state. And I would be more than happy to speak with you offline when I have more information; because I don't have anything definitive for you.

SENATOR KEAN: Okay. Because I think what the question will be -- not only the type of arbitration-- For it does seem that this is weighted, as passed by legislation; your mandate to implement is a very weighted process and arbitrary regulatory scheme.

So if we can, I guess, not only talk offline; but also, if you can, to the extent you have the research, can you provide that, through the Chair, to the rest of the Committee? Because I think the goal would be -- if we can fix this thing, we all want to get to the point where everybody has a predictable expense structure. People can get the standard of care that they want to and should -- they've earned throughout this process. So to the extent you're starting to see breakdowns within the system, my hope is that we can--

Sometimes, what happens in the Legislature, they look at something like this every 10 years. And I think that's not going to be in the best interest of the people who need the services that are being provided, and have an expectation of good health care within the process.

So if we can have a real-time conversation; saying that there's a way -- something we can fix real time; we're starting to notice complexities exist that may not have been anticipated. I would love to have that conversation, not only directly, but also through the Chair, so we can fix this thing in real time.

COMMISSIONER CARIDE: If I may, Senator.

We'll look into that for you, as I had said that I would. And I would be more than happy to share any information I have with the Chair, through the Chair.

But there is something that I would like to point out. Even though this sounds like it's a complex Bill, it's something that has been worked on, here in New Jersey, for 10 years; for a whole decade. And I would like to say that based on what I've seen in my sister states, we are in the forefront of addressing a big issue here.

Now, while there are kinks that have happened in the rollout of this particular program, I think that the ultimate goal of this law was to protect the consumer, the patient, from balance billing. And while this is in its infancy, and I would be premature to say to you that there are kinks -- I mean, that there are problems that need to be fixed at this time-- I think that we need to give the program a little bit more time to roll out and to see if, in fact-- And I know that I have to present information in about a year with regard to the program. But for me to say that there are problems now would not be fair to this program.

What I can say, though, is that it has achieved what it was supposed to achieve, which is to prevent the balance billing.

SENATOR KEAN: I think we all share the -- whatever you want to call it -- the *surprise bill*, or *not surprise bill*, or whatever it is -- I think we all share the goal of having something that's predictable for everybody involved in the system.

And what I'm trying to say is, I think there are even-- Just because things take 10 years to form, it doesn't mean the end product is as good as it needs to be. And I think that usually the thinner the bill, the better; the fewer pages of the bill, the better it is. But there are things I think we can do on a bipartisan basis. If you're starting to recognize that, please look at the Legislature as an ally, I hope, in fixing this going forward.

And if there are things you're starting to see; that you are having implantation issues, or impracticality issues that weren't anticipated, my hope is we can use this as a parallel track, through the Chair.

COMMISSIONER CARIDE: Absolutely, Senator.

And having come from the Legislature, I know what we can and can't do. And I've never considered anyone on this panel, or my brothers and sisters in the Assembly, as the enemy. On the contrary; they're friends, and they're the ones who really have the good intention for the residents here in New Jersey.

And again, I have to present; and one of the good things about the Bill is that it requires DOBI to come back in a year with information; not 10 years down the road. So that's good, because we're going to have fresher information. And I will present at that time; if the Chairwoman calls me to present, I'll be more than happy to do that and provide any information that I have gathered in a year period of time. And at that point, then, perhaps we can have a conversation as to where we might have missed or didn't miss.

SENATOR KEAN: And if in the interim, through the Chair, if we can have a conversation on a comparison of what New York currently does, as a state, to try to figure what they're doing and what we're not.

COMMISSIONER CARIDE: Fair enough.

SENATOR KEAN: Okay, thank you.

COMMISSIONER CARIDE: Thank you.

SENATOR POU: Thank you; thank you, Senator.

Senator Lagana.

SENATOR LAGANA: Thank you, Madam Chair.

Thank you, Commissioner; I appreciate your testimony, for being here, and for your hard work on this very -- it is a difficult issue; not only here, but across the country.

And I commend Senator Vitale on getting this Bill through, because it is an important piece of legislation. And we're doing a service to the people we represent in the state by not making them subject to these types of disputes anymore, because they can be pretty devastating to people.

From my own experiences thus far, having sat on the Committees in the Assembly when the Bill was being vetted, and having voted on the Bill in the Senate, and now meeting with certain stakeholders throughout the process just to see how it's, kind of, playing out in real time, are you aware of issues with regard to the misapplication of the law? And just to clarify that a little more -- meaning, are you aware of any issues where a bill is being submitted as an emergency bill; and before determining whether or not it's fully funded or self-funded, a payment is just being issued; and essentially saying, "We're paying this, pursuant to this" -- actually, it didn't even say the *law*; it said the Assembly Bill number. Are you aware of that type of misapplication; or have those complaints been made to you by any of the stakeholders?

COMMISSIONER CARIDE: Senator, I have been made aware of certain-- I was only given three examples of -- and that was very recent -- where the insurance carrier may have paid out, not knowing that it wasn't out-of-network, or incorrectly. With that said, it was just recently that I found out about this -- it was brought to my attention -- and I was provided with EOBs that were redacted.

Unfortunately, for my Department to be able to get involved, we need more information. And we have requested that those EOBs be provided to us unredacted. That way I have information as to the patient and the case number that they have for that particular carrier.

And then my Department can reach out to see what exactly is taking place there. Was it a mistake, or was it supposed to be this way? But without having the unredacted EOBs, I can't move forward.

But yes, there were three EOBs that were provided to me that they were redacted; and we have requested that they be provided unredacted so that we can then look into it.

SENATOR LAGANA: Because it seems that the way the process has -- as has been told to me -- is that when a bill is submitted, and in that time period where a payment has been issued and negotiation is supposed to begin -- pursuant to the word of the statute -- there are a lot of instances where the law was essentially misapplied; where it was not a fully funded plan, but it was a self-funded plan. As far as I'm aware; I don't know if anybody's opted-in to the statute yet. I'm not sure if that's your understanding either.

COMMISSIONER CARIDE: If I may, Senator, with regards to our self-funded plans, we have approximately 11 that have registered with us, or given their information that they have opted in.

SENATOR LAGANA: Okay.

COMMISSIONER CARIDE: But that's not a perfect picture, so to say, because there is no deadline with them having to inform DOBI of the fact that they are opting in. But we do have 11 that have notified the Department.

SENATOR LAGANA: Okay.

COMMISSIONER CARIDE: And with regards to your question concerning whether or not the law has been misapplied, I would truly appreciate if you have any-- If that comes across your desk, if anyone were to call your office and complain about the fact that the law was misapplied, if you-- I mean, you and I have communications going back and forth for a long time; we've known each other for a long time, so you know how to reach me. If you could provide it to me, then I could say, "Senator, I need this unredacted; can your individual provide it to us?" And we will be happy to look into it.

And again, I know that there are stakeholders here in the room; and I would appreciate that if they come across a situation like that, that they reach out to DOBI so that we can then take a look at it and then redirect it if it's necessary.

These are the kinks that I had mentioned at the beginning; and this is relatively in its early stages. So there are going to be missteps. Does it mean that the law doesn't work? No; it's just that there are missteps. And so we need to be apprised of it, so that we, then, can go out and reach out to the carriers and say, "Hey, what's going on?"

So I would appreciate if that would be forwarded to us.

SENATOR LAGANA: Okay.

So again, through the Chair, continuing on that point-- The process, as written, is a fairly quick process. I mean, the bill gets submitted; there's a payment made, there's a 30-day negotiation time frame. There's, maybe, an offer being made, or an offer not being made. And then after a

certain time period -- which is the 30 days -- and there's another 30 days whereby the provider is supposed to initiate an arbitration.

With the kinks that we're talking about, this obviously prolongs that process. So I think some of these things need to be worked out earlier on in the process. Because, again, anecdotally, from what I've been hearing, is that even the negotiation process may take a long time. And again, that may be by virtue of the law just being implemented, where maybe the carriers were unaware of the time period. And, you know, instead of the negotiation period taking 30 days, it took 90 days; or maybe they're still negotiating bills from the end of last year. And I think you'll probably find -- and we may hear from some people testifying today -- that that is occurring.

The process once the arbitration starts -- where, again, there is a backlog -- and I know they're trying to fix it by hiring some more attorneys and dealing with it on that end, through MAXIMUS -- but the awards are supposed to be issued within 30 days. We know that that's, obviously, taking a little bit of a longer time.

My question about the award, specifically, is -- from what I've seen -- is that the awards themselves don't appear to really offer much information about how the decision is being made. From what I can see from the actual award, is that the metric that is being used is a Fair Health metric; again, from the ones I've seen it looks like a percentage of Fair Health is being awarded, depending on a specific procedure code. So that-- Again, if that's what the arbitrator is considering, then that's what they're considering.

But I will say that under current New Jersey law, outside of the statute is actually a court case entitled *Cobo*-- Because we're dealing with the *usual and customary*. And, you know, one thing I don't think should get lost in the shuffle is that for a physician to prove that what it's billing is a reasonable amount, they have to show a pattern and practice of billing, and a pattern and practice of reimbursement, coupled with something else to show that what is being billed is fair.

I just want to make sure that the actual arbitrators are considering these cases; they're not looking at them with blinders on. And again, I've seen the numbers here; and this is the first time we're kind of seeing where they're falling. You know, make sure that's fair on both sides -- that the awards are being issued.

I think that maybe there should be more clarity within the awards, so that both the carrier and the provider understand exactly how the arbitrator is reaching that decision. I know MAXIMUS is going to be administering this until the end of the year, and I'm not sure if they're going to be bidding for it going forward. But I think that this is a system with about a thousand arbitrations filed. I believe that this is eventually going to be a system where there's going to be many thousands of arbitrations filed; and, you know, what I think that would make the process better is, again, more clarity within the awards. And I guess that it would be within your purview, as a regulator.

And, you know, possibly-- Because from what I understand, is that the parties don't actually see what each other is submitting. And being an attorney, you know that when someone's making their argument against you, you probably want to know what they're arguing, just to, you know, at

least maybe have a process whereby you can offer a response if you believe that the information is not what it should be.

But I know this current process kind of foreclosed on that. Each party submits something, and then decisions are being made; and you don't really get to see what the other person has submitted. And the carrier should know what they're submitting, and I think they should know what the carrier is submitting. I think it would make it a little fairer.

And as far as us, as the legislators, who are essentially creating these statutes whereby you have to live by, is there anything that's tying your hands, or is there anything that we can do better to allow you to develop the regulation a little, maybe, more expeditiously,; or maybe not to be so prescriptive in the actual word of the statute, to enable you to develop additional regulation? Or do you feel that the statute, as written, provides you with enough leeway to develop the full regulation that, you know, you're kind of prescribed to do?

COMMISSIONER CARIDE: Senator, there were a few things that we talked about, that you were talking about. And I want to just address them, as I was writing them down.

So just to clarify -- currently, there are no backlogs. The backlog that existed in February has been handled, and my understanding is that they're handling the cases as they're coming in. So they're doing the scheduling as they're supposed to. So there's a 30-day window, and that's what they're working on.

With regards to MAXIMUS, you're correct. We have a contract with-- Well, pursuant to the law, by the end of the year I have to go out to bid; and we're beginning to work on that. Whether or not

MAXIMUS will rebid, I don't know. You know, we'll find out what happens, when we go out to bid, who will be bidding -- which vendor will bid; so that we don't have an answer on.

I do take your statement, with regards to a little bit more information on the ARB statement, on the decisions; and that's something that I'll go back and look at; the same with the submissions that are not available to both parties. I will be honest with you -- I heard about it, for the first time, today, earlier today in my office. And that is something that I will be looking at; because having done arbitrations myself, it's always nice to know where both sides stand. So that is something that I will take back to my office and review.

And it's those things that I need the stakeholders to provide for me. When you were mentioning before that there -- you know, when I had said *kinks*, and that it's taking a longer time period. If something is not going correct at the very beginning -- if they can reach out to us, then we could try to correct it. And the whole purpose, right now, is to try to make this a functioning process. And so, yes, there are going to be mistakes along the way; hopefully minor mistakes. And the quicker that individuals and organizations get back to me on issues, the more that DOBI can get involved in trying to correct these issues so that the program functions the way it's supposed to function, which is efficiently.

With regards to your question concerning if there's anything that the Legislature can do for DOBI, as far as making this -- giving us more oversight or ability on this-- Currently, the way the law reads, we have interaction with our vendors. We don't get involved in the arbitration decision-making and whatever factors they use.

As I mentioned before to Senator Kean, I think that it's premature at this time to say, "I need help," because I don't know what will entail -- this arbitration process. We are working on it; it's in its infancy. I have to come back in about a year to give everyone an update as to how the awards went; and at that point, perhaps, we can sit down and say, "Things are working smoothly; we're fine at DOBI. I think the process is working." Or if we need some additional help or tools, I would be more than happy to talk to you about it.

But I think for me to sit here and say, "I need A, B, and C," would be very premature and unfair to this law, which is just beginning to kick off.

SENATOR LAGANA: Thank you.

SENATOR POU: Senator Kean, did you want--

SENATOR SARLO: Madam Chair--

SENATOR POU: Give me one second, Senator.

SENATOR KEAN: I'm sorry; this is also a little bit of a follow-up on the question we had that we were discussing yesterday, through the Chair; and to the Senator's comment.

When you talk about *self-funded*, the question is, are you using that term interchangeably with the *ERISA* plan; or are there things beyond an *ERISA* plan when you're describing it as a *self-funded*?

COMMISSIONER CARIDE: Your self-funded plans are *ERISA* plans; right.

SENATOR KEAN: Right; but I'm saying you are using that term interchangeably.

COMMISSIONER CARIDE: Yes. We call them *self-funded* because--

SENATOR KEAN: So there's nobody who's -- there is nobody is who is not in an ERISA plan who you are counting as a self-funder.

COMMISSIONER CARIDE: No; the plan itself--

SENATOR KEAN: Or self--

COMMISSIONER CARIDE: The plan itself is self-funded.

SENATOR KEAN: Correct; but I am just making sure, in your conversations, through the other Senator, that when you're saying people are choosing to opt in, and they are self-funded plans-- So you're saying that all of those self-funded plans -- the 11, I think, you were saying to Senator Lagana -- you're saying all of those self-funded plans are ERISA plans that are choosing to opt in.

COMMISSIONER CARIDE: Not all of them are ERISA; there are two main ones that also that have opted in to the plan.

SENATOR KEAN: Okay.

COMMISSIONER CARIDE: The law, the way it was written, and as you are aware, allows for self-funded plans to opt in if they choose to; they don't have to.

SENATOR KEAN: Right.

COMMISSIONER CARIDE: But if they choose not to do it, then their plan member can avail themselves of the arbitration system.

So while all I have, as far as information, is that there are 11 that have opted in -- two of which are MEWAs -- there could be others that I'm not aware of yet. That doesn't mean that there aren't more self-funded plans that have opted in.

SENATOR KEAN: Okay, thank you. Thank you for that clarification.

SENATOR POU: Thank you, Senator; thank you Commissioner.

SENATOR SARLO: Madam Chair, just a question for you.

Is MAXIMUS here? It would be helpful--

SENATOR POU: No; actually, I'm--

SENATOR SARLO: I think it would be helpful for them to come up.

SENATOR POU: I'm really happy you asked the question.

Sadly, I must say that they are not here. I was made aware of that very late yesterday evening. It's why I made the statement that I said, at the very beginning, in terms of the information that was provided to us, and my comments about how I felt that they should have been better prepared to handle this, in light of the fact that they knew that this law was going to take effect.

They opted not to be present; they did provide to the members -- and you all have a copy of their, I think it's a two-page -- a three page, I believe -- a three-page report. They did provide some breakdown, some of which we've been talking about a great deal, in terms of the total number of out-of-network cases, and what each of those breakdowns represent.

We do have one of their representatives, one of their lobbyists who can certainly convey and share -- go back to them with some of the input and information that is being asked today.

But, like you Senator, I wish they were here; because we certainly had a number of questions we wanted to ask, especially on something as important as this.

SENATOR SARLO: Just -- through you, Madam Chair, would the Commissioner have been able to require them to be here; or we don't have that ability to do that?

SENATOR POU: So I also asked the Commissioner that question yesterday, when we spoke. And the Commissioner indicated to me that-- And, you know, you're here; so, Commissioner, maybe you might want to just respond to the Senator's question. I know that I asked you that same question, and why don't you just -- in your words, rather than my paraphrasing it -- share with the Committee members your response.

Thank you, Senator Sarlo.

COMMISSIONER CARIDE: Senator, I do not believe that I have the authority to obligate them to be here.

I did advise them that I would be here, and any decision that they made was their decision.

SENATOR SARLO: Thank you.

SENATOR POU: Thank you.

Senator Vitale.

SENATOR VITALE: Thank you, Madam Chair; thank you, Commissioner for being here. And also, thank you for the time you spent with the Speaker and me, some weeks ago, when we were discussing the little bit of the backlog with the arbitration process.

This is not an easy Bill -- piece of legislation to implement, but I think you're doing a fine job. Look, it does take time; and I think when

you acknowledge that -- if we acknowledge that there are kinks from time to time, dealing with something that's maybe not so much as complex, but as important as this, you may find a bump in the road here and there. I think we've smoothed that out.

And it was always the intent of this legislation, of this law, that we first protect consumers from balance billing, from surprise bills -- to the tune of the \$220 million a year, or some number like that, I think it was; maybe less than that; \$420 million annually, which is real money for consumers who are-- We know that there is -- the law did not really allow there to be balance billing, but they were being balance billed nonetheless, when there's a dispute between the carrier and the provider. And most of the consumers who we heard from were scared to death about the implications of not paying that bill, and if it is-- That they never knew contacted the carrier to try to find some negotiation with the provider, or had not even known to do that or how to do that.

And so one thing we have learned, since this became law, is that we've saved average consumers, health care consumers, hundreds of millions of dollars in bills they should not be obligated to pay. And first and foremost, that was the real purpose of the legislation. That doesn't mean that the process to pay providers and to reasonably offer a payment by carriers isn't important either, because it is.

If we pay too much -- whatever that means -- you know, we know the cost of health care is extraordinary, and it's never going to go down. It's always going to be expensive, one way or the other. But if we were to pay a provider almost what they wanted, or what they billed, then we know that healthcare premiums would go through the ceiling, and

enrollment would drop; and we would wind up with probably half of the folks who were previously insured on Medicaid, and nobody wins there. So there's a real balance between a fair payment and a fair bill.

When I look at the numbers, so far, in this program, in its infancy, we look at 1,082 cases have all -- many of them, at least early on, have been resolved. We're still waiting for some documentation -- either the provider or the carrier. There were some that were withdrawn; 99 cases were withdrawn, 91 were dismissed, mostly because of lack of information by either party.

And so it seems to me that at least -- I may be biased, because I'm a sponsor of the Bill in the Senate -- but it seems to be working the way we intended it to work.

I wanted to ask you one question about the number of claims; maybe this is also a good question for Mr. Sanders from the Association -- but, on average, how many claims are submitted, say, monthly by all providers in the aggregate? Do you know--

COMMISSIONER CARIDE: Senator, unfortunately I would not be able to answer that question.

SENATOR VITALE: It's a lot, right? I mean, it's--

COMMISSIONER CARIDE: I don't have that information; I assume that it would be a lot.

SENATOR VITALE: Right; I mean, every day in a hospital, or in a physician's office, or somewhere, there are bills being sent to insurance companies.

COMMISSIONER CARIDE: I would say that that's a fair assumption that every day there are bills.

SENATOR VITALE: Right; hundreds of thousands of bills, over the span of a matter of months. And if we're looking at 1,000 cases of arbitration, there's a 100,000 claims; that's 1 percent of all claims. Not to minimize the importance of those bills being paid in a timely and fair manner, but I think it needs to sort of put this in perspective -- that this is a small amount of claims versus what some folks might believe is something that's tragic, and is undermining the ability for most providers to continue to provide their services.

It also doesn't mean that insurance companies are off the hook either; because, you know, they're notoriously thrifty with their payments, right? We also want them to be; so there's that balance between what's fair to the provider -- so that they can make a living and provide services, right? -- that's important to everyone -- and also keeping health care costs down. And so I'm hopeful that this process works out.

I looked at the chart that you had sent us, and the types of specialty involved: urology, dermatology, surgery, pediatric; all of it -- 99 percent of it emergent, not -- inadvertent. And it seems that the number of cases that were awarded in favor of carriers exceeded those awarded to the provider. But the aggregate dollar amount was greater for the provider than it was for the carrier, right? I think in your earlier testimony you said what the numbers were--

COMMISSIONER CARIDE: With regards to the carriers, the award was \$411,742. The award, to date, to the providers was \$1.8 million, with an additional \$224,932 because there were cases that were defaulted.

SENATOR VITALE: Right; so 75 percent versus 25 percent, more or less, if my percentages are right. And I'm not in the Budget Committee, thank God; no offense.

How many MEWAs-- There are three MEWAs in New Jersey, or four? How many MEWAs are there in New Jersey?

COMMISSIONER CARIDE: Two.

SENATOR VITALE: Two; so--

COMMISSIONER CARIDE: Two that I'm aware of, unless you know something that I don't know.

SENATOR VITALE: Well, so there's one for -- there is a provider one and a there's another one for all the different associations, right? They are part of the other MEWA?

COMMISSIONER CARIDE: There are two that I'm aware of, yes, that are with us.

SENATOR VITALE: Right; so just those two, and those two have opted in to the--

COMMISSIONER CARIDE: That's correct; the two that I'm--

SENATOR VITALE: Okay, they have opted in. The only two that exist are in the program.

COMMISSIONER CARIDE: --in New Jersey have opted in.

SENATOR VITALE: Okay; they have opted in.

But employees of ERISA plans -- and ERISA is not-- And obviously, we cannot obligate -- and there was a discussion about obligating ERISA plans into opting out of the law, if we required them to be in. We couldn't do that, because they're federally regulated, and that part of the

Bill would have been struck, probably pretty easily. So we allowed them to opt-in to the plan -- or to the program, rather.

But did you say, earlier, that individual employees can opt in to the arbitration, who are members of an ERISA plan?

COMMISSIONER CARIDE: The way the law reads, if the self-funded plan chooses not to opt in, the individual -- the plan member can avail himself or herself of the arbitration process.

SENATOR VITALE: Right.

During the course of the 10 years that we were negotiating, discussing this legislation, and every different iteration of it, one thing that stood out that we thought was important -- to the sponsors and to the providers -- was that they talked about cash flow issues -- right? -- with being held up -- their payments being held up for a prescribed period of time.

For the benefit of the members who are here today -- those who serve on Commerce, or who do not serve on Commerce, can you just quickly walk through the payment process for providers when they submit a bill that goes to arbitration?

COMMISSIONER CARIDE: The way the law is written, the process would be that the provider submits his or her bill; at that point, the insurance carrier will either provide them with an initial payment. If they agree, then they'll pay it off; if they don't agree, then it would be the initial payment with a letter saying that, "We believe the request is excessive." They would then negotiate; they have 30 days to negotiate. If at the end of the 30 days the carrier and the provider cannot reach an agreement, then the provider can file for the arbitration.

And then that will be reviewed. If it's determined that it's eligible to be in the program, at that point, then, the carrier will be notified so that they can then provide their documentation.

SENATOR VITALE: Can you talk about the eligibility of part of that then? So what does that mean?

COMMISSIONER CARIDE: So, for example, if the charge is for something that is not out-of-network, it would not be eligible. If the charge is for a plan that is from another state, it would not be eligible; if the submission was from a self-funded plan that didn't opt in. So those are things that they look at to make sure that they do qualify to be in the program.

SENATOR VITALE: So that's why we see some of these cases being kicked out of the process -- right? -- in your chart?

COMMISSIONER CARIDE: Correct.

SENATOR VITALE: So the provider, withdrawn; dismissed because of lack of information, withdrawn; a dispute concerning medical necessity -- there was only one case like that. One was out of scope with the out-of-network law; self-funded plan, didn't opt in, so that case was dismissed; and the plan was not issued in New Jersey.

So there were a total of nearly 90 cases out of the 1,000; so almost 10 percent -- almost 10 percent cases weren't even eligible for arbitration.

COMMISSIONER CARIDE: That's correct; so that's the first step of the process. They determine to make sure that the application for arbitration is eligible. Once they determine that it's eligible, then the process begins, where the carriers will be notified so that they can then

submit. And then there's a 30-day period where the arbitrator will look at all of the information provided; the final offers that were provided by both the carrier and the provider -- all of the documentation that is supposed to be submitted. And then they will -- the arbitrator will use their experience--

SENATOR VITALE: Sure.

Lastly, then -- I know we have other witnesses -- the offer that the plan makes the carrier, makes to the provider -- is that their last best offer?

COMMISSIONER CARIDE: So--

SENATOR VITALE: The way it's written? I mean, that's their offer, right?

COMMISSIONER CARIDE: Yes, right.

SENATOR VITALE: So they can only--

COMMISSIONER CARIDE: So they do an initial, and then a final offer.

SENATOR VITALE: Then a final offer, right? But the final offer happens during arbitration or after arbitration?

COMMISSIONER CARIDE: Right before arbitration.

SENATOR VITALE: Oh, I'm sorry; right before arbitration.

So that's their-- They're really -- they're stuck with that number.

COMMISSIONER CARIDE: Correct.

SENATOR VITALE: Right; so if they go in too low, or too high, or too whatever, that's the number they have to live with. And if the provider comes in with a number that's somewhat reasonable to the

arbitrator, it could be more likely that the provider would win their case, I think. I don't know what--

COMMISSIONER CARIDE: Well, my understanding is that the provider and the carrier provide their final number; and those are the numbers that they have to live with once they're in arbitration.

SENATOR VITALE: Right.

COMMISSIONER CARIDE: And then the arbitrator -- based on the information provided from MAXIMUS -- they will look at all the information, all the documents, the final offers. They will look at the CPT codes, locations, according to what we were provided by MAXIMUS; and they will determine -- based on their benchmarks, the sensitivity of the case, the complexity of the case -- and they will determine which party is the one who is closer to their determination. So they'll go with either/or.

SENATOR VITALE: Right; the law allows them to use any number of determinants in deciding what the numbers should be.

Does it also include some percentage of Fair Health?

COMMISSIONER CARIDE: The law is silent to the--

SENATOR VITALE: You're right.

COMMISSIONER CARIDE: --to the benchmarks.

SENATOR VITALE: All those elements are silent, right?

COMMISSIONER CARIDE: Right. What the law does say is that the arbitrator can use their experience in the health care pricing arbitration. So whatever benchmarks they're familiar with, that they have, that they feel would be more appropriate -- in this particular case, there's talk of Fair Health, there's talk of other benchmarks that they can use.

SENATOR VITALE: Right; thank you.

Thank you, Chairwoman.

SENATOR POU: Thank you, Senator.

Senator Cryan.

SENATOR CRYAN: Thanks.

Hi, Commissioner; how are you?

COMMISSIONER CARIDE: Good to see.

SENATOR CRYAN: It's good to see you.

COMMISSIONER CARIDE: It's been a while.

SENATOR CRYAN: Too long -- for me, not for you. (laughter)

A couple questions on the dismissal piece, and then a couple on the service providers.

So, for example, on the numbers that were provided to us -- which I know others have asked about -- for example, 16 dismissals were for the self-funded plan did not opt in to out-of-network; you know, the chart that's here? (indicates)

COMMISSIONER CARIDE: Yes.

SENATOR CRYAN: What's the follow-up? Like, why would 16 think of that; and do you review the dismissals for the reasons, and is there-- I mean, this is a new process.

COMMISSIONER CARIDE: Correct.

SENATOR CRYAN: So it makes one kind of wonder why does that happen and why would a provider think that? Like, can you go over the educational piece of what happens on these dismissals?

COMMISSIONER CARIDE: So the Department is not involved in the actual arbitration.

SENATOR CRYAN: Right; it's MAXIMUS.

COMMISSIONER CARIDE: It's MAXIMUS. So we don't have anything -- any information with regards to why the case was dismissed.

SENATOR CRYAN: Right.

COMMISSIONER CARIDE: I have heard that some of the cases might have been dismissed because of, say, a self-funded plan did not opt in. The individual wanted to avail himself of the arbitration program, and then the provider decided not to go against the individual. I have heard that.

SENATOR CRYAN: So does that seem like a gap to you, that somewhere along the way -- and it's early on in the process-- But, for example -- as Senator Vitale just pointed out -- it's pretty clear in the law on the opt-in piece. I mean, should we be directing a reg, or via regulation have MAXIMUS do some sort of follow-up on dismissals, as to why we have them and what we can do to -- for a lack of a better way of putting it -- maybe close the gap? Does that make sense, or is it too soon to tell?

COMMISSIONER CARIDE: I understand your question, and I really do think that it's too soon to tell if there's any additional piece that should be part of this law. I think that we need to work the process through and see how it all falls out in the end.

SENATOR CRYAN: The 68 not issued in New Jersey seems kind of-- Like, it leaps off the page; like, why is it even part of this?

Some other number questions for you.

So Joe mentioned, and I think Paul did -- Senator Sarlo, Senator Vitale -- the 1,082 figure that's on the top, in terms of total cases. Just taking out the *withdrawn* and *dismissed* leaves us with about 900 cases,

right? So if I look at this, 207 are carrier awarded, which is about 22 percent, right? You add the carrier awards -- as you mentioned in your testimony -- about \$411,000. If you add in the 15 that are defaulted to the provider, that's 150, or about 17 percent. It looks like it's kind of -- on the raw number -- it's kind of going one way or the other so far -- right? -- early in the game. But the \$1.8 million to the providers -- right? -- it's \$1.8 million, provider awarded. It takes, I think -- quick math -- carriers are getting about \$1,989 on an average award so far; the providers are getting \$13,330. It's way early; but does that trouble you, or does it seem out of scope? Or, from your view, what would your quick assessment of that be, or is there cause for concern or anything the Committee should be aware of?

COMMISSIONER CARIDE: We've been monitoring this, and we've been looking at the information that's been provided to us from MAXIMUS. I can't tell you that it's just leaping out that there's a problem here, because there have been cases that have gone to providers and to carriers. And I realize that the number of cases going in favor of the carriers is a little bit more than the provider.

SENATOR CRYAN: Five percent; not much. I mean, from a raw number standpoint.

COMMISSIONER CARIDE: From the raw numbers. I think that it would be a little bit-- I think that we need a little bit more time for this program to develop before we can say, "Yes, there's a problem here." I'm not at that point yet when I'm looking at this.

SENATOR CRYAN: Okay; because it looks like everybody is sharing the pain equally so far; roughly equally. Am I off on that assessment -- on raw, first numbers?

COMMISSIONER CARIDE: And Senator, I agree with you on that. I look at these numbers and I'm like, "Okay; it seems like everyone is sharing in the pain here."

So off the page, leaping at me -- I'm not worried that something is off-balance right now. But again, this is early into the process.

SENATOR CRYAN: How does MAXIMUS get paid; how do the arbitrators get paid?

COMMISSIONER CARIDE: So the way it works is, when the provider submits his application, they have to submit it with an application fee, which is \$72.50.

SENATOR CRYAN: Okay; how did that get figured out?  
(laughter)

COMMISSIONER CARIDE: Each party pays \$72.50 for the application. But the way it works is the provider pays it first, if, in fact, they are considered eligible; then the carrier is notified, and the carrier submits their responses with their application fee. If MAXIMUS determines that the provider's application does not qualify -- it's not eligible -- then they will notify the provider; but the application fee is kept.

If the parties are in for the arbitration, then the arbitration fee is \$450, of which each party pays half, \$225. So MAXIMUS is paid by the provider and the carrier.

SENATOR CRYAN: And they're paid roughly \$600 a case.

COMMISSIONER CARIDE: Roughly.

SENATOR CRYAN: Okay.

All right; thank you.

COMMISSIONER CARIDE: Thank you.

SENATOR POU: Thank you.

Senator Lagana.

SENATOR LAGANA: Thank you.

Just a couple of follow-ups.

On that issue, this is just taking-- When we're talking about numbers, we're talking the actual -- what's coming out of the awards. We're not taking into consideration the savings realized by the carrier, by people who are not filing arbitrations -- I mean, because there's been a significant reduction in actual reimbursement. So, I mean, we're talking about, probably, 1 percent of what's been filed, and the outcome of that. So, I mean, there's a whole other big picture here that is not part of this particular conversation; but it does exist, and is something we should also consider.

Procedurally speaking, I know that when we discussed the legislation, and it went through, there was a provision in there -- and this comes into effect when you're negotiating your new bid or the current bid -- there is a provision in the statute that requires the arbitrator to be AAA-approved. I think that that's just not-- AAA is a company, so we can't require the arbitrator to be approved by a company. They have to be independent, and we have to award whatever a company bids, based upon their own qualifications. Well, actually, no; based upon the qualifications that you determined to be the appropriate qualifications.

So I just want to point that out, so the Department doesn't run into any issues when they're looking at the bids, going forward.

And just to give you some direction, if you look at the PIP statute, which is N.J.S.A. 39:6A-5.1, it says -- let's see -- it says, "The organization administering dispute resolution shall utilize qualified professionals who serve on a full-time basis and who meet standards of competency established by the Commissioner." I think that's an important part of that statute that maybe you could utilize when determining who the next administrator is -- if it's MAXIMUS or somebody else -- and what you should consider, maybe, through regulation when you outline what the arbitrator -- what their qualifications should be and what demands you make on the administrator going forward.

SENATOR POU: Thank you.

Thank you.

Senator Vitale.

And Senator, just before, for the purposes of just making sure I announce this, I think we're going to stop with Senator Vitale's question, once you're done. And then -- because I know that we want to hear from so many of the other speakers that we have.

So thank you.

Senator Vitale.

SENATOR VITALE: So if my memory serves me correct, there are -- in the regulated marketplace in New Jersey -- 30 percent in the regulated market; or is that about right?

COMMISSIONER CARIDE: That's my understanding; correct.

SENATOR VITALE: Okay. So this law -- really, the law only extends to about 30 percent of the covered lives in New Jersey?

COMMISSIONER CARIDE: Correct.

SENATOR VITALE: And the rest are ERISA plans, right?

COMMISSIONER CARIDE: Correct.

SENATOR VITALE: And so providers are still able to balance bill patients of ERISA plans, since if they don't opt in to this program-- I mean, if patients don't avail themselves of the opportunity to bring cases to arbitration on their own; which is probably difficult to do -- right? -- unless they get some help or some information somewhere.

So this affects 30 percent of the marketplace. The only thing that we can do -- because the only thing New Jersey regulates is 30 percent; the rest is -- they're federally regulated and we can't really touch them. And so 70 percent of the covered lives in New Jersey are still eligible for balance billing; which is unfortunate, but it still takes place today, regardless of the spirit of the law that protects people who are covered under a regulated plan.

And then lastly, Senator Lagana brings up a good point. So the AAA piece of this is AAA-certified, right? That means the companies that are chosen to do this work have a certain certification, and ability, and training, and whatever, to do this work?

COMMISSIONER CARIDE: The way the law is written -- it asks that the arbitrators be AAA-certified. When we go out to bid, we'll see which companies will respond to the bids. And at that point, we'll determine what kind of a certification they have and what qualifications they have.

SENATOR POU: Thank you, Senator.

Thank you so very much, Commissioner. We really appreciate the information.

I'm sure there are going to still be many questions after this; that our office will be in contact with you. And I'm sure all of the stakeholders -- who are right behind you, seated right behind you -- will no doubt have some questions of their own.

So thank you very much for availing yourself for today's testimony and today's discussion.

Thank you.

COMMISSIONER CARIDE: Thank you, everyone.

SENATOR POU: Thank you very much.

Our next speaker -- I'm going to ask that if you would please come forward -- and that is Dr. Meyer, President of the New Jersey Neurosurgical Society; and Dr. Dupree, President of the New Jersey Society of Emergency Surgeons, Access to Care Coalition.

So I was looking down at my notes -- so I mentioned both the names, but I can't address you, because I don't-- So Dr. Meyer is-- Okay; and thank you, Dr. Dupree.

Okay; go ahead, please.

**DAVID J. DUPREE, M.D.:** Thank you all for having me today.

I want to thank you for looking into the follow-up for the Bill that was passed.

I'm here to report from the battlefield. I'm the one in the trenches, taking grenades. I'm a solo practice general surgeon; I'm the guy who-- I have no partners. Before this Bill was passed, I was on staff. I

testified here before; I did the majority of the free health care in Monmouth and Ocean counties. I was the only surgeon on staff at the Parker Family Health Clinic. I took emergency room calls at four hospitals; and the majority of my practice was doing emergency surgery, coming in, in the middle of the night. Very few people in this room knows what it feels like to get up at 3 in the morning, when it's 10 degrees outside, in the middle of a blizzard, to go in and operate on someone and save their life.

The last thing I've ever spoken about, at 3 o'clock in the morning, is what insurance they have, what insurance they don't have. And to be clear: there are a significant percentage of those patients who have no insurance; and I do it for free, and I'm happy to do it for free.

But the reality of this Bill has set into my practice. I've resigned from three hospitals because I can't make it; I'm going down. I resigned from the Family Health Clinic; they have no surgeons on staff now. I run a free Medicaid clinic at River View Medical Center; that's a fact, okay? And my private practice I now have to drop; I have to take young, healthy individuals and operate on them and make up for what I've lost in volume. I'm a solo-practice guy; I have five health insurances to pay, I have five employees. Every single night I go in; my kids barely know me. And this Bill has affected me; it may not affect large groups as much, but it's affecting me.

My next move I have to do -- I'm going to have to drop Medicare. I can't afford Medicare rates to operate on Medicare patients, which are more complicated and take longer time. So I'm going to have to narrow myself down to operating on 30-year-old inguinal hernias. I'm the one who goes in in the middle of the night.

You heard the Commissioner say -- it's 1,082 cases; that's 1,082 families biting their nails in a waiting room, wondering if their loved one is going to make it. This is not -- I'm not wiping somebody's nose; this is not what these cases are. These are emergencies; these are ruptured spleens, these are perforated colons in the middle of the night.

I'm in the trenches, taking grenades. I took an entire day off -- I can't even afford to take a day off to come here, but I did it because it's important to me and my practice.

My kids barely know me, as I say; I'm going down in practice because of this Bill. What the Commissioner didn't mention is, until the website was up in late January, all the claims that I submitted in September, October, November-- When you call Horizon, they don't talk to you because you have to punch in an ID number. I didn't have an ID, because I'm out-of-network; so all those claims were lost. In the first claim that I won-- I've lost, like, 70 percent of my arbitrations that I sent to Fair Health, by the way. I haven't been paid on the first one; the first payment is due May 10; that's a fact. I won one arbitration from back in, like, October; and by the time you get the process, and the e-mails, and the arbitrations, they say, "Oh, this is not part of the bill" or, "This is part of the bill." I haven't been paid on my first case; not one dollar. I've been approved -- I got approved April 10 for my first case that I arbitrated, that I won; and I still haven't been paid.

I had to change my practice because of what I've experienced with this out-of-network Bill. This is going to affect my practice so much that if I-- I can't even negotiate with insurance companies, by the way. I called Aetna; you know what Aetna told me? "We don't negotiate with solo

practice physicians.” They offered me 60 percent of Medicare, and they said, “Take it or leave it.”

SENATOR POU: I’m sorry; who told you that?

DR. DUPREE: So Aetna--

SENATOR POU: Oh.

DR. DUPREE: --I tried to go in-network. My next move was -- I’m going to try to go in network, and I tried to negotiate for rates. And they say, “We don’t negotiate with solo practice physicians. You have to be in a large group for us to negotiate with you. Our offer is 62 percent of Medicare, and that’s -- you can take it or leave it.”

I can’t sustain a practice. I would have to be employed by the hospital, or-- My dream is to be a small business owner; I want to own my own practice. I want to go to work; I want to have my own office. This is what I dreamed of doing since I was 5 years old. And this is being stripped away, layer by layer. That’s 1,082 cases. This is not \$900 million. This is real life. I’m in the trenches; this is the battlefield analysis of what’s going on.

SENATOR POU: Thank you, Dr. Dupree.

Dr. Meyer.

**SCOTT A. MEYER, M.D.:** Thank you.

In the interest of time -- and Chairwoman, with respect to what you said earlier, I’m going to -- I’m anticipating that a lot of people are going to talk about anecdotal experience, the difficulty with arbitration. So I’m going to try and provide a unique perspective that I could provide.

I’m a Board-certified neurosurgeon; I’m also a member of the largest neurosurgical practice in the State of New Jersey. So in that way,

David and I are sort of polar opposites in a way. And I can tell you that we're running into significant problems as a result of this Bill as well.

We have offices in Moorestown, Summit, Neptune, Pompton Plains, Jefferson, and soon-to-be Bridgewater. So we're a big practice, with nearly 70 employees.

The result of this law -- and to the point of the number of claims that we have -- even with that large practice we had to hire a legal firm to come represent us, to go through the arbitration process. And we're ramping that up still, trying to figure out how to do it. And that's a large practice; that's not a one-, two-, three-person practice.

What I want to talk to you about is the concept of *narrow networks* and *high-deductible insurances*, because I think the two go hand-in-hand. And while this law, for 30 percent of the covered lives in New Jersey -- they have protected them from financial ruin for an emergency -- 70 percent of covered lives are not impacted by it. But those people are being impacted as well, because they're not getting access to care, and this is how that works.

The way the insurance companies profit is, if you have a high-deductible plan -- say, \$5,000 for a relatively good plan; as high as \$7,000 for a lower-tier plan -- most people don't have that money, liquid, available to pay for care. So what do they do? They put off necessary medical care. It's just like you would if you have a problem with your car and you can't afford to pay for it, you don't.

But premiums are still pretty high. And they've done the research -- you know, you read the insurance magazines and trades -- it's a great process for maximizing profit.

The second thing is narrow networks; and New Jersey, thankfully, has passed legislation that explicitly directs the insurance industry to have an appropriate number of specialists and subspecialists available. Unfortunately, the government just says it has to be *reasonable*, whatever that means.

And so because of this law -- as David was alluding to -- we've lost the ability to negotiate. Even as a large group, we've had insurance self-funded plans and other plans tell us, "We're not interested in adding neurosurgeons." We have data metrics, quality outcomes, and we've been willing to provide those; and they still say, "You know what? We're not interested in talking." Why is that? Well, the average person changes insurance every three to five years. So if you put off necessary care long enough, odds are someone else is going to pay for it.

So it's a game; and if you have to travel or you have to wait-- We recently did a search, and one of my retired physicians was still being listed on an insurance plan as an *active participant* in their plan. He's not working anymore. How can you do this? So they don't update those.

So what we're doing is -- as part of this we did-- And it was admirable; and nobody wants patients to lose financial security, to go bankrupt because of it. Nobody chooses what illness they're going to get. And it's unreasonable to ask a consumer to say, "You know what? I think I'm going to have an aneurysm in one year; therefore, when I sign up for this policy I'm going to search to make sure, within 30 miles of my address, there's going to be a neurosurgeon who is trained in endovascular care to take care of me." You don't do that. You're told by the insurance industry,

“Well, we have a broad network of physicians,” and you take that at its word, and that’s not the case.

And because of ERISA, we don’t have, really, the ability to do that. Some of that can be done on the employer side; but I think, in some ways, this law has made that worse.

Thank you.

SENATOR POU: Thank you; thank you, Dr. Meyer.

I’m sorry; Senator Vitale.

SENATOR VITALE: Thank you.

Thank you, Doctor, and both of you for being here today.

Since October, how many claims have you submitted for payment that have gone to arbitration? Both of you, if you could answer, if you don’t mind.

DR. DUPREE: So I think there are about 15 cases that I wasn’t able to get before the e-mail, before the website was up at the end of January. I have about, I think, 15 or 20 cases.

SENATOR VITALE: And how many-- But since October--

DR. DUPREE: Well, again, October I submitted-- I couldn’t submit claims because when you--

SENATOR VITALE: I’m sorry; you’re right. When the website went live, you’re saying, about 15 or 20 cases?

DR. DUPREE: Right.

SENATOR VITALE: How many total cases have you had?

DR. DUPREE: I’ve had six cases, and four have been denied -- or I lost four.

SENATOR VITALE: That’s in arbitration; but overall--

DR. DUPREE: Right.

SENATOR VITALE: --how many cases have you had, though, since--

DR. DUPREE: Oh, I do about 60 or 70 cases a month.

SENATOR VITALE: Okay. So, percentage wise, it's a small percentage of overall procedures?

DR. DUPREE: Right, right. It's a small percentage, but that's the -- it's like a narrow profit margin for even a restaurant, right? Like, it's--

SENATOR VITALE: No, I'm not arguing with you.

DR. DUPREE: Right.

SENATOR VITALE: I'm just asking the question.

Doctor?

DR. MEYER: Yes, I'm not going to be able to give you a set number, in part because of the size of our practice; and we have a separate billing department and now a separate legal group that's doing it for us.

SENATOR VITALE: Sounds like a lot, though, probably, right?

DR. MEYER: What's that?

SENATOR VITALE: A lot?

DR. MEYER: Yes.

SENATOR VITALE: I mean, there are a lot of procedures.

DR. MEYER: Yes, it would be a decent number, but--

SENATOR VITALE: System-wide, sure.

DR. MEYER: But I also think that we were still trying to get that ramped up. So I expect that that number will increase as time goes on.

SENATOR VITALE: So before this law became effective, and you got caught up in the arbitration process, when you came across patients like this, or disputes with insurance companies, and you weren't able to reconcile the number that you wanted versus what they paid you, was there ever a time when you had to balance bill patients?

DR. DUPREE: No, I've never balance billed a patient; because before, when we negotiated claims, you were negotiating-- Horizon doesn't negotiate their claims; they send it to MultiPlan. So you're doing a third-party negotiator. But when I was-- I negotiated all my out-of-network claims myself, and we've always agreed on a dollar amount. It was very mutual, "Okay, let's--" And I've never had to balance bill a patient; almost 100 percent were agreed upon.

SENATOR VITALE: And your practice was practice-wide?

DR. MEYER: Same, same. There was, I think, laws with respect to the deductibles; we would always follow that. But we would never balance bill a patient.

SENATOR VITALE: Okay; thank you.

SENATOR POU: Senator Lagana.

SENATOR LAGANA: Thank you, Chair.

Do you find that you're encountering instances where you're disagreeing with the insurance carrier, as far as the application of the law? For instance, you don't believe the law applies to that specific surgery, for instance?

DR. DUPREE: Right; so if you call Horizon -- you can sit in my office and call Horizon, and you can get two different representatives on the phone at the same time. And one person will tell you that the Bill

applies, and one person will tell you that the Bill doesn't apply, on the same claim, for the same patient -- which happened today.

So they tell you what-- So what's happened is, in my practice I would-- You fill out the two-page application process, and go through all these arduous steps to arbitrate; and then they say, "Oh this doesn't apply to the Bill." So then you have to take it back, resubmit it -- this has happened -- so then you resubmit it, and then you go through all that paperwork, and then they say, "Oh, you know what? This does participate in the Bill." So you have to stop, go back, and redo the two-page application and go through all the-- I have claims that are, like, nine months old for the same thing.

And what happens is, Horizon-- I have claims here (indicates); I have a claim in front of me, on a patient who has elective out-of-network benefits. They pay at 90 percent of Fair Health; they have elective-- I went in and did an emergency operation; they paid one-tenth of what their out-of-network benefits were. And I had to settle, and I lost the arbitration -- on a patient who has out-of-network benefits that's supposed to pay at 90 percent of Fair Health.

I billed Fair Health, I lost the claim, and I got paid, like, one-eighth, or one-ninth, or whatever it was of their allowed amount, when they have those -- they have the plan. So I got penalized for doing an emergency operation on somebody I could have made eight times that amount electively.

SENATOR LAGANA: When you do run into the situation where there's a dispute -- you believe that the law doesn't apply, they're telling you it does apply -- have you-- In those instances, have you reached

out directly to DOBI to, maybe, submit some type of complaint or try to get somebody on the phone to offer you some guidance?

DR. DUPREE: You know, I have to tell you, again, I'm a solo practice guy; I have four employees. And it's so hard to authorize surgeries on top of everything else, do office hours. And I mean, I'm doing -- we do the best we can do. I have my office manager who does it; DOBI actually has been very good about responding, and communicating, and stuff. But it's very hard; there are so many moving parts in my day, it's like I can't-- It's very hard to have one person to just do it. I can't afford to just hire one person to just do all this stuff; I just -- I can't afford to do that. It would take one employee, full-time, to do all of it.

SENATOR LAGANA: When you do -- and I'm not sure if you have encountered the situation -- but if you've done a surgery and there is an agreement, let's say, that the law doesn't apply. I don't know; has this ever happened, where you've actually agreed with the carrier that the law doesn't apply, or--

DR. DUPREE: Yes.

SENATOR LAGANA: Okay. Now, in that instance, they're still paying you what they paid you, correct?

DR. DUPREE: Yes, they're still paying; and I bill at Fair Health. I bill 90th percent of Fair Health. So they pay, and actually still negotiate.

SENATOR LAGANA: Okay. How have those negotiations been, and what has been the ultimate outcome of those situations?

DR. DUPREE: It's just like it was before the Bill passed, in some of them. Some instances we'll agree to 90th percent of Fair Health.

They'll say, "Okay, we'll do 80 percent of Fair Health," and I'll say, "Okay, fine," and we'll sign it and send it in, and they submit payment.

SENATOR LAGANA: So that part of it is working normally, like it did--

DR. DUPREE: Correct.

SENATOR LAGANA: Okay; thank you.

SENATOR POU: Senator Kean.

SENATOR KEAN: I'm sorry; thank you.

Thank you.

Through the Chair, to follow up on Senator Lagana's questions.

You just brought up some of the -- the Chair would say the compliance time, compliance costs. But whether it's a smaller practice, an individual practice, or a broader practice, can you put a number on either time away from patients -- you know, compliance, costs -- what that has as an impact, either -- serving the patients?

DR. DUPREE: So I spent last Monday office hours -- I spent my lunch hour, for 45 minutes, on hold, trying to negotiate a claim for Horizon. I was on hold for 45 minutes. So while I was at my desk, I had to put the speaker phone on, try to eat my lunch, try to do my notes. And then when I get on the phone, they tell me I have to wait for a peer-to-peer; and then when the peer-to-peer comes on, it's a MultiPlan, and the MultiPlan says, when they negotiate-- There's no negotiating, by the way, these claims. Horizon gives them a number; a MultiPlan says, "No; this is the final payment." It's usually -- the one on Monday was \$600 more than the original payment; and then they said, "You have to take it or leave it, otherwise you're going to arbitration." That's how it works; there's no

negotiating. They say there's a negotiation process in this Bill; there's no negotiating. MultiPlan says, "This is the most we're going to pay you. It's \$600; you can take it or leave it." That's what they say on the phone.

So I say, "I'm not going to take it." Then they mail that \$600 to me. Then I have to do the arbitration, and application, and everything from there on out. It's not like we're negotiating 80 percent of Fair Health on the phone with MultiPlan. It doesn't work -- it's not been the case for every single case that I've spoken to them about. It's been \$600, another \$1,000, another \$800; like, that's what their offer is. It has never been anything close to Fair Health.

DR. MEYER: And I think, for us, it's a few full-time employees, plus there's this firm that we added. So I don't have a solid number, in terms of the cost yet. But there is going to be significant costs.

SENATOR KEAN: And neither of your organizations has balance billed prior; but the time away from patients and the cost of the overall organization to then try to provide services to the individuals is significant.

DR. MEYER: Yes.

SENATOR KEAN: Thank you.

SENATOR POU: Thank you so very much; thank you.

DR. MEYER: Thank you.

SENATOR POU: Okay, our next panel is going to be Jen Mancuso, the Executive Director of Fair Share Hospitals Collaborative; and Cathy Bennett, President and CEO of New Jersey Hospital Association.

And in preparation for our next panel, just so I can keep this moving, will be Dr. Stavros--

**S T A V R O S   C H R I S T O U D I A S,   M.D.:** (off mike)  
Christoudias.

SENATOR POU: Thank you; you can help me when you get up here.

And Dr. Randazzo, from the Doctor-Patient Alliance; and Dr. Mazzola.

**N E I L   E I C H E R:** Thank you, Madam Chairwoman.

We're going to be brief; and we're not going to be redundant.

SENATOR POU: Oh, I'm sorry, Tom; I forgot-- So Tom and Kristin; yes. (laughter)

MR. EICHER: So Neil Eicher, New Jersey Hospital Association; Jen Mancuso, Fair Share Collaborative; Kristen Silberstein, from Holy Name; and then Tom Baldosaro, from Inspira.

So good afternoon. We are appreciative of being able to offer our thoughts and experiences, as this Bill was signed into law last year.

My colleagues will focus on more of the contracting issues, while I'm going to spend just a little bit of time on the disclosure of information to patients prior to elective services.

First off, we do need to celebrate that this law is on the books to protect patients from surprise medical bills. A patient, as was said before -- a patient should not be exposed to these surprise medical bills when patients do everything they can to ensure that the hospital is in-network and the attending physician is in-network. So we applaud the Legislature and the Governor's Office for making this a priority.

When we testified earlier on this Bill, the last eight to ten years, we were given assurances that, as the law would roll out, we'd have

the opportunity to come back and give our perspective. So we're appreciative of having this opportunity. And I should note that from the hospital industry, we are -- we have a task force of different CEOs and CFOs who are reviewing the early impacts of the Bill, of the law; and we'd appreciate that we continue to have this dialogue, over the next couple of months; because as contracts become renewed with hospitals, then we get to see if there's a trend throughout the state.

And what makes it difficult when we are offering our thoughts on potential unintended consequences, is that New Jersey was the only state that was looking to include hospitals into this arbitration system. So it left us with the kind of ground that we weren't sure what exactly would happen.

So just a few notes on the implementation of the disclosure portion, before I turn to Jen.

We've documented everything in our testimony, so I won't read exactly what we've laid out.

I think one of the main points of the Bill is to provide for an informed patient, an informed consumer. But what we're finding is that, a lot of times, it's actually creating more confusion for a patient. And what I mean by this is-- First of all, the Commissioner of DOBI and the Commissioner of Health have been very open to listening to our concerns, so we're very appreciative of that. But in some cases, hospitals are left providing notification to patients about information that we don't have from the health insurance companies. So in some instances, when we're doing scheduling -- since a lot of it's done through electronic portals -- there's still this envision that it's all a paper-based system. So we're

required to tell the patient, “You’re protected from surprise medical bills, for example, if your ERISA plan is opted-in.” But if we don’t have that information from the carriers, we might be giving information to the patient that makes them think that they are protected, when -- in case the carrier has not opted-in.

So we asked DOBI to clarify that in upcoming regs, which we were happy to see.

And then the last point I’ll make is on the Department of Health guidance. We do think there is a section in their guidance that goes beyond the letter of the law. When we negotiated the transparency and disclosure sections, we voluntarily said that we would provide notification to the patients about our employed physicians and our hospital-based physicians -- about who would be in or out of that patient’s network.

However, there are other staff positions with privileges that we don’t know their contract status. And that is clear in the Bill, or in the law; however, the guidance from DOH, right now, goes beyond that by requiring us to tell the patient about every network status of every physician in the hospital.

So we look forward to working with the DOH and DOBI to clarify those problems, as we go forward.

So with that, Madam Chairwoman, I’ll turn to Jen.

SENATOR POU: Before you do, you were able to provide DOBI with those comments--

MR. EICHER: Yes.

SENATOR POU: --and questions?

MR. EICHER: Yes; they were very grateful (*sic*) with their time and access, yes.

SENATOR POU: All right; thank you.

JENNIFER MANCUSO: Thank you, chairwoman, and Senators.

My name is Jennifer Mancuso, Executive Director of the Fair Share Hospitals Collaborative.

Thank you for having us.

Like Neil mentioned a moment ago, I want to echo that our members are fully supportive of protecting patients from surprise medical billing, and are engaged in efforts to inform them the best that we possibly can to make sure that they don't inadvertently seek services from an out-of-network provider.

So while we support that practice fully and believe that the law was very well-intentioned, we are concerned that the arbitration process that was created to settle out-of-network disputes gives an advantage to insurers over providers; and that that doesn't only affect out-of-network negotiations, but directly affects in-network negotiations. The out-of-network law -- it calls for arbitration to settle disputes.

The key component to any fair mediation process is the pain should be shared equally by both parties; they should both be responsible. But we don't feel, and we're concerned, that this new system basically makes providers lose considerably more than insurers; and that advantage is the root of the problem. We fear that insurers will use this advantage as a pressure point during in-network negotiations.

In a fair, in-network negotiation between an insurer and a provider, sometimes the hospital or physician will choose to take a lower reimbursed rate for in-network services if they're assured that they're going to receive sufficient patient volume. If they can't agree upon a reasonable rate, then they can choose to go out-of-network and, in turn, the insurer can steer patients away from them.

Now, this balance basically ensures that providers stay in network and that they also receive a fair reimbursement for their services. But when an arbitration system limits the reimbursement that an insurer is going to pay for out-of-network services, insurers have little incentive to offer fair in-network negotiated rates. We don't think that it's coincidental that right after the law was adopted, two of my members -- very sizable health systems with a number of hospitals within their system -- faced a very, very difficult negotiation. Neither system had ever experienced such aggressive negotiation tactics before, but both were offered dramatically reduced rates by the insurer.

You know, we have also heard that a number of physician groups have had -- and individual physicians have had their contracts canceled on them, and have been forced to renegotiate a reduced rate to be in-network.

We're concerned that this behavior isn't an outlier, but that it could be a trend. We fear that if an insurer feels that they're gaining the upper hand and they succeed in this kind of process, then other insurers will follow.

I want to point out that almost all New Jersey hospitals are in-network; and the few hospitals that were operating as an outlier are now in-

network with the state's largest provider. We want to ensure that hospitals are able to stay in-network. It's important that we have healthy networks; not just for providers, but we want to make sure that we're not creating a patient access issue here. If you have less providers that are in network, it's farther that a patient will have to travel, more time that they'll have to wait for an appointment; it's less access to skilled providers.

We are 100 percent confident that the advocates of this law never intended for this to be used as a way to manipulate or suppress in-network negotiated rates. We believe that it was intended to protect patients from surprise medical bills; and again, we fully support that practice.

But if you're providing insurers with an advantage in the arbitration process, they're not going to have incentive to offer fair in-network negotiated rates or remain in-network with providers. So this will not only harm providers, but it could potentially harm the patients -- you know, the millions of patients that we care for every year.

I'd like to turn it over to Tom Baldosaro to give a very specific example and experience of how this is affecting him.

**THOMAS BALDOSARO:** Thank you very much; thank you for your time.

I want to reiterate, my name is Tom Baldosaro; I'm the Chief Financial Officer for Inspira Health. I've been in health care for 27 years; I've negotiated contracts for about 20 of those years. I have never worked at a hospital that was out-of-network. I've had hospital-based providers that were out-of-network; but the only reason we let them in the walls of our hospitals was because they promised not to balance bill. And we would

take it a step further -- our collection process is probably a little different than a lot of people. We don't credit report, we don't place liens on people's homes, and we don't sue them. At Inspira, we're never going to harm our community over their inability to pay a bill.

Now, we are one of the hospitals -- we were probably the first hospital out of the chute, after the legislation, that had a contract due. And the first offer I got was a 40 percent rate decrease. I've never been asked to take a rate decrease ever; our average increase, over the years I've been doing it, have been between 2 and 5 percent; nothing outrageous, nothing outlandish.

This particular payer that I've dealt with -- I never met the people prior, in the 20 years I was negotiating with them. We always did it through e-mail; it was that easy. And then they start this.

A lot of letters went out; we heard from the community, we heard from the employers. And I testified here about a year ago; and shame on me then -- all I talked about was the impact on Inspira. And that's not what I really found out it to be. It's the impact on the community. The community-- If you're familiar with where we're at -- we're in South Jersey; two of the counties we serve, Salem and Cumberland, are two of the poorest counties in the state. And some of the quotes I heard when I talked to people, "You've always been there for us. Why would they create a system that would allow an insurance company to remove you from their network? Where else can we go?" Those are some of the words I'm hearing. Again, if you know where we're at -- we're the only hospital in Cumberland County. People are calling me saying, "We have a baby due; where are we going to

have our baby? We can't get there." This is the impact that this legislation had.

As Jen talked about, when you have a negotiation, you need pain on both sides to keep people at the table. We have pain, okay? If we're out of network, we lose all of our elective stuff; we have a big public relations hit. The community loses, because they don't have access to care.

And with the arbitration system that was implemented -- if I look at what would happen-- So if I went into arbitration -- which I hope to never do, because then my community is out-of-network -- but if I do go, maybe I'll ask for what my last in-network rate was. Maybe I'll ask for 2 or 3 percent higher, or 5 percent -- the range that I've gotten. And if I win, great; I get that. What did the insurance company risk? Nothing; they had nothing to lose, zero. All they're paying me is what they would have paid me in the in-network rate. They have to delay payment; but they have no pain. There's no reason for them to negotiate, none; because all they have at risk is what they would have gotten in a normal negotiation. We can't have that; we can't treat our communities like that.

There's a reason, I believe, that no other state has hospitals in this legislation; because this is what happens.

We don't want to treat our community poorly; you don't want to treat our community poorly. But the challenge of this Bill has put us at risk. I'll tell you, the only reason that I'm in-network with that first payer was one, I took a contract I never would have taken because we want-- The community spoke to me. And two, it's because of this; it was because of the opportunity to come to you and hope that you would make change.

We were the first contract out of the chute. And, quite frankly, the best thing I could have done to prove pain would have been to go out-of-network. But that would have hurt too many people. The next time -- I already have another contract due in November, and they've already contacted us saying, "Hey, you're taking a rate decrease." I'm not going to take that contract; I can't. I can't afford to keep doing that.

I need your help. So to help our community and to help the healthcare community, we need to fix this, for us and for them.

I'll turn it over to my wise colleague.

**KRISTEN SILBERSTEIN:** Yes, I'll be brief as well.

So similarly, we predicted that this would change the leverage in negotiations. And Holy Name was actually pushed out-of-network by a major payer in their Medicare Advantage plan, prior to the New Jersey law being passed, because Federal law protects carriers in out-of-network situations -- in Medicare Advantage HMOs -- because they only have to pay 100 percent of the Medicare rate.

We found out we were out-of-network in that plan through a letter. There was no discussion, contract negotiation; nothing. It was a notification that, "You are going to be out-of-network in our new Medicare Advantage plan that we're selling in your county."

Similarly, the tenor of our rate negotiations with several payers has changed. We've always had very strong relationships with payers. We participate in every major plans' network willingly. We've considered ourselves to be good neighbors and have, again, had good relationships with payers historically.

Unfortunately, for some -- again, those tenors have changed. We were also very big proponents with our hospital-based groups. We, you know, do not want our patients being balance billed by physicians they have no choice in using, so we worked very hard to broker meetings between our hospital-based groups and insurers to make sure that they were all in-network.

We recently learned that our emergency group was given an untenable contract with a payer that they have had contracts with for many years. And they are now out-of-network with that plan.

So it seems counterintuitive to us that a Bill that was designed to protect consumers -- and we heard loud and clear, from the Bill sponsors, that they really thought that this would encourage more participation in networks, not less -- is actually having the opposite effect.

And the last point I'd like to make is that as all of us moved to value-based contracting, it's very important that we have collaboration between physicians, hospitals, and carriers. Again, putting providers out-of-network has the opposite effect on value-based contracts. We cannot manage those patients if we are not part of those networks.

So in spite of, you know, all the rhetoric around value-based purchasing, and quality, and continuity of care, this is actually having the opposite effect; and we really appreciate the time for you guys hearing us out today.

SENATOR POU: Thank you; thank you so very much.

Senator Vitale, followed by Senator Sarlo.

Senator Vitale.

SENATOR VITALE: Thank you, Chairwoman.

Which hospital do you represent? Did you say Holy Name?

MS. SILBERSTEIN: Holy Name, yes.

SENATOR VITALE: Okay; have you always been there, or were you somewhere else before?

MS. SILBERSTEIN: I was with Valley before Holy Name, yes.

SENATOR VITALE: At Valley.

So is Holy Name in-network with all plans, all carriers, or not now?

MS. SILBERSTEIN: We are in-network with all carriers; we are out-of-network with Horizon's Medicare Advantage plan.

SENATOR VITALE: Horizon has nothing to do with this Bill, though -- with this law.

So you're in network with all those plans -- right? -- all those commercial plans?

MS. SILBERSTEIN: Yes.

SENATOR VITALE: Okay. And so the out-of-network-- So were you in-network with the plans before this law took effect?

MS. SILBERSTEIN: Yes.

SENATOR VITALE: So were you balance-billing patients for-- No.

MS. SILBERSTEIN: Other than in-network deductibles and cost-sharing.

SENATOR VITALE: Right; or someone who was there, recognizing that-- Someone who did have an out-of-network benefit, and chose -- not in your plan, but chose to have the service done at your hospital. Of course they would pay more, because they were-- They would

pay the carrier for the services, right? They had an out-of-network benefit, but they weren't part of any of the carriers that were affiliated with your plan -- with your hospital.

MS. SILBERSTEIN: Regarding our hospital-based physicians?

SENATOR VITALE: Yes.

MS. SILBERSTEIN: Our hospital-based physicians were participating with all the major plans until recently, yes.

SENATOR VITALE: They also did too; okay.

And so prior to this law, you were -- you never balance-billed patients in the hospital, is that right?

MS. SILBERSTEIN: Correct; we were in-network.

SENATOR VITALE: You were in-network with all of them.

MS. SILBERSTEIN: Yes.

SENATOR VITALE: And now that the law is passed-- And how many of your cases are going to arbitration?

MS. SILBERSTEIN: We are still, thankfully, in-network with all of the major plans.

SENATOR VITALE: Right; so then what's your gripe with this law, with respect to not balance-billing patients?

MS. SILBERSTEIN: Our concern is the tenor of the negotiations with the carriers has changed.

SENATOR VITALE: Hasn't it always been difficult to work with carriers?

MS. SILBERSTEIN: No.

SENATOR VITALE: Really? Like-- I'm sorry; what I mean is, I've been here for a long time. I've not served on this Committee, but I've

been on the Health Committee for a long time. And I've heard, over and over and over again, from any number of providers -- doctors, hospitals, the like -- that it's grueling and torturous to work with insurance companies to negotiate a contract. And you're saying that's not the case; Neil, it's not the case with the hospitals?

MS. SILBERSTEIN: It is a negotiation; but I can tell you that the tenor of those negotiations has changed. So there's give-and-take on both sides during a negotiation. I've negotiated contracts pretty much my entire career. The tenor of the negotiations is, "Here's our final offer. You want to go out-of-network? Okay."

It took us almost an entire year to negotiate with one of the major carriers. We were in negotiations prior to the law going into effect; after the law went into effect, the tenor of that negotiation changed. The offer was taken off the table; there were delays in responding to our counteroffers. There were numerous overtures made to that carrier. We just recently came to terms; but that carrier has now -- our emergency room physicians are now out-of-network with that carrier.

SENATOR VITALE: So you're suggesting that -- so the out-of-network law now has changed the tenor of the negotiations with the carriers, correct? Right?

MS. SILBERSTEIN: Yes.

SENATOR VITALE: Okay. And that means that they're -- so that means that they're trying to squeeze you because if you go out-of-network -- as you suggested they said to you -- "Well, just go out-of-network," or, "You don't need to contract with us. You could always balance bill patients; you could always take us to arbitration."

MS. SILBERSTEIN: I believe that they've been emboldened by arbitration.

SENATOR VITALE: But you heard the numbers earlier, from the Commissioner that, on balance, the amount of money paid to providers far exceeds what they've been paid to carriers, right? So if you went out of -- if you were out-of-network, rather -- I'm sorry -- if you were going to arbitration with the majority of your -- or even some of your bills -- right? -- it would seem, though, that the bottom-line cost-benefit would be to the provider, and not to the plan.

MS. SILBERSTEIN: We were actually listening to the \$1.8 million, versus the \$411,000 -- something like that. We're not sure that that's apples-to-apples. I'm wondering if the \$1.8 million were payments that were made; versus the \$411,000, which was, maybe -- should that be added to the initial payment that the carrier then made? We weren't clear as to what the \$1.8 million actually represented. Was that an additional payment?

SENATOR VITALE: I don't want to take up any more time. We have the chart of the total amount of money paid--

MS. SILBERSTEIN: Yes; we just weren't sure--

SENATOR VITALE: -- to providers and to carriers.

Okay; thanks.

MR. BALDOSARO: Can I respond to that question, too, please?

Because, yes, what you've been told has certainly been right. There were times where we would yell back and forth with each other; scream, throw stuff in the room. But at the end of the day, when we're

staring at each other, nobody wanted the other one -- nobody wanted to be out-of-network. They didn't want to pay my charges in the E.D.; I didn't want to lose my elective volume. I didn't want to hurt the community. So we always came to a deal; always.

The tenor -- and I'll use a different term; I'll say the *stance* of the insurance company has changed. The tenor of the negotiations is the same, but the stance of an insurance company -- they don't care about going out-of-network anymore. They've been given a blueprint; they've been given a mother-may-I. "Here it is; it's the law. We can do this." They don't look bad.

So who gets hurt? The consumer gets hurt, the hospital gets hurt; because we lose the elective business. But they don't get hurt. The numbers -- I'd be curious what the numbers are, hospital versus provider; the hospitals versus physicians. But there's a lot more information; we would need to determine -- as my colleague said -- what that truly means.

But if you get to arbitration, then the community has been hurt, especially from a hospital perspective. Individual physicians might be a little different pockets; but when you talk major networks that provide the bulk of the care in the community, then if we get to that point, there's been harm. And it's not in the dollars you're seeing; it's in the pain for the community.

SENATOR POU: Thank you.

Senator Sarlo.

SENATOR SARLO: Yes, just one question.

To the hospital community as a whole: I get the tenor piece has changed. Putting the tenor, the more hostile approach from the carrier

aside -- putting that aside, does the hospital community, as a whole, feel that, post this bill, you are at a complete disadvantage on negotiating now? Are you at a disadvantage? I understand the tenor -- I understand that has changed. But do you feel when you are going into these negotiations, you are at a disadvantage?

MR. BALDOSARO: Absolutely. I've done -- I did one contract right before the legislation was enacted; it was in--

SENATOR SARLO: And are you speaking for all the hospitals, or just-- I know you're speaking for your hospital.

MR. BALDOSARO: I'm speaking for my colleagues.

SENATOR SARLO: Does the Hospital Association, as a whole, feel that way?

MR. EICHER: What we're noticing from these instances is, if this is a trend, then yes.

What's been difficult is that not every hospital has had a renegotiated contract yet, because they're a couple years. But they're all paying attention, and they're all concerned with what's the experience is so far.

SENATOR SARLO: Thank you; thank you, Madam Chair.

SENATOR POU: Thank you; thank you very much.

Okay; if I can just have our next panel come up as our current panel is departing.

Thank you very much, guys.

So Dr. Stavros Christoudias.

DR. CHRISTOUDIAS: Thank you so much for letting me testify today, Chairwoman Pou.

I just wanted to start off my testimony by, first of all, thanking Senator Vitale and Speaker Coughlin for having the bravery and the forethought to actually put forth this legislation. I think if you look at what's going on in national politics on this front, it kind of shows how forward-thinking they were, in terms of tackling this. And for this, I think they should absolutely be commended.

I think that -- I'm here today to highlight the fact, though, about the discussion surrounding this Bill. But I think that the term *surprise bill* is definitely a misnomer. Patients get sick; physicians perform a service to heal, oftentimes in the middle of the night, oftentimes when your kid is having a birthday party. And we run to the hospital and we make the patients better.

Usually, in emergencies -- and with regards to this Bill -- it's not a surprise that we expect to be paid for our work. I think what the surprise is, is that when the insurers are happy to collect a premium when the patient is healthy; the surprise is that they want to deny payment whenever they are sick. That's the real surprise. And somehow the actual materializing of a bill became a surprise. I think that that's quite clever marketing; I think it's quite clever effect. But I think a lot of people lose sight that we're smaller businesses that -- not any different from a small mom-and-pop shop -- a doctor performs a service and expects to be paid for that service.

So, really, I'd like to actually rename them *surprise denials*; although I doubt that that's going to stick.

When I testified last year before this Committee about this Bill, I was clear and steadfast then -- and our group has been steadfast since

our inception -- that we support the Bill. We think that patients need to be protected and advocated for, and we think that it's actually very close to being a pretty perfect Bill.

However, our biggest concern at the time was that there's no floor for payments for physicians. And just like we just heard what happens to hospitals, the same thing can happen to physicians when the insurers have no skin in the game, nor anything that they have to give up to negotiate for a network contract. We just have no leverage. I mean, you heard what Dr. Dupree, who's a lone physician, was told, just flat out, "We just won't even negotiate with you." I've been told the same thing.

I'm here, now, one year later from our testimony, to purport that my worst fears, as a small business, have absolutely come true. The insurers have used this Bill as an excuse to severely underpay us, and abuse thousands of other small businesses like mine. They've aimed to cash starve us, and drive many of us out a business; and the process is absolutely been devious and methodical.

They first devised language -- immediately, right after the passage of the Bill -- that was defamatory -- in legal terms, defamatory -- and sent, on every single Explanation of Benefits, to my patients that -- they stated in writing that they felt my charges were excessive. I actually charge below what most plans call *usual and customary* payment. They then moved their call centers for negotiations to the Philippines. We actually called; made it through -- ironically, without being in-network, which did require a little bit of trickery -- and were told that we're speaking to somebody in the Philippines, who told me -- and this is an exact quote, "I have absolutely no idea what to do."

After that they outright refused to negotiate in good faith, whatsoever; and they told us, flat out, on the first phone call the first day, “We want you to go to arbitration. We’re not paying you anymore; you’re going to arbitration.” That is not, whatsoever, called a good faith negotiation.

So they forced us into this backlog system. And I still have surgeries since September that I still haven’t been paid for.

Then, recently, and much more onerous, the most unthinkable thing happened; and I actually have them on recording admitting that they do this. They actually started applying the law to elective surgeries for the primary surgeon. So something I was relying on -- just like Senator Vitale said -- this law applies to the minority of cases, 30 percent of cases.

I actually have correspondence to DOBI saying this law was applied; the law was applied to it. It’s self-funded and not opted-in. And DOBI said, “Well, that’s ERISA; that’s federally managed. It’s not under our jurisdiction. You should probably make a Federal complaint out of that.” So a Federal complaint about a State law doesn’t exactly fall into a very well-defined place to make a complaint about. The Feds said, “It’s a State law; what are you complaining to us for?” The State says, “It’s a Federal law, it’s a Federal plan. Go complain to them.” This plan just goes unpaid, and now what do I do with it? It just goes unpaid and falls into this legal limbo. Or I can pay an attorney, at \$500 an hour, to try to figure out what to do with it -- more than the worth of the bill.

In the meantime, my practice -- which I was so proud of and sacrificed so much for -- has been absolutely decimated. I’ve taken two paychecks in the last six months, and I’ve had to fire an employee, an inner-

city single mom from Hackensack, who I could no longer afford to pay. And in a twist of irony, I'm on the verge of not being able to afford health insurance for my employees, or myself, or my family. Our financials have grown so pathetic that we don't even have cable TV in our waiting room anymore.

We actually had to move -- I have to laugh about it, because it's only to open your mouth without screaming about it -- because we had to go to single-ply toilet paper; and my partner is a proctologist. That's that stuff that melts when it gets wet. That's how bad things are right now.

My wife has been making my mortgage payment since February. I no longer spend the majority of my time worrying about a nuance to surgery to make it safer or better for the patient -- more painless. But now I'm losing sleep over how to slash costs; and whether or not I'm going to have to shutter my doors in a few months, and move my family away from my in-laws, my family, and their friends.

Before the Bill, the insurers paid me roughly 50 percent of my charges -- before this Bill passed. Today, they pay me 7 cents on the dollar, well below any point where I can be profitable. That's what I've been earning since September. I don't know one industry in New Jersey that can take 7 cents on the dollar for nine months on the chin.

They've grown so bold and they're flouting the regulations of the law because they know there's no penalty for abusing us. They've applied the law, time and time again now, to Federal ERISA plans; and the plans were rejected from arbitration. I have those plans, and I can show you those rejections. I've actually presented them to attorneys and said, "Does the law apply?" They said, "Yes."

So I would ask you to go back and look at those numbers of those plans that were rejected and say, “Why did you reject them?” Their argument was that it was issued out-of-state. The attorney who I consulted said that since the patient lives and works in New Jersey, the law applies.

Now, I want to be very clear. I’m working as hard as ever, busier than ever, and at complete capacity, at the point where I have to turn away patients. I’m absolutely working as hard as can be, except now I’m just not being paid for it.

I’ve been honored to be nominated by my peers as a *NJ Top Doc* almost every year I’ve been eligible. And here I am, being faced with a choice: 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, *WalletHub* ranked New Jersey as the worst state in the United States to practice medicine. At present, I’d have to agree with that ranking.

I’m ultimately asking our legislators to consider a floor for the initial payments to the providers; something at a sustainable rate and higher than 7 percent. I think that the only way that anybody can have leverage here is actually having that happen.

I think that the law has absolutely saved some money to patients, and for that I think it should be commended. But I think it’s saved nobody more money than the insurers.

In closing, I’d like to point out one last thing. If the insurers are enjoying a windfall by withholding payments to thousands of New Jersey physicians; and the State Treasurer, as far as I’d heard, said that this

hasn't saved the State quite that much money, then where is all that money? Has anybody's plans in this room gone down? I can tell you, mine haven't. We went up 13 percent this year.

I do have evidence, and I have -- I brought EOBs and 835s with me, that will show you that-- And it's actually quite interesting. There's an Explanation of Benefits; that is what they send to the patient, and that's their explanation of payment or denial of. Then there's something called an ERA 835, which is a federally mandated ledger, accounting ledger that explains why they did or did not pay us. What's very interesting to me is that I have four bills on EOBs showing me that they did not pay me because of the law. I have four ERAs citing five different reasons for not paying me.

What's interesting is also the biggest ones were called *contractual obligations*, something I've never once in my life had with an insurer: a contract. I'd also like to point out that third-party administrator contracts have an invoice policy of about 30 percent of savings because of a contract. So if they're calling this law a massive savings because of a contract to me, maybe we should start looking towards companies that are tax-exempt and making \$15 billion a year, and still look for savings; instead of the doctors and small businesses actually getting up in the middle of the night and doing the work.

Thank you for the opportunity to testify today. I do hope that you all work quickly; because I do know that a lot of our members in our doctors' group are really on the ropes.

When I first started growing up in New Jersey, in Bergen County, for about a million people in our state there were about 200 general surgeons in Bergen County. Today there are about 55.

All right; everybody keeps saying, "Doctors aren't leaving." Maybe all the doctors aren't leaving, but certainly the ones you want there in the middle of the night are.

Thank you very much for your time.

SENATOR POU: Thank you, Dr. Savros.

Let me just make mention of the fact -- of something that you commented on just now.

In my conversation with the Commissioner, with regards to -- if you are a New Jersey resident, but work out-of-state -- let's say, in this case, New York -- and you have a New York plan, according to the Commissioner this particular law does not apply.

DR. CHRISTOUDIAS: If you work in New York City. But if you-- If these were plans issued in Texas and Florida, both people -- for big conglomerate corporations that were self-funded out of those states, with the employees working at their subsidiary offices here, in New Jersey, living in New Jersey. That was what was planned. The patient was never asked, "Where do you live or work?" I can show you the rejection from MAXIMUS; the simple cited reason that it was rejected was that it was issued in another state.

I was very fortunate enough to sit down with Speaker Coughlin recently, who I showed that to, and he actually explicitly said to me, "The law applies to this plan."

SENATOR POU: Okay, great.

SENATOR CRYAN: I'm sorry; but how many of those are there?

DR. CHRISTOUDIAS: I have four; and our group has, roughly, 500 people. I mean, I don't know; there's about 8,000 surgeons in New Jersey. So, I mean, I have to extrapolate that number as saying there's probably -- I can probably hunt down the rest if you like. But MAXIMUS or DOBI would have the rest.

SENATOR CRYAN: No, the data, I think, shows 68; is that what's listed here?

SENATOR POU: Yes; plans not issued in New Jersey, 68. Those were some of the recent dismissals out of the 1,082 cases that, sort of--

DR. CHRISTOUDIAS: So if a plan is issued out-of-state, the patient lives here, works here, the law does not apply.

SENATOR POU: No, that's not what I said. The way the Commissioner indicated to me, based on my question-- Because I asked her to please explain the plan that's not issued in New Jersey -- why was that -- what was the meaning of that? Because it was part of the dismissal reasons given out of the 1,082 cases. And her comment was that it's her understanding that if you live in New Jersey, but work out-of-state -- in this case, I'm using New York state -- and your plan is from New York state, than the law does not apply.

DR. CHRISTOUDIAS: Okay; but if the plan was issued in Texas, it would be a pretty long commute for somebody from New Jersey to say that they work in Texas.

SENATOR POU: A very reasonable statement on your behalf; yes.

SENATOR CRYAN: And is that-- I'm sorry; but this-- So is that what has happened for most of these? Is it a New York thing, or is it-- Do you have any idea?

DR. CHRISTOUDIAS: I can show you four. I have them in my car; I'll even run out and grab them for you, if you like.

SENATOR CRYAN: I don't know about that. But through the Chair, would it be all right if we asked for one or two of those copies with all the appropriate--

SENATOR POU: If you would like to share that with us, that would be helpful; because then that will help us to really get a better understanding in terms of how the law is being applied.

DR. CHRISTOUDIAS: I'd love to.

SENATOR POU: Thank you; thank you very much.

And thank you for that clarification.

Dr. Mazzola; I'm going to get it right before the end.

Thank you very much; Dr. Mazzola.

**C A T H E R I N E M A Z Z O L A, M.D.:** So I want to thank you, the Chair, and all the members of the State Senate Committee, for allowing us to testify before you this afternoon.

I also wanted to thank Senator Vitale and Speaker Coughlin for their concern for patients, and their medical bills, and fair reimbursement.

My name is Dr. Cathy Mazzola; I'm a Board-certified pediatric neurosurgeon. I've been practicing in New Jersey since 2002, after I did my

medical school down in Newark, and I did my residency in neurosurgery in Newark as well.

I care for thousands of children with birth defects and other neurological problems.

My partner, Dr. Luke Tomycz and I -- we operated on three of the children from the Paramus bus accident on Route 80 last year. So I wanted to say thank you to Senator Joe Laguna from Paramus for his support and encouragement.

I, as a mother of five kids, and as a pediatric neurosurgeon -- I'm very concerned about the delivery of critical health care in New Jersey. When I started my practice in 2002, about 10 percent of my patients had managed Medicaid, and 1 percent had straight Medicaid. The private insurers, at that time, were paying about 80 to 90 percent of our surgical charges, and we were able to hire staff, build our practices, and support the necessary care for these children and their families.

But now, in 2019, only about 25 percent of my patients have private insurance, 74 percent have managed Medicaid, and about 1 percent have straight Medicaid. These are the poorest of the poor. Every year, I also provide free care to about three to five kids who have no insurance and who are not citizens of the United States. So for me, as a pediatric neurosurgeon, there is no reimbursement for this care that I provide, no benefit for providing the free care, and there's no protection, medically or legally, or any lesser risk. Even if I do everything perfectly, in many cases, if a child takes a turn for the worse I am held legally responsible.

I started my practice in 2009. I employ 14 staff and one other pediatric neurosurgeon. In July, August, and September of 2018, last

summer, I took no salary myself in order to keep the lights on at my practice. I couldn't sleep I was so stressed out.

My husband wanted, and he still wants us, to move to Florida; but I don't want to go. I want to stay in New Jersey. I look at the faces of my patients -- the kids on that school bus -- and I gave you a printout of the kids I operated on -- and I know that I belong in New Jersey. If our practice closes, that would be truly a disaster.

The other pediatric neurosurgery groups and pediatric surgery groups are feeling the same stressors as I am feeling. Frankly, we're at a tipping point in New Jersey.

I can't fix this health care problem. The ability of insurance companies to undercut doctors for their services is killing our practices. We are all small business owners, and we're struggling to make ends meet. I have insurance companies paying the 10 percent nurse practitioner fee for surgery, but they're not paying me my surgeon's fee.

Years later, after multiple appeals, multiple letters to DOBI, to ERISA, sometimes we get a little bit back. I hire collection companies; I listen to as many educational seminars as I can. I pay lawyers to interpret the regulations. I do my best to comply with unsubsidized government mandates; and still the bottom line is that if an insurance company can get away with not paying me, they will try to do that.

I enrolled in many managed Medicaid for a few reasons. I'm losing money on every single surgery I do for a Medicaid patient. New Jersey -- I don't know if you guys know this -- is the worst state in the United States for Medicaid reimbursement for children. For Medicaid, we

are paid 1 percent or less of our charges. For managed Medicaid, I'm collecting 3.5 percent of our charges.

I'm paying my staff more per hour than I myself get paid for an office visit.

Now that private insurance payments are going away, and we're being forced to arbitrate every claim, this is a hundred times worse. How could a restaurant run on 3 percent of collections? Did you ever eat dinner or get plumbing done in your house and hand over 3 percent of the bill? I don't think so.

I'm the Chair of the Ethics Committee for the American Association of Neurological Surgeons, and I'm sure that you all know what the Sunshine Rule is. If a drug company takes me out to dinner, it has to be reported on the CMS website. Because as a doctor, if I have a conflict of interest that should be public information for my patients. But when patients sign up for their insurance plan, are they told how much return on investment is given to their shareholders of that company, or what their doctor's satisfaction rating is for that insurance company, or how well that insurance company treats their physicians? No; they're not told how many hours I have to spend on the phone trying to get a prescription for an MRI of a brain for a child with a brain tumor authorized. I am spending 8 to 12 hours, per MRI authorization, for children with brain tumors. That is ridiculous. I don't get paid to get the authorization and, in many cases, for kids with Medicaid, I'm getting less than \$20 for the single office visit. I cannot afford to spend 10 hours on the phone.

New Jersey is losing many great pediatric surgeons, pediatric subspecialists, and doctors in general. I can tell you about the shortage of

pediatric surgeons and neurosurgeons in the state, if you're interested. These doctors are slowly being replaced with mid-level practitioners.

Maybe 99 percent of you don't ever need a doctor; but when your child has a brain tumor or if their school bus rolls over, you are going to be missing us badly.

I really love my patients and their families. All of these -- many of these pictures were taken at Giants stadium. I went there; there weren't any other doctors, except me, standing on the field with those kids.

Most of them don't understand what's going on in health care. It's really hard to tell a child and their family, "I'm sorry, but I can't afford to see you anymore;" when I can't negotiate to go in-network, and I'm not being paid fairly out-of-network, and the parent can't afford it, I cannot any longer provide free care; there's just no other option. And that's what's happening. I've had to stop seeing and caring for kids with straight Medicaid, and some of them managed Medicaid. And the recently enacted out-of-network law has only exacerbated this problem.

My question for this Committee is, where is all this money going? How many billions of dollars are invested in healthcare insurance companies, and who is really reaping the benefits? Patients are being denied services, denied MRIs, treatments, scans, X-rays; and doctors and hospitals are being underpaid or not even paid it all. So where is it going?

Now, we physicians have to hire lawyers to arbitrate payments for our services that maybe only five people in New Jersey can perform. Are you kidding? Lawyers charge me over \$500 an hour; if I collect anything through a lawyer, they're getting 30 percent of anything, which is already a

reduced rate. These lawyers don't accept Medicaid rates; they don't even accept managed Medicaid rates, and I can't afford your legislation.

I provide hundreds of thousands of dollars in free care every year. I don't get a tax break, I don't get anything; nothing, not even a thank-you letter from the State, hospital, or anyone, except my patients. And while I truly love my patients, and I love their thank-you letters, I can't work for free. I have to pay my employees, I have to pay their health care benefits, I have to pay taxes, I have to pay rent on my offices, I have to pay my malpractice.

I'm currently driving a 2013 Ford Explorer with 96,000 miles on it. I have three biological boys, two adopted daughters, and I'm the sole provider for my family.

I am begging you to fix this law and make the insurance companies pay 80 percent of our charges or the full Fair Health rate, without any arbitration; and to disclose any and all conflict of interest on their websites. I want patients to know what they're paying for. Right now, these people come in with cards that say *Blue Cross Blue Shield*, or some other company's name, and they think they have wonderful insurance. And when we get paid at Medicare rates, or a percent of Medicaid rates, the patient's parents don't understand because they were told they were fully insured. The insurance should be sold to the patient with layman's language, and fully understandable and everything completely disclosed.

Thank you for listening to me.

SENATOR POU: Dr. Randazzo.

**C I R O G. R A N D A Z Z O, M.D., MPH:** Thank you.

Good afternoon, Chairwoman Pou, and esteemed members of the Senate.

I'd like to thank you for the opportunity to testify before you.

My name is Ciro Randazzo, and I'm a Board-certified neurosurgeon and endovascular neurosurgeon, partner at IGEA Brain and Spine, which is four board-certified neurosurgeons; the Comprehensive Stroke Center Director at St. Joseph's Regional Medical Center in Paterson; a Board member of the New Jersey Doctor-Patient Alliance; and current Treasurer and President-elect of the New Jersey Neurosurgical Society.

Prior to my current positions, I was the Comprehensive Stroke Director at AtlanticCare Regional Medical Center in Atlantic City.

After finishing medical school at UMDNJ, I began neurosurgical residency at Thomas Jefferson in Philadelphia, just across the river. As a resident neurosurgeon there, we received numerous transfers from throughout New Jersey, because there was a shortage of neurosurgeons willing to take cranial calls in the southern part of the state. Malpractice was too high, reimbursement was too low, and there were simply not enough neurosurgeons to cover all the hospitals in South Jersey.

After training I accepted a job at AtlanticCare, and we were able to build a successful neurosurgical service line there. Within two years I was 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 out of state, a situation which I had seen many nights as a resident in Philadelphia.

After two years of recruitment, I was able to finally bring on a partner, and we doubled our volume to over a thousand cases. Due to poor

provider contracts, with two neurosurgeons doing more than a thousand new cases a year, and reducing transfers out of the state and saving lives, the hospital was unable to continue to support entry-level salaries for neurosurgeons, and we were forced to leave the practice when they told us we had to take a large pay cut. It took over a year-and-a-half to find one neurosurgeon to replace us; that replacement refused to work 24/7, and patients, once again, suffered by having to be transferred out of South Jersey after regular business hours. They basically closed for business, for neurosurgery, after 6 p.m.

That same situation is now beginning to develop throughout the entire state, after this Bill was passed. Unfortunately, though the out-of-network Bill has excellent protections for patients, it is devastating our ability to continue to build neurosurgical practices in New Jersey. New Jersey is not an easy state to practice medicine in; you've heard that over and over. Even before this law went into effect, New Jersey routinely ranked as the first or second least-friendly to practice medicine. It's sandwiched between two of the largest cities in the country, with spectacular historical healthcare institutions that many physicians would rather be at. It has one of the highest costs of living, continues to raise everyone's taxes and limit deductions, and has no protections for any physicians from frivolous malpractice claims. And it's one of the highest rates of malpractice costs in the country.

As a result, my practice is now seeing offers being turned down for new physicians, as we can no longer offer a competitive starting salary or a favorable practice environment in New Jersey. There are currently fewer than 80 neurosurgeons in New Jersey; this includes about nine pediatric

neurosurgeons. Many of the adult neurosurgeons do not even perform cranial surgery because the costs are too high and the risks are too high.

As a result of the out-of-network Bill, we have also had to outsource our billing to an out-of-state billing company, and layoff five employees of our billing staff, as collections have become increasingly difficult and obfuscated. In 2018, we performed the same amount of clinical work as 2017, and our reimbursements were reduced by one-third. 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, physicians, and politicians. Under this law, it took at least seven months before the first case was even heard and arbitrated. These delays in reimbursement significantly disrupt our ability to run a small business successfully. Furthermore, the out-of-network law has emboldened insurance companies to sell ever-higher-priced plans, which promise choice through false out-of-network benefits, all as they raise co-pays, co-insurance, and deductibles to deter patients from obtaining necessary and life-saving care. When a patient finally does seek out care, providers are then reimbursed as close to Medicare rates as possible by pegging those out-of-network benefits to 85 to 120 percent of Medicare. When the charges settle out, patients are paying more than the insurance companies for treatments, even though they are seeing in-network doctors.

As physicians, it is often difficult to discuss the cost of care with patients. The out-of-network Bill also requires us to inform patients of their financial responsibility. Though well-intentioned, it is extremely distasteful

and awkward, particularly in a life-threatening emergency. Should patients and their families really have to decide -- after I've spent hours building a rapport with them, and telling them their loved one has a very high likelihood of imminent death -- that they may want to consider an in-network or, possibly, lower cost option? How do you tell a family member that their loved one needs to have his or her head sawed open immediately, and then tell them, "You may want to 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 cost will be for a procedure. Even in regular hours, it's impossible to know a patient's costs because the plans, again, are so obfuscated.

Plan reimbursement varies even amongst in-network providers under the same geozip. We need further guidance from DOBI on how to handle these situations. Scott Meyer, who you heard from earlier, and myself are in competing practices in the same geozips. We do not know what-- Each of us participates in Horizon, yet there's no way for me to know what the cost-share would be if a patient saw me or him, because the insurance will never give us that information.

Ultimately, the real 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 rates without a standard or floor, simply look at Medicaid managed care plans. An emergency life-saving craniectomy pays \$500. In negotiations with Horizon NJ Health -- I have the number, I have the recording, and I have the person's name if you

would like -- despite telling them that they have not a single neurosurgeon who participates in their plan, they only offered to pay Medicare rates to be in-network. They will tell you they are losing money under these plans, which the Federal and State government fully fund. However, their financial statements reveal otherwise, as does Shelby Livingston in *Modern Healthcare's* recent article. Medicaid WellCare CEO Kenneth Burdick received a salary of \$12.7 million in 2018; his realized pay soared 130 percent.

We implore this Committee to establish a floor to provider reimbursement in New Jersey 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.

SENATOR POU: Thank you; thank you, Dr. Randazzo.

I just want to ask you a question.

In your testimony you were talking about that, as physicians, you need to console or discuss with the family member in terms of what their decision may be, at that very moment, when you're just about to decide on what to do with that emergent situation with that patient. Is that

a policy of DOBI, or is that a part of the regulation, is that part of the law that was just recently--

DR. RANDAZZO: Part of the out-of-network Bill.

SENATOR POU: The recent--

DR. RANDAZZO: The recent Bill.

SENATOR POU: Okay, all right.

DR. RANDAZZO: Yes, I believe we're required to discuss what the patient will be responsible for; and there has been some opinion that you could just say, "You will only be responsible for what you would be responsible to pay an in-network provider." But apparently, it's illegal to say that. So we just need guidance of how to find out how much patients will be responsible for; and if there's no way to know -- because it's 2 o'clock in the morning, and you're calling the Philippines, and no one's answering -- or a patient doesn't have their insurance card with them that specifies their plan, what do we tell them?

SENATOR POU: So, I'm sorry; just repeat one more time. What are they required by law to know prior to you performing that?

DR. RANDAZZO: What charges they will be responsible for; their cost-share.

SENATOR POU: And how will you know that at the moment of when you're discussing? Is that an estimate? Is that--

DR. RANDAZZO: It's impossible to know.

We, oftentimes, when we have pre-cert certifications for elective surgery, it's impossible to find out what that number is. Insurance companies are supposed to, in some cases, give us a summary plan description. Those are not always offered; they're not always accurate. And

so it's almost impossible to know what that is, in regular working business hours, with our surgical planners spending hours to figure out this information. In the middle of the night, it's impossible to find out.

SENATOR POU: And you mentioned that you're looking for guidance from the Commissioner of the Department of Banking and Insurance. Now, if it's stipulated in the statute, and it's clearly defined there, what kind of guidance, in your opinion, will be helpful for you to receive from DOBI when, in fact, it's so stated?

DR. RANDAZZO: Do we need to know an exact monetary value that we have to tell them? Is it sufficient to just say that, "Even if you're not in a plan that we participate in, the most we can balance bill you is what you would be balance billed if we were an in-network provider"? That seems to be the intent of the law; but when I presented that to attorneys to say, "What should I tell these patients?" the attorneys have said, "It's not that clear-cut. You can't just say that."

SENATOR POU: And the penalty of law if you should not be in compliance, by failing to tell them, is what, based on your understanding?

DR. RANDAZZO: I forget the exact value; I want to say it's about \$1,000.

SENATOR POU: What is it?

DR. CHRISTOUDIAS: You're reported to the Board of Medical Examiners.

SENATOR POU: You're reported to the Board--

DR. CHRISTOUDIAS: To the Board of Medical Examiners, yes; for not complying with the law -- which means that they're threatening your license.

Unfortunately, I don't believe there are any penalties on the insurers if they do not comply with the law.

SENATOR POU: Okay, thank you.

SENATOR SARLO: Just one small--

SENATOR POU: Senator Sarlo.

SENATOR SARLO: Dr. Randazzo, how many neurosurgeons in the state, roughly?

DR. RANDAZZO: There are about 80, and that includes, you know, all neurosurgeons who are listed; many of them are not practicing full-time.

SENATOR SARLO: And of the 80, all 80 of you are the physicians who are called throughout emergent times -- middle of the night for a car accident, gunshots; I mean, some of the most severe head traumas. Are you finding that the pool of 80 is starting to dwindle on responding to charity care responses?

DR. RANDAZZO: Absolutely. We've considered this with our practice. We cover two very busy inner city hospitals, Trinitas and Elizabeth, as well as St. Joe's. When we joined there, there was another practice that was really fully supported by the hospital. We're a small private practice; we did not ask for any money from the hospital, because we were able to cover our own costs by doing our own internal cost shifting.

At this point, we've been forced to go in-network at a terrible rate, just for survival. And we have to really consider if we can afford to give the free care at Trinitas and St. Joe's, going forward.

SENATOR SARLO: Thank you.

SENATOR KEAN: Madam Chair.

SENATOR POU: Senator Kean.

SENATOR KEAN: Thank you.

And through the Chair -- so 80 now; how many were there two years ago or four years ago? Is there a downward trend, do you know?

DR. RANDAZZO: So those 80 include the pediatric neurosurgeons; again, I think there's a between six and nine of those. Four years ago, I don't know how many there were.

SENATOR KEAN: Okay; and in the other specialties -- do you know if there's been a--

DR. MAZZOLA: So I can I can tell you from experience.

There are very few; there are two -- no, actually, three now Board-certified pediatric neurosurgeons who call New Jersey their home. It's me, Arno Fried, and Timothy Vogel. We have hired people who will work with us, but they're not Board certified yet. So it's those basic groups; and then the Columbia Group cross-covers.

But in reference to Paul Sarlo's question, I myself -- I used to drive out to Matheny to provide care for all the inpatient Medicaid children there. I used to cover all the kids at Wanaque who are on straight Medicaid. I can't do that anymore. So I don't drive out to Matheny anymore; I cannot see the Matheny kids anymore. I can't see the Wanaque kids. I cannot afford to take care of these kids; they are so sick. Many of

them have severe cerebral palsy, they have shunts, they have other issues. And financially, I just can't -- my practice can't support those patients.

SENATOR KEAN: And Stavros, do you have--

DR. CHRISTOUDIAS: No; I actually just had one other thing I just wanted to add to my testimony.

Because a lot of time, when Senator Vitale was up there, he was asking a lot of us, "Do you balance bill patients?" And I just wanted to point out that's actually a very dangerous question to answer here; because right now doctors are being put in a very, very tough position; particularly the private physician. There's a Federal law that says that if you write off too many bills, that's an inducement; you're breaking a Federal law. And yet, here we're being grilled, saying, "Do you do it, do you do it?" And if you say, "Yes, I write off money," the Federal law -- you're saying you're breaking. And yet, at the same time, if you say, "I don't write off money," right? I mean you're trying to be compliant. We have a Federal law that says you can't write off, and now we have a State law that says you have to write off. And you're being put in this really awkward position, where the Federal and State laws don't seem to jive; and right now we just unfortunately are not seeing, you know, a straight answer from somebody saying, "Can we write off; can we not?"

DR. MAZZOLA: Right. And I think it's also very misleading. Because, you know, for example, if it's -- God forbid, your child is hit by a car and you have an emergency epidural hematoma. And you get a bill from a neurosurgeon that's submitted to their insurance company. For example, let's use insurance company A, and I'm not in-network. Or let's say, even better yet, I am in-network, and they pay me at Medicare rates.

Most of these insurance companies, what they'll first do, as soon as they get a bill from a surgeon -- especially a neurosurgeon -- is they pay at Medicare rate. And they're hoping that you'll accept it, and you'll go away. But none of us do, so we have to appeal it.

In the meantime, you have the Federal legislation saying, "You must bill the patient." Legally, we have to; you have to send out three bills to the patient. So then the patient gets a bill from your office saying, "Your insurance company paid a Medicare rate; your doctor billed \$50,000. So you, the patient, are responsible for \$49,000."

The patient comes to my office crying, and I tell them, "Don't cry. Bring your EOB; you can sit down with my billing department." I have a three-team billing department; and this is why for two neurosurgeons you have to have three full-time employees to do this. They sit down with the mom, they give her a cup of coffee, a bottle of water, and try to calm her down, stop the crying, give her some tissues, and say, "Listen, you don't really owe the \$49,000. Let's look at your insurance company benefits. Dr. Mazzola is in Aetna, or in Blue Cross Blue Shield. So we have to submit the appeal for you; give us a copy of your EOB."

But this whole process takes months, years. I mean, I heard some doctors complaining that they have AR in the 90 day. We have cases that are three or four years old that I can't afford to write off because, maybe one day, I'll get a little bit.

SENATOR KEAN: And then -- so it seems to me, through the Chair, that you have, sort of, a dangerous situation. If it hasn't developed already, it's trending in that direction -- where you have greater uncertainty within the system. You have a double-blind system, where the insurance

companies are carrying money over time, so there's a profit incentive to not pay upfront. So you have got that carrying cost on one side versus the other; so you have the unbalanced. And you have a potential threat for-- You know, if you have two parents who are working, and then that parent comes in and tries to figure out, then, is it time to renegotiate or figure out what the plans are with you -- that's somebody who is not at work, potentially, right?

So you have a potentially crippling set of circumstances of uncertainty for real cost, financial, for the patients; penalties within their mental and other health, as they're trying to figure out how to balance things; and this uncertainty. All while-- And the final panelists who were saying do we have a situation where you don't know what you can tell people, and you don't have clarity.

My concern -- through, Madam Chair -- is, we can't wait a year for the DOBI Commissioner to come back with an assessment of what's going on and what's not going on. I mean, if this Legislature can do what's the anecdotal or for real, you know -- the anecdotal or legal things that have to be fixed, we have to fix this now.

Thank you.

SENATOR POU: Thank you; thank you, Senator.

Senator Cryan.

SENATOR CRYAN: I was just want to-- All three of you are clear that the proposed solution, from your eyes, is this idea of a floor payment. Is that correct? I just want to--

DR. CHRISTOUDIAS: Absolutely.

DR. RANDAZZO: Absolutely.

SENATOR CRYAN: And what is it; 80 -- you all are in the mode of 80 percent of Fair Health?

DR. CHRISTOUDIAS: Eighty; 80 is traditional UCR -- 80 to 90, depending on the plan.

SENATOR CRYAN: Thank you.

DR. CHRISTOUDIAS: Thank you.

DR. RANDAZZO: Thank you.

SENATOR POU: Thank you very much.

Our next panel is going to be -- and help me; forgive me if I mispronounce names here -- Nara Bald, the Billing Manager at Capital Medical Billing Solutions; and Darlene Prevocki.

Nara, do you have someone else with you?

**C L A U D I N E L E O N E, Esq.:** I'm just joining her just to-- I don't know if they put me on; but I'm not going to testify. I'm just going to set her up.

SENATOR POU: Okay; just one second then.

As Darlene-- Darlene, please take a seat.

Thank you very much.

If you would please identify yourself.

**N A R A B A L D:** Yes.

Madam Chairman, members of the Committee--

SENATOR POU: First, tell me your name.

MS. BALD: My name is Nara Bald.

SENATOR POU: Oh, you are Nara.

MS. BALD: Yes.

MS. LEONE: She's Nara; yes.

SENATOR POU: And you are?

MS. LEONE: I'm Claudine Leone; I'm a representative of several physicians' societies, for which Nara does the billing. So multiple--

SENATOR POU: Okay; so Nara's going to testify.

MS. LEONE: Nara is going to testify.

MS. BALD: Correct.

SENATOR POU: Okay; fine, very well.

Ms. Bald, please.

MS. BALD: Thank you.

My name is Nara Bald; and six-and-a-half years ago, my partner and I started Capital Medical Billing Solutions, a third-party billing company specializing in out-of-network recovery and providing consulting services.

We're contracted by out-of-network providers -- specialists, primarily, working out of ERs, who choose to outsource their billing aspects of the practice for one reason or another.

For years we have been successfully recovering funds from the insurance companies on incorrectly paid medical claims, and making sure our providers' claims were processed in accordance with the previous statute which did, believe it or not, protect the patient from unnecessary financial hardship.

Our clients' practices were thriving. They were able to open a number of satellite offices and hire additional staff. It also made it possible for them to reach more patients and provide emergent and urgent care when one was not available.

The success of our clients was also the success of Capital Medical Billing Solutions. And over the past six-and-a-half years, our company grew from 2 to 13. Today, we are the proud owners of a small business providing jobs to a number of New Jersey residents, as well as supporting the economy of our great state.

Today I would like to discuss a number of inconsistencies and unknowns contained in the recently passed Bill, A-2039, that went into effect on August 30, 2018.

Once the new law was passed, Capital Medical Billing Solutions was prepared to face the new challenges and deal with them head-on. For months prior to the new law going into effect, we worked on developing effective procedures and protocols allowing us to adapt to the new conditions of the industry.

To my surprise, despite the proactive approach of Capital Medical Billing Solutions, we found neither insurance companies nor MAXIMUS -- the independent decision review company -- were prepared.

From the beginning we have faced a number of challenges from both the carrier side as well as the independent decision review company. There are basic guidelines to determine whether or not the case is subject to the new law and is eligible for arbitration. One, the plan must be issued in New Jersey and be either fully insured, or self-funded but opted-in to this new law; and two, services for inadvertent care must be delivered in New Jersey by the out-of-network provider.

Unfortunately, more often than not, we are quoted incorrect benefits pertaining to the origin of the policies, as well as the mandates they follow, by the insurance representatives. It leads our office to take the

wrong turn and submit the arbitrations that are not warranted. It delays the appeals process and the payment coming into the office.

We are provided the explanations of benefits incorrectly, indicating A-2039 law, when the plan was not subject to it whatsoever; or when the services did not meet the required criteria, such as elective and/or scheduled procedures. You do have examples of these cases.

We have providers who have patients sign the waivers of liability; yet the law still applies.

Also we receive the explanation of benefits reflecting the new law, yet payments go to the patient instead of the provider.

Additionally, we have observed constant negligence on the carriers' behalf in adherence to timely guidelines for payment disputes.

Carriers have provided an e-mail avenue for initiating payment disputes. Naturally, any provider would choose this route, since it's free and provides instant confirmation. Unfortunately, we discovered the carriers do not address the dispute submitted in an encrypted HIPAA-compliant format, forcing providers to violate HIPAA compliance regulations. Subsequently, the negotiation process following the initiation of a payment dispute is virtually non-existent. Over the 30-day negotiation period, most of the time we don't get any settlement proposals at all.

We also found it's very disturbing that the State allowed MAXIMUS to start the implementation without verifying they had enough manpower to adequately handle the arbitration caseload. Since the end of November, Capital Medical Billing Solutions filed over 170 arbitration cases on behalf of its clients. Although filed in a timely manner, they were not accepted into MAXIMUS' system and processed for months. This

month alone we received two acceptance letters on two of the cases filed in December; that is over three-and-a-half months after the filing date. This delay affects the newer arbitrations, and the findings that we are not able to apply to the newer cases.

The first arbitration decisions for our providers were issued on April 8 of this year. One of their references to determine the awarded party is the allowance and charge amount ranging between the 80th and 95th percentile of the Fair Health database. Those values are significantly different from one another, and they vary sometimes 300 percent.

I was informed by their staff member that they will award the party who is the closest to that rationale; but no exact formula could be given on how they derive their final figure.

When decisions are made, we have observed a number of inconsistencies, such as issuing favorable decisions to the insurance company based on the false reimbursement data provided by the carrier. You do have an example of one of those cases as well, where the insurance company supplied the additional payment three months after the arbitration case was filed.

Utilization of incorrect geozip data, which differs from that of actual corresponding place of service, and prompting the decision to go into the carrier's favor.

Besides that, it is my understanding that if I'm supplying the evidence, my doctors fee schedule falls well within the prevailing rate of those for our geographic region. If the provider has gotten paid for years, based on 95 percent of billed charges, then this should be recognized as valid data, as we have established a precedent with this level of

reimbursement. Unfortunately, we find the proof -- the evidence we provide is being neglected.

Currently, all arbitration decisions are final; there is no provider appeal recourse available even when the independent decision review company clearly neglects to perform due diligence prior to making its final decision. This is one of the major things that needs to change, as the complexion of the medical practices depends upon an accurate, thorough review.

It is my understanding that this law was passed to make the out-of-network costs transparent. However, instead of amending the previous law to say that all providers must disclose their fees prior to delivering their services, we have opened up a plethora of issues by implementing the new law, full of flaws, inconsistencies, and ambiguities.

As doctors' reimbursements have been postponed due to delayed decisions of MAXIMUS, the independent decision review company, many were forced to let their employees go, downsize their practices, and move out of New Jersey.

These were only a few of many concerns presented to you today; and I hope this evidence is not neglected.

I appreciate the efforts of Madam Chairman, and the rest of the members of the Committee, to attempt to eliminate all of the inconsistencies, address all of the unknowns, and interpret all of the ambiguities before it is too late.

Together, I hope we can make a difference and help to develop a proper system, allowing New Jersey residents to receive the best possible

care with the least out-of-pocket expense, while providers are reimbursed at the fair rate.

Thank you.

**DARLENE PREVOCKI:** Hi; good afternoon.

My name is Darlene Prevocki; I do medical billing for a group of cardiologists who are hospital-based.

First and foremost, of course, I'd like to thank you for the opportunity to speak. 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, 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 more on being a patient advocate than a medical biller.

There are two types of hospital-based doctors who are being encompassed by this new law. The problem is not being caused by the smaller, fee-for-service physician groups, such as radiology, pathology, cardiology, and emergency room physicians. These doctor's bills are usually under \$200 after the insurance pays. The large expenses go into the thousands of dollars, and are being billed by specialists who we've heard here today are dealing with this problem.

Based on the structure of this law, as it is written today, however, the smaller groups of the physicians are going to be forced out of business within the next 30 to 90 days.

Since 1985, I have been billing for a group of 18 cardiologists who only bill for one single service: reading, interpretation, and report of EKGs. It's a \$95 charge, and 94 percent of our patients walk into the hospital through the emergency room, and they come in on an emergent basis.

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

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

Unfortunately, this new 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, they are now approving minimal amounts and forcing the 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 not have been implemented without a fee schedule attached.

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

The proposal I believe that will be made, is that they should mandate payments at the 85th percentile of the Fair Health benchmark. I feel that this would be a great start.

On a personal note, outside of this, listening to all of these doctors -- if they had a fee schedule that they knew that the insurances are going to pay-- Our specialists should be paid at 90, 100 percent of the Fair benchmark. They would have knowledge how to notify their patients of how much they're going to be responsible for; they would have some kind of guidance. I can't believe that the law was written without it, but--

Secondly, it appears that the law was originally written to cover New Jersey State employees and patients 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," and that they must elect to be entered into and subject to the terms and conditions.

In addition, once ERISA plans enroll into the *surprise law*, they must notify the members of this on their ID card, per item 6-e. I have been reviewing patient ID cards, and there is no indication showing that they're enrolled.

Currently, many self-funded 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 EOB that they are 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 these 11 enrolled carriers; and I'm waiting for DOBI to provide me with this list. I happened to speak with the Commissioner outside, and she says she has to see what she can disclose. 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 being unable to access a list of the enrolled carriers, there is no way for us to determine which insurances can 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 that they are enrolled and the effective date of that; *b)* specifying that a claim is being processed under the OON guidelines on the EOBs; and *c)* providing ID cards to their policyholders that indicates this information.

If they are not following these terms and conditions, then they should not be allowed to pay the smaller amount and notify the patients that they can't be balanced billed.

My third concern is their arbitration process set forth. This only allows arbitration on claims that exceed \$1,000 for the same patient, rendered during the same encounter. This is not outlined in item 10 of the

law, but it is noted on the DOBI bulletin 18-14. With this guideline in place, every insurance carrier will want to opt-in to the law because it will benefit them. The OON law incorporates all hospital-based doctors, large specialists and small practices alike. However, the only appeals that they will receive are those by the specialists whose bills exceed \$1,000. They will have the benefit knowing that all fee-for-service doctors -- the smaller practices within the hospital -- will have to accept their allowable as payment in full, and they will not have to arbitrate or negotiate on these claims.

Perhaps the law can exempt the smaller groups of doctors and/or place a limit on how much they can bill per encounter -- example, \$300 -- so that they can maintain their businesses.

The fourth area of concern is that DOBI instructed that smaller practices facilitate the option of Program for Independent Claim Payment Arbitration, the *PICPA* process. They state that this would enable us to aggregate different claims to exceed \$1,000 for each insurance carrier. However, the problem is that we would not be able to use this service because 94 percent of our EKG readings are performed on an emergent basis. Per the DOBI correspondence that I received, *PICPA* only handles non-emergent claims; and according to the website, they will not consider claims arising from self-funded plans or contracts with the Federal Employees Health Benefit Programs.

So between these two types of appeals -- arbitration and *PICPA* -- neither of these can be utilized by the smaller practices that perform services on different emergent care patients.

The recommendation I have is that one or both of these modalities be modified to accommodate aggregation of claims totaling over \$500 on emergent care patients processed by self-funded plans. However, please note we would not need a modification of the appeals process if the law mandated notifications to physicians when self-funded insurance carriers enroll into the law, present this information on the EOBs and ID cards, and if they 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, the law was set up with truly unobtainable time restrictions for the appeal process and procedures.

The law states that the first appeal must be done by the doctor within 30 days of the date of payment. These are usually sent by mail, which cuts down the office time to three weeks. The insurance carrier, then, has 30 days to respond and notify that they will not negotiate.

This is never done. Well, I can't say-- It's rarely done. I know, because I've submitted over a hundred negotiation letters to insurance carriers, and only one self-funded plan sends a response that they will not negotiate.

And then, within 30 days of that notice, doctors then must begin and submit an arbitration claim. Being in the billing environment with limited staff, I am in agreeance with the possible proposals being set forth that the time limitations be extended to, at the very least, a 90- to 150-day window in order to accommodate the increased volume of work that must be performed by the staff.

If changes are not made to this law, I'm not sure how we can continue to conduct business. The doctors are not receiving salaries; the practice is behind in paying monthly expenditures. And for the first time in 33 years, we have fallen behind in paying our bills. Insurances have been paying minimum amounts for the last six months. We have no way of knowing if they're enrolled or not; 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 introduction and enforcement of a fee schedule at the 85th to 100 percent of the Fair Health benchmark. Please consider implementation of this to be done on a retroactive basis, to assist offices in recouping the losses that they have incurred over the last four to six months. Without that, the doctors will continue to work for free and we'll be forced to close.

Two: Smaller practices, such as radiology, pathology, cardiology, and emergency room physicians are not the problem.

SENATOR POU: Darlene, I need to interrupt you.

How much longer do you have on your testimony?

MS. PREVOCKI: Just the last page.

SENATOR POU: Okay, thank you.

MS. PREVOCKI: I'm just giving my--

SENATOR POU: That's okay.

MS. PREVOCKI: It's just a wrap-up.

SENATOR POU: That's fine; thank you very much.

MS. PREVOCKI: I'm going to ask that smaller practices, like radiology, pathology, cardiology, and emergency room physicians, are not the problem. They're not causing the larger bill. I'm in hopes that we can either be exempt from the law, or provide us with an appeals process that will allow us to appeal. Right now we cannot.

The law must enforce an accessible list of the enrolled insurance carriers and their effective date on the DOBI website. Insurance carriers must notify us, via the EOB and the ID cards.

And lastly, the volume of work involved absolutely constitutes that we need time extensions on the current law.

I thank you for the time and consideration.

SENATOR POU: Darlene, first of all, thank you so very much. You gave some really very good suggestions. You actually made a couple of recommendations here, in terms of your overall experience and what you think might help to improve upon the process.

So I just want to thank you for your testimony.

Ms. Bald, it's my understanding that you've made representation, in part of your testimony, that there were -- you had 170 cases that were referred to -- I'm assuming you're referring to MAXIMUS for the--

MS. BALD: That is correct.

SENATOR POU: Okay; and that there were 27 or so cases that you've only heard back from. Are these actual 170 cases that you're still awaiting a response from them?

MS. BALD: No; out of 170 cases that we have filed--

SENATOR POU: Yes.

MS. BALD: --we have about 10 that were dismissed, and we have about 30 that were approved, and about another 25 that were denied.

SENATOR POU: Okay; so I understand that better. So it's a 170 in total--

MS. BALD: In total; that's right.

SENATOR POU: --and that's the breakdown that you've just provided us.

MS. BALD: That is correct.

SENATOR POU: All right; thank you for that clarification.

MS. BALD: Sure.

MS. LEONE: Chairwoman, Chairman?

SENATOR CRYAN: So you have 105 pending?

SENATOR POU: Do you; do you have 105 still pending?

MS. BALD: Yes.

SENATOR CRYAN: Because there are only 318 total.

MS. BALD: Well--

MS. LEONE: That's why I brought her. (laughter)

MS. BALD: As I mentioned previously, we were very well prepared to face this challenge. And we developed certain procedures and protocols that allowed us to move forward with the arbitration as soon as we had our first case.

SENATOR CRYAN: So, I'm sorry, Madam Chair, if it's all right?

SENATOR POU: Yes; actually, I think we're on the same page. But go ahead, Joe -- Senator.

SENATOR CRYAN: So you have a third of all the pending cases.

MS. BALD: Yes; correct.

SENATOR CRYAN: So what is the interaction or the back-and-forth? What have you been countered with? Wow; you have a third of them, in one group?

MS. BALD: Well, I have -- I bill for a number of specialists.

SENATOR CRYAN: Yes, right.

MS. BALD: So out of the ones that I have, five work out of emergency rooms, so those would be subject to the new law.

SENATOR CRYAN: Okay. So Ms. Bald, your group was prepared; you guys prepared for the law.

MS. BALD: That is correct.

SENATOR CRYAN: And are you getting a counter offer, or what--

MS. BALD: We do not get any counter offers. What I have noticed is that when we are supplying -- when we are submitting our arbitration cases along with the supporting documentation, they don't acknowledge, at all, any evidence.

SENATOR CRYAN: That's what you mentioned; right.

MS. BALD: Yes; they don't review any sort of precedence.

SENATOR CRYAN: So prior history doesn't count.

MS. BALD: Correct.

SENATOR CRYAN: So doctors' good faith -- any of that doesn't count.

MS. BALD: Negotiations are non-existent at all.

SENATOR CRYAN: So you're basically starting from scratch.

MS. BALD: Correct.

SENATOR CRYAN: And-- I'm sorry, Madam Chair.

SENATOR POU: No, please, go ahead.

SENATOR CRYAN: And what is the oldest case you have, if you don't mind me asking? Or do you have a sense of that?

MS. BALD: The oldest case I filed -- we filed the first cases on November 26.

SENATOR CRYAN: Okay; I'm kind of floored.

Do you have a sense as to when the 105 remaining -- which is what my quick math is--

MS. BALD: I have a chart.

SENATOR CRYAN: I bet you do. (laughter)

MS. BALD: I have a spreadsheet that has everything.

SENATOR CRYAN: Okay; and that chart shows dates--

MS. BALD: Exactly; it shows the patient's name, it shows the case number, it shows the date it was filed.

SENATOR CRYAN: Okay.

MS. BALD: I keep records of every acceptance letter and every decision that is made. I also can -- I have enough data to compile -- to make an analysis.

SENATOR CRYAN: Is there a predominant reason for the 105 being in the -- for a lack of a better way to put it -- the backlog at the moment? Is it just simply the ability-- Because as DOBI admitted -- told us, they added arbitrators to move this stuff. Is it simply the idea that they're catching up; is that the idea?

MS. BALD: I guess.

SENATOR CRYAN: Or you don't know?

MS. BALD: I guess, I guess. I've been in touch with Suzanne Tran from MAXIMUS; and I have advised her of my clients' concerns. I've asked her what's happening--

SENATOR CRYAN: Okay; do they respond?

MS. BALD: --and they -- she said, "I'm sorry," she was apologizing; at some point she blamed, kind of indirectly, DOBI, saying she thinks that she cannot issue any decisions.

SENATOR CRYAN: They wouldn't blame the other guy, would they? (laughter)

MS. BALD: But overall, I cannot believe that my company of 12 has filed 170 cases, and MAXIMUS did not process, with having a full staff.

SENATOR CRYAN: Two other questions. Do you have a commitment date from MAXIMUS on the resolution time frame of the 105? In other words, do they say, "We'll have an answer by X"?

MS. BALD: No, they do not do that; they do not do that. They simply send an acceptance letter, advising the provider that the letter will be issued to the insurance company, asking for their evidence.

SENATOR CRYAN: One other quick comment point.

I want to echo the Chairlady's-- Your very specific recommendations are incredibly helpful.

MS. PREVOCKI: I appreciate that; thank you.

SENATOR CRYAN: Thoughtful, obviously well-planned; and I wanted to echo that, because it was really well done. And thank you.

MS. PREVOCKI: I appreciate that.

SENATOR CRYAN: One of the things I'm just baffled about -- and maybe, Ms. Bald, you could help me -- the testimony here has been that arbitration is about 1 percent of the cases, if I understand that correctly. Somebody correct me, but it doesn't look like anybody's nodding a "no."

MS. PREVOCKI: Can I just-- It's for claims over \$1,000. All of the small doctors who want to arbitrate can't.

SENATOR CRYAN: Okay.

SENATOR POU: No, we're only talking about the ones for \$1,000 plus.

SENATOR CRYAN: A thousand or more.

MS. PREVOCKI: A thousand or more; correct.

SENATOR POU: Based on the law; based on the law.

SENATOR CRYAN: All right; and I don't pretend to know the volume of cases below \$1,000 or above. Medical, I would tend to believe lean towards \$1,000 or more.

But yet I've heard here doctors going out of business, layoffs, no cable. I mean, all sorts of stuff that -- it's kind of strange to me if it's only -- and I don't mean this as demeaning, just as somebody who sits here as a non-medical person -- how does 1 percent of the cases bring professionals to a point where they can't pay their bills? That finds me--

MS. BALD: It's not--

SENATOR CRYAN: I'm just lost on that point.

MS. BALD: If I may, it's not the 1 percent of cases. There are certain practices that do specialize in the emergency care only -- out-of-network emergency care only.

SENATOR CRYAN: Is that what your folks--

MS. BALD: That is correct; yes.

SENATOR CRYAN: So it's emergent care is where you're running into--

MS. BALD: That is correct. This is -- my doctors are there when the hospital does not even have a call. So they don't have the staff, they don't have the specialist who will come in and treat the patients. That's where -- if the hospital provides call, my doctor will be called in; my doctor will be requested. If not, the patient will have to be--

SENATOR CRYAN: And Darlene, does that go to your similar point about 94 percent of your EKGs and that kind of thing?

MS. PREVOCKI: Oh, absolutely.

SENATOR CRYAN: Okay, all right.

Thank you.

I'm sorry; thank you.

SENATOR POU: No, that's okay.

Thank you, Senator.

So just a real quick answer, because I really need to move to my next panel; after, of course, Senator Lagana's question.

A clarification on what you said. The 105 pending cases -- are any of them missing information, or are they waiting for information, or requested additional information that the provider is required to provide?

MS. BALD: No.

SENATOR POU: Okay.

MS. BALD: No.

SENATOR POU: So everything that they've asked for, they have. They just have not rendered a decision.

MS. BALD: Precisely.

SENATOR POU: Okay, thank you.

Senator Lagana.

SENATOR LAGANA: Thank you, Madam Chair.

I just want to clarify one point.

There are 318 cases that are pending an award or dismissal; but there's an additional 217 where they are awaiting additional information from a carrier or the provider.

SENATOR POU: That's why I asked.

SENATOR LAGANA: So we're upwards in the 500s, yes?

SENATOR POU: That's why I sked the question -- were any of those particular cases part of the missing documents that the carrier -- or, in this case, the arbitrator -- is--

SENATOR LAGANA: And it's also, from what I understand -- when an arbitration is submitted, they'll send a letter saying that they forwarded it to the carrier; they give them 15 days to respond.

SENATOR POU: Right.

SENATOR LAGANA: And actually, what I believe they're doing is, they are going to the carrier to confirm whether or not there's actual coverage; which, by the time you get to the point where they have to make a decision, it could be-- That's why it's kicking it out so many months.

SENATOR POU: But I thought there was a 72-hour response period for providing--

MS. BALD: That's the final notice.

SENATOR POU: Final notice; okay, thank you.

MS. LEONE: Chairwoman, could I just clarify one quick -- very quickly.

I don't want the delay -- of the understaffing at MAXIMUS to go unnoted, because it's having an impact now. So while you would have gotten a 30-day response from your arbitration, and you would have seen how things were playing out in this six, seven month period, Nara and other billing companies and practices are filing additional arbitration blind, that they would have known how to, maybe, adjust them.

So what we're asking the Commissioner now is to allow -- now that we're getting awards -- allow the doctors to go in and alter or adjust some of their arbitrations without having to withdraw it. Because now they see how MAXIMUS is--

SENATOR POU: I don't think the law allows that.

MS. LEONE: No, it doesn't; no, it doesn't. But they've let the plans do it, which is interesting; and they've let the plans alter the numbers.

So what's happening is now, you know, we were put at a disadvantage. We see how MAXIMUS is injecting these certain calculations of Fair Health; and we see that they're using geozips of where the service was provided, versus the practice. And now every doctor who has submitted, you know, 20, 30 arbitrations -- at different practices and Nara's -- says, "Oh, shoot; I used the geozip for my practice, like CMS

requires me to. I'm going to lose every case. I need to withdraw these and then just say goodbye."

SENATOR POU: So just for the record -- because I don't have you down as one of our-- Just identify yourself.

MS. LEONE: Yes; Claudine Leone; I'm Government Affairs Counsel.

SENATOR POU: Okay.

Last statement, please; and then I'm going to--

MS. BALD: Yes, sure.

SENATOR POU: --thank you, and then ask you to please--

MS. BALD: That's fine.

I just wanted to add that we are being penalized. Out of the three parties involved in the arbitration process, the provider is the one that was the only one who abided by the timely guidelines. And, right now, we are the ones being penalized. Somehow, MAXIMUS is getting away with holding onto the arbitrations, carriers are not paying their fair share, and we're not able to amend any of our pending arbitrations that we were trying so hard to submit on time.

SENATOR POU: Your point is well made; we are taking very copious notes, as you might imagine.

And I'm sure that a good number of these issues, questions, concerns will be certainly presented to the Commissioner for her to -- in those particular areas where she can respond, that is within the confines of the law, she will -- you know, we'll ask her to do that.

Some of those statements that you've made -- the law doesn't allow, because it's very clear in terms of the way the statute reads. And in

that regard, the only way that that can be changed is by changing the law itself.

Okay; thank you, ladies, so very much.

MS. PREVOCKI: Thank you.

SENATOR POU: Thank you for your testimony.

Our next panel is going to be the two physicians from the Garden State Bariatrics and Wellness Center. And I say it that way so that you can pronounce your names, please, so I don't kill it.

Hi, come on up.

And of course, from the New Jersey Medical Society.

Okay; and if you can just introduce yourselves, that way I can put that on the record.

**MARLENE M. KALAYILPARAMPIL:** Sure.

Good afternoon, Chairwoman Pou, and members of the Senate Commerce Committee, and Senator Lagana.

My name is Marlene Kalayilparampil; I'm the Manager of Government Relations at the Medical Society of New Jersey.

I want to thank you for inviting us today to discuss implementation and operation of the recently enacted out-of-network law.

To reiterate, MSNJ thanks and applauds the sponsors, and we support the law in its intent to protect patients from surprise billing.

We're here today to share some of what our members have been experiencing in regards to the application of the law.

Today with me I have two physicians, Dr. Michael Bilof and Dr. Basil Yurcisin; they are physicians at the Garden State Bariatric and

Wellness Center, with five practices throughout the state in five different counties: Essex, Ocean, Union, Burlington, and Monmouth.

They're here to provide testimony on the misapplication of the law on their services, and answer any of your questions that you may have.

I'll now turn it over to Dr. Bilof and Dr. Yurcisin.

SENATOR POU: Thank you.

Doctor.

**MICHAEL BILOF, M.D.:** Hi; thank you.

Good afternoon; I'm Dr. Bilof. I'm here with my partner, Dr. Yurcisin.

We really just want to bring the Committee's attention to a very specific issue that previous speakers have somewhat alluded to, but we want to kind of really highlight it more specifically.

So the intent of the Bill was to deal with care that was emergent, inadvertent, or involuntary. Our practice is a bariatric surgical practice; in common terms, *gastric bypass*, *gastric sleeve* -- those sorts of things that are, essentially, always performed in an elective and pre-authorized manner. And despite that and despite the codes that we use to bill these services -- being always elective and pre-authorized -- the carriers continue to cite this Bill on the EOBs -- several of which we provided in the packet -- they cite that Bill for reduced payment. And when we call to advise them that that's an inappropriate application of law, the responses we get are far from satisfactory.

And thus far we-- You know, again, we brought just a very small sample of the cases that have affected our practice; but our practice is representative of other bariatric surgical practices in the state. And we

have, in just in our practice, it has been applied about 30 or 40 times to completely elective, pre-authorized surgeries that in no way, shape, or form are emergent, inadvertent, or unauthorized.

SENATOR POU: I'm sorry; I want to just interrupt you for just a moment.

Have you reported any of this to DOBI?

DR. BILOF: Well, thus far we-- "No" is the short answer. We've been dealing with the Medical Society of New Jersey in the hopes of adjusting this through that mechanism.

SENATOR POU: Okay; and the reason why I'm saying that -- if it's a clear indication that there's a violation of the law, and that is indeed being applied in this particular case, we ought to know that. DOBI cannot take any action, or position, or help to remedy a problem if they're not aware of it, right?

So it's also important for us, as well as for the carriers, to see what's really happening. Because if that's the case, we need to know, as members of the Legislature, passing these laws. We want to make sure that they're in compliance; and it can only be done by making sure that you all provide that information.

MS. KALAYILPARAMPIL: And just to clarify -- we do have a process internally at MSNJ, where we work with our physicians; and then we try to work with the payers internally before we bring it to DOBI's attention. So that's what we are currently doing to ensure that there's accuracy in the problem.

DR. BILOF: Yes, we did-- I guess, MSNJ did send a letter to Horizon on our behalf, citing some of these EOBs. That was about a month ago; we're still awaiting a response.

SENATOR POU: All right; so let me see if I heard you clearly, in case-- So about a month ago you forwarded correspondence to Horizon. Did I say that correctly?

DR. BILOF: Yes; MSNJ did, yes.

SENATOR POU: Right; the New Jersey Medical Society did, outlining those particular issues that you wanted them to be aware of and address, I assume, as well as correct. But you're still awaiting a response.

MS. KALAYILPARAMPIL: Correct.

SENATOR POU: Okay; so if they're hearing, I'm sharing; just in case.

Okay; thank you.

**BASIL M. YURCISIN, M.D.:** So Senator--

SENATOR POU: Yes.

DR. YURCISIN: My name is Basil Yurcisin; I'm another one of the members of the practice.

Along with this timeline of the things we just discussed, we must realize that, since August 30, 2018, we've had over 40 of our procedures fall into this purview. Not only did we believe that this law didn't apply -- so we try to go through normal channels, which means calling the insurance provider, describing our situation, getting the lip service that, "Yes, yes, this does not apply to you. Please submit this claim for reprocessing." We believe in that process, we allowed it to go to reprocessing; then we receive EOBs to the effect, saying that this does apply

-- these out-of-network bills do apply. So now we're a month or two further down the line.

We reach out to our friends at the MSNJ for some support and some help in this situation; they start their process. Throughout the process now, we've started appeals; now the appeals are being denied and/or we are being subjected, or asked, to go through the arbitration process; which again, we do not feel applies to this situation. So we are getting the death by a thousand paper cuts kind of experience in this process.

SENATOR POU: Help me understand why you would be getting denied.

DR. YURCISIN: Please help me understand that. (laughter)

DR. BILOF: Exactly; we have the same question.

SENATOR POU: If it doesn't apply, it should automatically be processed; am I right?

DR. YURCISIN: Right; and we know that these patients-- Ahead of time, we know these patients have the benefit; we know they have a valid out-of-network benefit from their plan. We have a pre-authorization; they've gone through a three to six month process. This can't be something that was sprung upon them. We have an authorization number that we also send during the appeals, all of which are either ignored and a form letter is sent back to us. And again, that form letter is included in the packets that you have as the final--

DR. BILOF: A sample of one, yes.

DR. YURCISIN: One of the sample form letters saying that we were correctly processed at an in-network rate, which we're not in-network. So all of these things-- This is the culmination of just one example of a

claim; but we have over 30-plus claims that this has happened with, and only 4 have actually gone to appropriate negotiation as per what we used to do prior to the implementation of the out-of-network Bill. And they grow every day -- the amount that we have.

SENATOR POU: Thank you; thank you.

So in-- I know you referenced the letter. By any chance, did you include a copy of the letter that you forwarded--

DR. YURCISIN: It's there; it's the last item in the packet.

DR. BILOF: Are you referring to the letter we sent to Horizon?

DR. YURCISIN: Which letter?

DR. BILOF: Or just the standard form letter that we get back from Horizon?

SENATOR POU: No, I'm talking about the letter that you forwarded to Horizon.

DR. YURCISIN: Oh no, that's not in there.

MS. KALAYILPARAMPIL: No, that is not included.

SENATOR POU: I don't know if you want to share that with us--

MS. KALAYILPARAMPIL: If you would like, we will.

SENATOR POU: --but if it's of value for us to take a look at, and directly understand your concerns, you may want to just share that.

Thank you very much.

Yes.

DR. YURCISIN: I just wanted to echo a couple things.

Setting a floor would be very helpful for payments for the patients who actually this Bill does apply to. I think it's also very helpful to

have some kind of a repercussion for insurance companies that overreach and do things outside the realm of this law, so there's some reason for them to actually come to the table and negotiate for fear of some kind of a repercussion. As of right now, I'm not sure there is one.

SENATOR POU: Okay, all right.

Anything else that--

Senator, are we good? (no response)

Thank you so very much.

MS. KALAYILPARAMPIL: Thank you.

SENATOR POU: We really appreciate your testimony.

Okay, we're almost at the -- we're almost there, so thank you so very much for the balance of our guest speakers, or our speakers who have been hanging in there.

So I'm going to ask Mr. Sanders -- Ward Sanders, from the New Jersey Association of Health Plans, the President--

You're on the hot seat, Ward.

**WARD ELL SANDERS, Esq.:** I am.

Well, I thank you very much Madam Chair--

SENATOR POU: Thank you.

MR. SANDERS: --and I appreciate the invitation; and thank you for your stamina to all of those who have remained.

Ward Sanders with the New Jersey Association of Health Plans. We represent the major payers in the state.

I do appreciate the opportunity to testify here today.

There were a lot of things that were testified to, from Medicaid rates, to out-of-state plans, and lots of other things. I'm going to try to really focus in on the legislation that's the subject of the hearing.

And first I just want to start with a couple top-level observations about the law, if I could.

First, I do want to thank -- even though Senator Vitale is not here -- but I do want to thank the sponsors who worked on this legislation. There was a number who spent, you know, a lot of meetings with a lot of stakeholders, over a 10-year period that resulted in this law. First and foremost, this is a law about protecting consumers; and we do think that it's achieved that goal, in many respects, by protecting them against balance billing by providers, some transparency tools, and allowing for arbitration of these cases where consumers are payers in their cost-sharing and also in their premium; and that's impacted by this legislation. So I do think that it has worked to meet that, first and foremost. The sponsors often talked about that as their number one objective.

The second thing I wanted to mention was that you say this is a 10 years of discussions. And it was really just, I think, like, two weeks ago or three weeks ago that the arbitration decisions first started to come out. So we would argue for a longer look at the success or failure of the legislation; as I say, it's just that decisions really started coming out two weeks. As I was thinking about this, if this were a patient, I'd want to make sure that before we do a diagnosis and recommend a cure, that we make sure that we evaluate the patient more fully than just anecdotes and testimony here today.

The third is that I think the core issue at dispute, when all the dust has settled on this is, what are the best ways to determine price for services when there are no market forces at work? So, you know, the two areas that this legislation was trying to address were emergency services and services -- say, the network facility where you, as a consumer, had no choice in the matter and were sent to an out-of-network provider. Those areas do not allow for -- there's no contract behind that, if it's an out-of-network provider, and we want to protect the consumers. So that sets in motion the question of, "Well, how do we determine what's paid." Should we pay whatever is charged? And that had been the case, in many cases, prior to this law; and that was of concern.

I remember a number of cases here where there were -- there was one case where I was asked to comment on; it was \$18,000 for two or three stitches, and there were a lot of cases like that.

The third overall thing is that I do want to talk about scope, because that did come up here quite a few times, and I know a couple of Senators were trying to get at that.

The insured marketplace that this law generally applies to has shrunk, over time. So people used to talk about 30; it's really, now, about 1.4 million of New Jersey's 9 million residents are covered under insured plans that are governed by laws that we passed here. This also reaches to the State Health Benefits Program; there's another 800,000. So that's about 24 percent of New Jersey residents are covered under plans that are impacted by this. It would be larger if there were self-funded plans that were opting in; I think we heard that there were 11. So there might be some more folks.

But again, the vast majority of New Jerseyans are covered under self-funded plans that have not, so far, opted-in to this legislation. So when we look at the impact, we do want to keep that in mind.

And lastly, the top-level point that I do want to mention is that the law was not self-executing; and it required an enormous amount of work by hospitals, doctors, health plans, regulators, and other interested parties. The law had a 90-day effective time; so it was signed on June 1, and it was effective on August 30. Other states that did things like this had staggered effective dates, and something like an arbitration system. I think New York took, like, a year to set theirs up.

So one thing I think -- as we move forward as stakeholders, and policymakers, and health care -- we need to think about are we really asking too much, and are we requiring too much in the time frames that are happening here?

I can tell you that this was an enormous lift for the health plan community -- of all the things that they had to do. Ideally, you have regulatory guidance; so they made decisions along the way, absent regulatory guidance, this summer, because the law was effective on August 30; and some of the assumptions that they made were wrong. So they had to change systems and directions, and they have legal departments, and IT departments, and all sorts of folks working on this legislation. So it's sort of -- it's in the rearview mirror a little bit; but I think that some of the bumpy aspects of this legislation can be attributed to what was probably an over-ambitious time frame for rolling all of this out by all stakeholders.

SENATOR POU: Ward, just to clarify -- who was making some of the wrong decisions? Are you saying that as you were trying to

implement the law, you're saying that many of the plan insurers were trying to be in compliance with the law; but along the way, they were trying to do that and made some--

MR. SANDERS: Yes; but even before the regulatory guidance--  
For example--

SENATOR POU: I'm just trying to find out who you're talking about. Are you talking about the carriers, or are you talking about DOBI?

MR. SANDERS: I suspect it's--

:SENATOR POU: Are you talking about MAXIMUS? Are you talking about-- Who are we talking about?

MR. SANDERS: I suspect it's everyone. I think it's probably everybody.

SENATOR POU: Okay.

MR. SANDERS: I can tell you, from the plan community, you want-- The law had some ambiguities.

SENATOR POU: Sure, sure.

MR. SANDERS: It had some things that were unclear, some things that may even have been contradictory. But you're trying to execute on that, absent the guidance yet again-- And again, I'm not faulting DOBI, because this was way too fast for them to try to roll out, you know, regulations. They couldn't have done it, you know-- June 15 is when the plans kind of needed--

So as to application -- does this apply to a certain-- Like, how does this apply to MEWAs? That was one of the questions we had.

SENATOR POU: To what?

MR. SANDERS: To *MEWAs* -- *Multiple Employer Welfare Arrangements*. So carriers made some decisions about things like that. And I think you heard from the Hospital Association's testimony, the law said one thing when they got guidance from the Department of Health; I think it was in February. It was different than what they anticipated the legislation to look like. I'm sure that that was disruptive for the hospitals.

Again, I really don't want -- this is not meant as a criticism of regulators; it's just--

SENATOR POU: It needed some clarification.

MR. SANDERS: Yes.

SENATOR POU: And one more real quick one.

MR. SANDERS: Sure.

SENATOR POU: You mentioned that when you compare this -- the implementation of this legislation to that of -- when New York state did it, it took them over a year. And during that year process, did they perform or maintain status quo until such time they were able to, then, implement the law? Because then, if that was a provision or an option, then we wouldn't be -- a lot of what we're talking about, or some of the experiences, perhaps might have been different.

But I'm just trying to get a better understanding; because what you're saying is helpful to us.

MR. SANDERS: Yes, I don't know the answer to the question about how New York handled the status quo. Here, I think the--

SENATOR POU: Well, I assume bills were being paid during that one-year period. So either something--

MR. SANDERS: Well, I assume that there is balance billing of consumers, there were egregious charges, and there were billing challenges. So, yes, I'm assuming that that happened; as it was happening here in New Jersey, it was happening in New York.

I'm not sure I can try to get you information about what New York's rollout looked like. My point really was that it's a really complicated thing; they brought stakeholders in, they tried to figure out how this was all going to work. There was a lot of discussion, and there was time to have a mature kind of a process.

So I think it -- you know, some of the noise that you've heard today, and the delay on some of the decision-making from MAXIMUS, you know, almost could have been expected, in some ways, just because of the challenging time frames of it all. I'm sure the sponsors wanted to have the fix -- because consumers were hurting -- as soon as possible. So I'm sure that the impulse was to have an aggressive time frame. It just -- in trying to roll it out from all stakeholders, I think it was challenging.

SENATOR POU: I agree. I just wish that they were here to say that, on their own behalf

MR. SANDERS: Yes.

SENATOR POU: But you're right.

MR. SANDERS: A couple -- there were so many points made on the-- It's so late; I do-- I think what we may do is follow up with some points. You know, I would urge this Committee to hold people's feet to the fire on the statements that they made. And I just think we need to look under the hood a little bit, just to make sure that the assertions made were folks who understood the system.

I heard some questions about-- You know, one of the things I heard was about Medicare Advantage, and how this Bill impacted Medicare Advantage. That's something I'd love to talk to them about, and I will reach out to the hospital involved. But the law excluded Medicare Advantage; so I don't really understand how it had an impact on the Medicare Advantage network.

I will say that some of the questions we've had -- are there cost savings? You know, a big chunk of the savings -- to the extent there are any -- will go to the State Health Benefits Program; you know, as I say, there are about 800,000 there, and 1.4 million in the insured marketplace. So to the extent that there is savings as a part of this negotiation process and sort of arbitration process, it would be flowing to the State. And the insured marketplace -- I think it's still probably too early to give some sort of impact statement, because, as I say, it's so early in the process and the decisions really started coming out two weeks ago.

But remember that insurers have to meet minimum loss ratio requirements. So to the extent that the claims experience is going down, it pushes carriers -- to require them to lower their premiums when there are lower claims.

I did hear testimony -- and I hear this all the time -- this is not the only thing that changes in healthcare costs throughout the year. So if you reduce costs for out-of-network services by whatever -- 4 percent -- but drugs go up 6 percent, your premium may be going up. So I think I heard testimony here earlier -- I think it was from the Doctor-Patient Alliance -- like, "Well, my premiums going up and, you know, so my payment is going down. So how does that work?" You know, I think that an economist and

actuaries will have a more thorough review of that, and will point to the total cost of care as driving that.

But the savings that are attributed to this in the insured marketplace will flow through to consumers.

You know, we do have concerns as well -- I know Senator Kean is not here -- but, you know, to his point-- Just because it was 10 years in the making doesn't make it perfect. And so I do think there are opportunities; there are parts of this legislation that we have not liked from the start; and I think that it's okay to look at that and recommend solutions to try to address that. I just think trying to move forward with solutions today, or in the next month or so, before we've really had an opportunity to vet the assertions made by folks and to, sort of, really get into this, it would be premature.

In terms of the arbitration process-- You know, one of the concerns I heard was about the flow of -- the cash flow. I know that was-- The delay in some of the decisions made that a bit of a problem. But I did want to be clear that the payments here, required under the law and under the DOBI regulations -- I want to be clear about that process. It requires payment-- If you're not going to pay charges, you have to pay, within 20 days, your first offer. That's putting non-par providers in a better position than participating providers. Under the Prompt Pay Law that the Legislature passed, and DOBI implements, prompt payment is within 30 or 40 days, depending on whether it's an electronic claim or a paper claim. This requires a payment to the non-par provider within 20 days. So there's money that's going -- flowing to the provider quickly in this process; and then there's another payment that's made that may be made to increase the

offer, to try to drive a negotiated settlement. And that also happens fairly quickly. And as I say, some of the decision delay might affect the ultimate payment, where those providers who won. But I did want to be clear that there is funding that goes out the door quickly as part of this.

We have some concerns around some continued balance billing that we'd like to raise with folks. We would urge the folks who testified here today -- if they want to talk to me or they want to talk directly to the carrier to work on those problems-- I know they've raised issues, maybe, with the Medical Society or the Doctor-Patient Alliance. I would, you know, urge them to talk to the carriers, if they haven't; and if they didn't get satisfaction, to go to the Department of Insurance. The complaint form is a page long; I know that there was testimony that it was too complicated or too cumbersome. But I think it's fairly straightforward -- that process. And the Department -- to the extent that it is within their jurisdiction -- I'm sure will look at those cases to try to resolve them, if there's a conflict.

SENATOR POU: I think what you're saying is while we all understand it, I think what I also heard from some of the folks who testified is that it's not as if they're not availing themselves of the due process. They, obviously -- some of them testified that they are, in fact, communicating with the carriers. Unfortunately-- And they also mentioned, as well, that they've communicated with DOBI.

Unfortunately, some of the testimony that we heard -- we talked about the unnecessary and unfortunate long waiting of, you know, 40 minutes being on the phone, for example, to only receive an automatic response that will say, "You're not eligible to go to the next step," or have

reverse, to the previous item, that “we previously told you were not eligible; you’re now eligible.” So it’s really the exchange of that.

But I think, clearly, there is a mechanism, there’s a process, and one that ought to be continued to be followed. I think it’s creating a better environment, a better and a smoother business environment for all parties involved -- both from the provider, to the carrier, to ultimately MAXIMUS -- to making sure that everyone is able to do that. So it goes both ways, right?

MR. SANDERS: Understood. And there is no question the process could be improved; and folks will learn in this process, I think, identifying the claims that are subject to the legislation sometimes can be challenging. And, you know, I think all parties could probably improve the process.

I just -- I heard some of the frustration around, like a contract issued in another state. That’s going to be governed by another state; it’s not going to be governed by this legislation. And there were complaints about self-funded; you know, DOBI saying, “We can’t handle self-funded cases.” That’s just the nature of the risk; you know, the limitations in the Federal-State partnership.

So hopefully we can work through the issues that aren’t working well. And I do think that, with time, carriers will get better at this, providers will get better at this, hospitals and the regulators will get better at this. It just -- it was a complicated law to put together in 90 days.

We will provide-- There were a lot of comments here. And I know it’s very late, so we do want to follow up on some of the things that were said.

SENATOR POU: Before you end -- because, you know, I think we wanted you to have the opportunity to really be able to listen to all of the comments and concerns before I asked you to come up, so that we have a full -- a more comprehensive view, in terms of what is really out there, right or wrong, indifferent, or correct or not. The point is, it needed to be heard by all parties and all the stakeholders.

MR. SANDERS: Understood.

SENATOR POU: One of the things that I want to make sure that we ask is, how do you determine -- how do you ensure that you have sufficient physicians or carriers to attract them to come into your in-network? And what are you doing -- within all of your plans, your members -- to bring in those additional providers?

What I'm trying to get is, how do you-- As I was listening to the previous speakers, I was making sure that we were taking notes, in terms of -- so I cannot forget to ask you the question -- like, what measures are you taking to meet network adequacy requirements? There were some comments with regards to that.

So if you can address that question.

MR. SANDERS: That's a good question.

In many respects, the carriers' product is their network. So to be able to offer coverage, carriers have to have a network. Some states allow what are called *narrow networks*; New Jersey does not allow -- it's one of the few states, I think -- does not allow narrow network products in their commercial insured markets.

So if you want to offer coverage in certain areas, you have to have an adequate network. So I heard -- some of the testimony from the

hospitals was, you know, the only thing that drives insurers to the bargaining table is the threat of high, very high out-of-network costs. And I would say there are a lot of other things that drive the carrier to the table. And one is, if you have a hospital, a geographic exclusivity, the carrier -- they have enormous leverage over the carrier. The carrier has to have that hospital within its network or it can't offer a product in that area. That's enormous leverage, right? I mean, so to be able to offer products in certain areas, the Department of Insurance is going to look at it and say, "In the insured marketplace, do you have a sufficient number of hospitals, and doctors, and ambulatory surgical centers, and so forth?" There's a certain criteria that they need to meet. And, you know, the larger the networks, sometimes consumers find that more attractive. So *a*) they have to meet the adequacy requirements of the statute; *b*) they want to make themselves attractive to consumers. You know, if consumers really like a particular hospital in an area that's, again, enormous leverage for that hospital in the rate negotiation.

SENATOR POU: But you heard testimony -- I think it was the physician alliance group -- that talked about, and gave examples with regards to an area in South Jersey. I think they were -- one of the testimonies in terms of the lack of having sufficient -- my term -- so not having sufficient physicians in the neurosurgeon area. So how do we ensure, once again, that we have -- that we're meeting that type of network adequacy within those particular-- And what's the process; what's the process of recruiting or ensuring that you're able to add these additional physicians in those types of specialty areas, that otherwise would not be available, so as to prevent some of the-- You know, some of the horror

stories that were talked about, in terms of the distance; if it's an emergency in the middle of the night and, you know, you have -- I think somebody-- One of the physicians mentioned an aneurysm, or what have you.

So what happens then?

MR. SANDERS: Well, there are a lot of questions embedded in that; so I'll try to--

SENATOR POU: No; only one, only one. What is the process that your -- that the plans are using to add more physicians to the network to ensure adequacy requirements?

MR. SANDERS: Right; my adequacy requirement -- it is evaluated by the Department of Insurance. So carriers will submit their networks to the Department; they will run, like, geo tests, in terms of where your membership is, and how many providers are there, and evaluate your network to make sure that you meet the time and distance standards that are set forth in the rule. And time and distance standards are kind of the gold standard; I think we were one of the first states to require time and distance standards for your population.

SENATOR POU: Right.

MR. SANDERS: So DOBI is reviewing that. It could be that in -- and I don't know the specifics here -- but there may not be a pediatric oncologist in Cape May County; there may not be any. So we do have provider challenges in building networks, in some cases, because there's a provider challenge period, you know; just -- we don't have some folks in every geographic area.

Irrespective of that, carriers are required to provide coverage even if they don't have a certain subspecialty, or something like that, in

their network and a certain geographic area. They're required to provide coverage and to do something we call *single-case agreements* to make sure that consumers -- who have purchased, either through their employer, or union, or whatever, and have health coverage -- that they have access to care; because that's the promise that's been made. So even if it's a, you know, network-only plan, if there's a shortage and there's an access issue for a particular consumer, the law requires the carrier to provide coverage in those circumstances.

As to the third part of your question, I think it was about recruitment. And carriers have teams of folks that go out and will negotiate with hospitals, and doctors, and so forth. The rate negotiation process is something, as a trade association, I can't get involved with that. But I know that there are teams; I can get you a more complete answer. But they're trying to build networks and they have teams of folks that go out and negotiate. And if it's a subspecialty that was really hard to get, you see very high rates that are offered. If there's a surfeit of providers of a particular kind, you might see lower rates, because there's an overabundance and you don't need everybody in your network. There are certain kinds of providers where you have, you know, so many of. So it sort of depends on the provider type. But they do have a recruitment process for the positions; and the rate negotiation varies, depending -- I'm told, anyway -- on the type of provider and how scarce they are.

SENATOR POU: There was the one physician who said he was a sole practitioner. Is it your understanding that there's a policy or practice where many of your plan carriers do not negotiate, or will negotiate, with sole practitioners?

MR. SANDERS: I'm not close enough to know whether there's any, you know-- I would say that if you are a practice with 500 doctors, and it's the premier group in the area, they probably have better, you know--

SENATOR POU: Of course; I understand.

MR. SANDERS: So a sole proprietor in an area where there's a lot of doctors, then maybe there's not, you know, as much of an interest in that particular-- There are a lot of other things, other than whether it's a sole proprietor or large practice, that might come into play as well.

SENATOR POU: But then that would limit that one sole practitioner -- to not be eligible to join an in-network.

MR. SANDERS: So such a question as to whether plans have a red line--

SENATOR POU: Or policy of some sort.

MR. SANDERS: --and I'll get back to you. I don't think that's the case, but I'll--

SENATOR POU: Okay, okay. I know we heard that in the testimony today--

MR. SANDERS: Yes.

SENATOR POU: --so I wanted to--

MR. SANDERS: Yes, it may have been that-- Yes; I don't know what happened in that particular-- It's the challenge of a forum like this to try to resolve these questions--

SENATOR POU: Okay.

MR. SANDERS: --but I'm happy to get back to you to see if any plan has a policy of refusing to contract with a sole proprietor.

SENATOR POU: In your opening comments you made mention about how you-- Well, let me ask you, how do you determine -- or how do your carriers determine *excessive*? How do you define that? Because I think you referenced that in your opening remarks.

MR. SANDERS: Yes; I think that there's not one answer. I don't think that there is clarity in the statute or the regulation that says, "Here's what the first payment you have to make is; it's *X* percent of Medicare, or *X* percent of Fair Health, or *X* percent of your in-network rate." I don't think that there's guidance in the statute that says that. I think in practice it probably varies by carrier. And I believe it probably varies by the plan type that the consumer may have purchased as well.

So I think there's variation, and it may be that one plan has, you know, a flat rate that they do out the door. But just the carrier community is not -- I don't think is all in one place here; I think it varies by carrier and it varies sometimes by product.

SENATOR POU: So I know that -- we heard some -- I think some of the billing professionals who were here talked about a fee schedule. And I'm wondering if it's appropriate, in line of what you've just referred to, in terms of excessive -- how the carriers determine excessive billing or excessive charge. And then you calculate that payment that's offered to that EOB. What's your -- I'm wondering if you have an opinion, in terms of what was recommended with regards to a fee schedule? I think there was some testimony to that -- to give some kind of parameters -- a parameter to physicians on all different levels, in terms of what they should or should not do.

MR. SANDERS: One of my comments in my opening remarks was, I think that what folks are fighting about nationally, and what folks have fought about in states, and what folks are fighting about both before the law and after the law here is how do you determine that cost? If the consumer is insulated and the consumer didn't get to pick, and you want to protect them, and there's no contract of what the rate is, how do you determine the cost. Whether we're talking about the first payment, or the last payment, or the arbitrator's decision, I think ultimately folks are most concerned about the last one which is, where is that payment level.

I know there's been legislation in New Jersey to peg it at a 150 percent of Medicare, I think. I think Senator Lagana has some legislation that sets it at 85 percent of Fair Health charges. But this is the national dialogue: What's a fair payment? I think the providers will all say, "We don't like Medicare," or even a percentage of Medicare. I think the payers and consumers will say charge-based fee profiles inflate because it's completely controlled by the provider community, and what they charge is not a fair measure. Some States look sort of in between them; they'll look at some -- the average in-network rate, or some percentage of the average in-network rate.

But I think today's hearing was ultimately about-- The process could be improved; but I think it was probably -- there's a lot of concern about where that level is.

SENATOR POU: Sure, sure.

I can't agree with you more, in terms of the sentiments that you shared with all of us -- that we really want to make sure that we're protecting the consumer, in terms of not getting that surprise billing; and

making sure that is dealt with within both the carriers as well as the providers; along with making sure that they're able to perform the services that are anticipated or expected.

So I agree, in terms of the intent of what the legislation and the purpose of that, especially given the incredibly high costs of health care today in so many different realms.

I know that-- Along those lines, I'm just wondering how have your carriers' members -- did they change their billing process practices since the law's implementation; has that -- have they been able to make those necessary adjustments? Or how are those adjustments or changes impacting what you have heard today, in terms of the overall provider and providing that care.

MR. SANDERS: Right. So prior to the reform, there was a time where the responsibility was the carrier, under the Department of Banking and Insurance rules, to make sure the consumer wasn't balance billed. There wasn't a ban on balance billing, but if the carrier found out about it, they would have to pay whatever; and DOBI would say, up to charges.

So we saw some astronomical awards under the prior PICPA; it still exists. But that arbitration system-- And that was a challenge. I think in the Bill that was passed into law here in New Jersey, it does have a section that talks about cost containment being one of the goals of the legislation.

So have the plans changed their process? Yes, they had to, by law, set up this process. It requires different phases, you know; first payment, it allows for a second payment. It places a good-faith

responsibility on carriers to negotiate in good faith. There is not a similar requirement in the law on the provider community to negotiate in good faith.

We have seen cases-- There was one case the carrier showed me of 2,600 percent of Medicare; and the provider wanted charges. That's an awful lot of money. So does the dialogue, the negotiation, you know-- Sometime the provider says, "I want charges," that's it; and the negotiation kind of ends there.

But each case is different, each carrier is different. But did they change their processes? Yes; I mean, they had to, as a result of this law, to set up this process. It is the mechanism that's required under the law, and carriers are held to the standard. We think it's a little bit unfair -- and we raised this when the bill was going through -- is that we're required to show our best offer, while the provider doesn't. This is not true baseball-style arbitration, where you give two blind envelopes. This is -- we think, in some ways, actually in favor of the provider community -- it requires the carriers to say, "Here's my best offer, and here's the check for it. Now, provider, you can get to pick whatever amount you want, knowing what the plan has already given."

Most baseball-style arbitration is not really set up that way.

SENATOR POU: I think, however -- and then I'm going to pass it on to Senator Lagana -- but I think-- And, again, thank you; thank you for your information.

I think one of the things that they we're talking about is -- what we heard here today was -- how when it gets to that point, in terms of the arbitration process -- because you've been able to give your best offer and

that was not accepted -- you now go into the arbitration level. One of the suggestions -- and, you know, I'd be interested in knowing what your opinion, or what your feedback would be -- going in and knowing what information is equally being provided to the arbitrator, so that both sides will know whether -- what is being given for the purpose of making the decision on the arbitration, or the arbitrator. Do you think that that is something that would be helpful; because now that might certainly avoid even getting to the point of going through arbitration because, at least on both sides, you're both now dealing with shared information as to how you're arriving at that -- whatever that metric that you're applying. I have no idea.

MR. SANDERS: Yes. At the risk of being wrong, with respect to my members, because I haven't-- I think that there probably would be an appetite to see that. I think the carriers are curious to know what the providers are submitting in this; and having some way to verify that -- you know, is the information that they're providing a factual issue, and is it accurate?

SENATOR POU: Isn't that already being done, prior to-- When you -- as a provider, if I'm providing a service and I'm putting in a claim, aren't I responsible or required by -- as a matter of first impression -- to go in and say to you, "Here's what I've performed, this is what I'm doing." I mean, I would assume you have that already at the carrier.

MR. SANDERS: Yes, there are claim submission requirements, and they have to submit a claim as part of this.

SENATOR POU: Sure.

MR. SANDERS: So yes. What I was talking about -- which I thought you were asking about -- was, the decisions the provider gives some things-- I mean, it's a hearing on the papers, right? It's not an oral argument kind of setting.

SENATOR POU: Okay.

MR. SANDERS: They consider the information that is submitted.

So the carrier doesn't get to see what the provider is submitting to the arbitrator.

SENATOR POU: That is what I'm referring to--

MR. SANDERS: Yes.

SENATOR POU: --but I was just--

MR. SANDERS: I don't know what -- the carriers don't know what they're providing, and would love to -- I think there would be some appetite for -- let's-- I'll double-check with our membership, but I think there'd be an interest. That might be something we agree on.

SENATOR POU: I thought I heard some of the providers share, or make mention of the same thing. It was either them, or the other group.

MR. SANDERS: I heard it earlier too; I can't remember who it was.

SENATOR POU: Yes.

MR. SANDERS: But it struck me, anyway, as I don't know that that's such a bad idea. I think the payers would love to be able to see what the providers had submitted, and I'm sure vice versa. I don't know

why that would harm the integrity of the process, and it might help solve some problems of instinct, anyway.

SENATOR POU: Yes.

Senator Lagana; thank you for your patience, sir.

SENATOR LAGANA: It's okay.

Thank you, Chairwoman.

We had a discussion earlier about a policy that's potentially issued out-of-state; a person lives in New Jersey. They have their business -- wherever their employer's from.

MR. SANDERS: Yes.

SENATOR LAGANA: So the health benefits plan is defined, under the statute, as -- it says it means, "A benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this state."

Can you just clarify that a little bit--

MR. SANDERS: Yes.

SENATOR LAGANA: --I mean, because it kind of seems to me like, if you are a resident of New Jersey, even though-- Let's say, I work in New York City, right? I'm from Bergen County, I work in New York City. My employer provides me insurance, but I live in -- again I live in the town of Bergen. I go to Hackensack to the hospital. You know, where does that leave that patient?

MR. SANDERS: Right; so at the risk of disagreeing with the Speaker, apparently -- I don't know; somebody said that he offered some -- opined on this -- but that language is found in almost every insurance statute in New Jersey. So if we pass, in that exact same language, a

mandate to cover -- what's a recent one? -- you know, so we have a law on in vitro fertilization. It will say this applies to health benefits plans issued or issued for delivery in this state.

So insurance is purchased sometimes by individuals; but more often by groups -- employer, or it could be unions. So we're talking about the insured marketplace, where risk is transferred to the insurance company. When we pass laws in New Jersey, it applies to those plans that are issued under New Jersey law to New Jersey employers. They may have an employee in Pennsylvania, or Kentucky, or California, or whatever; the laws of those states don't apply to our coverage. If someone lives in Bergen County and they receive care from a Bergen County provider that is licensed by the state, but they receive their insurance through a New York employer -- you know, Mike's Bike Shop in Manhattan -- the laws of New York would apply to that, even though it's a New Jersey consumer and a New Jersey doctor.

So the law that was just passed -- in my estimation, anyway; and I think it's DOBI's take on it as well -- would not apply to that person in New York.

So to answer your question about where is there relief; the relief is, what are the laws of New York? And so that plan would be covered -- even though they're a New Jersey resident and a New Jersey doctor, they would look to their relief under the plan there.

If it was a self-funded plan, it's a little bit different, because it could be a plan that chooses to opt-in under our law; and so there might be relief through our arbitration system in that case. But if it's insured and it's

issued in New York, it would be covered under New York law, not under New Jersey law.

SENATOR LAGANA: Okay.

We covered a lot today. It's been it's been a long day; I don't want to go too far out.

But having, again, been part of this process for many years now myself--

MR. SANDERS: Yes.

SENATOR LAGANA: --understanding what I thought to be were going to be issues with arbitration, I kind of was talking about it for a while. I mean, in my private practice I do PIP arbitrations; I've been doing it for more than a decade, so I see how healthcare claims are handled in the auto realm; a lot different, obviously, with a fee schedule. There are a lot of procedure codes, which are not on the fee schedule, which we argue when we argue UCR. And they've proven a little bit differently. So, you know, I see a system that works pretty good; and then I see a system here that works pretty bad -- badly. Since the bill was rolled out to where we are now, I feel like what I've been kind of putting out there kind of came true to a certain degree.

Now, we're talking about singular issues: How much is a procedure worth? You know, and again, in my estimation, for a physician to prove that a certain procedure is fair and reasonable -- I mean, we talk about UCR -- what's usual, customary, what's reasonable?

And a way to prove that is to show, again, what a physician has been billing, what the rate of payment has been. There are other metrics that we should consider. It's not the end-all, but these are the

considerations. Obviously, just because the doctor was getting \$30,000 for four stitches for so many years, it doesn't mean that that's a reasonable amount; I completely understand that.

But the frustration comes into play where, again, the law went into effect; the regulations did not. So it was kind of like this reverse roll out, where typically we see a law enable the Department to begin to develop the regulation; and then it kind of slow-rolls out while they have some guidance. In this case, we're kind of working backwards a little bit.

So on day one, we had a law go into effect; and, you know, if you're putting yourself in the doctors' shoes, you have now physicians who are out-of-network; and a lot of more general surgeons, or plastic surgeons -- or we heard from the neuros and everyone kind of in between -- who were used to getting paid, let's say, \$15,000 for a hernia repair. Now they're getting paid \$1,500. And again, this is just kind of a smack in the face overnight. And the insurers are in a position where now they're saying, "Okay, well, we can kind of use our own metric to pay what we think is fair and reasonable;" and again, we don't know what that is yet. I mean, you just testified it's different for each carrier; we don't know what each person's using. And now we have this arbitration process that's been kind of slow rolled.

At some point, I think there's -- we have to meet in the middle, as far as what is considered fair and reasonable. And I think the arbitration process is -- I think it is a way that we can meet in the middle. Because if awards start coming in, let's say, for a hernia repair, and the awards are coming in at \$15,000, I think there's going to have to be an adjustment on

both sides. Just like if awards are coming in on a procedure where they are getting paid the \$2,500 -- there has to be an adjustment on both sides.

I agree; I think, early on, we need to see some more awards come out to see how these numbers are, kind of -- where they're standing at. But I do think that, you know, this is kind of day one, really, in us re-examining this whole system.

Now, I am not a fan of baseball-style. I agree with you; I don't think it is really even baseball-style. I say this all the time -- baseball-style arbitration doesn't work in baseball, so I don't know why we're doing it here. I think that we have to allow the arbitrator to really make a determination, based upon what's available to them. And I think it's fair that both parties see what they're submitting. I mean, the carriers should see what the physicians are submitting, right? I mean, just like the physicians should see what the carriers are submitting. And if there is an opportunity for each to respond, saying, "You know what? You're using the wrong information," or, "You know, your argument isn't based upon the documentation that you're telling this arbitrator--" So I think it's a little fairer for the parties to really see what's being submitted.

But again, I think the arbitrator should really be giving more of a leeway to say, "Okay; well, if I have this bill in front of me that's \$20,000 for a wound repair, and the insurance carrier has paid \$1,800; but based upon the information in front of me, I think this is really worth about \$6,500." I think the arbitrator should be given leeway to make that award. I don't think that they should have to say, "Well this is kind of closer to this, so let me just give this," because that's really what's happening here. I mean, I don't really think that's fair to either side; I think that the

arbitrator should be given a leeway. Because what that does is -- and I see this in PIP -- it does have the effect of reducing costs. Because now if certain procedures are coming down or certain procedures are coming up, things will kind of adjust themselves; where there may not be really the push to arbitrate every claim. Because, again, the carrier is saying, "Okay; well, this is really where the arbitrators are falling for this procedure code. During negotiations, we're going to offer close to that; you know, will you take 80 percent of what this is?" I think the provider is going to say, "Okay; you know, I won't go to arbitration. That's fine." And if on the other hand, say, "Well, look, we're getting paid X amount of dollars, you're billing this high outrageous rate, but you know where the arbitration awards are coming. We'll give you about what the arbitration awards are coming, minus 10 percent, to make this go away without binding arbitration."

You know, I think this will have the effect of not having so many arbitrations; and I think it will, you know, in many instances reduce the cost of health care too, I think, overall, as far as where the claims will be. Some will rise and some will go down; but I think the whole baseball-style is not going to ultimately work out. I think that the things that we saw from the beginning -- you know, the EOBs that were being submitted where just the Assembly Bill number was being cited, where the actual statute wasn't being cited -- there was a lot of confusion on the part of the providers. And I think there was a lot of confusion on the part of the carriers, because of them trying to figure out, "How do we apply this," right? But then on the provider side we have payments that were being applied to procedures that were not -- that were self-funded plans, not fully

funded plans. And there was a lot of confusion. “What do we do with this? Who do we respond to? Where’s DOBI going to come down on this?”

So, you know, I think that we have to -- I think ultimately we’re going to have to make some changes here to adjust the system. But, you know, putting ourselves in the shoes of the providers, I think we have to admit that this was a huge smack in the face to a lot of physicians in New Jersey, because there was a substantial reduction in what the rate of payment was to what they’re getting now.

So I just--

SENATOR POU: Did you want to ask--

SENATOR LAGANA: No, no, no; I’m just venting. (laughter)

SENATOR POU: Okay, I was wondering-- Okay.

SENATOR LAGANA: Yes, yes.

SENATOR POU: I didn’t know if you needed a response--

SENATOR LAGANA: It’s been a long day.

SENATOR POU: --because you had a lot going on there.

SENATOR LAGANA: No, I’m just putting out there what--  
I’ve been sitting here for five hours--

MR. SANDERS: And Senator, I’d love the opportunity to--  
It’s late; if I could have one quick minute.

SENATOR LAGANA: And I--

SENATOR POU: I just wasn’t sure if there was going to be a  
question along the way, so I wanted to, kind of--

SENATOR LAGANA: Okay, what do you say to that?  
(laughter)

MR. SANDERS: You've always been very generous with your time, and so I--

SENATOR LAGANA: And that's all I'm going to say.

MR. SANDERS: Just first on -- you used the term *slow rolled*. I don't want -- I don't want to get you meant to say that-- I don't think the Department has dragged its feet; I don't think any regulatory-- I mean, Treasury has-- I just think it was overly aggressive in the time frame in the law.

SENATOR LAGANA: Agreed.

MR. SANDERS: I think folks are working really hard to comply.

You have categorized this as -- I think you said a *failure* -- this particular mechanism. I do think it's too early; and I think that they'll be some shared learning in this process that will hopefully drive folks to avoid this. I mean, it was one of the goals of the legislation. But if you are charging 2,600 -- you know, yes, you're going to get a haircut if you were charging 2,600 hundred percent of Medicare. And you're not going to -- this mechanism, I don't think, is going to reward folks who, sort of, have very high request rates. I think that the folks that do will see themselves losing a lot, and will-- If I were counseling them, I'd probably say, maybe, you know, if you're a carrier, maybe, you know, you should pay more if you're losing. And, you know, a physician -- if you're losing all these, maybe you should charge a little less.

So -- and again, we've just seen the decisions two weeks ago. So to say that this mechanism fails, I do think it's premature to reach that conclusion.

And, you know, at the end of the day, you know, a more aggressive schedule, in terms of cost reduction from where folks were getting paid, will help (indiscernible) benefits program and its rates; it will help insurance premium-paying taxpayers in their rates; it will help consumers who appeal these cases when it's in the DOBI regulations. You make that first offer as a carrier and you say, "This is what we're going to pay," and you issue an Explanation of Benefits and say, "Consumer, here's your cost sharing."

If you up that amount and try to sweeten the deal for the provider in your offer, and you're paying more as a carrier, that is going to increase the cost-sharing if a consumer has a deductible and coinsurance. That higher award that the carrier's negotiating on behalf of the consumer, in some respects, and that higher payment level will cost the consumer more in their cost-sharing. And obviously -- I think in chapter 78 -- for the State employees -- they pay -- I think it's up to 35 percent of the premium. To the extent that claims costs are reduced, that will help on the premium side for State employees and school employees as well. To the extent that you have higher reimbursement levels, obviously, it's more advantageous for the provider community. And I guess this is one of those "eyes of the beholder" questions -- where's the sweet spot in all this -- that I just think it's a little bit too early to judge this a failure at trying to find that sweet spot.

SENATOR POU: Thank you.

MR. SANDERS: I only have another hour, I swear. (laughter)

SENATOR POU: Oh, okay.

Did you want to provide us with any additional information of your testimony -- that you wanted to share?

MR. SANDERS: I think I'm okay in the testimony; I do-- You know, there was a lot of stuff that was talked about today that I think is -- might benefit from some clarity and some discussion.

SENATOR POU: I think that would be helpful.

MR. SANDERS: And so we'll try to listen back to the testimony and provide some thoughtful commentary and some suggestions.

SENATOR POU: So I'm going to ask for you to do that. And then, when you do that, if you can provide it through the Chair--

MR. SANDERS: Absolutely.

SENATOR POU: --and I'll make sure that all of our members get a copy of that.

I think today's conversation has certainly helped to address a number of different issues. Many, many questions still remain; and I agree with you -- I think while we all have our own opinion as to how long it took and how we all got here, I do agree that we should be closely monitoring this, over the next couple of months. Because as the Commissioner did -- as she stated in her testimony, two things. One is that while it is true that the regulations have not yet been formally submitted, and announced, and officially adopted, she did make reference to the fact that much of what she expects that will be in those regulations, will be very likely to mirror that of what her 28-page bulletin announcement, that was brought out and released in November. So we'll see how they might differ; how greatly they might differ from that particular area. Somehow she appeared to indicate that that may not be that big of a difference.

I know that she's still taking meetings, and conversations, and discussions with stakeholders. So to the extent that anyone -- and all of you

-- want to continue to push that information and that envelope to her in that regard, I suggest that you continue to do that, so that can be clearly and properly responded to in the regs, if that is to be the case.

I also know that -- my final statement on that, with regards to her testimony -- one of the things that she did also say is that she will be coming back to us in a year and providing a report on the outcome of the implementation of this new law, and how the program is working; and what is the experience of both the carrier, the providers, and that of the implementation of the arbitration process.

So I think all of us will certainly be looking forward to that, at the time. But clearly, there's some other, more immediate situations that I think came out of this meeting.

And we still have yet to hear from our two final speakers -- I think we have three -- they're all coming up as a group -- but we want to be able to make sure to get everyone's input.

Thank you, Ward.

MR. SANDERS: Thank you.

SENATOR POU: Thank you for your testimony, and we look forward to your information.

Thank you.

Our next speakers -- and I want to really extend my appreciation for your patience -- if you would please come forward, Dudley Burdge from the CWA; Bridgette Devane-- Is Bridget here?

UNIDENTIFIED MEMBER OF AUDIENCE: She  
(indiscernible)

SENATOR POU: Okay.

And thank you so much for your patience, Dudley.

And Maura Collings-- How do you say that?

**MAURA COLLINGSGRU:** (off mike) Collingsgru.

**SENATOR POU:** Collingsgru; thank you so much for your patience as well. And I promise to pay very close attention.

Thank you.

**DUDLEY BURDGE:** Well, I think we do want to thank you for the opportunity -- as I think you have pointed out with Ward -- to listen to all the testimony today and take it all in.

Do you want to go first?

**MS. COLLINGSGRU:** I will keep it really brief.

I don't know that, after such a long day, anything really needs to be repeated. And we, too, will digest this and respond, I think, more thoroughly in a letter to the Committee.

Just a couple things that weren't pointed out that I think are really important to note.

The history of this Bill -- and the context that this discussion needs to have that's missing -- is that, on an annual basis, 168,000 New Jerseyans were receiving these inadvertent out-of-network bills where they had no control; they were just victimized by these bills. And many of them were having immense problems with medical debt and things like that. This was a long-standing problem hundreds of thousands of New Jerseyans had to deal with. So that was the context of what we're talking about.

And I've not heard a lot about consumers today, which is a little concerning to me.

I would also, like Ward, encourage you to not take things at face value. There were a lot of linkages made that have nothing to do with this Bill.

Having sat through several years of exhaustive negotiations with every stakeholder, the sponsors of this Bill were really intentional in bringing all the stakeholders in. And for me, it's a little ironic that some of the things I'm hearing them say we would like to have in this Bill -- they actually opposed in negotiation.

So there's a long, long history here; and I think it would behoove all of us to--

SENATOR POU: Maura, when you say *they*, who are you referring to? The providers or the carriers?

MS. COLLINGSGRU: Well, some of the providers.

SENATOR POU: Okay.

MS. COLLINGSGRU: I think that it would behoove us all to just breathe a little. I do think a three-month implementation was very ambitious; but I have to say, as a consumer advocate, we had no intention of slowing it down. We had people, on a daily basis, who were impacted. We had people call us in August, "Am I covered?" "No, you're not yet." So people were dealing with these problems right up until the date of implementation. And we can't help them, but we can help this going forward.

And to do that, I think what we can do is really make sure that we're clear about these things, like the ID card. There was a provision that the ID card must have a marker on it to let providers know that this plan had opted in.

The ERISA issue is not something any of us can deal with, and that's being dealt with at the Federal level.

The requirement a doctor talked about at 2 o'clock in the morning, and having to give this information. There is no requirement in an emergency to divulge the information at that point, right? You have time to get that information to a consumer.

SENATOR POU: So if I may just stop you there. Because I know that we heard from two of the physicians who talked about that.

MS. COLLINGSGRU: Yes.

SENATOR POU: And I don't know that it's clear to them that -- how they are to perform that responsibility. And I think they're looking for guidance; that's what I got out of it.

And I think you're absolutely correct. This hearing was to really be a combination of multiple issues; certainly, the consumer being our number one. But I think in order to also help them we need to ensure that the providers and the carriers have a full understanding of what their responsibilities are.

MS. COLLINGSGRU: Sure.

SENATOR POU: And to the extent that they don't want to be in non-compliance, or in violation and reportable to the -- what did they say it was? The medical--

MS. COLLINGSGRU: The Medical Examiner.

SENATOR POU: The Medical Examiner, right; the Board of Medical Examiners. To the extent that they don't want to do that, that's really the point that I think-- They were looking for guidance. I think you helped to -- when you make mention of that, that certainly, then, poses the

question -- if you're making that statement, where are you in the law, in the statute? Where is that clearly stated or stipulated?

MS. COLLINGSGRU: I don't have the law with me; but I know--

SENATOR POU: No, no, no; I'm sorry. I don't mean to say--

MS. COLLINGSGRU: Yes.

SENATOR POU: --tell me right this very second.

MS. COLLINGSGRU: Oh, okay.

SENATOR POU: I'm just saying I would be interested to see where, in the law, it's clearly stated that those steps are defined, in terms of making sure that that's the case.

MS. COLLINGSGRU: So I think there are two things, right? The guidance that's coming out--

SENATOR POU: Right.

MS. COLLINGSGRU: --and the guidance that's been issued to date, I think is still trickling down -- not just to providers, but to consumers.

SENATOR POU: Yes.

MS. COLLINGSGRU: Like, I'm here today to say, "Can we have, as we're having this discussion -- let's talk about a public education campaign." When you go to the DOBI website, it should be front and center. Here's the information, not only for consumers -- but providers could access that information. So there are some real commonsense things we can do.

It is -- you know, there's a lot to be said about the fact that we did not set a specific payment parameter; and there were many stakeholders who disagreed with doing that. And one of the reasons was, you can't --

you would have a one-size-fits-all solution. If you say you're a neurosurgeon, it doesn't matter if you're out-of-network; whatever your situation is, you get paid X amount -- a percentage of Medicare. That would be one-size-fits-all. The problem is, is that when we look at this payment issue, we have to keep in mind many providers had a business model to be out-of-network. That is how they made oodles of money. They're not going to make that money now, and they shouldn't be making that money. But a fair payment system is definitely something worthy of having. But I would urge the Committee, and all the legislators, to wait for the information and allow this law to really be fully implemented; and allow things to unwind as they are currently going. Because I just don't think-- The house is not burning down.

So, thank you. I wish I could buy you all dinner, but--  
(laughter)

SENATOR POU: Thank you for the offer, just the same -- or the thought, I should say.

MS. COLLINGSGRU: And I do have HPAE, Bridget Devane--

SENATOR POU: Yes.

MS. COLLINGSGRU: They were here, but they had to leave. So I do have their testimony, and I will give that to you.

SENATOR POU: Thank you; thank you very much.

Dudley.

MR. BURDGE: Well, I have written testimony; and it's going to hit some of the same points.

And I think there are two really major points. The first is, I just -- a little bit from you, Madam Chairperson, and from Senator Vitale.

You know, this is just an astoundingly expensive state for health care. I mean, it's really off the charts, and we're not getting better. You know, we used to be neck-and-neck with Massachusetts; well, since part of, so-called, *Romneycare* was -- they began to set yearly targets for healthcare expenditures in Massachusetts. And I was very skeptical that that would work. But, you know, the proof seems to be in the numbers. They are now -- I think they're about 18 percent less, when you look at some of the national surveys of the Health Care Cost Institute that takes data from Medicare and from most of the major carriers.

And, you know, really pretty much in terms of the East Coast, you know, we are at the top. And so, really, the only states that are above us are small, rural states that I suspect, part of the problem is, because they have a lot of small hospitals. And, you know, there are expenses in running a hospital, no matter what the size. And, you know, in some sense you can say they're less efficient; but, you know, they have a different situation that we don't have in New Jersey.

The other thing, in terms of price, is-- You know, looking at the Health Care Cost Institute study -- the place where New Jersey is really much more expensive than other places -- it's pretty much expensive across the board -- but it's professional services, which, you know, we've been talking about, pretty much, all day here.

The other kind of point on this is, I think that we haven't talked about -- and I'm not sure why this is the case -- the impact on ordinary people in New Jersey. And, I mean, we're talking about, typically, family health plans. If you're in, you know, a decent-sized group that goes anywhere from, you know, \$25,000 to \$30,000 a year. And, you know, I

think the average is, people pay now, 26 percent of premiums. And, you know, the Kaiser Family Fund says that, essentially, families end up paying about 40, 45 percent of health care. You know, that's in the \$10,000 to \$12,000 a year bracket. And I'm not criticizing this; and it's a conversation that we had. But, you know, we talk constantly about the property tax burden. Well, you know, the health care burden on families is really very similar in a lot of ways.

So, I mean, kind of, I think that the point we make is -- at the CWA -- that, you know, if the Legislature is looking at any changes, that they keep that in mind -- that particularly high cost in New Jersey, and do nothing to exacerbate that.

The other thing I wanted to talk about is, as you know, CWA recently came to a collective bargaining agreement with the State and with the Governor. And we went in-- I guess if I were following Maura, the one-size-fits-all matter -- although I think it's a little more complicated and a little more nuanced than that.

So we switched from using Fair Health -- which I think is a problematic system, because it's prone to manipulation -- to 175 percent of Medicare for out-of-network, and produced really significant savings from that. Which is-- You know, I think we all were pretty surprised when the Governor indicated that, actually, healthcare costs for the State, in terms of employees and retirees, were going to go down pretty significantly this year. And that's a piece of it. And, you know, I think the anticipation is, most of the State employees will be going to that.

And, you know, we would just submit for your consideration that that might be a system that we should take a look at and see how it

works. Because I think there's some advantages to it. One which I didn't hear discussed at all today is-- I think somebody said, "Well, the providers aren't going to like the percentage of Medicare." And that may be true of many of the providers who were here today; maybe not all of them.

But there are a lot of people who don't do well under the current system; and, you know, I'm particularly talking about speech therapists, primary care doctors, mental health therapists. And that actually our anticipation -- even though there's going to be very significant savings, from going to 175 percent -- that the speech therapists are going -- if they're out-of-network, they're going to get paid more; that the mental health therapists are going to get paid more.

So thank you very much for your time.

SENATOR POU: Thank you, thank you.

Did you have any questions? (no response)

Thank you so very much, Dudley and Maura.

Again, thank you for your testimony; but also for your patience in waiting until this point.

MR. BURDGE: Thank you for yours.

SENATOR POU: Ladies and gentlemen, I thank you, once again.

That concludes our Senate Commerce Committee hearing on the out-of-network discussion.

Senator Lagana, did you have any parting last words? I'm going to -- you have been so good being here. Do you want to say good night to everyone? (laughter)

SENATOR LAGANA: I just want to say thank you, to you, Chair, for having this Committee hearing.

Thank you to the Senator President for working with us on this.

I agree with all the stakeholders; and I mentioned this early on -- this is about protecting the consumer; I mean, first and foremost. And the cost of health care has become a tremendous burden, which we do need to kind of rein in.

I think that there is a happy medium, somewhere along the line here. We are working out a lot of the kinks that we've kind of talked about early on. I look forward to working with all the interested parties to just kind of keep an eye on this and make sure that the law gets implemented the way it should have, and that the spirit of the legislation reaches its full extent.

So I thank everyone; I look forward to, maybe, some future meetings. Although they probably won't let me sub in again; (laughter) but I loved being here today, so thank you for having me.

SENATOR POU: We loved having you.

So thank you, Senator; thank you very much.

Good night, everyone. Have a safe trip home.

**(MEETING CONCLUDED)**