Access to Care Coalition

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Dear Commissioner:

As the Access to Care Coalition, we write to provide analysis and suggestions for implementation of the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" (P.L.2018, c.32).

As a general note, we would greatly appreciate public guidance from the Department about the effective date of the new law. **If no sections take effect before regulations are promulgated, it would be a great help for stakeholders to be advised of that**.

PHYSICIAN DISCLOSURE

Physicians stand ready to comply with the disclosure requirements of the bill. We will seek guidance from the Department of Law and Public Safety and advise DOBI of any requests made to that Department.

As for interactions with health insurance laws, we urge DOBI to **clarify and ensure that carriers shall not be permitted to use any minor or accidental compliance error to deny, delay, or recoup payment.** The penalties in the new law should be the only repercussion of any violations of the disclosure requirements.

CARRIER DISCLOSURE

We hope that the following information required by Section 6 of the new law is **proactively (not passively through a website) provided** at the beginning of any coverage period, and upon any change in policy and renewals:
1) a clear and understandable description of the plan's out-of-network health care benefits, including the methodology used by the entity to determine the allowed amount for out-of-network services;
(2) the allowed amount the plan will reimburse under that methodology.

We also hope that **DOBI specifically requires that the same methodology and consistent benchmarking is used throughout various documents.** For example, currently, carriers will state their benefit or allowed amount as a percentage of Medicare in one place and then as a percentage of Fair Health in another. This inconsistency increases confusion for patients and physicians.

We anticipate that carriers may refer to the consumer tools provided by Fair Health to comply with these disclosure requirements also in Section 6 of the new law:
(1) examples of anticipated out-of-pocket costs for frequently billed out-of-network services;
(2) information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services.

However, **we urge DOBI to explicitly require that the information required above is accurate and cannot be changed without notice or appeal**. In many cases, physicians' staff contact payers in an effort to provide patients with accurate cost information prior to scheduled procedures, only to later receive payment much lower than the originally stated amount. This, of course, leads to surprise patient billing.

We note that the new law specifies that the Commissioner may add requirements. We urge the Department to **require explanations to patients and physicians regarding State laws that apply to a claim**. Part of the confusion has been that, even under current laws, carriers do not explain on Explanation of Benefits forms (EOBs) and Remittance Advice letters (RAs) when a claim falls under state law (N.J.A.C. 11:22-5.8), which requires that at an in-network facility:
1) the patient will only be responsible for the in network rate and
2) the carrier is responsible for paying the provider either the statutory rate (SHBP or SEHBP) or some other negotiated rate to cover the cost of care.

We also ask that EOBs and RAs for patients with SHB and SEHB Program plans state the relevant payment laws so that patient liabilities and payment requirements are clear (N.J.S.A. 52:14-17.46.7 and 52:14-17.29).

Finally, we remind the Department that the disclosure requirements for carriers only apply to State-regulated plans, i.e. about 30% of the market. We urge enactment of an employer mandate to help the remaining New Jerseyans better understand benefits under their plans and ask for your support in continuing that effort so that patients' literacy on the most important piece of determining their costs is as robust as possible.
See: http://www.njleg.state.nj.us/2018/Bills/S1000/791_I1.HTM

In the meantime, at the least, through DOBI regulations, **carriers should be mandated to "opt in" to disclosure requirements in Section 6 of P.L. 2018 c32 if they choose to "opt in" to Section 10**.

PROVIDER/CARRIER ARBITRATION – IMPLEMENTATION
We urge the Department to implement the new provider/carrier arbitration system within the existing framework. Given that the law states that DOBI may use the current vendor, we encourage Maximus to administer the new system. We envision a two track system, with the only difference to initiate arbitration being that the existing PICPA track has a $1000 minimum claim threshold and the new track has a $1000 delta between the charge and carrier's offer as the trigger. The only difference between the results should be that the existing PICPA track uses traditional arbitration, with the arbitrator being allowed to come up with a fair settlement payment amount (capped at the 90th percentile of Fair Health, based on the SHBP statute), and the new track requires the arbitrator to pick either the provider or carrier's final offer (baseball style). The arguments and rationale offered by either side to defend their requests should remain open for either track.

On the new $1000 arbitration threshold, we would appreciate if the Department **would clarify if the trigger applies to the original charge and offer of payment or the final offer.** For example, if the charge is $2000, but carrier offers $1000, then offers $1500, should the physician initiate baseball arbitrate or should she use the existing PICPA framework if she does not wish to accept the $1500?

PROVIDER/CARRIER ARBITRATION – OPT IN

The Coalition is very concerned about the federal preemption issues with the opt-in provision. We believe that federal law, including case law like the U.S. Supreme Court *Gobielle* case, prohibit the State from adjudicating federally-regulated claims through arbitration. Physicians should have the right to expect federal law to regulate billing and payment if they treat a patient with a federally-regulated plan.

If the opt in does stand, we hope that **DOBI will share annual statistics** of how many employers opt in and how many employees are covered, so that stakeholders may assess trends in the marketplace. We are interested to see if the 70/30 split of federal/state plan coverage changes. We also hope that **DOBI advises healthcare providers (via groups like NJHA and MSNJ) when employers opt in,** so that local providers are prepared. Though the information will appear on a patient's insurance card, it will also be very helpful for providers to know who the employer is. For example, if a practice serves a large group of employees from ABC Corporation in Camden County, the practice should be able to anticipate changing billing and payment for that patient population. This opt in information should also be posted on the Department's website.

PATIENT ARBITRATION

The physician community is greatly concerned about the new patient arbitration, as it is heavily slanted against physicians. As such, it should be a narrow and limited option for patients if it is deemed legal. Employers who do not opt in to the new law should not be able to use this as a tool to punish or attack physicians who treat their employees. We feel strongly that there are federal preemption issues in allowing a patient to dispute a charge if it has already been submitted to a federally-regulated plan for payment. As such, **this new mechanism should only apply if insurance is not billed or the patient is uninsured.**

The "hold harmless" required by N.J.A.C. 11:22-5.8 cannot be extended to patients with federal plans without the opt in, since it would unfairly limit physician leverage and payment security. But, this arbitration system is an end run creating the same one-sided prohibition. The fact that the arbitration is binding on what a physician can collect, but non-binding on what the carrier must pay, is patently unfair. It essentially only brings the "hold harmless" provisions of State law into play, without providing physicians with payment security on the back end, since, due to preemption, a federally-regulated plan can pay or not pay whatever it wishes. As we have stated, the front end and back end must work together to shield patients from unfair charges while balancing the need to keep physician practices solvent and maintain patient access to quality care in the State. (The SHBP is a perfect example of this balanced system, with a hold harmless for patients, but also a requirement of a payment of 70% of the 90th percentile of Usual Customary Rate (UCR) for the out-of-network physician. This system has not incented physicians to be out of network or increase charges.) As such, i**f the arbitration is non-binding on the carrier, it should also be non-binding on the physician**. Otherwise, the State is interfering with federal claim payment processes. No other state allows patient arbitration for federally-regulated plans for precisely these preemption concerns.

Finally, there is no threshold or minimum charge or delta amount to trigger arbitration, so that patients may initiate arbitration for **any** inadvertent charge. **We recommend using the Fair Health charge database as a UCR benchmark, as New York does in its provider/carrier arbitration, and ask that DOBI set a threshold so that any charge at or below the 80th percentile of the scale for a particular code is considered fair and may not be arbitrated**.

As a reminder, the Board of Medical Examiners already allows patients to file complaints about "excessive" fees.

WAIVER OF COST SHARING

The legislative intent of this provision of the new law, which was previously a stand-alone bill, was to prohibit advertisements and announcements of "free" care for patients. This behavior has largely been addressed. As such, we urge a narrow application to this potentially disruptive prohibition. First, due to the preemption issues discussed above, we **urge DOBI to clarify that this new prohibition applies only to patients with State-regulated plans.**

Second, **we seek clarification that a "pattern" of waivers cannot be inducement if it is done after a service and that an "inducement" must also be defined as a promise of waiver before care is rendered**. Case law supports this interpretation, as stated in *Garcia v. Health Net of N.J.* (App. Div. 2009) (unpublished), in which the court stated that submission of claim and failure to collect co-pay is not unlawful where the provider had the right to collect but did not always do so.

In addition, we seek clarification on the safe harbors allowed by the new law. We assume that waivers for indigent patients, especially in the age of the rise of high deductible plans, are not illegal. We **urge DOBI to provide examples of safe harbor provisions that apply, including federal provisions, and to state clearly that any additions or expansions also apply** (for example, HHS OIG just expanded safe harbors in 2016).

For example, under federal law, remuneration does not mean the waiver of copays and deductibles if:
(i) the waiver is not offered as part of any advertisement or solicitation; (ii) the person does not routinely waive coinsurance or deductible amounts; and (iii) the person (I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or (II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts.
https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm

https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol5/xml/CFR-2017-title42-vol5-part1003.xml#seqnum1003.160

In addition, certain federal laws offer:

- protection for certain cost-sharing waivers, including: pharmacy waivers of cost-sharing for financially needy beneficiaries; and waivers of cost-sharing for emergency ambulance services furnished by State- or municipality-owned ambulance services;
- protection for certain remuneration between Medicare Advantage (MA) organizations and federally qualified health centers (FQHCs);
- protection for discounts by manufacturers on drugs furnished to beneficiaries under the Medicare Coverage Gap Discount Program; and
- protection for free or discounted local transportation services that meet specified criteria

Federal law also allows:

- copayment reductions for certain hospital outpatient department services;
- certain waiver that poses a **low risk of harm and promotes access to care;**
- coupons, rebates, or other retailer reward programs that meet specified requirements;
- certain waivers for **financially needy individuals;** and
- copayment waivers for the first fill of generic drugs.

Lastly, we **seek clarification that this new prohibition cannot be used as a reason for an accusation under the New Jersey Consumer Fraud Act or to the Office of Insurance Fraud Protection, used for any action or investigation by the Board of Medical Examiners or considered a violation of the New Jersey Insurance Fraud Prevention Act.** Again, case law supports this interpretation, as the Court in the *Garcia v. Health Net of N.J*. found no violation of the New Jersey Insurance Fraud Protection Act where the provider did not always collect co- insurance. We are already aware of "witch hunts" by carriers that can tie physician practices up with time and costs and hope to avoid the exacerbation of this practice.

NETWORK ADEQUACY

We thank DOBI for enforcing network adequacy standards and for looking into instances of access issues.

Numerous national medical societies and patient advocacy groups have formally called for more stringent state laws and regulations to specifically ensure patient access to in-network physicians at in-network facilities on a "reasonable and timely basis." See: *"Declaration on Network Adequacy and Patient Access to In-Network Physicians"* attached. Similarly, American Medical Association (AMA) policy, states:

> Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible. *Network Adequacy- H.285.908*

States are now specifically focusing on facility-based physicians. For example, in March 2016, California adopted new rules to require that health plans submit prior to approval:

> (14) A report describing, for each network hospital, the percentage of physicians in each of the specialties of (A) emergency medicine, (B) anesthesiology, (C) radiology, (D) pathology, and (E) neonatology practicing in the hospital who are in the insurer's network(s). *California Code of Regulations Title 10, Section 2240.5 (d) (14)*

Similarly, Louisiana establishes in law a network adequacy requirement that: "each health insurance issuer shall maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers." *RS 22:1019.2* Under this law, a: "Facility-based physician" means a physician licensed to practice medicine who is required by the base health care facility to provide services in a base health care facility, including an anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care services." *RS 22:1019.1*

In order to ensure that New Jersey patients have access to in-network physician specialists at hospitals and other facilities we **urge DOBI to require the newly required audits to specifically require that**:

> **A health insurance carrier shall annually submit to the Department an access report describing, for each network hospital, the percentage of physicians in each of the specialties of (A) emergency medicine, (B) anesthesiology, (C) radiology and radiation oncology, (D) pathology, and (E) hospitalists practicing in the hospital who are in the insurer's network(s) so as to ensure enrollees with reasonable and timely access to these in-network physicians.**
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> **When determining the adequacy of a proposed provider network, the Department must consider whether the health insurance carrier's proposed access plan includes a sufficient number of contracted providers practicing at the same facilities with which the carrier has contracted for the proposed network to reasonably ensure enrollees have in-network access for covered benefits delivered at that in-network facility.**

STATE COST AUDITS

In *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, 751, F.3d 740 (6th Cir. 2014), cert. denied, 135 U.S. 404 (U.S. Oct. 20, 2014), the Court affirmed a $6 million judgment for charging undisclosed fees to employee benefit plans and calling them medical costs. Blue Cross Blue Shield of Michigan was held liable for violating its fiduciary duties. Third party administrators (TPA), including managed care companies like the Blue Cross and Blue Shield entities, have an obligation to disclose and charge only fees that are permitted under their administrative services contracts. Sponsors of employee benefit plans, including employers and trustees of Taft-Hartley benefit plans, should be vigilant to make sure that administrators are not over-charging for their services. Sponsors should consider periodic audits to uncover and recover over-charges. The experience of Hi-Lex Controls demonstrates that third party administrators can and do over-charge for their services, and it is very unlikely that the over-charges are limited to Blue Cross Blue Shield of Michigan. Employers, including state and local governments, should ensure that third parties are working for them. This issue can seriously impact a government, union, or company's bottom line and the health of its employee/members. Costs for healthcare administration should be both legitimate and transparent. TPAs can and do hide "undisclosed" administrative compensation fees within medical claims payments. These undisclosed fees, which can account for 30%-60% of a plan sponsor's health care budget, may be siphoned into the TPA variance account through "retention reallocations" and "cross plan overpayment" offsets, among other techniques**. We urge DOBI to work with Treasury to audit TPA contracts and costs.**

CLOSING

Thank you for your consideration of our concerns and proposals for the implementation of P.L.2018, c.32. We believe they will improve patients' knowledge and navigation of the healthcare system.

A summary of our requests is attached. We are available for any follow up or information requests.

SUMMARY OF REQUESTED DOBI REGULATIONS:

Physician Disclosure:

1. Clarify and ensure that carriers are not be permitted to use any minor or accidental compliance error to deny, delay, or recoup payment.

Carrier Disclosure:

1. Require information to be proactively (not passively through a website) provided at the beginning of any coverage period, and upon any change in policy and renewals.
2. Require that the same methodology and consistent benchmarking are used throughout documents.
3. Require that the information provided is accurate and cannot be changed without notice or appeal.
4. Require Explanation of Benefits forms (EOBs) and Remittance Advice letters (RAs) to contain explanations to patients and physicians about which State laws apply to claims.
5. Mandate that carriers "opt in" to disclosure requirements if they choose to "opt in" to Section 10.

Provider/Carrier Arbitration

1. Establish a two track system and clarify if the trigger applies to the original charge and offer of payment or the final offer for the new track.
2. Share annual statistics of how many employers opt in and how many employees are covered.
3. Share names of employers that opt in each year.

Patient Arbitration:

1. Clarify that patient arbitration applies only if insurance is not billed or the patient is uninsured.
2. Make arbitration for physicians non-binding since it is non-binding on the carrier.
3. Set a threshold so that any charge at or below the 80th percentile of Fair Health for a particular code is considered fair and may not be arbitrated.

Waiver of Cost Sharing:

1. Clarify that this new prohibition applies only to patients with State-regulated plans.
2. Clarify that a "pattern" of waivers cannot be inducement if it is done after a service and that an "inducement" must also be defined as a promise of waiver before care is rendered.
3. Provide examples of safe harbor provisions that apply, including federal provisions, and state clearly that any additions or expansions also apply.
4. Clarify that this new prohibition cannot be used as a reason for an accusation under the NJ Consumer Fraud Act or to the Office of Insurance Fraud Protection, used for any action or investigation by the Board of Medical Examiners or considered a violation of the NJ Insurance Fraud Prevention Act.

Network Adequacy:

1. Require the newly required audits to specifically require that: A health insurance carrier shall annually submit to the Department an access report describing, for each network hospital, the percentage of physicians in each of the specialties of (A) emergency medicine, (B) anesthesiology, (C) radiology/radiation oncology, (D) pathology, and (E) hospitalists practicing in the hospital who are in the insurer's network(s).
2. Require a carrier's proposed access plan includes a sufficient number of contracted providers practicing at the same facilities with which the carrier has contracted for the proposed network.