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September 4, 2018

Dear Commissioner:

Thank you for the opportunity to comment on the Department's draft Bulletin which provides guidance on the implementation of the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" (P.L.2018, c.32). We appreciate your interest in our input and are available to answer any questions about the following comments and recommendations.

As a threshold matter, we are concerned about determinations of the applicability of the law. Based on the Bulletin, the Department is allowing carriers to make the determination as to whether a claim is a result of inadvertent or involuntary services. This is untenable, especially if a provider does not even engage with the carrier, as in the case of assigned benefits. As such, **treatment should be considered properly disclosed, thus NOT inadvertent or involuntary, unless otherwise known.** Further, any service provided by an out of network provider that is knowingly or voluntarily elected is outside of the purview of the hold harmless and arbitration processes. The Bulletin should state this clearly. We ask that the Bulletin clearly state that all elective voluntary care is excluded from the hold harmless and arbitration provisions and that any elective service provided with proper disclosures in compliance with C.26:2SS-5 is never an "inadvertent" service.

Despite properly executed multi-party disclosure requirements in the law, a carrier can conclude every out of network claim is inadvertent or involuntary without additional supporting documentation to the contrary. The broad and vague definition of "inadvertent out-of-network services" can potentially be abused by insurers to classify appropriately disclosed elective and scheduled services as "inadvertent," thus unfairly reducing payments or agreed upon patient liabilities. Physicians and facilities should not have to send signed disclosure forms with every claim to show that a patient knowingly and voluntarily elected treatment. Again, many providers do not send claims directly to carriers. In addition, for those facility-based physicians who do not see patients in advance of treatment (e.g. emergency and anesthesia), or at all (e.g. pathology and radiology), evidence of a facility disclosure of employed and contracted physicians should satisfy the provider disclosure requirements.

The Bulletin states that arbitration is not available for certain types of claims, including cosmetic care, without definition and without distinguishing between cosmetic services that are not a covered benefit and those that are medically necessary and a covered service (page 5). For example, post-mastectomy breast reconstruction is a covered medically necessary cosmetic service. It also excludes experimental or investigational treatment even if it may be a covered service. Preferably, these or any services should not be singled out without definitions or exceptions. We ask that the bullets be removed and replaced with: **a disclosed, voluntary treatment.**

If a service is truly inadvertent or involuntary, **the carrier's Explanation of Benefits (EOB) and Remittance Advice (RA) must clearly state that the claim falls under this law, which requires the patient to be held harmless to her in-network liability**, in addition to the information to be included in the EOB and RA required by the Bulletin (Initial Out Of Network Claims Processing section of the Bulletin). This is the first time a physician will see her balance billing limits and negotiation options. Otherwise, a physician will never know her patient billing parameters or her negotiation rights.

CLAIMS PROCESSING AND ARBITRATION

We greatly appreciate the Department's attempt to lay out the claim process from beginning to end. However, the Bulletin uses a term that is not used in healthcare, "**allowed charge**." A charge is a physician's fee or what she bills. Carriers use "allowed amounts" to determine payments, but that is not always the same as the offer of payment. For example, if there is an out of network benefit in the patient's plan, the carrier will likely offer to pay according to that benefit. As such, the terms "portion of the allowed charge" and "allowed charge" should be changed throughout the document and replaced with "**offer of payment**" in most instances.

Allowed charge is usually used in the document to reflect a carrier's payment, but it is sometimes used to reflect the physician's charge (e.g. the bullets at the bottom of page 3). In those instances, "allowed charge" should be changed to "charge."

The bullets at the end of page three should read as follows:

- That the final **offer of payment** has been successfully negotiated…;
- The amounts of the initial **charge**, initial carrier payment, and the covered person's cost-sharing based on those amounts;
- The amounts of the **final offer of payment**, and the covered person's final cost-sharing for the claim as of the time of reprocessing…

As for the information required in the initial EOB and RA, the Bulletin allows and requires the carrier **to use term "excessive"** with regard to billed charges**.** The use of this term is inappropriate. It is inflammatory and pejorative and will confuse patients. If the carrier is indicating that a charge is excessive, but a payment is later increased following negotiation or arbitration, the statement is incorrect. Further, it is inappropriate for carriers to determine "excessive" fees in a free market environment. Similar to premiums, pricing is a complex determination based on numerous federal and state legal and regulatory requirements with which a provider must comply. And, the term is no longer used due to national class action settlement agreements. The Medical Society of New Jersey (MSNJ) has discussed this with DOBI on several occasions over years, with a long-standing position against the use of "excessive fee" in communications from payers to patients. As they noted to DOBI in 2014, the court in one class action stated: "Consistent with the desire that Plan Members receive accurate communications that do not disparage Non-Participating Physicians, each such EOB shall indicate the amount for which the Physician may bill the Member and state 'physician may bill you' such amount, or contain language to substantially similar effect, and shall not characterize disallowed amounts as unreasonable." DOBI has consistently agreed and prohibited such language. As such, the notices should simply state that **the carrier disputes the charge.**

As for the timing of the steps of the negotiation, seven days for a provider to notify a carrier of intent to reject the carrier's payment is insufficient. In many instances, the remittance may not reach the correct person at the facility in that timeframe. Therefore, we respectfully **request that providers be afforded at the least the same amount of time that a carrier has to determine it will not pay charges: 20 days, not seven**. We also request that DOBI require carriers to recognize formally agreed upon **designees** to receive RAs. Finally, carriers should also be required to have an **electronic means for providers to notify that payment is rejected**, with automatic confirmation of receipt.

ARBITRATION OF CLAIMS FOR INADVERTANT AND INVOLUNTARY OUT-OF-NETWORK TREATMENT

Given that Maximus will be the vendor of the new system, **we ask that the Bulletin make clear that the existing Program for Independent Claims Payment Arbitration (PICPA) track still exists, highlighting the difference of the two $1,000 triggers**. The only other difference between the results should be that PICPA uses traditional arbitration, with the arbitrator being allowed to come up with a fair settlement payment amount, 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. PICPA is a mature program with detailed instructions and FAQs, which parties should still be able to rely on going forward.

Maintaining both tracks is particularly important because of the Department's statement that in-plan exception claims are not eligible for the new track (page 5). We question the rationale of this decision, as physicians who provide care when the carrier has failed to provide an adequate network should be first in line to receive fair payments for their services. If the patient is held harmless, the physician should be made whole. **We urge the Department to either remove the prohibition or clarify that these physicians may use the existing PICPA program, since they provided a benefit to both the patient and carrier.** An in-plan exception is not the same as a single case agreement, in which there is a negotiated arrangement between a physician and carrier.

In addition, we urge the Department to clarify that the *Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims* may be used as the required **Consent to Release of Medical Records for Claim Payment and Arbitration** form, since it is used for patient consent in PICPA today.

Finally, we urge the Department to clarify that a **carrier's payment is considered paid when deposited, especially since the option for arbitration is closed 30 days after a "final" payment is made. Payments are usually made by electronic funds transfer, so the deposits can be tracked.**

PROCESS FOR ARBITRATION WITHOUT OPT-IN BY SELF-FUNDED HEALTH BENEFIT PLANS

The physician community is greatly concerned about the new patient arbitration, as it is heavily slanted against physicians after they provide critical care, exacerbating the insurance industry-created tension between physicians and patients. As such, it should be a narrow and limited option for patients, if it is deemed legal. Self-funded 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, **a patient with an out-of-network benefit should not have access to this arbitration**, since the plan dictates how the claim should be adjudicated. It should also be clear it is **not available for voluntary services**, since the other arbitration provisions only apply to "inadvertent out-of-network services, or services at an in-network or out-of-network health care facility on an emergency or urgent basis."

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 State Health Benefits Program is a perfect example of this balanced system, with a hold harmless for patients, but also a requirement of a payment of percentages 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 amount to trigger patient 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. We ask that the Department 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 by a patient**.

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

OUT-OF-NETWORK BILLING AND COST SHARING WAIVERS

We urge the Department to require initial EOBs and RAs issued for out of network claims to include a patient's in-network liability formula and dollar amount. Otherwise, physicians will not know what it is and will not be able to comply with the requirements of C.26-2SS-7(a).

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 before, 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 failure to collect co-pay is not unlawful.

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 high deductible plans, are not illegal. We **urge the Department to provide examples of safe harbor provisions that apply, including federal provisions, and to state clearly that any additions or expansions also apply** (e.g. 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. See https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm and 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;
- Certain remuneration between Medicare Advantage (MA) organizations and federally qualified health centers (FQHCs);
- Discounts by manufacturers on drugs furnished to beneficiaries under the Medicare Coverage Gap Discount Program; and
- Free or discounted local transportation services that meet specified criteria

Federal law also allows:

- Copayment reductions for certain hospital outpatient department services;
- Certain waivers that pose 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 when 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.

DISCLOSURE AND TRANSPARENCY

We note that very important aspects of mandated carrier disclosures are left out of the Bulletin. C.26:2SS-6 of the law requires disclosures to reduce patient surprises and increase their ability to estimate their costs. The Bulletin references the requirement for carries to explain out of network benefits, but leaves off the important details that follow the requirement. As such, we urge the addition of the rest of the requirements into the Bulletin:

> "b.(1)…including the methodology used by the entity to determine the allowed amount for out-of-network services;
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> (2) the allowed amount the plan will reimburse under that methodology and, in situations in which a covered person requests allowed amounts associated with a specific Current Procedural Terminology code, the portion of the allowed amount the plan will reimburse and the portion of the allowed amount that the covered person will pay, including an explanation that the covered person will be required to pay the difference between the allowed amount as defined by the carrier's plan and the charges billed by an out-of-network provider;
>
> (3) examples of anticipated out-of-pocket costs for frequently billed out-of-network services;
>
> (4) 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;
>
> (5) information in response to a covered person's request, concerning whether a health care provider is an in-network provider."

We urge the Department to add these details to the bulletin. As stated in our July letter, we hope that **the Department 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 urge the Department 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 also ask that EOBs and RAs for patients with State Health Benefits and Small Employer Health Benefits 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, it should be made clear in this Bulletin that **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**.

SPECIFIC DISCLOSURES (Page 13)

Though it is listed in the disclosure section, our concern with the following portion of the Bulletin is actually more procedural. The third, fourth and fifth bullets of the list of **specific disclosures** seem to interpret the new law to allow increased patient cost-sharing when a claim is settled through negotiation, but not when it is settled through arbitration. This is repeated in the template located in the Appendix. However, this interpretation creates problems with compliance with benefit design and the law itself. It seems that the Bulletin is acknowledging that plan documents and plan benefit structures should be honored so that, if a patient's liability under a plan is a percentage of a total payment, then her liability goes up as the total goes up. The law requires physicians to collect whatever is due unless there is hardship. As such, pursuant to this Bulletin, physicians would be violating the waiver prohibition, if they do not collect the increased patient liability according to the plan's formula if the liability goes up based on an arbitration. Creating two different patient liability scenarios, in spite of the plan's formula or the waiver prohibition is problematic. We urge the Department to apply consistent patient liability requirements in the spirit of the law's aim to clarify and simplify the patient's role in the claim process.

If the Department decides that negotiation and arbitration do in fact create different patient liabilities, the Bulletin should state clearly that the "settlement may increase the covered' person's cost sharing above the amount indicated in the initial EOB" **based on the person's insurance plan benefit design.**

CLOSING

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

Access to Coalition Members:

American College of Surgeons, New Jersey Chapter
Medical Society of New Jersey
Mednax
NJ American College of Emergency Physicians
NJ Spine Society
New Jersey Academy of Family Physicians
New Jersey Academy of Ophthalmologists
New Jersey Association of Ambulatory Surgery Centers
New Jersey Association of Osteopathic Physicians and Surgeons
The Medical Transportation Association of New Jersey
New Jersey College of Emergency Physicians
New Jersey Neurosurgical Society
New Jersey Orthopedic Society
New Jersey Patient Care and Access Coalition
New Jersey Podiatric Medical Society
New Jersey Society of Emergency Surgeons
New Jersey Society of Interventional Pain Physicians
New Jersey Society of Pathologists
New Jersey Society of Plastic Surgeons
New Jersey State Society of Anesthesiologists
Radiology Society of NJ