MSNJ
MEDICAL SOCIETY OF NEW JERSEY

PHONE: 609●896●1766 | **FAX**: 609●896●1368 | **WEB SITE**: www.msnj.org
2 PRINCESS ROAD | LAWRENCEVILLE, NJ 08648-2302

October 26, 2016

Dear Chairman and Members of the Assembly Appropriations Committee:

The Medical Society of New Jersey (MSNJ) supports increased transparency on cost and liability for patients. However, we oppose legislation that arbitrarily reduces payments to dedicated physicians who provide quality care. On behalf of thousands of members, **MSNJ respectfully opposes A-1952.**

According to a recently released survey conducted by New Jersey law firm Brach Eichler, most New Jersey physicians (95.31%, up from 89.89% in 2014) believe that the changing healthcare environment has negatively impacted them. More than 39% said that they felt an increased administrative burden (e.g. insurance paperwork), while 26.5% said reduced reimbursement and 15.6% reported reduced time spent with patients were among the most harmful changes. We ask the committee to be cognizant of this dire outlook and ask that we maintain our shared desire to ensure we retain the best quality of care and access to care in New Jersey by retaining the best physicians.

STATE-REGULATED PLANS

New Jersey limited patient costs decades ago. For patients with State-regulated health plans, State regulation (N.J.A.C. 11:22-5.8) protects patients from exposure to out of network bills by limiting their liability to in network rates for emergency and other hospital services. On the back end, healthcare providers rely on the patient's health insurance company to cover the rest of the cost of the healthcare service that has already been provided. This removal of payment anxiety helps patients focus on their medical care. Insurers complain that providers exploit this patient protection, charging unfairly high rates, increasing their cost and forcing them to raise premiums to cover those costs. This is untrue. Most out of network charges are negotiated and paid at fair rates. For the few unusually high charges, the New Jersey Department Of Banking and Insurance (DOBI) has an arbitration program called Program for Independent Claims Payment Arbitration (PICPA), a **dispute resolution** process insurance companies may use to lower costs.

More importantly, insurers routinely fail to follow this patient protection rule. DOBI charged a landmark fine against Aetna in 2007 for "not attempting in good faith to effectuate prompt, fair and equitable satisfaction of claims for services rendered by non-participating providers for emergency care…" and "for failure to limit a covered person's liability for services rendered by non-participating providers for emergency care…." Just last month, DOBI fined UnitedHealthcare Insurance and related carriers (UHC), stating that "DOBI has received consumer complaints against UHC regarding balance billing and other collection activity by out-of-network providers" and showing that UHC "issued some Summary of Benefit and Coverage forms for calendar years 2015 and 2016 which incorrectly showed the network cost sharing amounts" for patients. They were underpaying providers and overcharging members, creating stress for both parties. **We must enforce our consumer protections before enacting new laws that punish physicians.**

MSNJ opposes A-1952 because it creates a new arbitration process that caps payments for all out of network physicians at drastically low rates (Medicare). This is especially punitive because patients are already protected by the **hold harmless regulation**. Legislation that changes the market so drastically as to reduce out of network payments to rates below in network rates is unproductive if we want to attract innovation and quality care. Out of network rates must be higher than in network to ensure that health insurers include an adequate number of physicians in their networks. Patients and employers pay for this coverage; they deserve the predictability and peace of mind of **robust networks**. Perverse incentives that allow insurers to avoid bringing physician in network harm patients. **Even if out of network costs are lowered for insurance companies, premiums will not go down. Health insurance profits are rising at record rates; savings are not returned to consumers.**

We recommend the use of the usual and customary rate (**UCR**) as a dispute resolution payment calculation or even a cap for truly high, outlier charges in State regulated plans. The SHBP uses Fair Health to determine UCR. **Fair Health** excludes high, outlier payments in its UCR calculations, so that savings are embedded. The SHBP caps out of network payments at a percentage of the database's UCR. Many other programs and states use Fair Health to make fair out of network payments, recognizing the need to retain quality physicians.

FEDERALLY-REGULATED PLANS AND ACA

Only about 30% of consumers in the state are protected by the hold harmless regulation. This is no surprise, as most consumers are insured through their employers, who largely choose plans outside of the purview of DOBI regulation, or through the ACA. Employers choose federally-regulated self-funded health plans for various reasons. One main reason is lower employer cost when compared to State plans. But, the plans often have higher cost sharing and exposure for employees. **Employers can easily limit this exposure by offering HSAs or HRAs or by choosing State-regulated plans**.

The good news is that the ACA also recognized the issue of surprise bills by emergency departments for New Jersey consumers with plans sold on the exchange. The law prohibits higher copayments or co-insurance for out-of-network emergency room services. But, health insurance companies have taken gross advantage of the ACA, slashing payments to physicians by as much as 70%. A New Jersey law codifying such payment reductions will be devastating. Physicians must be able to ask the insurers to cover the rest of the cost of care when patients are held harmless to amounts as low as zero.

STATE SAVINGS ARE LIMITED

There have been claims that this bill would reduce State costs, in particular health benefit programs, through the provisions allowing federally-regulated plans to "opt in" to a State dispute resolution program and payment cap. But, according to a report to the State from Horizon, only 15% of providers for SHBP are out of network and most of them are NOT hospital physicians. Horizon states that SHBP costs come from: physical therapy, acupuncture, behavioral and chiropractic services. If those out-of-network providers were brought in network, the report anticipates $150 million in savings, not $1 billion as some have stated. In fact, in another report to the State regarding potential savings, Horizon states that "**all anesthesiologists in New Jersey participate** so we have removed that one issue that had been problematic in the past." **It is clear that bringing physicians in network is the answer and hospital physicians are not the problem**.

COSTS WILL OUTWEIGH SAVINGS: Litigation on Medicare and Preemption

Only one other state has limited out of network payments to Medicare rates: California. The law was just signed in September and is already being litigated. The Association of American Physicians and Surgeons filed suit this month. "This bill basically empowers private insurance companies to set prices for physicians and other caregivers who are not even in their network." *Physicians sue over California law on out-of-network billing, San Francisco Chronicle, October 17, 2016*

There is also a great potential for litigation on the "opt in" scheme. The bill would allow self-insured plans to "opt in" to a State dispute resolution program for out of network claims. **Federal preemption** is the invalidation of a state law that conflicts with federal law. U.S. courts tend to side with the federal government in preemption cases. In *Gobeille v. Liberty Mutual Insurance Co.*, the Supreme Court recently ruled that state health claim databases cannot require federally regulated plans to share their data with them. If the sharing of this information is preempted, A-1952's opt in is also preempted. With the severability sections (20 and 21) upholding the patient billing ban, insurers will be off the hook and physicians will never have payment security under this bill.

CONCLUSION

We recognize the concern about "surprise" bills for patients exposed to bills for hospital-based care due to their employer-sponsored benefit structure. We strongly believe that increased **transparency** will reduce this concern. As such, we support A-4228, requiring increased notice by physicians, hospitals and insurance companies. We agree that each industry must do better at sharing information, including network status and estimated cost and liability for patients, so they are educated healthcare consumers.

A-1952 caps all out of network physician payments, even those who wish to be in network, but cannot find fair contracts or fair payments. State and federal law already limit patient costs for emergency and other hospital care. The best way to limit remaining costs is to require providers and carriers to educate consumers and require robust provider networks.

HEALTH INSURANCE COMPANIES ARE DOING WELL

The national average base salary for all insurance industry CEOs: $544,100 (not including bonuses and stock options). Compare this to the national family-practice physician average salary: $165,300
http://www.nytimes.com/interactive/2014/05/17/sunday-review/100000002886175.embedded.html

"And those numbers almost certainly understate the payment gap, since top executives frequently earn the bulk of their income in non-salary compensation…the chief executive of Aetna, earned a salary of about $977,000 in 2012 but a total compensation package of over $36 million, the bulk of it from stocks vested and options he exercised that year."
Medicine's Top Earners Are Not the M.D.s
http://www.nytimes.com/2014/05/18/sunday-review/doctors-salaries-are-not-the-big-cost.html?_r=0

In New Jersey "the CEO of Horizon drew a salary of nearly $935,000 and bonuses of $7.8 million in 2009. Pay and bonuses to the company's nine highest-paid executives that year totaled $24.3 million, up from $15.1 million the previous year."
Blue Cross executive pay scrutinized
http://www.northjersey.com/news/blue-cross-executive-pay-scrutinized-1.285927

Profit and salaries are only going up.

"Profit jumped almost 29% year over year in the first quarter, totaling more than $1.4 billion. UnitedHealth's revenue increased 13% to $35.8 billion."
UnitedHealth books another profitable quarter, raises 2015 outlook
http://www.modernhealthcare.com/article/20150416/NEWS/304169977

"Cigna's fourth-quarter net income was $467 million, compared with $361 million in the same period of 2013. Profit on the year increased 42% to $2.1 billion."
Cigna closes 2014 with profitable quarter
http://www.modernhealthcare.com/article/20150205/NEWS/150209968

"Aetna recorded more than $2 billion in profit in fiscal 2014, the highest level in the company's history and a signal that healthcare reform continues to treat the health insurance industry well."
Aetna closes 2014 with record profit, up 6.6% for the year
http://www.modernhealthcare.com/article/20150203/NEWS/302039967

"Simply put, greater access to health insurance has led to more customers for the insurance giants. And UnitedHealth is not the only company to benefit. The other four members of the so-called Big Five health insurers -- Aetna (AET), Cigna (CI), Humana (HUM), and Anthem (ANTM) (formerly WellPoint) -- have all beaten the S&P 500 over the past five years or so as well."
Thanks, Obamacare! Health insurer stocks soar
http://money.cnn.com/2015/01/21/investing/unitedhealth-earnings-obamacare

THE RECORD SEPTEMBER 13, 2016 LAST UPDATED: TUESDAY, SEPTEMBER 13, 2016, 1:20 AM

Opinion: Misleading health insurance plans must be fixed

BY LARRY DOWNS

THE RECENT expansion of complicated health plan benefit designs, with narrow provider networks, steep patient cost sharing and incomprehensible coverage limits, is enough to leave consumers wondering: What exactly did I "buy"?

Reports show that consumers are less and less satisfied with their plans, having little confidence that their health insurance will protect them financially if they or a family member become ill.

Even the most diligent consumers who take time to understand exactly how their health insurance policy works cannot get key information on payments. The surprise medical bill is a classic example. Even people who buy high-end policies with an out-of-network benefit so they may have a broad choice of health care options are seeing these bills. They pay higher premiums for the "luxury" of choosing physicians based on quality, rather than cost. But the often embarrassingly low payment for treatment creates large payment gaps that are passed along to patients, creating surprise bills.

Example
Suppose your health insurance coverage for out-of-network services is based on a 70/30 co-insurance benefit design. In this scenario, you would assume that you would pay 30 percent of the amount billed for a medical service. If your physician files a $1,000 claim to the health plan for an out-of-network service, your assumption is the health plan will pay $700 and you will pay $300 (30 percent).

This is not the case. Health plans pay their percentage of the claim based on what they think the service is worth – what they call the maximum allowable amount for that particular medical service. So for a $1,000 claim, the maximum allowable amount could be $530. This means that the insurance pays 70 percent of $530, which is only $374. The remaining portion of the $1,000 charge is left up to the patient, a whopping $626. Surprised?

Ironically, these low payments for health care services come as health insurance profits soar. As reported last year, all five of the major health insurers beat the S&P 500 index over the past five years.

Some say physicians and hospitals not participating in their plans drive large amounts of "cost" in the system. Yet insurance companies design physician and hospital networks that actually exclude large numbers of quality providers, creating more out-of-network providers and more consumer surprises.

Administrative costs
And, the fact is, physician payments make up a small percentage of health care costs. According to a recent study by the Commonwealth Fund, American insurers spent more than twice as much as any other developed country per person on administrative costs.

The percentage of premium revenue allocated to administrative costs and profit ranged from 16.5 to 27.1 percent. The interventions and profits of this third-party industry have only increased in the 20 years since that report, damaging patient access to quality care.
Physicians are on the front lines taking care of you and your family. While their focus should be solely on care, they instead must bear the brunt of patient frustration when insurers do not provide the coverage expected or promised.

The physician-patient relationship, which was once sacred, is marred today by mutual frustration toward third-party payers. But insurers can control cost and reduce frustration very simply: reduce administrative burden, cover the treatments needed to keep people healthy and include in their networks the dedicated physicians who provide those treatments.

Insurers should provide members with the access and coverage paid for through premiums – this is true consumer protection.