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June 28, 2017

The Honorable Loretta Weinberg
Senate Majority Leader
New Jersey Senate
State House
P.O. Box 099
Trenton, NJ 08625-0099

The Honorable Vincent Prieto
Speaker
New Jersey General Assembly
State House
P.O. Box 098
Trenton, NJ 08625-0098

Re: AMA concerns with S1285/A1952

Dear Majority Leader and Speaker:

On behalf of the American Medical Association (AMA) and our physician and student members, I write to state our concerns with Senate Bill (S) 1285 and Assembly Bill (A) 1952, and ask that you revise these bills to protect patients from unexpected out-of-network costs in a way that does not undercut incentives for insurers and physicians to fairly contract.

The AMA fully understands the need to address the issue of unanticipated patient costs, including costs that result from unexpectedly receiving out-of-network care at participating hospitals. In fact, at our recent House of Delegates Annual Meeting, policy on a fair solution to balance billing was adopted. (Policy attached.) The AMA supports holding patients harmless when they receive unanticipated out-of-network care, but such a hold harmless policy should be accompanied by strong network adequacy protections and a fair level of out-of-network coverage based on charges from an independent data source. A ban on balance billing without the other prongs can have a detrimental impact on the market and access to care.

S1285 and A1952 would force physicians to accept any contract terms offered by an insurer, fair or not, in order to practice at a hospital, and for hospital-based physicians, there is simply no alternative. Moreover, by capping physician payments at a percentage of Medicare or insurer-determined rates when a contract is not in place, physicians come to the negotiating table, if even invited, without any negotiating tools. This is antithetical to the way contract negotiations traditionally function, as insurers are incented to contract with physicians to receive discounted rates and physicians receive volume, prompt pay and other inducements. These bills make an already tilted playing field even more unfair for physicians.

In a market such as New Jersey's, where very few insurers dominate and fair contracting may already be challenged, out-of-network payments should not be subjectively determined by the insurers in a black box, but rather in a transparent fashion based on data from independent sources. This helps patients understand the scope of their coverage prior to hospital care, and physicians and insurers can negotiate contracts in good faith.

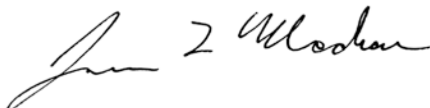
Moreover, if this legislation were to be enacted, it would eliminate options for physicians in the health care market in New Jersey, leading to even greater access issues for patients. Providers across the state will feel the impact of this legislation on their bottom lines, forcing them to make tough decisions that may include closing their practices and leaving the state. Moreover, it would not only impact patients who may not have access to hospital-based care, but New Jersey's economy as well. Physicians are a significant economic driver in New Jersey, creating $39 billion in economic output, supporting 234,906 jobs and contributing $1.7 billion in state and local tax revenues. As such, the AMA believes it is impossible to enact S1285 and A1952 without unintended consequences to New Jersey's economy.

Finally, the AMA believes this legislation would have a significant impact on health care innovation in your state. Now, more than ever, physicians are investing in technology to advance the care they provide. Electronic health records are expensive but allow physicians to share patient data with other providers, access registries and health information exchanges, e-prescribe, and complete authorizations in minutes rather than days. Additionally, physicians are investing in new delivery of care models such as accountable care organizations and other value-based designs. These new models have the potential to greatly improve coordination and quality of care for patients, but cannot be explored without significant investments from physicians and other health care providers. When New Jersey physicians are paid significantly below market rates, they simply will not be able to make these investments.

For the reasons above, we ask that you oppose S1285 and A1952 in their current forms. We would look forward to an opportunity to work with you and all New Jersey stakeholders to craft a solution to balance billing that protects patients by providing fair out-of-network coverage. If you have any questions, please contact Emily Carroll, Senior Legislative Attorney, Advocacy Resource Center at emily.carroll@ama-assn.org or (312) 464-4967.

Thank you for your consideration of our concerns.

Sincerely,



James L. Madara, MD

Attachment
cc: Medical Society of New Jersey

AMA Policy

AMA policy adopted at the 2017 Annual AMA House of Delegates meeting confirms the following principles related to unanticipated out-of-network care:

1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.