Out-of-Network Testimony

Assembly Financial Institutions and Insurance Committee
January 29, 2018

NJHA counts among its members nearly 400 hospitals, health systems and post-acute members across the state – a true community of healthcare providers caring for people in all settings. My name is Cathleen Bennett, President and CEO at NJHA. As a not-for-profit trade association, we work with our members to provide accessible and quality healthcare in their communities. As part of our recent strategic planning process, we are recommitting ourselves to the mission of improving the health of the people of New Jersey. Thank you for allowing me to testify today on this important issue.

Let me first start by saying this – NJHA agrees that patients should not be receiving surprise inadvertent out of network medical bills when they make every effort possible to access in-network services. As the point of service for many scheduled procedures, hospitals play a role in solving this problem.

We also feel strongly that protecting a patient from surprise medical bills is a shared responsibility among hospitals, physicians, and insurers. We commend the sponsors for dedicating much of their time to crafting legislation to protect patients from these bills. We also commend the sponsors for bringing multiple stakeholders to the table to offer constructive recommendations to improve the legislation, including NJHA.

Hospital Leadership

Hospitals and health systems have made great strides at improving quality and bending the cost curve. Working together through NJHA quality collaboratives, N.J. members have averted more than 77,000 cases of patient harm over five years, with $641 million in health cost savings. Our goal is "high-value" care – the highest quality at the lowest cost.

Let's face it: Navigating an insurance plan can be daunting for healthcare consumers. NJHA has provided many resources to help consumers better understand their insurance coverage and avoid getting a surprise medical bill. A few examples include:

- Our Price Compare website that provides information on hospital charges http://www.njhospitalpricecompare.com/;
- Our online Guide to Using Health Insurance http://www.njha.com/media/402101/putting-the-pieces-together-16.pdf which provides step-by-step information on issues such as referrals, pre-approvals and in network versus out of network;
- Our new online Consumer Resources portal with a wealth of practical information http://www.njha.com/njha-consumer-resources/; and
- Our Patient Financial Resource Toolkit which provides notification forms, sample web language and other tools for our members to help patients better understand insurance coverage, pricing and out-of-pocket costs http://www.njha.com/resources/toolkits/patient-financial-resouces-toolkit/

And in the event an individual receives a surprise medical bill, the NJHA Board of Trustees adopted Compassionate Billing Guidelines for our members to use when a patient is paying their own medical costs, including provisions for discounts and payment plans.

Provider / Payer Relationship

For hospitals to achieve the quality improvements and cost savings measures mentioned above, they must be paid fairly by insurance companies for care delivered. However, hospitals are constantly battling insurance companies for payments. According to our internal analysis, an estimated 130,000 managed care claims are denied annually, totaling about $250 million in reimbursement. Studies show that hospitals spend about $118 per appeal on average. Using that as a guidepost, we estimate that hospitals spend about $15 million annually on claims appeals. Hospitals win on appeal approximately 2/3 of the time. This means that hospitals are unnecessarily spending money and resources fighting for payments justly owed to them.

Hospitals are also feeling the pressure of unilateral changes being implemented by insurance companies. In December, Horizon NJ Health announced a policy change to its Medicaid managed care product for our most vulnerable population, stating that it will no longer reimburse hospitals for any costs related to the hospital readmission that happens fewer than 30 calendar days after the first admission unless it is determined to be medically necessary, with a few exceptions. For Medicaid patients, what happens in their homes and communities has a tremendous impact on their health – for example, do they have a home to be discharged to? Does it have heat? Do they have access to healthy foods, or transportation to their follow-up appointments? These are the social issues that fall to hospitals.

This is just one example of unilateral changes that insurance companies are making to avoid reimbursing hospitals what was negotiated and contracted for.

Concerns with Arbitration System

Over the past few years, NJHA has worked closely with the bill sponsors and stakeholders at achieving a legislative solution. We are grateful for all of the time, effort, and consideration given to the concerns of the hospital community on this bill. We also appreciate two key amendments to the legislation:

1. The bill removes the payment range previously included in the arbitration process that would have required payment to be no greater than 250% of the Medicare rate; and
2. The amendments to section 7c, which would have required hospitals to track all of the network statuses and billing practices of all of the physicians within the walls of the facility.

Despite these positive amendments, NJHA remains concerned with the current arbitration process within the bill. NJHA is willing to accept an arbitration process to resolve disputed out of network claims so long as the process does not favor one side over the other. The current version of the legislation allows the payer to withhold payment to the hospital for up to 60 days before making a final payment. This may cause significant cash flow issues for hospitals struggling to make payroll and provide exceptional levels of care to our patients.

We respectfully request that consideration be given to requiring an interim payment that must be made to the hospital in a timely manner. This would ensure that cash flow is not disturbed and would allow the provider and payer to continue to negotiate a fair rate, while the patient remains out of the deliberations.

It is our belief that the process as written would give the health insurance industry substantial leverage over the provider community when negotiating fair in-network rates. If a payer offers inadequate rates, the hospital's only leverage is to push away from the table. An arbitration system for out of network payments that unfairly benefits the insurance industry would provide leverage to the insurer to push the hospital out of network and at minimum significantly inhibit our abilities to negotiate adequate in-network rates.

Conclusion

NJHA wants to be a constructive partner with the Legislature and other stakeholders in the discussion of the out of network issue. We appreciate being asked to testify today and look forward to working with members of the committee over the next few weeks to improve this legislation for the patients of this state.

Thank you for allowing me to testify today on this very important issue.