EPSTEIN BECKER GREEN
employee benefits
CLIENT ALERT

August 2018

Self-Funded ERISA Health Plans and New Jersey's "Surprise" Out-of-Network Medical Bill Law: Are You In or Out? It's Time to Decide

By Tzvia Feiertag and Christopher A. McMican

On June 1, 2018, New Jersey Governor Phil Murphy signed the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act ("Surprise Medical Bill Law"), which is intended to protect against "surprise" out-of-network ("OON") medical bills for certain services. Examples would be medical bills related to emergency room visits performed by health care facilities and professionals in New Jersey where the patient had no choice in selecting the health care provider.

As detailed in our prior Client Alert, the Surprise Medical Bill Law applies to health care facilities, individual health care professionals, and carriers—as well as to self-funded health plans (defined by the Surprise Medical Bill Law as self-funded health plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA")) that voluntarily elect to be subject to its requirements ("Electing Plans"). ***Since the end-of-August effective date of the Surprise Medical Bill Law is quickly approaching, sponsors of self-funded ERISA health plans covering participants who receive health care services in New Jersey should now be considering whether they will elect to be subject to the Surprise Medical Bill Law's requirements and protections*.**

Self-Funded Health Plans Impacted by the Surprise Medical Bill Law

Although the Surprise Medical Bill Law will mostly impact employers with self-funded ERISA health plans covering employees (and their dependents) working and residing in New Jersey (as they are most likely to obtain health care services in the state), the law could potentially impact any self-funded ERISA health plan to the extent it covers participants (even those residing or living outside of New Jersey) who receive health care services in New Jersey. While not entirely clear, it would appear that self-funded health plans that are *not* governed by ERISA, such as government or church plans, are automatically subject to the law. In addition, multiple employer welfare arrangements (sometimes known as "MEWAs") are also subject to the new Surprise Medical Law as a "carrier." Fully insured health plans subject to the Surprise Medical Bill Law will need to

meet the new requirements, but the insurance carriers, and not the plan sponsors, will generally be responsible for compliance.

While many other states, including California and New York, have adopted or proposed similar "surprise medical bill" legislation, those bills generally have not applied to services covered by self-funded health plans. This makes New Jersey's Surprise Medical Bill Law unique in that it applies to self-funded ERISA health plans that opt in.

Protections, Requirements, and Disclosure Requirements of the Surprise Medical Bill Law Impacting Electing Plans

The Surprise Medical Bill Law provides new protections to patients receiving health care for "inadvertent" and "emergency or urgent" OON services in New Jersey, and is described as "in the public interest to reform the health care delivery system in New Jersey to enhance consumer protections, create a system to resolve certain health care billing disputes, contain rising costs, and measure success with respect to these goals." Generally, under the Surprise Medical Bill Law, health care facilities and providers are prohibited from billing a covered person for inadvertent, emergency, or urgent OON services (including laboratory testing ordered by an in-network provider and performed by an OON bioanalytical laboratory) in excess of that person's deductible, copayment, or coinsurance amount that would otherwise apply to similar in-network services under his or her health care plan. The Surprise Medical Bill Law also expressly prohibits an OON health care provider from waiving or rebating any cost sharing (such as a deductible, copayment, or coinsurance) as an incentive to induce a person to obtain health care services from that provider.

The Surprise Medical Bill Law includes an automatic assignment of payment to the health care provider for the OON services. This effectively requires insurance carriers and Electing Plans to pay any reimbursements directly to the provider without the covered person's involvement.

An Electing Plan is also required, among many other disclosure requirements, to ensure that covered persons know to forward to the Electing Plan any bills that they receive directly from an OON provider. Although not entirely clear from the statute, it appears that the Electing Plan can then either pay the billed amount or notify the provider within 20 days that it considers the bill to be excessive. If the latter is the case, the Electing Plan and the provider have 30 days to attempt to reach a settlement. If the Electing Plan and the provider are unable to reach an agreement, the Electing Plan will make a payment for the amount of its final offer, and, the provider, the Electing Plan, or a covered person can proceed to the Surprise Medical Bill Law's newly established binding arbitration provisions to address the disputed amount.

An Electing Plan must also, in a form and manner that is to be prescribed by the New Jersey Department of Banking and Insurance ("DOBI"), issue a health insurance identification card to the primary insured under the plan. The card must indicate that the plan is self-funded and has elected to be subject to the Surprise Medical Bill Law.

Election Process

An employer that sponsors a self-funded health plan that wishes to be subject to the Surprise Medical Bill Law must make an election by providing notice, on an annual basis, to the DOBI attesting to the Electing Plan's intended participation and agreement to comply with the Surprise Medical Bill Law. To date, the DOBI has not issued regulations or sub-regulatory guidance describing the manner in which a plan must give notice, but such guidance is expected prior to the effective date.

Interplay with Federal Law

Federal law contains similar rules that must be considered before an election is made. For example, the Affordable Care Act ("ACA") added new patient protections requiring federally regulated non-grandfathered group health plans to comply with the "Greatest of Three Rule" and reimburse for OON emergency services by paying the greatest of three possible amounts: (1) the amount negotiated with in-network providers for the emergency services furnished, (2) the amount for the emergency service calculated using the same method that the plan generally uses to determine payments for OON services (often, the "usual, customary, and reasonable charges") with in-network cost sharing, or (3) the amount that would be paid under Medicare for the emergency service.

Interim regulations issued in 2010 provide that the Greatest of Three Rule was intended to mitigate the financial risk that patients faced when health care providers balance bill for the difference between the provider charges and the amount collected from the plan (or health insurance carrier) and from the patient in the form of a copayment or coinsurance amount. Final regulations issued in 2015 under the ACA clarified that the Greatest of Three Rule did not prohibit balance billing; rather, the Greatest of Three Rule was designed to reduce potential amounts of balance billing to participants where the plan would pay a required amount, and it was ***not*** intended to apply in states, such as California, that effectively prohibit balance billing (with a few other caveats). At that time, there were some who were urging the government to require plans to use a transparent national database to determine a market rate for OON amounts. In response to litigation, the government, in a May 1, 2018, clarification to the final regulations, rejected the national database proposal and reiterated that the Greatest of Three Rule was intended "to establish a floor on the payment amount for out-of-network emergency services" and that states are free to enact rules that allow for payment of higher amounts by plans. With the enactment of the Surprise Medical Bill Law, New Jersey is doing just that.

On the ERISA front, the "preemption" doctrine generally allows self-funded ERISA plans operating in multiple states to be administered in a uniform manner, and employers are provided with great latitude to design their plans free from state mandates. Self-funded ERISA plans are generally not subject to state insurance mandates because of this preemption concept and its corollary (sometimes referred to as the "Deemer Clause") since self-funded plans are generally not "deemed" to be an insurance policy subject to state insurance mandates. The Surprise Medical Bill Law acknowledges that not all health plans are fully insured, and, as such, a self-funded ERISA health plan may opt

into the Surprise Medical Bill Law. The opt-in procedure seemingly is the new legislation's way of attempting to avoid preemption. Notably, there have also been recent attempts at federal legislation that would prohibit balance billing.

Considerations and Takeaways for Employers

In advance of the August effective date, sponsors of self-funded ERISA health plans covering participants who receive health care services in New Jersey should review the advantages and disadvantages of electing to be subject to the Surprise Medical Bill Law with their employee benefits counsel and other advisors. With input from their third-party administrators and counsel, plan sponsors will want to weigh the administrative burdens of complying with the Surprise Medical Bill Law's protections and disclosure requirements against the protective advantages offered to its covered participants.

Electing Plans

Most notably, Electing Plans will be sparing participants from being balance billed for "inadvertent OON services" and services provided on an "emergency or urgent basis" in excess of the deductible, copayment, or coinsurance amount, and will potentially be shifting the dispute resolution process to the Electing Plan and provider without participant involvement. Additionally, an employer sponsoring a self-funded ERISA health plan that is contemplating making the election should also consider:

- making the appropriate plan amendment and applicable changes to other plan documentation and communications to explain its adherence to the Surprise Medical Bill Law;

- subjecting the plan to the Surprise Medical Bill Law's state requirements and binding arbitration and the resulting consequences;

- how the claims procedures in the plan, summary plan description, or carrier documents may be impacted by the arbitration process;

- how any anti-assignment language in the plan-related documentation would be impacted by the Surprise Medical Bill Law's automatic assignment of benefits provision;

- how any documentation changes will address employees in different states; and

- the impact on the Electing Plan's tax code nondiscrimination testing and risk profile if opting into the Surprise Medical Bill Law results in any contrasting treatment relative to participants in different states.

Employers wishing to maintain Electing Plans should continue to monitor any guidance issued by both state and federal governments, including guidance by the DOBI as to additional information on making the election and the required disclosures.

Non-Electing Plans

Sponsors of self-funded health plans that do not wish to opt into the Surprise Medical Bill Law at this time do not need to take any action and can revisit that decision at a later date, if they so choose. However, as a general matter, sponsors of non-Electing Plans should review their plan document and participant communication materials to ensure that any language regarding balance billing is consistent with their intended plan design and administration. Additionally, they should be aware that covered persons who are participants in a self-funded health plan that does not elect to be subject to the Surprise Medical Bill Law may be balanced billed by the provider for OON services (unless certain state laws apply). If the dispute is not resolved within 30 days, the covered person and provider may proceed to binding arbitration. The arbitrator's decision also will include a non-binding recommendation, to the self-funded health plan, of an amount that would be reasonable to contribute to payment for the OON service. The plan participant and provider will be required to split the arbitrator's fees equally unless the payment would pose a financial hardship to the plan member.

* * *

For more information about this Client Alert, please contact:

Tzvia Feiertag	**Christopher A. McMican**
Newark	248-515-4245
973-639-8270	312-499-1438
tfeiertag@ebglaw.com	cmcmican@ebglaw.com