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CLIENT ALERT

New Jersey's Surprise Medical Bill Law:
Part 1: Regulatory Issuances by New Jersey Agencies

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Earlier this year, New Jersey Governor Phil Murphy signed into law the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act ("Law"),[1] creating a statutory framework attempting to protect consumers from medical bills for out-of-network ("OON") services that they had no choice in selecting, often referred to as "surprise bills" in similar legislation in other jurisdictions.

Two days prior to the Law's August 30, 2018, effective date, the New Jersey Division of Consumer Affairs released a summary ("Summary") of the provisions of the Law that apply to health care professionals in general and identifies those that apply to physicians in particular.[2] On that same day, the New Jersey Department of Banking and Insurance ("DOBI") provided a Synopsis of the Implementation of the Law ("Synopsis") and informed the public that it intends to issue a bulletin that provides regulatory guidance consistent with the Law.[3] DOBI opened a brief comment window for interested stakeholders, which closed on September 4, 2018, and has indicated that it intends to promulgate related regulations "in the near future."

This Client Alert, which is Part 1 of a two-part series on the Law, summarizes key components of the Summary and the Synopsis, which includes regulatory guidance on claims processing and arbitration, OON billing and cost-sharing waivers, and disclosure and transparency. (Part 2 of this series will compare the Law to recent surprise bill laws in New York and California.)

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[1] Assembly Bill No. 2039, signed by Governor Murphy on June 1, 2018, *available at*: http://www.njleg.state.nj.us/bills/BillView.asp?BillNumber=A2039.

[2] Summary of the provisions of P.L. 2018, c. 32 for health care professionals, The New Jersey Division of Consumer Affairs, *available at:* https://www.njconsumeraffairs.gov/Documents/PL2018-c32-Provision-Summary.pdf.

[3] Synopsis of the Implementation of P.L. 2018, C.32 (N.J.S.A.26:2SS-1 TO-20), Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (Aug. 28, 2018), *available at*: https://njaasc.org/wp-content/uploads/2018/08/Synopsis-OON-PL-2018-c-32.pdf.

This Client Alert also is the companion to two earlier Client Alerts that summarized the key provisions of the Law.[4]

I. Key Components of the Division of Consumer Affairs' Summary

The Summary provides an abbreviated overview of the Law's requirements for "health care professionals," with a focus on physicians and disclosure requirements. In addition, the Summary reiterates that health care professionals must make disclosures of the health benefits plans in which a professional participates prior to the provision of non-emergency services (in writing or through a website) and at the time of an appointment (verbally or in writing).

According to the Summary, if health care professionals do not participate in a patient's plan, then, prior to scheduling a non-emergency procedure, the professionals must:

- inform the patient that the amount (or the estimated amount) that they will bill for the procedure is available upon request (and such disclosure must be made if requested),

- inform the patient that he or she will be financially liable for OON services in excess of the copayment, deductible, or coinsurance and that he or she may be responsible for costs in excess of those allowed by a health benefits plan, and

- advise the patient to contact his or her health benefits plan for consultation on costs.

The Summary also addresses "physicians" directly as a reminder of their obligation to inform a patient, to the extent possible, about the other providers that will be involved with him or her in the provision of the service, including the following services: anesthesiology, laboratory, pathology, radiology, or assistant surgery services.

As a reminder, the Summary indicates that, if professionals do not participate in a patient's network and nonetheless deliver services without complying with the disclosure provisions, the professionals may not balance bill.

The Summary is an unofficial interpretation that does not separately address the requirements for facilities licensed in New Jersey. Facilities and health care professionals should reach out to legal counsel for additional guidance on how to comply with the Law's requirements in order to ensure that they are not prohibited from collecting a full bill for OON services.

[4] These earlier Client Alerts are available at https://www.ebglaw.com/news/new-jerseys-surprise-medical-bill-law-implications-and-national-trends/ and https://www.ebglaw.com/news/self-funded-erisa-health-plans-and-new-jerseys-surprise-out-of-network-medical-bill-law-are-you-in-or-out-its-time-to-decide/.

II. Key Components of DOBI's Synopsis

The Synopsis focuses primarily on obligations for New Jersey "carriers" and self-funded Employee Retirement Income Security Act of 1974 ("ERISA") health benefits plans covering New Jersey residents that opt in under the Section 9 of the Law ("Electing Self-Funded Plans") as well as other self-funded health plans that have elected to not "opt into" the Law ("Non-Electing Self-Funded Plans"). Other than a reference to provider obligations as a part of the arbitration process, the Synopsis does not address the significant obligations that "providers" will be required to comply with under the Law.

Claims Processing, Negotiation, and Arbitration

Carriers and Electing Self-Funded Plans

The Synopsis provides that, upon receipt of a claim for inadvertent or involuntary OON treatment, a carrier must either pay the charges as billed by the OON provider or determine within 20 days of receipt of the claim that the billed charges are excessive. From there, the carrier must remit payment for its portion of what had been initially determined to be the allowed charge to the OON provider and issue an Explanation of Benefits ("EOB") to the covered person explaining that the carrier finds the claim to be for excessive, inadvertent, and/or involuntary OON benefits and that an OON provider may reject the carrier's payment and negotiate a different amount. If an OON provider opts to negotiate with the carrier, negotiations can only last for 30 days after the carrier's initial payment of its portion of the allowed charge. The OON provider must advise the carrier of its intent to reject the carrier's payment of its portion of the initial allowed charge as payment in full within seven business days of receipt of the carrier's portion of the allowed charge.

If a settlement is achieved within the 30-day period, the Synopsis explains that the carrier must remit payment for its portion of the outstanding amount of the negotiated allowed charge to the OON provider within 30 days of the settlement. The payment must include remittance advice to the OON provider and a final EOB to the member explaining the negotiated amount, the amounts of the initial and negotiated allowed charge and carrier payment (including the differences between the two), and the covered person's cost sharing based on those amounts.

If a settlement is not achieved within seven days of the end of the 30-day period, the carrier must issue a pre-arbitration EOB to the covered person and remittance advice to the OON provider. Both materials must state that a negotiated settlement was not achieved, the amount of the initial and final allowed charge and carrier payment (and the covered person's cost sharing based on those amounts), the additional amount paid by the carrier with a pre-arbitration EOB calculated as the difference between the initial and final allowed charges, and a statement that the covered person's cost sharing will not increase further, even if the carrier and OON provider enter into arbitration.

The Synopsis also provides in-depth guidance into the Law's new arbitration process for carriers and Electing Self-Funded Plans. The arbitration provisions are triggered for claims occurring after the Law's effective date, August 30, 2018, and do not apply to voluntary OON treatment or OON treatment provided through an in-plan exception.

For claims not resolved as "paid in full" pursuant to the Synopsis's outlined claimed negotiations process, the carrier, OON health care provider, or covered person can request to enter binding arbitration within 30 days of payment of the carrier's final offer if the difference between the carrier's final offer allowed charge and the final offer of the OON provider is $1,000 or higher and all applicable preauthorization or notice requirements of the health benefits plan were complied with. The Synopsis also outlines disputes that cannot be resolved through the arbitration process, including a dispute as to whether a treatment or service was medically necessary, an experimental or investigational treatment or service, a cosmetic treatment or service, or a medical or dental treatment or service for which the carrier should have authorized services to be performed by an OON provider through an in-plan exception. Notably, the Synopsis emphasizes that OON providers cannot attempt to collect reimbursement from the plan member until a request for arbitration is filed.

DOBI plans to use its current Independent Claims Payment Arbitration system vendor, MAXIMUS, Inc., to administer the OON Arbitration Program until August 30, 2019. Afterwards, DOBI will open up the procurement process to seek a new vendor. During the first year, MAXIMUS will post OON arbitration filing instructions on its website. MAXIMUS will accept for processing complete applications that reflect:

- health benefits plans (including Electing Self-Funded Plans) delivered or issued for delivery in New Jersey that are not an out-of-state or federal plan, including Managed Medicaid;
- a disputed amount for $100 or more;
- a New Jersey-licensed OON provider that rendered an inadvertent or involuntary service;
- that the covered person was enrolled in the health benefits plan at the time that service was rendered;
- the party's final offer for the allowed charge;
- a fully executed Consent to Release of Medical Records for Claim Payment and Arbitration form; and
- the initiating party's submission of all necessary information and the applicable fee.

MAXIMUS will acknowledge receipt of the application within seven days and will notify the initiating party of any deficiencies. Applications will be considered withdrawn if not

resolved within 15 days. Initiating parties do not have the opportunity to supplement the record outside of what is included in the initial application. Within 30 days of receipt of a completed application, the arbitrator will issue a decision. If the health care provider is successful, the carrier must remit payment within 20 days of the decision. This payment must be made in full and cannot increase cost sharing for the covered person. Untimely payments will be charged interest. Carriers must also notify a covered person of the arbitration decision if the covered person was not a party to the arbitration within 30 days of the decision.

Employers and other plan sponsors contemplating whether to "opt into" the Law thereby becoming an Electing Self-Funded Plan should review the various considerations noted in our prior Client Alert and discuss with their third-party administrators and employee benefits attorneys the potential impact of electing to be subject to the Law. Sponsors of Electing Self-Funded Plans should ensure, among other things, that their plan documents and other plan communications have been amended to reflect their election and that consideration has been given to the interaction of this Law to other provisions of the plan, such as claims and appeals procedures.

Non-Electing Self-Funded Plans

Plan members or OON providers may initiate binding arbitration against a Non-Electing Self-Funded Plan if there is no resolution of a payment dispute within 30 days after the plan member is sent a bill for services. Voluntary OON claims are not eligible for arbitration. The arbitration process for Non-Electing Self-Funded Plans is similar to the process outlined above, provided that:

- the application states that:
    - the health benefits plan is self-funded and has opted not to participate in OON arbitration pursuant to the Law (i.e., a Non-Electing Self-Funded Plan);
    - the self-funded plan covers inadvertent and involuntary OON services;
    - the member was enrolled in the self-funded plan when the services were rendered; and
    - the member has been balanced billed by an OON provider;
- the application includes a fully executed Consent to Release of Medical Records for Claims Payment and Arbitration form; and
- the initiating party has submitted all necessary information and the applicable fee.

New Identification Card Requirements for Self-Funded Plans

The Synopsis appears to require that ***all*** entities providing or administering self-funded health plans, i.e., Electing Self-Funded Plans and Non-Electing Self-Funded Plans, issue

a health plan identification card to the primary covered person upon issuance of a new or renewal plan or the self-funded plan's opt-in to OON arbitration. Identification cards must include, among other things, a clear indication that the plan is self-funded and whether the plan intends to participate in arbitration by indicating "NJ Arbitration – Yes as of [date]" or "NJ Arbitration - No," respectively. Electing Self-Funded Plans must also make an information filing with DOBI about the form of the identification card to the DOBI at the address provided in the Synopsis.

ERISA Preemption Issues

The arbitration and identification card provisions of the Law, specifically as applied to Non-Electing Self-Funded Plans, raise numerous questions about whether such provisions would be preempted by ERISA. Self-funded ERISA plans are generally not subject to state insurance mandates because of ERISA's 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 Law acknowledges that not all health plans are fully insured, and, as such, a self-funded ERISA health plan may opt into the Law. The opt-in procedure seemingly is the Law's way of attempting to avoid preemption, but then the Law, as explained in the Synopsis, seems to regulate Non-Electing Self-Funded Plans as well by applying the arbitration and identification provisions (albeit in a different manner) to such plans. ERISA's preemption clause is intended to allow ERISA-covered self-funded plans operating in multiple states to administer their plans in a uniform manner free from state mandates. It remains to be seen whether sponsors of Non-Electing Self-Funded Plans will challenge the applicability of the Law to their plans based on ERISA's preemption doctrine.

OON Billing and Cost-Sharing Waivers

The Synopsis provides that a covered person cannot be balance billed by an OON health care provider for any inadvertent or involuntary OON claims beyond what that person would have incurred had the service been performed in-network. Further, OON health care providers cannot "directly or indirectly, knowingly waive, rebate, give, pay, or offer the waiver, rebate, give, or pay all or part" of a covered person's deductible, copayment, or coinsurance as an inducement for the covered person to seek services from that provider. This can be done on a limited basis if it is not offered as part of any advertisement or solicitation, is not done routinely, is determined that the covered person is in financial need, or falls within a federal fraud and abuse safe harbor concerning patient cost sharing.

Disclosure/Transparency

"Carriers"[5] must provide covered persons with clear and understandable descriptions of the benefits for services rendered by OON providers that are covered under their specific

[5] While the Synopsis, as described above, discusses the opt-in process for arbitration for Electing Self-Funded Plans, it does not discuss disclosure and transparency requirements for Electing Self-Funded Plans

health benefits plans. Carriers' websites and telephone hotlines should have been updated by August 30, 2018, when the Law went into effect, but customized summaries must be published starting with plans issued or renewed on or after January 19, 2019. DOBI will develop a template summary that carriers may use to provide the Law's required disclosures. The Synopsis includes an Appendix containing contemplated disclosure language, which includes, in part, how the plan covers medically necessary treatment on an emergency or urgent basis by OON providers, that a covered person's cost sharing for OON treatment is limited to cost sharing under the plan applicable for the same services when received in-network, a description of the ability for carriers and OON providers to negotiate or enter into arbitration, and how all plans will cover treatment for OON providers if in-network providers are not available. Carriers may opt to create their own disclosures but must include DOBI's contemplated disclosure language.

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that opt in. There may be disclosure requirements for Electing Self-Funded Plans, however, so Electing Self-Funded Plans should reach out to legal counsel for additional guidance on compliance.