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New Jersey Regulates Out-Of-Network Billing

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News alert for all New Jersey health care providers! A new law went into effect yesterday (August 30, 2018) that changes billing requirements for out-of-network services in New Jersey. Known as the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act," the bill, true to its name, puts forward an effort to regulate out-of-network ("OON") billing and prevent patients from receiving "surprise bills."

Much of the discussion in the bill regarding its purposes focuses on OON services provided by an OON provider at an in-network facility resulting in patients receiving large, unexpected bills. The preamble even cites surprise bills for "hospital emergency room procedures or for charges by providers that the consumer had no choice in selecting" as a problem for New Jersey consumer. However, in an effort to prevent these situations, the bill's sweeping definitions may apply to more health care professionals than those intended, leading to several questions about how to comply with this new law.

As it stands, the bill applies to carriers (health benefits plans), health care facilities, and health care professionals. Here are a few highlights from the new law:

1. **Disclosure Requirements:** The bill sets out lengthy and specific disclosure requirements for health care facilities, health care professionals, physicians, and carriers.
    - Health care facility means a general acute care hospital, satellite emergency department, hospital-based off-site ambulatory care facility, or ambulatory surgery facility. See Section 4 of the bill for health care facility disclosure obligations.
    - Health care professional means an individual acting within the scope of his licensure or certification, who provides a covered service defined by the health benefits plan. See Section 5 of the bill for health care professional and physician-specific disclosure obligations.
    - Carrier means an entity that contracts or offers to contract to provide services under a

health benefits plan. See Section 6 of the bill for carrier disclosure obligations.

2. **Billing Requirements:** The establishes specific requirements for carriers, health care facilities, and health care providers with regard to billing and payment for OON services, for example:

    - Medically necessary services provided at any health care facility on an emergency or urgent basis: neither the *health care facility* nor the *health care professional may* bill the patient in excess of his or her deductible, copayment, or coinsurance ("cost-sharing amount") applicable to in-network benefits provided under his or her health benefits plan. Carrier and facility must agree on payment or go through binding arbitration.

    - Inadvertent out-of-network services: *health care professional* shall not bill the patient in excess of any cost-sharing amounts pursuant to his or her health benefits plan (i.e., no balance billing).

        - "Inadvertent out-of-network services" means covered services provided by an out-of-network health care provider in an in-network facility when in-network providers are unavailable in that facility. "Inadvertent out-of-network services" also includes "laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory." The bill further requires carriers and health care facilities and professionals to adhere to specific timing requirements with respect to payment terms and enter into arbitration if they cannot agree on such terms.

3. **No Waiver of Patient Cost-Sharing Amounts:** The new law makes it clear that an OON provider may not waive, rebate, give, or pay all or part of the patient's in-network cost-sharing obligation as an inducement for the patient to seek health care services from that provider.

Questions that Remain

Stakeholders expected regulations to provide guidance in advance of the law's effective date, but unfortunately regulations were not promulgated in time. The Department of Banking and Insurance released a guidance document Monday evening, August 27th, stating that it intends to propose regulations and is seeking comments on the guidance document. In our opinion, the guidance document did not address, and we are hopeful that regulations will clarify a few questions about the new law:

- Does the law apply to laboratory services ordered during an office visit and not at or through a healthcare facility?

- Does the law apply to a bio-analytical laboratory director, and if so, would such a licensee be required to adhere to the disclosure requirements?

- Why are bio-analytical laboratories called out in the definition of "inadvertent out-of-network services?" Does the law not apply to OON clinical laboratory testing (as differentiated from OON bio-analytical laboratory testing) ordered by an in-network provider?

- What is meant by “unavailable” in the definition of inadvertent out-of-network services?
- Will there be any clarification regarding the circumstances under which a waiver or reduction of cost-sharing obligations is permissible (for example for those patients who qualify for financial assistance programs)?

We will continue to monitor regulations as they are released and hope to provide clarity on the scope of the new law. Comments to the Department of Banking and Insurance are due via email by **Tuesday, September 4, 2018.**

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