

New Jersey's Surprise Medical Bill Law: Implications and National Trends

By Jackie Selby, Lauren A. Farruggia, and Kevin J. Malone

June 2018

I. Executive Summary

After nearly decade of deliberation, on June 1, 2018, New Jersey Governor Phil Murphy signed into law the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (“Law”),¹ creating regulations 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. The Law will significantly impact billing procedures and reimbursement rates, and it will impose new disclosure requirements in New Jersey. The Law applies to New Jersey health care facilities,² individual health care professionals,³ carriers,⁴ and, in some instances, self-funded plans.⁵ Medicaid (including Medicaid managed care organizations), Medicare (including Medicare Advantage plans), and TRICARE are not impacted by the Law.

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 A “health care facility” refers to “a general acute care hospital, satellite emergency department, hospital based off-site ambulatory care facility in which ambulatory surgical cases are performed, or ambulatory surgery facility licensed pursuant to P.L. 1971, c.136 (C:26:2H-1 et seq.).” *Id.* at (3).

³ A “health care professional” refers to “an individual, acting within the scope of his licensure or certification, who provides a covered service defined by the health benefits plan.” *Id.*

⁴ A “carrier” refers to

an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefits plan, including: an insurance company authorized to issue health benefits plans; a health maintenance organization; a health, hospital, or medical service corporation; a multiple employer welfare arrangement; the State Health Benefits Program and the School Employees’ Health Benefits Program; or any other entity providing a health benefits plan. Except as provided under the provisions of this act, “carrier” shall not include any other entity providing or administering a self-funded health benefits plan.

Id.

⁵ A “self-funded health benefit plan” or “self-funded plan” is defined as “a self-insured health benefits plan governed by the provisions of the federal ‘Employee Retirement Income Security Act of 1974’ 29 U.S.C. s.1001 et seq.” *Id.* Self-funded plans must elect to be subject to the Law’s requirements. *Id.* at (9)(d).

The Law follows other states' recent attempts to address issues that arise when beneficiaries receive OON services without a reasonable opportunity for consent.⁶ New Jersey has incorporated many of the key design elements of “surprise bill” legislation that has already been enacted or is under consideration around the country, but has introduced a number of differing provisions. In particular, New Jersey is prioritizing new disclosure obligations for carriers, facilities, and individual health care professionals; leaves reimbursement rate decisions up to carriers and health care professionals themselves with arbitration as a fallback option if a carrier deems the bill to be excessive and the provider does not accept the carrier’s final offer payment; and includes monetary penalty provisions for noncompliance.

For affected providers, health plans, and insurers in New Jersey, the Law presents a new business and compliance challenge that needs to be addressed immediately. The new requirements will go into effect on the 90th day after enactment, on or around August 27, 2018, so stakeholders should act quickly to create a plan to successfully navigate the new regime. This may include discussions with the New Jersey Department of Banking and Insurance and the Department of Health, which will promulgate implementing regulations and subregulatory guidance within the 90-day period.

⁶ Legislation similar to Assembly Bill No. 2039 has recently been enacted in California (Assembly Bill 72, signed Sept. 26, 2016, available at: https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72); Colorado (C.R.S.A. § 10-16-704 provides a hold-harmless protection for services rendered by OON providers at an in-network facility where a patient cannot reasonably know that the service provider is OON, available at: <https://codes.findlaw.com/co/title-10-insurance/co-rev-st-sect-10-16-704.html>); Connecticut (Public Act No. 15-146, signed June 30, 2015, provides enhanced disclosure and hold-harmless protections for surprise bills, available at: <https://www.cga.ct.gov/2015/act/pa/2015PA-00146-R00SB-00811-PA.htm>); Florida (HB 221, signed Apr. 14, 2016, adds balance bill protection for patients, available at: <https://www.flsenate.gov/Session/Bill/2016/221/BillText/er/PDF>); Maryland (Maryland Health – General Section 19-710.1 does not have a concept of “surprise bill” but does impose reimbursement limits on OON services in general, available at: <http://mgaleg.maryland.gov/webmgafirmStatutesText.aspx?article=ghg§ion=19-710.1&ext=html&session=2017RS&tab=subject5>); New York (Emergency Medical Services and Surprise Bill, Financial Services Law Article 6, signed Mar. 31, 2014, available at: <http://www.dfs.ny.gov/consumer/hprotection.htm>); Oregon (HB 2339, signed June 22, 2017, available at: <https://gov.oregonlive.com/bill/2017/HB2339/>); and Texas (Senate Bill 481 built upon earlier restrictions to create additional transparency and make mediation available for more patients, available at: <http://www.tdi.texas.gov/news/2015/tdi09102015.html>). Several other states (and the U.S. Congress) have recently proposed similar measures: Georgia (SB 382, “Surprise Billing and Consumer Protection Act,” passed the House on Mar. 23, 2018, available at: <http://www.legis.ga.gov/legislation/en-US/Display/20152016/SB/382>); New Hampshire (HB 1809, the House concurred with the Senate amendment on May 10, 2018, available at: <https://legiscan.com/NH/text/HB1809/2018>); New Mexico (HB 313, “Surprise Billing Protection Act,” available at: <https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0313.pdf>); Pennsylvania (Balance Billing Legislation House Bill No. 1553, Session of 2017, available at: <http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2017&sessInd=0&billBody=H&billTyp=B&billNbr=1553&pn=2803>); Virginia (HB 1584, referred to the Committee on Commerce and Labor on Jan. 18, 2018, available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?181+ful+HB1584+hil>); and the U.S. Congress (H.R. 3770, “End Surprise Billing Act of 2015,” introduced Oct. 20, 2015, and referred to the Subcommittee on Health, available at: <https://www.congress.gov/bill/114th-congress/house-bill/3770>).

Providers, plans, and insurers operating in other states, especially in those states where legislation has been proposed and debated but not yet enacted, should take careful note of the provisions of the Law as a model that other states or the U.S. Congress may soon adopt.

To help put the Law provisions in context, a follow-up to this Client Alert will provide a detailed chart comparing the Law to California's Surprise Bill Statute (Assembly Bill 72) and New York's Emergency Medical Services and Surprise Bills Law (Financial Services Law Article 6), which are considered some of the more comprehensive state surprise bill laws.

II. New Jersey's Approach to Surprise Bills

a. Definition of "Surprise Bills"⁷

The Law provides new protections for "inadvertent" and "emergency or urgent" OON services. Inadvertent OON services are health care services that are (i) "covered under a managed care health benefits plan that provides a network" and (ii) are "provided by an [OON] health care provider" at an in-network health care facility.⁸

The Law borrows the definition of "emergency services" from the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which includes treatment for:

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impair to bodily function, or
- (iii) serious dysfunction of any bodily organ; or . . .

a pregnant woman who is having contractions –

- (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
- (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.⁹

⁷ The Law only uses the term "surprise bill" colloquially in discussing the legislative intent; otherwise, the Law uses the "inadvertent" and "emergency or urgent" OON services language.

⁸ Inadvertent OON services also include laboratory testing "ordered by an in-network provider" but performed by "an [OON] bio-analytical laboratory." Assembly Bill No. 2039 at (3).

⁹ *Id.* at (7)(a); EMTALA, 42 U.S.C. § 1395dd(e). Neither EMTALA nor the Law defines "urgent."

Generally, health care facilities and providers are prohibited from billing a covered person for inadvertent, emergency, or urgent OON services in excess of that person's deductible, copayment, or coinsurance amount applicable to in-network services under his or her health care plan. However, the Law allows a covered person to elect an OON provider for a health care service, as long as the person "knowingly, voluntarily, and specifically" selects the OON provider with full knowledge that the provider is OON. Additionally, the covered person must have had the opportunity to select an in-network provider but selected the OON provider instead. Providers that regularly deliver services on an OON basis that may be subject to the Law should plan on developing policies and procedures to ensure that the full knowledge standard and the in-network provider opportunity are met prior to the delivery of services.

Carriers are required to ensure that a covered person is not billed for inadvertent OON services in excess of what that individual would have incurred with an in-network provider. Self-funded plans are able to opt in to the requirements and protections of the Law pursuant to Section 9.¹⁰

OON providers can (but are not required to) directly bill the carrier for rendered services. Among many other disclosure requirements, a carrier is required to ensure that members know to forward bills to the carrier that they receive directly from an OON provider. The carrier 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 carrier and the provider have 30 days to attempt to reach a settlement. If the carrier and the provider are unable to reach an agreement, the carrier will make a payment for the amount of its final offer. The provider, carrier, or a covered person can proceed to the Law's newly established binding arbitration provisions, discussed more below.

b. Disclosure Requirements for Facilities and Professionals

The Law imposes new disclosure requirements on facilities, individual health care professionals, carriers, and self-funded health plans (should they elect to be subject to the Law's requirements and protections).

Before scheduling a non-emergency or elective procedure with a covered person, a health care facility is now required to disclose whether the facility is in-network. Facilities must also advise the covered person to (i) ask his or her physician whether the physician is in-network or OON and (ii) contact his or her carrier for further consultation on costs.

A facility must also make available to the public a list of the facility's "standard charges" for all items and services provided by the facility, consistent with Section 2718(e) of the Patient Protection and Affordable Care Act ("PPACA").¹¹ Neither the PPACA nor the

¹⁰ Assembly Bill No. 2039 at (7)(e), (9)(d).

¹¹ This section provides that "[e]ach hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under [the Social Security Act]." 42 U.S.C. § 300GG-18(e).

Law defines “standard charges,” and the federal government has not yet enforced Section 2718(e). A recent Centers for Medicare & Medicaid Services (“CMS”) proposed rule seeks to bring life to Section 2718(e) and requests public comment to solidify the definition of “standard charges.”¹² Accordingly, New Jersey facilities will need to carefully follow CMS’s rule, if it is finalized, and monitor how the Department of Banking and Insurance’s implementing regulations address this issue in order to fully comply with the Law.

In addition, a facility must post on its website a list of health benefit plans in which the facility is a participating provider and a statement that individual physicians’ services are not included in the facility’s charges, along with a disclaimer that some physicians may not participate with the same health benefit plans as the facility. Facilities must also encourage patients to contact their physicians and carrier directly to determine whether a particular physician’s services are in-network, and a facility must list the name, mailing address, and telephone number of all physicians employed by the facility. The Law also requires a facility to notify covered persons promptly if the facility’s network status changes with respect to the covered person’s health benefit plan, although the Law does not specify how the facility must provide notice.

A facility must annually report to the Department of Health a list of all health benefit plans with which the facility has an in-network agreement. Health care facilities should expect the Department of Health to promulgate implementing regulations and provide subregulatory guidance describing the content and design of the anticipated disclosure forms and the manner in which the disclosure form must be provided.

Like health care facilities, an individual health care professional is required by the Law to disclose the health benefit plans with which he or she participates prior to engaging a covered person in non-emergency services, including laboratory testing ordered by an in-network professional and performed by an OON bio-analytical laboratory. If a health care professional does not participate in the covered person’s health benefit plan, the health care professional must inform the covered person that the professional is OON. Here, the disclosure requirements differ from that required of facilities: professionals must provide a covered person with both a billing estimate and the associated Current Procedural Technology (“CPT”) codes, if requested. A professional must also disclose to a covered person that the covered person has a financial responsibility to pay for services provided by an OON professional.

As is the case for facilities, the Law requires a physician, in particular, to (i) advise a covered person to contact the covered person’s carrier for further information on such costs, and (ii) provide identifying information for any other health care professional in

¹² 88 Fed. Reg. 20,164, 20,548 (May 7, 2018), available at <https://www.gpo.gov/fdsys/pkg/FR-2018-05-07/pdf/2018-08705.pdf>. The proposed rule seeks public comment on the definition of “standard charges” and provides several different options: “the average or median rates for the items on the chargemaster; the average or median rates for groups of services commonly billed together (such as for an MS–DRG), as determined by the hospital based on its billing patterns, or the average discount off the chargemaster amount across all payers, either for each item on the chargemaster or for groups of services commonly billed together.” *Id.* at 20,549.

connection with the physician's intended care,¹³ along with instructions for how to determine whether the other provider participates with the covered person's health benefit plan.

The Law requires a health care professional to promptly notify a covered person if the health care professional's participation with the covered person's health benefit plan changes during the course of treatment. Health care professionals should expect the related professional or occupational licensing board within the Department of Law and Public Safety to promulgate implementing regulations and provide subregulatory guidance describing the content and design of the anticipated disclosure form.

c. Disclosure Requirements for Carriers and Self-Funded Plans

The Law now requires a carrier to update its website within 20 days of the addition or termination of a provider from the carrier's network, or a change in a physician's affiliation with a facility. This does not include self-funded plans, unless a self-funded plan elects to be subject to the Law, as described below. Each carrier must now also provide a covered person with a clear and understandable description of the plan's OON health care benefits, including the methodology used to determine the amount allowed for OON services and the amount of reimbursement available; examples of anticipated out-of-pocket costs for frequently billed OON services; written and online information that reasonably permits a covered person to calculate anticipated out-of-pocket, OON costs; information concerning whether a particular provider is in-network; and access to a consumer telephone hotline for questions about network status and out-of-pocket costs. The Law does not, however, provide specific requirements related to a carrier's methodology for determining the amount allowed for OON services or for reimbursement.

A carrier must also notify the covered person if the network status of a particular facility or provider changes after the carrier authorizes a health service from that facility or provider, although the Law does not specify the timing or method of notice. The Law also compels carriers to include in Explanation of Benefits documents and all consumer reimbursement correspondence that "inadvertent and involuntary" OON charges are not subject to balance billing beyond the financial responsibility incurred under the terms of the contract for in-network service.

In addition, a carrier must now also calculate anticipated savings resulting from the reduction in OON claims payments under the Law and must pay for an annual audit of its provider network by an independent auditing firm to assess the carrier's conformance with the Law. Audit findings must be submitted to the Health Commissioner, who will display the results on the Department of Health's website. Carriers that have failed to

¹³ This information would include other professionals performing "anesthesiology, laboratory, pathology, radiology, or assistant surgeon services" (Assembly Bill No. 2039 at (5)(b)), as well as identifying information for "any other physicians" performing "pre-admission, testing, registration, or admission" for covered persons who are admitted or who will receive outpatient care (*Id.* at (5)(c)).

achieve provider network adequacy¹⁴ under federal and state law could be subject to new penalties under the Law.

Carriers should expect the Department of Banking and Insurance to promulgate regulations that describe the manner in which carriers should include the number of all claims that are denied or downcoded in a carrier's annual public and regulatory filings.

The Law also imposes new disclosure requirements for self-funded plans to the extent that they elect to subject themselves to the Law's purview.¹⁵ In order to make an election, a self-funded plan must provide annual notice to the Department of Health attesting to the plan's intended participation. Self-funded plans should look out for Department of Health regulations and subregulatory guidance describing the manner in which a plan must give notice. Once a self-funded plan elects to participate, it must amend its employee benefit plan, coverage policies, contracts, and any other related documents to explain its adherence to the Law.

A provider that provides inadvertent OON services or emergency or urgent services must bill the carrier (and a self-funded plan, if it elects to be subject to the Law), and the carrier has 20 days of the receipt of the claim to determine whether it considers the claim to be excessive, and then an additional 30 days to negotiate a settlement with the provider. The provider may not collect any cost sharing from covered persons beyond the applicable deductible, copayment, or coinsurance that would apply for in-network services.

d. Arbitration Requirements

As with many other surprise bill statutes, the Law creates detailed binding arbitration provisions to resolve disputes when a carrier and a provider cannot agree on a reimbursement rate for OON services provided on an emergency, urgent, or inadvertent basis, or where a self-funded plan (that has elected to be subject to the Law) and an OON provider are unable to resolve a payment dispute. The Department of Health is responsible for selecting experienced arbitrators.

During arbitration, the carrier or self-funded plan and the provider will negotiate the disputed reimbursement rate. The arbitrator must take both positions into account and must ultimately produce written findings summarizing the final binding amount that the arbitrator determines is reasonable for the service.

e. Penalties

Any person or entity that violates the Law will be liable for a penalty—up to \$100 per violation for health care professionals, and up to \$1,000 per violation for carriers and

¹⁴ The PPACA sought to establish federal network adequacy standards. See 42 U.S.C. § 18031(c) (requiring qualified health plans in the Marketplace to “ensure a sufficient choice of providers” and “provide information to enrollees and prospective enrollees on the availability of in-network and [OON] providers”). Many states, including New Jersey, have their own network adequacy provisions. See N.J. Stat. § 26:2S-18; N.J. Admin. Code § 11:24C-4.5, 4.6.

¹⁵ Assembly Bill No. 2039 at (9)(d).

HEALTH CARE & LIFE SCIENCES

health care facilities (every day qualifies as a separate violation, but no provider will be liable for more than \$25,000 per occurrence). Carriers and health care facilities that fail to comply with the Law will be referred to the Health Commissioner for appropriate action, whereas noncompliant health care professionals will be referred to the appropriate professional or occupational licensing board.

* * *

*This Client Alert was authored by **Jackie Selby, Lauren A. Farruggia, and Kevin J. Malone.** For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

This document has been provided for informational purposes only and is not intended and should not be construed to constitute legal advice. Please consult your attorneys in connection with any fact-specific situation under federal law and the applicable state or local laws that may impose additional obligations on you and your company.

About Epstein Becker Green

Epstein Becker & Green, P.C., is a national law firm with a primary focus on health care and life sciences; employment, labor, and workforce management; and litigation and business disputes. Founded in 1973 as an industry-focused firm, Epstein Becker Green has decades of experience serving clients in health care, financial services, retail, hospitality, and technology, among other industries, representing entities from startups to Fortune 100 companies. Operating in locations throughout the United States and supporting domestic and multinational clients, the firm's attorneys are committed to uncompromising client service and legal excellence. For more information, visit www.ebglaw.com.

If you would like to be added to our mailing list or need to update your contact information, please contact Lisa C. Blackburn at lblackburn@ebglaw.com or 202-861-1887.