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LEGAL ALERT

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New Law Limits Out-of-Network Coverage and Prohibits Balance Billing

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After eight years of often contentious debate, the New Jersey Legislature has passed the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act" (A2039/S485) (the "Act"), which prohibits the surprise balance billing of patients by out-of-network ("OON") providers for amounts unpaid by insurance carriers and health plans. The Act is currently with the Governor for his signature, which is expected any day, and the law will take effect 90 days from its enactment.

OON providers (as opposed to in-network providers) have not entered into contractual agreements with insurance carriers and health benefit plans for fixed fees. This leads to higher bills for OON charges and results in increased cost sharing obligations for the patient. In an in-network arrangement, the patient is generally responsible for a co-pay. In an OON arrangement, the patient will often have a percentage-based coinsurance and deductible, and will be liable for these sums as well for the balance of any sums not paid by the carrier or health group plans. Carriers and health plans will often pay these bills at a reduced rate of reimbursement, relying on murky language in their plans and policies to avoid any greater obligations. If not aware of the OON status of the provider, patients are often shocked to receive bills far in excess of their in-network obligations. This is exacerbated if the patient is the recipient of emergent services where he or she does not have an option as to the provider.

The Act relieves patients from the financial responsibility of paying the balance of an OON bill in excess of their in-network co-pays, unless they make a "knowing, voluntary, and specific" selection of the OON provider. In emergency situations, the patient's choice is deemed involuntary and the patient will not be responsible for any amount greater than the applicable in-network co-pay. The provider and carrier must either mutually agree on an amount or proceed to a newly established arbitration program for resolution.

Although couched as a protection to patients, the legislation is also a huge boon to carriers and health plans who will accrue massive savings from limiting their responsibility to pay OON charges, despite the higher premiums paid for this coverage. A fiscal estimate for the Act reflects a savings of over $164 million for State Employee Benefit plans alone. OON providers, however, will suffer by having to either adhere to the administratively burdensome notification and disclosure requirements or face possible violations if not compliant. Moreover, the bargaining power of all providers in the health care market will be severely limited by the reduction of reimbursements for OON coverage in that more providers will seek in-network

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arrangements due to the difficulties associated with obtaining remuneration under OON plans. Consequently, this will enable carriers and plans to offer lower rates in their negotiated agreements.

The Act applies to OON acute care hospitals, hospital-based offsite ambulatory surgery centers (ASCs), emergency satellite departments and independently licensed ASCs as well as any individual health care professional providing a covered service under the scope of his or her license or certification. In an elective situation, where the patient has notice of the procedure, the provider must first disclose its network status in writing, explain to the patient the difference between the in-network and OON costs and provide detailed information about the expected charges, including the expected billed amount. A facility must make available to the public its usual charges (in accordance with federal guidelines) and specific information about the plans and carriers it has contracted with, the names and other contact information for any health care professionals or professionals affiliated with the facility, and if they are in-network or OON with the facility's and the patient's carrier or group health plan.

Health care professionals must provide similar disclosures, including an estimated cost of their services and the CPT codes assigned for these costs at the patient's request. If a provider is referring a patient to an OON provider, it must inform the patient of this fact and provide contact information for the referral as well as provide information for any in-network health arrangements that may be available.

In order to provide even greater transparency, carriers and group health care plans are required to provide their members with information about the amount of the reimbursement of the benefit, including details about their methodology and calculations, and inform the patient of his or her responsibility prior to the procedure.

The Act is clear that a mere disclosure of OON status is not enough for a provider to receive any reimbursement for OON services based on the patient's knowing, voluntary and specific choice. Although not addressed in the Act, as a matter of practice, OON providers generally require the patient to sign an assignment of benefits agreement so that they are able to receive reimbursement directly from the carrier or group health plan and to stand in the shoes of the patient when it comes to disputes. Without clear written proof of this acceptance and the express assignment of OON benefits, the OON provider will almost certainly not be able to bill for these elective services as it will be easily argued that in the absence of the patient's informed selection, the provider lacks standing to pursue or file the claim. The Department of Health is charged with the development of a disclosure form in accordance with the Act's safeguards. Lest the subscribers or members of these policies or plans not be aware of these protections, the Act requires carriers and group health plans providing OON benefits to inform their consumers of these measures on any reimbursement correspondence, including a clear statement that the patient is not responsible for any inadvertent or involuntary OON network charges on any explanation of benefit forms.

The Act also provides protections for patients against costs for inadvertent OON services (including an in-network provider referring to an OON lab) and for OON services provided in an emergent or urgent setting. The Act only holds the patient responsible for an in-network co-pay in these situations. Although the Act provides the OON provider in an emergent setting to be the recipient of a constructive assignment of benefits of any reimbursements the patient receives, it merely requires the carrier to ensure that the patient will not be responsible and fails to specify any amount or outline any standard to govern the payment to the OON provider for these services.

Based on this constructive assignment of benefits in the emergent setting, the Act enables the OON provider to bill the carrier for the services provided and requires the carrier to either pay or make an alternative offer, which it must pay. If the provider thinks this payment is insufficient and the amount in dispute is more than $1,000.00, the provider can seek arbitration.

Self-funded plans are exempt from the Act, unless the plan elects to be subject. Even if the plan does not elect, the Act still requires the OON provider to advise the patient of its status and the increased costs for OON services. If a member of a self-funded plan seeks emergency services of an OON provider, the Act provides for an arbitration process between the provider and the patient wherein the arbitrator will be able to mediate a settlement.

Likewise, the Act does not apply to Medicare, Medicaid, automobile medical payment insurance, workers' compensation, TRICARE, disability, accident only, credit, disability, long term care, personal injury protections plans and hospital confinement indemnity coverage or dental plans.

It is apparent that the intent of the bill is to limit access to OON benefits for anything other than highly specialized services. Providers are encouraged to review their in-network agreements and other arrangements and to analyze their payer mix to see how they will be affected. Assignment of benefits forms should also be reviewed and drafted to incorporate the disclosure and notification requirements of the Act, so as to assure proof of the patient's knowing, voluntary and specific selection of the OON provider.

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