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NJ Out of Network Health Bill Signed

New Jersey now has a new law aimed at curtailing out-of-network (OON) healthcare costs. Notably, the new law won't apply to self-insured plans (which make up about 70% of the group health plans in New Jersey). However, self-funded plans can voluntarily opt in and follow the law. The law aims to put an end to high OON bills patients and insurers are charged by hospitals and doctors who don't participate in an insurer's network and won't accept an insurer's reimbursement as full payment. Patients are often "balance billed" for the remainder of the fee. Patients receiving care at an in-network hospital will often receive a large bill because a specialist, such as a radiologist or anesthesiologist, who assisted in their care was not part of their insurance network. The new law seeks to address the issue with several transparency requirements mandating greater disclosure as described below.

Healthcare Provider Responsibilities. The law places certain responsibilities on healthcare facilities and healthcare professionals to notify patients about services they will provide. For example:

- hospitals must disclose to patients which OON providers will be charging them before a patient undergoes treatment or surgery,
- hospitals and medical professionals must disclose on their websites and to their patients which health insurance coverage, if any, they accept and the cost of OON services as well as the insurance plans accepted by the specialists they do business with, such as anesthesiologists and pathologists, and
- if the network status of a hospital or other medical facility changes, the hospital must notify the patient promptly.

Health Insurance Carrier Responsibilities. The law also places a variety of responsibilities on health insurance carriers. Carriers include insurance companies authorized to issue health benefits plans; HMOs; health, hospital, or medical service corporations; multiple employer welfare arrangements (MEWAs); entities under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; and any other carrier providing a health benefits plan. Under the law, a carrier must update the carrier's website within 20 days of the addition or termination of a provider from the network or a change in a physician's affiliation with a facility. With respect to OON services, for each health benefits plan offered, a carrier is required to provide a covered person with:

- a clear and understandable description of the plan's OON healthcare benefits, including the

methodology used by the carrier to determine reimbursement for OON services,

- the allowed amount the plan will reimburse under that methodology,
- examples of anticipated out-of-pocket costs for frequently billed OON services,
- information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for OON services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for OON services and the usual and customary cost of OON services,
- information in response to a covered person's request, concerning whether a healthcare provider is an in-network provider,
- such other information as the commissioner determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to estimate their out-of-pocket cost for an OON service and make a well-informed healthcare decision, and
- access to a telephone hotline that shall be operated no less than 16 hours per day for consumers to call with questions about network status and out-of-pocket costs.

The law also addresses situations in which a carrier authorizes a covered healthcare service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to OON before the authorized service is performed. The law requires the carrier to notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

Binding Arbitration Process. Medical providers and payers (insurers) who can't settle a billing dispute on their own when a patient involuntarily receives OON care can submit evidence to a state-regulated, binding arbitration process and then must accept the decision of an independent expert who decides between the final offers presented by both sides.

Regulations and promulgations related to the new law are expected to be issued by the state shortly. We will issue appropriate updates as more information becomes available. Contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220 should you have any questions. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.