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Surprise! New Jersey Health Care Providers Face Compliance With New Federal Out-of-Network Law

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In addition to providing funding for the federal government and for COVID-19 relief, the recently enacted Consolidated Appropriations Act, 2021, also includes legislation to safeguard patients from unexpected or "surprise" medical charges.

Effective January 1, 2022, the "No Surprises Act," shields patients from otherwise unanticipated high costs of care delivered by medical providers that are not within a patient's health plan network. Often, when an insured patient receives "out-of-network" care, generally on an emergent or unexpected basis, the patient's health plan does not cover some or all of the costs of those services, leaving the patient to pay the balance of the bill.

Several states, including New Jersey, have enacted a patchwork of laws in recent years to curb the practice of shifting unpaid medical costs onto patients. The new federal law will now ensure patients in every state receive similar price protections.

New Jersey's Out-of-network Law

In 2018, New Jersey enacted the Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act. Before then, many Garden State patients faced the possibility of "surprise" health care costs if they unexpectedly received medical treatment from an out-of-network provider or at an out-of-network facility.

One of the first states in the nation to enact comprehensive patient protection legislation, New Jersey included three primary components in the Act: (1) consumer price transparency and network disclosure requirements; (2) the establishment of a resolution process for out-of-network payment disputes between health plans and providers; and (3) billing protections for patients who receive "inadvertent out-of-network services" or out-of-network services provided on an "emergency or urgent basis," as the law defines those terms. With just over a year of data reported, the law has begun to show promise: out-of-network claims spending has dropped in both the individual and small employer health markets.

Yet because states are generally preempted from regulating self-funded health plans governed by the Employee Retirement Income Security Act of 1974, New Jerseyans who receive medical services under a self-funded plan are not guaranteed the same protections as patients with fully insured individual or small employer plans regulated by the state Department of Banking and Insurance. And Garden State providers must similarly account for this bifurcated regulatory framework when complying with New Jersey's out-of-network law.

The Federal No Surprises Act

Much like the New Jersey law, the "No Surprises Act," holds patients harmless from unanticipated costs of medical treatment beyond their in-network cost-sharing responsibilities under their health plans. Among other provisions, the law (1) prohibits balance billing; (2) requires health plans and providers to make available enhanced access to health care service pricing information, network status, and advanced notice of the cost associated with medical care; and (3) establishes a dispute resolution process for payment disputes between plans and providers.

1. Prohibiting Surprise Billing

Patients most often receive services from an out-of-network provider under two scenarios: (1) when receiving emergency medical treatment at an out-of-network hospital, or (2) when receiving

nonemergent treatment at an in-network facility but by an out-of-network provider and without their informed consent.

Patients who unexpectedly receive medical services from a provider out-of-network with the patient's health benefit plan will be required to pay no more than if the provider had been in-network with the patient's plan. The law prohibits plans and providers from shifting any additional, "surprise" costs onto the patient.

2. Consumer Transparency

The law also mandates increased transparency from both plans and providers so that patients may better understand their cost-sharing responsibilities before a scheduled health visit. Among these new transparency requirements, health plans must provide their members with an "advanced explanation of benefits" before an elective procedure that discloses the provider's network status and a "good faith" estimate of the member's cost-sharing obligations. Providers must similarly make efforts to obtain the patient's enrollment status and also disclose a "good faith" estimate of expected charges.

3. Dispute Resolution

If a provider and plan cannot agree on payment for out-of-network services rendered to a covered patient, the law establishes an "independent dispute resolution" process to settle payment disputes through binding arbitration. Similar to winner-take-all, "baseball style" arbitration, providers and plans will submit a payment offer to an independent arbitrator, who will determine which of the two offers to select using a list of review criteria supplied by Congress.

Takeaways

Garden State providers have until January 1, 2022, before the new law becomes effective. In the meantime, providers should develop new policies and procedures so that they are prepared to comply with the law on its effective date and conduct advanced trainings so staff can become familiar with the law's requirements.

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