



GOVERNMENT RELATIONS

Lockton Companies



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New Jersey enacts patient protection law for out-of-network care: Self-funded ERISA plans allowed to opt in

New Jersey is the latest state to enact a law designed to protect health plan enrollees from surprise billings for out-of-network care. To date, approximately twenty states have enacted laws that offer some level of protection for enrollees in insured health plans. These laws can prohibit balance billing, require the insurer hold the patient harmless for any out-of-network charges or require arbitration of billing grievances.

No such federal protection applies to enrollees under self-funded Employee Retirement Income Security Act (ERISA) plans. Because ERISA could pre-empt any such state laws attempting to apply to self-funded plans, most states have excluded ERISA plans from any prohibitions from out-of-network billing.

New Jersey has taken a novel approach in attempting to allow enrollees in self-funded ERISA plans the same protections that apply to insured plans, if the plan sponsor opts in to the new law. It's possible the new law may be challenged in court on the grounds of ERISA pre-emption.

Lockton comment: While the Affordable Care Act (ACA) contains several consumer protections, such as an out-of-pocket limit for plans not grandfathered, those prohibitions do not apply to out-of-network care. Although the ACA requires coverage for emergency care, those rules do not prohibit balance billing by an out-of-network health provider.

Surprise billings for out-of-network (OON) care

New Jersey Governor Phil Murphy recently signed into law the Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act that is intended to protect patients from surprise bills for out-of-network care. Typically, balance billing occurs with respect to out-of-network emergency care or for ancillary services related to in-network, nonemergency care, such as lab tests and anesthesia.

The law becomes effective on Aug. 30, 2018, (90 days following the enactment date of June 1) and applies to any health benefits plan that pays or provides hospital and medical expense benefits for covered services and is delivered or issued for delivery in New Jersey through a carrier, including any insured multiple employer welfare arrangement (MEWA). Specifically excluded from the new law are dental coverage, hospital indemnity insurance, TRICARE supplement insurance, Medicaid, Medicare, Medicare

Advantage, accident only, credit, disability, long-term care, automobile medical payment insurance, personal injury protection insurance and workers' compensation.

Lockton comment: Regulators will need to address several issues related to the application of the new law. Nothing in the law indicates it is limited to New Jersey residents – all that is required is the insurance contract be delivered or issued for delivery in New Jersey. Similarly, the law appears to apply to healthcare providers located outside New Jersey if the patient is covered under a policy delivered or issued for delivery in New Jersey. It is not clear how the state intends to enforce the provisions relative to out-of-state providers. Further clarification on these issues will be welcomed.

New consumer protections

The law has many new requirements that apply to both health providers and health insurers:

- Out-of-network billing for emergency and urgent care: For care received on an "emergency or urgent basis," the law restricts the amount a provider may charge in excess of deductible, copayment, or coinsurance amount applicable to in-network services.
- Disclosure and transparency: For nonemergency or nonurgent care, the law requires providers to better inform patients before services are rendered. This includes informing patients of the following:
 - The in- or out-of-network status of the providers, as well as a disclaimer regarding the responsibility of the patient to pay any additional out-of-network fees.
 - An estimate of fees. The law also includes a requirement for facilities to establish public postings regarding standard charges.

Furthermore, unless the patient knowingly, voluntarily and specifically chooses an out-of-network provider, no out-of-pocket charges apply in excess of the charges for the in-network procedure. In addition, the law applies to inadvertent use of out-of-network providers (pursuant to the rules in the law).

- Network changes: Health insurance carriers are required to provide written notice of changes to their network within 20 days of the addition or termination of a network provider. If a carrier authorizes a service to be performed by an in-network provider, and the provider or facility status changes to out-of-network before the service is performed, the carrier must notify the covered person that the provider or facility is no longer in-network at least 30 days prior to the authorized service being performed. Otherwise, the covered person's financial responsibility is limited to the financial responsibility that would have been incurred had the provider been in-network.
- Arbitration: A new arbitration process applies to resolve out-of-network billing disputes. Where insurance carriers and providers cannot agree on an acceptable reimbursement for services, an arbitrator would choose between one of two final offers submitted by the parties. The arbitration rule is also available for enrollees who are covered under a self-funded ERISA plan that chooses not to be covered by the law (more discussion below).

Health insurers or health facilities who violate the rules face penalties of up to \$1,000 per violation per day, up to \$25,000 per occurrence.

Self-funded ERISA plans

The law contains rules allowing self-funded ERISA plans to choose to be covered by the same rules that apply to insured plans. To do so, the plan must do the following:

- File an annual notice with the state that the plan intends to be covered by the new law,
- Amend its plan documents to address compliance with the New Jersey law, and
- Issue health insurance identification cards indicating the plan has elected to be covered by the law.

Lockton comment: Many employers with self-funded plans may want to opt in to the new rules despite the procedural headaches for doing so. Their employees will be expecting the protections offered by the law, and we expect plan administrators will be in a position to provide the same services for self-funded plans that will apply to fully insured plans. Generally, employers will not want to put their employees in a worse financial position in circumstances where balance billing could occur.

The state regulators still need to address the mechanics of the election and whether third-party administrators of self-funded ERISA plans will be able to file the elections on behalf of the plans they administer. It remains to be seen what guidance, if any, will be issued by state regulators prior to the law's effective date.

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