Self-Funded Group Health Plan Sponsors Face Choice Under New Jersey Surprise Billing Law

Issue Date: August 2018

New Jersey recently became the latest state to enact a law aimed at safeguarding patients from crippling unexpected bills following emergency medical treatment. The Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (Act) addresses a healthcare marketplace legislators say is rife with surprise out-of-network charges, balance billing, and oppressive debt collection actions despite certain Affordable Care Act provisions aimed at curbing these practices.

Summary

Key provisions of the Act, which takes effect August 30, 2018, include the following:

- Healthcare providers will generally be prohibited from charging more for emergency or urgent services rendered by a provider or facility that is out of a group health plan's provider network than the amounts the plan would charge patients for the same services if rendered by an in-network provider or facility.
- Rights to payment for services will be assigned directly to providers, meaning an insurance carrier for an insured group health plan will pay the amounts directly to a provider without patient involvement.
- Patients, carriers, providers and, in some cases, self-funded group health plan sponsors will have to follow specific arbitration procedures to resolve disputes over unpaid bills.
- Medical facilities and practitioners will have to more clearly disclose their network status; advise individuals to carefully check with any physician arranging facility services to verify network status; and inform individuals that, at an in-network health care facility, they will not be responsible for amounts above any in-network copayment, deductible, or coinsurance unless they knowingly, voluntarily, and specifically select an out-of-network provider to provide services.
- Health care providers who have made the necessary disclosures will no longer be able to initiate debt collection actions for any higher amount than applies to an in-network procedure in most cases.

The Act generally applies to all insurance carriers, practitioners and facilities providing medical coverage or care in New Jersey. On the other hand, the Act generally does not apply to a self-funded group health plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) unless the plan sponsor affirmatively opts to be covered and notifies its participants that it has opted in.

Self-Funded Health Plans

A self-funded plan group health plan sponsor may opt in annually using a form not yet developed or published by the New Jersey Department of Banking and Insurance (DOBI). A plan sponsor that opts in also must issue a health insurance identification card to participants to alert them that the plan has elected to be subject to the Act. The DOBI has yet to produce or publish a template identification card. Plan sponsors who do not opt in will not be subject to any fine, penalty or other negative consequence.

Given there is no harm to self-funded plan sponsors who do not opt in, they will need to balance a desire to help protect their participants from surprise medical bills against the administrative burden of following the Act's notice provisions and the potentially higher plan costs associated with following the Act's arbitration provisions.

Self-funded plan sponsors also should be fully aware of the other potential effects of opting in to the Act. For example, plan sponsors will need to amend their plans and claims procedures, as well as modify employee communications to explain how the Act will affect plan operations and participation. Plan sponsors also will need to understand how the Act's payment and arbitration provisions will impact any anti-assignment provisions that currently serve to insulate against providers seeking payment for unpaid medical bills directly from the plan.

Additional Important Items

Finally, the Act's arbitration provisions will add to plan expenses and could bind a plan sponsor to pay even more for medical costs if an arbitrator sides with a provider's assessment of the appropriate charge for services rendered. The plan sponsor also will bear at least half of the arbitrator's expenses and fees. If an arbitrator finds that the plan sponsor acted in bad faith – which is a difficult standard to predict – a plan sponsor will have to pay all arbitration expenses and fees. Additionally, a plan sponsor would need to bear the cost of any legal counsel it engages to handle the arbitration.

Plan sponsors should also be aware that even if they do not opt in to be covered by the Act, their participants still will benefit from it. Specifically, if an out-of-network provider and a self-funded plan participant do not resolve a disputed charge within 30 days after the participant receives the disputed bill, he or she may initiate binding arbitration to determine proper payment. More importantly, the Act prohibits a provider from collecting or attempting to collect reimbursement, including initiation of any collection proceedings, until the provider files a request for arbitration with the DOBI. The provider and participant will evenly split arbitration expenses unless they pose a financial hardship to the participant, in which case the DOBI will require the arbitrator to waive some or all of its costs.

Takeaway

Plan sponsors who have been embroiled in disputes over surprise out-of-network charges billed to their participants will no doubt agree with the Act's purpose. But, despite the Act's looming effective date, plan sponsors will need to wait at least until DOBI clarifies the Act's critical provisions and releases required forms and identification cards before opting into be covered. Moreover, prudence might warrant self-funded plan sponsors waiting to opt in until they have enough time to assess the Act's administrative and financial impact on overall plan operations.

If you have questions regarding the Act and its possible impact on your self-funded group health plan, please contact a member of your Frenkel benefits team.