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A Review of New Jersey's "Out-of-Network (OON) Consumer Protection, Transparency, Cost Containment and Accountability Act"

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Objectives

- Explain the Act's key provisions
  - Who is covered by the Act
  - Non-emergencies v. inadvertent, emergent or urgent care
  - Disclosure requirements
  - Patient hold harmless and balance billing prohibitions
  - Assignment of benefits and waiver of copays
  - Arbitration process
- Understand how the act affects physician practices
- Explain implementation strategies specific to physician practices

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- Dedicated to all size groups and independent physicians
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- Services:
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  - Practice Consulting Services
  - Compliance Services
  - Legislative Updates
  - Online and Onsite Education
  - Practice Management Tools

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- The Health Care Group represents clients in:
  - Health care business transactions
  - Healthcare mergers and acquisitions
  - Billing and coding audits and investigations
  - Regulatory compliance, including HIPAA
  - Medical practice employment and human resource questions
  - Licensing board investigations and litigation

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Overview

Assembly Bill 2039

- The Out-of-Network (OON) Consumer Protection, Transparency, Cost Containment & Accountability Act (the Act)
- Signed June 1, 2018
- Effective August 29, 2018
- Applies to state-regulated insurance plans
  - About 30% of plans
- Does not apply to federally regulated self-funded plans
  - About 70% of New Jersey's insurance market

Who is Covered by the Act?

- General Acute Care Hospitals
- Satellite Emergency Departments
- Hospital-based off-site Ambulatory Care Facilities
  - Where surgical care is performed
- Ambulatory Surgery Facilities
- Health Care Professionals acting within the scope of his/her licensure or certification
  - Includes, but is not limited to a physician and other health care professionals (e.g., Nurse Practitioners, Physician Assistants, etc.)

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Insurance Carriers Subject to the Act

- Insurance company authorized to issue health benefit plans
  - State-regulated insurance plans
- Health Maintenance Organizations (HMO)
- Health, Hospital, or Medical Service Corporations
- Multiple Employer Welfare Arrangements
- State Health Benefits Program
- School Employee' Health Benefits Program

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Insurance Carriers Not Included

- Self-Funded Plans were not included in the definition of a Carrier
- Can elect to opt-in to participate
- To opt-in must:
  - Notify Department of Banking and Insurance (DOBI) of intent
  - Issue a health insurance identification card to the primary insurer indicating that the plan is Self-Funded and has elected to be subject to the Act
    - Health care providers and covered person's need to know that the plan has opted in

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Suggested Action Items

Question:

- How will I know which self-funded plans have opted in at this time?

Answer:

- Initiate uniform OON law policies/procedures to comply with the law

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Insurance Plans Not Covered by the Act

- Medicaid
  - Included Medicaid Managed care
- Medicare
  - Includes Medicare Advantage Plans
- Accident Only
- Credit
- Disability Plans
- Long-term Care
- TRICARE Supplement coverage
- Workers' Compensation
  - Or similar law
- Automobile medical payment issuance
- Dental Plan
- Personal Injury Protection (PIP) Insurance
- Hospital Confinement Indemnity Coverage

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What does the Act do?

- Requires Providers to:
  - Disclosure network status
    - Plan and facility participation
  - Posting on their website of specific information e.g., Plans participating in and facilities
  - Notification and reporting requirements
  - Prohibits Balance Billing of Patients
    - Misrepresentation of network status
    - Emergency or Urgent services at an OON Facility
    - Receipt of inadvertent OON service at an In-Network Facility

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Penalties

- **Health Care Professional**
  - $100 per violation
  - Every day upon which a violation occurs shall be considered a separation violation
  - No health care professional shall be liable for a penalty greater than $2,500 for each occurrence
  - Report to licensing board
- **Health Care Facility or Carrier**
  - $1,000 per violation
  - Everyday upon which a violation occurs is considered a separate violation
  - No health care facility or carrier is liable for a penalty greater than $25,000 for each occurrence
  - Report to Commissioner of Health

Disclosure Requirements

Healthcare Professional Disclosures

- **Non-Emergency Services**
  - Prior to scheduling appointment – list participating health benefits plans and facilities you are affiliated with on website or in writing
  - At time of appointment – List participating health plans and facility affiliations verbally or in writing
  - If provider does not participate in covered person's health plan (OON)
    1. Disclose OON status
    2. Patient can request estimated amount they will be billed
  - Upon request:
    1. Estimated amount
    2. Associated CPT codes
    3. Inform patient of their financial responsibility in excess of deductible, co-pay or co-insurance
    4. Recommend patient contact their health benefits carrier for consultation of costs

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Healthcare Professional Disclosures

- **Procedures in Office, Coordinated or Referrals**
  - Office-based Procedures – involves other providers, e.g., anesthesiology, pathology, radiology, laboratory, assistant surgeon, MUST provide:
    - ► Name, practice name, mailing address and telephone number
  - Provide instruction on how patient can determine which plan the other providers participate in
  - Recommend the patient contact their health benefits carrier for consultation of costs.

***** If PCP or internist performs unscheduled procedure in office, the required disclosures may be made verbally at time of service.

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Healthcare Professional Disclosures

- **Scheduled Facility Service Inpatient or Outpatient**
  - Provide the patient and facility with:
    - Name, practice name, mailing address and telephone number of other physicians whose services will be arranged by you and who are scheduled at the time of preadmission, registration or admission.
  - Provide instruction on how patient can determine which plan the other providers participate in
  - Recommend patient contact their health benefits carrier for consultation of costs.
  - Promptly notify patient if the network status of the provider changes between the time scheduled and time procedure takes place.

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Physician Office Action Items

- Have one person coordinate and manage the overall process for this change
  - Must be someone who knows your revenue cycle and has a broad understanding of your practice
  - Someone who can manage the changes needed in a timely manner
  - Act as a liaison with other physician offices, health care facilities, and carriers
  - Physician needs to be oversight
- Review the Health Plans you participate in
  - Look at which plans you do not contract with or participate in
  - Remember this is not just at the Carrier level but down to the specific plan

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Physician Office Action Items

- Review your Financial Forms
  - You will need a "Disclosure Form" listing the health plans you participate in and the facilities you are affiliated with
    - Incorporate the disclosure form into your "Patient Registration Packet" – not just new patients
    - Must also include language on OON
    - Obtain patient signatures on all forms, especially if the patient knowingly and voluntarily uses you, if you are OON
    - Will need to be updated frequently if plan participation changes
- Develop a "script" for your schedulers/front desk, patient care team and others
  - Need to know what to say when a patient calls and:
    - Wants to set an appointment or needs a referral or to schedule a procedure etc.

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Physician Office Action Items

- Ensure list of carriers and health plans are kept up-to-date
  - Make sure staff knows plans participating in
    - Train them on this Act, they are on your front lines
  - If you have your carriers posted on your website be careful
    - It will need to be down to the plan level
    - You will need to keep it up-to-date
    - Put your web developer or webmaster on notice
- If you have items posted in your office stating what you participate, these must be kept up-to-date with your most current participation information

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Physician Action Items

- If you are have privileges at a health care facility, make sure you are provided with the notification of the provisions of this Act
  - Make sure you know the health benefits plan the facility has an in-network contract with
- Ensure you keep your plan participation information updated with the facility
  - Including accurate contact information
- Communicate any changes with the health care facility

Patient Hold Harmless Or Balance Billing Prohibition

Definitions

- **Knowingly, Voluntarily and Specifically Selected OON Provider**
  - Patient chose the specific provider with full knowledge that provider is OON with respect to the person's health benefits plan, even though he/she had opportunity to go to an in-network provider. Disclosure by a provider of network status shall not render a covered person's decision to proceed with treatment from that provider as a choice made knowingly.
- **Emergency Services**
  - Medical condition manifesting by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances and/or symptoms of Substance Use Disorder… which a prudent layperson could expect the absence of immediate medical attention to result in:
    1. Placing the health of patient or unborn child in serious jeopardy
    2. Serious impairment to bodily functions
    3. Serious dysfunction of a bodily organ or part
- **Urgent**
  - Treatment of a non-life threatening condition requiring care by healthcare professional within 24 hours. (NJ Dept of Banking and Insurance, Bulletin #18-14, Issued 11/20/18)
- **Inadvertent OON Services**
  - Healthcare services covered under a managed care health benefits plan that provides a network; and provided by an OON provider in the event a covered person utilized an in-network facility for covered healthcare services, and for any reason, in-network healthcare services are unavailable in that facility. (Ex: anesthesiologist, radiologist or pathologist during and otherwise in-network procedures.)

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Patient Hold Harmless: Non-Emergency "Knowingly or Voluntarily"

- Unless the covered person, at the time of disclosure, has knowingly, voluntarily, and specifically selected an out-of-network provider to provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network service
  - If the hospital indicates it is "in-network," the hospital cannot bill patient amounts in excess of in-network copayment, deductible, coinsurance amount
- Any bills, charges or attempts to collect by the facility, or health care professional involved in the procedure, in excess of the covered persons' copayment, deductible, or coinsurance as provided in the person's health benefits plan should be reported **IF not consented to knowingly and voluntarily**
- Health care facility must promptly notify patient if the facility's network status changes in between the time notice is provided and the time the procedure takes place.

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Healthcare Professional Balance Billing Prohibitions

- An OON provider **cannot** bill patient in excess of deductible, copay, or coinsurance (i.e. cost-sharing), applicable to in-network under his/her insurance plan for:
  - Emergency or Urgent medically necessary services
  - Inadvertent OON Services
- Provider **can** still bill the carrier
  - Dispute amounts must be ≥ $1000

Physician Office Action Items

- Create a Non-Emergency OON Provider Form
  - Estimated charges
  - CPT codes
  - Patient financial responsibility
    1. Any deductible, copay or coinsurance
    2. Excess amount above the allowed amount by health benefits plan
  - Patient to contact his/her health benefits plan for further information about benefits/coverage.
  - Acknowledgement statement that patient knowingly, voluntarily and specifically selected the OON provider
  - Patient signature and date

Assignment of Benefits and Waiver of Copays

Assignment of Benefits

- Inadvertent OON services, or services at an in-network or OON health care facility on an emergency or urgent basis, benefits provided by a carrier shall be assigned to the out-of-network provider
- Once the benefit is assigned:
  - **Any reimbursement paid by the carrier shall be paid directly to the out-of-network provider**
  - No action is required on the part of the patient
  - **The carrier shall provide the out-of-network provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the person**

Waiver of Copays: Violation

- To entice patients to use OON providers services,
  - That provider cannot, directly or indirectly knowingly waive, rebate, give, pay or offers to waive, rebate, give or pay all or part of the deductible, copay, or coinsurance owed by a patient
- An OON provider may waive, rebate, give, pay or offer to waive rebate, give, or pay all or part of deductible, copay owed by a patient if:
  - Not offered as part of advertisement
  - OON provider does not waive routinely
  - Good faith efforts made to determine a financial need; or
  - Fails to collect patient's deductible, copay, coinsurance after making reasonable efforts, which doesn't need to include sending to collections
  - Waiver, rebate, gift, payment or offer falls within any safe harbor under federal laws related to fraud and abuse concerning patient cost sharing.

Physician Office Action Items

- Develop a financial hardship policy/procedure that is uniformly and consistently implemented by all providers in a practice
  - Have a list of reduced charges (per CPT code) used when hardship is appropriate
  - Create a financial hardship form for patients to sign with patient responsibilities
- Create a payment plan

Claims Processing, Negotiation and Arbitration

Only for Inadvertent and/or Emergency or Urgent (Involuntary) Services: Non-elective services

Initial OON Claims Processing

- Out-of-network benefits will be assigned directly to provider
- Provider will bill the carrier for services provided in urgent or emergent situation (inadvertent and/or involuntary)
- The carrier can:
  - Pay the requested amount **OR**
  - Notify the provider within 20 days of receipt of the claim that it deems the claim excessive and remit electronically or by certified mail, payment for its portion of the initial allowed charge amount
- The carrier will provide methods to initiate negotiation, which must include certified mail, email and online form submission with remittance advice

OON Negotiation

- The OON provider:
  - Has the right to negotiate with the carrier for 30 days from the date of the receipt of the carrier's notification
    - Billed charges exceeded the amount the carrier determined as allowed charges
  - Must Advise carrier of intent to reject the payment within 30 days of receipt of the carrier's notification; and
  - Must use the notification method identified by the carrier (certified mail, email and/or online form submission)
- If the OON provider does not contact the carrier within 30 days of receipt of the carrier's notification, then the OON provider cannot seek redress through arbitration.
- If the parties cannot agree, binding arbitration is initiated
  - Disputed amount ≥ $1000

Arbitration

- The carrier or the provider must:
  - Notify the other that arbitration has been initiated within 30 days of the final offer
  - File the arbitration request with MAXIMUS (Independent Claims Payment Arbitrator used by NJ Department of Health)
  - Each party submits their final offer and a written submission
  - The arbitrator reviews the written submissions and selects one of the final offers.
  - NOT based on usual and customary as in NY and CT (Ex: Fair Health)
  - The decision is final and binding on both parties (1 of the 2 amounts submitted by the parties)
  - The decision is supposed to be issued 30 days after the request is filed.

Arbitration

- Arbitrator must consider:
  - Training, education and experience of the provider
  - The provider's usual charge for the service
  - Circumstances and complexity of the case
  - Patient characteristics (co-morbidities, etc.)
  - Average in-network payment
  - Average out-of-network payment
- The amount awarded must be paid within 20 days of decision.

Arbitration

- Arbitrator's fees will be split by the parties, unless determined carrier didn't act in good faith
- IMPORTANT: Arbitration is not available to patients who select an out-of-network provider for elective services
- ONLY FOR EMERGENCY AND URGENT MEDICAL SERVICES (Inadvertent and/or involuntary) – NOT ELECTIVE SERVICES

Physician Office Action Items

- Timely receipt, time-stamping and processing of mail
- Keep a log of all issues
  - Specific to each carrier
  - Carrier interpretations
- If discrepancies with the law and/or regulations
  - Contact carrier
  - Contact NJ DOBI to lodge a complaint

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Potential Office Business Impact

- Increased workload for billing, front desk, checkout and other staff
  - It will take more time for the registration process or to schedule a patient for a procedure
  - Referrals will need to be handled differently
- Decreased revenue from:
  - Patient liability OON carriers
  - OON carriers who no longer have to worry about their members getting balanced billed
- Balances on accounts may need to be manually reconciled
  - Expected account receivables may not be accurate
  - There will be no determination as to the correct amount allowed or expected payment amount
- Changes with patients plans through the year

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