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LONG-PENDING LEGISLATION PLACES NEW OBLIGATIONS ON OUT-OF-NETWORK PROVIDERS

Major changes in New Jersey by passing the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act

On June 1st, New Jersey Governor Phil Murphy signed into law the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the "Act") affecting healthcare facilities, medical practitioners and health insurance providers. This act places responsibility on healthcare providers to notify patients about services they will provide, and is designed to protect patients from surprise out-of-network healthcare charges.

There are many specific measures laid out in this law. Here are some of the key takeaways as listed directly in Assembly Bill No. 2039 from the New Jersey Legislature website:

- The bill also requires healthcare facilities that are in-network with respect to any health benefits plan to ensure that:
  - All providers providing services in the facility on an emergency or urgent basis accept reimbursement rates in accordance with the bill's provisions.
  - All healthcare professionals that are contracted with the facility to perform services in the facility are also in-network with respect to all health benefits plans with which the facility is in-network.
  - To report certain information to the Department of Health.
- A healthcare professional who is a physician is also required to make certain notifications concerning healthcare providers scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission. The physician shall provide instructions or information as to how to determine the health benefits plans in which the healthcare provider participates and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.
- The bill requires that a professional disclose to a covered person in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the healthcare professional is affiliated prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a healthcare professional does not participate in the network of the covered person's health benefits plan, the healthcare professional shall, in terms the covered person typically understands:
  - Inform the covered person that the professional is out-of-network and that the amount or estimated amount the healthcare professional will bill the covered person for the services is available upon request.
  - Upon receipt of a request from a covered person, disclose to the covered person in writing the amount or estimated amount that the healthcare professional will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided.
  - Inform the covered person that the covered person will have a financial responsibility applicable to healthcare services provided by an out-of-network professional.
  - Inform the covered person to contact the covered person's carrier for further consultation on those costs.
- If the network status of the facility changes as it relates to the covered person's health benefits plan, the bill requires the facility to notify the covered person promptly.
- Healthcare facilities are now required to:
  - Disclose whether the healthcare facility is in-network or out-of-network with respect to the covered person's health benefits plan.
  - Advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is in-network or out-of-network with respect to the covered person's health benefits plan and provide information about how to determine the health plans participated in by any physician reasonably anticipated to provider services.
  - Advise the covered person that at a healthcare facility that is in-network with respect to the person's health benefits plan that the covered person will have a financial responsibility applicable to an in-network procedure and unless the covered person 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 procedure.
  - Advise the covered person that at a healthcare facility that is out-of-network with respect to the covered person's health benefits plan that certain healthcare services will be provided on an out-of-network basis.
- Healthcare facilities must post the following on their website:
  - The health benefits plans in which the facility is a participating provider.
  - A statement concerning certain physician services provided in the facility.
  - As applicable, the name, mailing address, and telephone number of the physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology or radiology.
  - As applicable, the name, mailing address, and telephone number of physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.
- The bill also provides that if a covered person receives: inadvertent out-of-network services; or medically necessary services at an in-network or out-of-network healthcare facility on an emergency or urgent basis, the healthcare professional performing those services shall:
  - In the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount.
  - In the case of emergency and urgent services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount.
- If the carrier and the professional cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or professional may initiate binding arbitration.

Please click here to read the full statement containing additional details on the new legislation. Needless to say, the immense detail in this new law will bring hefty changes for healthcare facilities, as well as their providers. Concerned about how this may affect your organization? Our CG Healthcare Experts are here to help you analyze the best methods to move forward. Contact Mike Lewis, MBA, FACMPE and Deb Mathis, CPA, CHBC today.

Source:

A2039 AFI Statement 3/5/18 CC. (2018, March 5). Retrieved August 9, 2018, from http://www.njleg.state.nj.us/2018/Bills/A2500/2039_S1.HTM