**DISCLAIMER**

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he New Jersey Hospital Association’s (NJHA) Out-of-Network Implementation Toolkit (hereinafter “materials”) are intended to be tools that hospitals may use to implement and comply with the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.” The information provided in these materials should not be relied upon or regarded as legal advice. No specific representation is made, nor should be implied, nor shall NJHA or any other party involved in creating, producing or delivering this material be liable in any manner whatsoever for any direct, incidental, consequential, indirect or punitive damages arising out of your use of these materials. NJHA makes no warranties or representations, express or implied, as to the accuracy or completeness of the information contained or referenced herein. This publication is provided “AS IS” WITHOUT WARRANTY OF ANY KIND, EITHER EXPRESSED OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, OR NON-INFRINGEMENT. Some jurisdictions do not allow the exclusion of implied warranties, so the above exclusion may not apply to you. All images and information contained in these materials are copyrighted and otherwise proprietary. No use of this information is permitted without the prior written consent of NJHA. If you have other questions or concerns, please contact NJHA’s Legal Affairs at 609.275.4089.

**Physician Awareness Outreach**

[Hospital] is a strong proponent of price transparency. Therefore, we want to ensure the healthcare professionals working within [hospital] are aware of the protections for patients against receiving bills in **emergent** or **inadvertent** situations pursuant to the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” (“OON”).

A healthcare professional providing services in [hospital] must be aware that they must not **balance bill** patients who are enrolled in a fully insured health benefit plan issued in New Jersey or self-funded health plan provided by an employer that has chosen to opt in and elect to subject itself to the OON law. For patients covered under the OON law, financial responsibility for emergent or inadvertent out-of-network services is limited to the in-network cost-sharing amounts only. An out-of-network provider may initiate binding arbitration in instances where it is unable to negotiate an acceptable reimbursement amount with the carrier.

Additionally, even if a patient has a self-funded plan that has not elected to subject itself to the OON law, out-of-network providers must allow for a **thirty (30)-day** period, from the date the plan member is sent a bill, for negotiations between the self-funded patient enrollee and the provider. The­ provider must file a request for arbitration, if an amount can’t be agreed upon following that 30-day period, and the provider wishes to collect, attempt to collect or initiate collections for any monies above the patient’s cost-sharing amounts and what the health   
plan paid.

In accordance with the law, physicians are required to disclose in writing or via an Internet website the health benefit plans they participate with and the facilities with which they are affiliated. These disclosures also need to be made either verbally or in writing at the time of the appointment.

For patients who **knowingly, voluntarily and specifically** choose to utilize your services on an out-of-network basis, simply informing patients that you do not accept their insurance or are out-of-network does not satisfy the necessary standard established under the OON law. In these instances, you must inform patients **prior** to scheduling a **non-emergent** procedure:

That you are out of network with the plan; and

They can receive the amount or an estimated amount that you will bill the patient upon request.

If the patient requests such information, upon receipt of the request, you must disclose to the patient in writing:

* The amount or estimated amount you will bill for the service;
* The CPT codes associated with that service, noting that there may be unforeseen medical circumstances that may arise;
* The patient will have a financial responsibility greater than the copayment, deductible, or coinsurance;
* The patient may also be responsible for any costs greater than the amount allowed by the health benefits plan; and
* The patient should contact the carrier for more information about the costs for the services.

You must also provide the patient and [hospital name] with the name, practice name, mailing address and telephone number of any other physician whose services you will arrange for and are scheduled at the time of the preadmission, testing, registration or admission at the time the non-emergent services are scheduled.

If your network status changes prior to providing the services, you must contact the patient promptly.

A full copy of the law may be found at <http://www.njleg.state.nj.us/2018/Bills/PL18/32_.PDF>.