The New Jersey Hospital Association’s (“NJHA”) Federal/State Surprise Billing Requirements Toolkit (“Materials”) is intended to serve as tools that member hospitals may use to implement and comply with the requirements of both the New Jersey “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” and the federal “No Surprises Act.” Member hospitals should not regard any information provided in these Materials as specific legal advice, and they should consult with their own legal counsel for additional guidance as appropriate. NJHA and any other party involved in creating, producing, or delivering these Materials shall not be liable for any direct, incidental, consequential, indirect, or punitive damages arising out of the use of these Materials. The further distribution of these Materials is prohibited without the prior written consent of NJHA.

The information contained within the Materials is provided to assist members’ compliance efforts to protect consumers from surprise medical bills as required by law effective Jan. 1, 2022. However, it must be noted that the federal law requirements were issued as interim final rules—that are subject to change and are only accurate as of the date released.

Both the New Jersey out-of-network law and the federal No Surprises Act established independent dispute resolution (IDR) processes to resolve payment disputes between out-of-network providers and carriers.

While both processes are “baseball-style” arbitration, meaning that each party makes an offer and the arbitrator chooses one as the payment amount, the specifics of the processes concerning the factors for consideration, the assignment of independent dispute resolution entities (“IDREs”) and deadlines vary.

Under New Jersey law, the parties each provide the arbitrators with a final amount and any supporting documentation that they believe supports their submission regarding the correct payment amount.

However, the federal process allows both parties to submit the amount they believe is the correct payment, but the arbitrators must begin with the presumption that the qualified payment amount (QPA) is the correct payment amount. The qualified payment amount is a concept unique to the federal law and it establishes that the median in-network contracted rate, as identified by the payer, is a reasonable market-based rate. The arbitrator can consider other factors but only after providers share credible evidence that a material difference exists. Several legal challenges, as well as members of Congress, are questioning the Administration’s provisions related to the QPA. However, as of publication, the rules are still scheduled to go into effect on Jan. 1, 2022.

NJHA continues to seek clarification concerning the outstanding question of whether New Jersey’s law meets the definition of a “state-specific” law that would take precedence over federal law for plans governed by state law. New Jersey’s law does not have an established payment amount for arbitrators to consider. Therefore, CMS could determine that New Jersey’s process does not provide the same level of consumer protection and would therefore require the federal process to also apply to plans currently subject to state law. In order to ensure providers are fully informed about the numerous process differences, this document has been developed based on the presumption that state law will continue to apply.

An additional process difference includes the way, and number of, IDREs to be selected. New Jersey state law allows the Department of Banking and Insurance to contract through a request for proposal process with one or more arbitration entities that meet the requirements. At this time, New Jersey only uses one arbitration entity. For the federal process, CMS will accept applications from arbitration entities, allow stakeholders to provide comments on applicants that meet the requirements and will then approve a number of entities from which the parties can mutually agree to use, or an arbitration entity will be assigned by CMS.

Below is a chart of the different arbitration deadlines for the various processes. It should be noted that the federal process establishes that the timeframes largely apply to business days. The state process uses calendar days.

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| **PROCESS DEADLINES** | **STATE PROCESS**  NJ Regulated Plans, State and School Employees Health Benefits Plans and Self-Funded Plans That Opt-In | **FEDERAL PROCESS**  Self-Funded Plans |
| Negotiation Period | 30 days from receipt of carrier’s notice the billed amount is excessive. | 30 business days from receipt of initial payment or notice of denial. |
| Final Submissions Due | 7 days following the end of the negotiation period the carrier makes its final payment. This is the amount that is taken into arbitrations. | 10 business days after the date the IDREis selected (see selection deadlines below) |
| Arbitration Initiated | 30 days from the carrier’s final payment file with DOBI and notify carrier of initiation. | 4 business days starting on the business day after the negotiation period ends |
| IDRE Selection | N/A | 3 business days from the initiation date to mutually agree on a certified IDRE |
| Department Select IDR Entity | N/A | 6 business days triggered by the initiation date. |
| Arbitration Decision Due | 30 days from the date filed | 30 business days from the date of IDRE selection |
| Additional Payment Due (if applicable) | 20 days from the date of arbitration decision or interest starts to accrue. | 30 business days after arbitration decision |

It is notable that under federal regulations there is a “90-day lockout period.” Any party that initiates the arbitration process is “locked out” from taking the same party to arbitration for the same item or service for 90 days following a decision. This is one instance where the timeframe is based on calendar days.

Similarly, the federal arbitration process for patients to use in instances when a good faith estimate is substantially different from the billed amount uses calendar days. Providers should be aware that uninsured and self-pay patients have 120 calendar days from the date the patient receives a bill, to access an arbitration process if the bill is “substantially in excess,” defined as greater than $400, from the good faith estimate.