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.

New Jersey law requires certain providers to, among other things, provide patients with multiple notices when they contact the hospital or surgery center to schedule an appointment. These requirements apply to general acute care hospitals, satellite emergency departments, hospital-based off-site ambulatory facilities that perform ambulatory surgical procedures and ambulatory surgery facilities.

The federal “No Surprises Act” and its implementing regulations also establish disclosure requirements which are effective Jan. 1, 2022.

While the federal requirements defer to states that have state-based surprise billing protections, the federal requirements still must be overlaid on the state mandates to ensure full compliance.

**Comparison of State and Federal Disclosure Methods**

While both the state and federal requirements have disclosures that must be made to consumers, there are some differences in the information that must be contained in the disclosures, the timing of the disclosures, and the methods for disclosure. For comparison:

|  |  |
| --- | --- |
| **Federal Disclosure Methods***(Effective Jan. 1, 2022)* | **State Disclosure Methods***(Currently In Effect)* |
| Public Website | Public Website |
| Signage At Location  | Verbally When Scheduling |
| Document | Document |

Healthcare facilities subject to the requirements must provide disclosures through the methods identified above, both state and federal.

The federal requirements regarding the public website disclosure method indicate that the information must appear on a searchable homepage of the provider's or facility's website.

*Please note, the federal requirements for a website are in addition to existing state requirements. More information on the state requirements can be found here:* [The New Jersey Hospital Association (njha.com)](https://www.njha.com/resources/toolkits/oon-implementation-toolkit/)

With respect to the required signage disclosure, a provider or facility must post the sign prominently, at the location of the provider or facility.

**Proper Disclosure Notice Example Based on CMS’ Model**

*There are several issues on which NJHA continues to seek clarification from state and federal officials. We are awaiting a response concerning the state’s intention to develop a state-specific document for disclosures and if so, the extent to which the document’s language will apply to the various disclosure methods. Given that CMS indicated use of the model notice would meet the good faith effort standard, we recommend using CMS’ model disclosure notice below while we await further details.***Your Rights and Protections Against Surprise Medical Bills**

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

# What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

# You are protected from balance billing for:

## Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan’s in- network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

The New Jersey Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act (P.L.2018, c.32) (the “Act”), was signed into law on June 1, 2018, and became effective on August 30, 2018. The state law enhanced protections for consumers who receive health care services from out-of-network providers under the circumstances described below. These enhancements include:

* transparency and various disclosure requirements by providers and carriers;
* the creation of an arbitration system for out-of-network payment disputes; and
* protections for consumers for certain out-of-network bills.

## Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

**You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.**

**When balance billing isn’t allowed, you also have the following protections:**

* You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
* Your health plan generally must:
	+ Cover emergency services without requiring you to get approval for services in advance (prior authorization).
	+ Cover emergency services by out-of-network providers.
	+ Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
	+ Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you’ve been wrongly billed,** you may contact The New Jersey Department of Banking and Insurance at [NJDOBI | How To Request Assistance - Consumer Inquiries and Complaints (state.nj.us)](https://www.state.nj.us/dobi/consumer.htm) or **609-292-7272** or the Consumer Hotline **1-800-446-7467.**

Visit [No Surprises Act | CMS](https://www.cms.gov/nosurprises) for more information about your rights under federal law.

Visit [NJDOBI | Out-of-network Consumer Protections (state.nj.us)](https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html) for more information about your rights under state laws.

**Required Information Sharing with Covered Persons**

New Jersey law requires that information be shared with covered persons when they call to schedule an appointment. There is no similar requirement in the No Surprises Act. However, state and federal law both require that a person receive specific information in a document.

Below is the language we recommend using, based on New Jersey law, when engaging with a covered person over the phone to schedule an appointment.

***In-Network Facility (Fully Insured or Self-Funded Opt-In)***

When a patient contacts the facility to schedule an appointment for **a non-emergency** or **elective covered procedure,** they must first be informed:

* The facility is in-network.
* The patient should contact the physician ordering the healthcare services to determine whether that physician is in-network or out-of-network.
* Where they can find information on the insurance plans that the hospital’s employed and contracted physicians participate with. If the patient prefers a hard copy, it must be provided.
* They will not be expected to pay more than the in-network copayment, deductible, or coinsurance unless they specifically select an out-of-network physician, which can lead to higher out-of-pocket costs.
* Any in-network medical bills that a patient receives for more than the patient’s copayment, deductible, or coinsurance should be reported to the patient’s health insurance plan and the relevant regulatory agency, such as the Department of Banking and Insurance.
* Any network status change for the hospital or surgery center must be shared with the patient prior to the scheduled date of the healthcare services.

***Out-of-Network Facility (Fully Insured and Self-Funded Opt-In)***

Prior to scheduling a **non-emergent** or **elective** service for a patient that has a health insurance plan that is a fully insured, New Jersey-issued plan or is a self-funded plan that elects to be subject to the OON law AND your facility is out-of-network with that plan, you must notify the patient:

* *The facility is out-of-network with their health insurance plan.*
* *They could be charged more than the in-network copayment, coinsurance or deductible.*
* *They could be charged for the amount between what the insurance company pays the facility and what the facility bills the patient for the services.*
* *They should check with the physician ordering the healthcare services to determine if that physician is in-network or out-of-network with the patient’s health insurance plan.*
* *How to find out if any physician who is reasonably expected to provide services to the patient participates in their health insurance plan.*
* *You aren’t required to receive care from an out-of-network provider. You can choose to get care from a provider or facility in your health plan’s network, which may cost you less.*

***Self-Funded Plans That Do Not Opt-In***

Previously, under New Jersey law, providers were required to make certain disclosures if a patient was enrolled in a self-funded plan that did not elect to be subject to state law.

Given that self-funded plans must choose to either opt-in to state law requirements or follow federal requirements, the above disclosures are no longer relevant as the patient will now receive disclosures tailored to the specific process the self-funded plan has chosen to follow.

There are additional requirements governing notices that must be provided to patients in a document. Requirements for these notices are in the *Federal-State Notice of Patient Protections* resource.