The Law Offices of

COHEN & HOWARD, LLP

Conquering NJ's Out-Of-Network Law

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Background

- Law Firm in New Jersey for over 25 years with attorneys admitted in NJ, NY, CT and PA
- Represents out-of-network providers to increase reimbursements on denied or under-reimbursed ERISA and Non-ERISA claims
- Our firm represents providers through all phases of the out-of-network cycle
- Cohen and Howard represents over 100 out-of-network providers

What is the Stated Intent of the Legislation?

- Consumer protection. Consumers can no longer be balance billed for “Emergency or Urgent” care services or for “Inadvertent Out-of-Network Services”.
- Reduce the financial stress, deteriorating morale among providers, and reduced quality of care for consumers caused by “inadequate reimbursement” by carriers and government payers.
- Protect carriers and consumers from perceived excessive charges by certain health care professionals.
- “Resolve certain health care billing disputes” through negotiations.

Types of Plans

- **ERISA** – All private-sector employer plans, whether they are fully-insured or self-insured
- **Non-ERISA** – Plans offered by state and local government, 501(c)(3) or sold in the individual market, whether fully-insured or self-insured
- **Fully-Insured** – Assumption of Risk is on Insurance Company
- **Self-Insured** – Assumption of Risk is on Employer

What Plans Are Subject to NJ Surprise Bill?

OVERALL NJ PATIENTS COVERED UNDER SURPRISE BILL = 20 to 30%

Definitely:

- Fully-Insured Non-ERISA
- State Health Benefits Program
- School Employees' Health Benefits Program

Questionable:

- Fully-Insured ERISA – May be Preempted by ERISA

What Is Not Subject to NJ Surprise Bill?

OVERALL NJ PATIENTS COVERED UNDER SELF INSURED PLANS = 70 to 80%

- Self-Insured Non-ERISA Plans according to DOBI
- Self-Insured ERISA Plans that have not opted in

<u>Other Lines of Insurance Not Part of Bill:</u>

- PIP, Workers Compensation, Tricare
- Medicare and Medicaid
- Federal Employees

What Services Are Subject to Law?

Emergency and Urgent Basis – Covers In and Out-of-Network Facilities

Inadvertent Services – Only applies to In-Network Facilities

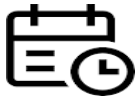
- Must be managed care health benefits plan that provides a network; and
- Facility must be in-network hospital under patient's plan; and
- In-Network Provider is unavailable for **ANY REASON**

➢Query: What happens when a patient is seen in the ER in an out-of-network hospital and the patient is admitted for surgery, does the Surprise Bill apply?

➢Query: How does this play out with network adequacy laws?

New Provider Disclosures

Healthcare Professionals
Non-emergent services



Prior to appointment must list participating plans and hospital affiliations on website or in writing

At time of appointment must list participating plans orally or in writing

If OON, prior to scheduling procedure provider shall disclose OON status and that estimated amount of bill is available upon request

Upon request of patient for service and associated CPT code, OON provider must then disclose in writing:

Amount or estimated amount expected to bill and CPT codes for service*

Inform patient will be financially responsible for charges in excess of patient deductible, co-pay or co-insurance and may be responsible for amounts in excess of those allowed per health plan*

Recommend patient contact carrier

For Physician Procedures
In office, coordinated or referred care

Provide contact information of other known medical providers (anesthesiology, pathology, etc.) scheduled to be involved in office surgery

Instruction on how a patient can determine which plan other providers participate in

Recommend patient contact carrier

Physician Covered Services
Scheduled *inpatient | outpatient*

Provide patient & facility, contact information of other physicians to be arranged by OON and who are scheduled at time of pre-admission, registration or admission

Instruction on how a patient can determine which plan other providers participate in

Recommend patient contact carrier

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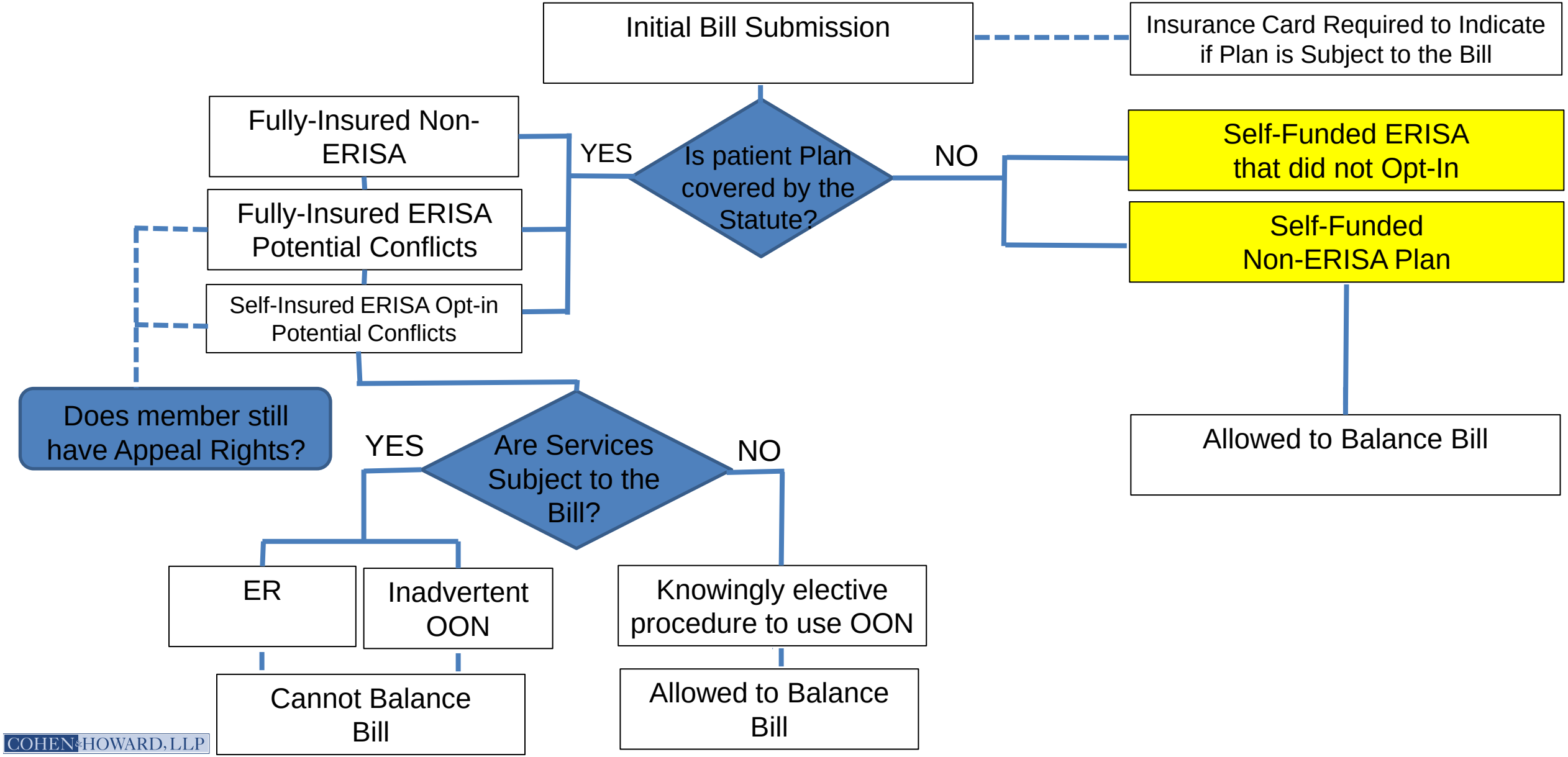
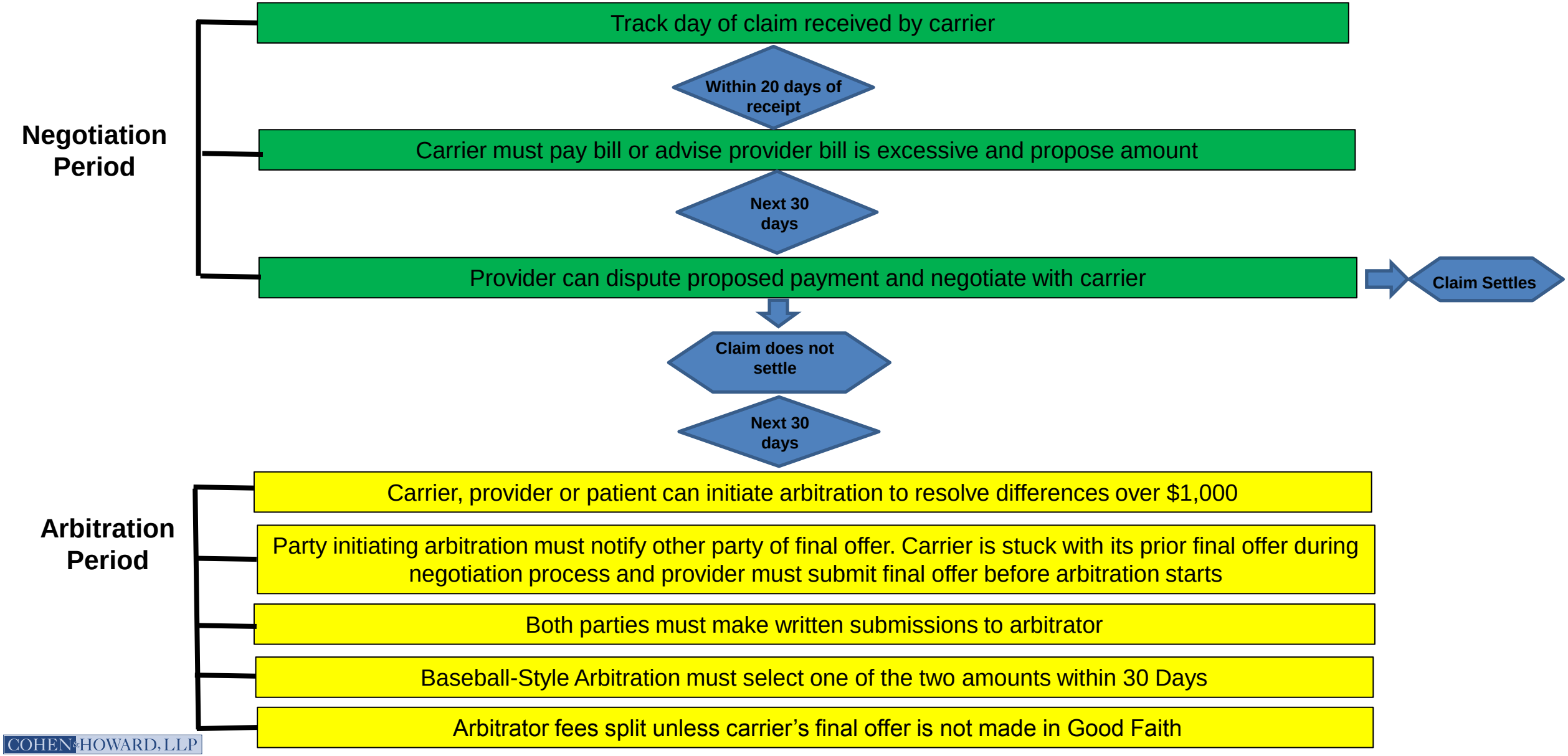
* Estimate is non-binding; Provider must update for any change in network status with regard to patient plan prior to any procedure
Division of Consumer Affairs will be specifying in further detail the content and design of these disclosures.

Is Claim Subject to Surprise Bill?



Arbitration Process for ER and Inadvertent OON



Overcoming the Assumption that CMS Rates Apply

- State Health Benefit Plan's current fee schedule pays at 90% of Fair Health
- Carrier communication and websites have referenced the use of UCR as basis to make payments
- Maximus, Inc. (DOBI Arbitration) has awarded ER out-of-network providers 90% of Fair Health
- New York and Connecticut Surprise Bill laws center around payments for ER at UCR
- Our firm has compiled a database of payments made to out-of-network providers up to 100% of billed charges

Positives to Be Taken from Surprise Bill

- Takes the decision as to payment amount out of the hands of the carrier. Payment amount to be determined by an independent third-party
- Establishes a procedure that should expedite payments, negotiations, and resolution of claims
- Statute creates an assignment of payment directly to provider, eliminating kept checks
- Puts onus on carrier to respond to initial claim submission within 20 days or (arguably) waives its right to object to the billed charges
- Baseball-Style Arbitration should necessitate increased offers made by the carrier due to the "all-or-nothing" nature of baseball arbitration
- Creates a potential cost (arbitration fees and attorneys' fees) associated with each underpayment which should increase offers made by carriers
- Requires carriers to provide greater transparency as to their out-of-network benefit and fee schedules
- Carrier has obligation to report to DOBI the number of claims submitted by providers that are denied or down coded and the reason for the denial or down coding

Negatives to Be Taken from Surprise Bill

- Unlikely Insurance Companies will ever initiate arbitration – burden on provider to initiate and share in costs
- Efforts to eliminate the out-of-network on-call specialists may be taken by the Hospitals
- Possibility of driving down in-network rates if more providers seek to join networks
- Arbitrators could default to CMS and/or plan rates
- Onerous disclosure requirements
- Elective process of out-of-network provider may be subject to scrutiny

Points to Ponder

- Can and will ERISA self-insured plans elect to opt-in?
- How is the carrier going to decide whether services are inadvertent?
- Be aware of varying patient obligations for ER vs. Inadvertent Services.
- How does provider know how and when to bill its patients?
- Will carriers try to avoid arbitration by reimbursing a reasonable amount in order to avoid drawing attention of DOBI and associated reporting?

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