Rising health-care costs are the principal focus of health-care reform. While the cause of the escalation is undoubtedly complex and multifaceted, it is argued that out-of-network (ONET) provider charges and practices have contributed, in varying degrees, to the increase in health insurance premiums. As a result, several states restrict ONET provider charges as well as the practice of "balance billing" patients, particularly in the case of emergency care.

On the other hand, many providers feel they are underpaid and are increasingly frustrated with insurer and government efforts to restrict or reduce their compensation in the midst of the growing administrative cost associated with the provision of health care. This article reviews New Jersey law with respect to ONET reimbursement rates and balance billing, and recent ONET legislative initiatives. Knowledge of the law in this area is key to guiding health-care providers with respect to the often difficult decision to be "in" or "out" of insurer networks, which can significantly impact their patient volume and compensation.

**Out-of-Network Balance Billing-"Surprise" Patient Charges**

Private health insurance coverage is often obtained through some form of managed care organization (MCO) arrangement whereby a network of health-care professionals are engaged to provide care to MCO enrollees, such as in the case of a health maintenance organization (HMO) or a preferred provider organization (PPO). An MCO contracts with "in-network" providers to render care to enrollees at set, often discounted, rates. In-network providers are generally required to accept the contract rate as payment in full and are prohibited from billing the enrollees for any amount (other than any applicable deductible, co-payment and/or co-insurance). Conversely, if an MCO enrollee receives services from an ONET health-care provider who has no contract with the MCO, the ONET provider is permitted to balance bill the MCO enrollee for the difference between what the MCO paid for the ONET services (if the ONET services were covered and were paid for at all) and the ONET provider's total charge. Therefore, MCO enrollees can expect that if they choose to receive care from an ONET provider, they will generally be exposed to much greater financial responsibility.

However, there are many cases where MCO enrollees have unanticipated ONET financial exposure. For instance, an insured may receive care from an in-network facility, such as a hospital, expecting that all services will be covered at in-network rates, only to realize that other providers who rendered care at the facility were ONET, such as radiologists and anesthesiologists. Also, if an MCO enrollee requires emergency care, the enrollee will often not have the option to choose an in-network facility and/or in-network providers within that facility. As a result, many enrollees receive "surprise" balance bills from ONET providers, the amounts of which can often be significant depending on an ONET provider's charges, the services rendered and the amount the MCO paid for the ONET services. (On the other end of the spectrum, many ONET providers will not balance bill patients and may waive deductible, co-payment
and/or co-insurance amounts. This practice has independently received much attention and is the focus of litigation and legislative efforts but is outside the scope of this article.)

**N.J. Law Regarding Out-of-Network Balance Billing**

New Jersey law in the ONET area is essentially a patchwork of statutes, regulations and interpretations of the New Jersey Department of Banking and Insurance (DOBI). One of the most significant sources of New Jersey precedent with respect to ONET balance billing is DOBI Order A07-59, pursuant to which DOBI levied fines against Aetna for "refusing to appropriately cover" certain ONET care, including emergency care. Aetna attempted to restrict payment to ONET providers, which resulted in ONET providers balance billing Aetna enrollees for often significant charges. DOBI interpreted its regulations-at N.J.A.C. 11:22-5.6(b)(1) (which was recodified and is now located at 11:22-5.8(b)(1)), 11:24-5.3(b), 11:24-5.1(a)(1) and 11:24-9.1(d)(9)-to prohibit an HMO member from having balance billing liability in the case of "services rendered by ONET providers for emergency care, during admissions to a network hospital by a network provider and where a member is referred by the HMO to a nonparticipating provider." In such situations, DOBI determined that:

Aetna must pay the [ONET] provider a benefit large enough to insure that the [ONET] provider does not balance bill the member for the difference between his billed charges and the Aetna payment, even if it means that Aetna must pay the provider's billed charges less the member's network copayment, coinsurance or deductible.

The DOBI order ultimately places the burden on the HMO to protect the insured from ONET balance billing; it does not prohibit ONET health-care providers from engaging in the practice of balance billing. Critics of the DOBI order argue that since it places no restriction on the provider with respect to balance billing, the order has provided a mechanism for ONET providers to demand higher levels of reimbursement for certain care, such as emergency care, thereby accelerating the rise in the cost of health-care services and insurance premiums. Providers argue the order appropriately places the burden with the HMO to ensure adequate reimbursement.

Some additional DOBI regulations that address ONET reimbursement and, arguably, impact balance billing, are as follows:

- **N.J.A.C. 11:22-5.8(b)(2)-** All contracts issued by HMOs and health service corporations, and all "selective contracting arrangement" (SCA) policies issued by insurance companies, must provide that "a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is an out-of-network provider, shall be limited to the co-payment, deductible and/or co-insurance applicable to network services." Pursuant to N.J.A.C. 11:22-5.2, an SCA is "a health benefit plan issued by an insurance company that provides covered services and supplies through a network of providers, and pays benefits for covered services and supplies provided by out-of-network providers."

- **N.J.A.C. 11:4-37.3(b)(2)-** Plans using an SCA must "provide that the cost sharing applied to the covered person for emergency care shall be the same regardless of whether the services were rendered by network or out-of-network providers."
- N.J.A.C. 11:4-37.3(b)(7)-Carriers that offer SCAs may not "calculate benefits for services provided by [ONET] providers by using negotiated fees agreed to by network providers."

**Proposed N.J. Out-of-Network Legislation**

New Jersey lawmakers have proposed several pieces of ONET legislation in recent years. One of the more significant bills currently pending is the "New Jersey All-Payer Claims Database Act" (S1216/A952). This act would establish a publicly accessible all-payer claims database. DOBI would be required to use the database to set a payment range, with minimum and maximum allowable payments, for covered medically necessary ONET services provided at network facilities where in-network services are unavailable. The database would be created by mandating health-care providers and payers to report, at least annually, certain information such as data regarding insurance claims; eligibility and enrollment; utilization; safety and quality; outcomes; and costs. Unless a covered person specifically rejects an assignment of benefits to the ONET provider in writing, the benefits for such services must be assigned to the ONET provider, the ONET provider may not bill the covered person for any amount (except for applicable deductible, co-payment and/or co-insurance amounts), and the insurance carrier must pay the ONET provider directly.

The act also establishes a binding arbitration process where insurance carriers and providers can resolve payment disputes. According to the All-Payer Claims Database Council—an organization dedicated to promoting all-payer claims databases throughout the Country—approximately 20 states have or are in the process of implementing some form of an all-payer claims database. One of the biggest hurdles states face in establishing these databases is justifying the significant costs of implementing, maintaining and securing them.

The following highlights provisions of other notable ONET bills currently pending in New Jersey:

- (S2536/A3771) Requires providers in certain managed care plans with in- and ONET benefits to give patients written notice when referring them to an ONET provider.

- (S869/A1069). Requires (1) insurers to disclose their ONET reimbursement methodology at the time of enrollment and make information regarding ONET benefits easily available thereafter; (2) facilities to provide written disclosures concerning ONET care, in-network alternatives and patients' financial responsibility prior to nonemergent procedures; and (3) physicians to notify patients of their ONET financial responsibility, including by providing a cost-estimate, prior to delivering nonemergent services. Plans may not terminate a provider's participation for making an ONET referral.

- (S2605/A3945). Requires network providers to obtain patient consent prior to utilizing ONET professionals to provide covered services.

- (S860). Providers must notify patients of ONET financial responsibility, including by providing a cost estimate, prior to delivering nonemergent services. Permits ONET providers to waive patient
financial responsibility under certain circumstances, including financial hardship. Plans must disclose certain information on their websites, such as quality rankings and ONET benefits.

(S1191/A3321). Establishes the "Center for the Study of Health Care Billing Data," which would utilize billing data required to be supplied by health plans to create a database of usual and customary charges. Any plans providing both in- and ONET benefits in managed care plans must utilize the database to determine responsibility for ONET charges.

The fate of these bills is uncertain. In the fall of 2014, the Assembly Financial Institutions and Insurance Committee held hearings focused on ONET care with the goal to propose new ONET legislation. As of the writing of this article, such legislation has yet to be introduced. However, it is clear that legislative efforts will continue to focus on ONET issues. Health-care providers and their counsel should closely review developments in this area to assist providers in their network contracting decisions."

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