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**BULLETIN NO. 21-14**

**TO:** **ALL INSURANCE COMPANIES AUTHORIZED TO ISSUE HEALTH BENEFITS PLANS, HEALTH MAINTENANCE ORGANIZATIONS, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS, THE STATE HEALTH BENEFITS PROGRAM, THE SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM, ENTITIES PROVIDING HEALTH BENEFITS PLANS, AND OTHER INTERESTED PARTIES**

**FROM:** **MARLENE CARIDE, COMMISSIONER**

**RE:** **IMPLEMENTATION OF THE FEDERAL NO SURPRISES ACT**

The Out-Of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act, P.L. 2018, c. 32 (codified at N.J.S.A. 26:2SS-1 to -20), ("NJ Act"), was enacted on June 1, 2018, and became effective on August 30, 2018. More recently, on December 27, 2020, the No Surprises Act ("Federal Act"), as part of the Consolidated Appropriations Act ("CAA") of 2021 (P.L. 116-260)[1], was enacted. The Federal Act takes effect on January 1, 2022 and applies to health plans issued or renewed on or after January 1, 2022.

Both the NJ Act and the Federal Act establish, among other things, consumer protections from surprise bills for inadvertent and emergency out-of-network health care services. On November 20, 2018, the Department of Banking and Insurance ("Department") issued Bulletin 18-14[2] to provide guidance with respect to the NJ Act. The Department now issues this bulletin to update Bulletin 18-14 in light of the Federal Act.

In general, while the Federal Act sets a minimum standard that applies to all health plans, including self-funded plans, federal employee plans, and "grandfathered" plans, states' laws remain operative so long as they do not prevent the application of the federal law.[3] Therefore, to the extent that the NJ Act applies, the Department will continue to enforce the NJ Act consistent with the guidance in Bulletin 18-14 as it relates to plans and circumstances subject to the NJ Act.

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[1] See CAA, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020) (enacting several new laws, including the No Surprises Act at div. BB, tit. I, 134 Stat. at 2757-2890).
[2] See the following link: https://www.state.nj.us/dobi/bulletins/blt18_14.pdf
[3] See 42 U.S.C. 300gg-23(a)(1); 86 Fed. Reg. at 36,886.

With respect to federally regulated plans, the federal Departments of Health and Human Services, Labor, and Treasury (collectively referred to as "the federal Departments") will enforce the provisions of the Federal Act. Federally regulated plans include self-funded plans that have not opted into applicable portions of the NJ Act. Additionally, the federal Departments will enforce provisions of the Federal Act with respect to particular services that are not governed by the NJ Act, such as air ambulances[4], and with respect to services rendered outside New Jersey.

- **Claims Processing and Arbitration:** The NJ Act creates an arbitration process pursuant to N.J.S.A. 26:2SS-10. The Federal Act created a separate Independent Dispute Resolution ("IDR") process that takes effect January 1, 2022 and applies to nearly all private employer plans and individual insurance. Federal rules related to the IDR process, released on September 30, 2021, establish the federal IDR process that out-of-network providers, including facilities and providers of air ambulance services, plans, and issuers in the group and individual markets may use to determine the out-of-network rate for applicable items or services after an unsuccessful open negotiation.

However, the federal guidance permits the application of the New Jersey law as it relates to state-regulated plans and self-funded plans that opt-in to the state arbitration process. Therefore, the arbitration process established in the NJ Act will continue to apply to disputes relating to state-regulated plans and self-funded plans that opt-in to the NJ Act. The State arbitration process under the NJ Act will continue as provided in Bulletin 18-14, while the federal IDR process will now apply to disputes relating to self-funded plans that did not opt in and in circumstances where the NJ Act does not apply.

Thus, a self-funded plan may continue to opt to be subject to the claims processing and arbitration provisions, as provided in Bulletin 18-14. A self-funded plan that previously opted into the New Jersey arbitration by filing an ID card with the Department may opt out of the NJ Act arbitration if it wishes to be subject to the federal IDR established under the Federal Act. If a self-funded plan wishes to opt-out of the NJ arbitration, notification should be sent to the Department at least two weeks in advance of such an opt-out taking effect. This informational filing should be submitted to the Department at the following email address: lifehealth@dobi.nj.gov

In short, with respect to out-of-network payment disputes between entities regulated under the NJ Act, such disputes continue to be subject to the state arbitration process. Any disputes between entities not regulated under the NJ Act, i.e. between a provider and a self-funded plan that has not opted-in to the NJ Arbitration provisions, and to services not covered by the NJ Act, i.e. air ambulance and services rendered out-of-state, may follow the federal IDR process.

- **Out-of-Network Billing:** The NJ Act prohibits providers from billing covered persons for inadvertent and/or involuntary out-of-network services for any amount above the amount resulting from the application of network level cost-sharing to the allowed charge/amount. See N.J.S.A. 26:2SS-7 to -9. The Department advises that to the extent that the balance billing protections contained in the Federal Law extend beyond the state law balance billing prohibitions, the Department will be referring complaints or balance billing prohibitions to the federal Departments or relevant state regulatory agencies as appropriate.[5]

- **ID cards:** The Federal Act requires that insurance cards issued to enrollees must have the following information: the applicable deductibles and out-of-pocket maximum limitations, as well as a telephone number and website address for individuals to use in seeking

[4] See 86 Fed. Reg. at 36,885.
[5] See 86 Fed. Reg. at 36,877.

assistance.[6] N.J.A.C. 11:22-8.3 contains certain similar requirements, but will be amended to conform with the requirements in the Federal Act, including adding maximum out-of-pocket maximums and appropriate telephone and website address information. In the meantime, carriers should implement these requirements in good faith at the next opportunity to update Identification Cards. The requirements contained in Bulletin 18-14 regarding self-funded opt-in information on the identification card remain operative.

- **Broker commissions:** The Federal Act[7] requires carriers offering individual health insurance coverage to disclose to enrollees prior to plan selection the amount of any direct or indirect compensation that the plan will pay to the agent or broker associated with that enrollment. This disclosure must also be included on any documentation confirming the enrollment. Issuers must also annually report this information to the Secretary of HHS. Such a requirement must be included in documentation to consumers as soon as possible after January 1, 2022. Each individual market carrier shall submit prior to sending to consumer a specimen of this disclosure document to the Department at the following email address: lifehealth@dobi.nj.gov

On August 20, 2021, the federal Departments released Frequently Asked Questions that advised deferred enforcement for certain provisions of the Federal Act.[8] Specifically, deferred enforcement for a comparison tool for price and quality information was delayed until plan year 2023.[9] Additional requirements related to an advance Explanation of Benefits were delayed until regulations can be adopted.[10] As outlined in Bulletin 18-14, the NJ Act also requires certain disclosure and transparency requirements for managed care plans. Specifically, carriers are required to: maintain up-to-date website postings of network providers; provide clear and detailed information regarding how voluntary out-of-network services are covered for plans that feature out-of-network coverage; provide examples of out-of-network costs; provide treatment specific information as to estimated costs when requested by a covered person; and maintain a telephone hotline to address questions. See N.J.S.A. 26:2SS-6. The Department will continue to enforce the state laws' counterparts to the Federal Act until the federal provisions take effect.

Except as identified above, Bulletin 18-14 remains in effect for applicable regulated entities in New Jersey. To the extent Bulletin 18-14 is less inclusive or does not apply, the Federal Act will govern.

The Department anticipates proposing any necessary regulations to implement the above in the near future. Interested parties may access the Department's website at http://www.nj.gov/dobi/legsregs.htm to determine whether those regulations have been proposed.

12/30/21

Date

Marlene Caride
Commissioner

[6] See PHS Act 2799A-1(e).
[7] See PHS Act 2746.
[8] See the following link: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf
[9] See PHS Act 2799A-4.
[10] See PHS Act 2799A-1(f).

Appeal and Arbitration Processes Grid

| Process Name | Issues that can be Resolved | Who can Initiate | Who Decides | Citations |
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| Independent Health Care Appeals Program (established by Health Care Quality Act)<br><br>IHCAP | Medical Necessity of services, including whether a service is experimental, investigational, cosmetic, and dental rather than medical, whether an in-plan exception is warranted, and whether services are required on an emergency or urgent basis | Covered person, or provider acting with consent of the covered person | Independent Utilization Review Organizations under contract with the Commissioner, MAXIMUS as of 1/1/22 | N.J.S.A. 26:2S-11 and 12, N.J.A.C. 11:24-8.7 and N.J.A.C. 11:24A-3.6 |
| Program for Independent Claims Payment Arbitration (established by Health Claims Authorization, Processing and Payment Act)<br><br>PICPA | What is the appropriate payment for a covered service rendered by a provider, excludes disputes that can be submitted to the IHCAP and OON Arbitration | Network providers - any type of covered service, Out-of-network providers – services that do not qualify as inadvertent or emergency or urgent | Nationally recognized independent arbitration organization under contract with the Commissioner, currently MAXIMUS | N.J.S.A. 17:48-8.4e(2), N.J.S.A. 17:48A-7.12e(2), N.J.S.A. 17:48E-10.1e(2), N.J.S.A. 17B:26-9.1e(2), N.J.S.A. 17B:27-44.2e(2), N.J.S.A. 26:2J-8.1e(2), N.J.S.A. 17:48F-13.1e(2) and N.J.A.C. 11:22-1.13 |

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| Out-of-Network Inadvertent and Emergent/Urgent Arbitration (established by Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act)<br><br>OON Arbitration | Whether the final offer of the carrier or the final offer of the out-of-network provider is the appropriate reimbursement for inadvertent or emergency or urgent services rendered by the out-of-network provider where the person is covered by an insured plan, MEWA, SHBP/SEHBP or by a self-funded plan that opts to participate in the binding OON Arbitration process,<br><br>Or<br><br>What is a reasonable payment for inadvertent, emergency or urgent (involuntary) services rendered by the out-of-network provider when the person is covered by a self-funded plan that does not opt to participate in the binding OON Arbitration process | Out-of-network providers and carriers for insured plans, MEWAs, SHBP/SEHBP, out-of-network providers and plan administrators for self-funded plans that opt in to OON Arbitration, and covered persons and out-of-network providers for self-funded plans that do not opt in to OON Arbitration | Entity with experience in health care pricing arbitration and using American Arbitration Association certified arbitrations that is under contract with the Department, MAXIMUS | N.J.S.A. 26:2SS-10 |

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| Federal Independent Dispute Resolution (IDR) Established under the federal No Surprises Act | Determining the out-of-network rate that federally-regulated plans (that have not opted into the arbitration process in under the Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act) are required to pay providers for claims subject to surprise billing protections under PHS Act section 2799A-1 subsection (a)(1) or (b)(1), regarding coverage of emergency services and coverage of non-emergency services performed by nonparticipating providers at certain participating facilities. | Out-of-network providers and federally-regulated plans that have not opted into the OON arbitration under the Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act. | Independent Dispute Resolution (IDR) entities selected by the federal Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (collectively, the Departments). | Section 2799A-1(c)(6) of the Public Health Service Act (PHS Act), as amended by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021. |