



November 29, 2019

State of New Jersey  
Department of Banking and Insurance  
Office of the Commissioner  
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**Comments on Notice of Intended Rulemaking on Proposed New Rules and Amendments  
N.J.A.C. 11:24D to Implement the Out-of-Network Consumer Protection, Transparency,  
Cost Containment and Accountability Act.**

Dear Commissioner Caride:

New Jersey Appleseed Public Interest Law Center respectfully submits, on behalf of the NJ for Health Care, the following comments to the New Jersey Department of Banking and Insurance in response to the advance notice of intended rulemaking action seeking to implement the disclosure and arbitration requirements set forth in the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act, N.J.S.A. 26:2SS-1 to 20 (“Out-of-Network Act”).

NJ For Health Care is a broad-based coalition of health care, consumer, senior, student, disability, women's, labor, faith-based, civil rights and social justice organizations working to bring guaranteed, high quality, affordable health care to all New Jersey residents. We are dedicated to common sense, consumer friendly solutions to ensure that all residents are able to secure the health care they need, when they need it at a price they can afford. Representatives of NJ for Health Care were active in the stakeholder meetings convened by the sponsors of the Out-of-Network Act, where we sought to represent the interests of all consumers, who had become alarmed at the increasing number of surprise medical bills they were receiving from New Jersey health care providers. See “Surprise Medical Bills: What they are and how to stop them, while ensuring access to needed services and adequate payment to providers” (<https://www.njappleseed.org/healthcare>). It is thus through the consumer perspective that we offer these comments to assist the Department in improving the intended rules to ensure that they

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set forth clear directives that, in practice, will protect consumers from inadvertent medical bills rules and will be understood by individual patients, not just professionals employed by insurance plans and healthcare providers. Towards that end, we provide the following:

**N.J.A.C. 11:24D-1.1 Purpose and Scope**

NJ for Health Care believes that this rule adequately states the purpose and reach of the Out-of-Network Act thus informing the public as to who is and who is not covered by the Act. However, we assert that the regulation needs to do more in order to properly inform individuals covered by state regulated plans of the full nature of their protections regarding surprise medical bills. Prior to the enactment of the Out-of-Network Act, individuals covered by state regulated plans were already protected from balanced bills arising from emergency treatment provided anywhere in the country, and surprise out-of-network bills arising from treatment provided in an in-network hospital whether the out-of-network provider was licensed in New Jersey. Accordingly, we suggest that a sentence be added in this section of the regulations that informs consumers that nothing in this Act is intended to restrict, limit, curtail previous protections, such as the right not to be responsible for balanced bills arising from emergency treatment or inadvertent health services provided by an out-of-network provider in an in-network hospital located in another state.

Similarly, this section of the regulation adequately makes clear that the regulations only apply to self-funded plans that elect to participate in the claims processing and arbitration requirements of the Out-of-Network Act, and that such plans are not subject to the transparency requirements of the proposed rules. Notwithstanding, NJ for Health Care would like this section to say more. First, the regulations should note that there is nothing in the regulations prohibiting a self-funded plan from voluntarily adopting the transparency requirements of the proposed rule. Furthermore, we would like the Department, within these regulations or through other means, to inform self-funded plans of the opportunity to opt-in, and specifically, to specify the procedure they need to undertake in order to do so. At minimum, the Department, in furtherance of the Act's goal to "reform the health system" and "contain rising costs" should highlight the Act's reach to self-funded plans that "opt-in" on the Department's website, where it should also explain to consumers how they can bring such option to the attention of their employers. Information about the opportunity for self-funded plans to participate in the arbitration requirements of the Act, and instructions on how to do so should also be shared with the U.S. and New Jersey Departments of Labor and other appropriate agencies. If the Act is going to effect change in our State and cover a substantial majority of the insured residents, self-insured plans must be encouraged to opt in. Such encouragement should be the Department's explicit policy and should be set forth in the proposed rules. We believe such policy is consistent with the Out-of-Network Act's language and legislative intent.

**N.J.A.C. 11:24D-1.3 Transparency Disclosures**

In accord with the explicit language of the Out-of-Network Bill, the transparency disclosure template (N.J.A.C. 11:24D-1.3(a)(1)) set forth in the proposed rules states: "(3) That a

covered person's cost-sharing for inadvertent and/or involuntary out-of-network services is limited to the network level cost-sharing under the plan[.]” The fourth disclosure on the template then explains that a settlement between the carrier with the out-of-network health care provider “may increase the covered person's cost sharing liability above the amount indicated in the initial Explanation of Benefits.” Similarly, the disclosure requirements under **N.J.A.C. 11:24D-2.1 (Processing Claims for Inadvertent and/or Involuntary Out-of-Network Services Prior to Arbitration)** require the carrier to inform the covered person that “(E) if the negotiation is pursued and results in an agreement, the amount of the allowed charge may increase, which . . . may increase the covered person's cost sharing liability for the out-of-network claim.” See also Proposed new rule **N.J.A.C. 11:24D-2.1(f)**(if a negotiated settlement is not reached, the carrier must “(3) provide a notice to the covered person . . .(iv) . . .[whether] the covered person's total cost-sharing liability either has or has not increased. . .”).

Although people who understand the process and the law will not see any inconsistency between the two disclosures, we believe that the average consumer may be confused. On the one hand their cost sharing is limited to in-network levels and on the other hand, a negotiated settlement between the carrier and the provider may result in an increase in the cost-sharing set forth in the initial Explanation of Benefits. The logical fact that is missing is that the increase in the covered person's cost sharing that may result from a negotiated settlement is capped at the in-network rate. Accordingly, NJ for Health Care suggests adding that phrase to each of the sentences throughout the proposed regulations where the fact that a person's cost-sharing may increase due to a negotiated settlement between the carrier and the provider is discussed.

### **N.J.A.C. 11:2-17.9 Rules for Fair and Equitable Settlements Application to Life and Health Insurance**

The Department proposes to amend this regulation to “prohibit carriers, that issue health benefits plans in New Jersey with voluntary out-of-network benefits, from setting the initially determined allowed charge for inadvertent and/or involuntary out-of-network services at an amount that is less than the allowed charge for the same out-of-network services rendered on a voluntary basis under that same health benefits plan.” This provision directly conflicts with specific terms of the Act, is illogical, defeats one of the stated purposes of the Act, which is to contain rising costs, and is *ultra vires*.

First, there is no reason why a carrier's initial offer for an inadvertent and/or involuntary out-of-network service should differ for a person whose plan has voluntary out-of-network benefits from a person who does not have such benefits. The Act repeatedly states that a person who receives involuntary out-of-network is protected from balanced billing, and may be liable for cost sharing for the service only at in-network levels. The fact that a covered person may also have out-of-network benefits, and the terms of those benefits, should not be relevant to the carrier's initial offer of payment to the provider for such inadvertent or emergency services. Also, requiring the initially determined allowed charge for inadvertent services to be no less than the allowed charge for the same out-of-network services rendered on a voluntary basis (which is not a negotiated rate and one where the insured person is typically required to pay a significant portion thereof) would simply feed the increasing cost trend and undermine a stated goal of the Act-- *i.e.*, to contain costs.

Furthermore, the legislature specifically rejected including specific benchmarks and criteria to be employed in the arbitration process, and the Department thus has no authority to do so. At one time during the process, NJ for Health Care was a supporter of using Medicare rates or the median paid in-network claims rate as the primary factor to be considered during the arbitration process. The legislature ultimately decided not to include any defined measures in the Out-of-Network Act; rather, the Act directs the parties to make their final offer and directs the arbitrator, in what is called a baseball arbitration, to choose one or the other. Accordingly, the Act does authorize the Department to require the carrier to make a specific minimum offer when inadvertent or emergency services are provided to one of its insured; and thus, this amendment must be eliminated.

### **N.J.A.C. 11:24D-2.3 Self-Funded Health benefits plans -- Out-of-Network Arbitration Without Plan Opt-In**

In general, the proposed rules set forth in this regulation are directed at New Jersey residents whose self-funded health benefits plans have not opted to participate in the Act's processing and arbitration provisions and providers who provide inadvertent out-of-network services to them. Accordingly, NJ for Healthcare is requesting that the Department clarify certain provisions of the proposed new rule and make a concerted effort to speak clearly, unambiguously and directly so that average consumers can understand how to avail themselves of the arbitration system that is now available to them.

Pursuant to N.J.A.C. 11:24D-2.3(a), a member of a self-funded health benefits plan or the out-of-network provider may request binding arbitration for claims for inadvertent and/or involuntary out-of-network services "provided that: (1) there is no resolution of a payment dispute within 30 days after the member is sent a bill for the services." The proposed regulations applicable to carriers are very detailed as to what constitutes a final offer, and also specify that an "arbitration vendor will reject an out-of-network arbitration application received in excess of 30 days after the provider's receipt of the carrier's notification of its final offer allowed charge." N.J.A.C. 11:24D-2.2(e). We would like the Department to make clear that such stringent time limitations are not applicable to individuals, who receive a bill from provider, and then typically seek information from their carrier or employer before engaging in a negotiation with the provider. It often takes more than 30 days, if not months, before an individual realizes that they are in an impasse with the provider and are facing collection. Instead, we would like the rule to guide the individual consumer as to whether she faces any time barriers and how best to proceed. Currently, we have spoken to consumers who visit the Department's website and come away with the impression that they must file an application for arbitration within 30 days of receipt of the provider's bill; and always, that time period has passed before they realize that they are liable for an inadvertent out-of-network surprise medical bill. Both the regulation and the Department's website must make clear that that is not the case. N.J.A.C. 11:24D-2.3(b) implicitly does so by stating that after the 30-day negotiation period, either the provider or the member may initiate arbitration without requiring them to do so within any given time period. We would just request that the regulation explicitly state whether there are time limitations by when the member or provider must file for arbitration, and if so, what those time constraints are.

In accord with the Act, proposed rule N.J.A.C. 11:24D-2.3(c) provides “that the out-of-network health provider may not then subsequently [after the 30-day negotiation period] bill the member or initiate collection activity until the provider has filed a request for arbitration pursuant to this section.” It is our position that this regulation is not good policy and may conflict with New Jersey’s Fair Debt Collection Act, which requires a creditor to seek collection only with respect to a final and accurate debt. Debt collection must only be commenced after an arbitrator has resolved the dispute, or the individual debtor declines to initiate an arbitration or participate in an arbitration. In addition, the rule if interpreted literally would not permit the provider to bill the member or initiate collection activity if the covered member initiated arbitration and the provider was merely a respondent. It is not clear if that is what the legislature intended. Accordingly, we request that the Department find a workable solution that would only permit a provider to initiate collection activity after an arbitrator has resolved the dispute and/or the member declines to participate in an arbitration.

N.J.A.C. 11:24D-2.3(e) simply states that “arbitrations without plan opt-in will be administered by the Department’s out-of-network arbitration vendor.” This proposed rule, as well as N.J.A.C. 11:24D-2.3(f) inadequately informs an individual consumer whose plan has not opted in on how to proceed. These regulations must be much more specific and instruct an individual on where to find and obtain an out-of-network arbitration application, where to find the identity and mailing and electronic address of the Department’s arbitration vendor, and any other logistical information that will help them engage in the process. Furthermore, a guide as to the types of information an applicant should provide the arbitrator in order to justify their final offer to the provider would be appropriate. The process should be accessible to individuals representing themselves, especially since these are consumers who are typically fighting surprise medical bills that they cannot afford.

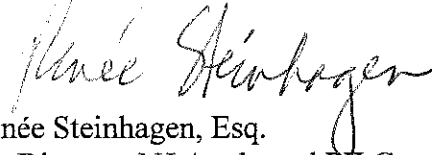
### **N.J.A.C. 11:24D-2.2 Arbitration of Claims for Inadvertent and/or Involuntary Out-of-Network Services**

Consistent with the Out-of-Network Act, proposed rule N.J.A.C. 11:24D-2.2(a) removes claims that do not equal or exceed \$1000 from the arbitration provisions of the Act. Instead for all inadvertent and/or involuntary out-of-network claims where the dispute does not equal or exceed \$1,000, “the initiating party may file for arbitration under the New Jersey Program for Independent Claims Payment Arbitration established by the Health Claims Authorization Processing and Payment Act, provided that the claim is otherwise eligible for, and the initiating party complies with the applicable rules of, arbitration under the New Jersey Program for Independent Claims Payment Arbitration.” From a consumer perspective, this regulation raises numerous questions and is not sufficiently informative. The Department either through regulation or on its website must provide contact information for the New Jersey Program for Independent Claims Payment Arbitration, and should at minimum specify who is eligible to initiate such arbitrations: are individual members of self-funded plans eligible to file for arbitration? Are non-New Jersey residents who receive emergency or inadvertent out-of-network services in New Jersey hospitals permitted to file for arbitration? Are arbitration fees fixed? In order for this regulation to accurately inform consumers of their potential remedies when faced with a surprise medical bill of less than \$1,000, this regulation must be fleshed out.

On behalf of New Jersey consumers, we look forward to the Department's promulgation of regulations that give logistical clarity to the consumer protections set forth in the Out-of-Network Act; and that render the dispute resolution system understandable to individual consumers by providing specific instructions on how to navigate the system once they have inadvertently received out-of-network health services.

Thank you for providing NJ for Health Care with the opportunity to submit our comments on the proposed rules.

Respectfully,



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-and-

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