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.

**Federal and State Restrictions on Balance Billing**

**When Not to Balance Bill**

Under federal law, a patient can never be billed in the following circumstances:

* Emergency services
* Unforeseen urgent medical needs arising when non-emergent care is furnished
* Ancillary services, including items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
* Items and services provided by assistant surgeons, hospitalists, and intensivists
* Diagnostic services including radiology and lab services
* Items and services provided by an out-of-network provider if there is not another in-network provider who can provide that service in that facility

**Detailed Scope of Patient Protections Against Surprise Medical Bills**

New Jersey’s Out-of-Network statute already prohibits healthcare providers, including professionals and facilities, from balance billing patients beyond in-network cost-sharing, unless the covered person “**knowingly, voluntarily and specifically selected an out-of-network provider.**”

The providers impacted by New Jersey’s law include:

* General acute care hospitals
* Satellite emergency departments
* Hospital-based off-site ambulatory care facilities in which ambulatory surgical cases are performed
* Ambulatory surgery facilities.

The federal No Surprises Act (NSA) similarly applies to healthcare facilities. However, it is applicable to additional healthcare facilities. Additionally, the NSA is more nuanced in that its applicability is further defined by the type of service provided. For example, under the NSA, patients are protected from surprise medical bills for emergency services and certain non-emergency services.

In the context of non-emergency services, the NSA defines a facility as:

* Hospitals, as defined at n 1861(e) of the Social Security Act (this includes rehabilitation hospitals as well as long term acute care hospitals)
* Hospital outpatient departments
* Critical access hospitals
* Ambulatory surgical centers.

For the purpose of emergency services, the NSA defines a facility as:

* Hospital emergency rooms
* Freestanding emergency departments
* Urgent care centers that are licensed to provide emergency care
* Air ambulance transportation.

The NSA further defines emergency services to also include post-stabilization services provided in a hospital following an emergency visit.

Post-stabilization care is considered emergency care until a physician determines the patient can travel safely to another in-network facility using non-medical transport, that such a facility is available and will accept the transfer, and that the transfer will not cause the patient other unreasonable burdens.

Furthermore, there are certain circumstances when a patient cannot be billed for non-emergency services provided at in-network facilities by out-of-network providers.

The requirements related to the NSA define non-emergency services as:

* Emergency medicine
* Anesthesiology
* Pathology
* Radiology
* Neonatology
* Items and services provided by assistant surgeons, hospitalists, and intensivists
* Diagnostic services, including radiology and laboratory services
* Items and services provided by a nonparticipating provider, if there is no participating provider who can furnish such item or service at the facility.

If the item or service falls outside all of the foregoing, the law does allow for patient billing but only if patients give prior written consent to waive their rights under the NSA and be billed more by out-of-network providers.

Finally, providers should be aware that they are never allowed to ask patients to waive their rights for emergency services or for certain other non-emergency services or situations described above. Consent must be given voluntarily and cannot be required, although providers can refuse care if consent is denied.

Information on the notice and consent process for patient billing is available in the Federal/State Disclosure Notice and Consent for Patient Billing resource within this toolkit.