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CATASTROPHIC ILLNESS IN
CHILDREN RELIEF FUND
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ADVISORY BULLETIN
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To: New Jersey Health Coverage Carriers, New Jersey Medicaid, Health Care Providers, Applicant Families, and other CICRF Stakeholders

From: Christian Heiss
Executive Director

Re: Non-Payment for Out-of-Network Ambulatory Care

The Catastrophic Illness in Children Relief Fund (CICRF, or the Fund) protects New Jersey families against the potentially devastating financial consequence of chronic or single episodes of serious illness of a child. The Fund is governed by a Commission that includes private individuals and, as ex officio members, the Commissioners of Health, Human Services, Children and Families, Banking and Insurance, and the State Treasurer.

The Commission's key duties are to: (1) review and make decisions on applications for financial assistance to the Fund, and (2) develop policies and procedures for the Fund's operation. The Commission conducts an annual review of its regulations and periodically reviews Fund procedures. During a recent review of regulations, the Commission focused on defined terms and Fund procedures in light of those definitions.

As explained further below, the Commission determined that existing state law and regulation **preclude any payment for ambulatory services received from out-of-network providers or facilities, where the use of out-of-network provider or facility by a child with comprehensive health coverage was not inadvertent, urgent, or due to an emergency**. The Commission directed the State Office of the Fund to process new applications and reconsiderations under this determination, effective for applications received on or after October 1, 2019.

The Law and Regulations

N.J.S.A. 26:2-149 states: "Catastrophic illness" means any illness or condition the medical expenses of which are **not covered by any other State or federal program or any insurance contract** and exceed 10% of the first $100,000 of annual income of a family plus 15% of the excess income over $100,000.

N.J.A.C. 10:155-1.2 provides regulatory guidance regarding the definition of catastrophic illness and states: "medical expenses… not covered by any other source, including, but not limited to, other State or Federal agency programs, insurance contracts, trusts, proceeds from fundraising, or settlements relative to the medical condition of a child…"

N.J.S.A. 26:2SS-1 et seq. requires out-of-network health care facilities and providers to notify consumers regarding their network status, estimated costs, and financial responsibility of the consumer. Further, it:

- provides a structure for arbitration to negotiate payment between insurers and providers for inadvertent out-of-network services, and
- prohibits out-of-network providers from inducing a consumer to seek health care services from that provider by waiving, rebating, giving, or paying for all or part of a deductible, copayment, or coinsurance or offering such payment.

What Does the Law Mean?

The CICRF Commission believes that state law and regulation are clear that the Fund is the payer of last resort for children's medical expenses.

If any other source of funding for the medical services are available, they must be utilized prior to the family receiving benefits from the Fund.

The legislation creating the Fund anticipated families applying to the Fund for out-of-network care for emergent care or serious illness or injury where the specific expertise and services of an out-of-network facility, provider, or specialist were warranted. The legislation did not contemplate the Fund as a source of coverage for all voluntary out-of-network services, or as a means to circumvent the provider networks or payment policies of established health coverage programs, including Medicaid.

Impact on Applicant Families

Families that have previously applied to the Fund for costs incurred as a result of ambulatory care received from out-of-network providers should anticipate that the Commission will determine such expenses ineligible if submitted to the Fund again. If the child's health coverage includes out-of-network benefits as is the case for Preferred Provider Organization (PPO) and Point-of-Service (POS) plans, the Fund will continue to consider out-of-network cost sharing, such as deductibles or copayments and any balance billing, as eligible expenses.

Families are encouraged to work with their health carrier to find in-network providers for future care, or to request an in-plan exception to use an out-of-network provider, when appropriate. Staff at the State Office of the Fund and Special Child Health and Early

Intervention Services case managers are available to help families understand the resources available to them.

Impact on Providers and Facilities

Under N.J.S.A. 26:2SS-1 et seq., providers and facilities in New Jersey are required to notify consumers regarding their network status, estimated costs, and financial responsibility of the consumer. Providers and facilities should no longer expect that the Fund will provide reimbursement on behalf of children receiving ambulatory services outside of their health insurance network. Providers who wish to continue to treat the children previously treated on an out-of-network basis are encouraged to consider participation in the networks of the plans in which their patients are covered.

Impact on Health Plans

Health plans may see a small increase in future utilization by families that have relied on the Fund for out-of-network services and now seek in-network care.

Key Definitions

Ambulatory services: Medical services performed on an outpatient basis, without admission to a hospital or other facility. Ambulatory care is provided in settings such as dialysis clinics, ambulatory surgical centers, hospital outpatient departments, and the offices or other practice sites of physicians and other health professionals.

Comprehensive health coverage: Plans that cover a wide range of health services (also known as major medical health insurance). Limited-benefit plans, which include critical illness plans, indemnity plans (policies that only pay a pre-determined amount, regardless of total charges), and "hospital cash" policies, are not considered comprehensive health coverage.

Emergency and Urgent Care: As defined in N.J.A.C. 11:24-5.3, to include (but not limited to): (1) medical and psychiatric care available 24 hours a day; (2) trauma services at any designated Level I or II trauma center as medically necessary; (3) out-of-service-area medical care when medically necessary for urgent or emergency conditions where the member cannot reasonably access in-network services; (4) prehospital care and hospital services regardless of location when medically necessary for injury or emergency illness; and (5) medical screening and examination upon arrival in a hospital, as required by the 42 U.S.C. § 1395dd.

Inadvertent care: Services covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility.