

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or <mailto:refdesk@njstatelib.org>

REPORTS:

HEARINGS:

NEWSPAPER ARTICLES: Yes

"Murphy signs out-of-network health care bill," NJBIZ, 6-1-2018

"Murphy declares end to surprise medical bills," Burlington County Times, 6-3-2018

"OKs bill to save you from out of network med cost\$," The Jersey Journal, 6-2-2018

"N.J. closes loopholes in surprise health bills - Murphy signs bill to close loopholes in surprise medical bills," The Press of Atlantic City, 6-2-2018

"Murphy signs medical bill law – measure closes holes in out-of-network rules," The Record, 6-2-2018

"'Win' in fight vs. surprise medical bills - Governor signs legislation aiming to curb problem," The Star-Ledger, 6-2-2018

"Gov. declares end to 'surprise medical bills' - Murphy signs bill into law: Supporters say it will protect thousands of New Jerseyans," The Times, 6-2-2018

"Surprise Out-of-Network Medical Bills Outlawed," New Jersey Law Journal, page 46, Vol. 224, No. 28

RWH/JA

Title 26.
Chapter 2SS.
(New)
Health Care
Consumer
Protection.
§§1-20 -
C.26:2SS-1 to
26:2SS-20
§21 - Note

P.L. 2018, CHAPTER 32, *approved June 1, 2018*
Assembly, No. 2039 (*First Reprint*)

1 **AN ACT** concerning health insurance and health care providers and
2 supplementing various parts of the statutory law.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6

7 1. This act shall be known and may be cited as the “Out-of-
8 network Consumer Protection, Transparency, Cost Containment and
9 Accountability Act.”

10

11 2. The Legislature finds and declares that:

12 a. The health care delivery system in New Jersey needs reforms
13 that will enhance consumer protections, create a system to resolve
14 certain health care billing disputes, contain rising costs, and measure
15 success with respect to these goals;

16 b. Despite existing State and federal laws and regulations to
17 protect against certain surprise out-of-network charges, these charges
18 continue to pose a problem for health care consumers in New Jersey.
19 Many consumers find themselves with surprise bills for hospital
20 emergency room procedures or for charges by providers that the
21 consumer had no choice in selecting;

22 c. While the Patient Protection and Affordable Care Act added
23 new patient protections requiring federally-regulated group health
24 plans to reimburse for out-of-network emergency service by paying
25 the greatest of three possible amounts: (1) the amount negotiated with
26 in-network providers for the emergency service furnished; (2) the
27 amount for the emergency service calculated using the same method
28 the plan generally uses to determine payments for out-of-network
29 services; or (3) the amount that would be paid under Medicare for the
30 emergency service, patients continue to face out-of-network charges
31 for surprise bills;

EXPLANATION – Matter enclosed in bold-faced brackets **[thus]** in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined **thus** is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AAP committee amendments adopted April 5, 2018.

1 d. Out-of-network benefits are a health insurance benefit
2 enhancement for which insureds pay an additional premium, but in
3 recent years, out-of-network coverage has been used inappropriately as
4 a means to diminish consumers' health insurance coverage, exposing
5 consumers to additional costs;

6 e. Carriers and consumers continue to report exorbitant charges
7 by certain health care professionals and facilities for out-of-network
8 services, including balance billing, and in certain cases, consumers'
9 bills are referred to collection, which contributes to the increasing
10 costs of health care services and insurance and imposes hardships on
11 health care consumers;

12 f. Health care providers and hospitals report that inadequate
13 reimbursement from carriers and government payers is causing
14 financial stress on safety net hospitals, deteriorating morale among
15 providers and reduced quality of care for consumers;

16 g. It is, therefore, in the public interest to reform the health care
17 delivery system in New Jersey to enhance consumer protections, create
18 a system to resolve certain health care billing disputes, contain rising
19 costs, and measure success with respect to these goals.

20
21 3. As used in this act:

22 "Carrier" means an entity that contracts or offers to contract to
23 provide, deliver, arrange for, pay for, or reimburse any of the costs
24 of health care services under a health benefits plan, including: an
25 insurance company authorized to issue health benefits plans; a
26 health maintenance organization; a health, hospital, or medical
27 service corporation; a multiple employer welfare arrangement; the
28 State Health Benefits Program and the School Employees' Health
29 Benefits Program; or any other entity providing a health benefits
30 plan. Except as provided under the provisions of this act, "carrier"
31 shall not include any other entity providing or administering a self-
32 funded health benefits plan.

33 "Commissioner" means the Commissioner of Banking and
34 Insurance.

35 "Covered person" means a person on whose behalf a carrier is
36 obligated to pay health care expense benefits or provide health care
37 services.

38 "Department" means the Department of Banking and Insurance.

39 "Emergency or urgent basis" means all emergency and urgent
40 care services including, but not limited to, the services required
41 pursuant to N.J.A.C.11:24-5.3.

42 "Health benefits plan" means a benefits plan which pays or
43 provides hospital and medical expense benefits for covered
44 services, and is delivered or issued for delivery in this State by or
45 through a carrier. For the purposes of this act, "health benefits
46 plan" shall not include the following plans, policies or contracts:
47 Medicaid, Medicare, Medicare Advantage, accident only, credit,
48 disability, long-term care, TRICARE supplement coverage,

1 coverage arising out of a workers' compensation or similar law,
2 automobile medical payment insurance, personal injury protection
3 insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), a
4 dental plan as defined pursuant to section 1 of P.L.2014, c.70
5 (C.26:2S-26) and hospital confinement indemnity coverage.

6 "Health care facility" means a general acute care hospital,
7 satellite emergency department, hospital based off-site ambulatory
8 care facility in which ambulatory surgical cases are performed, or
9 ambulatory surgery facility, licensed pursuant to P.L.1971, c.136
10 (C.26:2H-1 et seq.).

11 "Health care professional" means an individual, acting within the
12 scope of his licensure or certification, who provides a covered
13 service defined by the health benefits plan.

14 "Health care provider" or "provider" means a health care
15 professional or health care facility.

16 "Inadvertent out-of-network services" means health care services
17 that are: covered under a managed care health benefits plan that
18 provides a network; and provided by an out-of-network health care
19 provider in the event that a covered person utilizes an in-network
20 health care facility for covered health care services and, for any
21 reason, in-network health care services are unavailable in that
22 facility. "Inadvertent out-of-network services" shall include
23 laboratory testing ordered by an in-network health care provider and
24 performed by an out-of-network bio-analytical laboratory.

25 "Knowingly, voluntarily, and specifically selected an out-of-
26 network provider" means that a covered person chose the services
27 of a specific provider, with full knowledge that the provider is out-
28 of-network with respect to the covered person's health benefits
29 plan, under circumstances that indicate that covered person had the
30 opportunity to be serviced by an in-network provider, but instead
31 selected the out-of-network provider. Disclosure by a provider of
32 network status shall not render a covered person's decision to
33 proceed with treatment from that provider a choice made
34 "knowingly" pursuant to this definition.

35 "Medicaid" means the State Medicaid program established
36 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

37 "Medical necessity" or "medically necessary" means or describes
38 a health care service that a health care provider, exercising his or
39 her prudent clinical judgment, would provide to a covered person
40 for the purpose of evaluating, diagnosing, or treating an illness,
41 injury, disease, or its symptoms and that is: in accordance with the
42 generally accepted standards of medical practice; clinically
43 appropriate, in terms of type, frequency, extent, site, and duration,
44 and considered effective for the covered person's illness, injury, or
45 disease; not primarily for the convenience of the covered person or
46 the health care provider; and not more costly than an alternative
47 service or sequence of services at least as likely to produce

1 equivalent therapeutic or diagnostic results as to the diagnosis or
2 treatment of that covered person's illness, injury, or disease.

3 "Medicare" means the federal Medicare program established
4 pursuant to Pub.L.89-97 (42 U.S.C. s.1395 et seq.).

5 "Self-funded health benefits plan" or "self-funded plan" means a
6 self-insured health benefits plan governed by the provisions of the
7 federal "Employee Retirement Income Security Act of 1974,"
8 29 U.S.C. s.1001 et seq.

9

10 4. a. Prior to scheduling an appointment with a covered person
11 for a non-emergency or elective procedure and in terms the covered
12 person typically understands, a health care facility shall:

13 (1) disclose to the covered person whether the health care
14 facility is in-network or out-of-network with respect to the covered
15 person's health benefits plan;

16 (2) advise the covered person to check with the physician
17 arranging the facility services to determine whether or not that
18 physician is in-network or out-of-network with respect to the
19 covered person's health benefits plan and provide information about
20 how to determine the health plans participated in by any physician
21 who is reasonably anticipated to provide services to the covered
22 person;

23 (3) advise the covered person that at a health care facility that is
24 in-network with respect to the person's health benefits plan:

25 (a) the covered person will have a financial responsibility
26 applicable to an in-network procedure and not in excess of the
27 covered person's copayment, deductible, or coinsurance as provided
28 in the covered person's health benefits plan;

29 (b) unless the covered person, at the time of the disclosure
30 required pursuant to this subsection, has knowingly, voluntarily,
31 and specifically selected an out-of-network provider to provide
32 services, the covered person will not incur any out-of-pocket costs
33 in excess of the charges applicable to an in-network procedure;

34 (c) any bills, charges or attempts to collect by the facility, or
35 any health care professional involved in the procedure, in excess of
36 the covered person's copayment, deductible, or coinsurance as
37 provided in the covered person's health benefits plan in violation of
38 subparagraph (b) of this paragraph should be reported to the
39 covered person's carrier and the relevant regulatory entity; and

40 (d) that if the covered person's coverage is provided through an
41 entity providing or administering a self-funded health benefits plan
42 that does not elect to be subject to the provisions of section 9 of this
43 act, that:

44 (i) certain health care services may be provided on an out-of-
45 network basis, including those services associated with the health
46 care facility;

47 (ii) the covered person may have a financial responsibility
48 applicable to health care services provided by an out-of-network

1 provider, in excess of the covered person's copayment, deductible,
2 or coinsurance, and the covered person may be responsible for any
3 costs in excess of those allowed by the person's self-funded health
4 benefits plan; and

5 (iii) the covered person should contact the covered person's self-
6 funded health benefits plan sponsor for further consultation on
7 those costs; and

8 (4) advise the covered person that at a health care facility that is
9 out-of-network with respect to the covered person's health benefits
10 plan:

11 (a) certain health care services may be provided on an out-of-
12 network basis, including those health care services associated with
13 the health care facility;

14 (b) the covered person may have a financial responsibility
15 applicable to health care services provided at an out-of-network
16 facility, in excess of the covered person's copayment, deductible, or
17 coinsurance, and the covered person may be responsible for any
18 costs in excess of those allowed by their health benefits plan; and

19 (c) that the covered person should contact the covered person's
20 carrier for further consultation on those costs.

21 b. In a form that is consistent with federal guidelines, a health
22 care facility shall make available to the public a list of the facility's
23 standard charges for items and services provided by the facility.

24 c. A health care facility shall post on the facility's website:

25 (1) the health benefits plans in which the facility is a
26 participating provider;

27 (2) a statement that:

28 (a) physician services provided in the facility are not included in
29 the facility's charges;

30 (b) physicians who provide services in the facility may or may
31 not participate with the same health benefits plans as the facility;

32 (c) the covered person should check with the physician
33 arranging for the facility services to determine the health benefits
34 plans in which the physician participates; and

35 (d) the covered person should contact their carrier for further
36 consultation on those costs;

37 (3) as applicable, the name, mailing address, and telephone
38 number of the hospital-based physician groups that the facility has
39 contracted with to provide services including, but not limited to,
40 anesthesiology, pathology, and radiology; and

41 (4) as applicable, the name, mailing address, and telephone
42 number of physicians employed by the facility and whose services
43 may be provided at the facility, and the health benefits plans in
44 which they participate.

45 d. If, between the time the notice required pursuant to
46 subsection a. of this section is provided to the covered person and
47 the time the procedure takes place, the network status of the facility

1 changes as it relates to the covered person's health benefits plan,
2 the facility shall notify the covered person promptly.

3 e. The Department of Health shall specify in further detail the
4 content and design of the disclosure form and the manner in which
5 the form shall be provided.

6
7 5. a. Except as provided in subsection f. of this section, a
8 health care professional shall disclose to a covered person in writing
9 or through an internet website the health benefits plans in which the
10 health care professional is a participating provider and the facilities
11 with which the health care professional is affiliated prior to the
12 provision of non-emergency services, and verbally or in writing, at
13 the time of an appointment. If a health care professional does not
14 participate in the network of the covered person's health benefits
15 plan, the health care professional shall, in terms the covered person
16 typically understands:

17 (1) Prior to scheduling a non-emergency procedure inform the
18 covered person that the professional is out-of-network and that the
19 amount or estimated amount the health care professional will bill
20 the covered person for the services is available upon request;

21 (2) Upon receipt of a request from a covered person for the
22 service and the Current Procedural Terminology (CPT) codes
23 associated with that service, disclose to the covered person in
24 writing the amount or estimated amount that the health care
25 professional will bill the covered person for the service, and the
26 CPT codes associated with that service, absent unforeseen medical
27 circumstances that may arise when the health care service is
28 provided;

29 (3) Inform the covered person that the covered person will have
30 a financial responsibility applicable to health care services provided
31 by an out-of-network professional, in excess of the covered
32 person's copayment, deductible, or coinsurance, and the covered
33 person may be responsible for any costs in excess of those allowed
34 by their health benefits plan; and

35 (4) Advise the covered person to contact the covered person's
36 carrier for further consultation on those costs.

37 b. A health care professional who is a physician shall provide
38 the covered person, to the extent the information is available, with
39 the name, practice name, mailing address, and telephone number of
40 any health care provider scheduled to perform anesthesiology,
41 laboratory, pathology, radiology, or assistant surgeon services in
42 connection with care to be provided in the physician's office for the
43 covered person or coordinated or referred by the physician for the
44 covered person at the time of referral to, or coordination of, services
45 with that provider. The physician shall provide instructions as to
46 how to determine the health benefits plans in which the health care
47 provider participates and recommend that the covered person should

1 contact the covered person's carrier for further consultation on costs
2 associated with these services.

3 c. A physician shall, for a covered person's scheduled facility
4 admission or scheduled outpatient facility services, provide the
5 covered person and the facility with the name, practice name,
6 mailing address, and telephone number of any other physician
7 whose services will be arranged by the physician and are scheduled
8 at the time of the pre-admission, testing, registration, or admission
9 at the time the non-emergency services are scheduled, and
10 information as to how to determine the health benefits plans in
11 which the physician participates, and recommend that the covered
12 person should contact the covered person's carrier for further
13 consultation on costs associated with these services.

14 d. The receipt or acknowledgement by any covered person of
15 any disclosure required pursuant to this section shall not waive or
16 otherwise affect any protection under existing statutes or
17 regulations regarding in-network health benefits plan coverage
18 available to the covered person or created under this act.

19 e. If, between the time the notice required pursuant to
20 subsection a. of this section is provided to the covered person and
21 the time the procedure takes place, the network status of the
22 professional changes as it relates to the covered person's health
23 benefits plan, the professional shall notify the covered person
24 promptly.

25 f. In the case of a primary care physician or internist
26 performing an unscheduled procedure in that provider's office, the
27 notice required pursuant this section may be made verbally at the
28 time of the service.

29 g. The appropriate professional or occupational licensing board
30 within the Division of Consumer Affairs in the Department of Law
31 and Public Safety shall specify in further detail the content and
32 design of the disclosure form and the manner in which the form
33 shall be provided.

34

35 6. a. A carrier shall update the carrier's website within 20 days
36 of the addition or termination of a provider from the carrier's
37 network or a change in a physician's affiliation with a facility,
38 provided that in the case of a change in affiliation the carrier has
39 had notice of such change.

40 b. With respect to out-of-network services, for each health
41 benefits plan offered, a carrier shall, consistent with State and
42 federal law, provide a covered person with:

43 (1) a clear and understandable description of the plan's out-of-
44 network health care benefits, including the methodology used by the
45 entity to determine the allowed amount for out-of-network services;

46 (2) the allowed amount the plan will reimburse under that
47 methodology and, in situations in which a covered person requests
48 allowed amounts associated with a specific Current Procedural

- 1 Terminology code, the portion of the allowed amount the plan will
2 reimburse and the portion of the allowed amount that the covered
3 person will pay, including an explanation that the covered person
4 will be required to pay the difference between the allowed amount
5 as defined by the carrier's plan and the charges billed by an out-of-
6 network provider;
- 7 (3) examples of anticipated out-of-pocket costs for frequently
8 billed out-of-network services;
- 9 (4) information in writing and through an internet website that
10 reasonably permits a covered person or prospective covered person
11 to calculate the anticipated out-of-pocket cost for out-of-network
12 services in a geographical region or zip code based upon the
13 difference between the amount the carrier will reimburse for out-of-
14 network services and the usual and customary cost of out-of-
15 network services;
- 16 (5) information in response to a covered person's request,
17 concerning whether a health care provider is an in-network
18 provider;
- 19 (6) such other information as the commissioner determines
20 appropriate and necessary to ensure that a covered person receives
21 sufficient information necessary to estimate their out-of-pocket cost
22 for an out-of-network service and make a well-informed health care
23 decision; and
- 24 (7) access to a telephone hotline that shall be operated no less
25 than 16 hours per day for consumers to call with questions about
26 network status and out-of-pocket costs.
- 27 c. If a carrier authorizes a covered health care service to be
28 performed by an in-network health care provider with respect to any
29 health benefits plan, and the provider or facility status changes to
30 out-of-network before the authorized service is performed, the
31 carrier shall notify the covered person that the provider or facility is
32 no longer in-network as soon as practicable. If the carrier fails to
33 provide the notice at least 30 days prior to the authorized service
34 being performed, the covered person's financial responsibility shall
35 be limited to the financial responsibility the covered person would
36 have incurred had the provider been in-network with respect to the
37 covered person's health benefits plan.
- 38 d. A carrier shall incorporate into the Explanation of Benefits
39 and all reimbursement correspondence to the consumer and the
40 provider clear and concise notification that inadvertent and
41 involuntary out-of-network charges are not subject to balance
42 billing above and beyond the financial responsibility incurred under
43 the terms of the contract for in-network service. Any attempt by the
44 provider to collect, bill, or invoice funds should be promptly
45 reported to the carrier's customer service department at the phone
46 number that the carrier shall provide on the Explanation of Benefits
47 and all reimbursement correspondence to the consumer.

1 e. A carrier, and any other entity providing or administering a
2 self-funded health benefits plan that elects to be subject to section 9
3 of this act, shall issue a health insurance identification card to the
4 primary insured under a health benefits plan. In a form and manner
5 to be prescribed by the department, the card shall indicate whether
6 the plan is insured or, in the case of self-funded plans that elect to
7 be subject of section 9 of this act, whether the plan is self-funded
8 and whether the plan elected to be subject to this act.

9 ¹f. A carrier shall include in the carrier's annual public
10 regulatory filings, and in a manner to be determined by the
11 Department of Banking and Insurance, the number of claims
12 submitted by health care providers to the carrier which are denied or
13 down coded by the carrier and the reason for the denial or down
14 coding determination.¹

15
16 7. a. If a covered person receives medically necessary services
17 at any health care facility on an emergency or urgent basis as
18 defined by the Emergency Medical Treatment and Active Labor
19 Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160
20 (C.26:2H-18.64), the facility shall not bill the covered person in
21 excess of any deductible, copayment, or coinsurance amount
22 applicable to in-network services pursuant to the covered person's
23 health benefits plan.

24 b. If a covered person receives medically necessary services at
25 an out-of-network health care facility on an emergency or urgent
26 basis as defined by the Emergency Medical Treatment and Active
27 Labor Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992,
28 c.160 (C.26:2H-18.64), and the carrier and facility cannot agree on
29 the final offer as a reimbursement rate for these services pursuant to
30 section 9 of this act, the carrier, health care facility, or covered
31 person, as applicable, may initiate binding arbitration pursuant to
32 section 10 or 11 of this act.

33 c. If a health care facility is in-network with respect to any
34 health benefits plan, the facility shall ensure that all providers
35 providing services in the facility on an emergency or inadvertent
36 basis are provided notification of the provisions of this act and
37 information as to each health benefits plan with which the facility
38 has a contract to be in-network.

39 d. A health care facility that contracts with a carrier to be in-
40 network with respect to any health benefits plan shall annually
41 report to the Department of Health the health benefits plans with
42 which the facility has an agreement to be in-network.

43 e. Subsections a. and b. of this section shall only apply to
44 providers providing services to members of entities providing or
45 administering a self-funded health benefits plan and its plan
46 members if the entity elects to be subject to section 9 of this act
47 pursuant to subsection d. of that section.

1 f. The Department of Health shall make the information
2 collected pursuant to subsection d. of this section available to the
3 Department of Banking and Insurance.
4

5 8. a. If a covered person receives inadvertent out-of-network
6 services or medically necessary services at an in-network or out-of-
7 network health care facility on an emergency or urgent basis as
8 defined by the Emergency Medical Treatment and Active Labor
9 Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160
10 (C.26:2H-18.64), the health care professional performing those
11 services shall:

12 (1) in the case of inadvertent out-of-network services, not bill
13 the covered person in excess of any deductible, copayment, or
14 coinsurance amount; and

15 (2) in the case of emergency and urgent services, not bill the
16 covered person in excess of any deductible, copayment, or
17 coinsurance amount, applicable to in-network services pursuant to
18 the covered person's health benefits plan.

19 b. If the carrier and the professional cannot agree on a
20 reimbursement rate for the services provided pursuant to subsection
21 a. of this section, pursuant to section 9 of this act the carrier,
22 professional, or covered person, as applicable, may initiate binding
23 arbitration pursuant to section 10 or 11 of this act.

24 c. This section shall only apply to providers providing services
25 to members of entities providing or administering a self-funded
26 health benefits plan and its plan members if the entity elects to be
27 subject to section 9 of this act pursuant to subsection d. of that
28 section.
29

30 9. Notwithstanding any law, rule, or regulation to the contrary:

31 a. With respect to a carrier, if a covered person receives
32 inadvertent out-of-network services, or services at an in-network or
33 out-of-network health care facility on an emergency or urgent basis,
34 the carrier shall ensure that the covered person incurs no greater
35 out-of-pocket costs than the covered person would have incurred
36 with an in-network health care provider for covered services.
37 Pursuant to sections 7 and 8 of this act, the out-of-network provider
38 shall not bill the covered person, except for applicable deductible,
39 copayment, or coinsurance amounts that would apply if the covered
40 person utilized an in-network health care provider for the covered
41 services. In the case of services provided to a member of a self-
42 funded plan that does not elect to be subject to the provisions of this
43 section, the provider shall be permitted to bill the covered person in
44 excess of the applicable deductible, copayment, or coinsurance
45 amounts.

46 b. (1) With respect to inadvertent out-of-network services, or
47 services at an in-network or out-of-network health care facility on
48 an emergency or urgent basis, benefits provided by a carrier that the

1 covered person receives for health care services shall be assigned to
2 the out-of-network health care provider, which shall require no
3 action on the part of the covered person. Once the benefit is
4 assigned as provided in this subsection:

5 (a) any reimbursement paid by the carrier shall be paid directly
6 to the out-of-network provider; and

7 (b) the carrier shall provide the out-of-network provider with a
8 written remittance of payment that specifies the proposed
9 reimbursement and the applicable deductible, copayment, or
10 coinsurance amounts owed by the covered person.

11 (2) An entity providing or administering a self-funded health
12 benefits plan that elects to participate in this section pursuant to
13 subsection d. of this section, shall comply with the provisions of
14 paragraph (1) of this subsection.

15 c. If inadvertent out-of-network services or services provided
16 at an in-network or out-of-network health care facility on an
17 emergency or urgent basis are performed in accordance with
18 subsection a. of this section, the out-of-network provider may bill
19 the carrier for the services rendered. The carrier may pay the billed
20 amount or the carrier shall determine within ~~1[30]~~ 20¹ days from
21 the date of the receipt of the claim for the services whether the
22 carrier considers the claim to be excessive, and if so, the carrier
23 shall notify the provider of this determination within ~~1[30]~~ 20¹
24 days of the receipt of the claim. If the carrier provides this
25 notification, the carrier and the provider shall have 30 days from the
26 date of this notification to negotiate a settlement. The carrier may
27 attempt to negotiate a final reimbursement amount with the out-of-
28 network health care provider which differs from the amount paid by
29 the carrier pursuant to this subsection. If there is no settlement
30 reached after the 30 days, the carrier shall pay the provider their
31 final offer for the services. If the carrier and provider cannot agree
32 on the final offer as a reimbursement rate for these services, the
33 carrier, provider, or covered person, as applicable, may initiate
34 binding arbitration within 30 days of the final offer, pursuant to
35 section 10 or 11 of this act. In addition, in the event that arbitration
36 is initiated pursuant to section 10 of this act, the payment shall be
37 subject to the binding arbitration provisions of paragraphs (4) and
38 (5) of subsection b. of section 10 of this act.

39 d. With respect to an entity providing or administering a self-
40 funded health benefits plan and its plan members, this section shall
41 only apply if the plan elects to be subject to the provisions of this
42 section. To elect to be subject to the provisions of this section, the
43 self-funded plan shall provide notice, on an annual basis, to the
44 department, on a form and in a manner prescribed by the
45 department, attesting to the plan's participation and agreeing to be
46 bound by the provisions of this section. The self-funded plan shall
47 amend the employee benefit plan, coverage policies, contracts and

1 any other plan documents to reflect that the benefits of this section
2 shall apply to the plan's members.

3

4 10. a. If attempts to negotiate reimbursement for services
5 provided by an out-of-network health care provider, pursuant to
6 subsection c. of section 9 of this act, do not result in a resolution of
7 the payment dispute, and the difference between the carrier's and
8 the provider's final offers is not less than \$1,000, the carrier or out-
9 of-network health care provider may initiate binding arbitration to
10 determine payment for the services.

11 b. The binding arbitration shall adhere to the following
12 requirements:

13 (1) The party requesting arbitration shall notify the other party
14 that arbitration has been initiated and state its final offer before
15 arbitration ¹, which in the case of the carrier shall be the amount
16 paid pursuant to subsection c. of section 9 of this act¹. In response
17 to this notice, the ¹~~nonrequesting party~~ out-of-network provider¹
18 shall inform the ¹~~requesting party~~ carrier¹ of its final offer before
19 the arbitration occurs;

20 (2) Arbitration shall be initiated by filing a request with the
21 department;

22 (3) The department shall contract, through the request for
23 proposal process, every three years, with one or more entities that
24 have experience in health care pricing arbitration. The arbitrators
25 shall be American Arbitration Association certified arbitrators. The
26 department may initially utilize the entity engaged under the
27 "Health Claims Authorization, Processing, and Payment Act,"
28 P.L.2005, c.352 (C.17B:30-48 et seq.), for arbitration under this act;
29 however, after a period of one year from the effective date of this
30 act, the selection of the arbitration entity shall be through the
31 Request for Proposal process. Claims that are subject to arbitration
32 pursuant to the provisions of this act, which previously would be
33 subject to arbitration pursuant to the "Health Claims Authorization,
34 Processing, and Payment Act," shall instead be subject to this act;

35 (4) The arbitration shall consist of a review of the written
36 submissions by both parties, which shall include the final offer for
37 the payment by the carrier for the out-of-network health care
38 provider's fee made pursuant to subsection c. of section 9 of this act
39 ¹~~], or a lower offer,~~¹ and the final offer by the out-of-network
40 provider for the fee the provider will accept as payment from the
41 carrier; and

42 (5) The arbitrator's decision shall be one of the two amounts
43 submitted by the parties as their final offers and shall be binding on
44 both parties. The decision of the arbitrator shall include written
45 findings and shall be issued within ¹~~45~~ 30¹ days after the request
46 is filed with the department. The arbitrator's expenses and fees
47 shall be split equally among the parties except in situations in which

1 the arbitrator determines that the payment made by the carrier was
2 not made in good faith, in which case the carrier shall be
3 responsible for all of the arbitrator's expenses and fees. Each party
4 shall be responsible for its own costs and fees, including legal fees
5 if any.

6 c. ¹**[In** making a determination pursuant to subsection b. of this
7 section, the arbitrator shall consider:

8 (1) the level of training, education, and experience of the health
9 care professional;

10 (2) the health care provider's usual charge for comparable
11 services provided in-network and out-of-network with respect to
12 any health benefits plans;

13 (3) the circumstances and complexity of the particular case,
14 including the time and place of the service;

15 (4) individual patient characteristics; and

16 (5) as certified by an independent actuary:

17 (a) the average in-network amount paid for the service by that
18 carrier; and

19 (b) the average amount paid for that service to other out-of-
20 network providers by that carrier.

21 d. ¹**[**(1) The amount awarded by the arbitrator ¹that is in excess
22 of any payment already made pursuant to subsection c. of section 9
23 of this act¹ shall be paid within 20 days of the arbitrator's decision
24 as provided in subsection b. of this section.

25 (2) The interest charges for overdue payments, pursuant to
26 P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the
27 pendency of a decision under subsection b. of this section and any
28 interest required to be paid a provider pursuant to P.L.1999, c.154
29 (C.17B:30-23 et al.) shall not accrue until after 20 days following
30 an arbitrator's decision as provided in subsection b. of this section,
31 but in no circumstances longer than 150 days from the date that the
32 out-of-network provider billed the carrier for services rendered,
33 unless both parties agree to a longer period of time.

34 ¹**[e.] d.**¹ This section shall apply only if the covered person
35 complies with any applicable preauthorization or review
36 requirements of the health benefits plan regarding the determination
37 of medical necessity to access in-network inpatient or outpatient
38 benefits.

39 ¹**[f.] e.**¹ This section shall not apply to a covered person who
40 knowingly, voluntarily, and specifically selected an out-of-network
41 provider for health care services.

42 ¹**[g.] f.**¹ In the event an entity providing or administering a
43 self-funded health benefits plan elects to be subject to the
44 provisions of section 9 of this act, as provided in subsection d. of
45 that section, the provisions of this section shall apply to a self-
46 funded plan in the same manner as the provisions of this section
47 apply to a carrier. If a self-funded plan does not elect to be subject

1 to the provision of section 9 of this act, a member of that plan may
2 initiate binding arbitration as provided in section 11 of this act.

3
4 11. a. If attempts to negotiate reimbursement for services
5 between an out-of-network health care provider and a member of a
6 self-funded plan that does not elect to be subject to the provision of
7 section 9 of this act do not result in a resolution of the payment
8 dispute within 30 days after the plan member is sent a bill for the
9 services, the plan member or out-of-network health care provider
10 may initiate binding arbitration to determine payment for the
11 services. Unless negotiations for reimbursement result in an
12 agreement between the provider and the plan member within the 30
13 days, a provider shall not collect or attempt to collect
14 reimbursement, including initiation of any collection proceedings,
15 until the provider files a request for arbitration with the department
16 pursuant to this section.

17 b. The binding arbitration shall adhere to the following
18 requirements:

19 (1) Arbitration shall be initiated by filing a request with the
20 department. The department shall establish a process to notify the
21 other party that arbitration has been initiated and to inform a plan
22 member of the process to arbitrate pursuant to this section;

23 (2) The arbitrator with which the department contracts pursuant
24 to section 10 of this act shall conduct the arbitration pursuant to this
25 section;

26 (3) The arbitrator shall consider information supplied by both
27 parties; and

28 (4) The arbitrator's decision shall include written findings,
29 including a final binding amount that the arbitrator determines is
30 reasonable for the service, which shall include a non-binding
31 recommendation to the entity providing or administering the self-
32 funded health benefits plan of an amount that would be reasonable
33 for the entity to contribute to payment for the service, and shall be
34 issued within ¹~~45~~ 30¹ days after the request is filed with the
35 department.

36 c. The arbitrator's expenses and fees shall be divided equally
37 among the parties, unless the payment would pose a financial
38 hardship to the plan member, in which case the department shall
39 establish an agreement with the arbitrator to waive any part or all of
40 the cost of arbitration. Each party shall be responsible for its own
41 costs and fees, including legal fees, if any.

42 d. ¹~~In~~ making a determination pursuant to subsection b. of this
43 section, the arbitrator shall consider:

44 (1) the level of training, education, and experience of the health
45 care professional;

46 (2) the health care provider's usual charge for comparable
47 services provided in-network and out-of-network with respect to
48 any health benefits plans;

- 1 (3) the circumstances and complexity of the particular case,
2 including the time and place of the service;
3 (4) individual patient characteristics;
4 (5) as certified by an independent actuary:
5 (a) the average in-network amount paid for the service by that
6 self-funded plan; and
7 (b) the average amount paid for that service to other out-of-
8 network providers by that self-funded plan; and
9 (6) the out-of-network benefit design of the member's health
10 plan and the amount the entity providing or administering the self-
11 funded health benefits plan contributes, if anything, to the cost of
12 the service.

13 e.]¹ This section shall not apply to a covered person who
14 knowingly, voluntarily, and specifically selected an out-of-network
15 provider for health care services.

16

17 12. On or before January 31 of each calendar year, the
18 commissioner shall consult with the Department of the Treasury,
19 the relevant professional and occupational licensing boards within
20 the Division of Consumer Affairs in the Department of Law and
21 Public Safety, and the Department of Health, to obtain information
22 to compile and make publicly available, on the department's
23 website:

24 a. A list of all arbitrations filed pursuant to section 10 and 11
25 of this act between January 1 and December 31 of the previous
26 calendar year, including the percentage of all claims that were
27 arbitrated.

28 (1) For each arbitration decision, the list shall include but not be
29 limited to:

30 (a) an indication of whether the decision was in favor of the
31 carrier or the out-of-network health care provider;

32 (b) the arbitration bids offered by each side and the award
33 amount;

34 (c) the category and practice specialty of each out-of-network
35 health care provider involved in an arbitration decision, as
36 applicable; and

37 (d) a description of the service that was provided and billed for.

38 (2) The list of arbitration decisions shall not include any
39 information specifically identifying the provider, carrier, or covered
40 person involved in each arbitration decision.

41 b. The percentage of facilities and hospital-based professionals,
42 by specialty, that are in-network for each carrier in this State as
43 reported pursuant to subsection d. of section 7 of this act.

44 c. The number of complaints the department receives relating
45 to out-of-network health care charges.

46 d. The number of and description of claims received by the
47 State Health Benefits Program and the School Employees' Health

1 Benefits Program for in-State emergency out-of-network health care
2 and inadvertent out-of-network health care.

3 e. Annual trends on health benefits plan premium rates, total
4 annual amount of spending on inadvertent and emergency out-of-
5 network costs by carriers, and medical loss ratios in the State to the
6 extent that the information is available.

7 f. The number of physician specialists practicing in the State in
8 a particular specialty and whether they are in-network or out-of-
9 network with respect to the carriers that administer the State Health
10 Benefits Program, the School Employees' Health Benefits Program,
11 the qualified health plans in the federally run health exchange in the
12 State, and other health benefits plans offered in the State.

13 g. The results of the network audit required pursuant to section
14 16 of this act.

15 h. ¹A summary of the information submitted to the department
16 pursuant to subsection f. of section 6 of this act concerning the
17 number of claims submitted by health care providers to carriers
18 which are denied or down coded by the carrier and the reasons for
19 the denials or down coding determinations.

20 i.¹ Any other benchmarks or information obtained pursuant to
21 this act that the commissioner deems appropriate to make publicly
22 available to further the goals of the act.

23

24 13. a. A carrier shall provide a written notice, in a form and
25 manner to be prescribed by the Commissioner of Banking and
26 Insurance, to each covered person of the protections provided to
27 covered persons pursuant to this act. The notice shall include
28 information on how a consumer can contact the department or the
29 appropriate regulatory agency to report and dispute an out-of-network
30 charge. The notice required pursuant to this section shall be posted on
31 the carrier's website.

32 b. The commissioner shall provide a notice on the department's
33 website containing information for consumers relating to the
34 protections provided by this act, information on how consumers can
35 report and file complaints with the department or the appropriate
36 regulatory agency relating to any out-of-network charges, and
37 information and guidance for consumers regarding arbitrations filed
38 pursuant to section 11 of this act.

39

40 14. ¹a.¹ A carrier shall calculate, as part of rate filings required
41 to be filed under New Jersey law, the savings that result from a
42 reduction in out-of-network claims payments pursuant to the
43 provisions of this act. The department shall include that
44 information in the information provided on the department's
45 website pursuant to section 12 of this act.

46 ¹b. The department shall report to the Governor, and to the
47 Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1),
48 no later than 12 months after the effective date of this act and

1 annually thereafter, on the savings to policyholders and the
2 healthcare system that result from the provisions of this act. The
3 report shall contain an analysis of the information compiled
4 pursuant to section 12 of this act.¹
5

6 15. a. It shall be a violation of this act if an out-of-network health
7 care provider, directly or indirectly related to a claim, knowingly
8 waives, rebates, gives, pays, or offers to waive, rebate, give or pay all
9 or part of the deductible, copayment, or coinsurance owed by a
10 covered person pursuant to the terms of the covered person's health
11 benefits plan as an inducement for the covered person to seek health
12 care services from that provider. As the commissioner shall prescribe
13 by regulation, a pattern of waiving, rebating, giving or paying all or
14 part of the deductible, copayment or coinsurance by a provider shall be
15 considered an inducement for the purposes of this subsection.

16 b. This section shall not apply to any waiver, rebate, gift,
17 payment, or offer that falls within a safe harbor under federal laws
18 related to fraud and abuse concerning patient cost-sharing, including,
19 but not limited to, anti-kickback, self-referral, false claims, and civil
20 monetary penalties, including any advisory opinions issued by the
21 Centers for Medicare and Medicaid Services or the Office of Inspector
22 General pertaining to those laws.
23

24 16. A carrier which offers a managed care plan shall provide for
25 an annual audit of its provider network by an independent private
26 auditing firm. The audit shall be at the expense of the carrier and the
27 carrier shall submit the audit findings to the commissioner. The
28 commissioner shall make the results of the audit available on the
29 department's website. If the audit contains a determination that a
30 carrier has failed to maintain an adequate network of providers in
31 accordance with applicable federal or State law, in addition to any
32 other penalties or remedies available under federal or State law, it shall
33 be a violation of this act and the commissioner may initiate such action
34 as the commissioner deems appropriate to ensure compliance with this
35 act and network adequacy laws.
36

37 17. a. A person or entity that violates any provision of this act,
38 or the rules and regulations adopted pursuant hereto, shall be liable to
39 a penalty as provided in this subsection. The penalty shall be collected
40 by the commissioner in the name of the State in a summary proceeding
41 in accordance with the "Penalty Enforcement Law of 1999," P.L.1999,
42 c.274 (C.2A:58-10 et seq.).

43 (1) A health care facility or carrier that violates any provision of
44 this act shall be liable to a penalty of not more than \$1,000 for each
45 violation. Every day upon which a violation occurs shall be
46 considered a separate violation, but no facility or carrier shall be liable
47 to a penalty greater than \$25,000 for each occurrence.

1 (2) A person or entity not covered by paragraph (1) of this
2 subsection that violates the requirements of this act shall be liable to a
3 penalty of not more than \$100 for each violation. Every day upon
4 which a violation occurs shall be considered a separate violation, but
5 no person or entity shall be liable to a penalty greater than \$2,500 for
6 each occurrence.

7 b. Upon a finding that a person or entity has failed to comply with
8 the requirements of this act, including the payment of a penalty as
9 determined under subsection a. of this section, the commissioner may:

10 (1) in the case of a carrier, initiate such action as the commissioner
11 determines appropriate;

12 (2) in the case of a health care facility, refer the matter to the
13 Commissioner of Health for such action as the Commissioner of
14 Health determines appropriate; or

15 (3) in the case of a health care professional, refer the matter to the
16 appropriate professional or occupational licensing board within the
17 Division of Consumer Affairs in the Department of Law and Public
18 Safety for such action as that board determines appropriate.

19

20 18. The Commissioner of Banking and Insurance, the
21 Commissioner of Health and any relevant licensing board in the
22 Division of Consumer Affairs in the Department of Law and Public
23 Safety under Title 45 of the Revised Statutes may, as appropriate,
24 adopt rules and regulations, pursuant to the "Administrative Procedure
25 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), in order to effectuate the
26 purposes of this act.

27

28 19. The provisions of this act shall be severable, and if any
29 provision of this act shall be held invalid, or held invalid with respect
30 to any particular health benefits plan or carrier, such invalidity shall
31 not affect the other provisions hereof, or application of those
32 provisions to other health benefits plans or carriers.

33

34 20. Nothing in this act shall be construed to apply to an entity
35 providing or administering a self-funded health benefits plan which is
36 subject to the "Employee Retirement Income Security Act of 1974,"
37 except as provided in subsection d. of section 9 of this act for such an
38 entity to elect to be subject to certain provisions of the act.

39

40 21. This act shall take effect on the 90th day next following
41 enactment. The Commissioner of Banking and Insurance, the
42 Department of Health and any relevant licensing board may take
43 such anticipatory administrative action in advance thereof as shall
44 be necessary for the implementation of this act.

45

46

47 "Out-of-network Consumer Protection, Transparency, Cost
48 Containment and Accountability Act."

ASSEMBLY, No. 2039

STATE OF NEW JERSEY 218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Assemblyman CRAIG J. COUGHLIN

District 19 (Middlesex)

District 19 (Middlesex)

Assemblyman GARY S. SCHAER

District 36 (Bergen and Passaic)

Assemblywoman PAMELA R. LAMPITT

District 6 (Burlington and Camden)

Co-Sponsored by:

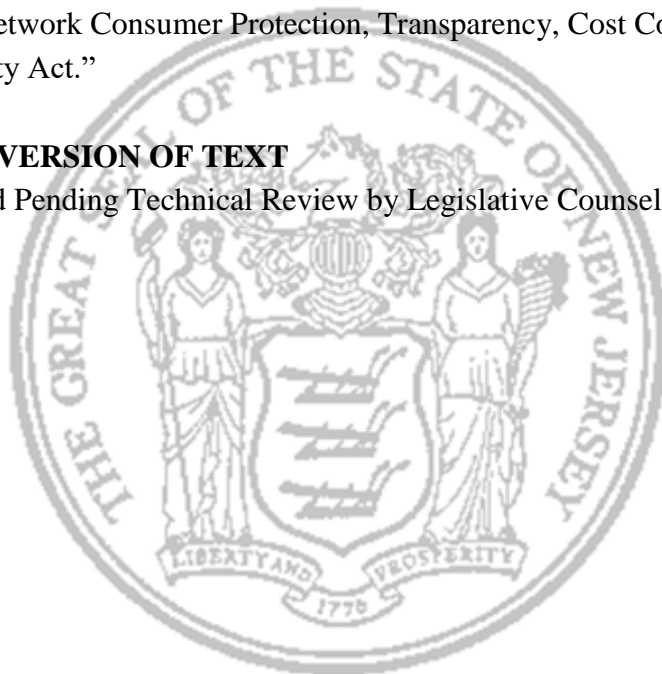
Assemblyman Giblin, Assemblywomen Jasey, Tucker, Assemblyman Caputo, Assemblywomen Vainieri Huttle, Caride, Assemblymen Danielsen, Johnson, Green, Assemblywomen Mosquera, Quijano, Assemblymen McKeon, Barclay, Assemblywomen Jones, Lopez and Murphy

SYNOPSIS

“Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.”

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



(Sponsorship Updated As Of: 2/16/2018)

1 AN ACT concerning health insurance and health care providers and
2 supplementing various parts of the statutory law.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6

7 1. This act shall be known and may be cited as the “Out-of-
8 network Consumer Protection, Transparency, Cost Containment and
9 Accountability Act.”

10

11 2. The Legislature finds and declares that:

12 a. The health care delivery system in New Jersey needs reforms
13 that will enhance consumer protections, create a system to resolve
14 certain health care billing disputes, contain rising costs, and measure
15 success with respect to these goals;

16 b. Despite existing State and federal laws and regulations to
17 protect against certain surprise out-of-network charges, these charges
18 continue to pose a problem for health care consumers in New Jersey.
19 Many consumers find themselves with surprise bills for hospital
20 emergency room procedures or for charges by providers that the
21 consumer had no choice in selecting;

22 c. While the Patient Protection and Affordable Care Act added
23 new patient protections requiring federally-regulated group health
24 plans to reimburse for out-of-network emergency service by paying
25 the greatest of three possible amounts: (1) the amount negotiated with
26 in-network providers for the emergency service furnished; (2) the
27 amount for the emergency service calculated using the same method
28 the plan generally uses to determine payments for out-of-network
29 services; or (3) the amount that would be paid under Medicare for the
30 emergency service, patients continue to face out-of-network charges
31 for surprise bills;

32 d. Out-of-network benefits are a health insurance benefit
33 enhancement for which insureds pay an additional premium, but in
34 recent years, out-of-network coverage has been used inappropriately as
35 a means to diminish consumers’ health insurance coverage, exposing
36 consumers to additional costs;

37 e. Carriers and consumers continue to report exorbitant charges
38 by certain health care professionals and facilities for out-of-network
39 services, including balance billing, and in certain cases, consumers’
40 bills are referred to collection, which contributes to the increasing
41 costs of health care services and insurance and imposes hardships on
42 health care consumers;

43 f. Health care providers and hospitals report that inadequate
44 reimbursement from carriers and government payers is causing
45 financial stress on safety net hospitals, deteriorating morale among
46 providers and reduced quality of care for consumers;

47 g. It is, therefore, in the public interest to reform the health care
48 delivery system in New Jersey to enhance consumer protections, create

1 a system to resolve certain health care billing disputes, contain rising
2 costs, and measure success with respect to these goals.

3

4 3. As used in this act:

5 “Carrier” means an entity that contracts or offers to contract to
6 provide, deliver, arrange for, pay for, or reimburse any of the costs
7 of health care services under a health benefits plan, including: an
8 insurance company authorized to issue health benefits plans; a
9 health maintenance organization; a health, hospital, or medical
10 service corporation; a multiple employer welfare arrangement; the
11 State Health Benefits Program and the School Employees’ Health
12 Benefits Program; or any other entity providing a health benefits
13 plan. Except as provided under the provisions of this act, “carrier”
14 shall not include any other entity providing or administering a self-
15 funded health benefits plan.

16 “Commissioner” means the Commissioner of Banking and
17 Insurance.

18 “Covered person” means a person on whose behalf a carrier is
19 obligated to pay health care expense benefits or provide health care
20 services.

21 “Department” means the Department of Banking and Insurance.

22 “Emergency or urgent basis” means all emergency and urgent
23 care services including, but not limited to, the services required
24 pursuant to N.J.A.C.11:24-5.3.

25 "Health benefits plan" means a benefits plan which pays or
26 provides hospital and medical expense benefits for covered
27 services, and is delivered or issued for delivery in this State by or
28 through a carrier. For the purposes of this act, “health benefits
29 plan” shall not include the following plans, policies or contracts:
30 Medicaid, Medicare, Medicare Advantage, accident only, credit,
31 disability, long-term care, TRICARE supplement coverage,
32 coverage arising out of a workers' compensation or similar law,
33 automobile medical payment insurance, personal injury protection
34 insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), a
35 dental plan as defined pursuant to section 1 of P.L.2014, c.70
36 (C.26:2S-26) and hospital confinement indemnity coverage.

37 “Health care facility” means a general acute care hospital,
38 satellite emergency department, hospital based off-site ambulatory
39 care facility in which ambulatory surgical cases are performed, or
40 ambulatory surgery facility, licensed pursuant to P.L.1971, c.136
41 (C.26:2H-1 et seq.).

42 “Health care professional” means an individual, acting within the
43 scope of his licensure or certification, who provides a covered
44 service defined by the health benefits plan.

45 “Health care provider” or “provider” means a health care
46 professional or health care facility.

47 “Inadvertent out-of-network services” means health care services
48 that are: covered under a managed care health benefits plan that

1 provides a network; and provided by an out-of-network health care
2 provider in the event that a covered person utilizes an in-network
3 health care facility for covered health care services and, for any
4 reason, in-network health care services are unavailable in that
5 facility. __“Inadvertent out-of-network services” shall include
6 laboratory testing ordered by an in-network health care provider and
7 performed by an out-of-network bio-analytical laboratory.

8 “Knowingly, voluntarily, and specifically selected an out-of-
9 network provider” means that a covered person chose the services
10 of a specific provider, with full knowledge that the provider is out-
11 of-network with respect to the covered person’s health benefits
12 plan, under circumstances that indicate that covered person had the
13 opportunity to be serviced by an in-network provider, but instead
14 selected the out-of-network provider. Disclosure by a provider of
15 network status shall not render a covered person’s decision to
16 proceed with treatment from that provider a choice made
17 “knowingly” pursuant to this definition.

18 “Medicaid” means the State Medicaid program established
19 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

20 "Medical necessity" or "medically necessary" means or describes
21 a health care service that a health care provider, exercising his or
22 her prudent clinical judgment, would provide to a covered person
23 for the purpose of evaluating, diagnosing, or treating an illness,
24 injury, disease, or its symptoms and that is: in accordance with the
25 generally accepted standards of medical practice; clinically
26 appropriate, in terms of type, frequency, extent, site, and duration,
27 and considered effective for the covered person's illness, injury, or
28 disease; not primarily for the convenience of the covered person or
29 the health care provider; and not more costly than an alternative
30 service or sequence of services at least as likely to produce
31 equivalent therapeutic or diagnostic results as to the diagnosis or
32 treatment of that covered person's illness, injury, or disease.

33 “Medicare” means the federal Medicare program established
34 pursuant to Pub.L.89-97 (42 U.S.C. s.1395 et seq.).

35 “Self-funded health benefits plan” or “self-funded plan” means a
36 self-insured health benefits plan governed by the provisions of the
37 federal “Employee Retirement Income Security Act of 1974,” 29
38 U.S.C. s.1001 et seq.

39

40 4. a. Prior to scheduling an appointment with a covered person
41 for a non-emergency or elective procedure and in terms the covered
42 person typically understands, a health care facility shall:

43 (1) disclose to the covered person whether the health care
44 facility is in-network or out-of-network with respect to the covered
45 person’s health benefits plan;

46 (2) advise the covered person to check with the physician
47 arranging the facility services to determine whether or not that
48 physician is in-network or out-of-network with respect to the

1 covered person's health benefits plan and provide information about
2 how to determine the health plans participated in by any physician
3 who is reasonably anticipated to provide services to the covered
4 person;

5 (3) advise the covered person that at a health care facility that is
6 in-network with respect to the person's health benefits plan:

7 (a) the covered person will have a financial responsibility
8 applicable to an in-network procedure and not in excess of the
9 covered person's copayment, deductible, or coinsurance as provided
10 in the covered person's health benefits plan;

11 (b) unless the covered person, at the time of the disclosure
12 required pursuant to this subsection, has knowingly, voluntarily,
13 and specifically selected an out-of-network provider to provide
14 services, the covered person will not incur any out-of-pocket costs
15 in excess of the charges applicable to an in-network procedure;

16 (c) any bills, charges or attempts to collect by the facility, or
17 any health care professional involved in the procedure, in excess of
18 the covered person's copayment, deductible, or coinsurance as
19 provided in the covered person's health benefits plan in violation of
20 subparagraph (b) of this paragraph should be reported to the
21 covered person's carrier and the relevant regulatory entity; and

22 (d) that if the covered person's coverage is provided through an
23 entity providing or administering a self-funded health benefits plan
24 that does not elect to be subject to the provisions of section 9 of this
25 act, that:

26 (i) certain health care services may be provided on an out-of-
27 network basis, including those services associated with the health
28 care facility;

29 (ii) the covered person may have a financial responsibility
30 applicable to health care services provided by an out-of-network
31 provider, in excess of the covered person's copayment, deductible,
32 or coinsurance, and the covered person may be responsible for any
33 costs in excess of those allowed by the person's self-funded health
34 benefits plan; and

35 (iii) the covered person should contact the covered person's self-
36 funded health benefits plan sponsor for further consultation on
37 those costs; and

38 (4) advise the covered person that at a health care facility that is
39 out-of-network with respect to the covered person's health benefits
40 plan:

41 (a) certain health care services may be provided on an out-of-
42 network basis, including those health care services associated with
43 the health care facility;

44 (b) the covered person may have a financial responsibility
45 applicable to health care services provided at an out-of-network
46 facility, in excess of the covered person's copayment, deductible, or
47 coinsurance, and the covered person may be responsible for any
48 costs in excess of those allowed by their health benefits plan; and

- 1 (c) that the covered person should contact the covered person's
2 carrier for further consultation on those costs.
- 3 b. In a form that is consistent with federal guidelines, a health
4 care facility shall make available to the public a list of the facility's
5 standard charges for items and services provided by the facility.
- 6 c. A health care facility shall post on the facility's website:
- 7 (1) the health benefits plans in which the facility is a
8 participating provider;
- 9 (2) a statement that:
- 10 (a) physician services provided in the facility are not included in
11 the facility's charges;
- 12 (b) physicians who provide services in the facility may or may
13 not participate with the same health benefits plans as the facility;
- 14 (c) the covered person should check with the physician
15 arranging for the facility services to determine the health benefits
16 plans in which the physician participates; and
- 17 (d) the covered person should contact their carrier for further
18 consultation on those costs;
- 19 (3) as applicable, the name, mailing address, and telephone
20 number of the hospital-based physician groups that the facility has
21 contracted with to provide services including, but not limited to,
22 anesthesiology, pathology, and radiology; and
- 23 (4) as applicable, the name, mailing address, and telephone
24 number of physicians employed by the facility and whose services
25 may be provided at the facility, and the health benefits plans in
26 which they participate.
- 27 d. If, between the time the notice required pursuant to
28 subsection a. of this section is provided to the covered person and
29 the time the procedure takes place, the network status of the facility
30 changes as it relates to the covered person's health benefits plan,
31 the facility shall notify the covered person promptly.
- 32 e. The Department of Health shall specify in further detail the
33 content and design of the disclosure form and the manner in which
34 the form shall be provided.
- 35
- 36 5. a. Except as provided in subsection f. of this section, a
37 health care professional shall disclose to a covered person in writing
38 or through an internet website the health benefits plans in which the
39 health care professional is a participating provider and the facilities
40 with which the health care professional is affiliated prior to the
41 provision of non-emergency services, and verbally or in writing, at
42 the time of an appointment. If a health care professional does not
43 participate in the network of the covered person's health benefits
44 plan, the health care professional shall, in terms the covered person
45 typically understands:
- 46 (1) Prior to scheduling a non-emergency procedure inform the
47 covered person that the professional is out-of-network and that the

1 amount or estimated amount the health care professional will bill
2 the covered person for the services is available upon request;

3 (2) Upon receipt of a request from a covered person for the
4 service and the Current Procedural Terminology (CPT) codes
5 associated with that service, disclose to the covered person in
6 writing the amount or estimated amount that the health care
7 professional will bill the covered person for the service, and the
8 CPT codes associated with that service, absent unforeseen medical
9 circumstances that may arise when the health care service is
10 provided;

11 (3) Inform the covered person that the covered person will have
12 a financial responsibility applicable to health care services provided
13 by an out-of-network professional, in excess of the covered
14 person's copayment, deductible, or coinsurance, and the covered
15 person may be responsible for any costs in excess of those allowed
16 by their health benefits plan; and

17 (4) Advise the covered person to contact the covered person's
18 carrier for further consultation on those costs.

19 b. A health care professional who is a physician shall provide
20 the covered person, to the extent the information is available, with
21 the name, practice name, mailing address, and telephone number of
22 any health care provider scheduled to perform anesthesiology,
23 laboratory, pathology, radiology, or assistant surgeon services in
24 connection with care to be provided in the physician's office for the
25 covered person or coordinated or referred by the physician for the
26 covered person at the time of referral to, or coordination of, services
27 with that provider. The physician shall provide instructions as to
28 how to determine the health benefits plans in which the health care
29 provider participates and recommend that the covered person should
30 contact the covered person's carrier for further consultation on costs
31 associated with these services.

32 c. A physician shall, for a covered person's scheduled facility
33 admission or scheduled outpatient facility services, provide the
34 covered person and the facility with the name, practice name,
35 mailing address, and telephone number of any other physician
36 whose services will be arranged by the physician and are scheduled
37 at the time of the pre-admission, testing, registration, or admission
38 at the time the non-emergency services are scheduled, and
39 information as to how to determine the health benefits plans in
40 which the physician participates, and recommend that the covered
41 person should contact the covered person's carrier for further
42 consultation on costs associated with these services.

43 d. The receipt or acknowledgement by any covered person of
44 any disclosure required pursuant to this section shall not waive or
45 otherwise affect any protection under existing statutes or
46 regulations regarding in-network health benefits plan coverage
47 available to the covered person or created under this act.

1 e. If, between the time the notice required pursuant to
2 subsection a. of this section is provided to the covered person and
3 the time the procedure takes place, the network status of the
4 professional changes as it relates to the covered person's health
5 benefits plan, the professional shall notify the covered person
6 promptly.

7 f. In the case of a primary care physician or internist
8 performing an unscheduled procedure in that provider's office, the
9 notice required pursuant this section may be made verbally at the
10 time of the service.

11 g. The appropriate professional or occupational licensing board
12 within the Division of Consumer Affairs in the Department of Law
13 and Public Safety shall specify in further detail the content and
14 design of the disclosure form and the manner in which the form
15 shall be provided.

16

17 6. a. A carrier shall update the carrier's website within 20 days
18 of the addition or termination of a provider from the carrier's
19 network or a change in a physician's affiliation with a facility,
20 provided that in the case of a change in affiliation the carrier has
21 had notice of such change.

22 b. With respect to out-of-network services, for each health
23 benefits plan offered, a carrier shall, consistent with State and
24 federal law, provide a covered person with:

25 (1) a clear and understandable description of the plan's out-of-
26 network health care benefits, including the methodology used by the
27 entity to determine the allowed amount for out-of-network services;

28 (2) the allowed amount the plan will reimburse under that
29 methodology and, in situations in which a covered person requests
30 allowed amounts associated with a specific Current Procedural
31 Terminology code, the portion of the allowed amount the plan will
32 reimburse and the portion of the allowed amount that the covered
33 person will pay, including an explanation that the covered person
34 will be required to pay the difference between the allowed amount
35 as defined by the carrier's plan and the charges billed by an out-of-
36 network provider;

37 (3) examples of anticipated out-of-pocket costs for frequently
38 billed out-of-network services;

39 (4) information in writing and through an internet website that
40 reasonably permits a covered person or prospective covered person
41 to calculate the anticipated out-of-pocket cost for out-of-network
42 services in a geographical region or zip code based upon the
43 difference between the amount the carrier will reimburse for out-of-
44 network services and the usual and customary cost of out-of-
45 network services;

46 (5) information in response to a covered person's request,
47 concerning whether a health care provider is an in-network
48 provider;

1 (6) such other information as the commissioner determines
2 appropriate and necessary to ensure that a covered person receives
3 sufficient information necessary to estimate their out-of-pocket cost
4 for an out-of-network service and make a well-informed health care
5 decision; and

6 (7) access to a telephone hotline that shall be operated no less
7 than 16 hours per day for consumers to call with questions about
8 network status and out-of-pocket costs.

9 c. If a carrier authorizes a covered health care service to be
10 performed by an in-network health care provider with respect to any
11 health benefits plan, and the provider or facility status changes to
12 out-of-network before the authorized service is performed, the
13 carrier shall notify the covered person that the provider or facility is
14 no longer in-network as soon as practicable. If the carrier fails to
15 provide the notice at least 30 days prior to the authorized service
16 being performed, the covered person's financial responsibility shall
17 be limited to the financial responsibility the covered person would
18 have incurred had the provider been in-network with respect to the
19 covered person's health benefits plan.

20 d. A carrier shall incorporate into the Explanation of Benefits
21 and all reimbursement correspondence to the consumer and the
22 provider clear and concise notification that inadvertent and
23 involuntary out-of-network charges are not subject to balance
24 billing above and beyond the financial responsibility incurred under
25 the terms of the contract for in-network service. Any attempt by the
26 provider to collect, bill, or invoice funds should be promptly
27 reported to the carrier's customer service department at the phone
28 number that the carrier shall provide on the Explanation of Benefits
29 and all reimbursement correspondence to the consumer.

30 e. A carrier, and any other entity providing or administering a
31 self-funded health benefits plan that elects to be subject to section 9
32 of this act, shall issue a health insurance identification card to the
33 primary insured under a health benefits plan. In a form and manner
34 to be prescribed by the department, the card shall indicate whether
35 the plan is insured or, in the case of self-funded plans that elect to
36 be subject of section 9 of this act, whether the plan is self-funded
37 and whether the plan elected to be subject to this act.

38
39 7. a. If a covered person receives medically necessary services
40 at any health care facility on an emergency or urgent basis as
41 defined by the Emergency Medical Treatment and Active Labor
42 Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160
43 (C.26:2H-18.64), the facility shall not bill the covered person in
44 excess of any deductible, copayment, or coinsurance amount
45 applicable to in-network services pursuant to the covered person's
46 health benefits plan.

47 b. If a covered person receives medically necessary services at
48 an out-of-network health care facility on an emergency or urgent

1 basis as defined by the Emergency Medical Treatment and Active
2 Labor Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992,
3 c.160 (C.26:2H-18.64), and the carrier and facility cannot agree on
4 the final offer as a reimbursement rate for these services pursuant to
5 section 9 of this act, the carrier, health care facility, or covered
6 person, as applicable, may initiate binding arbitration pursuant to
7 section 10 or 11 of this act.

8 c. If a health care facility is in-network with respect to any
9 health benefits plan, the facility shall ensure that all providers
10 providing services in the facility on an emergency or inadvertent
11 basis are provided notification of the provisions of this act and
12 information as to each health benefits plan with which the facility
13 has a contract to be in-network.

14 d. A health care facility that contracts with a carrier to be in-
15 network with respect to any health benefits plan shall annually
16 report to the Department of Health the health benefits plans with
17 which the facility has an agreement to be in-network.

18 e. Subsections a. and b. of this section shall only apply to
19 providers providing services to members of entities providing or
20 administering a self-funded health benefits plan and its plan
21 members if the entity elects to be subject to section 9 of this act
22 pursuant to subsection d. of that section.

23 f. The Department of Health shall make the information
24 collected pursuant to subsection d. of this section available to the
25 Department of Banking and Insurance.

26
27 8. a. If a covered person receives inadvertent out-of-network
28 services or medically necessary services at an in-network or out-of-
29 network health care facility on an emergency or urgent basis as
30 defined by the Emergency Medical Treatment and Active Labor
31 Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160
32 (C.26:2H-18.64), the health care professional performing those
33 services shall:

34 (1) in the case of inadvertent out-of-network services, not bill
35 the covered person in excess of any deductible, copayment, or
36 coinsurance amount; and

37 (2) in the case of emergency and urgent services, not bill the
38 covered person in excess of any deductible, copayment, or
39 coinsurance amount, applicable to in-network services pursuant to
40 the covered person's health benefits plan.

41 b. If the carrier and the professional cannot agree on a
42 reimbursement rate for the services provided pursuant to subsection
43 a. of this section, pursuant to section 9 of this act the carrier,
44 professional, or covered person, as applicable, may initiate binding
45 arbitration pursuant to section 10 or 11 of this act.

46 c. This section shall only apply to providers providing services
47 to members of entities providing or administering a self-funded
48 health benefits plan and its plan members if the entity elects to be

1 subject to section 9 of this act pursuant to subsection d. of that
2 section.

3

4 9. Notwithstanding any law, rule, or regulation to the contrary:

5 a. With respect to a carrier, if a covered person receives
6 inadvertent out-of-network services, or services at an in-network or
7 out-of-network health care facility on an emergency or urgent basis,
8 the carrier shall ensure that the covered person incurs no greater
9 out-of-pocket costs than the covered person would have incurred
10 with an in-network health care provider for covered services.
11 Pursuant to sections 7 and 8 of this act, the out-of-network provider
12 shall not bill the covered person, except for applicable deductible,
13 copayment, or coinsurance amounts that would apply if the covered
14 person utilized an in-network health care provider for the covered
15 services. In the case of services provided to a member of a self-
16 funded plan that does not elect to be subject to the provisions of this
17 section, the provider shall be permitted to bill the covered person in
18 excess of the applicable deductible, copayment, or coinsurance
19 amounts.

20 b. (1) With respect to inadvertent out-of-network services, or
21 services at an in-network or out-of-network health care facility on
22 an emergency or urgent basis, benefits provided by a carrier that the
23 covered person receives for health care services shall be assigned to
24 the out-of-network health care provider, which shall require no
25 action on the part of the covered person. Once the benefit is
26 assigned as provided in this subsection:

27 (a) any reimbursement paid by the carrier shall be paid directly
28 to the out-of-network provider; and

29 (b) the carrier shall provide the out-of-network provider with a
30 written remittance of payment that specifies the proposed
31 reimbursement and the applicable deductible, copayment, or
32 coinsurance amounts owed by the covered person.

33 (2) An entity providing or administering a self-funded health
34 benefits plan that elects to participate in this section pursuant to
35 subsection d. of this section, shall comply with the provisions of
36 paragraph (1) of this subsection.

37 c. If inadvertent out-of-network services or services provided
38 at an in-network or out-of-network health care facility on an
39 emergency or urgent basis are performed in accordance with
40 subsection a. of this section, the out-of-network provider may bill
41 the carrier for the services rendered. The carrier may pay the billed
42 amount or the carrier shall determine within 30 days from the date
43 of the receipt of the claim for the services whether the carrier
44 considers the claim to be excessive, and if so, the carrier shall
45 notify the provider of this determination within 30 days of the
46 receipt of the claim. If the carrier provides this notification, the
47 carrier and the provider shall have 30 days from the date of this
48 notification to negotiate a settlement. The carrier may attempt to

1 negotiate a final reimbursement amount with the out-of-network
2 health care provider which differs from the amount paid by the
3 carrier pursuant to this subsection. If there is no settlement reached
4 after the 30 days, the carrier shall pay the provider their final offer
5 for the services. If the carrier and provider cannot agree on the final
6 offer as a reimbursement rate for these services, the carrier,
7 provider, or covered person, as applicable, may initiate binding
8 arbitration within 30 days of the final offer, pursuant to section 10
9 or 11 of this act. In addition, in the event that arbitration is initiated
10 pursuant to section 10 of this act, the payment shall be subject to
11 the binding arbitration provisions of paragraphs (4) and (5) of
12 subsection b. of section 10 of this act.

13 d. With respect to an entity providing or administering a self-
14 funded health benefits plan and its plan members, this section shall
15 only apply if the plan elects to be subject to the provisions of this
16 section. To elect to be subject to the provisions of this section, the
17 self-funded plan shall provide notice, on an annual basis, to the
18 department, on a form and in a manner prescribed by the
19 department, attesting to the plan's participation and agreeing to be
20 bound by the provisions of this section. The self-funded plan shall
21 amend the employee benefit plan, coverage policies, contracts and
22 any other plan documents to reflect that the benefits of this section
23 shall apply to the plan's members.
24

25 10. a. If attempts to negotiate reimbursement for services
26 provided by an out-of-network health care provider, pursuant to
27 subsection c. of section 9 of this act, do not result in a resolution of
28 the payment dispute and the difference between the carrier's and the
29 provider's final offers is not less than \$1000, the carrier or out-of-
30 network health care provider may initiate binding arbitration to
31 determine payment for the services.

32 b. The binding arbitration shall adhere to the following
33 requirements:

34 (1) The party requesting arbitration shall notify the other party
35 that arbitration has been initiated and state its final offer before
36 arbitration. In response to this notice, the nonrequesting party shall
37 inform the requesting party of its final offer before the arbitration
38 occurs;

39 (2) Arbitration shall be initiated by filing a request with the
40 department;

41 (3) The department shall contract, through the request for
42 proposal process, every three years, with one or more entities that
43 have experience in health care pricing arbitration. The arbitrators
44 shall be American Arbitration Association certified arbitrators. The
45 department may initially utilize the entity engaged under the
46 "Health Claims Authorization, Processing, and Payment Act,"
47 P.L.2005, c.352 (C.17B:30-48 et seq.), for arbitration under this act;
48 however, after a period of one year from the effective date of this

1 act, the selection of the arbitration entity shall be through the
2 Request for Proposal process. Claims that are subject to arbitration
3 pursuant to the provisions of this act, which previously would be
4 subject to arbitration pursuant to the “Health Claims Authorization,
5 Processing, and Payment Act,” shall instead be subject to this act;

6 (4) The arbitration shall consist of a review of the written
7 submissions by both parties, which shall include the final offer for
8 the payment by the carrier for the out-of-network health care
9 provider’s fee made pursuant to subsection c. of section 9 of this
10 act, or a lower offer, and the final offer by the out-of-network
11 provider for the fee the provider will accept as payment from the
12 carrier; and

13 (5) The arbitrator’s decision shall be one of the two amounts
14 submitted by the parties as their final offers and shall be binding on
15 both parties. The decision of the arbitrator shall include written
16 findings and shall be issued within 45 days after the request is filed
17 with the department. The arbitrator’s expenses and fees shall be
18 split equally among the parties except in situations in which the
19 arbitrator determines that the payment made by the carrier was not
20 made in good faith, in which case the carrier shall be responsible
21 for all of the arbitrator’s expenses and fees. Each party shall be
22 responsible for its own costs and fees, including legal fees if any.

23 c. In making a determination pursuant to subsection b. of this
24 section, the arbitrator shall consider:

25 (1) the level of training, education, and experience of the health
26 care professional;

27 (2) the health care provider’s usual charge for comparable
28 services provided in-network and out-of-network with respect to
29 any health benefits plans;

30 (3) the circumstances and complexity of the particular case,
31 including the time and place of the service;

32 (4) individual patient characteristics; and

33 (5) as certified by an independent actuary:

34 (a) the average in-network amount paid for the service by that
35 carrier; and

36 (b) the average amount paid for that service to other out-of-
37 network providers by that carrier.

38 d. (1) The amount awarded by the arbitrator shall be paid within
39 20 days of the arbitrator’s decision as provided in subsection b. of
40 this section.

41 (2) The interest charges for overdue payments, pursuant to
42 P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the
43 pendency of a decision under subsection b. of this section and any
44 interest required to be paid a provider pursuant to P.L.1999,
45 c.154 (C.17B:30-23 et al.) shall not accrue until after 20 days
46 following an arbitrator’s decision as provided in subsection b. of
47 this section, but in no circumstances longer than 150 days from the

1 date that the out-of-network provider billed the carrier for services
2 rendered, unless both parties agree to a longer period of time.

3 e. This section shall apply only if the covered person complies
4 with any applicable preauthorization or review requirements of the
5 health benefits plan regarding the determination of medical
6 necessity to access in-network inpatient or outpatient benefits.

7 f. This section shall not apply to a covered person who
8 knowingly, voluntarily, and specifically selected an out-of-network
9 provider for health care services.

10 g. In the event an entity providing or administering a self-
11 funded health benefits plan elects to be subject to the provisions of
12 section 9 of this act, as provided in subsection d. of that section, the
13 provisions of this section shall apply to a self-funded plan in the
14 same manner as the provisions of this section apply to a carrier. If a
15 self-funded plan does not elect to be subject to the provision of
16 section 9 of this act, a member of that plan may initiate binding
17 arbitration as provided in section 11 of this act.

18

19 11. a. If attempts to negotiate reimbursement for services
20 between an out-of-network health care provider and a member of a
21 self-funded plan that does not elect to be subject to the provision of
22 section 9 of this act do not result in a resolution of the payment
23 dispute within 30 days after the plan member is sent a bill for the
24 services, the plan member or out-of-network health care provider
25 may initiate binding arbitration to determine payment for the
26 services. Unless negotiations for reimbursement result in an
27 agreement between the provider and the plan member within the 30
28 days, a provider shall not collect or attempt to collect
29 reimbursement, including initiation of any collection proceedings,
30 until the provider files a request for arbitration with the department
31 pursuant to this section.

32 b. The binding arbitration shall adhere to the following
33 requirements:

34 (1) Arbitration shall be initiated by filing a request with the
35 department. The department shall establish a process to notify the
36 other party that arbitration has been initiated and to inform a plan
37 member of the process to arbitrate pursuant to this section;

38 (2) The arbitrator with which the department contracts pursuant
39 to section 10 of this act shall conduct the arbitration pursuant to this
40 section;

41 (3) The arbitrator shall consider information supplied by both
42 parties; and

43 (4) The arbitrator's decision shall include written findings,
44 including a final binding amount that the arbitrator determines is
45 reasonable for the service, which shall include a non-binding
46 recommendation to the entity providing or administering the self-
47 funded health benefits plan of an amount that would be reasonable

1 for the entity to contribute to payment for the service, and shall be
2 issued within 45 days after the request is filed with the department.

3 c. The arbitrator's expenses and fees shall be divided equally
4 among the parties, unless the payment would pose a financial
5 hardship to the plan member, in which case the department shall
6 establish an agreement with the arbitrator to waive any part or all of
7 the cost of arbitration. Each party shall be responsible for its own
8 costs and fees, including legal fees, if any.

9 d. In making a determination pursuant to subsection b. of this
10 section, the arbitrator shall consider:

11 (1) the level of training, education, and experience of the health
12 care professional;

13 (2) the health care provider's usual charge for comparable
14 services provided in-network and out-of-network with respect to
15 any health benefits plans;

16 (3) the circumstances and complexity of the particular case,
17 including the time and place of the service;

18 (4) individual patient characteristics;

19 (5) as certified by an independent actuary:

20 (a) the average in-network amount paid for the service by that
21 self-funded plan; and

22 (b) the average amount paid for that service to other out-of-
23 network providers by that self-funded plan; and

24 (6) the out-of-network benefit design of the member's health
25 plan and the amount the entity providing or administering the self-
26 funded health benefits plan contributes, if anything, to the cost of
27 the service.

28 e. This section shall not apply to a covered person who
29 knowingly, voluntarily, and specifically selected an out-of-network
30 provider for health care services.

31

32 12. On or before January 31 of each calendar year, the
33 commissioner shall consult with the Department of the Treasury,
34 the relevant professional and occupational licensing boards within
35 the Division of Consumer Affairs in the Department of Law and
36 Public Safety, and the Department of Health, to obtain information
37 to compile and make publicly available, on the department's
38 website:

39 a. A list of all arbitrations filed pursuant to section 10 and 11
40 of this act between January 1 and December 31 of the previous
41 calendar year, including the percentage of all claims that were
42 arbitrated.

43 (1) For each arbitration decision, the list shall include but not be
44 limited to:

45 (a) an indication of whether the decision was in favor of the
46 carrier or the out-of-network health care provider;

47 (b) the arbitration bids offered by each side and the award
48 amount;

- 1 (c) the category and practice specialty of each out-of-network
2 health care provider involved in an arbitration decision, as
3 applicable; and
- 4 (d) a description of the service that was provided and billed for.
- 5 (2) The list of arbitration decisions shall not include any
6 information specifically identifying the provider, carrier, or covered
7 person involved in each arbitration decision.
- 8 b. The percentage of facilities and hospital-based professionals,
9 by specialty, that are in-network for each carrier in this State as
10 reported pursuant to subsection d. of section 7 of this act.
- 11 c. The number of complaints the department receives relating
12 to out-of-network health care charges.
- 13 d. The number of and description of claims received by the
14 State Health Benefits Program and the School Employees' Health
15 Benefits Program for in-State emergency out-of-network health care
16 and inadvertent out-of-network health care.
- 17 e. Annual trends on health benefits plan premium rates, total
18 annual amount of spending on inadvertent and emergency out-of-
19 network costs by carriers, and medical loss ratios in the State to the
20 extent that the information is available.
- 21 f. The number of physician specialists practicing in the State in
22 a particular specialty and whether they are in-network or out-of-
23 network with respect to the carriers that administer the State Health
24 Benefits Program, the School Employees' Health Benefits Program,
25 the qualified health plans in the federally run health exchange in the
26 State, and other health benefits plans offered in the State.
- 27 g. The results of the network audit required pursuant to section
28 16 of this act.
- 29 h. Any other benchmarks or information obtained pursuant to
30 this act that the commissioner deems appropriate to make publicly
31 available to further the goals of the act.
- 32
- 33 13. a. A carrier shall provide a written notice, in a form and
34 manner to be prescribed by the Commissioner of Banking and
35 Insurance, to each covered person of the protections provided to
36 covered persons pursuant to this act. The notice shall include
37 information on how a consumer can contact the department or the
38 appropriate regulatory agency to report and dispute an out-of-network
39 charge. The notice required pursuant to this section shall be posted on
40 the carrier's website.
- 41 b. The commissioner shall provide a notice on the department's
42 website containing information for consumers relating to the
43 protections provided by this act, information on how consumers can
44 report and file complaints with the department or the appropriate
45 regulatory agency relating to any out-of-network charges, and
46 information and guidance for consumers regarding arbitrations filed
47 pursuant to section 11 of this act.

1 14. A carrier shall calculate, as part of rate filings required to be
2 filed under New Jersey law, the savings that result from a reduction in
3 out-of-network claims payments pursuant to the provisions of this act.
4 The department shall include that information in the information
5 provided on the department's website pursuant to section 12 of this
6 act.

7
8 15. a. It shall be a violation of this act if an out-of-network health
9 care provider, directly or indirectly related to a claim, knowingly
10 waives, rebates, gives, pays, or offers to waive, rebate, give or pay all
11 or part of the deductible, copayment, or coinsurance owed by a
12 covered person pursuant to the terms of the covered person's health
13 benefits plan as an inducement for the covered person to seek health
14 care services from that provider. As the commissioner shall prescribe
15 by regulation, a pattern of waiving, rebating, giving or paying all or
16 part of the deductible, copayment or coinsurance by a provider shall be
17 considered an inducement for the purposes of this subsection.

18 b. This section shall not apply to any waiver, rebate, gift,
19 payment, or offer that falls within a safe harbor under federal laws
20 related to fraud and abuse concerning patient cost-sharing, including,
21 but not limited to, anti-kickback, self-referral, false claims, and civil
22 monetary penalties, including any advisory opinions issued by the
23 Centers for Medicare and Medicaid Services or the Office of Inspector
24 General pertaining to those laws.

25
26 16. A carrier which offers a managed care plan shall provide for
27 an annual audit of its provider network by an independent private
28 auditing firm. The audit shall be at the expense of the carrier and the
29 carrier shall submit the audit findings to the commissioner. The
30 commissioner shall make the results of the audit available on the
31 department's website. If the audit contains a determination that a
32 carrier has failed to maintain an adequate network of providers in
33 accordance with applicable federal or State law, in addition to any
34 other penalties or remedies available under federal or State law, it shall
35 be a violation of this act and the commissioner may initiate such action
36 as the commissioner deems appropriate to ensure compliance with this
37 act and network adequacy laws.

38
39 17. a. A person or entity that violates any provision of this act, or
40 the rules and regulations adopted pursuant hereto, shall be liable to a
41 penalty as provided in this subsection. The penalty shall be collected
42 by the commissioner in the name of the State in a summary proceeding
43 in accordance with the "Penalty Enforcement Law of 1999," P.L.1999,
44 c.274 (C.2A:58-10 et seq.).

45 (1) A health care facility or carrier that violates any provision of
46 this act shall be liable to a penalty of not more than \$1,000 for each
47 violation. Every day upon which a violation occurs shall be

1 considered a separate violation, but no facility or carrier shall be liable
2 to a penalty greater than \$25,000 for each occurrence.

3 (2) A person or entity not covered by paragraph (1) of this
4 subsection that violates the requirements of this act shall be liable to a
5 penalty of not more than \$100 for each violation. Every day upon
6 which a violation occurs shall be considered a separate violation, but
7 no person or entity shall be liable to a penalty greater than \$2,500 for
8 each occurrence.

9 b. Upon a finding that a person or entity has failed to comply with
10 the requirements of this act, including the payment of a penalty as
11 determined under subsection a. of this section, the commissioner may:

12 (1) in the case of a carrier, initiate such action as the commissioner
13 determines appropriate;

14 (2) in the case of a health care facility, refer the matter to the
15 Commissioner of Health for such action as the Commissioner of
16 Health determines appropriate; or

17 (3) in the case of a health care professional, refer the matter to the
18 appropriate professional or occupational licensing board within the
19 Division of Consumer Affairs in the Department of Law and Public
20 Safety for such action as that board determines appropriate.

21
22 18. The Commissioner of Banking and Insurance, the
23 Commissioner of Health and any relevant licensing board in the
24 Division of Consumer Affairs in the Department of Law and Public
25 Safety under Title 45 of the Revised Statutes may, as appropriate,
26 adopt rules and regulations, pursuant to the "Administrative Procedure
27 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), in order to effectuate the
28 purposes of this act.

29
30 19. The provisions of this act shall be severable, and if any
31 provision of this act shall be held invalid, or held invalid with respect
32 to any particular health benefits plan or carrier, such invalidity shall
33 not affect the other provisions hereof, or application of those
34 provisions to other health benefits plans or carriers.

35
36 20. Nothing in this act shall be construed to apply to an entity
37 providing or administering a self-funded health benefits plan which is
38 subject to the "Employee Retirement Income Security Act of 1974,"
39 except as provided in subsection d. of section 9 of this act for such an
40 entity to elect to be subject to certain provisions of the act.

41
42 21. This act shall take effect on the 90th day next following
43 enactment. The Commissioner of Banking and Insurance, the
44 Department of Health and any relevant licensing board may take
45 such anticipatory administrative action in advance thereof as shall
46 be necessary for the implementation of this act.

STATEMENT

1
2
3 This bill is entitled the “Out-of-network Consumer Protection,
4 Transparency, Cost Containment and Accountability Act.” The bill
5 reforms various aspects of the health care delivery system in New
6 Jersey to increase transparency in pricing for health care services,
7 enhance consumer protections, create an arbitration system to
8 resolve certain health care billing disputes, contain rising costs
9 associated with out-of-network health care services, and measure
10 success with regard to these goals.

11
12 DISCLOSURE

13 The bill places certain responsibilities on health care facilities
14 and health care professionals to notify patients about services that
15 they will provide. The bill uses the term “health care provider” to
16 include both facilities and professionals.

17 Specifically with regard to health care facilities, prior to
18 scheduling an appointment with a covered person for a non-
19 emergency or elective procedure, and in terms the covered person
20 typically understands, a health care facility is required to:

21 (1) disclose whether the health care facility is in-network or out-
22 of-network with respect to the covered person’s health benefits
23 plan;

24 (2) advise the covered person to check with the physician
25 arranging the facility services to determine whether or not that
26 physician is in-network or out-of-network with respect to the
27 covered person’s health benefits plan and provide information about
28 how to determine the health plans participated in by any physician
29 reasonably anticipated to provider services;

30 (3) advise the covered person that at a health care facility that is
31 in-network with respect to the person’s health benefits plan that the
32 covered person will have a financial responsibility applicable to an
33 in-network procedure and unless the covered person has knowingly,
34 voluntarily, and specifically selected an out-of-network provider to
35 provide services, the covered person will not incur any out-of-
36 pocket costs in excess of the charges applicable to an in-network
37 procedure; and

38 (4) advise the covered person that at a health care facility that is
39 out-of-network with respect to the covered person’s health benefits
40 plan that certain health care services will be provided on an out-of-
41 network basis.

42 In addition, in a form that is consistent with federal guidelines, a
43 health care facility is required to establish, update, and make public
44 through posting on the facility’s website a list of the facility’s
45 standard charges for items and services provided by the facility.

46 Among these disclosures, a health care facility shall post on the
47 facility’s website:

- 1 (1) the health benefits plans in which the facility is a
2 participating provider;
- 3 (2) a statement concerning certain physician services provided in
4 the facility;
- 5 (3) as applicable, the name, mailing address, and telephone
6 number of the physician groups that the facility has contracted with
7 to provide services including, but not limited to, anesthesiology,
8 pathology, or radiology; and
- 9 (4) as applicable, the name, mailing address, and telephone
10 number of physicians employed by the facility and whose services
11 may be provided at the facility, and the health benefits plans in
12 which they participate.

13 If the network status of the facility changes as it relates to the
14 covered person's health benefits plan, the bill requires the facility to
15 notify the covered person promptly.

16 With regard to health care professionals, the bill requires that a
17 professional disclose to a covered persons in writing or through an
18 internet website the health benefits plans in which the health care
19 professional is a participating provider and the facilities with which
20 the health care professional is affiliated prior to the provision of
21 non-emergency services, and verbally or in writing, at the time of
22 an appointment. If a health care professional does not participate in
23 the network of the covered person's health benefits plan, the health
24 care professional shall, in terms the covered person typically
25 understands:

- 26 (1) Inform the covered person that the professional is out-of-
27 network and that the amount or estimated amount the health care
28 professional will bill the covered person for the services is available
29 upon request;
- 30 (2) Upon receipt of a request from a covered person, disclose to
31 the covered person in writing the amount or estimated amount that
32 the health care professional will bill the covered person absent
33 unforeseen medical circumstances that may arise when the health
34 care service is provided;
- 35 (3) inform the covered person that the covered person will have a
36 financial responsibility applicable to health care services provided
37 by an out-of-network professional; and
- 38 (4) inform the covered person to contact the covered person's
39 carrier for further consultation on those costs.

40 A health care professional who is a physician is also required to
41 make certain notifications concerning health care providers
42 scheduled to perform anesthesiology, laboratory, pathology,
43 radiology, or assistant surgeon services in connection with care to
44 be provided in the physician's office or whose services will be
45 arranged by the physician and are scheduled at the time of the pre-
46 admission, testing, registration, or admission. The physician shall
47 provide instructions or information as to how to determine the
48 health benefits plans in which the health care provider participates

1 and recommend that the covered person should contact the covered
2 person's carrier for further consultation on costs associated with
3 these services.

4 A physician shall, for a covered person's scheduled facility
5 admission or scheduled outpatient facility services, provide the
6 covered person and the facility with certain information about other
7 physicians whose services will be arranged.

8 The bill clarifies that the receipt or acknowledgement by any
9 covered person of any disclosures required under this section of the
10 bill shall not waive or otherwise affect any protection under existing
11 statutes or regulations regarding in-network health benefits plan
12 coverage available to the covered person or created under the bill.

13 The bill also places a variety of responsibilities on health
14 insurance carriers. Carriers include insurance companies authorized
15 to issue health benefits plans; health maintenance organizations;
16 health, hospital, or medical service corporations; multiple employer
17 welfare arrangements; entities under contract with the State Health
18 Benefits Program and the School Employees' Health Benefits
19 Program to administer a health benefits plan; and any other carrier
20 providing a health benefits plan.

21 Specifically, a carrier must update the carrier's website within 20
22 days of the addition or termination of a provider from the network
23 or a change in a physician's affiliation with a facility. With respect
24 to out-of-network services, for each health benefits plan offered, a
25 carrier is required to, consistent with State and federal law, provide
26 a covered person with:

27 (1) a clear and understandable description of the plan's out-of-
28 network health care benefits, including the methodology used by the
29 carrier to determine reimbursement for out-of-network services;

30 (2) the allowed amount the plan will reimburse under that
31 methodology;

32 (3) examples of anticipated out-of-pocket costs for frequently
33 billed out-of-network services;

34 (4) information in writing and through an internet website that
35 reasonably permits a covered person or prospective covered person
36 to calculate the anticipated out-of-pocket cost for out-of-network
37 services in a geographical region or zip code based upon the
38 difference between the amount the carrier will reimburse for out-of-
39 network services and the usual and customary cost of out-of-
40 network services;

41 (5) information in response to a covered person's request,
42 concerning whether a health care provider is an in-network
43 provider;

44 (6) such other information as the commissioner determines
45 appropriate and necessary to ensure that a covered person receives
46 sufficient information necessary to estimate their out-of-pocket cost
47 for an out-of-network service and make a well-informed health care
48 decision; and

1 (7) access to a telephone hotline that shall be operated no less
2 than 16 hours per day for consumers to call with questions about
3 network status and out-of-pocket costs.

4 The bill also addresses situations in which a carrier authorizes a
5 covered health care service to be performed by an in-network health
6 care provider with respect to any health benefits plan, and the
7 provider or facility status changes to out-of-network before the
8 authorized service is performed. The bill requires the carrier to
9 notify the covered person that the provider or facility is no longer
10 in-network as soon as practicable. If the carrier fails to provide the
11 notice at least 30 days prior to the authorized service being
12 performed, the covered person's financial responsibility shall be
13 limited to the financial responsibility the covered person would
14 have incurred had the provider been in-network with respect to the
15 covered person's health benefits plan.

16 17 OUT-OF-NETWORK BILLING

18 The bill places certain limitations on charges by out-of-network
19 providers in two situations: (1) if a covered person receives
20 medically necessary services at any health care facility on an
21 emergency or urgent basis; and (2) inadvertent out-of-network
22 services. The bill defines "inadvertent out-of-network services" to
23 mean health care services that are: covered under a managed care
24 health benefits plan that provides a network; and provided by an
25 out-of-network health care provider in the event that a covered
26 person utilizes an in-network health care facility for covered health
27 care services and, due to any reason, in-network health care services
28 are unavailable in that facility. "Inadvertent out-of-network
29 services" includes laboratory testing ordered by an in-network
30 health care provider and performed by an out-of-network bio-
31 analytical laboratory.

32 The bill protects a covered person receiving medically necessary
33 services at any health care facility on an emergency or urgent basis
34 by prohibiting the provider from billing the covered person in
35 excess of any deductible, copayment, or coinsurance amount
36 applicable to in-network services pursuant to the covered person's
37 health benefits plan.

38 With regard to medically necessary services at an out-of-network
39 health care facility on an emergency or urgent basis, if the carrier
40 and facility cannot agree on a reimbursement rate for these services
41 within 30 days after the carrier is billed for the service, the carrier
42 or health care facility may initiate binding arbitration.

43 The bill also requires health care facilities that are in-network
44 with respect to any health benefits plan to ensure that:

45 (1) all providers providing services in the facility on an
46 emergency or urgent basis accept reimbursement rates in
47 accordance with the bill's provisions;

1 (2) all health care professionals that are contracted with the
2 facility to perform services in the facility are also in-network with
3 respect to all health benefits plans with which the facility is in-
4 network; and

5 (3) to report certain information to the Department of Health.
6 The bill also provides that if a covered person receives: inadvertent
7 out-of-network services; or medically necessary services at an in-
8 network or out-of-network health care facility on an emergency or
9 urgent basis, the health care professional performing those services
10 shall:

11 (1) in the case of inadvertent out-of-network services, not bill the
12 covered person in excess of any deductible, copayment, or
13 coinsurance amount; and

14 (2) in the case of emergency and urgent services, not bill the
15 covered person in excess of any deductible, copayment, or
16 coinsurance amount.

17 If the carrier and the professional cannot agree on a
18 reimbursement rate for these services within 30 days after the
19 carrier is billed for the service, the carrier or professional may
20 initiate binding arbitration.

21 The prohibitions on balance-billing would only apply to entities
22 providing or administering a self-funded health benefits plan and its
23 plan members if the self-funded entity elects to be subject to section
24 9 of the bill, which requires the plan to ensure that the plan
25 members incur no greater out-of-pocket costs than had they gone to
26 an in-network provider and for benefits provided by the plan to be
27 assigned to the out-of-network provider, which thereby subjects the
28 plan to arbitration under the bill.

29

30 ARBITRATION

31 For certain emergency and out-of-network billing situations
32 between providers and carriers, the bill establishes an arbitration
33 system. As it relates to self-funded health plans that do not elect to
34 be subject to arbitration under the bill, the bill provides for
35 arbitration between the self-funded plan member and the out-of-
36 network provider if attempts to negotiate reimbursement for
37 services do not result in a resolution of the payment dispute.

38 The bill provides that, in the event that a covered person receives
39 inadvertent out-of-network services or services at an in-network or
40 out-of-network health care facility on an emergency or urgent basis,
41 the carrier, or self-funded plan that opts into the section, shall
42 ensure that the covered person incurs no greater out-of-pocket costs
43 than the covered person would have incurred with an in-network
44 health care provider for covered services. The out-of-network
45 provider is prohibited from billing the covered person, except for
46 applicable deductible, copayment, or coinsurance amounts that
47 would apply if the covered person utilized an in-network health care
48 provider for the covered services. In these situations, the benefits

1 that the covered person receives for health care services shall be
2 assigned to the out-of-network health care provider, which requires
3 no action on the part of the covered person. Once the benefits are
4 assigned:

5 (1) any reimbursement paid by the carrier, or self-funded plan
6 that opts in, shall be paid directly to the out-of-network provider;
7 and

8 (2) the carrier, or self-funded plan that opts in, shall provide the
9 out-of-network provider with a written remittance of payment that
10 specifies the proposed reimbursement and the applicable deductible,
11 copayment, or coinsurance amounts owed by the covered person.

12 If inadvertent out-of-network services or medically necessary
13 services at an in-network or out-of-network health care facility on
14 an emergency or urgent basis are performed, the out-of-network
15 provider may bill the carrier, or self-funded plan that opts in, for the
16 services rendered. The carrier, or self-funded plan that opts in, may
17 pay the billed amount or attempt to negotiate reimbursement with
18 the out-of-network health care provider.

19 If attempts to negotiate reimbursement for services provided by
20 an out-of-network health care provider do not result in a resolution
21 of the payment dispute within 30 days after the carrier is billed for
22 the services by the out-of-network health care provider, the carrier,
23 or self-funded plan that opts in, or out-of-network health care
24 provider may initiate binding arbitration to determine payment for
25 the services if the difference between the carrier's or self-funded
26 plan's final offer and the provider's final offer is not less than
27 \$1,000.

28 The binding arbitration system established under the bill
29 provides that the party requesting arbitration shall notify the other
30 party that arbitration has been initiated.

31 Arbitration shall be initiated by filing a request with the
32 department. The arbitrators selected by the department shall be one
33 or more entities that have experience in health care pricing
34 arbitration and must be certified by the American Arbitration
35 Association.

36 Arbitration is not available in the case of a covered person who
37 willfully selected to access an out-of-network health care provider
38 for health care services.

39

40 ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-
41 OF-NETWORK PROVIDER

42 In the case of a member of a self-funded plan that does not elect
43 to opt-in to the arbitration and balance-billing protections of the
44 bill, the plan member or out-of-network health care provider may
45 initiate binding arbitration to determine payment for the services by
46 filing a request with the department. Unless negotiations for
47 reimbursement result in an agreement between the provider and the
48 plan member within the 30 days, a provider shall not collect or

1 attempt to collect reimbursement, including initiation of any
2 collection proceedings, until the provider files a request for
3 arbitration.

4 This decision must be issued within 45 days after the request for
5 arbitration is filed with the department.

6 The arbitrator's expenses and fees shall be split equally among
7 the parties. Each party shall be responsible for its own costs and
8 fees, including legal fees, if any.

9

10 INCREASED TRANSPARENCY

11 The bill also provides that on or before January 31 of each
12 calendar year, the commissioner shall consult with the Department
13 of the Treasury, the relevant professional and occupational
14 licensing boards within the Division of Consumer Affairs in the
15 Department of Law and Public Safety, and the Department of
16 Health to obtain information to compile and make publicly
17 available certain information, on the department's website,
18 including a list of all arbitrations filed and the award amount.

19 The bill provides that a carrier shall provide a written notice to
20 each covered person of the protections provided to covered persons
21 pursuant to the bill. The notice shall include information on how a
22 consumer can contact the department or the appropriate regulatory
23 agency to report and dispute an out-of-network charge. The notice
24 shall be posted on the carrier's website.

25 The bill also provides that a carrier shall calculate, as part of rate
26 filings required to be filed under New Jersey law, the savings that
27 result from a reduction in out-of-network claims payments pursuant
28 to the provisions of the bill. The department is required to make that
29 information available on the department's website.

30

31 PROVIDER NETWORK AUDIT

32 Under the bill, a carrier which offers a managed care plan is
33 required to provide for an annual audit of its provider network by an
34 independent private auditing firm. The audit is to be at the expense
35 of the carrier and the carrier shall submit the audit findings to the
36 commissioner. The commissioner will make the results of the audit
37 available on the department's website. If the audit contains a
38 determination that a carrier has failed to maintain an adequate
39 network of providers in accordance with applicable federal or State
40 law, in addition to any other penalties or remedies available under
41 federal or State law, it would be a violation of the bill and the
42 commissioner is permitted to initiate such action as the
43 commissioner deems appropriate to ensure compliance with this bill
44 and network adequacy laws.

45

46 WAIVER OF COST SHARING

47 The bill also provides that it is a violation of the bill's provisions
48 if an out-of-network health care provider, directly or indirectly

1 related to a claim, knowingly waives, rebates, gives, pays, or offers
2 to waive, rebate, give or pay all or part of the deductible,
3 copayment, or coinsurance owed by a covered person pursuant to
4 the terms of the covered person's health benefits plan as an
5 inducement for the covered person to seek health care services from
6 that provider. The bill specifies that a pattern of waiving, rebating,
7 giving or paying all or part of the deductible, copayment or
8 coinsurance by a provider shall be considered an inducement. The
9 bill provides that this section does not apply to any waiver, rebate,
10 gift, payment, or offer that falls within a safe harbor under federal
11 laws related to fraud and abuse concerning patient cost-sharing,
12 including, but not limited to, anti-kickback, self-referral, false
13 claims, and civil monetary penalties. One such safe harbor is for a
14 financial hardship.

15

16 PENALTIES

17 A person or carrier that violates any provision of the bill, or the
18 rules and regulations adopted pursuant thereto, is liable to a penalty
19 as provided in the bill. Further, upon a finding that a person or
20 carrier has failed to comply with the requirements of the bill,
21 including the payment of a penalty, the commissioner may:

22 (1) in the case of a carrier, initiate such action as the
23 commissioner determines appropriate;

24 (2) in the case of a health care facility, refer the matter to the
25 Commissioner of Health for such action as the Commissioner of
26 Health determines appropriate; or

27 (3) in the case of a health care professional, refer the matter to
28 the appropriate professional and occupational licensing board
29 within the Division of Consumer Affairs in the Department of Law
30 and Public Safety for such action as that board determines
31 appropriate.

32 Finally, the effective date of the bill is the 90th day following
33 enactment.

[Corrected Copy]

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE
COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2039

STATE OF NEW JERSEY

DATED: MARCH 5, 2018

The Assembly Financial Institutions and Insurance Committee reports favorably Assembly Bill No. 2039.

This bill is entitled the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.” The bill reforms various aspects of the health care delivery system in New Jersey to increase transparency in pricing for health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes, contain rising costs associated with out-of-network health care services, and measure success with regard to these goals.

DISCLOSURE

The bill places certain responsibilities on health care facilities and health care professionals to notify patients about services that they will provide. The bill uses the term “health care provider” to include both facilities and professionals.

Specifically with regard to health care facilities, prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, and in terms the covered person typically understands, a health care facility is required to:

(1) disclose whether the health care facility is in-network or out-of-network with respect to the covered person’s health benefits plan;

(2) advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is in-network or out-of-network with respect to the covered person’s health benefits plan and provide information about how to determine the health plans participated in by any physician reasonably anticipated to provide services;

(3) advise the covered person that at a health care facility that is in-network with respect to the person’s health benefits plan that the covered person will have a financial responsibility applicable to an in-network procedure and unless the covered person has knowingly, voluntarily, and specifically selected an out-of-network provider to

provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure; and

(4) advise the covered person that at a health care facility that is out-of-network with respect to the covered person's health benefits plan that certain health care services will be provided on an out-of-network basis.

In addition, in a form that is consistent with federal guidelines, a health care facility is required to establish, update, and make public through posting on the facility's website a list of the facility's standard charges for items and services provided by the facility.

Among these disclosures, a health care facility shall post on the facility's website:

(1) the health benefits plans in which the facility is a participating provider;

(2) a statement concerning certain physician services provided in the facility;

(3) as applicable, the name, mailing address, and telephone number of the physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, or radiology; and

(4) as applicable, the name, mailing address, and telephone number of physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.

If the network status of the facility changes as it relates to the covered person's health benefits plan, the bill requires the facility to notify the covered person promptly.

With regard to health care professionals, the bill requires that a professional disclose to a covered persons in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the health care professional is affiliated prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care professional does not participate in the network of the covered person's health benefits plan, the health care professional shall, in terms the covered person typically understands:

(1) Inform the covered person that the professional is out-of-network and that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request;

(2) Upon receipt of a request from a covered person, disclose to the covered person in writing the amount or estimated amount that the health care professional will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided;

(3) inform the covered person that the covered person will have a financial responsibility applicable to health care services provided by an out-of-network professional; and

(4) inform the covered person to contact the covered person's carrier for further consultation on those costs.

A health care professional who is a physician is also required to make certain notifications concerning health care providers scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission. The physician shall provide instructions or information as to how to determine the health benefits plans in which the health care provider participates and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

A physician shall, for a covered person's scheduled facility admission or scheduled outpatient facility services, provide the covered person and the facility with certain information about other physicians whose services will be arranged.

The bill clarifies that the receipt or acknowledgement by any covered person of any disclosures required under this section of the bill shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the covered person or created under the bill.

The bill also places a variety of responsibilities on health insurance carriers. Carriers include insurance companies authorized to issue health benefits plans; health maintenance organizations; health, hospital, or medical service corporations; multiple employer welfare arrangements; entities under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; and any other carrier providing a health benefits plan.

Specifically, a carrier must update the carrier's website within 20 days of the addition or termination of a provider from the network or a change in a physician's affiliation with a facility. With respect to out-of-network services, for each health benefits plan offered, a carrier is required to, consistent with State and federal law, provide a covered person with:

(1) a clear and understandable description of the plan's out-of-network health care benefits, including the methodology used by the carrier to determine reimbursement for out-of-network services;

(2) the allowed amount the plan will reimburse under that methodology;

(3) examples of anticipated out-of-pocket costs for frequently billed out-of-network services;

(4) information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services;

(5) information in response to a covered person's request, concerning whether a health care provider is an in-network provider;

(6) such other information as the commissioner determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to estimate their out-of-pocket cost for an out-of-network service and make a well-informed health care decision; and

(7) access to a telephone hotline that shall be operated no less than 16 hours per day for consumers to call with questions about network status and out-of-pocket costs.

The bill also addresses situations in which a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed. The bill requires the carrier to notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

OUT-OF-NETWORK BILLING

The bill places certain limitations on charges by out-of-network providers in two situations: (1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) inadvertent out-of-network services. The bill defines "inadvertent out-of-network services" to mean health care services that are: 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, due to any reason, in-network health care services are unavailable in that facility. "Inadvertent out-of-network services" includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

The bill protects a covered person receiving medically necessary services at any health care facility on an emergency or urgent basis by prohibiting the provider from billing the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan.

With regard to medically necessary services at an out-of-network health care facility on an emergency or urgent basis, if the carrier and facility cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or health care facility may initiate binding arbitration.

The bill also requires health care facilities that are in-network with respect to any health benefits plan to ensure that:

- (1) all providers providing services in the facility on an emergency or inadvertent basis are provided notifications of the bill's provisions and information as to each health benefits plan with which the facility has a contract to be in-network;
- (2) to report annually certain information to the Department of Health.

The bill also provides that if a covered person receives: inadvertent out-of-network services; or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, the health care professional performing those services shall:

- (1) in the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount; and
- (2) in the case of emergency and urgent services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount.

If the carrier and the professional cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or professional may initiate binding arbitration.

The prohibitions on balance-billing would only apply to entities providing or administering a self-funded health benefits plan and its plan members if the self-funded entity elects to be subject to section 9 of the bill, which requires the plan to ensure that the plan members incur no greater out-of-pocket costs than had they gone to an in-network provider and for benefits provided by the plan to be assigned to the out-of-network provider, which thereby subjects the plan to arbitration under the bill.

ARBITRATION

For certain emergency and out-of-network billing situations between providers and carriers, the bill establishes an arbitration system. As it relates to self-funded health plans that do not elect to be subject to arbitration under the bill, the bill provides for arbitration between the self-funded plan member and the out-of-network provider if attempts to negotiate reimbursement for services do not result in a resolution of the payment dispute.

The bill provides that, in the event that a covered person receives inadvertent out-of-network services or services at an in-network or out-of-network health care facility on an emergency or urgent basis, the carrier, or self-funded plan that opts into the section, shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services. The out-of-network provider is prohibited from billing the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network health care provider for the covered services. In these situations, the benefits that the covered person receives for health care services shall be assigned to the out-of-network health care provider, which requires no action on the part of the covered person. Once the benefits are assigned:

(1) any reimbursement paid by the carrier, or self-funded plan that opts in, shall be paid directly to the out-of-network provider; and

(2) the carrier, or self-funded plan that opts in, shall provide the out-of-network provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

If inadvertent out-of-network services or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis are performed, the out-of-network provider may bill the carrier, or self-funded plan that opts in, for the services rendered. The carrier, or self-funded plan that opts in, may pay the billed amount or attempt to negotiate reimbursement with the out-of-network health care provider.

If attempts to negotiate reimbursement for services provided by an out-of-network health care provider do not result in a resolution of the payment dispute within 30 days after the carrier is billed for the services by the out-of-network health care provider, the carrier, or self-funded plan that opts in, or out-of-network health care provider may initiate binding arbitration to determine payment for the services if the difference between the carrier's or self-funded plan's final offer and the provider's final offer is not less than \$1,000.

The binding arbitration system established under the bill provides that the party requesting arbitration shall notify the other party that arbitration has been initiated.

Arbitration shall be initiated by filing a request with the department. The arbitrators selected by the department shall be one or more entities that have experience in health care pricing arbitration and must be certified by the American Arbitration Association.

Arbitration is not available in the case of a covered person who willfully selected to access an out-of-network health care provider for health care services.

ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-OF-NETWORK PROVIDER

In the case of a member of a self-funded plan that does not elect to opt-in to the arbitration and balance-billing protections of the bill, the plan member or out-of-network health care provider may initiate binding arbitration to determine payment for the services by filing a request with the department. Unless negotiations for reimbursement result in an agreement between the provider and the plan member within the 30 days, a provider shall not collect or attempt to collect reimbursement, including initiation of any collection proceedings, until the provider files a request for arbitration.

This decision must be issued within 45 days after the request for arbitration is filed with the department.

The arbitrator's expenses and fees shall be split equally among the parties. Each party shall be responsible for its own costs and fees, including legal fees, if any.

INCREASED TRANSPARENCY

The bill also provides that on or before January 31 of each calendar year, the commissioner shall consult with the Department of the Treasury, the relevant professional and occupational licensing boards within the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Health to obtain information to compile and make publicly available certain information, on the department's website, including a list of all arbitrations filed and the award amount.

The bill provides that a carrier shall provide a written notice to each covered person of the protections provided to covered persons pursuant to the bill. The notice shall include information on how a consumer can contact the department or the appropriate regulatory agency to report and dispute an out-of-network charge. The notice shall be posted on the carrier's website.

The bill also provides that a carrier shall calculate, as part of rate filings required to be filed under New Jersey law, the savings that

result from a reduction in out-of-network claims payments pursuant to the provisions of the bill. The department is required to make that information available on the department's website.

PROVIDER NETWORK AUDIT

Under the bill, a carrier which offers a managed care plan is required to provide for an annual audit of its provider network by an independent private auditing firm. The audit is to be at the expense of the carrier and the carrier shall submit the audit findings to the commissioner. The commissioner will make the results of the audit available on the department's website. If the audit contains a determination that a carrier has failed to maintain an adequate network of providers in accordance with applicable federal or State law, in addition to any other penalties or remedies available under federal or State law, it would be a violation of the bill and the commissioner is permitted to initiate such action as the commissioner deems appropriate to ensure compliance with this bill and network adequacy laws.

WAIVER OF COST SHARING

The bill also provides that it is a violation of the bill's provisions if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. The bill specifies that a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement. The bill provides that this section does not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties. One such safe harbor is for a financial hardship.

PENALTIES

A person or carrier that violates any provision of the bill, or the rules and regulations adopted pursuant thereto, is liable to a penalty as provided in the bill. Further, upon a finding that a person or carrier has failed to comply with the requirements of the bill, including the payment of a penalty, the commissioner may:

(1) in the case of a carrier, initiate such action as the commissioner determines appropriate;

(2) in the case of a health care facility, refer the matter to the Commissioner of Health for such action as the Commissioner of Health determines appropriate; or

(3) in the case of a health care professional, refer the matter to the appropriate professional and occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety for such action as that board determines appropriate.

Finally, the effective date of the bill is the 90th day following enactment.

This bill was pre-filed for introduction in the 2018-2019 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

[Corrected Copy]

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE
COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2039

STATE OF NEW JERSEY

DATED: MARCH 5, 2018

The Assembly Financial Institutions and Insurance Committee reports favorably Assembly Bill No. 2039.

This bill is entitled the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.” The bill reforms various aspects of the health care delivery system in New Jersey to increase transparency in pricing for health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes, contain rising costs associated with out-of-network health care services, and measure success with regard to these goals.

DISCLOSURE

The bill places certain responsibilities on health care facilities and health care professionals to notify patients about services that they will provide. The bill uses the term “health care provider” to include both facilities and professionals.

Specifically with regard to health care facilities, prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, and in terms the covered person typically understands, a health care facility is required to:

(1) disclose whether the health care facility is in-network or out-of-network with respect to the covered person’s health benefits plan;

(2) advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is in-network or out-of-network with respect to the covered person’s health benefits plan and provide information about how to determine the health plans participated in by any physician reasonably anticipated to provide services;

(3) advise the covered person that at a health care facility that is in-network with respect to the person’s health benefits plan that the covered person will have a financial responsibility applicable to an in-network procedure and unless the covered person has knowingly, voluntarily, and specifically selected an out-of-network provider to

provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure; and

(4) advise the covered person that at a health care facility that is out-of-network with respect to the covered person's health benefits plan that certain health care services will be provided on an out-of-network basis.

In addition, in a form that is consistent with federal guidelines, a health care facility is required to establish, update, and make public through posting on the facility's website a list of the facility's standard charges for items and services provided by the facility.

Among these disclosures, a health care facility shall post on the facility's website:

(1) the health benefits plans in which the facility is a participating provider;

(2) a statement concerning certain physician services provided in the facility;

(3) as applicable, the name, mailing address, and telephone number of the physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, or radiology; and

(4) as applicable, the name, mailing address, and telephone number of physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.

If the network status of the facility changes as it relates to the covered person's health benefits plan, the bill requires the facility to notify the covered person promptly.

With regard to health care professionals, the bill requires that a professional disclose to a covered persons in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the health care professional is affiliated prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care professional does not participate in the network of the covered person's health benefits plan, the health care professional shall, in terms the covered person typically understands:

(1) Inform the covered person that the professional is out-of-network and that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request;

(2) Upon receipt of a request from a covered person, disclose to the covered person in writing the amount or estimated amount that the health care professional will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided;

(3) inform the covered person that the covered person will have a financial responsibility applicable to health care services provided by an out-of-network professional; and

(4) inform the covered person to contact the covered person's carrier for further consultation on those costs.

A health care professional who is a physician is also required to make certain notifications concerning health care providers scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission. The physician shall provide instructions or information as to how to determine the health benefits plans in which the health care provider participates and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

A physician shall, for a covered person's scheduled facility admission or scheduled outpatient facility services, provide the covered person and the facility with certain information about other physicians whose services will be arranged.

The bill clarifies that the receipt or acknowledgement by any covered person of any disclosures required under this section of the bill shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the covered person or created under the bill.

The bill also places a variety of responsibilities on health insurance carriers. Carriers include insurance companies authorized to issue health benefits plans; health maintenance organizations; health, hospital, or medical service corporations; multiple employer welfare arrangements; entities under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; and any other carrier providing a health benefits plan.

Specifically, a carrier must update the carrier's website within 20 days of the addition or termination of a provider from the network or a change in a physician's affiliation with a facility. With respect to out-of-network services, for each health benefits plan offered, a carrier is required to, consistent with State and federal law, provide a covered person with:

(1) a clear and understandable description of the plan's out-of-network health care benefits, including the methodology used by the carrier to determine reimbursement for out-of-network services;

(2) the allowed amount the plan will reimburse under that methodology;

(3) examples of anticipated out-of-pocket costs for frequently billed out-of-network services;

(4) information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services;

(5) information in response to a covered person's request, concerning whether a health care provider is an in-network provider;

(6) such other information as the commissioner determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to estimate their out-of-pocket cost for an out-of-network service and make a well-informed health care decision; and

(7) access to a telephone hotline that shall be operated no less than 16 hours per day for consumers to call with questions about network status and out-of-pocket costs.

The bill also addresses situations in which a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed. The bill requires the carrier to notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

OUT-OF-NETWORK BILLING

The bill places certain limitations on charges by out-of-network providers in two situations: (1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) inadvertent out-of-network services. The bill defines "inadvertent out-of-network services" to mean health care services that are: 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, due to any reason, in-network health care services are unavailable in that facility. "Inadvertent out-of-network services" includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

The bill protects a covered person receiving medically necessary services at any health care facility on an emergency or urgent basis by prohibiting the provider from billing the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan.

With regard to medically necessary services at an out-of-network health care facility on an emergency or urgent basis, if the carrier and facility cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or health care facility may initiate binding arbitration.

The bill also requires health care facilities that are in-network with respect to any health benefits plan to ensure that:

- (1) all providers providing services in the facility on an emergency or inadvertent basis are provided notifications of the bill's provisions and information as to each health benefits plan with which the facility has a contract to be in-network;
- (2) to report annually certain information to the Department of Health.

The bill also provides that if a covered person receives: inadvertent out-of-network services; or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, the health care professional performing those services shall:

- (1) in the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount; and
- (2) in the case of emergency and urgent services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount.

If the carrier and the professional cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or professional may initiate binding arbitration.

The prohibitions on balance-billing would only apply to entities providing or administering a self-funded health benefits plan and its plan members if the self-funded entity elects to be subject to section 9 of the bill, which requires the plan to ensure that the plan members incur no greater out-of-pocket costs than had they gone to an in-network provider and for benefits provided by the plan to be assigned to the out-of-network provider, which thereby subjects the plan to arbitration under the bill.

ARBITRATION

For certain emergency and out-of-network billing situations between providers and carriers, the bill establishes an arbitration system. As it relates to self-funded health plans that do not elect to be subject to arbitration under the bill, the bill provides for arbitration between the self-funded plan member and the out-of-network provider if attempts to negotiate reimbursement for services do not result in a resolution of the payment dispute.

The bill provides that, in the event that a covered person receives inadvertent out-of-network services or services at an in-network or out-of-network health care facility on an emergency or urgent basis, the carrier, or self-funded plan that opts into the section, shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services. The out-of-network provider is prohibited from billing the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network health care provider for the covered services. In these situations, the benefits that the covered person receives for health care services shall be assigned to the out-of-network health care provider, which requires no action on the part of the covered person. Once the benefits are assigned:

(1) any reimbursement paid by the carrier, or self-funded plan that opts in, shall be paid directly to the out-of-network provider; and

(2) the carrier, or self-funded plan that opts in, shall provide the out-of-network provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

If inadvertent out-of-network services or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis are performed, the out-of-network provider may bill the carrier, or self-funded plan that opts in, for the services rendered. The carrier, or self-funded plan that opts in, may pay the billed amount or attempt to negotiate reimbursement with the out-of-network health care provider.

If attempts to negotiate reimbursement for services provided by an out-of-network health care provider do not result in a resolution of the payment dispute within 30 days after the carrier is billed for the services by the out-of-network health care provider, the carrier, or self-funded plan that opts in, or out-of-network health care provider may initiate binding arbitration to determine payment for the services if the difference between the carrier's or self-funded plan's final offer and the provider's final offer is not less than \$1,000.

The binding arbitration system established under the bill provides that the party requesting arbitration shall notify the other party that arbitration has been initiated.

Arbitration shall be initiated by filing a request with the department. The arbitrators selected by the department shall be one or more entities that have experience in health care pricing arbitration and must be certified by the American Arbitration Association.

Arbitration is not available in the case of a covered person who willfully selected to access an out-of-network health care provider for health care services.

ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-OF-NETWORK PROVIDER

In the case of a member of a self-funded plan that does not elect to opt-in to the arbitration and balance-billing protections of the bill, the plan member or out-of-network health care provider may initiate binding arbitration to determine payment for the services by filing a request with the department. Unless negotiations for reimbursement result in an agreement between the provider and the plan member within the 30 days, a provider shall not collect or attempt to collect reimbursement, including initiation of any collection proceedings, until the provider files a request for arbitration.

This decision must be issued within 45 days after the request for arbitration is filed with the department.

The arbitrator's expenses and fees shall be split equally among the parties. Each party shall be responsible for its own costs and fees, including legal fees, if any.

INCREASED TRANSPARENCY

The bill also provides that on or before January 31 of each calendar year, the commissioner shall consult with the Department of the Treasury, the relevant professional and occupational licensing boards within the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Health to obtain information to compile and make publicly available certain information, on the department's website, including a list of all arbitrations filed and the award amount.

The bill provides that a carrier shall provide a written notice to each covered person of the protections provided to covered persons pursuant to the bill. The notice shall include information on how a consumer can contact the department or the appropriate regulatory agency to report and dispute an out-of-network charge. The notice shall be posted on the carrier's website.

The bill also provides that a carrier shall calculate, as part of rate filings required to be filed under New Jersey law, the savings that

result from a reduction in out-of-network claims payments pursuant to the provisions of the bill. The department is required to make that information available on the department's website.

PROVIDER NETWORK AUDIT

Under the bill, a carrier which offers a managed care plan is required to provide for an annual audit of its provider network by an independent private auditing firm. The audit is to be at the expense of the carrier and the carrier shall submit the audit findings to the commissioner. The commissioner will make the results of the audit available on the department's website. If the audit contains a determination that a carrier has failed to maintain an adequate network of providers in accordance with applicable federal or State law, in addition to any other penalties or remedies available under federal or State law, it would be a violation of the bill and the commissioner is permitted to initiate such action as the commissioner deems appropriate to ensure compliance with this bill and network adequacy laws.

WAIVER OF COST SHARING

The bill also provides that it is a violation of the bill's provisions if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. The bill specifies that a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement. The bill provides that this section does not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties. One such safe harbor is for a financial hardship.

PENALTIES

A person or carrier that violates any provision of the bill, or the rules and regulations adopted pursuant thereto, is liable to a penalty as provided in the bill. Further, upon a finding that a person or carrier has failed to comply with the requirements of the bill, including the payment of a penalty, the commissioner may:

(1) in the case of a carrier, initiate such action as the commissioner determines appropriate;

(2) in the case of a health care facility, refer the matter to the Commissioner of Health for such action as the Commissioner of Health determines appropriate; or

(3) in the case of a health care professional, refer the matter to the appropriate professional and occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety for such action as that board determines appropriate.

Finally, the effective date of the bill is the 90th day following enactment.

This bill was pre-filed for introduction in the 2018-2019 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

ASSEMBLY, No. 2039

STATE OF NEW JERSEY 218th LEGISLATURE

DATED: APRIL 16, 2018

SUMMARY

- Synopsis:** “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.”
- Type of Impact:** Annual State and Local Government Cost Savings, Annual State Revenue Increase, Annual Revenue Decreases to University Hospital and Bergen Regional Medical Center.
- Agencies Affected:** Department of Banking and Insurance, Department of the Treasury, Department of Health, Division of Consumer Affairs in the Department of Law and Public Safety, State Health Benefits Program, School Employees’ Health Benefits Program, health benefits plans offered by certain local units, University Hospital, and Bergen Regional Medical Center.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State and Local Government Cost Savings – Decreased Employee Health Insurance Costs	Indeterminate
State Revenue Increase – Penalty Collections	Indeterminate
University Hospital Revenue Decrease – Reduced Payments for Out-Of-Network Services	Indeterminate
Bergen Regional Medical Center Revenue Decrease – Reduced Payments for Out-Of-Network Services	Indeterminate

- The Office of Legislative Services (OLS) notes that the bill may result in indeterminate annual cost savings to the State Health Benefits Program, the School Employees’ Health Benefits Program, and health benefits plans offered by local units due to a decrease in out-of-network charges.
- The OLS notes that enactment of the bill may result in an indeterminate annual decrease in revenue from out-of-network charges to: University Hospital, an independent non-profit

legal entity that is an instrumentality of the State located in Newark; and Bergen Regional Medical Center, a county-owned entity located in Paramus.

- The OLS notes that enactment of the bill would result in an indeterminate annual State revenue increase to the General Fund due to the collection of penalties established under the bill.
- Additionally, this bill requires the Department of Health, the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Banking and Insurance to collect and report certain information. Such requirements, however, may not result in additional costs to the respective departments as the expenses associated with these activities could likely be absorbed into the departments' existing operating budgets.

BILL DESCRIPTION

This bill is entitled the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.” The bill reforms various aspects of the health care delivery system in New Jersey to increase transparency in pricing for health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes, contain rising costs associated with out-of-network health care services, and measure success with regard to these goals.

FISCAL ANALYSIS

EXECUTIVE BRANCH

The Executive Branch has not submitted a formal, written fiscal note for this bill, but the Department of the Treasury has provided informal information to the OLS indicating that covered persons under the Horizon NJ Direct plans within the State Health Benefits Program and the School Employees' Health Benefits Program filed 3,253,180 out-of-network claims in fiscal year 2015. As of September 30, 2016, the State has paid out \$895,854,618 for the cost of those claims. These data include all out-of-network claims and costs under the Horizon NJ Direct plans, not just the emergency and inadvertent claims to which the bill applies. Furthermore, these data do not include out-of-network claims and costs associated with any other plans offered by the State and School Employee Health Benefits Plans, such as Horizon tiered plans, Horizon HMO plans, or any Aetna plans.

OFFICE OF LEGISLATIVE SERVICES

The OLS notes that the enactment of the bill may result in indeterminate annual cost savings to the State Health Benefits Program, the School Employees' Health Benefits Program, and health benefits plans offered by local units due to a decrease in out-of-network charges.

The OLS also notes that the enactment of the bill may result in an indeterminate annual decrease in revenue from out-of-network charges to: University Hospital, an independent non-profit legal entity that is an instrumentality of the State located in Newark; and Bergen Regional Medical Center, a county-owned entity located in Paramus.

The OLS notes further that enactment of the bill would result in an indeterminate annual State revenue increase to the General Fund due to the collection of penalties established under the bill.

Additionally, this bill requires the Department of Health, the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Banking and Insurance to collect and report certain information. Such requirements, however, may not result in additional costs to the respective departments as the expenses associated with these activities could likely be absorbed into the departments' existing operating budgets.

Out-of-network Billing

Currently, when an individual covered by a network-based health benefits plan receives care from an out-of-network health care provider under circumstances that could not be avoided, the individual is partially protected under State rules and regulations. Specifically, N.J.A.C.11:22-5.8(b) states that a covered person's liability for services rendered during a hospitalization in a network hospital, regardless of whether the admitting physician is in-network or out-of-network, shall, in most situations, be limited to the copayment, deductible, and/or coinsurance applicable to network services. The rule partially protects members of certain health benefits plans from being billed more than the in-network rate for services rendered at the time of care, and suggests that health benefits plans are responsible for protecting their members and absorbing the excess costs associated with out-of-network charges. While the rule only applies to health maintenance organizations (HMOs) and other non-HMO network-based plans, some self-insured plans, such as the State Health Benefits Program and the School Employees' Health Benefits Program, follow similar out-of-network practice rules. The rule does not limit the amounts that out-of-network providers can charge the carriers or the State plans, which in some cases pay up to the billed charges if a lower amount cannot be negotiated.

This bill places certain limitations on charges by out-of-network providers in two situations: (1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) inadvertent out-of-network services. The OLS notes that limiting charges by out-of-network health care providers in such a manner may provide direct savings to covered persons and health benefits plans in the State. Under the bill's definition of "carrier," this includes the State Health Benefits Program and the School Employees' Health Benefits Program and any entity providing a health benefits plan that is not self-funded. However, other self-funded plans could be included under the bill's provisions if the plan elects to be subject to them. The savings that may be realized for the State and local units would be the result of a decrease in costs associated with out-of-network charges. Under the bill, health benefits plans would pay out-of-network providers the amounts, subject to a statutorily-prescribed ceiling, resulting from a mandatory arbitration process, if the carrier and the provider cannot agree on a reimbursement rate.

In testimony submitted to the Assembly Appropriations Committee in October of 2016, Dudley Burdge, who represents the Communications Workers of America and is also a commissioner on the State Health Benefits Commission, estimated that the direct savings from an earlier version of the bill to the State and School Employee Health Benefits Plans due to decreases in out-of-network payments to physicians, hospitals, and other providers of medical services would be approximately \$133 million annually. Furthermore, the New Jersey Pension and Health Benefits Review Commission reported in February 2016 that general reform to the statutes and regulations that govern out-of-network provider reimbursement, in conjunction with other reforms in the health care delivery system, would save the State an estimated \$164 million in the first fiscal year of implementation.

Additionally, the Department of the Treasury has provided informal information to the OLS indicating that covered persons under the Horizon NJ Direct plans within the State Health Benefits Program and the School Employees' Health Benefits Program filed 3,253,180 out-of-network claims in fiscal year 2015. As of September 30, 2016, the State has paid out \$895,854,618 for the cost of those claims. The OLS notes that these data include all out-of-network claims and costs under the Horizon NJ Direct plans, not just the emergency and inadvertent claims to which the bill applies. Furthermore, these data do not include out-of-network claims and costs associated with any other plans offered by the State and School Employee Health Benefits Plans, such as Horizon tiered plans, Horizon HMO plans, or any Aetna plans.

However, since insufficient data are available to estimate the impact that limiting certain charges by out-of-network providers would have on the State Health Benefits Program, the School Employees' Health Benefits Program, and health benefits plans offered by local units, the OLS is unable to determine the direct savings that may be realized to these health benefits plans.

Furthermore, the OLS also notes that the enactment of the bill may result in an indeterminate annual decrease in revenue from out-of-network charges to: University Hospital, an independent non-profit legal entity that is an instrumentality of the State located in Newark; and Bergen Regional Medical Center, a county-owned entity located in Paramus.

Penalties

Penalties established under this bill range from \$100 to \$2,500 for violations committed by individuals or entities, and \$1,000 to \$25,000 for violations committed by health care facilities. The OLS, however, cannot determine the nature and number of infractions that may be committed, and therefore the amount of revenue generated, under the bill.

Reporting

This bill places certain responsibilities on health care facilities and health care professionals to report certain information to the Department of Health and the Division of Consumer Affairs in the Department of Law and Public Safety. The reported information would be shareable with the Department of Banking and Insurance. Furthermore, the bill requires the Department of Banking and Insurance to issue a report to the Governor and Legislature and make publicly available, on the department's website, certain information regarding the bill. The collection and reporting of such information may not result in additional costs to the respective departments as the expenses associated with these activities could likely be absorbed into the departments' existing operating budgets.

Section: Commerce, Labor and Industry

Analyst: Juan C. Rodriguez
Associate Fiscal Analyst

Approved: Frank W. Haines III
Legislative Budget and Finance Officer

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

SENATE, No. 485

STATE OF NEW JERSEY 218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Co-Sponsored by:

Senator Ruiz

SYNOPSIS

“Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.”

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



(Sponsorship Updated As Of: 4/6/2018)

1 AN ACT concerning health insurance and health care providers and
2 supplementing various parts of the statutory law.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6

7 1. This act shall be known and may be cited as the “Out-of-
8 network Consumer Protection, Transparency, Cost Containment and
9 Accountability Act.”

10

11 2. The Legislature finds and declares that:

12 a. The health care delivery system in New Jersey needs reforms
13 that will enhance consumer protections, create a system to resolve
14 certain health care billing disputes, contain rising costs, and measure
15 success with respect to these goals;

16 b. Despite existing State and federal laws and regulations to
17 protect against certain surprise out-of-network charges, these charges
18 continue to pose a problem for health care consumers in New Jersey.
19 Many consumers find themselves with surprise bills for hospital
20 emergency room procedures or for charges by providers that the
21 consumer had no choice in selecting;

22 c. While the Patient Protection and Affordable Care Act added
23 new patient protections requiring federally-regulated group health
24 plans to reimburse for out-of-network emergency service by paying
25 the greatest of three possible amounts: (1) the amount negotiated with
26 in-network providers for the emergency service furnished; (2) the
27 amount for the emergency service calculated using the same method
28 the plan generally uses to determine payments for out-of-network
29 services; or (3) the amount that would be paid under Medicare for the
30 emergency service, patients continue to face out-of-network charges
31 for surprise bills;

32 d. Out-of-network benefits are a health insurance benefit
33 enhancement for which insureds pay an additional premium, but in
34 recent years, out-of-network coverage has been used inappropriately as
35 a means to diminish consumers’ health insurance coverage, exposing
36 consumers to additional costs;

37 e. Carriers and consumers continue to report exorbitant charges
38 by certain health care professionals and facilities for out-of-network
39 services, including balance billing, and in certain cases, consumers’
40 bills are referred to collection, which contributes to the increasing
41 costs of health care services and insurance and imposes hardships on
42 health care consumers;

43 f. Health care providers and hospitals report that inadequate
44 reimbursement from carriers and government payers is causing
45 financial stress on safety net hospitals, deteriorating morale among
46 providers and reduced quality of care for consumers;

47 g. It is, therefore, in the public interest to reform the health care
48 delivery system in New Jersey to enhance consumer protections, create

1 a system to resolve certain health care billing disputes, contain rising
2 costs, and measure success with respect to these goals.

3

4 3. As used in this act:

5 “Carrier” means an entity that contracts or offers to contract to
6 provide, deliver, arrange for, pay for, or reimburse any of the costs
7 of health care services under a health benefits plan, including: an
8 insurance company authorized to issue health benefits plans; a
9 health maintenance organization; a health, hospital, or medical
10 service corporation; a multiple employer welfare arrangement; the
11 State Health Benefits Program and the School Employees’ Health
12 Benefits Program; or any other entity providing a health benefits
13 plan. Except as provided under the provisions of this act, “carrier”
14 shall not include any other entity providing or administering a self-
15 funded health benefits plan.

16 “Commissioner” means the Commissioner of Banking and
17 Insurance.

18 “Covered person” means a person on whose behalf a carrier is
19 obligated to pay health care expense benefits or provide health care
20 services.

21 “Department” means the Department of Banking and Insurance.

22 “Emergency or urgent basis” means all emergency and urgent
23 care services including, but not limited to, the services required
24 pursuant to N.J.A.C.11:24-5.3.

25 "Health benefits plan" means a benefits plan which pays or
26 provides hospital and medical expense benefits for covered
27 services, and is delivered or issued for delivery in this State by or
28 through a carrier. For the purposes of this act, “health benefits
29 plan” shall not include the following plans, policies or contracts:
30 Medicaid, Medicare, Medicare Advantage, accident only, credit,
31 disability, long-term care, TRICARE supplement coverage,
32 coverage arising out of a workers' compensation or similar law,
33 automobile medical payment insurance, personal injury protection
34 insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), a
35 dental plan as defined pursuant to section 1 of P.L.2014, c.70
36 (C.26:2S-26) and hospital confinement indemnity coverage.

37 “Health care facility” means a general acute care hospital,
38 satellite emergency department, hospital based off-site ambulatory
39 care facility in which ambulatory surgical cases are performed, or
40 ambulatory surgery facility, licensed pursuant to P.L.1971, c.136
41 (C.26:2H-1 et seq.).

42 “Health care professional” means an individual, acting within the
43 scope of his licensure or certification, who provides a covered
44 service defined by the health benefits plan.

45 “Health care provider” or “provider” means a health care
46 professional or health care facility.

47 “Inadvertent out-of-network services” means health care services
48 that are: covered under a managed care health benefits plan that

1 provides a network; and provided by an out-of-network health care
2 provider in the event that a covered person utilizes an in-network
3 health care facility for covered health care services and, for any
4 reason, in-network health care services are unavailable in that
5 facility. “Inadvertent out-of-network services” shall include
6 laboratory testing ordered by an in-network health care provider and
7 performed by an out-of-network bio-analytical laboratory.

8 “Knowingly, voluntarily, and specifically selected an out-of-
9 network provider” means that a covered person chose the services
10 of a specific provider, with full knowledge that the provider is out-
11 of-network with respect to the covered person’s health benefits
12 plan, under circumstances that indicate that covered person had the
13 opportunity to be serviced by an in-network provider, but instead
14 selected the out-of-network provider. Disclosure by a provider of
15 network status shall not render a covered person’s decision to
16 proceed with treatment from that provider a choice made
17 “knowingly” pursuant to this definition.

18 “Medicaid” means the State Medicaid program established
19 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

20 "Medical necessity" or "medically necessary" means or describes
21 a health care service that a health care provider, exercising his or
22 her prudent clinical judgment, would provide to a covered person
23 for the purpose of evaluating, diagnosing, or treating an illness,
24 injury, disease, or its symptoms and that is: in accordance with the
25 generally accepted standards of medical practice; clinically
26 appropriate, in terms of type, frequency, extent, site, and duration,
27 and considered effective for the covered person's illness, injury, or
28 disease; not primarily for the convenience of the covered person or
29 the health care provider; and not more costly than an alternative
30 service or sequence of services at least as likely to produce
31 equivalent therapeutic or diagnostic results as to the diagnosis or
32 treatment of that covered person's illness, injury, or disease.

33 “Medicare” means the federal Medicare program established
34 pursuant to Pub.L.89-97 (42 U.S.C. s.1395 et seq.).

35 “Self-funded health benefits plan” or “self-funded plan” means a
36 self-insured health benefits plan governed by the provisions of the
37 federal “Employee Retirement Income Security Act of 1974,” 29
38 U.S.C. s.1001 et seq.

39

40 4. a. Prior to scheduling an appointment with a covered person
41 for a non-emergency or elective procedure and in terms the covered
42 person typically understands, a health care facility shall:

43 (1) disclose to the covered person whether the health care
44 facility is in-network or out-of-network with respect to the covered
45 person’s health benefits plan;

46 (2) advise the covered person to check with the physician
47 arranging the facility services to determine whether or not that
48 physician is in-network or out-of-network with respect to the

1 covered person's health benefits plan and provide information about
2 how to determine the health plans participated in by any physician
3 who is reasonably anticipated to provide services to the covered
4 person;

5 (3) advise the covered person that at a health care facility that is
6 in-network with respect to the person's health benefits plan:

7 (a) the covered person will have a financial responsibility
8 applicable to an in-network procedure and not in excess of the
9 covered person's copayment, deductible, or coinsurance as provided
10 in the covered person's health benefits plan;

11 (b) unless the covered person, at the time of the disclosure
12 required pursuant to this subsection, has knowingly, voluntarily,
13 and specifically selected an out-of-network provider to provide
14 services, the covered person will not incur any out-of-pocket costs
15 in excess of the charges applicable to an in-network procedure;

16 (c) any bills, charges or attempts to collect by the facility, or
17 any health care professional involved in the procedure, in excess of
18 the covered person's copayment, deductible, or coinsurance as
19 provided in the covered person's health benefits plan in violation of
20 subparagraph (b) of this paragraph should be reported to the
21 covered person's carrier and the relevant regulatory entity; and

22 (d) that if the covered person's coverage is provided through an
23 entity providing or administering a self-funded health benefits plan
24 that does not elect to be subject to the provisions of section 9 of this
25 act, that:

26 (i) certain health care services may be provided on an out-of-
27 network basis, including those services associated with the health
28 care facility;

29 (ii) the covered person may have a financial responsibility
30 applicable to health care services provided by an out-of-network
31 provider, in excess of the covered person's copayment, deductible,
32 or coinsurance, and the covered person may be responsible for any
33 costs in excess of those allowed by the person's self-funded health
34 benefits plan; and

35 (iii) the covered person should contact the covered person's self-
36 funded health benefits plan sponsor for further consultation on
37 those costs; and

38 (4) advise the covered person that at a health care facility that is
39 out-of-network with respect to the covered person's health benefits
40 plan:

41 (a) certain health care services may be provided on an out-of-
42 network basis, including those health care services associated with
43 the health care facility;

44 (b) the covered person may have a financial responsibility
45 applicable to health care services provided at an out-of-network
46 facility, in excess of the covered person's copayment, deductible, or
47 coinsurance, and the covered person may be responsible for any
48 costs in excess of those allowed by their health benefits plan; and

- 1 (c) that the covered person should contact the covered person's
2 carrier for further consultation on those costs.
- 3 b. In a form that is consistent with federal guidelines, a health
4 care facility shall make available to the public a list of the facility's
5 standard charges for items and services provided by the facility.
- 6 c. A health care facility shall post on the facility's website:
- 7 (1) the health benefits plans in which the facility is a
8 participating provider;
- 9 (2) a statement that:
- 10 (a) physician services provided in the facility are not included in
11 the facility's charges;
- 12 (b) physicians who provide services in the facility may or may
13 not participate with the same health benefits plans as the facility;
- 14 (c) the covered person should check with the physician
15 arranging for the facility services to determine the health benefits
16 plans in which the physician participates; and
- 17 (d) the covered person should contact their carrier for further
18 consultation on those costs;
- 19 (3) as applicable, the name, mailing address, and telephone
20 number of the hospital-based physician groups that the facility has
21 contracted with to provide services including, but not limited to,
22 anesthesiology, pathology, and radiology; and
- 23 (4) as applicable, the name, mailing address, and telephone
24 number of physicians employed by the facility and whose services
25 may be provided at the facility, and the health benefits plans in
26 which they participate.
- 27 d. If, between the time the notice required pursuant to
28 subsection a. of this section is provided to the covered person and
29 the time the procedure takes place, the network status of the facility
30 changes as it relates to the covered person's health benefits plan,
31 the facility shall notify the covered person promptly.
- 32 e. The Department of Health shall specify in further detail the
33 content and design of the disclosure form and the manner in which
34 the form shall be provided.
- 35
- 36 5. a. Except as provided in subsection f. of this section, a
37 health care professional shall disclose to a covered person in writing
38 or through an internet website the health benefits plans in which the
39 health care professional is a participating provider and the facilities
40 with which the health care professional is affiliated prior to the
41 provision of non-emergency services, and verbally or in writing, at
42 the time of an appointment. If a health care professional does not
43 participate in the network of the covered person's health benefits
44 plan, the health care professional shall, in terms the covered person
45 typically understands:
- 46 (1) Prior to scheduling a non-emergency procedure inform the
47 covered person that the professional is out-of-network and that the

1 amount or estimated amount the health care professional will bill
2 the covered person for the services is available upon request;

3 (2) Upon receipt of a request from a covered person for the
4 service and the Current Procedural Terminology (CPT) codes
5 associated with that service, disclose to the covered person in
6 writing the amount or estimated amount that the health care
7 professional will bill the covered person for the service, and the
8 CPT codes associated with that service, absent unforeseen medical
9 circumstances that may arise when the health care service is
10 provided;

11 (3) Inform the covered person that the covered person will have
12 a financial responsibility applicable to health care services provided
13 by an out-of-network professional, in excess of the covered
14 person's copayment, deductible, or coinsurance, and the covered
15 person may be responsible for any costs in excess of those allowed
16 by their health benefits plan; and

17 (4) Advise the covered person to contact the covered person's
18 carrier for further consultation on those costs.

19 b. A health care professional who is a physician shall provide
20 the covered person, to the extent the information is available, with
21 the name, practice name, mailing address, and telephone number of
22 any health care provider scheduled to perform anesthesiology,
23 laboratory, pathology, radiology, or assistant surgeon services in
24 connection with care to be provided in the physician's office for the
25 covered person or coordinated or referred by the physician for the
26 covered person at the time of referral to, or coordination of, services
27 with that provider. The physician shall provide instructions as to
28 how to determine the health benefits plans in which the health care
29 provider participates and recommend that the covered person should
30 contact the covered person's carrier for further consultation on costs
31 associated with these services.

32 c. A physician shall, for a covered person's scheduled facility
33 admission or scheduled outpatient facility services, provide the
34 covered person and the facility with the name, practice name,
35 mailing address, and telephone number of any other physician
36 whose services will be arranged by the physician and are scheduled
37 at the time of the pre-admission, testing, registration, or admission
38 at the time the non-emergency services are scheduled, and
39 information as to how to determine the health benefits plans in
40 which the physician participates, and recommend that the covered
41 person should contact the covered person's carrier for further
42 consultation on costs associated with these services.

43 d. The receipt or acknowledgement by any covered person of
44 any disclosure required pursuant to this section shall not waive or
45 otherwise affect any protection under existing statutes or
46 regulations regarding in-network health benefits plan coverage
47 available to the covered person or created under this act.

1 e. If, between the time the notice required pursuant to
2 subsection a. of this section is provided to the covered person and
3 the time the procedure takes place, the network status of the
4 professional changes as it relates to the covered person's health
5 benefits plan, the professional shall notify the covered person
6 promptly.

7 f. In the case of a primary care physician or internist
8 performing an unscheduled procedure in that provider's office, the
9 notice required pursuant this section may be made verbally at the
10 time of the service.

11 g. The appropriate professional or occupational licensing board
12 within the Division of Consumer Affairs in the Department of Law
13 and Public Safety shall specify in further detail the content and
14 design of the disclosure form and the manner in which the form
15 shall be provided.

16

17 6. a. A carrier shall update the carrier's website within 20 days
18 of the addition or termination of a provider from the carrier's
19 network or a change in a physician's affiliation with a facility,
20 provided that in the case of a change in affiliation the carrier has
21 had notice of such change.

22 b. With respect to out-of-network services, for each health
23 benefits plan offered, a carrier shall, consistent with State and
24 federal law, provide a covered person with:

25 (1) a clear and understandable description of the plan's out-of-
26 network health care benefits, including the methodology used by the
27 entity to determine the allowed amount for out-of-network services;

28 (2) the allowed amount the plan will reimburse under that
29 methodology and, in situations in which a covered person requests
30 allowed amounts associated with a specific Current Procedural
31 Terminology code, the portion of the allowed amount the plan will
32 reimburse and the portion of the allowed amount that the covered
33 person will pay, including an explanation that the covered person
34 will be required to pay the difference between the allowed amount
35 as defined by the carrier's plan and the charges billed by an out-of-
36 network provider;

37 (3) examples of anticipated out-of-pocket costs for frequently
38 billed out-of-network services;

39 (4) information in writing and through an internet website that
40 reasonably permits a covered person or prospective covered person
41 to calculate the anticipated out-of-pocket cost for out-of-network
42 services in a geographical region or zip code based upon the
43 difference between the amount the carrier will reimburse for out-of-
44 network services and the usual and customary cost of out-of-
45 network services;

46 (5) information in response to a covered person's request,
47 concerning whether a health care provider is an in-network
48 provider;

1 (6) such other information as the commissioner determines
2 appropriate and necessary to ensure that a covered person receives
3 sufficient information necessary to estimate their out-of-pocket cost
4 for an out-of-network service and make a well-informed health care
5 decision; and

6 (7) access to a telephone hotline that shall be operated no less
7 than 16 hours per day for consumers to call with questions about
8 network status and out-of-pocket costs.

9 c. If a carrier authorizes a covered health care service to be
10 performed by an in-network health care provider with respect to any
11 health benefits plan, and the provider or facility status changes to
12 out-of-network before the authorized service is performed, the
13 carrier shall notify the covered person that the provider or facility is
14 no longer in-network as soon as practicable. If the carrier fails to
15 provide the notice at least 30 days prior to the authorized service
16 being performed, the covered person's financial responsibility shall
17 be limited to the financial responsibility the covered person would
18 have incurred had the provider been in-network with respect to the
19 covered person's health benefits plan.

20 d. A carrier shall incorporate into the Explanation of Benefits
21 and all reimbursement correspondence to the consumer and the
22 provider clear and concise notification that inadvertent and
23 involuntary out-of-network charges are not subject to balance
24 billing above and beyond the financial responsibility incurred under
25 the terms of the contract for in-network service. Any attempt by the
26 provider to collect, bill, or invoice funds should be promptly
27 reported to the carrier's customer service department at the phone
28 number that the carrier shall provide on the Explanation of Benefits
29 and all reimbursement correspondence to the consumer.

30 e. A carrier, and any other entity providing or administering a
31 self-funded health benefits plan that elects to be subject to section 9
32 of this act, shall issue a health insurance identification card to the
33 primary insured under a health benefits plan. In a form and manner
34 to be prescribed by the department, the card shall indicate whether
35 the plan is insured or, in the case of self-funded plans that elect to
36 be subject of section 9 of this act, whether the plan is self-funded
37 and whether the plan elected to be subject to this act.

38
39 7. a. If a covered person receives medically necessary services
40 at any health care facility on an emergency or urgent basis as
41 defined by the Emergency Medical Treatment and Active Labor
42 Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160
43 (C.26:2H-18.64), the facility shall not bill the covered person in
44 excess of any deductible, copayment, or coinsurance amount
45 applicable to in-network services pursuant to the covered person's
46 health benefits plan.

47 b. If a covered person receives medically necessary services at
48 an out-of-network health care facility on an emergency or urgent

1 basis as defined by the Emergency Medical Treatment and Active
2 Labor Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992,
3 c.160 (C.26:2H-18.64), and the carrier and facility cannot agree on
4 the final offer as a reimbursement rate for these services pursuant to
5 section 9 of this act, the carrier, health care facility, or covered
6 person, as applicable, may initiate binding arbitration pursuant to
7 section 10 or 11 of this act.

8 c. If a health care facility is in-network with respect to any
9 health benefits plan, the facility shall ensure that all providers
10 providing services in the facility on an emergency or inadvertent
11 basis are provided notification of the provisions of this act and
12 information as to each health benefits plan with which the facility
13 has a contract to be in-network.

14 d. A health care facility that contracts with a carrier to be in-
15 network with respect to any health benefits plan shall annually
16 report to the Department of Health the health benefits plans with
17 which the facility has an agreement to be in-network.

18 e. Subsections a. and b. of this section shall only apply to
19 providers providing services to members of entities providing or
20 administering a self-funded health benefits plan and its plan
21 members if the entity elects to be subject to section 9 of this act
22 pursuant to subsection d. of that section.

23 f. The Department of Health shall make the information
24 collected pursuant to subsection d. of this section available to the
25 Department of Banking and Insurance.

26

27 8. a. If a covered person receives inadvertent out-of-network
28 services or medically necessary services at an in-network or out-of-
29 network health care facility on an emergency or urgent basis as
30 defined by the Emergency Medical Treatment and Active Labor
31 Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160
32 (C.26:2H-18.64), the health care professional performing those
33 services shall:

34 (1) in the case of inadvertent out-of-network services, not bill
35 the covered person in excess of any deductible, copayment, or
36 coinsurance amount; and

37 (2) in the case of emergency and urgent services, not bill the
38 covered person in excess of any deductible, copayment, or
39 coinsurance amount,
40 applicable to in-network services pursuant to the covered person's
41 health benefits plan.

42 b. If the carrier and the professional cannot agree on a
43 reimbursement rate for the services provided pursuant to subsection
44 a. of this section, pursuant to section 9 of this act the carrier,
45 professional, or covered person, as applicable, may initiate binding
46 arbitration pursuant to section 10 or 11 of this act.

47 c. This section shall only apply to providers providing services
48 to members of entities providing or administering a self-funded

1 health benefits plan and its plan members if the entity elects to be
2 subject to section 9 of this act pursuant to subsection d. of that
3 section.

4
5 9. Notwithstanding any law, rule, or regulation to the contrary:

6 a. With respect to a carrier, if a covered person receives
7 inadvertent out-of-network services, or services at an in-network or
8 out-of-network health care facility on an emergency or urgent basis,
9 the carrier shall ensure that the covered person incurs no greater
10 out-of-pocket costs than the covered person would have incurred
11 with an in-network health care provider for covered services.
12 Pursuant to sections 7 and 8 of this act, the out-of-network provider
13 shall not bill the covered person, except for applicable deductible,
14 copayment, or coinsurance amounts that would apply if the covered
15 person utilized an in-network health care provider for the covered
16 services. In the case of services provided to a member of a self-
17 funded plan that does not elect to be subject to the provisions of this
18 section, the provider shall be permitted to bill the covered person in
19 excess of the applicable deductible, copayment, or coinsurance
20 amounts.

21 b. (1) With respect to inadvertent out-of-network services, or
22 services at an in-network or out-of-network health care facility on
23 an emergency or urgent basis, benefits provided by a carrier that the
24 covered person receives for health care services shall be assigned to
25 the out-of-network health care provider, which shall require no
26 action on the part of the covered person. Once the benefit is
27 assigned as provided in this subsection:

28 (a) any reimbursement paid by the carrier shall be paid directly
29 to the out-of-network provider; and

30 (b) the carrier shall provide the out-of-network provider with a
31 written remittance of payment that specifies the proposed
32 reimbursement and the applicable deductible, copayment, or
33 coinsurance amounts owed by the covered person.

34 (2) An entity providing or administering a self-funded health
35 benefits plan that elects to participate in this section pursuant to
36 subsection d. of this section, shall comply with the provisions of
37 paragraph (1) of this subsection.

38 c. If inadvertent out-of-network services or services provided
39 at an in-network or out-of-network health care facility on an
40 emergency or urgent basis are performed in accordance with
41 subsection a. of this section, the out-of-network provider may bill
42 the carrier for the services rendered. The carrier may pay the billed
43 amount or the carrier shall determine within 30 days from the date
44 of the receipt of the claim for the services whether the carrier
45 considers the claim to be excessive, and if so, the carrier shall
46 notify the provider of this determination within 30 days of the
47 receipt of the claim. If the carrier provides this notification, the
48 carrier and the provider shall have 30 days from the date of this

1 notification to negotiate a settlement. The carrier may attempt to
2 negotiate a final reimbursement amount with the out-of-network
3 health care provider which differs from the amount paid by the
4 carrier pursuant to this subsection. If there is no settlement reached
5 after the 30 days, the carrier shall pay the provider their final offer
6 for the services. If the carrier and provider cannot agree on the final
7 offer as a reimbursement rate for these services, the carrier,
8 provider, or covered person, as applicable, may initiate binding
9 arbitration within 30 days of the final offer, pursuant to section 10
10 or 11 of this act. In addition, in the event that arbitration is initiated
11 pursuant to section 10 of this act, the payment shall be subject to
12 the binding arbitration provisions of paragraphs (4) and (5) of
13 subsection b. of section 10 of this act.

14 d. With respect to an entity providing or administering a self-
15 funded health benefits plan and its plan members, this section shall
16 only apply if the plan elects to be subject to the provisions of this
17 section. To elect to be subject to the provisions of this section, the
18 self-funded plan shall provide notice, on an annual basis, to the
19 department, on a form and in a manner prescribed by the
20 department, attesting to the plan's participation and agreeing to be
21 bound by the provisions of this section. The self-funded plan shall
22 amend the employee benefit plan, coverage policies, contracts and
23 any other plan documents to reflect that the benefits of this section
24 shall apply to the plan's members.

25

26 10. a. If attempts to negotiate reimbursement for services
27 provided by an out-of-network health care provider, pursuant to
28 subsection c. of section 9 of this act, do not result in a resolution of
29 the payment dispute, and the difference between the carrier's and
30 the provider's final offers is not less than \$1,000, the carrier or out-
31 of-network health care provider may initiate binding arbitration to
32 determine payment for the services.

33 b. The binding arbitration shall adhere to the following
34 requirements:

35 (1) The party requesting arbitration shall notify the other party
36 that arbitration has been initiated and state its final offer before
37 arbitration. In response to this notice, the nonrequesting party shall
38 inform the requesting party of its final offer before the arbitration
39 occurs;

40 (2) Arbitration shall be initiated by filing a request with the
41 department;

42 (3) The department shall contract, through the request for
43 proposal process, every three years, with one or more entities that
44 have experience in health care pricing arbitration. The arbitrators
45 shall be American Arbitration Association certified arbitrators. The
46 department may initially utilize the entity engaged under the
47 "Health Claims Authorization, Processing, and Payment Act,"
48 P.L.2005, c.352 (C.17B:30-48 et seq.), for arbitration under this act;

1 however, after a period of one year from the effective date of this
2 act, the selection of the arbitration entity shall be through the
3 Request for Proposal process. Claims that are subject to arbitration
4 pursuant to the provisions of this act, which previously would be
5 subject to arbitration pursuant to the “Health Claims Authorization,
6 Processing, and Payment Act,” shall instead be subject to this act;

7 (4) The arbitration shall consist of a review of the written
8 submissions by both parties, which shall include the final offer for
9 the payment by the carrier for the out-of-network health care
10 provider’s fee made pursuant to subsection c. of section 9 of this
11 act, or a lower offer, and the final offer by the out-of-network
12 provider for the fee the provider will accept as payment from the
13 carrier; and

14 (5) The arbitrator’s decision shall be one of the two amounts
15 submitted by the parties as their final offers and shall be binding on
16 both parties. The decision of the arbitrator shall include written
17 findings and shall be issued within 45 days after the request is filed
18 with the department. The arbitrator’s expenses and fees shall be
19 split equally among the parties except in situations in which the
20 arbitrator determines that the payment made by the carrier was not
21 made in good faith, in which case the carrier shall be responsible
22 for all of the arbitrator’s expenses and fees. Each party shall be
23 responsible for its own costs and fees, including legal fees if any.

24 c. In making a determination pursuant to subsection b. of this
25 section, the arbitrator shall consider:

26 (1) the level of training, education, and experience of the health
27 care professional;

28 (2) the health care provider’s usual charge for comparable
29 services provided in-network and out-of-network with respect to
30 any health benefits plans;

31 (3) the circumstances and complexity of the particular case,
32 including the time and place of the service;

33 (4) individual patient characteristics; and

34 (5) as certified by an independent actuary:

35 (a) the average in-network amount paid for the service by that
36 carrier; and

37 (b) the average amount paid for that service to other out-of-
38 network providers by that carrier.

39 d. (1) The amount awarded by the arbitrator shall be paid
40 within 20 days of the arbitrator’s decision as provided in subsection
41 b. of this section.

42 (2) The interest charges for overdue payments, pursuant to
43 P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the
44 pendency of a decision under subsection b. of this section and any
45 interest required to be paid a provider pursuant to P.L.1999, c.154
46 (C.17B:30-23 et al.) shall not accrue until after 20 days following
47 an arbitrator’s decision as provided in subsection b. of this section,
48 but in no circumstances longer than 150 days from the date that the

1 out-of-network provider billed the carrier for services rendered,
2 unless both parties agree to a longer period of time.

3 e. This section shall apply only if the covered person complies
4 with any applicable preauthorization or review requirements of the
5 health benefits plan regarding the determination of medical
6 necessity to access in-network inpatient or outpatient benefits.

7 f. This section shall not apply to a covered person who
8 knowingly, voluntarily, and specifically selected an out-of-network
9 provider for health care services.

10 g. In the event an entity providing or administering a self-
11 funded health benefits plan elects to be subject to the provisions of
12 section 9 of this act, as provided in subsection d. of that section, the
13 provisions of this section shall apply to a self-funded plan in the
14 same manner as the provisions of this section apply to a carrier. If a
15 self-funded plan does not elect to be subject to the provision of
16 section 9 of this act, a member of that plan may initiate binding
17 arbitration as provided in section 11 of this act.

18

19 11. a. If attempts to negotiate reimbursement for services
20 between an out-of-network health care provider and a member of a
21 self-funded plan that does not elect to be subject to the provision of
22 section 9 of this act do not result in a resolution of the payment
23 dispute within 30 days after the plan member is sent a bill for the
24 services, the plan member or out-of-network health care provider
25 may initiate binding arbitration to determine payment for the
26 services. Unless negotiations for reimbursement result in an
27 agreement between the provider and the plan member within the 30
28 days, a provider shall not collect or attempt to collect
29 reimbursement, including initiation of any collection proceedings,
30 until the provider files a request for arbitration with the department
31 pursuant to this section.

32 b. The binding arbitration shall adhere to the following
33 requirements:

34 (1) Arbitration shall be initiated by filing a request with the
35 department. The department shall establish a process to notify the
36 other party that arbitration has been initiated and to inform a plan
37 member of the process to arbitrate pursuant to this section;

38 (2) The arbitrator with which the department contracts pursuant
39 to section 10 of this act shall conduct the arbitration pursuant to this
40 section;

41 (3) The arbitrator shall consider information supplied by both
42 parties; and

43 (4) The arbitrator's decision shall include written findings,
44 including a final binding amount that the arbitrator determines is
45 reasonable for the service, which shall include a non-binding
46 recommendation to the entity providing or administering the self-
47 funded health benefits plan of an amount that would be reasonable

1 for the entity to contribute to payment for the service, and shall be
2 issued within 45 days after the request is filed with the department.

3 c. The arbitrator's expenses and fees shall be divided equally
4 among the parties, unless the payment would pose a financial
5 hardship to the plan member, in which case the department shall
6 establish an agreement with the arbitrator to waive any part or all of
7 the cost of arbitration. Each party shall be responsible for its own
8 costs and fees, including legal fees, if any.

9 d. In making a determination pursuant to subsection b. of this
10 section, the arbitrator shall consider:

11 (1) the level of training, education, and experience of the health
12 care professional;

13 (2) the health care provider's usual charge for comparable
14 services provided in-network and out-of-network with respect to
15 any health benefits plans;

16 (3) the circumstances and complexity of the particular case,
17 including the time and place of the service;

18 (4) individual patient characteristics;

19 (5) as certified by an independent actuary:

20 (a) the average in-network amount paid for the service by that
21 self-funded plan; and

22 (b) the average amount paid for that service to other out-of-
23 network providers by that self-funded plan; and

24 (6) the out-of-network benefit design of the member's health
25 plan and the amount the entity providing or administering the self-
26 funded health benefits plan contributes, if anything, to the cost of
27 the service.

28 e. This section shall not apply to a covered person who
29 knowingly, voluntarily, and specifically selected an out-of-network
30 provider for health care services.

31

32 12. On or before January 31 of each calendar year, the
33 commissioner shall consult with the Department of the Treasury, the
34 relevant professional and occupational licensing boards within the
35 Division of Consumer Affairs in the Department of Law and Public
36 Safety, and the Department of Health, to obtain information to compile
37 and make publicly available, on the department's website:

38 a. A list of all arbitrations filed pursuant to section 10 and 11 of
39 this act between January 1 and December 31 of the previous calendar
40 year, including the percentage of all claims that were arbitrated.

41 (1) For each arbitration decision, the list shall include but not be
42 limited to:

43 (a) an indication of whether the decision was in favor of the
44 carrier or the out-of-network health care provider;

45 (b) the arbitration bids offered by each side and the award amount;

46 (c) the category and practice specialty of each out-of-network
47 health care provider involved in an arbitration decision, as applicable;

48 and

- 1 (d) a description of the service that was provided and billed for.
- 2 (2) The list of arbitration decisions shall not include any
3 information specifically identifying the provider, carrier, or covered
4 person involved in each arbitration decision.
- 5 b. The percentage of facilities and hospital-based professionals,
6 by specialty, that are in-network for each carrier in this State as
7 reported pursuant to subsection d. of section 7 of this act.
- 8 c. The number of complaints the department receives relating to
9 out-of-network health care charges.
- 10 d. The number of and description of claims received by the State
11 Health Benefits Program and the School Employees' Health Benefits
12 Program for in-State emergency out-of-network health care and
13 inadvertent out-of-network health care.
- 14 e. Annual trends on health benefits plan premium rates, total
15 annual amount of spending on inadvertent and emergency out-of-
16 network costs by carriers, and medical loss ratios in the State to the
17 extent that the information is available.
- 18 f. The number of physician specialists practicing in the State in a
19 particular specialty and whether they are in-network or out-of-network
20 with respect to the carriers that administer the State Health Benefits
21 Program, the School Employees' Health Benefits Program, the
22 qualified health plans in the federally run health exchange in the State,
23 and other health benefits plans offered in the State.
- 24 g. The results of the network audit required pursuant to section
25 16 of this act.
- 26 h. Any other benchmarks or information obtained pursuant to this
27 act that the commissioner deems appropriate to make publicly
28 available to further the goals of the act.
- 29
- 30 13. a. A carrier shall provide a written notice, in a form and
31 manner to be prescribed by the Commissioner of Banking and
32 Insurance, to each covered person of the protections provided to
33 covered persons pursuant to this act. The notice shall include
34 information on how a consumer can contact the department or the
35 appropriate regulatory agency to report and dispute an out-of-network
36 charge. The notice required pursuant to this section shall be posted on
37 the carrier's website.
- 38 b. The commissioner shall provide a notice on the department's
39 website containing information for consumers relating to the
40 protections provided by this act, information on how consumers can
41 report and file complaints with the department or the appropriate
42 regulatory agency relating to any out-of-network charges, and
43 information and guidance for consumers regarding arbitrations filed
44 pursuant to section 11 of this act.
- 45
- 46 14. A carrier shall calculate, as part of rate filings required to be
47 filed under New Jersey law, the savings that result from a reduction in
48 out-of-network claims payments pursuant to the provisions of this act.

1 The department shall include that information in the information
2 provided on the department's website pursuant to section 12 of this
3 act.

4
5 15. a. It shall be a violation of this act if an out-of-network health
6 care provider, directly or indirectly related to a claim, knowingly
7 waives, rebates, gives, pays, or offers to waive, rebate, give or pay all
8 or part of the deductible, copayment, or coinsurance owed by a
9 covered person pursuant to the terms of the covered person's health
10 benefits plan as an inducement for the covered person to seek health
11 care services from that provider. As the commissioner shall prescribe
12 by regulation, a pattern of waiving, rebating, giving or paying all or
13 part of the deductible, copayment or coinsurance by a provider shall be
14 considered an inducement for the purposes of this subsection.

15 b. This section shall not apply to any waiver, rebate, gift,
16 payment, or offer that falls within a safe harbor under federal laws
17 related to fraud and abuse concerning patient cost-sharing, including,
18 but not limited to, anti-kickback, self-referral, false claims, and civil
19 monetary penalties, including any advisory opinions issued by the
20 Centers for Medicare and Medicaid Services or the Office of Inspector
21 General pertaining to those laws.

22
23 16. A carrier which offers a managed care plan shall provide for
24 an annual audit of its provider network by an independent private
25 auditing firm. The audit shall be at the expense of the carrier and the
26 carrier shall submit the audit findings to the commissioner. The
27 commissioner shall make the results of the audit available on the
28 department's website. If the audit contains a determination that a
29 carrier has failed to maintain an adequate network of providers in
30 accordance with applicable federal or State law, in addition to any
31 other penalties or remedies available under federal or State law, it shall
32 be a violation of this act and the commissioner may initiate such action
33 as the commissioner deems appropriate to ensure compliance with this
34 act and network adequacy laws.

35
36 17. a. A person or entity that violates any provision of this act, or
37 the rules and regulations adopted pursuant hereto, shall be liable to a
38 penalty as provided in this subsection. The penalty shall be collected
39 by the commissioner in the name of the State in a summary proceeding
40 in accordance with the "Penalty Enforcement Law of 1999," P.L.1999,
41 c.274 (C.2A:58-10 et seq.).

42 (1) A health care facility or carrier that violates any provision of
43 this act shall be liable to a penalty of not more than \$1,000 for each
44 violation. Every day upon which a violation occurs shall be
45 considered a separate violation, but no facility or carrier shall be liable
46 to a penalty greater than \$25,000 for each occurrence.

47 (2) A person or entity not covered by paragraph (1) of this
48 subsection that violates the requirements of this act shall be liable to a

1 penalty of not more than \$100 for each violation. Every day upon
2 which a violation occurs shall be considered a separate violation, but
3 no person or entity shall be liable to a penalty greater than \$2,500 for
4 each occurrence.

5 b. Upon a finding that a person or entity has failed to comply with
6 the requirements of this act, including the payment of a penalty as
7 determined under subsection a. of this section, the commissioner may:

8 (1) in the case of a carrier, initiate such action as the commissioner
9 determines appropriate;

10 (2) in the case of a health care facility, refer the matter to the
11 Commissioner of Health for such action as the Commissioner of
12 Health determines appropriate; or

13 (3) in the case of a health care professional, refer the matter to the
14 appropriate professional or occupational licensing board within the
15 Division of Consumer Affairs in the Department of Law and Public
16 Safety for such action as that board determines appropriate.

17

18 18. The Commissioner of Banking and Insurance, the
19 Commissioner of Health and any relevant licensing board in the
20 Division of Consumer Affairs in the Department of Law and Public
21 Safety under Title 45 of the Revised Statutes may, as appropriate,
22 adopt rules and regulations, pursuant to the "Administrative Procedure
23 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), in order to effectuate the
24 purposes of this act.

25

26 19. The provisions of this act shall be severable, and if any
27 provision of this act shall be held invalid, or held invalid with respect
28 to any particular health benefits plan or carrier, such invalidity shall
29 not affect the other provisions hereof, or application of those
30 provisions to other health benefits plans or carriers.

31

32 20. Nothing in this act shall be construed to apply to an entity
33 providing or administering a self-funded health benefits plan which is
34 subject to the "Employee Retirement Income Security Act of 1974,"
35 except as provided in subsection d. of section 9 of this act for such an
36 entity to elect to be subject to certain provisions of the act.

37

38 21. This act shall take effect on the 90th day next following
39 enactment. The Commissioner of Banking and Insurance, the
40 Department of Health and any relevant licensing board may take
41 such anticipatory administrative action in advance thereof as shall
42 be necessary for the implementation of this act.

43

44

STATEMENT

45

46 This bill is entitled the "Out-of-network Consumer Protection,
47 Transparency, Cost Containment and Accountability Act." The bill
48 reforms various aspects of the health care delivery system in New

1 Jersey to increase transparency in pricing for health care services,
2 enhance consumer protections, create an arbitration system to
3 resolve certain health care billing disputes, contain rising costs
4 associated with out-of-network health care services, and measure
5 success with regard to these goals.

6

7 DISCLOSURE

8 The bill places certain responsibilities on health care facilities
9 and health care professionals to notify patients about services that
10 they will provide. The bill uses the term “health care provider” to
11 include both facilities and professionals.

12 With regard to health care facilities, prior to scheduling an
13 appointment with a covered person for a non-emergency or elective
14 procedure, and in terms the covered person typically understands,
15 the bill requires a health care facility to:

16 (1) disclose whether the health care facility is in-network or out-
17 of-network with respect to the covered person’s health benefits
18 plan;

19 (2) advise the covered person to check with the physician
20 arranging the facility services to determine whether or not that
21 physician is in-network or out-of-network with respect to the
22 covered person’s health benefits plan and provide information about
23 how to determine the health plans participated in by any physician
24 reasonably anticipated to provide services;

25 (3) advise the covered person that at a health care facility that is
26 in-network with respect to the person’s health benefits plan that the
27 covered person will have a financial responsibility applicable to an
28 in-network procedure and not in excess of the charges applicable to
29 an in-network procedure, as well as, certain notifications for
30 covered persons whose self-funded employers opt out of the bill;
31 and

32 (4) advise the covered person that at a health care facility that is
33 out-of-network with respect to the covered person’s health benefits
34 plan that certain health care services may be provided on an out-of-
35 network basis.

36 In addition, in a form that is consistent with federal guidelines,
37 the bill requires a health care facility to establish, update, and make
38 public through posting on the facility’s website a list of the
39 facility’s standard charges for items and services provided by the
40 facility.

41 Among these disclosures, a health care facility shall post on the
42 facility’s website:

43 (1) the health benefits plans in which the facility is a
44 participating provider;

45 (2) a statement concerning certain physician services provided
46 in the facility;

47 (3) as applicable, the name, mailing address, and telephone
48 number of the physician groups that the facility has contracted with

1 to provide services including, but not limited to, anesthesiology,
2 pathology, or radiology; and

3 (4) as applicable, the name, mailing address, and telephone
4 number of physicians employed by the facility and whose services
5 may be provided at the facility, and the health benefits plans in
6 which they participate.

7 If the network status of the facility changes as it relates to the
8 covered person's health benefits plan, the bill requires the facility to
9 notify the covered person promptly.

10 With regard to health care professionals, the bill requires that a
11 professional disclose to a covered person in writing or through an
12 internet website the health benefits plans in which the health care
13 professional is a participating provider and the facilities with which
14 the health care professional is affiliated prior to the provision of
15 non-emergency services, and verbally or in writing, at the time of
16 an appointment. If a health care professional does not participate in
17 the network of the covered person's health benefits plan, the health
18 care professional shall, in terms the covered person typically
19 understands:

20 (1) Inform the covered person that the professional is out-of-
21 network and that the amount or estimated amount the health care
22 professional will bill the covered person for the services is available
23 upon request;

24 (2) Upon receipt of a request from a covered person for the
25 service and the Current Procedural Terminology (CPT) codes
26 associated with the service, disclose to the covered person in
27 writing the amount or estimated amount that the health care
28 professional will bill the covered person for the service and the CPT
29 codes associated with that service absent unforeseen medical
30 circumstances that may arise when the health care service is
31 provided;

32 (3) inform the covered person that the covered person will have
33 a financial responsibility applicable to health care services provided
34 by an out-of-network professional; and

35 (4) advise the covered person to contact the covered person's
36 carrier for further consultation on those costs.

37 The bill also requires a health care professional who is a
38 physician to make certain notifications concerning health care
39 providers scheduled to perform anesthesiology, laboratory,
40 pathology, radiology, or assistant surgeon services in connection
41 with care to be provided in the physician's office or whose services
42 will be arranged by the physician and are scheduled at the time of
43 the pre-admission, testing, registration, or admission. The
44 physician shall provide instructions or information as to how to
45 determine the health benefits plans in which the health care
46 provider participates and recommend that the covered person should
47 contact the covered person's carrier for further consultation on costs
48 associated with these services.

1 A physician shall, for a covered person's scheduled facility
2 admission or scheduled outpatient facility services, provide the
3 covered person and the facility with certain information about other
4 physicians whose services will be arranged.

5 The bill clarifies that the receipt or acknowledgement by any
6 covered person of any disclosures required under this section of the
7 bill shall not waive or otherwise affect any protection under existing
8 statutes or regulations regarding in-network health benefits plan
9 coverage available to the covered person or created under the bill.

10 The bill also places a variety of responsibilities on health
11 insurance carriers. "Carriers" include insurance companies
12 authorized to issue health benefits plans; health maintenance
13 organizations; health, hospital, or medical service corporations;
14 multiple employer welfare arrangements; the State Health Benefits
15 Program and the School Employees' Health Benefits Program; and
16 any other carrier providing a health benefits plan.

17 Specifically, a carrier must update the carrier's website within 20
18 days of the addition or termination of a provider from the carrier's
19 network or a change in a physician's affiliation with a facility.
20 With respect to out-of-network services, for each health benefits
21 plan offered, a carrier is required to, consistent with State and
22 federal law, provide a covered person with:

23 (1) a clear and understandable description of the plan's out-of-
24 network health care benefits, including the methodology used by the
25 carrier to determine the allowed amount for out-of-network
26 services;

27 (2) the allowed amount the plan will reimburse under that
28 methodology;

29 (3) examples of anticipated out-of-pocket costs for frequently
30 billed out-of-network services;

31 (4) information in writing and through an internet website that
32 reasonably permits a covered person or prospective covered person
33 to calculate the anticipated out-of-pocket cost for out-of-network
34 services in a geographical region or zip code based upon the
35 difference between the amount the carrier will reimburse for out-of-
36 network services and the usual and customary cost of out-of-
37 network services;

38 (5) information in response to a covered person's request,
39 concerning whether a health care provider is an in-network
40 provider;

41 (6) such other information as the Commissioner of Banking and
42 Insurance determines appropriate and necessary to ensure that a
43 covered person receives sufficient information necessary to estimate
44 their out-of-pocket cost for an out-of-network service and make a
45 well-informed health care decision; and

46 (7) access to a telephone hotline that shall be operated no less
47 than 16 hours per day for consumers to call with questions about
48 network status and out-of-pocket costs.

1 The bill also addresses situations in which a carrier authorizes a
2 covered health care service to be performed by an in-network health
3 care provider with respect to any health benefits plan, and the
4 provider or facility status changes to out-of-network before the
5 authorized service is performed. The bill requires the carrier to
6 notify the covered person that the provider or facility is no longer
7 in-network as soon as practicable. If the carrier fails to provide the
8 notice at least 30 days prior to the authorized service being
9 performed, the covered person's financial responsibility shall be
10 limited to the financial responsibility the covered person would
11 have incurred had the provider been in-network with respect to the
12 covered person's health benefits plan.

13 The bill also requires a carrier to incorporate into the
14 Explanation of Benefits and all reimbursement correspondence to
15 the consumer and the provider clear and concise notification that
16 inadvertent and involuntary out-of-network charges are not subject
17 to balance billing above and beyond the financial responsibility
18 incurred under the terms of the contract for in-network service.

19 The bill also requires a carrier, and any other entity providing or
20 administering a self-funded health benefits plan that elects to be
21 subject to this bill, to issue a health insurance identification card to
22 the primary insured under a health benefits plan. In a form and
23 manner to be prescribed by the department, the card shall indicate
24 whether the plan is insured or, in the case of self-funded plans that
25 elect to be subject to this bill, whether the plan is self-funded and
26 whether the plan if elected to be subject to this bill.

27

28 OUT-OF-NETWORK BILLING

29 The bill places certain limitations on charges by out-of-network
30 providers in two situations: (1) if a covered person receives
31 medically necessary services at any health care facility on an
32 emergency or urgent basis; and (2) inadvertent out-of-network
33 services. The bill defines "inadvertent out-of-network services" as
34 health care services that are: covered under a managed care health
35 benefits plan that provides a network; and provided by an out-of-
36 network health care provider in the event that a covered person
37 utilizes an in-network health care facility for covered health care
38 services and, due to any reason, in-network health care services are
39 unavailable in that facility. "Inadvertent out-of-network services"
40 includes laboratory testing ordered by an in-network health care
41 provider and performed by an out-of-network bio-analytical
42 laboratory.

43 The bill protects a covered person receiving medically necessary
44 services at any health care facility on an emergency or urgent basis
45 by prohibiting the provider from billing the covered person in
46 excess of any deductible, copayment, or coinsurance amount
47 applicable to in-network services pursuant to the covered person's
48 health benefits plan.

1 With regard to medically necessary services at an out-of-network
2 health care facility on an emergency or urgent basis, if the carrier
3 and facility cannot agree on a reimbursement rate for these services,
4 as specified in a process set forth in the bill, the carrier, health care
5 facility, or covered person, as applicable, may initiate binding
6 arbitration.

7 The bill also requires health care facilities that are in-network
8 with respect to any health benefits plan to ensure that:

9 (1) all providers providing services in the facility on an
10 emergency or inadvertent basis are provided notifications of the
11 bill's provisions and information as to each health benefits plan
12 with which the facility has a contract to be in-network;

13 (2) to report annually certain information to the Department of
14 Health.

15 The bill also provides that if a covered person receives:
16 inadvertent out-of-network services; or medically necessary
17 services at an in-network or out-of-network health care facility on
18 an emergency or urgent basis, the health care professional
19 performing those services shall:

20 (1) in the case of inadvertent out-of-network services, not bill
21 the covered person in excess of any in-network deductible,
22 copayment, or coinsurance amount; and

23 (2) in the case of emergency and urgent services, not bill the
24 covered person in excess of any in-network deductible, copayment,
25 or coinsurance amount.

26 If the carrier and the professional cannot agree on a
27 reimbursement rate for these services, the carrier, professional, or
28 covered person, as applicable, may initiate binding arbitration
29 pursuant to the provisions of this bill.

30 The prohibitions on balance-billing would only apply to
31 providers providing services to members of entities providing or
32 administering a self-funded health benefits plan and its plan
33 members if the self-funded entity elects to be subject to section 9 of
34 the bill, which requires the plan to ensure that the plan members
35 incur no greater out-of-pocket costs than had they gone to an in-
36 network provider and for benefits provided by the plan to be
37 assigned to the out-of-network provider, which thereby subjects the
38 plan to arbitration under the bill.

39

40 ARBITRATION

41 For certain emergency and out-of-network billing situations
42 between providers and carriers, the bill establishes an arbitration
43 system. As it relates to self-funded health plans that do not elect to
44 be subject to arbitration under the bill, the bill provides for
45 arbitration between the self-funded plan member and the out-of-
46 network provider if attempts to negotiate reimbursement for
47 services do not result in a resolution of the payment dispute.

1 The bill provides that, in the event that a covered person receives
2 inadvertent out-of-network services or services at an in-network or
3 out-of-network health care facility on an emergency or urgent basis,
4 the carrier, or self-funded plan that opts into the section, shall
5 ensure that the covered person incurs no greater out-of-pocket costs
6 than the covered person would have incurred with an in-network
7 health care provider for covered services. The out-of-network
8 provider is prohibited from billing the covered person, except for
9 applicable deductible, copayment, or coinsurance amounts that
10 would apply if the covered person utilized an in-network health care
11 provider for the covered services. In these situations, the benefits
12 that the covered person receives for health care services shall be
13 assigned to the out-of-network health care provider, which requires
14 no action on the part of the covered person. Once the benefits are
15 assigned:

16 (1) any reimbursement paid by the carrier, or self-funded plan
17 that opts in, shall be paid directly to the out-of-network provider;
18 and

19 (2) the carrier, or self-funded plan that opts in, shall provide the
20 out-of-network provider with a written remittance of payment that
21 specifies the proposed reimbursement and the applicable deductible,
22 copayment, or coinsurance amounts owed by the covered person.

23 If inadvertent out-of-network services or medically necessary
24 services at an in-network or out-of-network health care facility on
25 an emergency or urgent basis are performed, the out-of-network
26 provider may bill the carrier, or self-funded plan that opts in, for the
27 services rendered. The carrier, or self-funded plan that opts in, may
28 pay the billed amount or the carrier shall determine within 30 days
29 from the date of the receipt of the claim for the services whether the
30 carrier considers the claim to be excessive, and if so, the carrier
31 shall notify the provider of this determination within 30 days of the
32 receipt of the claim. If the carrier provides this notification, the
33 carrier and the provider shall have 30 days from the date of this
34 notification to negotiate a settlement. The carrier may attempt to
35 negotiate a final reimbursement amount with the out-of-network
36 health care provider which differs from the amount paid by the
37 carrier. If there is no settlement reached after the 30 days, the
38 carrier shall pay the provider their final offer for the services. If the
39 carrier and provider cannot agree on the final offer as a
40 reimbursement rate for these services, the carrier, provider, or
41 covered person, as applicable, may initiate binding arbitration
42 within 30 days of the final offer. In addition, in the event that
43 arbitration is initiated, the payment shall be subject to the binding
44 arbitration provisions of the bill.

45 If attempts to negotiate reimbursement for services provided by
46 an out-of-network health care provider do not result in a resolution
47 of the payment dispute within 30 days after the carrier is billed for
48 the services by the out-of-network health care provider, the carrier,

1 or self-funded plan that opts in, or out-of-network health care
2 provider may initiate binding arbitration to determine payment for
3 the services if the difference between the carrier's or self-funded
4 plan's final offer and the provider's final offer is not less than
5 \$1,000.

6 The binding arbitration system established under the bill
7 provides that the party requesting arbitration shall notify the other
8 party that arbitration has been initiated.

9 Arbitration shall be initiated by filing a request with the
10 department. The arbitrators selected by the department shall be one
11 or more entities that have experience in health care pricing
12 arbitration and must be certified by the American Arbitration
13 Association. The arbitration shall consist of a review of the written
14 submissions by both parties, which shall include the final offer for
15 the payment by the carrier for the out-of-network provider's fee, or
16 a lower amount, and the final offer by the out-of-network provider
17 for the fee the provider will accept.

18 The arbitrator's decision shall be one of the two amounts
19 submitted by the parties as their final offers and shall be binding on
20 both parties. The arbitrator's expenses and fees shall be split
21 equally among the parties except in situations in which the
22 arbitrator determines the carrier's payment to the provider was not
23 made in good faith, in which case the carrier shall be responsible
24 for all of the arbitrator's expenses and fees. Each party shall be
25 responsible for its own costs and fees.

26 Arbitration is not available in the case of a covered person who
27 knowingly, voluntarily and specifically selected to access an out-of-
28 network health care provider for health care services.

29

30 ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-
31 OF-NETWORK PROVIDER

32 In the case of a member of a self-funded plan that does not elect
33 to opt-in to the arbitration and balance-billing protections of the
34 bill, the plan member or out-of-network health care provider may
35 initiate binding arbitration to determine payment for the services by
36 filing a request with the Department of Banking and Insurance.
37 Unless negotiations for reimbursement result in an agreement
38 between the provider and the plan member within the 30 days, a
39 provider shall not collect or attempt to collect reimbursement,
40 including initiation of any collection proceedings, until the provider
41 files a request for arbitration.

42 The arbitrator is required to consider information supplied by
43 both parties and to issue written findings, including a final binding
44 amount that the arbitrator determines is reasonable for the service.
45 The arbitrator's decision shall include a non-binding
46 recommendation to the entity providing or administering the self-
47 funded health benefits plan of an amount that would be reasonable
48 for the entity to contribute to payment for the service. This decision

1 must be issued within 45 days after the request for arbitration is
2 filed with the department.

3 The arbitrator's expenses and fees shall be split equally among
4 the parties, unless the payment would pose a financial hardship to
5 the plan member, in which case the department shall establish an
6 agreement with the arbitrator to waive any part or all of the cost of
7 the arbitration. Each party shall be responsible for its own costs
8 and fees, including legal fees, if any.

9

10 INCREASED TRANSPARENCY

11 The bill also provides that on or before January 31 of each
12 calendar year, the Commissioner of Banking and Insurance shall
13 consult with the Department of the Treasury, the relevant
14 professional and occupational licensing boards within the Division
15 of Consumer Affairs in the Department of Law and Public Safety,
16 and the Department of Health to obtain information to compile and
17 make publicly available certain information, on the department's
18 website, including a list of all arbitrations filed and the award
19 amount.

20 The bill provides that a carrier shall provide a written notice to
21 each covered person of the protections provided to covered persons
22 pursuant to the bill. The notice shall include information on how a
23 consumer can contact the department or the appropriate regulatory
24 agency to report and dispute an out-of-network charge. The notice
25 shall be posted on the carrier's website.

26 The bill also provides that a carrier shall calculate, as part of rate
27 filings required to be filed under New Jersey law, the savings that
28 result from a reduction in out-of-network claims payments pursuant
29 to the provisions of the bill. The department is required to make
30 that information available on the department's website.

31

32 PROVIDER NETWORK AUDIT

33 Under the bill, a carrier which offers a managed care plan is
34 required to provide for an annual audit of its provider network by an
35 independent private auditing firm. The audit is to be at the expense
36 of the carrier and the carrier shall submit the audit findings to the
37 commissioner. The commissioner will make the results of the audit
38 available on the department's website. If the audit contains a
39 determination that a carrier has failed to maintain an adequate
40 network of providers in accordance with applicable federal or State
41 law, in addition to any other penalties or remedies available under
42 federal or State law, it would be a violation of the bill and the
43 commissioner is permitted to initiate such action as the
44 commissioner deems appropriate to ensure compliance with this bill
45 and network adequacy laws.

1 WAIVER OF COST SHARING

2 The bill also provides that it is a violation of the bill's provisions
3 if an out-of-network health care provider, directly or indirectly
4 related to a claim, knowingly waives, rebates, gives, pays, or offers
5 to waive, rebate, give or pay all or part of the deductible,
6 copayment, or coinsurance owed by a covered person pursuant to
7 the terms of the covered person's health benefits plan as an
8 inducement for the covered person to seek health care services from
9 that provider. The bill specifies that a pattern of waiving, rebating,
10 giving or paying all or part of the deductible, copayment or
11 coinsurance by a provider shall be considered an inducement. The
12 bill provides that this section does not apply to any waiver, rebate,
13 gift, payment, or offer that falls within a safe harbor under federal
14 laws related to fraud and abuse concerning patient cost-sharing,
15 including, but not limited to, anti-kickback, self-referral, false
16 claims, and civil monetary penalties. One such safe harbor is for a
17 financial hardship.

18

19 PENALTIES

20 A person or carrier that violates any provision of the bill, or the
21 rules and regulations adopted pursuant thereto, is liable to a penalty
22 as provided in the bill. Further, upon a finding that a person or
23 carrier has failed to comply with the requirements of the bill,
24 including the payment of a penalty, the commissioner may:

25 (1) in the case of a carrier, initiate such action as the
26 commissioner determines appropriate;

27 (2) in the case of a health care facility, refer the matter to the
28 Commissioner of Health for such action as the Commissioner of
29 Health determines appropriate; or

30 (3) in the case of a health care professional, refer the matter to
31 the appropriate professional and occupational licensing board
32 within the Division of Consumer Affairs in the Department of Law
33 and Public Safety for such action as that board determines
34 appropriate.

35 The effective date of the bill is the 90th day following enactment.

[Corrected Copy]

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 485

with committee amendments

STATE OF NEW JERSEY

DATED: APRIL 5, 2018

The Senate Commerce Committee reports favorably and with committee amendments Senate Bill No. 485.

This bill, as amended, is entitled the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.” The bill reforms various aspects of the health care delivery system in New Jersey to increase transparency in pricing for health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes, contain rising costs associated with out-of-network health care services, and measure success with regard to these goals.

DISCLOSURE

The bill places certain responsibilities on health care facilities and health care professionals to notify patients about services that they will provide. The bill uses the term “health care provider” to include both facilities and professionals.

Specifically with regard to health care facilities, prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, and in terms the covered person typically understands, a health care facility is required to:

(1) disclose whether the health care facility is in-network or out-of-network with respect to the covered person’s health benefits plan;

(2) advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is in-network or out-of-network with respect to the covered person’s health benefits plan and provide information about how to determine the health plans participated in by any physician reasonably anticipated to provider services;

(3) advise the covered person that at a health care facility that is in-network with respect to the person’s health benefits plan that the covered person will have a financial responsibility applicable to an in-network procedure and unless the covered person has knowingly,

voluntarily, and specifically selected an out-of-network provider to provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure; and

(4) advise the covered person that at a health care facility that is out-of-network with respect to the covered person's health benefits plan that certain health care services will be provided on an out-of-network basis.

In addition, in a form that is consistent with federal guidelines, a health care facility is required to establish, update, and make public through posting on the facility's website a list of the facility's standard charges for items and services provided by the facility.

Among these disclosures, a health care facility shall post on the facility's website:

(1) the health benefits plans in which the facility is a participating provider;

(2) a statement concerning certain physician services provided in the facility;

(3) as applicable, the name, mailing address, and telephone number of the physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, or radiology; and

(4) as applicable, the name, mailing address, and telephone number of physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.

If the network status of the facility changes as it relates to the covered person's health benefits plan, the bill requires the facility to notify the covered person promptly.

With regard to health care professionals, the bill requires that a professional disclose to a covered persons in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the health care professional is affiliated prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care professional does not participate in the network of the covered person's health benefits plan, the health care professional shall, in terms the covered person typically understands:

(1) Inform the covered person that the professional is out-of-network and that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request;

(2) Upon receipt of a request from a covered person, disclose to the covered person in writing the amount or estimated amount that the health care professional will bill the covered person absent

unforeseen medical circumstances that may arise when the health care service is provided;

(3) inform the covered person that the covered person will have a financial responsibility applicable to health care services provided by an out-of-network professional; and

(4) inform the covered person to contact the covered person's carrier for further consultation on those costs.

A health care professional who is a physician is also required to make certain notifications concerning health care providers scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission. The physician shall provide instructions or information as to how to determine the health benefits plans in which the health care provider participates and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

A physician shall, for a covered person's scheduled facility admission or scheduled outpatient facility services, provide the covered person and the facility with certain information about other physicians whose services will be arranged.

The bill clarifies that the receipt or acknowledgement by any covered person of any disclosures required under this section of the bill shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the covered person or created under the bill.

The bill also places a variety of responsibilities on health insurance carriers. Carriers include insurance companies authorized to issue health benefits plans; health maintenance organizations; health, hospital, or medical service corporations; multiple employer welfare arrangements; entities under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; and any other carrier providing a health benefits plan.

Specifically, a carrier must update the carrier's website within 20 days of the addition or termination of a provider from the network or a change in a physician's affiliation with a facility. With respect to out-of-network services, for each health benefits plan offered, a carrier is required to, consistent with State and federal law, provide a covered person with:

(1) a clear and understandable description of the plan's out-of-network health care benefits, including the methodology used by the carrier to determine reimbursement for out-of-network services;

(2) the allowed amount the plan will reimburse under that methodology;

(3) examples of anticipated out-of-pocket costs for frequently billed out-of-network services;

(4) information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services;

(5) information in response to a covered person's request, concerning whether a health care provider is an in-network provider;

(6) such other information as the commissioner determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to estimate their out-of-pocket cost for an out-of-network service and make a well-informed health care decision; and

(7) access to a telephone hotline that shall be operated no less than 16 hours per day for consumers to call with questions about network status and out-of-pocket costs.

The bill also addresses situations in which a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed. The bill requires the carrier to notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

Finally, a carrier is required to include in the carrier's annual public regulatory filings, and in a manner to be determined by the Department of Banking and Insurance, the number of claims submitted by health care providers to the carrier which are denied or down coded by the carrier and the reason for the denial or down coding determination.

OUT-OF-NETWORK BILLING

The bill places certain limitations on charges by out-of-network providers in two situations: (1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) inadvertent out-of-network services. The bill defines "inadvertent out-of-network services" to mean health care services that are: 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, due to any reason, in-network health care services are unavailable in that facility. “Inadvertent out-of-network services” includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

The bill protects a covered person receiving medically necessary services at any health care facility on an emergency or urgent basis by prohibiting the provider from billing the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person’s health benefits plan.

With regard to medically necessary services at an out-of-network health care facility on an emergency or urgent basis, if the carrier and facility cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or health care facility may initiate binding arbitration.

The bill also requires health care facilities that are in-network with respect to any health benefits plan to ensure that:

- (1) all providers providing services in the facility on an emergency or inadvertent basis are provided notifications of the bill’s provisions and information as to each health benefits plan with which the facility has a contract to be in-network;
- (2) to report annually certain information to the Department of Health.

The bill also provides that if a covered person receives: inadvertent out-of-network services; or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, the health care professional performing those services shall:

- (a) in the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount; and
- (b) in the case of emergency and urgent services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount.

If the carrier and the professional cannot agree on a reimbursement rate for these services within a certain time period after the carrier is billed for the service, the carrier or professional may initiate binding arbitration.

The prohibitions on balance-billing would only apply to entities providing or administering a self-funded health benefits plan and its plan members if the self-funded entity elects to be subject to section 9 of the bill, which requires the plan to ensure that the plan members incur no greater out-of-pocket costs than had they gone to an in-network provider and for benefits provided by the plan to be

assigned to the out-of-network provider, which thereby subjects the plan to arbitration under the bill.

ARBITRATION

For certain emergency and out-of-network billing situations between providers and carriers, the bill establishes an arbitration system. As it relates to self-funded health plans that do not elect to be subject to arbitration under the bill, the bill provides for arbitration between the self-funded plan member and the out-of-network provider if attempts to negotiate reimbursement for services do not result in a resolution of the payment dispute.

The bill provides that, in the event that a covered person receives inadvertent out-of-network services or services at an in-network or out-of-network health care facility on an emergency or urgent basis, the carrier, or self-funded plan that opts into the section, shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services. The out-of-network provider is prohibited from billing the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network health care provider for the covered services. In these situations, the benefits that the covered person receives for health care services shall be assigned to the out-of-network health care provider, which requires no action on the part of the covered person. Once the benefits are assigned:

(1) any reimbursement paid by the carrier, or self-funded plan that opts in, shall be paid directly to the out-of-network provider; and

(2) the carrier, or self-funded plan that opts in, shall provide the out-of-network provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

If inadvertent out-of-network services or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis are performed, the out-of-network provider may bill the carrier, or self-funded plan that opts in, for the services rendered. The carrier, or self-funded plan that opts in, may pay the billed amount or attempt to negotiate reimbursement with the out-of-network health care provider.

If attempts to negotiate reimbursement for services provided by an out-of-network health care provider do not result in a resolution of the payment dispute with certain time periods, the carrier must pay the provider their final offer for the services. The carrier, or self-funded plan that opts in, or out-of-network health care provider may initiate binding arbitration to determine payment for the

services if the difference between the carrier's or self-funded plan's final offer and the provider's final offer is not less than \$1,000.

The binding arbitration system established under the bill provides that the party requesting arbitration shall notify the other party that arbitration has been initiated.

Arbitration shall be initiated by filing a request with the department. The arbitrators selected by the department shall be one or more entities that have experience in health care pricing arbitration and must be certified by the American Arbitration Association.

Arbitration is not available in the case of a covered person who willfully selected to access an out-of-network health care provider for health care services.

ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-OF-NETWORK PROVIDER

In the case of a member of a self-funded plan that does not elect to opt-in to the arbitration and balance-billing protections of the bill, the plan member or out-of-network health care provider may initiate binding arbitration to determine payment for the services by filing a request with the department. Unless negotiations for reimbursement result in an agreement between the provider and the plan member within the 30 days, a provider shall not collect or attempt to collect reimbursement, including initiation of any collection proceedings, until the provider files a request for arbitration.

This decision must be issued within 30 days after the request for arbitration is filed with the department.

The arbitrator's expenses and fees shall be split equally among the parties. Each party shall be responsible for its own costs and fees, including legal fees, if any.

INCREASED TRANSPARENCY

The bill also provides that on or before January 31 of each calendar year, the commissioner shall consult with the Department of the Treasury, the relevant professional and occupational licensing boards within the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Health to obtain information to compile and make publicly available certain information, on the department's website, including a list of all arbitrations filed and the award amount.

The bill provides that a carrier shall provide a written notice to each covered person of the protections provided to covered persons pursuant to the bill. The notice shall include information on how a consumer can contact the department or the appropriate regulatory agency to report and dispute an out-of-network charge. The notice shall be posted on the carrier's website.

The bill also provides that a carrier shall calculate, as part of rate filings required to be filed under New Jersey law, the savings that result from a reduction in out-of-network claims payments pursuant to the provisions of the bill. The department is required to make that information available on the department's website.

The department is to issue a report to the Governor and Legislature within one year, and annually thereafter, on the savings to policyholders and the healthcare system resulting from the bill's enactment, including analysis of certain information compiled by the department pursuant to the bill's provisions.

PROVIDER NETWORK AUDIT

Under the bill, a carrier which offers a managed care plan is required to provide for an annual audit of its provider network by an independent private auditing firm. The audit is to be at the expense of the carrier and the carrier shall submit the audit findings to the commissioner. The commissioner will make the results of the audit available on the department's website. If the audit contains a determination that a carrier has failed to maintain an adequate network of providers in accordance with applicable federal or State law, in addition to any other penalties or remedies available under federal or State law, it would be a violation of the bill and the commissioner is permitted to initiate such action as the commissioner deems appropriate to ensure compliance with this bill and network adequacy laws.

WAIVER OF COST SHARING

The bill also provides that it is a violation of the bill's provisions if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. The bill specifies that a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement. The bill provides that this section does not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties. One such safe harbor is for a financial hardship.

PENALTIES

A person or carrier that violates any provision of the bill, or the rules and regulations adopted pursuant thereto, is liable to a penalty as provided in the bill. Further, upon a finding that a person or carrier has failed to comply with the requirements of the bill, including the payment of a penalty, the commissioner may:

(1) in the case of a carrier, initiate such action as the commissioner determines appropriate;

(2) in the case of a health care facility, refer the matter to the Commissioner of Health for such action as the Commissioner of Health determines appropriate; or

(3) in the case of a health care professional, refer the matter to the appropriate professional and occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety for such action as that board determines appropriate.

Finally, the effective date of the bill is the 90th day following enactment.

COMMITTEE AMENDMENTS:

The committee amendments:

- Condense the time frame carriers have to pay certain out-of-network claims or notify the provider the claim is excessive, and in cases where arbitration is initiated, the timeframe for the arbitrator to issue a decision. The timeframe for carriers to pay the claim or notify the provider the claim is excessive is reduced from 30 to 20 days and the time frame for the arbitrator to issue a decision is reduced from 45 to 30 days.

- Provide that the carrier's final payment for out-of-network services made pursuant to section 9 of the bill must be the same as the carrier's final offer in arbitration.

- Remove the provision requiring the arbitrator to consider certain factors in making a determination.

- Require carriers to provide information to the department concerning the number of claims submitted by health care providers to the carrier which are denied or down coded by the carrier and the reason for the denial or down coding determination. The department is directed to include a summary of that information on the department's website.

- Require the department to issue a report to the Governor and Legislature within one year, and annually thereafter, on the savings to policyholders and the healthcare system resulting from the bill's enactment, including analysis of certain information compiled by the department pursuant to the bill's provisions.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 485

STATE OF NEW JERSEY

DATED: APRIL 5, 2018

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 485 (1R).

This bill, entitled the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act,” reforms aspects of the State health care delivery system to increase transparency in pricing for health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes, contain rising costs associated with out-of-network health care services, and measure success with regard to these goals.

DISCLOSURE

The bill places certain responsibilities on health care facilities and health care professionals to notify patients about services that they will provide. The bill uses the term “health care provider” to include both facilities and professionals.

Specifically with regard to health care facilities, prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, and in terms the covered person typically understands, a health care facility is required to:

(1) disclose whether the health care facility is in-network or out-of-network with respect to the covered person’s health benefits plan;

(2) advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is in-network or out-of-network with respect to the covered person’s health benefits plan and provide information about how to determine the health plans participated in by any physician reasonably anticipated to provider services;

(3) advise the covered person that at a health care facility that is in-network with respect to the person’s health benefits plan that the covered person will have a financial responsibility applicable to an in-network procedure and unless the covered person has knowingly, voluntarily, and specifically selected an out-of-network provider to provide services, the covered person will not incur any out-of-

pocket costs in excess of the charges applicable to an in-network procedure; and

(4) advise the covered person that at a health care facility that is out-of-network with respect to the covered person's health benefits plan that certain health care services will be provided on an out-of-network basis.

In addition, in a form that is consistent with federal guidelines, a health care facility is required to establish, update, and make public through posting on the facility's website a list of the facility's standard charges for items and services provided by the facility.

Among these disclosures, a health care facility shall post on the facility's website:

(1) the health benefits plans in which the facility is a participating provider;

(2) a statement concerning certain physician services provided in the facility;

(3) as applicable, the name, mailing address, and telephone number of the physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, or radiology; and

(4) as applicable, the name, mailing address, and telephone number of physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.

If the network status of the facility changes as it relates to the covered person's health benefits plan, the bill requires the facility to notify the covered person promptly.

With regard to health care professionals, the bill requires that a professional disclose to a covered persons in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the health care professional is affiliated prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care professional does not participate in the network of the covered person's health benefits plan, the health care professional shall, in terms the covered person typically understands:

(1) Inform the covered person that the professional is out-of-network and that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request;

(2) Upon receipt of a request from a covered person, disclose to the covered person in writing the amount or estimated amount that the health care professional will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided;

(3) inform the covered person that the covered person will have a financial responsibility applicable to health care services provided by an out-of-network professional; and

(4) inform the covered person to contact the covered person's carrier for further consultation on those costs.

A health care professional who is a physician is also required to make certain notifications concerning health care providers scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission. The physician shall provide instructions or information as to how to determine the health benefits plans in which the health care provider participates and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

A physician shall, for a covered person's scheduled facility admission or scheduled outpatient facility services, provide the covered person and the facility with certain information about other physicians whose services will be arranged.

The bill clarifies that the receipt or acknowledgement by any covered person of any disclosures required under this section of the bill shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the covered person or created under the bill.

The bill also places a variety of responsibilities on health insurance carriers. Carriers include insurance companies authorized to issue health benefits plans; health maintenance organizations; health, hospital, or medical service corporations; multiple employer welfare arrangements; entities under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; and any other carrier providing a health benefits plan.

Specifically, a carrier must update the carrier's website within 20 days of the addition or termination of a provider from the network or a change in a physician's affiliation with a facility. With respect to out-of-network services, for each health benefits plan offered, a carrier is required to, consistent with State and federal law, provide a covered person with:

(1) a clear and understandable description of the plan's out-of-network health care benefits, including the methodology used by the carrier to determine reimbursement for out-of-network services;

(2) the allowed amount the plan will reimburse under that methodology;

(3) examples of anticipated out-of-pocket costs for frequently billed out-of-network services;

(4) information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services;

(5) information in response to a covered person's request, concerning whether a health care provider is an in-network provider;

(6) such other information as the commissioner determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to estimate their out-of-pocket cost for an out-of-network service and make a well-informed health care decision; and

(7) access to a telephone hotline that shall be operated no less than 16 hours per day for consumers to call with questions about network status and out-of-pocket costs.

The bill also addresses situations in which a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed. The bill requires the carrier to notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

Finally, a carrier is required to include in the carrier's annual public regulatory filings, and in a manner to be determined by the Department of Banking and Insurance, the number of claims submitted by health care providers to the carrier which are denied or down coded by the carrier and the reason for the denial or down coding determination.

OUT-OF-NETWORK BILLING

The bill places certain limitations on charges by out-of-network providers in two situations: (1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) inadvertent out-of-network services. The bill defines "inadvertent out-of-network services" to mean health care services that are: 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, due to any reason, in-network health care services are unavailable in that facility. “Inadvertent out-of-network services” includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

The bill protects a covered person receiving medically necessary services at any health care facility on an emergency or urgent basis by prohibiting the provider from billing the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person’s health benefits plan.

With regard to medically necessary services at an out-of-network health care facility on an emergency or urgent basis, if the carrier and facility cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or health care facility may initiate binding arbitration.

The bill also requires health care facilities that are in-network with respect to any health benefits plan to ensure that:

(1) all providers providing services in the facility on an emergency or inadvertent basis are provided notifications of the bill’s provisions and information as to each health benefits plan with which the facility has a contract to be in-network;

(2) to report annually certain information to the Department of Health.

The bill also provides that if a covered person receives: inadvertent out-of-network services; or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, the health care professional performing those services shall:

(a) in the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount; and

(b) in the case of emergency and urgent services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount.

If the carrier and the professional cannot agree on a reimbursement rate for these services within a certain time period after the carrier is billed for the service, the carrier or professional may initiate binding arbitration.

The prohibitions on balance-billing would only apply to entities providing or administering a self-funded health benefits plan and its plan members if the self-funded entity elects to be subject to section 9 of the bill, which requires the plan to ensure that the plan members incur no greater out-of-pocket costs than had they gone to an in-network provider and for benefits provided by the plan to be assigned to the out-of-network provider, which thereby subjects the plan to arbitration under the bill.

ARBITRATION

For certain emergency and out-of-network billing situations between providers and carriers, the bill establishes an arbitration system. As it relates to self-funded health plans that do not elect to be subject to arbitration under the bill, the bill provides for arbitration between the self-funded plan member and the out-of-network provider if attempts to negotiate reimbursement for services do not result in a resolution of the payment dispute.

The bill provides that, in the event that a covered person receives inadvertent out-of-network services or services at an in-network or out-of-network health care facility on an emergency or urgent basis, the carrier, or self-funded plan that opts into the section, shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services. The out-of-network provider is prohibited from billing the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network health care provider for the covered services. In these situations, the benefits that the covered person receives for health care services shall be assigned to the out-of-network health care provider, which requires no action on the part of the covered person. Once the benefits are assigned:

(1) any reimbursement paid by the carrier, or self-funded plan that opts in, shall be paid directly to the out-of-network provider; and

(2) the carrier, or self-funded plan that opts in, shall provide the out-of-network provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

If inadvertent out-of-network services or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis are performed, the out-of-network provider may bill the carrier, or self-funded plan that opts in, for the services rendered. The carrier, or self-funded plan that opts in, may pay the billed amount or attempt to negotiate reimbursement with the out-of-network health care provider.

If attempts to negotiate reimbursement for services provided by an out-of-network health care provider do not result in a resolution of the payment dispute with certain time periods, the carrier must pay the provider their final offer for the services. The carrier, or self-funded plan that opts in, or out-of-network health care provider may initiate binding arbitration to determine payment for the services if the difference between the carrier's or self-funded plan's final offer and the provider's final offer is not less than \$1,000.

The binding arbitration system established under the bill provides that the party requesting arbitration shall notify the other party that arbitration has been initiated.

Arbitration shall be initiated by filing a request with the department. The arbitrators selected by the department shall be one or more entities that have experience in health care pricing arbitration and must be certified by the American Arbitration Association.

Arbitration is not available in the case of a covered person who willfully selected to access an out-of-network health care provider for health care services.

ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-OF-NETWORK PROVIDER

In the case of a member of a self-funded plan that does not elect to opt-in to the arbitration and balance-billing protections of the bill, the plan member or out-of-network health care provider may initiate binding arbitration to determine payment for the services by filing a request with the department. Unless negotiations for reimbursement result in an agreement between the provider and the plan member within the 30 days, a provider shall not collect or attempt to collect reimbursement, including initiation of any collection proceedings, until the provider files a request for arbitration.

This decision must be issued within 30 days after the request for arbitration is filed with the department.

The arbitrator's expenses and fees shall be split equally among the parties. Each party shall be responsible for its own costs and fees, including legal fees, if any.

INCREASED TRANSPARENCY

The bill also provides that on or before January 31 of each calendar year, the commissioner shall consult with the Department of the Treasury, the relevant professional and occupational licensing boards within the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Health to obtain information to compile and make publicly available certain information, on the department's website, including a list of all arbitrations filed and the award amount.

The bill provides that a carrier shall provide a written notice to each covered person of the protections provided to covered persons pursuant to the bill. The notice shall include information on how a consumer can contact the department or the appropriate regulatory agency to report and dispute an out-of-network charge. The notice shall be posted on the carrier's website.

The bill also provides that a carrier shall calculate, as part of rate filings required to be filed under New Jersey law, the savings that

result from a reduction in out-of-network claims payments pursuant to the provisions of the bill. The department is required to make that information available on the department's website.

The department is to issue a report to the Governor and Legislature within one year, and annually thereafter, on the savings to policyholders and the healthcare system resulting from the bill's enactment, including analysis of certain information compiled by the department pursuant to the bill's provisions.

PROVIDER NETWORK AUDIT

Under the bill, a carrier which offers a managed care plan is required to provide for an annual audit of its provider network by an independent private auditing firm. The audit is to be at the expense of the carrier and the carrier shall submit the audit findings to the commissioner. The commissioner will make the results of the audit available on the department's website. If the audit contains a determination that a carrier has failed to maintain an adequate network of providers in accordance with applicable federal or State law, in addition to any other penalties or remedies available under federal or State law, it would be a violation of the bill and the commissioner is permitted to initiate such action as the commissioner deems appropriate to ensure compliance with this bill and network adequacy laws.

WAIVER OF COST SHARING

The bill also provides that it is a violation of the bill's provisions if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. The bill specifies that a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement. The bill provides that this section does not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties. One such safe harbor is for a financial hardship.

PENALTIES

A person or carrier that violates any provision of the bill, or the rules and regulations adopted pursuant thereto, is liable to a penalty as provided in the bill. Further, upon a finding that a person or

carrier has failed to comply with the requirements of the bill, including the payment of a penalty, the commissioner may:

(1) in the case of a carrier, initiate such action as the commissioner determines appropriate;

(2) in the case of a health care facility, refer the matter to the Commissioner of Health for such action as the Commissioner of Health determines appropriate; or

(3) in the case of a health care professional, refer the matter to the appropriate professional and occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety for such action as that board determines appropriate.

Finally, the effective date of the bill is the 90th day following enactment.

FISCAL IMPACT:

The Office of Legislative Services (OLS) notes that the bill may result in indeterminate annual cost savings to the State Health Benefits Program, the School Employees' Health Benefits Program, and health benefits plans offered by local units due to a decrease in out-of-network charges.

The OLS notes that enactment of the bill may result in an indeterminate annual decrease in revenue from out-of-network charges to: a) University Hospital, an independent non-profit legal entity that is an instrumentality of the State located in Newark; and b) Bergen Regional Medical Center, a county-owned entity located in Paramus.

The OLS notes that enactment of the bill would result in an indeterminate annual State revenue increase to the General Fund due to the collection of penalties established under the bill.

Additionally, this bill requires the Department of Health, the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Banking and Insurance to collect and report certain information. Such requirements, however, may not result in additional costs to the respective departments as the expenses associated with these activities could likely be absorbed into the departments' existing operating budgets.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

SENATE, No. 485

STATE OF NEW JERSEY 218th LEGISLATURE

DATED: APRIL 16, 2018

SUMMARY

Synopsis: “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.”

Type of Impact: Annual State and Local Government Cost Savings, Annual State Revenue Increase, Annual Revenue Decreases to University Hospital and Bergen Regional Medical Center.

Agencies Affected: Department of Banking and Insurance, Department of the Treasury, Department of Health, Division of Consumer Affairs in the Department of Law and Public Safety, State Health Benefits Program, School Employees’ Health Benefits Program, health benefits plans offered by certain local units, University Hospital, and Bergen Regional Medical Center.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State and Local Government Cost Savings – Decreased Employee Health Insurance Costs	Indeterminate
State Revenue Increase – Penalty Collections	Indeterminate
University Hospital Revenue Decrease – Reduced Payments for Out-Of-Network Services	Indeterminate
Bergen Regional Medical Center Revenue Decrease – Reduced Payments for Out-Of- Network Services	Indeterminate

- The Office of Legislative Services (OLS) notes that the bill may result in indeterminate annual cost savings to the State Health Benefits Program, the School Employees’ Health Benefits Program, and health benefits plans offered by local units due to a decrease in out-of-network charges.
- The OLS notes that enactment of the bill may result in an indeterminate annual decrease in revenue from out-of-network charges to: University Hospital, an independent non-profit legal entity that is an instrumentality of the State located in Newark; and Bergen Regional Medical Center, a county-owned entity located in Paramus.

- The OLS notes that enactment of the bill would result in an indeterminate annual State revenue increase to the General Fund due to the collection of penalties established under the bill.
- Additionally, this bill requires the Department of Health, the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Banking and Insurance to collect and report certain information. Such requirements, however, may not result in additional costs to the respective departments as the expenses associated with these activities could likely be absorbed into the departments' existing operating budgets.

BILL DESCRIPTION

This bill is entitled the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act." The bill reforms various aspects of the health care delivery system in New Jersey to increase transparency in pricing for health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes, contain rising costs associated with out-of-network health care services, and measure success with regard to these goals.

FISCAL ANALYSIS

EXECUTIVE BRANCH

The Executive Branch has not submitted a formal, written fiscal note for this bill, but the Department of the Treasury has provided informal information to the OLS indicating that covered persons under the Horizon NJ Direct plans within the State Health Benefits Program and the School Employees' Health Benefits Program filed 3,253,180 out-of-network claims in fiscal year 2015. As of September 30, 2016, the State has paid out \$895,854,618 for the cost of those claims. These data include all out-of-network claims and costs under the Horizon NJ Direct plans, not just the emergency and inadvertent claims to which the bill applies. Furthermore, these data do not include out-of-network claims and costs associated with any other plans offered by the State and School Employee Health Benefits Plans, such as Horizon tiered plans, Horizon HMO plans, or any Aetna plans.

OFFICE OF LEGISLATIVE SERVICES

The OLS notes that the enactment of the bill may result in indeterminate annual cost savings to the State Health Benefits Program, the School Employees' Health Benefits Program, and health benefits plans offered by local units due to a decrease in out-of-network charges.

The OLS also notes that the enactment of the bill may result in an indeterminate annual decrease in revenue from out-of-network charges to: University Hospital, an independent non-profit legal entity that is an instrumentality of the State located in Newark; and Bergen Regional Medical Center, a county-owned entity located in Paramus.

The OLS notes further that enactment of the bill would result in an indeterminate annual State revenue increase to the General Fund due to the collection of penalties established under the bill.

Additionally, this bill requires the Department of Health, the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Banking and Insurance to collect and report certain information. Such requirements, however, may not result in additional costs to the respective departments as the expenses associated with these activities could likely be absorbed into the departments' existing operating budgets.

Out-of-network Billing

Currently, when an individual covered by a network-based health benefits plan receives care from an out-of-network health care provider under circumstances that could not be avoided, the individual is partially protected under State rules and regulations. Specifically, N.J.A.C.11:22-5.8(b) states that a covered person's liability for services rendered during a hospitalization in a network hospital, regardless of whether the admitting physician is in-network or out-of-network, shall, in most situations, be limited to the copayment, deductible, and/or coinsurance applicable to network services. The rule partially protects members of certain health benefits plans from being billed more than the in-network rate for services rendered at the time of care, and suggests that health benefits plans are responsible for protecting their members and absorbing the excess costs associated with out-of-network charges. While the rule only applies to health maintenance organizations (HMOs) and other non-HMO network-based plans, some self-insured plans, such as the State Health Benefits Program and the School Employees' Health Benefits Program, follow similar out-of-network practice rules. The rule does not limit the amounts that out-of-network providers can charge the carriers or the State plans, which in some cases pay up to the billed charges if a lower amount cannot be negotiated.

This bill places certain limitations on charges by out-of-network providers in two situations: (1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) inadvertent out-of-network services. The OLS notes that limiting charges by out-of-network health care providers in such a manner may provide direct savings to covered persons and health benefits plans in the State. Under the bill's definition of "carrier," this includes the State Health Benefits Program and the School Employees' Health Benefits Program and any entity providing a health benefits plan that is not self-funded. However, other self-funded plans could be included under the bill's provisions if the plan elects to be subject to them. The savings that may be realized for the State and local units would be the result of a decrease in costs associated with out-of-network charges. Under the bill, health benefits plans would pay out-of-network providers the amounts, subject to a statutorily-prescribed ceiling, resulting from a mandatory arbitration process, if the carrier and the provider cannot agree on a reimbursement rate.

In testimony submitted to the Assembly Appropriations Committee in October of 2016, Dudley Burdge, who represents the Communications Workers of America and is also a commissioner on the State Health Benefits Commission, estimated that the direct savings from an earlier version of the bill to the State and School Employee Health Benefits Plans due to decreases in out-of-network payments to physicians, hospitals, and other providers of medical services would be approximately \$133 million annually. Furthermore, the New Jersey Pension and Health Benefits Review Commission reported in February 2016 that general reform to the statutes and regulations that govern out-of-network provider reimbursement, in conjunction with other reforms in the health care delivery system, would save the State an estimated \$164 million in the first fiscal year of implementation.

Additionally, the Department of the Treasury has provided informal information to the OLS indicating that covered persons under the Horizon NJ Direct plans within the State Health Benefits Program and the School Employees' Health Benefits Program filed 3,253,180 out-of-network claims in fiscal year 2015. As of September 30, 2016, the State has paid out \$895,854,618 for the cost of those claims. The OLS notes that these data include all out-of-network claims and costs under the Horizon NJ Direct plans, not just the emergency and inadvertent claims to which the bill applies. Furthermore, these data do not include out-of-network claims and costs associated with any other plans offered by the State and School Employee Health Benefits Plans, such as Horizon tiered plans, Horizon HMO plans, or any Aetna plans.

However, since insufficient data are available to estimate the impact that limiting certain charges by out-of-network providers would have on the State Health Benefits Program, the School Employees' Health Benefits Program, and health benefits plans offered by local units, the OLS is unable to determine the direct savings that may be realized to these health benefits plans.

Furthermore, the OLS also notes that the enactment of the bill may result in an indeterminate annual decrease in revenue from out-of-network charges to: University Hospital, an independent non-profit legal entity that is an instrumentality of the State located in Newark; and Bergen Regional Medical Center, a county-owned entity located in Paramus.

Penalties

Penalties established under this bill range from \$100 to \$2,500 for violations committed by individuals or entities, and \$1,000 to \$25,000 for violations committed by health care facilities. The OLS, however, cannot determine the nature and number of infractions that may be committed, and therefore the amount of revenue generated, under the bill.

Reporting

This bill places certain responsibilities on health care facilities and health care professionals to report certain information to the Department of Health and the Division of Consumer Affairs in the Department of Law and Public Safety. The reported information would be shareable with the Department of Banking and Insurance. Furthermore, the bill requires the Department of Banking and Insurance to issue a report to the Governor and Legislature and make publicly available, on the department's website, certain information regarding the bill. The collection and reporting of such information may not result in additional costs to the respective departments as the expenses associated with these activities could likely be absorbed into the departments' existing operating budgets.

Section: Commerce, Labor and Industry

Analyst: Juan C. Rodriguez
Associate Fiscal Analyst

Approved: Frank W. Haines III
Legislative Budget and Finance Officer

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).



[Home](#) | [Administration](#) ▾ | [Key Initiatives](#) ▾ | [News and Events](#) ▾ | [Social](#) ▾ | [Contact Us](#) ▾

Newark, N.J.

Governor Murphy Takes Action on Legislation

05/30/2018

TRENTON – Today, Governor Phil Murphy announced that he has signed the following bills into law:

A2787 (Dancer, Andrzejczak, Houghtaling, Rooney/Cruz-Perez, Singer) – Extends pilot program authorizing special occasion events at wineries on preserved farmland; implements reporting requirement.

A3380 (McKeon, Murphy, Lampitt, Conaway/Vitale, Singleton) – “New Jersey Health Insurance Market Preservation Act.”

S482 (Vitale/Vainieri Huttle, Quijano, Jasey) – Authorizes certain gestational carrier agreements.

S846 (Turner, Cruz-Perez/Pintor Marin, Mukherji, Gusciora, Jones, Sumter) – Reinstates and extends duration of certain UEZs; requires DCA to study UEZ program and report recommendations to the Legislature.

S868 (Sweeney, Vitale/Coughlin, Jasey, Schaer)– Permits candidates for school board to circulate petitions jointly and be bracketed together on ballot; permits short nonpolitical designation of principles on petitions and ballots.

S1217 (Sweeney, Smith/Mazzeo, Armato, DeAngelo) – Requires BPU consideration and approval of amended application for qualified wind energy project offshore in certain NJ territorial waters.

S1870 (Vitale, Ruiz/Speight, Quijano, McKnight) – Requires Child Fatality and Near Fatality Review Board to study racial and ethnic disparities that contribute to infant mortality.

S1876 (Ruiz, Corrado/Vainieri Huttle, Caputo, Jasey) – Requires Commissioner of Education to include data on chronic absenteeism and disciplinary suspensions on School Report Card and requires public schools to make certain efforts to combat chronic absenteeism.

S1878 (Vitale, Singleton/McKeon, Lampitt, Murphy) – "New Jersey Health Insurance Premium Security Act;" establishes health insurance reinsurance plan.

S1894 (Ruiz, Turner/Lampitt, Sumter, Barclay) – Requires "breakfast after the bell" program in all schools with 70% or more of students eligible for free or reduced price meals.

S1895 (Ruiz, Turner/Lampitt, Jones, Wimberly) – Requires certain school districts to submit report on nonparticipation in "Community Eligibility Provision" of National School Lunch and School Breakfast Programs.

S1896 (Ruiz, Turner/Lampitt, Wimberly, Jones) – Requires school district to report at least biannually to Department of Agriculture number of students who are denied school breakfast or school lunch.

S1897 (Ruiz, Turner/Lampitt, Pintor Marin, Barclay) – Expands summer meal program to all school districts with 50 percent or more of students eligible for free or reduced price meals.

S2247 (Sweeney/Burzichelli, Mukherji, Murphy) – Allows charitable assets set aside from the sale of nonprofit hospital to for-profit entity to be allocated to successor nonprofit charitable entity that is establishing and operating

equivalent nonprofit hospital.

Governor Murphy also announced that he has conditionally vetoed the following bills:

S879 (Sweeney/Burzichelli, Taliaferro, Murphy) – Amends definition of "existing major hazardous waste facility" in "Major Hazardous Waste Facilities Siting Act."

[Copy of message on S879](#)

S976 (Vitale, Bateman/Vainieri Huttie, Lagana, Mukherji) – "Revised State Medical Examiner Act"; establishes Office of the Chief State Medical Examiner in DOH.

[Copy of message on S976](#)

S1968 (Pou/Wimberly, Mukherji, Sumter) – Extends document submission deadline for certain residential and mixed use parking projects under Economic Redevelopment and Growth Grant program; increases maximum credit amounts awarded for certain residential and mixed use parking projects.

[Copy of message on S1968](#)

[Back to Top](#)

Powered by  **Translate** [Select Language](#)

[Translator Disclaimer](#)

Governor Phil Murphy

Statewide

Home

Administration

Governor Phil Murphy

Lt. Governor Sheila

Oliver

First Lady Tammy

Snyder Murphy

Cabinet

Boards, Commissions

& Authorities

Internship

Opportunities

Governor's Residence

- Drumthwacket

Key Initiatives

Economy & Jobs

Education

Environment

Health

Law & Justice

Transportation

News & Events

Press Releases

Public Addresses

Executive Orders

Statements on

Legislation

Administration Reports

Transition Reports

Social

Facebook

Twitter

Instagram

Snapchat

YouTube

Contact Us

Scheduling Requests

Contact Us

NJ Home

Services A to Z

Departments/Agencies

FAQs

Contact Us

Privacy Notice

Legal Statement &

Disclaimers

Accessibility

Statement

[Corrected Copy]

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2039

with committee amendments

STATE OF NEW JERSEY

DATED: APRIL 5, 2018

The Assembly Appropriations Committee reports favorably Assembly Bill No. 2039, with committee amendments.

As amended, this bill, entitled the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act,” reforms various aspects of the health care delivery system in New Jersey to increase transparency in pricing for health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes, contain rising costs associated with out-of-network health care services, and measure success with regard to these goals.

DISCLOSURE

The bill places certain responsibilities on health care facilities and health care professionals to notify patients about services that they will provide. The bill uses the term “health care provider” to include both facilities and professionals.

Specifically with regard to health care facilities, prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, and in terms the covered person typically understands, a health care facility is required to:

(1) disclose whether the health care facility is in-network or out-of-network with respect to the covered person’s health benefits plan;

(2) advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is in-network or out-of-network with respect to the covered person’s health benefits plan and provide information about how to determine the health plans participated in by any physician reasonably anticipated to provider services;

(3) advise the covered person that at a health care facility that is in-network with respect to the person’s health benefits plan that the covered person will have a financial responsibility applicable to an in-network procedure and unless the covered person has knowingly,

voluntarily, and specifically selected an out-of-network provider to provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure; and

(4) advise the covered person that at a health care facility that is out-of-network with respect to the covered person's health benefits plan that certain health care services will be provided on an out-of-network basis.

In addition, in a form that is consistent with federal guidelines, a health care facility is required to establish, update, and make public through posting on the facility's website a list of the facility's standard charges for items and services provided by the facility.

Among these disclosures, a health care facility shall post on the facility's website:

(1) the health benefits plans in which the facility is a participating provider;

(2) a statement concerning certain physician services provided in the facility;

(3) as applicable, the name, mailing address, and telephone number of the physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, or radiology; and

(4) as applicable, the name, mailing address, and telephone number of physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.

If the network status of the facility changes as it relates to the covered person's health benefits plan, the bill requires the facility to notify the covered person promptly.

With regard to health care professionals, the bill requires that a professional disclose to a covered persons in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the health care professional is affiliated prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care professional does not participate in the network of the covered person's health benefits plan, the health care professional shall, in terms the covered person typically understands:

(1) Inform the covered person that the professional is out-of-network and that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request;

(2) Upon receipt of a request from a covered person, disclose to the covered person in writing the amount or estimated amount that the health care professional will bill the covered person absent

unforeseen medical circumstances that may arise when the health care service is provided;

(3) inform the covered person that the covered person will have a financial responsibility applicable to health care services provided by an out-of-network professional; and

(4) inform the covered person to contact the covered person's carrier for further consultation on those costs.

A health care professional who is a physician is also required to make certain notifications concerning health care providers scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission. The physician shall provide instructions or information as to how to determine the health benefits plans in which the health care provider participates and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

A physician shall, for a covered person's scheduled facility admission or scheduled outpatient facility services, provide the covered person and the facility with certain information about other physicians whose services will be arranged.

The bill clarifies that the receipt or acknowledgement by any covered person of any disclosures required under this section of the bill shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the covered person or created under the bill.

The bill also places a variety of responsibilities on health insurance carriers. Carriers include insurance companies authorized to issue health benefits plans; health maintenance organizations; health, hospital, or medical service corporations; multiple employer welfare arrangements; entities under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; and any other carrier providing a health benefits plan.

Specifically, a carrier must update the carrier's website within 20 days of the addition or termination of a provider from the network or a change in a physician's affiliation with a facility. With respect to out-of-network services, for each health benefits plan offered, a carrier is required to, consistent with State and federal law, provide a covered person with:

(1) a clear and understandable description of the plan's out-of-network health care benefits, including the methodology used by the carrier to determine reimbursement for out-of-network services;

(2) the allowed amount the plan will reimburse under that methodology;

(3) examples of anticipated out-of-pocket costs for frequently billed out-of-network services;

(4) information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services;

(5) information in response to a covered person's request, concerning whether a health care provider is an in-network provider;

(6) such other information as the commissioner determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to estimate their out-of-pocket cost for an out-of-network service and make a well-informed health care decision; and

(7) access to a telephone hotline that shall be operated no less than 16 hours per day for consumers to call with questions about network status and out-of-pocket costs.

The bill also addresses situations in which a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed. The bill requires the carrier to notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

Finally, a carrier is required to include in the carrier's annual public regulatory filings, and in a manner to be determined by the Department of Banking and Insurance, the number of claims submitted by health care providers to the carrier which are denied or down coded by the carrier and the reason for the denial or down coding determination.

OUT-OF-NETWORK BILLING

The bill places certain limitations on charges by out-of-network providers in two situations: (1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) inadvertent out-of-network services. The bill defines "inadvertent out-of-network services" to mean health care services that are: 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, due to any reason, in-network health care services are unavailable in that facility. “Inadvertent out-of-network services” includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

The bill protects a covered person receiving medically necessary services at any health care facility on an emergency or urgent basis by prohibiting the provider from billing the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person’s health benefits plan.

With regard to medically necessary services at an out-of-network health care facility on an emergency or urgent basis, if the carrier and facility cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or health care facility may initiate binding arbitration.

The bill also requires health care facilities that are in-network with respect to any health benefits plan to ensure that:

(1) all providers providing services in the facility on an emergency or inadvertent basis are provided notifications of the bill’s provisions and information as to each health benefits plan with which the facility has a contract to be in-network.

(2) to report annually certain information to the Department of Health.

The bill also provides that if a covered person receives: inadvertent out-of-network services; or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, the health care professional performing those services shall:

(a) in the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount; and

(b) in the case of emergency and urgent services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount.

If the carrier and the professional cannot agree on a reimbursement rate for these services within a certain time period after the carrier is billed for the service, the carrier or professional may initiate binding arbitration.

The prohibitions on balance-billing would only apply to entities providing or administering a self-funded health benefits plan and its plan members if the self-funded entity elects to be subject to section 9 of the bill, which requires the plan to ensure that the plan members incur no greater out-of-pocket costs than had they gone to an in-network provider and for benefits provided by the plan to be

assigned to the out-of-network provider, which thereby subjects the plan to arbitration under the bill.

ARBITRATION

For certain emergency and out-of-network billing situations between providers and carriers, the bill establishes an arbitration system. As it relates to self-funded health plans that do not elect to be subject to arbitration under the bill, the bill provides for arbitration between the self-funded plan member and the out-of-network provider if attempts to negotiate reimbursement for services do not result in a resolution of the payment dispute.

The bill provides that, in the event that a covered person receives inadvertent out-of-network services or services at an in-network or out-of-network health care facility on an emergency or urgent basis, the carrier, or self-funded plan that opts into the section, shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services. The out-of-network provider is prohibited from billing the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network health care provider for the covered services. In these situations, the benefits that the covered person receives for health care services shall be assigned to the out-of-network health care provider, which requires no action on the part of the covered person. Once the benefits are assigned:

(1) any reimbursement paid by the carrier, or self-funded plan that opts in, shall be paid directly to the out-of-network provider; and

(2) the carrier, or self-funded plan that opts in, shall provide the out-of-network provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

If inadvertent out-of-network services or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis are performed, the out-of-network provider may bill the carrier, or self-funded plan that opts in, for the services rendered. The carrier, or self-funded plan that opts in, may pay the billed amount or attempt to negotiate reimbursement with the out-of-network health care provider.

If attempts to negotiate reimbursement for services provided by an out-of-network health care provider do not result in a resolution of the payment dispute with certain time periods, the carrier must pay the provider their final offer for the services. The carrier, or self-funded plan that opts in, or out-of-network health care provider may initiate binding arbitration to determine payment for the

services if the difference between the carrier's or self-funded plan's final offer and the provider's final offer is not less than \$1,000.

The binding arbitration system established under the bill provides that the party requesting arbitration shall notify the other party that arbitration has been initiated.

Arbitration shall be initiated by filing a request with the department. The arbitrators selected by the department shall be one or more entities that have experience in health care pricing arbitration and must be certified by the American Arbitration Association.

Arbitration is not available in the case of a covered person who willfully selected to access an out-of-network health care provider for health care services.

ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-OF-NETWORK PROVIDER

In the case of a member of a self-funded plan that does not elect to opt-in to the arbitration and balance-billing protections of the bill, the plan member or out-of-network health care provider may initiate binding arbitration to determine payment for the services by filing a request with the department. Unless negotiations for reimbursement result in an agreement between the provider and the plan member within the 30 days, a provider shall not collect or attempt to collect reimbursement, including initiation of any collection proceedings, until the provider files a request for arbitration.

This decision must be issued within 30 days after the request for arbitration is filed with the department.

The arbitrator's expenses and fees shall be split equally among the parties. Each party shall be responsible for its own costs and fees, including legal fees, if any.

INCREASED TRANSPARENCY

The bill also provides that on or before January 31 of each calendar year, the commissioner shall consult with the Department of the Treasury, the relevant professional and occupational licensing boards within the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Health to obtain information to compile and make publicly available certain information, on the department's website, including a list of all arbitrations filed and the award amount.

The bill provides that a carrier shall provide a written notice to each covered person of the protections provided to covered persons pursuant to the bill. The notice shall include information on how a consumer can contact the department or the appropriate regulatory agency to report and dispute an out-of-network charge. The notice shall be posted on the carrier's website.

The bill also provides that a carrier shall calculate, as part of rate filings required to be filed under New Jersey law, the savings that result from a reduction in out-of-network claims payments pursuant to the provisions of the bill. The department is required to make that information available on the department's website.

The department is to issue a report to the Governor and Legislature within one year, and annually thereafter, on the savings to policyholders and the healthcare system resulting from the bill's enactment, including analysis of certain information compiled by the department pursuant to the bill's provisions.

PROVIDER NETWORK AUDIT

Under the bill, a carrier which offers a managed care plan is required to provide for an annual audit of its provider network by an independent private auditing firm. The audit is to be at the expense of the carrier and the carrier shall submit the audit findings to the commissioner. The commissioner will make the results of the audit available on the department's website. If the audit contains a determination that a carrier has failed to maintain an adequate network of providers in accordance with applicable federal or State law, in addition to any other penalties or remedies available under federal or State law, it would be a violation of the bill and the commissioner is permitted to initiate such action as the commissioner deems appropriate to ensure compliance with this bill and network adequacy laws.

WAIVER OF COST SHARING

The bill also provides that it is a violation of the bill's provisions if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. The bill specifies that a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement. The bill provides that this section does not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties. One such safe harbor is for a financial hardship.

PENALTIES

A person or carrier that violates any provision of the bill, or the rules and regulations adopted pursuant thereto, is liable to a penalty

as provided in the bill. Further, upon a finding that a person or carrier has failed to comply with the requirements of the bill, including the payment of a penalty, the commissioner may:

(1) in the case of a carrier, initiate such action as the commissioner determines appropriate;

(2) in the case of a health care facility, refer the matter to the Commissioner of Health for such action as the Commissioner of Health determines appropriate; or

(3) in the case of a health care professional, refer the matter to the appropriate professional and occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety for such action as that board determines appropriate.

Finally, the effective date of the bill is the 90th day following enactment.

COMMITTEE AMENDMENTS:

The committee amendments:

- Condense the time frame carriers have to pay certain out-of-network claims or notify the provider the claim is excessive, and in cases where arbitration is initiated, the timeframe for the arbitrator to issue a decision. The timeframe for carriers to pay the claim or notify the provider the claim is excessive is reduced from 30 to 20 days and the time frame for the arbitrator to issue a decision is reduced from 45 to 30 days.

- Provide that the carrier's final payment for out-of-network services made pursuant to section 9 of the bill must be the same as the carrier's final offer in arbitration.

- Remove the provision requiring the arbitrator to consider certain factors in making a determination.

- Require carriers to provide information to the department concerning the number of claims submitted by health care providers to the carrier which are denied or down coded by the carrier and the reason for the denial or down coding determination. The department is directed to include a summary of that information on the department's website.

- Require the department to issue a report to the Governor and Legislature within one year, and annually thereafter, on the savings to policyholders and the healthcare system resulting from the bill's enactment, including analysis of certain information compiled by the department pursuant to the bill's provisions.

FISCAL IMPACT:

The Office of Legislative Services (OLS) notes that the bill may result in indeterminate annual cost savings to the State Health Benefits Program, the School Employees' Health Benefits Program, and health benefits plans offered by local units due to a decrease in out-of-

network charges. The OLS notes that enactment of the bill may result in an indeterminate annual decrease in revenue from out-of-network charges to: a) University Hospital, an independent non-profit legal entity that is an instrumentality of the State located in Newark; and b) Bergen Regional Medical Center, a county-owned entity located in Paramus. The OLS notes that enactment of the bill would result in an indeterminate annual State revenue increase to the General Fund due to the collection of penalties established under the bill.

Additionally, this bill requires the Department of Health, the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Banking and Insurance to collect and report certain information. Such requirements, however, may not result in additional costs to the respective departments as the expenses associated with these activities could likely be absorbed into the departments' existing operating budgets.