ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1952

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 20, 2016

The Assembly Financial Institutions and Insurance Committee reports favorably and with committee amendments Assembly Bill No. 1952.

This bill is entitled the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act." The bill, as amended, 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. "Physician" is separately defined, and includes optometrists.

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 health care professional who is 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 carrier's 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) the approximate dollar amount that the carrier will pay for a specific out-of-network service;

(7) 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

(8) 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 urgent basis accept reimbursement rates in accordance with the bill’s provisions;

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

(3) to report 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.

The arbitrator's decision shall be binding on both parties and shall be a fixed amount that is within a range of 90% to 200% of the applicable payment rate under the federal Medicare program for that service. The arbitrator's expenses and fees shall be split equally among the parties. Each party shall be responsible for its own costs and fees.

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.

The arbitrator is required to consider information supplied by both parties and to issue written findings, including a final binding amount within a range of 90% to 200% of the applicable payment rate under the federal Medicare program for that service. The arbitrator's decision shall include a non-binding recommendation to the entity providing or administering the self-funded health benefits plan of an amount that would be reasonable for the entity to contribute to payment for the service. 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.

The bill was pre-filed for introduction in the 2016-2017 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

COMMITTEE AMENDMENTS:

The committee amended the bill as follows:

- In section 3, added a definition of "physician" to the bill, and included optometrists within that definition.

- In section 4, added a requirement that health care facilities, prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, must provide information about how to determine the health plans participated in by any physician who is reasonably anticipated to provide services.

- In section 6, added a requirement that carriers provide covered persons with the allowed amount that the plan will reimburse, using the methodology for out of network reimbursements; and that consumers have at least 16-hour per day access to a telephone hotline for information about network status and out of pocket costs.

- In section 7, added a requirement that all in-network health care facilities must ensure that all health care professionals that are contracted with the facility to perform services in the facility are also in-network with respect to all health benefits plans with which the facility is in-network.

- In section 7, added a requirement as to health care facilities that must report to the Department of Health about in-network plans, that the facilities must also report confirmation that professionals contracted with the facility are in the same networks as the facility.

- In sections 7 and 8, removed certain language relating to tiered network plans which required, in emergencies, that the covered person would only be responsible for the lowest cost sharing amount applicable to in-network services.

- In section 10, removed peer review component from the arbitration process; removes "baseball" arbitration process that required arbitrator to select one of the two amounts submitted by each party; requires arbitrator to decide on a fixed amount that is within a range of 90% to 200% of the applicable payment rate under the Medicare program for that service; removed list of factors that arbitrator must consider.

- In section 11, as to situations in which a plan member of a self-funded plan or an out-of-network provider brings arbitration against a self-funded plan member, revises arbitration procedures to make them largely parallel to the arbitration system provided for in the amendments to section 10, as noted above.

- In section 12, removed certain language regarding arbitration that is no longer applicable due to revisions to arbitration system by amendments to section 10, as noted above.

- In section 21, revised effective date of the bill from July 1, 2016 to the 90th day following enactment.