

**ASSEMBLY, No. 1952**

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**STATE OF NEW JERSEY**

**217th LEGISLATURE**

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PRE-FILED FOR INTRODUCTION IN THE 2016 SESSION

**Sponsored by:**

**Assemblyman CRAIG J. COUGHLIN**

**District 19 (Middlesex)**

**Assemblyman GARY S. SCHAER**

**District 36 (Bergen and Passaic)**

**Assemblyman TROY SINGLETON**

**District 7 (Burlington)**

**Assemblywoman PAMELA R. LAMPITT**

**District 6 (Burlington and Camden)**

**Assemblywoman L. GRACE SPENCER**

**District 29 (Essex)**

**Co-Sponsored by:**

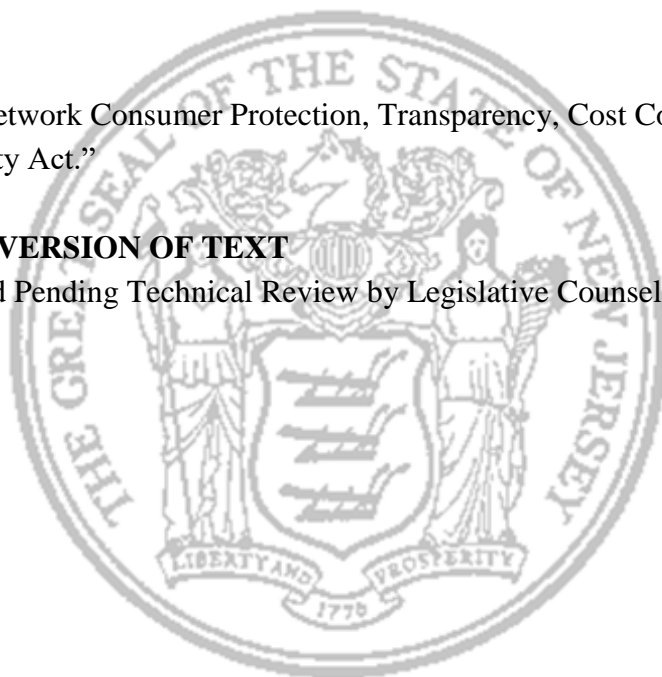
**Assemblymen Eustace, Giblin, Assemblywomen Jasey, Tucker,  
Assemblyman Caputo, Assemblywoman Oliver, Assemblyman Ciattarelli,  
Assemblywomen Vainieri Huttel, Caride and Assemblyman Danielsen**

**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: 5/27/2016)**

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

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

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

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

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

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

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

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

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

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

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

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

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

24 “Region” means a group of counties as follows:

- 25 (1) Essex, Hudson, and Union counties;
- 26 (2) Bergen and Passaic counties;
- 27 (3) Monmouth, Morris, Sussex, and Warren counties;
- 28 (4) Hunterdon, Middlesex, and Somerset counties;
- 29 (5) Burlington, Camden, and Mercer counties; and
- 30 (6) Atlantic, Cape May, Ocean, Salem, Cumberland, and  
31 Gloucester counties.

32  
33 4. a. Prior to scheduling an appointment with a covered person  
34 for a non-emergency or elective procedure and in terms the covered  
35 person typically understands, a health care facility shall:

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

39 (2) advise the covered person to check with the physician  
40 arranging the facility services to determine whether or not that  
41 physician is in-network or out-of-network with respect to the covered  
42 person’s health benefits plan;

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

45 (a) the covered person will have a financial responsibility  
46 applicable to an in-network procedure and not in excess of the covered  
47 person’s copayment, deductible, or coinsurance as provided in the  
48 covered person’s health benefits plan;

1 (b) unless the covered person, at the time of the disclosure required  
2 pursuant to this subsection, has knowingly, voluntarily, and  
3 specifically selected an out-of-network provider to provide services,  
4 the covered person will not incur any out-of-pocket costs in excess of  
5 the charges applicable to an in-network procedure; and  
6 (c) any bills, charges or attempts to collect by the facility, or any  
7 health care professional involved in the procedure, in excess of the  
8 covered person's copayment, deductible, or coinsurance as provided in  
9 the covered person's health benefits plan in violation of subparagraph  
10 (b) of this paragraph should be reported to the covered person's carrier  
11 and the relevant regulatory entity; and  
12 (4) advise the covered person that at a health care facility that is  
13 out-of-network with respect to the covered person's health benefits  
14 plan:  
15 (a) certain health care services will be provided on an out-of-  
16 network basis, including those health care services associated with the  
17 health care facility;  
18 (b) the covered person will have a financial responsibility  
19 applicable to health care services provided at an out-of-network  
20 facility, in excess of the covered person's copayment, deductible, or  
21 coinsurance, and the covered person may be responsible for any costs  
22 in excess of those allowed by their health benefits plan; and  
23 (c) that the covered person should contact the covered person's  
24 carrier for further consultation on those costs.  
25 b. In a form that is consistent with federal guidelines, a health  
26 care facility shall make available to the public a list of the facility's  
27 standard charges for items and services provided by the facility.  
28 c. A health care facility shall post on the facility's website:  
29 (1) the health benefits plans in which the facility is a participating  
30 provider;  
31 (2) a statement that:  
32 (a) physician services provided in the facility are not included in  
33 the facility's charges;  
34 (b) physicians who provide services in the facility may or may not  
35 participate with the same health benefits plans as the facility;  
36 (c) the covered person should check with the physician arranging  
37 for the facility services to determine the health benefits plans in which  
38 the physician participates; and  
39 (d) the covered person should contact their carrier for further  
40 consultation on those costs;  
41 (3) as applicable, the name, mailing address, and telephone  
42 number of the hospital-based physician groups that the facility has  
43 contracted with to provide services including, but not limited to,  
44 anesthesiology, pathology, and radiology; and  
45 (4) as applicable, the name, mailing address, and telephone  
46 number of physicians employed by the facility and whose services  
47 may be provided at the facility, and the health benefits plans in which  
48 they participate.

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

6 e. The Department of Health shall specify in further detail the  
7 content and design of the disclosure form and the manner in which the  
8 form shall be provided.

9

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

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

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

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

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

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

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

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

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

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

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

32

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

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

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

44 (2) examples of anticipated out-of-pocket costs for frequently  
45 billed out-of-network services;

46 (3) information in writing and through an internet website that  
47 reasonably permits a covered person or prospective covered person to  
48 calculate the anticipated out-of-pocket cost for out-of-network services

1 in a geographical region or zip code based upon the difference  
2 between the amount the carrier will reimburse for out-of-network  
3 services and the usual and customary cost of out-of-network services;

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

6 (5) the approximate dollar amount that the carrier will pay for a  
7 specific out-of-network service; and

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

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

24

25 7. a. If a covered person receives medically necessary services at  
26 any health care facility on an emergency or urgent basis, the facility  
27 shall not bill the covered person in excess of the lowest deductible,  
28 copayment, or coinsurance amount applicable to in-network services  
29 pursuant to the covered person's health benefits plan.

30 b. If a covered person receives medically necessary services at an  
31 out-of-network health care facility on an emergency or urgent basis,  
32 and the carrier and facility cannot agree on a reimbursement rate for  
33 these services within 30 days after the carrier is billed for the service,  
34 the carrier, health care facility, or covered person, as applicable, may  
35 initiate binding arbitration pursuant to section 10 or 11 of this act.

36 c. If a health care facility is in-network with respect to any health  
37 benefits plan, the facility shall ensure that all providers providing  
38 services in the facility on an emergency or urgent basis accept  
39 reimbursement rates in accordance with section 8 of this act.

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

43 (1) the health benefits plans with which the facility has an  
44 agreement to be in-network;

45 (2) the number of health care professionals, by specialty, that  
46 provide services in the facility and whether those professionals  
47 participate in the same health benefits networks as the facility; and



1 (3) if any health care professionals that provide services in the  
2 facility are not in-network with respect to any health benefits plan in  
3 which the facility is in-network, confirmation that the facility has an  
4 agreement in place for professionals providing services in the facility  
5 to otherwise comply with section 8 of this act.

6 e. This section shall only apply to entities providing or  
7 administering a self-funded health benefits plan and its plan members  
8 if the entity elects to be subject to section 9 of this act pursuant to  
9 subsection d. of that section.

10 f. The Department of Health shall make the information collected  
11 pursuant to subsection d. of this section available to the Department of  
12 Banking and Insurance.

13  
14 8. a. If a covered person receives inadvertent out-of-network  
15 services or medically necessary services at an in-network or out-of-  
16 network health care facility on an emergency or urgent basis, the  
17 health care professional performing those services shall:

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

21 (2) in the case of emergency and urgent services, not bill the  
22 covered person in excess of the lowest deductible, copayment, or  
23 coinsurance amount,  
24 applicable to in-network services pursuant to the covered person's  
25 health benefits plan.

26 b. If the carrier and the professional cannot agree on a  
27 reimbursement rate for the services provided pursuant to subsection a.  
28 of this section within 30 days after the carrier is billed for the service,  
29 the carrier, professional, or covered person, as applicable, may initiate  
30 binding arbitration pursuant to section 10 or 11 of this act.

31 c. This section shall only apply to entities providing or  
32 administering a self-funded health benefits plan and its plan members  
33 if the entity elects to be subject to section 9 of this act pursuant to  
34 subsection d. of that section.

35  
36 9. Notwithstanding any law, rule, or regulation to the contrary:

37 a. With respect to a carrier, if a covered person receives  
38 inadvertent out-of-network services, or services at an in-network or  
39 out-of-network health care facility on an emergency or urgent basis,  
40 the carrier shall ensure that the covered person incurs no greater out-  
41 of-pocket costs than the covered person would have incurred with an  
42 in-network health care provider for covered services. Pursuant to  
43 sections 7 and 8 of this act, the out-of-network provider shall not bill  
44 the covered person, except for applicable deductible, copayment, or  
45 coinsurance amounts that would apply if the covered person utilized an  
46 in-network health care provider for the covered services.

47 b. (1) With respect to inadvertent out-of-network services, or  
48 services at an in-network or out-of-network health care facility on an

1 emergency or urgent basis, benefits provided by a carrier that the  
2 covered person receives for health care services shall be assigned to  
3 the out-of-network health care provider, which shall require no action  
4 on the part of the covered person. Once the benefit is assigned as  
5 provided in this subsection:

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

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

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

16 c. If inadvertent out-of-network services or services provided at  
17 an in-network or out-of-network health care facility on an emergency  
18 or urgent basis are performed in accordance with subsection a. of this  
19 section, the out-of-network provider may bill the carrier for the  
20 services rendered. The carrier may pay the billed amount or attempt to  
21 negotiate reimbursement with the out-of-network health care provider.

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

33  
34 10. a. If attempts to negotiate reimbursement for services  
35 provided by an out-of-network health care provider, pursuant to  
36 subsection c. of section 9 of this act, do not result in a resolution of the  
37 payment dispute within 30 days after the carrier is billed for the  
38 services by the out-of-network health care provider, and the difference  
39 between the carrier's and the provider's final offers is not less than  
40 \$1000, the carrier or out-of-network health care provider may initiate  
41 binding arbitration to determine payment for the services.

42 b. The binding arbitration shall adhere to the following  
43 requirements:

44 (1) The party requesting arbitration shall notify the other party that  
45 arbitration has been initiated and state its final offer before arbitration.  
46 In response to this notice, the nonrequesting party shall inform the  
47 requesting party of its final offer before the arbitration occurs;

1 (2) Arbitration shall be initiated by filing a request with the  
2 department. Upon initiation of arbitration, the department shall notify  
3 the parties that they have 15 days to initiate peer review pursuant to  
4 subsection e. of this section;

5 (3) The department shall contract, through the request for proposal  
6 process, every three years, with one or more entities that have  
7 experience in health care pricing arbitration. The arbitrators shall be  
8 American Arbitration Association certified arbitrators. The department  
9 may initially utilize the entity engaged under the “Health Claims  
10 Authorization, Processing, and Payment Act,” P.L.2005, c.352  
11 (C.17B:30-48 et seq.), for arbitration under this act; however, after a  
12 period of one year from the effective date of this act, the selection of  
13 the arbitration entity shall be through the Request for Proposal process.  
14 Claims that are subject to arbitration pursuant to the provisions of this  
15 act, which previously would be subject to arbitration pursuant to the  
16 “Health Claims Authorization, Processing, and Payment Act,” shall  
17 instead be subject to this act;

18 (4) In the case of fees for services provided by an out-of-network  
19 physician, the arbitration process may include submission of the  
20 disputed charge to a peer review panel pursuant to subsection e. of this  
21 section;

22 (5) The arbitration shall consist of a review of the written  
23 submissions by both parties, which shall include the final offer for the  
24 payment by the carrier for the out-of-network health care provider’s  
25 fee, and the final offer by the out-of-network provider for the fee the  
26 provider will accept as payment from the carrier; and

27 (6) The arbitrator’s decision shall be one of the two amounts  
28 submitted by the parties as their final offers and shall be binding on  
29 both parties. The decision of the arbitrator shall include written  
30 findings and shall be issued within 45 days after the request is filed  
31 with the department. The arbitrator’s expenses and fees shall be split  
32 equally among the parties. Each party shall be responsible for its own  
33 costs and fees, including legal fees if any.

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

36 (1) the level of training, education, and experience of the health  
37 care professional;

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

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

43 (4) individual patient characteristics;

44 (5) as certified by an independent actuary:

45 (a) the average in-network amount paid for the service by that  
46 carrier;

47 (b) the average amount paid for that service to other out-of-  
48 network providers by that carrier; and

1 (c) the average reimbursement accepted by the provider from that  
2 carrier for the service in the past 12 months;

3 (6) (a) the Medicare rate paid in the same region to the same type  
4 of health care provider for the same classification of health care  
5 facility in which the service took place; and

6 (b) the billed amount for the same type of procedure as reported by  
7 a New Jersey public entity that establishes or sponsors a health care  
8 claims data base for all geographical areas of the State; or a non-profit  
9 or for-profit commercially available usual, customary and reasonable  
10 fee schedule data base provider. No such data base provider shall have  
11 an ownership or controlling interest in, or be an affiliate of any entity  
12 with a pecuniary interest in the application of the database including  
13 an insurer, healthcare provider, arbitrator, holding company of an  
14 insurer, health care provider, or trade association in the field of  
15 insurance, health benefits or provider of healthcare; and

16 (7) if either party initiated a peer review pursuant to subsection e.  
17 of this section, the determination of the peer review panel.

18 d. (1) The amount awarded by the arbitrator shall be paid within  
19 20 days of the arbitrator's decision as provided in subsection b. of this  
20 section.

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

30 e. Upon the initiation of arbitration by either party, in situations  
31 in which one party is an out-of-network physician, either party may  
32 elect, within 15 days of the notice required pursuant to paragraph (1)  
33 of subsection b. of this section, to submit the disputed charge to a peer  
34 review panel. The Board of Medical Examiners, in consultation with  
35 members of the profession, shall oversee and arrange for appropriate,  
36 qualified panels comprised of licensed physicians who are board  
37 certified in the same specialty as the billing physician. The physician  
38 and the carrier may each select one physician to comprise the panel to  
39 review the disputed charge. Within 15 days of the request for peer  
40 review, the panel shall review materials submitted by both parties and  
41 issue to both parties a non-binding guidance memorandum as to the  
42 appropriate range of fees to be paid to the provider for the billed  
43 service. The parties shall split equally the cost of the physicians  
44 selected to conduct the peer review, not to exceed \$500.

45 f. This section shall apply only if the covered person complies  
46 with any applicable preauthorization or review requirements of the  
47 health benefits plan regarding the determination of medical necessity  
48 to access in-network inpatient or outpatient benefits.

1 g. This section shall not apply to a covered person who  
2 knowingly, voluntarily, and specifically selected an out-of-network  
3 provider for health care services.

4 h. In the event an entity providing or administering a self-funded  
5 health benefits plan elects to be subject to the provisions of section 9  
6 of this act, as provided in subsection d. of that section, the provisions  
7 of this section shall apply to a self-funded plan in the same manner as  
8 the provisions of this section apply to a carrier. If a self-funded plan  
9 does not elect to be subject to the provision of section 9 of this act, a  
10 member of that plan may initiate binding arbitration as provided in  
11 section 11 of this act.

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

25 b. The binding arbitration shall adhere to the following  
26 requirements:

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

31 (2) The arbitrator with which the department contracts pursuant to  
32 section 10 of this act shall conduct the arbitration pursuant to this  
33 section;

34 (3) The arbitrator shall consider information supplied by both  
35 parties; and

36 (4) The arbitrator's decision shall include written findings,  
37 including a final binding amount that the arbitrator determines is  
38 reasonable for the service, which shall include a non-binding  
39 recommendation to the entity providing or administering the self-  
40 funded health benefits plan of an amount that would be reasonable for  
41 the entity to contribute to payment for the service, and shall be issued  
42 within 45 days after the request is filed with the department.

43 c. When the arbitrator's decision indicates that the provider's  
44 requested fee is reasonable, payment for the cost of arbitration shall be  
45 the responsibility of the plan member, unless the payment would pose  
46 a financial hardship to the plan member, in which case the department  
47 shall establish an agreement with the arbitrator to waive any part or all  
48 of the cost of arbitration. When the arbitrator determines that the

1 provider's requested fee is unreasonable, payment for the cost of the  
2 arbitration shall be the responsibility of the provider.

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

5 (1) the level of training, education, and experience of the health  
6 care professional;

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

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

12 (4) individual patient characteristics;

13 (5) as certified by an independent actuary:

14 (a) the average in-network amount paid for the service by that self-  
15 funded plan;

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

18 (c) the average reimbursement accepted by the provider from that  
19 self-funded plan for the service in the past 12 months;

20 (6) (a) the Medicare rate paid in the same region to the same type  
21 of health care provider for the same classification of health care  
22 facility in which the service took place;

23 (b) the billed amount for the same type of procedure as reported by  
24 a New Jersey public entity that establishes or sponsors a health care  
25 claims data base for all geographical areas of the State; or a non-profit  
26 or for-profit commercially available usual, customary and reasonable  
27 fee schedule data base provider. No such data base provider shall have  
28 an ownership or controlling interest in, or be an affiliate of any entity  
29 with a pecuniary interest in the application of the database including  
30 an insurer, healthcare provider, arbitrator, holding company of an  
31 insurer, health care provider, or trade association in the field of  
32 insurance, health benefits or provider of healthcare; and

33 (7) the out-of-network benefit design of the member's health plan  
34 and the amount the entity providing or administering the self-funded  
35 health benefits plan contributes, if anything, to the cost of the service.

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

39

40 12. On or before January 31 of each calendar year, the  
41 commissioner shall consult with the Department of the Treasury, the  
42 relevant professional and occupational licensing boards within the  
43 Division of Consumer Affairs in the Department of Law and Public  
44 Safety, and the Department of Health, to obtain information to compile  
45 and make publicly available, on the department's website:

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

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

1 report and file complaints with the department or the appropriate  
2 regulatory agency relating to any out-of-network charges, and  
3 information and guidance for consumers regarding arbitrations filed  
4 pursuant to section 11 of this act.

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

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

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

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

43  
44 17. a. A person or entity that violates any provision of this act, or  
45 the rules and regulations adopted pursuant hereto, shall be liable to a  
46 penalty as provided in this subsection. The penalty shall be collected  
47 by the commissioner in the name of the State in a summary proceeding



1 in accordance with the "Penalty Enforcement Law of 1999," P.L.1999,  
2 c.274 (C.2A:58-10 et seq.).

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

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

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

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

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

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

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

34  
35 19. The provisions of this act shall be severable, and if any  
36 provision of this act shall be held invalid, or held invalid with respect  
37 to any particular health benefits plan or carrier, such invalidity shall  
38 not affect the other provisions hereof, or application of those  
39 provisions to other health benefits plans or carriers.

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

46  
47 21. This act shall take effect on July 1, 2016. The  
48 Commissioner of Banking and Insurance, the Department of Health

1 and any relevant licensing board may take such anticipatory  
2 administrative action in advance thereof as shall be necessary for  
3 the implementation of this act.

4  
5  
6 STATEMENT

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

16  
17 DISCLOSURE

18  
19 The bill places certain responsibilities on health care facilities  
20 and health care professionals to notify patients about services that  
21 they will provide. The bill uses the term “health care provider” to  
22 include both facilities and professionals.

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

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

30 (2) advise the covered person to check with the physician  
31 arranging the facility services to determine whether or not that  
32 physician is in-network or out-of-network with respect to the  
33 covered person’s health benefits plan;

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

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

46 In addition, in a form that is consistent with federal guidelines, a  
47 health care facility is required to establish, update, and make public

1 through posting on the facility's website a list of the facility's  
2 standard charges for items and services provided by the facility.

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

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

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

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

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

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

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

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

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

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

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

44 A health care professional who is a physician is also required to  
45 make certain notifications concerning health care providers  
46 scheduled to perform anesthesiology, laboratory, pathology,  
47 radiology, or assistant surgeon services in connection with care to  
48 be provided in the physician's office or whose services will be

1 arranged by the physician and are scheduled at the time of the pre-  
2 admission, testing, registration, or admission. The physician shall  
3 provide instructions or information as to how to determine the  
4 health benefits plans in which the health care provider participates  
5 and recommend that the covered person should contact the covered  
6 person's carrier for further consultation on costs associated with  
7 these services.

8 A health care professional who is a physician shall, for a covered  
9 person's scheduled facility admission or scheduled outpatient  
10 facility services, provide the covered person and the facility with  
11 certain information about other physicians whose services will be  
12 arranged.

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

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

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

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

35 (2) examples of anticipated out-of-pocket costs for frequently  
36 billed out-of-network services;

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

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

47 (5) the approximate dollar amount that the carrier will pay for a  
48 specific out-of-network service; and

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.

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

#### 18 19 OUT-OF-NETWORK BILLING

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

35 The bill protects a covered person receiving medically necessary  
36 services at any health care facility on an emergency or urgent basis  
37 by prohibiting the provider from billing the covered person in  
38 excess of the lowest deductible, copayment, or coinsurance amount  
39 applicable to in-network services pursuant to the covered person's  
40 health benefits plan. So, for example, in the case of health benefits  
41 plans with a tiered network, in these situations the provider is only  
42 permitted to bill the covered person at the tier 1 cost sharing  
43 amount.

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

1 The bill also requires health care facilities that are in-network  
2 with respect to any health benefits plan to ensure that all providers  
3 providing services in the facility on an emergency or urgent basis  
4 accept reimbursement rates in accordance with the bill's provisions  
5 and to report certain information to the Department of Health.

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

11 (1) in the case of inadvertent out-of-network services, not bill  
12 the 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 the lowest deductible, copayment, or  
16 coinsurance amount,  
17 applicable to in-network services pursuant to the covered person's  
18 health benefits plan.

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

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

31

32 ARBITRATION

33

34 For certain emergency and out-of-network billing situations  
35 between providers and carriers, the bill establishes an arbitration  
36 system. The arbitration system, as it pertains to health care  
37 providers, includes an optional non-binding peer-review process. In  
38 addition, as it relates to self-funded health plans that do not elect to  
39 be subject to arbitration under the bill, the bill provides for  
40 arbitration between the self-funded plan member and the out-of-  
41 network provider if attempts to negotiate reimbursement for  
42 services do not result in a resolution of the payment dispute.

43 The bill provides that, in the event that a covered person receives  
44 inadvertent out-of-network services or services at an in-network or  
45 out-of-network health care facility on an emergency or urgent basis,  
46 the carrier, or self-funded plan that opts into the section, shall  
47 ensure that the covered person incurs no greater out-of-pocket costs  
48 than the covered person would have incurred with an in-network

1 health care provider for covered services. The out-of-network  
2 provider is prohibited from billing the covered person, except for  
3 applicable deductible, copayment, or coinsurance amounts that  
4 would apply if the covered person utilized an in-network health care  
5 provider for the covered services. In these situations, the benefits  
6 that the covered person receives for health care services shall be  
7 assigned to the out-of-network health care provider, which requires  
8 no action on the part of the covered person. Once the benefits are  
9 assigned:

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

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

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

24 If attempts to negotiate reimbursement for services provided by  
25 an out-of-network health care provider do not result in a resolution  
26 of the payment dispute within 30 days after the carrier is billed for  
27 the services by the out-of-network health care provider, the carrier,  
28 or self-funded plan that opts in, or out-of-network health care  
29 provider may initiate binding arbitration to determine payment for  
30 the services if the difference between the carrier's or self-funded  
31 plan's final offer and the provider's final offer is not less than  
32 \$1,000.

33 The binding arbitration system established under the bill  
34 provides that the party requesting arbitration shall notify the other  
35 party that arbitration has been initiated and state its final offer  
36 before arbitration. In response to this notice, the nonrequesting  
37 party shall inform the requesting party of its final offer before the  
38 arbitration occurs.

39 Arbitration shall be initiated by filing a request with the  
40 department. Upon initiation, the department shall notify the parties  
41 that they have 15 days to initiate the peer review process provided  
42 by the bill in situations in which one party is an out-of-network  
43 physician. The arbitrators selected by the department shall be one or  
44 more entities that have experience in health care pricing arbitration  
45 and must be certified by the American Arbitration Association.

46 The arbitrator's decision shall be one of the two amounts  
47 submitted by the parties as their final offers and shall be binding on  
48 both parties. The arbitrator's expenses and fees shall be split

1 equally among the parties. Each party shall be responsible for its  
2 own costs and fees.

3 In making a determination, the arbitrator is to consider:

4 (1) the level of training, education, and experience of the health  
5 care professional;

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

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

11 (4) individual patient characteristics;

12 (5) as certified by an independent actuary: (a) the average in-  
13 network amount paid for the service by that carrier: (b) the average  
14 amount paid for that service to other out-of-network providers by  
15 that carrier: and (c) the average reimbursement accepted by the  
16 provider from that carrier for the service in the past 12 months; and

17 (6) (a) the Medicare rate paid in the same region to the same type  
18 of health care provider for the same classification of health care  
19 facility in which the service took place; and (b) the billed amount  
20 for the same type of procedure as reported by a New Jersey public  
21 entity that establishes or sponsors a health care claims data base for  
22 all geographical areas of the State; or a non-profit or for-profit  
23 commercially available usual, customary and reasonable fee  
24 schedule data base provider. No such data base provider shall have  
25 an ownership or controlling interest in, or be an affiliate of any  
26 entity with a pecuniary interest in the application of the database  
27 including an insurer, health care provider, arbitrator, holding  
28 company of an insurer, health care provider, or trade association in  
29 the field of insurance, health benefits or provider of healthcare; and

30 (7) if either party initiated a peer review, the determination of the  
31 peer review panel.

32 The amount awarded by the arbitrator shall be paid within 20  
33 days of the arbitrator's decision, and interest shall not accrue until  
34 after 20 days following the decision.

35 Upon the initiation of arbitration by either party, in situations in  
36 which one party is an out-of-network physician, either party may  
37 elect, within 15 days of the notice of arbitration, to submit the  
38 disputed charge to a peer review panel. The Board of Medical  
39 Examiners, in consultation with members of the profession, shall  
40 oversee and arrange for appropriate, qualified panels comprised of  
41 licensed physicians who are board certified in the same specialty as  
42 the billing physician. Within 15 days of the request for peer review,  
43 the panel shall issue a non-binding guidance memorandum as to the  
44 range of fees to be paid to the provider for the billed service. The  
45 parties shall split equally the cost of the physicians selected to  
46 conduct the peer review, not to exceed \$500.



1 Arbitration is not available in the case of a covered person who  
2 willfully selected to access an out-of-network health care provider  
3 for health care services.  
4

5 ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-  
6 OF-NETWORK PROVIDER  
7

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

18 The arbitrator is required to consider information supplied by  
19 both parties and issue written findings, including a final binding  
20 amount that the arbitrator determines is reasonable for the service,  
21 which shall include a non-binding recommendation to the entity  
22 providing or administering the self-funded health benefits plan of  
23 an amount that would be reasonable for the entity to contribute to  
24 payment for the service. This decision must be issued within 45  
25 days after the request for arbitration is filed with the department.

26 When the arbitrator's decision indicates that the provider's  
27 requested fee is reasonable, payment for the cost of arbitration is  
28 the responsibility of the plan member, unless the payment would  
29 pose a financial hardship to the plan member, in which case the  
30 department is directed to establish an agreement with the arbitrator  
31 to waive any part or all of the cost of arbitration. When the  
32 arbitrator determines that the provider's requested fee is  
33 unreasonable, payment for the cost of the arbitration shall be the  
34 responsibility of the provider.

35 In making a determination, the arbitrator must consider certain  
36 information as indicated in the bill.  
37

38 INCREASED TRANSPARENCY  
39

40 The bill also provides that on or before January 31 of each  
41 calendar year, the commissioner shall consult with the Board of  
42 Medical Examiners and the Department of Health to obtain  
43 information to compile and make publicly available certain  
44 information, on the department's website, including a list of all  
45 arbitrations filed, and an indication of whether the decision was in  
46 favor of the carrier or the out-of-network health care provider.

47 The bill provides that a carrier shall provide a written notice to  
48 each covered person of the protections provided to covered persons

1 pursuant to the bill. The notice shall include information on how a  
2 consumer can contact the department or the appropriate regulatory  
3 agency to report and dispute an out-of-network charge. The notice  
4 shall be posted on the carrier's website.

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

10

11 PROVIDER NETWORK AUDIT

12

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

26

27 WAIVER OF COST SHARING

28

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

1 PENALTIES

2

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

8 (1) in the case of a carrier, initiate such action as the  
9 commissioner 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  
14 the appropriate professional and occupational licensing board  
15 within the Division of Consumer Affairs in the Department of Law  
16 and Public Safety for such action as that board determines  
17 appropriate.

18 Finally, the effective date of the bill is July 1, 2016.