

[Second Reprint]

**ASSEMBLY, No. 1952**

**STATE OF NEW JERSEY**  
**217th LEGISLATURE**

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)**

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**District 6 (Burlington and Camden)**

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**SYNOPSIS**

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

**CURRENT VERSION OF TEXT**

As reported by the Assembly Appropriations Committee on October 27, 2016, with amendments.

**(Sponsorship Updated As Of: 12/16/2016)**

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

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

<sup>1</sup>Assembly AFI committee amendments adopted June 20, 2016.

<sup>2</sup>Assembly AAP committee amendments adopted October 27, 2016.

1 financial stress on safety net hospitals, deteriorating morale among  
2 providers and reduced quality of care for consumers;

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

7

8 3. As used in this act:

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

21 “Commissioner” means the Commissioner of Banking and  
22 Insurance.

23 “Covered person” means a person on whose behalf a carrier is  
24 obligated to pay health care expense benefits or provide health care  
25 services.

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

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

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

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

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

4 “Health care provider” or “provider” means a health care  
5 professional or health care facility.

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

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

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

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

29 <sup>1</sup>“Physician” means a person licensed to practice medicine and  
30 surgery pursuant to chapter 9 of Title 45 of the Revised Statutes and  
31 shall include a person licensed as an optometrist pursuant to R.S.  
32 45:12-1 et seq.<sup>1</sup>

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

- 34 (1) Essex, Hudson, and Union counties;  
35 (2) Bergen and Passaic counties;  
36 (3) Monmouth, Morris, Sussex, and Warren counties;  
37 (4) Hunterdon, Middlesex, and Somerset counties;  
38 (5) Burlington, Camden, and Mercer counties; and  
39 (6) Atlantic, Cape May, Ocean, Salem, Cumberland, and  
40 Gloucester counties.

41

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

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

1 (2) advise the covered person to check with the physician  
2 arranging the facility services to determine whether or not that  
3 physician is in-network or out-of-network with respect to the  
4 covered person's health benefits plan 'and provide information  
5 about how to determine the health plans participated in by any  
6 physician who is reasonably anticipated to provide services to the  
7 covered person<sup>1</sup>;

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

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

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

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

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

28 (a) certain health care services will be provided on an out-of-  
29 network basis, including those health care services associated with  
30 the health care facility;

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

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

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

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

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

44 (2) a statement that:

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

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

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

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

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

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

14 d. If, between the time the notice required pursuant to  
15 subsection a. of this section is provided to the covered person and  
16 the time the procedure takes place, the network status of the facility  
17 changes as it relates to the covered person's health benefits plan,  
18 the facility shall notify the covered person promptly.

19 e. The Department of Health shall specify in further detail the  
20 content and design of the disclosure form and the manner in which  
21 the form shall be provided.

22

23 5. a. Except as provided in subsection f. of this section, a health  
24 care professional shall disclose to a covered person in writing or  
25 through an internet website the health benefits plans in which the  
26 health care professional is a participating provider and the facilities  
27 with which the health care professional is affiliated prior to the  
28 provision of non-emergency services, and verbally or in writing, at the  
29 time of an appointment. If a health care professional does not  
30 participate in the network of the covered person's health benefits plan,  
31 the health care professional shall, in terms the covered person typically  
32 understands:

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

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

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

- 1 (4) Inform the covered person to contact the covered person's  
2 carrier for further consultation on those costs.
- 3 b. A health care professional who is a physician shall provide the  
4 covered person, to the extent the information is available, with the  
5 name, practice name, mailing address, and telephone number of any  
6 health care provider scheduled to perform anesthesiology, laboratory,  
7 pathology, radiology, or assistant surgeon services in connection with  
8 care to be provided in the physician's office for the covered person or  
9 coordinated or referred by the physician for the covered person at the  
10 time of referral to, or coordination of, services with that provider. The  
11 physician shall provide instructions as to how to determine the health  
12 benefits plans in which the health care provider participates and  
13 recommend that the covered person should contact the covered  
14 person's carrier for further consultation on costs associated with these  
15 services.
- 16 c. A health care professional who is a physician shall, for a  
17 covered person's scheduled facility admission or scheduled outpatient  
18 facility services, provide the covered person and the facility with the  
19 name, practice name, mailing address, and telephone number of any  
20 other physician whose services will be arranged by the physician and  
21 are scheduled at the time of the pre-admission, testing, registration, or  
22 admission at the time the non-emergency services are scheduled, and  
23 information as to how to determine the health benefits plans in which  
24 the physician participates, and recommend that the covered person  
25 should contact the covered person's carrier for further consultation on  
26 costs associated with these services.
- 27 d. The receipt or acknowledgement by any covered person of any  
28 disclosure required pursuant to this section shall not waive or  
29 otherwise affect any protection under existing statutes or regulations  
30 regarding in-network health benefits plan coverage available to the  
31 covered person or created under this act.
- 32 e. If, between the time the notice required pursuant to subsection  
33 a. of this section is provided to the covered person and the time the  
34 procedure takes place, the network status of the professional changes  
35 as it relates to the covered person's health benefits plan, the  
36 professional shall notify the covered person promptly.
- 37 f. In the case of a primary care physician or internist performing  
38 an unscheduled procedure in that provider's office, the notice required  
39 pursuant this section may be made verbally at the time of the service.
- 40 g. The appropriate professional or occupational licensing board  
41 within the Division of Consumer Affairs in the Department of Law  
42 and Public Safety shall specify in further detail the content and design  
43 of the disclosure form and the manner in which the form shall be  
44 provided.
- 45
- 46 6. a. A carrier shall update the carrier's website within 20 days  
47 of the addition or termination of a provider from the insurer's  
48 network or a change in a physician's affiliation with a facility,

1 provided that in the case of a change in affiliation the carrier has  
2 had notice of such change.

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

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

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

11 (3)<sup>1</sup> examples of anticipated out-of-pocket costs for frequently  
12 billed out-of-network services;

13 ~~[(3)]~~ (4)<sup>1</sup> information in writing and through an internet  
14 website that reasonably permits a covered person or prospective  
15 covered person to calculate the anticipated out-of-pocket cost for  
16 out-of-network services in a geographical region or zip code based  
17 upon the difference between the amount the carrier will reimburse  
18 for out-of-network services and the usual and customary cost of  
19 out-of-network services;

20 ~~[(4)]~~ (5)<sup>1</sup> information in response to a covered person's  
21 request, concerning whether a health care provider is an in-network  
22 provider;

23 ~~[(5)]~~ (6)<sup>1</sup> the approximate dollar amount that the carrier will  
24 pay for a specific out-of-network service; ~~[and]~~<sup>1</sup>

25 ~~[(6)]~~ (7)<sup>1</sup> such other information as the commissioner  
26 determines appropriate and necessary to ensure that a covered  
27 person receives sufficient information necessary to estimate their  
28 out-of-pocket cost for an out-of-network service and make a well-  
29 informed health care decision<sup>1</sup>; and

30 (8) access to a telephone hotline that shall be operated no less  
31 than 16 hours per day for consumers to call with questions about  
32 network status and out-of-pocket costs<sup>1</sup>.

33 c. If a carrier authorizes a covered health care service to be  
34 performed by an in-network health care provider with respect to any  
35 health benefits plan, and the provider or facility status changes to  
36 out-of-network before the authorized service is performed, the  
37 carrier shall notify the covered person that the provider or facility is  
38 no longer in-network as soon as practicable. If the carrier fails to  
39 provide the notice at least 30 days prior to the authorized service  
40 being performed, the covered person's financial responsibility shall  
41 be limited to the financial responsibility the covered person would  
42 have incurred had the provider been in-network with respect to the  
43 covered person's health benefits plan.

44

45 7. a. If a covered person receives medically necessary services  
46 at any health care facility on an emergency or urgent basis, the  
47 facility shall not bill the covered person in excess of ~~the lowest~~<sup>1</sup>



1 any<sup>1</sup> deductible, copayment, or coinsurance amount applicable to  
2 in-network services pursuant to the covered person's health benefits  
3 plan.

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

11 c. If a health care facility is in-network with respect to any  
12 health benefits plan, the facility shall ensure that <sup>1</sup>:

13 (1)<sup>1</sup> all providers providing services in the facility on an  
14 emergency or urgent basis accept reimbursement rates in  
15 accordance with section 8 of this act <sup>1</sup>; and

16 (2) all health care professionals that are contracted with the  
17 facility to perform services in the facility are also in-network with  
18 respect to all health benefits plans with which the facility is in-  
19 network<sup>1</sup>.

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

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

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

28 (3) if any health care professionals that provide services in the  
29 facility are not in-network with respect to any health benefits plan  
30 in which the facility is in-network, confirmation that the facility has  
31 an agreement in place for professionals providing services in the  
32 facility to otherwise comply with section 8 of this act <sup>1</sup>, and if any  
33 professionals are contracted with the facility to perform services in  
34 the facility, confirmation that those professionals are in-network  
35 with the same health benefits plan networks as the facility as  
36 provided in paragraph (2) of subsection c. of this section<sup>1</sup>.

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

41 f. The Department of Health shall make the information  
42 collected pursuant to subsection d. of this section available to the  
43 Department of Banking and Insurance.

44  
45 8. a. If a covered person receives inadvertent out-of-network  
46 services or medically necessary services at an in-network or out-of-

1 network health care facility on an emergency or urgent basis, the  
2 health care professional performing those services shall:

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

6 (2) in the case of emergency and urgent services, not bill the  
7 covered person in excess of <sup>1</sup>【the lowest】 any<sup>1</sup> deductible,  
8 copayment, or coinsurance amount,  
9 applicable to in-network services pursuant to the covered person's  
10 health benefits plan.

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

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

21

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

23 a. With respect to a carrier, if a covered person receives  
24 inadvertent out-of-network services, or services at an in-network or  
25 out-of-network health care facility on an emergency or urgent basis,  
26 the carrier shall ensure that the covered person incurs no greater out-  
27 of-pocket costs than the covered person would have incurred with an  
28 in-network health care provider for covered services. Pursuant to  
29 sections 7 and 8 of this act, the out-of-network provider shall not bill  
30 the covered person, except for applicable deductible, copayment, or  
31 coinsurance amounts that would apply if the covered person utilized an  
32 in-network health care provider for the covered services.

33 b. (1) With respect to inadvertent out-of-network services, or  
34 services at an in-network or out-of-network health care facility on an  
35 emergency or urgent basis, benefits provided by a carrier that the  
36 covered person receives for health care services shall be assigned to  
37 the out-of-network health care provider, which shall require no action  
38 on the part of the covered person. Once the benefit is assigned as  
39 provided in this subsection:

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

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

46 (2) An entity providing or administering a self-funded health  
47 benefits plan that elects to participate in this section pursuant to

1 subsection d. of this section, shall comply with the provisions of  
2 paragraph (1) of this subsection.

3 c. If inadvertent out-of-network services or services provided at  
4 an in-network or out-of-network health care facility on an emergency  
5 or urgent basis are performed in accordance with subsection a. of this  
6 section, the out-of-network provider may bill the carrier for the  
7 services rendered. The carrier may pay the billed amount or attempt to  
8 negotiate reimbursement with the out-of-network health care provider.

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

20  
21 10. a. If attempts to negotiate reimbursement for <sup>1</sup>medically  
22 necessary inadvertent out-of-network<sup>1</sup> services provided by an out-  
23 of-network health care provider <sup>1</sup>or services provided at an in-  
24 network or out-of-network facility on an emergency or urgent  
25 basis<sup>1</sup>, pursuant to subsection c. of section 9 of this act, do not  
26 result in a resolution of the payment dispute within 30 days after the  
27 carrier is billed for the services by the out-of-network health care  
28 provider, and the difference between the carrier's and the provider's  
29 final offers is not less than \$1000, the carrier or out-of-network  
30 health care provider may initiate binding arbitration to determine  
31 payment for the services.

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

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

39 (2) Arbitration shall be initiated by filing a request with the  
40 department <sup>1</sup>. Upon initiation of arbitration, the department shall  
41 notify the parties that they have 15 days to initiate peer review  
42 pursuant to subsection e. of this section<sup>1</sup>;

43 (3) The department shall contract, through the request for  
44 proposal process, every three years, with one or more entities that  
45 have experience in health care pricing arbitration. The arbitrators  
46 shall be American Arbitration Association certified arbitrators. The  
47 department may initially utilize the entity engaged under the

1 “Health Claims Authorization, Processing, and Payment Act,”  
2 P.L.2005, c.352 (C.17B:30-48 et seq.), for arbitration under this act;  
3 however, after a period of one year from the effective date of this  
4 act, the selection of the arbitration entity shall be through the  
5 Request for Proposal process. Claims that are subject to arbitration  
6 pursuant to the provisions of this act, which previously would be  
7 subject to arbitration pursuant to the “Health Claims Authorization,  
8 Processing, and Payment Act,” shall instead be subject to this act;

9 <sup>1</sup>[(4) In the case of fees for services provided by an out-of-  
10 network physician, the arbitration process may include submission  
11 of the disputed charge to a peer review panel pursuant to subsection  
12 e. of this section;

13 (5) [(4)]<sup>1</sup> The arbitration shall consist of a review of the written  
14 submissions by both parties <sup>1</sup>[], which shall include the final offer  
15 for the payment by the carrier for the out-of-network health care  
16 provider’s fee, and the final offer by the out-of-network provider  
17 for the fee the provider will accept as payment from the carrier];<sup>1</sup>  
18 and

19 <sup>1</sup>[(6) (5)]<sup>1</sup> The arbitrator’s decision shall be <sup>1</sup>[one of the two  
20 amounts submitted by the parties as their final offers and shall be]  
21 binding on both parties and shall be a fixed amount that is within a  
22 range of <sup>2</sup>[90%] 100%<sup>2</sup> to <sup>2</sup>[200%] 250%<sup>2</sup> of the applicable  
23 payment rate under the federal Medicare program for that service<sup>1</sup>.  
24 The decision of the arbitrator shall include written findings and  
25 shall be issued within 45 days after the request is filed with the  
26 department. The arbitrator’s expenses and fees shall be split  
27 equally among the parties. Each party shall be responsible for its  
28 own costs and fees, including legal fees if any.

29 c. <sup>1</sup>[In making a determination pursuant to subsection b. of this  
30 section, the arbitrator shall consider:

31 (1) the level of training, education, and experience of the health  
32 care professional;

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

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

38 (4) individual patient characteristics;

39 (5) as certified by an independent actuary:

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

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

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

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

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

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

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

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

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

45 f. <sup>1</sup> d. <sup>1</sup> This section shall apply only if the covered person  
46 complies with any applicable preauthorization or review  
47 requirements of the health benefits plan regarding the determination

1 of medical necessity to access in-network inpatient or outpatient  
2 benefits.

3 **1[g.] e.**<sup>1</sup> This section shall not apply to a covered person who  
4 knowingly, voluntarily, and specifically selected an out-of-network  
5 provider for health care services.

6 **1[h.] f.**<sup>1</sup> In the event an entity providing or administering a  
7 self-funded health benefits plan elects to be subject to the  
8 provisions of section 9 of this act, as provided in subsection d. of  
9 that section, the provisions of this section shall apply to a self-  
10 funded plan in the same manner as the provisions of this section  
11 apply to a carrier. If a self-funded plan does not elect to be subject  
12 to the provision of section 9 of this act, a member of that plan may  
13 initiate binding arbitration as provided in section 11 of this act.

14

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

28 b. The binding arbitration shall adhere to the following  
29 requirements:

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

34 (2) The arbitrator with which the department contracts pursuant  
35 to section 10 of this act shall conduct the arbitration pursuant to this  
36 section;

37 (3) The arbitrator shall consider information supplied by both  
38 parties; and

39 (4) <sup>1</sup>The arbitrator's decision shall be a fixed amount within a  
40 range of <sup>2</sup>[90%] 100%<sup>2</sup> to <sup>2</sup>[200%] 250%<sup>2</sup> of the applicable  
41 payment rate under the federal Medicare program for that service.<sup>1</sup>

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

1 days after the request is filed with the department. <sup>1</sup>The arbitrator's  
2 expenses and fees shall be split equally among the parties. Each  
3 party shall be responsible for its own costs and fees, including legal  
4 fees if any.<sup>1</sup>

5 c. <sup>1</sup>When the arbitrator's decision indicates that the provider's  
6 requested fee is reasonable, payment for the cost of arbitration shall  
7 be the responsibility of the plan member, unless the payment would  
8 pose a financial hardship to the plan member, in which case the  
9 department shall establish an agreement with the arbitrator to waive  
10 any part or all of the cost of arbitration. When the arbitrator  
11 determines that the provider's requested fee is unreasonable,  
12 payment for the cost of the arbitration shall be the responsibility of  
13 the provider.

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

16 (1) the level of training, education, and experience of the health  
17 care professional;

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

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

23 (4) individual patient characteristics;

24 (5) as certified by an independent actuary:

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

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

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

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

34 (b) the billed amount for the same type of procedure as reported  
35 by a New Jersey public entity that establishes or sponsors a health  
36 care claims data base for all geographical areas of the State; or a  
37 non-profit or for-profit commercially available usual, customary  
38 and reasonable fee schedule data base provider. No such data base  
39 provider shall have an ownership or controlling interest in, or be an  
40 affiliate of any entity with a pecuniary interest in the application of  
41 the database including an insurer, healthcare provider, arbitrator,  
42 holding company of an insurer, health care provider, or trade  
43 association in the field of insurance, health benefits or provider of  
44 healthcare; and

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

1 e.]<sup>1</sup> 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  
5 12. On or before January 31 of each calendar year, the  
6 commissioner shall consult with the Department of the Treasury,  
7 the relevant professional and occupational licensing boards within  
8 the Division of Consumer Affairs in the Department of Law and  
9 Public Safety, and the Department of Health, to obtain information  
10 to compile and make publicly available, on the department's  
11 website:

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

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

18 (a) <sup>1</sup>an indication of whether the decision was in favor of the  
19 carrier or the out-of-network health care provider;

20 (b) the arbitration bids offered by each side and <sup>1</sup>the award  
21 amount;

22 <sup>1</sup>~~[(c)]~~ (b)<sup>1</sup> the category and practice specialty of each out-of-  
23 network health care provider involved in an arbitration decision, as  
24 applicable; and

25 <sup>1</sup>~~[(d)]~~ (c)<sup>1</sup> a description of the service that was provided and  
26 billed for.

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

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

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

35 d. The number of and description of claims received by the  
36 State Health Benefits Program and the School Employees' Health  
37 Benefits Program for in-State emergency out-of-network health care  
38 and inadvertent out-of-network health care.

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

43 f. The number of physician specialists practicing in the State in  
44 a particular specialty and whether they are in-network or out-of-  
45 network with respect to the carriers that administer the State Health  
46 Benefits Program, the School Employees' Health Benefits Program,



1 the qualified health plans in the federally run health exchange in the  
2 State, and other health benefits plans offered in the State.

3 g. The results of the network audit required pursuant to section  
4 16 of this act.

5 h. Any other benchmarks or information obtained pursuant to  
6 this act that the commissioner deems appropriate to make publicly  
7 available to further the goals of the act.

8

9 13. a. A carrier shall provide a written notice, in a form and  
10 manner to be prescribed by the Commissioner of Banking and  
11 Insurance, to each covered person of the protections provided to  
12 covered persons pursuant to this act. The notice shall include  
13 information on how a consumer can contact the department or the  
14 appropriate regulatory agency to report and dispute an out-of-network  
15 charge. The notice required pursuant to this section shall be posted on  
16 the carrier's website.

17 b. The commissioner shall provide a notice on the department's  
18 website containing information for consumers relating to the  
19 protections provided by this act, information on how consumers can  
20 report and file complaints with the department or the appropriate  
21 regulatory agency relating to any out-of-network charges, and  
22 information and guidance for consumers regarding arbitrations filed  
23 pursuant to section 11 of this act.

24

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

31

32 15. a. It shall be a violation of this act if an out-of-network health  
33 care provider, directly or indirectly related to a claim, knowingly  
34 waives, rebates, gives, pays, or offers to waive, rebate, give or pay all  
35 or part of the deductible, copayment, or coinsurance owed by a  
36 covered person pursuant to the terms of the covered person's health  
37 benefits plan as an inducement for the covered person to seek health  
38 care services from that provider. As the commissioner shall prescribe  
39 by regulation, a pattern of waiving, rebating, giving or paying all or  
40 part of the deductible, copayment or coinsurance by a provider shall be  
41 considered an inducement for the purposes of this subsection.

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

1       16. A carrier which offers a managed care plan shall provide for  
2 an annual audit of its provider network by an independent private  
3 auditing firm. The audit shall be at the expense of the carrier and the  
4 carrier shall submit the audit findings to the commissioner. The  
5 commissioner shall make the results of the audit available on the  
6 department's website. If the audit contains a determination that a  
7 carrier has failed to maintain an adequate network of providers in  
8 accordance with applicable federal or State law, in addition to any  
9 other penalties or remedies available under federal or State law, it shall  
10 be a violation of this act and the commissioner may initiate such action  
11 as the commissioner deems appropriate to ensure compliance with this  
12 act and network adequacy laws.

13  
14       17. a. A person or entity that violates any provision of this act, or  
15 the rules and regulations adopted pursuant hereto, shall be liable to a  
16 penalty as provided in this subsection. The penalty shall be collected  
17 by the commissioner in the name of the State in a summary proceeding  
18 in accordance with the "Penalty Enforcement Law of 1999," P.L.1999,  
19 c.274 (C.2A:58-10 et seq.).

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

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

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

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

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

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

43  
44       18. The Commissioner of Banking and Insurance, the  
45 Commissioner of Health and any relevant licensing board in the  
46 Division of Consumer Affairs in the Department of Law and Public  
47 Safety under Title 45 of the Revised Statutes may, as appropriate,  
48 adopt rules and regulations, pursuant to the "Administrative Procedure

1 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), in order to effectuate the  
2 purposes of this act.

3

4 19. The provisions of this act shall be severable, and if any  
5 provision of this act shall be held invalid, or held invalid with respect  
6 to any particular health benefits plan or carrier, such invalidity shall  
7 not affect the other provisions hereof, or application of those  
8 provisions to other health benefits plans or carriers.

9

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

15

16 21. This act shall take effect on <sup>1</sup>**July 1, 2016** the 90<sup>th</sup> day  
17 next following enactment<sup>1</sup>. The Commissioner of Banking and  
18 Insurance, the Department of Health and any relevant licensing  
19 board may take such anticipatory administrative action in advance  
20 thereof as shall be necessary for the implementation of this act.