STATEMENT TO

[Second Reprint]

ASSEMBLY, No. 1952

with Assembly Floor Amendments
(Proposed by Assemblyman COUGHLIN)

ADOPTED: JUNE 29, 2017

These Assembly amendments revise the bill as follows:

- In section 3, add definitions of "medical necessity" and "self-funded health benefits plan."

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

- In section 4, add a requirement for the facility to make certain disclosures about self-funded health benefits plan coverage.

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

- In section 6, add a requirement that carriers provide certain notifications in the Explanation of Benefits regarding balance billing, and that carriers and self-funded health benefits plans issue health insurance identification cards with certain notifications on the cards.

- In section 7, add a requirement as to health care facilities that must report to the Department of Health about in-network plans, that the facilities must also notify all providers providing services in the facility on an emergency or inadvertent basis of the provisions of the bill and information as to each health benefits plans with which the facility has a contract to be in-network.

- In section 7, remove a requirement that health care professionals that are contracted with the facility to perform services in the facility are in-network with respect to all plans with which the facility is in-network.

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

- In sections 7 and 8, clarify that emergency or urgent basis means the same as that term is defined in certain State and federal laws.

- In section 9, add a framework for the carrier to, within certain time periods: notify a provider that an out-of-network claim is excessive; negotiate a settlement; and pay a final offer to the provider. The carrier, provider, or covered person, as applicable, may proceed to arbitration if the claim is not settled by this process.

- In section 10, remove the peer review component from the arbitration process and clarified that a carrier may make a lower offer in arbitration than their final offer for payment, but if the final offer for payment was not made in good faith, the carrier shall pay the arbitrator's expenses and fees.

- In section 10, provide that arbitrators' decisions must be one of the two amounts submitted by the parties as their final offers, and, in sections 10 and 11, remove requirements that provide for a fixed amount within a range for those decisions.

- In section 10, include a list of factors that an arbitrator must consider when making a determination pursuant to the bill.

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