

SENATE, No. 485

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Co-Sponsored by:

Senator Ruiz

SYNOPSIS

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

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



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

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

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. This act shall be known and may be cited as the “Out-of-
8 network Consumer Protection, Transparency, Cost Containment and
9 Accountability Act.”

10
11 2. The Legislature finds and declares that:

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

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

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

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

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

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

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

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

3

4 3. As used in this act:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39
40 4. a. Prior to scheduling an appointment with a covered person
41 for a non-emergency or elective procedure and in terms the covered
42 person typically understands, a health care facility shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 amount or estimated amount the health care professional will bill
2 the covered person for the services is available upon request;
- 3 (2) Upon receipt of a request from a covered person for the
4 service and the Current Procedural Terminology (CPT) codes
5 associated with that service, disclose to the covered person in
6 writing the amount or estimated amount that the health care
7 professional will bill the covered person for the service, and the
8 CPT codes associated with that service, absent unforeseen medical
9 circumstances that may arise when the health care service is
10 provided;
- 11 (3) Inform the covered person that the covered person will have
12 a financial responsibility applicable to health care services provided
13 by an out-of-network professional, in excess of the covered
14 person's copayment, deductible, or coinsurance, and the covered
15 person may be responsible for any costs in excess of those allowed
16 by their health benefits plan; and
- 17 (4) Advise the covered person to contact the covered person's
18 carrier for further consultation on those costs.
- 19 b. A health care professional who is a physician shall provide
20 the covered person, to the extent the information is available, with
21 the name, practice name, mailing address, and telephone number of
22 any health care provider scheduled to perform anesthesiology,
23 laboratory, pathology, radiology, or assistant surgeon services in
24 connection with care to be provided in the physician's office for the
25 covered person or coordinated or referred by the physician for the
26 covered person at the time of referral to, or coordination of, services
27 with that provider. The physician shall provide instructions as to
28 how to determine the health benefits plans in which the health care
29 provider participates and recommend that the covered person should
30 contact the covered person's carrier for further consultation on costs
31 associated with these services.
- 32 c. A physician shall, for a covered person's scheduled facility
33 admission or scheduled outpatient facility services, provide the
34 covered person and the facility with the name, practice name,
35 mailing address, and telephone number of any other physician
36 whose services will be arranged by the physician and are scheduled
37 at the time of the pre-admission, testing, registration, or admission
38 at the time the non-emergency services are scheduled, and
39 information as to how to determine the health benefits plans in
40 which the physician participates, and recommend that the covered
41 person should contact the covered person's carrier for further
42 consultation on costs associated with these services.
- 43 d. The receipt or acknowledgement by any covered person of
44 any disclosure required pursuant to this section shall not waive or
45 otherwise affect any protection under existing statutes or
46 regulations regarding in-network health benefits plan coverage
47 available to the covered person or created under this act.

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

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

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

16

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (2) in the case of emergency and urgent services, not bill the
38 covered person in excess of any deductible, copayment, or
39 coinsurance amount,

40 applicable to in-network services pursuant to the covered person's
41 health benefits plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (4) individual patient characteristics; and

34 (5) as certified by an independent actuary:

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

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

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

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

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

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

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

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

18

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

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

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

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

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

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

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

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

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

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

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

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

18 (4) individual patient characteristics;

19 (5) as certified by an independent actuary:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 d. The number of and description of claims received by the State
11 Health Benefits Program and the School Employees' Health Benefits
12 Program for in-State emergency out-of-network health care and
13 inadvertent out-of-network health care.

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

18 f. The number of physician specialists practicing in the State in a
19 particular specialty and whether they are in-network or out-of-network
20 with respect to the carriers that administer the State Health Benefits
21 Program, the School Employees' Health Benefits Program, the
22 qualified health plans in the federally run health exchange in the State,
23 and other health benefits plans offered in the State.

24 g. The results of the network audit required pursuant to section
25 16 of this act.

26 h. Any other benchmarks or information obtained pursuant to this
27 act that the commissioner deems appropriate to make publicly
28 available to further the goals of the act.

29

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

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

45

46 14. A carrier shall calculate, as part of rate filings required to be
47 filed under New Jersey law, the savings that result from a reduction in
48 out-of-network claims payments pursuant to the provisions of this act.

1 The department shall include that information in the information
2 provided on the department's website pursuant to section 12 of this
3 act.
4

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

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

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

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

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

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

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

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

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

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

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

17
18 18. The Commissioner of Banking and Insurance, the
19 Commissioner of Health and any relevant licensing board in the
20 Division of Consumer Affairs in the Department of Law and Public
21 Safety under Title 45 of the Revised Statutes may, as appropriate,
22 adopt rules and regulations, pursuant to the "Administrative Procedure
23 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), in order to effectuate the
24 purposes of this act.

25
26 19. The provisions of this act shall be severable, and if any
27 provision of this act shall be held invalid, or held invalid with respect
28 to any particular health benefits plan or carrier, such invalidity shall
29 not affect the other provisions hereof, or application of those
30 provisions to other health benefits plans or carriers.

31
32 20. Nothing in this act shall be construed to apply to an entity
33 providing or administering a self-funded health benefits plan which is
34 subject to the "Employee Retirement Income Security Act of 1974,"
35 except as provided in subsection d. of section 9 of this act for such an
36 entity to elect to be subject to certain provisions of the act.

37
38 21. This act shall take effect on the 90th day next following
39 enactment. The Commissioner of Banking and Insurance, the
40 Department of Health and any relevant licensing board may take
41 such anticipatory administrative action in advance thereof as shall
42 be necessary for the implementation of this act.

43 44 STATEMENT

45
46 This bill is entitled the "Out-of-network Consumer Protection,
47 Transparency, Cost Containment and Accountability Act." The bill
48 reforms various aspects of the health care delivery system in New

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

6
7 DISCLOSURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27

28 OUT-OF-NETWORK BILLING

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

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

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

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

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

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

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

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

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

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

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

39

40 ARBITRATION

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

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

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

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

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

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

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

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

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

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

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

29
30 ARBITRATION BY SELF-FUNDED PLAN MEMBER OR OUT-
31 OF-NETWORK PROVIDER

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

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

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

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

9

10 INCREASED TRANSPARENCY

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

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

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

31

32 PROVIDER NETWORK AUDIT

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

1 WAIVER OF COST SHARING

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

18

19 PENALTIES

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

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

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

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

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