SENATE, No. 3201

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED NOVEMBER 26, 2018

Sponsored by:
Senator JOSEPH A. LAGANA
District 38 (Bergen and Passaic)
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SYNOPSIS

Revises certain aspects of out-of-network arbitration process under the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act."

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning arbitration processes for payment for certain out-of-network health care services and amending P.L.2018, 32.

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

1. Section 3 of P.L.2018, c.32 (C.26:2SS-3) is amended to read as follows:

3. As used in this act:

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

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier is obligated to pay health care expense benefits or provide health care services.

"Department" means the Department of Banking and Insurance.

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

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

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

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 <u>thus</u> is new matter.

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

"Health care provider" or "provider" means a health care professional or health care facility.

"Inadvertent out-of-network services" means health care services that are: covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility, unless those services were disclosed as provided in section 5 of P.L.2018, c.32 (C.26:2SS-5). Inadvertent out-of-network services" shall include laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

"Knowingly, voluntarily, and specifically selected an out-of-network provider" means that a covered person chose the services of a specific provider, with full knowledge that the provider is out-of-network with respect to the covered person's health benefits plan, under circumstances that indicate that covered person had the opportunity to be serviced by an in-network provider, but instead selected the out-of-network provider. Disclosure by a provider of network status shall not render a covered person's decision to proceed with treatment from that provider a choice made "knowingly" pursuant to this definition.

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

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

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

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

(cf: P.L.2018, c.32, s.3)

2. Section 9 of P.L.2018, c.32 (C.26:2SS-9) is amended to read as follows:

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

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

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

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

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

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

c. If inadvertent out-of-network services or services provided at an in-network or out-of-network health care facility on an emergency or urgent basis are performed in accordance with subsection a. of this section, the out-of-network provider may bill the carrier for the services rendered. The carrier may pay the provider the billed amount or **[**the carrier shall determine**]** pay at least the amount set by the 85th percentile of the FAIR Health Charge Benchmark database for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area, which shall be deemed the carrier's final offer for purposes of P.L.2018, c.32, (C.26:2SS-1 et seq.) within 20 days from the date of the receipt of the claim for the services. The carrier shall determine whether the carrier considers the claim to be excessive, and if so, the carrier shall notify the provider of this determination within 20 days of the receipt of the

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

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

cf: (P.L.2018, c.32, s.9)

3. Section 10 of P.L.2018, c.32 (C.26:2SS-10) is amended to read as follows:

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

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

(1) The party requesting arbitration shall notify the other party that arbitration has been initiated and state its final offer before arbitration, which in the case of the carrier shall be the amount paid pursuant to subsection c. of section 9 of this act. In response to this notice, the out-of-network provider shall inform the carrier of its final offer before the arbitration occurs;

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

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

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

(5) The arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers and shall be binding on both parties. The decision of the arbitrator shall include written findings and shall be issued within 30 days after the request is filed with the department. The arbitrator's expenses and fees shall be split equally among the parties except in situations in which the arbitrator determines that the payment made by the carrier was not made in good faith, in which case the carrier shall be responsible for all of the arbitrator's expenses and fees. Each party shall be responsible for its own costs and fees, including legal fees if any.

c. (1) The amount awarded by the arbitrator that is in excess of any payment already made pursuant to subsection c. of section 9 of this act shall be paid within 20 days of the arbitrator's decision as provided in subsection b. of this section.

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

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

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

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

(cf: P.L.2018, c.32, s.10)

4. This act shall take effect on the first day of the fourth month next following enactment and shall apply to arbitration requests filed with the Department of Banking and Insurance on or after the day of enactment.

STATEMENT

This bill amends the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" to revise certain aspects of the arbitration processes established in that act for claims involving health insurance carriers subject to the provisions of the act.

The act establishes an arbitration system for out-of-network health care services provided in certain emergency and inadvertent situations that result in payment disputes between health insurance carriers and health care providers. As to this arbitration system, the bill removes the requirement that the difference between the carrier's and provider's final offer must be not less than $1,000 for the dispute to proceed to arbitration.

The bill also requires a carrier to pay the provider the billed amount, or pay at least the amount set by the 85th percentile of the FAIR Health Charge Benchmark database for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area, which shall be deemed the carrier's final offer for purposes of the act. The carrier shall determine within 20 days from the date of the receipt of the claim for the services whether the carrier considers the claim to be excessive, and if so, the carrier shall notify the provider of this determination within 20 days of the receipt of the claim. If the carrier provides this notification, the carrier and the provider shall have 30 days from the date of this notification to negotiate a settlement. If there is no settlement the carrier, provider, or covered person, as applicable, may initiate binding arbitration within two years after the provision of the health care

service that is the subject of the claim, using the procedures set forth in the act.

FAIR Health is an independent, nonprofit organization that manages a nationwide database of privately billed health insurance claims.

The bill also revises the definition of "inadvertent out-of-network services."