ASSEMBLY, No. 1920

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

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SYNOPSIS

Requires certain disclosures to consumers regarding health care costs.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

(Sponsorship Updated As Of: 8/28/2018)

AN ACT concerning certain health insurance network disclosures and supplementing P.L.1997, c.192 (C.26:2S-1 et al.).

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

1. 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; an entity under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; or any other entity providing a 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.

"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 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.), and hospital confinement indemnity coverage.

"Health care facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"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 professional" includes, but is not limited to, a physician or other health care professional licensed pursuant to Title 45 of the Revised Statutes.

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

2. a. A health care facility shall disclose to a covered person in writing or through an internet website the health benefits plans in which the health care facility is a participating provider prior to the

provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care facility does not participate in the network of the covered person's health benefits plan, and the person deliberately and voluntarily elects to receive services from the health care facility, the health facility shall, in terms the covered person typically understands:

(1) inform the covered person that the facility is out-of-network and that the amount or estimated amount the health care facility will bill the covered person for the services is available upon request;

(2) upon receipt of a request from a covered person, disclose to the covered person the amount or estimated amount that the health care facility will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided;

(3) inform the covered person that the covered person may have a financial responsibility applicable to health care services provided by the facility, in excess of the covered person's copayment, deductible, or coinsurance, and the covered person may be responsible for any costs in excess of those allowed by their health benefits plan; and

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

b. A health care facility shall disclose to a covered person in writing or through an internet website the following information relating to the physician services provided to a covered person, in terms the covered person typically understands:

(1) inform the covered person that physician services provided in the facility are not included in the facility's charges;

(2) advise the covered person to check with, as applicable, the facility-based physician groups that the facility has contracted with to provide services including anesthesiology, pathology, or radiology to determine the health benefits plans in which they participate;

(3) provide to the covered person, as applicable, the name, mailing address and telephone number of the facility-based physician groups that the facility has contracted with to provide services including anesthesiology, pathology, or radiology; and

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

c. The Department of Health shall specify in further detail the design of the disclosure form and the manner in which the form shall be provided.

3. a. A health care professional shall disclose to a covered person in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the health care professional is affiliated prior to the provision of non-emergency services, and

verbally or in writing, at the time of an appointment. If a health care professional does not participate in the network of the covered person's health benefits plan, and the person deliberately and voluntarily elects to receive services from the health care professional, the health care professional shall, in terms the covered person typically understands:

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

(2) upon receipt of a request from a covered person, disclose to the covered person the amount or estimated amount that the health care professional will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided;

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

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

b. A health care professional providing health care services to a covered person requiring a scheduled facility admission or scheduled outpatient facility service, shall provide the covered person with the name, practice name, mailing address, and telephone number of any other physician, if known ahead of time, whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission at the time the non-emergency services are scheduled, information as to how to determine the health benefits plans in which the physician participates, and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

4. a. A carrier shall disclose to a covered person under a health benefits plan that provides coverage for scheduled or elective services whether the health care provider scheduled to provide a health care service is an in-network provider and, with respect to out-of-network coverage, disclose the approximate dollar amount that the health benefit plan will pay for the specific out-of-network health service. The carrier shall also inform the covered person that such approximation is non-binding on the health benefit plan and that the approximate amount that the health benefit plan will pay for a specific out-of-network service may change.

b. A carrier shall update the carrier's website within 15 days of the addition or termination of a provider from the carrier's network or a change in a physician's affiliation with a facility.

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

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

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

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

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

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

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

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

(8) access to a telephone hotline that shall be operational 24 hours a day for consumers to call with questions about network status and out-of-pocket costs.

d. Carriers shall utilize patient engagement programs, at least one in every county, to raise product benefit awareness and to provide product benefit education and counseling to employers and employees. Patient engagement programs shall be created and funded by carriers and administered by community based organizations for the purpose of providing education and counseling to employers and employees on their health care benefits in order to prevent surprise billing to the consumer.

e. If a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed, the carrier shall notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall

be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

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

5. The commissioner shall provide a notice on the department's website containing information for consumers relating to the protections provided by this act and information on how consumers can report and file complaints with the department or the appropriate regulatory agency relating to any out-of-network charges.

6. This act shall take effect 90 days after enactment.

STATEMENT

This bill, which supplements the "Health Care Quality Act," requires health care facilities, health care professionals and health insurance carriers to make certain disclosures regarding health insurance network status.

With regard to health care facilities, the bill requires that they disclose to a covered person in writing or through an internet website the health benefits plans in which the health care facility is a participating provider prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care facility does not participate in the network of the covered person's health benefits plan, and the person deliberately and voluntarily elects to receive services from the health care facility, the health facility shall, in terms the covered person typically understands:

(1) inform the covered person that the facility is out-of-network and that the amount or estimated amount the health care facility will bill the covered person for the services is available upon request;

(2) upon receipt of a request from a covered person, disclose to the covered person the amount or estimated amount that the health care facility will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided;

(3) inform the covered person that the covered person may have a financial responsibility applicable to health care services provided

by the facility, in excess of the covered person's copayment, deductible, or coinsurance, and the covered person may be responsible for any costs in excess of those allowed by their health benefits plan; and

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

Under the bill, a health care facility shall also disclose to a covered person in writing or through an internet website the following information relating to the physician services provided to a covered person, in terms the covered person typically understands:

(1) inform the covered person that physician services provided in the facility are not included in the facility's charges;

(2) advise the covered person to check with, as applicable, the facility-based physician groups that the facility has contracted with to provide services including anesthesiology, pathology, or radiology to determine the health benefits plans in which they participate;

(3) provide to the covered person, as applicable, the name, mailing address and telephone number of the facility-based physician groups that the facility has contracted with to provide services including anesthesiology, pathology, or radiology; and

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

With regard to health care professionals, the bill requires that they disclose to covered persons in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the health care professional is affiliated prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care professional does not participate in the network of the covered person's health benefits plan, and the person deliberately and voluntarily elects to receive services from the health care professional, the health care professional shall, in terms the covered person typically understands:

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

(2) upon receipt of a request from a covered person, disclose to the covered person the amount or estimated amount that the health care professional will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided;

(3) inform the covered person that the covered person may have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of the covered person's copayment, deductible, or coinsurance, and the covered

person may be responsible for any costs in excess of those allowed by their health benefits plan; and

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

A health care professional providing health care services to a covered person requiring a scheduled facility admission or scheduled outpatient facility service, is required to provide the covered person with the name, practice name, mailing address, and telephone number of any other physician, if known ahead of time, whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission at the time the non-emergency services are scheduled, information as to how to determine the health benefits plans in which the physician participates, and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

With regard to carriers, they must disclose to a covered person under a health benefits plan that provides coverage for scheduled or elective services whether the health care provider scheduled to provide a health care service is an in-network provider and with respect to out-of-network coverage, disclose the approximate dollar amount that the health benefit plan will pay for the specific out-of-network health service. The carrier shall also inform the covered person that such approximation is non-binding on the health benefit plan and that the approximate amount that the health benefit plan will pay for a specific out-of-network service may change.

A carrier is required to also update the carrier's website within 15 days of the addition or termination of a provider from the carrier's network or a change in a physician's affiliation with a facility.

With respect to out-of-network services, for each health benefits plan offered, a carrier must, consistent with State and federal law, provide a covered person with:

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

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

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

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

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

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

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

(8) access to a telephone hotline that shall be operational 24 hours a day for consumers to call with questions about network status and out-of-pocket costs.

Carriers must also create funds and utilize patient engagement programs, at least one in every county, to raise product benefit awareness and to provide product benefit education and counseling to employers and employees.

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

A carrier must provide a written notice to each covered person of the protections provided to covered persons pursuant to the bill's provisions. The Commissioner of Banking and Insurance is also required to provide a notice on the department's website containing information for consumers relating to the protections provided by the bill's provisions and information on how consumers can report and file complaints with the department or the appropriate regulatory agency relating to any out-of-network charges.