

ASSEMBLY, No. 1920

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Assemblyman RAJ MUKHERJI

District 33 (Hudson)

Assemblyman JOSEPH A. LAGANA

District 38 (Bergen and Passaic)

Assemblyman JON M. BRAMNICK

District 21 (Morris, Somerset and Union)

Co-Sponsored by:

Assemblywoman Chaparro

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)

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

3

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

6

7 1. As used in this act:

8 “Carrier” means an entity that contracts or offers to contract to
9 provide, deliver, arrange for, pay for, or reimburse any of the costs
10 of health care services under a health benefits plan, including: an
11 insurance company authorized to issue health benefits plans; a
12 health maintenance organization; a health, hospital, or medical
13 service corporation; a multiple employer welfare arrangement; an
14 entity under contract with the State Health Benefits Program and
15 the School Employees’ Health Benefits Program to administer a
16 health benefits plan; or any other entity providing a health benefits
17 plan.

18 “Commissioner” means the Commissioner of Banking and
19 Insurance.

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

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

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

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

37 “Health care professional” means an individual, acting within the
38 scope of his licensure or certification, who provides a covered
39 service defined by the health benefits plan. “Health care
40 professional” includes, but is not limited to, a physician or other
41 health care professional licensed pursuant to Title 45 of the Revised
42 Statutes.

43 “Health care provider” or “provider” means a health care
44 professional or health care facility.

45

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

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

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

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

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

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

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

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

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

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

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

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

43
44 3. a. A health care professional shall disclose to a covered
45 person in writing or through an internet website the health benefits
46 plans in which the health care professional is a participating
47 provider and the facilities with which the health care professional is
48 affiliated prior to the provision of non-emergency services, and

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

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

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

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

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

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

36
37 4. a. A carrier shall disclose to a covered person under a health
38 benefits plan that provides coverage for scheduled or elective
39 services whether the health care provider scheduled to provide a
40 health care service is an in-network provider and, with respect to
41 out-of-network coverage, disclose the approximate dollar amount
42 that the health benefit plan will pay for the specific out-of-network
43 health service. The carrier shall also inform the covered person that
44 such approximation is non-binding on the health benefit plan and
45 that the approximate amount that the health benefit plan will pay for
46 a specific out-of-network service may change.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12
13 5. The commissioner shall provide a notice on the department's
14 website containing information for consumers relating to the
15 protections provided by this act and information on how consumers
16 can report and file complaints with the department or the
17 appropriate regulatory agency relating to any out-of-network
18 charges.

19
20 6. This act shall take effect 90 days after enactment.

21
22
23 STATEMENT

24
25 This bill, which supplements the "Health Care Quality Act,"
26 requires health care facilities, health care professionals and health
27 insurance carriers to make certain disclosures regarding health
28 insurance network status.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 A carrier is required to also update the carrier's website within
28 15 days of the addition or termination of a provider from the
29 carrier's network or a change in a physician's affiliation with a
30 facility.

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

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

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

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

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

1 (5) information in response to a covered person's request,
2 concerning whether a health care provider is an in-network
3 provider;
4 (6) the approximate dollar amount that the carrier will pay for a
5 specific out-of-network service;
6 (7) such other information as the commissioner determines
7 appropriate and necessary to ensure that a covered person receives
8 sufficient information necessary to estimate their out-of-pocket cost
9 for an out-of-network service and make a well-informed health care
10 decision; and
11 (8) access to a telephone hotline that shall be operational 24
12 hours a day for consumers to call with questions about network
13 status and out-of-pocket costs.
14 Carriers must also create funds and utilize patient engagement
15 programs, at least one in every county, to raise product benefit
16 awareness and to provide product benefit education and counseling
17 to employers and employees.
18 If a carrier authorizes a covered health care service to be
19 performed by an in-network health care provider with respect to any
20 health benefits plan, and the provider or facility status changes to
21 out-of-network before the authorized service is performed, the
22 carrier shall notify the covered person that the provider or facility is
23 no longer in-network as soon as practicable. If the carrier fails to
24 provide the notice at least 30 days prior to the authorized service
25 being performed, the covered person's financial responsibility shall
26 be limited to the financial responsibility the covered person would
27 have incurred had the provider been in-network with respect to the
28 covered person's health benefits plan.
29 A carrier must provide a written notice to each covered person of
30 the protections provided to covered persons pursuant to the bill's
31 provisions. The Commissioner of Banking and Insurance is also
32 required to provide a notice on the department's website containing
33 information for consumers relating to the protections provided by
34 the bill's provisions and information on how consumers can report
35 and file complaints with the department or the appropriate
36 regulatory agency relating to any out-of-network charges.