

Title 26.
Chapter 2SS.
(New)
Health Care
Consumer
Protection.
§§1-20 -
C.26:2SS-1 to
26:2SS-20
§21 - Note

P.L. 2018, CHAPTER 32, *approved June 1, 2018*
Assembly, No. 2039 (*First Reprint*)

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;

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 **thus** is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AAP committee amendments adopted April 5, 2018.

1 d. Out-of-network benefits are a health insurance benefit
2 enhancement for which insureds pay an additional premium, but in
3 recent years, out-of-network coverage has been used inappropriately as
4 a means to diminish consumers' health insurance coverage, exposing
5 consumers to additional costs;

6 e. Carriers and consumers continue to report exorbitant charges
7 by certain health care professionals and facilities for out-of-network
8 services, including balance billing, and in certain cases, consumers'
9 bills are referred to collection, which contributes to the increasing
10 costs of health care services and insurance and imposes hardships on
11 health care consumers;

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

16 g. It is, therefore, in the public interest to reform the health care
17 delivery system in New Jersey to enhance consumer protections, create
18 a system to resolve certain health care billing disputes, contain rising
19 costs, and measure success with respect to these goals.

20

21 3. As used in this act:

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

33 "Commissioner" means the Commissioner of Banking and
34 Insurance.

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

38 "Department" means the Department of Banking and Insurance.

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

42 "Health benefits plan" means a benefits plan which pays or
43 provides hospital and medical expense benefits for covered
44 services, and is delivered or issued for delivery in this State by or
45 through a carrier. For the purposes of this act, "health benefits
46 plan" shall not include the following plans, policies or contracts:
47 Medicaid, Medicare, Medicare Advantage, accident only, credit,
48 disability, long-term care, TRICARE supplement coverage,

1 coverage arising out of a workers' compensation or similar law,
2 automobile medical payment insurance, personal injury protection
3 insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), a
4 dental plan as defined pursuant to section 1 of P.L.2014, c.70
5 (C.26:2S-26) and hospital confinement indemnity coverage.

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

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

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

16 "Inadvertent out-of-network services" means health care services
17 that are: covered under a managed care health benefits plan that
18 provides a network; and provided by an out-of-network health care
19 provider in the event that a covered person utilizes an in-network
20 health care facility for covered health care services and, for any
21 reason, in-network health care services are unavailable in that
22 facility. "Inadvertent out-of-network services" shall include
23 laboratory testing ordered by an in-network health care provider and
24 performed by an out-of-network bio-analytical laboratory.

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

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

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

1 equivalent therapeutic or diagnostic results as to the diagnosis or
2 treatment of that covered person's illness, injury, or disease.

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

5 "Self-funded health benefits plan" or "self-funded plan" means a
6 self-insured health benefits plan governed by the provisions of the
7 federal "Employee Retirement Income Security Act of 1974,"
8 29 U.S.C. s.1001 et seq.

9

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

13 (1) disclose to the covered person whether the health care
14 facility is in-network or out-of-network with respect to the covered
15 person's health benefits plan;

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

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

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

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

34 (c) any bills, charges or attempts to collect by the facility, or
35 any health care professional involved in the procedure, in excess of
36 the covered person's copayment, deductible, or coinsurance as
37 provided in the covered person's health benefits plan in violation of
38 subparagraph (b) of this paragraph should be reported to the
39 covered person's carrier and the relevant regulatory entity; and

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

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

47 (ii) the covered person may have a financial responsibility
48 applicable to health care services provided by an out-of-network

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

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

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

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

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

19 (c) that the covered person should contact the covered person's
20 carrier for further consultation on those costs.

21 b. In a form that is consistent with federal guidelines, a health
22 care facility shall make available to the public a list of the facility's
23 standard charges for items and services provided by the facility.

24 c. A health care facility shall post on the facility's website:

25 (1) the health benefits plans in which the facility is a
26 participating provider;

27 (2) a statement that:

28 (a) physician services provided in the facility are not included in
29 the facility's charges;

30 (b) physicians who provide services in the facility may or may
31 not participate with the same health benefits plans as the facility;

32 (c) the covered person should check with the physician
33 arranging for the facility services to determine the health benefits
34 plans in which the physician participates; and

35 (d) the covered person should contact their carrier for further
36 consultation on those costs;

37 (3) as applicable, the name, mailing address, and telephone
38 number of the hospital-based physician groups that the facility has
39 contracted with to provide services including, but not limited to,
40 anesthesiology, pathology, and radiology; and

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

45 d. If, between the time the notice required pursuant to
46 subsection a. of this section is provided to the covered person and
47 the time the procedure takes place, the network status of the facility

1 changes as it relates to the covered person's health benefits plan,
2 the facility shall notify the covered person promptly.

3 e. The Department of Health shall specify in further detail the
4 content and design of the disclosure form and the manner in which
5 the form shall be provided.

6
7 5. a. Except as provided in subsection f. of this section, a
8 health care professional shall disclose to a covered person in writing
9 or through an internet website the health benefits plans in which the
10 health care professional is a participating provider and the facilities
11 with which the health care professional is affiliated prior to the
12 provision of non-emergency services, and verbally or in writing, at
13 the time of an appointment. If a health care professional does not
14 participate in the network of the covered person's health benefits
15 plan, the health care professional shall, in terms the covered person
16 typically understands:

17 (1) Prior to scheduling a non-emergency procedure inform the
18 covered person that the professional is out-of-network and that the
19 amount or estimated amount the health care professional will bill
20 the covered person for the services is available upon request;

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

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

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

37 b. A health care professional who is a physician shall provide
38 the covered person, to the extent the information is available, with
39 the name, practice name, mailing address, and telephone number of
40 any health care provider scheduled to perform anesthesiology,
41 laboratory, pathology, radiology, or assistant surgeon services in
42 connection with care to be provided in the physician's office for the
43 covered person or coordinated or referred by the physician for the
44 covered person at the time of referral to, or coordination of, services
45 with that provider. The physician shall provide instructions as to
46 how to determine the health benefits plans in which the health care
47 provider participates and recommend that the covered person should

1 contact the covered person's carrier for further consultation on costs
2 associated with these services.

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

14 d. The receipt or acknowledgement by any covered person of
15 any disclosure required pursuant to this section shall not waive or
16 otherwise affect any protection under existing statutes or
17 regulations regarding in-network health benefits plan coverage
18 available to the covered person or created under this act.

19 e. If, between the time the notice required pursuant to
20 subsection a. of this section is provided to the covered person and
21 the time the procedure takes place, the network status of the
22 professional changes as it relates to the covered person's health
23 benefits plan, the professional shall notify the covered person
24 promptly.

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

29 g. The appropriate professional or occupational licensing board
30 within the Division of Consumer Affairs in the Department of Law
31 and Public Safety shall specify in further detail the content and
32 design of the disclosure form and the manner in which the form
33 shall be provided.

34

35 6. a. A carrier shall update the carrier's website within 20 days
36 of the addition or termination of a provider from the carrier's
37 network or a change in a physician's affiliation with a facility,
38 provided that in the case of a change in affiliation the carrier has
39 had notice of such change.

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

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

46 (2) the allowed amount the plan will reimburse under that
47 methodology and, in situations in which a covered person requests
48 allowed amounts associated with a specific Current Procedural

- 1 Terminology code, the portion of the allowed amount the plan will
2 reimburse and the portion of the allowed amount that the covered
3 person will pay, including an explanation that the covered person
4 will be required to pay the difference between the allowed amount
5 as defined by the carrier's plan and the charges billed by an out-of-
6 network provider;
- 7 (3) examples of anticipated out-of-pocket costs for frequently
8 billed out-of-network services;
- 9 (4) information in writing and through an internet website that
10 reasonably permits a covered person or prospective covered person
11 to calculate the anticipated out-of-pocket cost for out-of-network
12 services in a geographical region or zip code based upon the
13 difference between the amount the carrier will reimburse for out-of-
14 network services and the usual and customary cost of out-of-
15 network services;
- 16 (5) information in response to a covered person's request,
17 concerning whether a health care provider is an in-network
18 provider;
- 19 (6) such other information as the commissioner determines
20 appropriate and necessary to ensure that a covered person receives
21 sufficient information necessary to estimate their out-of-pocket cost
22 for an out-of-network service and make a well-informed health care
23 decision; and
- 24 (7) access to a telephone hotline that shall be operated no less
25 than 16 hours per day for consumers to call with questions about
26 network status and out-of-pocket costs.
- 27 c. If a carrier authorizes a covered health care service to be
28 performed by an in-network health care provider with respect to any
29 health benefits plan, and the provider or facility status changes to
30 out-of-network before the authorized service is performed, the
31 carrier shall notify the covered person that the provider or facility is
32 no longer in-network as soon as practicable. If the carrier fails to
33 provide the notice at least 30 days prior to the authorized service
34 being performed, the covered person's financial responsibility shall
35 be limited to the financial responsibility the covered person would
36 have incurred had the provider been in-network with respect to the
37 covered person's health benefits plan.
- 38 d. A carrier shall incorporate into the Explanation of Benefits
39 and all reimbursement correspondence to the consumer and the
40 provider clear and concise notification that inadvertent and
41 involuntary out-of-network charges are not subject to balance
42 billing above and beyond the financial responsibility incurred under
43 the terms of the contract for in-network service. Any attempt by the
44 provider to collect, bill, or invoice funds should be promptly
45 reported to the carrier's customer service department at the phone
46 number that the carrier shall provide on the Explanation of Benefits
47 and all reimbursement correspondence to the consumer.

1 e. A carrier, and any other entity providing or administering a
2 self-funded health benefits plan that elects to be subject to section 9
3 of this act, shall issue a health insurance identification card to the
4 primary insured under a health benefits plan. In a form and manner
5 to be prescribed by the department, the card shall indicate whether
6 the plan is insured or, in the case of self-funded plans that elect to
7 be subject of section 9 of this act, whether the plan is self-funded
8 and whether the plan elected to be subject to this act.

9 ¹f. A carrier shall include in the carrier's annual public
10 regulatory filings, and in a manner to be determined by the
11 Department of Banking and Insurance, the number of claims
12 submitted by health care providers to the carrier which are denied or
13 down coded by the carrier and the reason for the denial or down
14 coding determination.¹

15
16 7. a. If a covered person receives medically necessary services
17 at any health care facility on an emergency or urgent basis as
18 defined by the Emergency Medical Treatment and Active Labor
19 Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160
20 (C.26:2H-18.64), the facility shall not bill the covered person in
21 excess of any deductible, copayment, or coinsurance amount
22 applicable to in-network services pursuant to the covered person's
23 health benefits plan.

24 b. If a covered person receives medically necessary services at
25 an out-of-network health care facility on an emergency or urgent
26 basis as defined by the Emergency Medical Treatment and Active
27 Labor Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992,
28 c.160 (C.26:2H-18.64), and the carrier and facility cannot agree on
29 the final offer as a reimbursement rate for these services pursuant to
30 section 9 of this act, the carrier, health care facility, or covered
31 person, as applicable, may initiate binding arbitration pursuant to
32 section 10 or 11 of this act.

33 c. If a health care facility is in-network with respect to any
34 health benefits plan, the facility shall ensure that all providers
35 providing services in the facility on an emergency or inadvertent
36 basis are provided notification of the provisions of this act and
37 information as to each health benefits plan with which the facility
38 has a contract to be in-network.

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

43 e. Subsections a. and b. of this section shall only apply to
44 providers providing services to members of entities providing or
45 administering a self-funded health benefits plan and its plan
46 members if the entity elects to be subject to section 9 of this act
47 pursuant to subsection d. of that section.

1 f. The Department of Health shall make the information
2 collected pursuant to subsection d. of this section available to the
3 Department of Banking and Insurance.
4

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

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

15 (2) in the case of emergency and urgent services, not bill the
16 covered person in excess of any deductible, copayment, or
17 coinsurance amount, applicable to in-network services pursuant to
18 the covered person's health benefits plan.

19 b. If the carrier and the professional cannot agree on a
20 reimbursement rate for the services provided pursuant to subsection
21 a. of this section, pursuant to section 9 of this act the carrier,
22 professional, or covered person, as applicable, may initiate binding
23 arbitration pursuant to section 10 or 11 of this act.

24 c. This section shall only apply to providers providing services
25 to members of entities providing or administering a self-funded
26 health benefits plan and its plan members if the entity elects to be
27 subject to section 9 of this act pursuant to subsection d. of that
28 section.
29

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

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

46 b. (1) With respect to inadvertent out-of-network services, or
47 services at an in-network or out-of-network health care facility on
48 an emergency or urgent basis, benefits provided by a carrier that the

1 covered person receives for health care services shall be assigned to
2 the out-of-network health care provider, which shall require no
3 action on the part of the covered person. Once the benefit is
4 assigned as provided in this subsection:

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

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

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

15 c. If inadvertent out-of-network services or services provided
16 at an in-network or out-of-network health care facility on an
17 emergency or urgent basis are performed in accordance with
18 subsection a. of this section, the out-of-network provider may bill
19 the carrier for the services rendered. The carrier may pay the billed
20 amount or the carrier shall determine within ~~1[30]~~ 20¹ days from
21 the date of the receipt of the claim for the services whether the
22 carrier considers the claim to be excessive, and if so, the carrier
23 shall notify the provider of this determination within ~~1[30]~~ 20¹
24 days of the receipt of the claim. If the carrier provides this
25 notification, the carrier and the provider shall have 30 days from the
26 date of this notification to negotiate a settlement. The carrier may
27 attempt to negotiate a final reimbursement amount with the out-of-
28 network health care provider which differs from the amount paid by
29 the carrier pursuant to this subsection. If there is no settlement
30 reached after the 30 days, the carrier shall pay the provider their
31 final offer for the services. If the carrier and provider cannot agree
32 on the final offer as a reimbursement rate for these services, the
33 carrier, provider, or covered person, as applicable, may initiate
34 binding arbitration within 30 days of the final offer, pursuant to
35 section 10 or 11 of this act. In addition, in the event that arbitration
36 is initiated pursuant to section 10 of this act, the payment shall be
37 subject to the binding arbitration provisions of paragraphs (4) and
38 (5) of subsection b. of section 10 of this act.

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

1 any other plan documents to reflect that the benefits of this section
2 shall apply to the plan's members.

3

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

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

13 (1) The party requesting arbitration shall notify the other party
14 that arbitration has been initiated and state its final offer before
15 arbitration ¹, which in the case of the carrier shall be the amount
16 paid pursuant to subsection c. of section 9 of this act¹. In response
17 to this notice, the ¹~~nonrequesting party~~ out-of-network provider¹
18 shall inform the ¹~~requesting party~~ carrier¹ of its final offer before
19 the arbitration occurs;

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

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

35 (4) The arbitration shall consist of a review of the written
36 submissions by both parties, which shall include the final offer for
37 the payment by the carrier for the out-of-network health care
38 provider's fee made pursuant to subsection c. of section 9 of this act
39 ¹~~], or a lower offer,~~¹ and the final offer by the out-of-network
40 provider for the fee the provider will accept as payment from the
41 carrier; and

42 (5) The arbitrator's decision shall be one of the two amounts
43 submitted by the parties as their final offers and shall be binding on
44 both parties. The decision of the arbitrator shall include written
45 findings and shall be issued within ¹~~45~~ 30¹ days after the request
46 is filed with the department. The arbitrator's expenses and fees
47 shall be split equally among the parties except in situations in which

1 the arbitrator determines that the payment made by the carrier was
2 not made in good faith, in which case the carrier shall be
3 responsible for all of the arbitrator's expenses and fees. Each party
4 shall be responsible for its own costs and fees, including legal fees
5 if any.

6 c. ¹**[In making a determination pursuant to subsection b. of this**
7 **section, the arbitrator shall consider:**

8 (1) the level of training, education, and experience of the health
9 care professional;

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

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

15 (4) individual patient characteristics; and

16 (5) as certified by an independent actuary:

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

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

21 d. ¹**[**(1) The amount awarded by the arbitrator ¹that is in excess
22 of any payment already made pursuant to subsection c. of section 9
23 of this act¹ shall be paid within 20 days of the arbitrator's decision
24 as provided in subsection b. of this section.

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

34 ¹**[e.] d.**¹ This section shall apply only if the covered person
35 complies with any applicable preauthorization or review
36 requirements of the health benefits plan regarding the determination
37 of medical necessity to access in-network inpatient or outpatient
38 benefits.

39 ¹**[f.] e.**¹ This section shall not apply to a covered person who
40 knowingly, voluntarily, and specifically selected an out-of-network
41 provider for health care services.

42 ¹**[g.] f.**¹ In the event an entity providing or administering a
43 self-funded health benefits plan elects to be subject to the
44 provisions of section 9 of this act, as provided in subsection d. of
45 that section, the provisions of this section shall apply to a self-
46 funded plan in the same manner as the provisions of this section
47 apply to a carrier. If a self-funded plan does not elect to be subject

1 to the provision of section 9 of this act, a member of that plan may
2 initiate binding arbitration as provided in section 11 of this act.

3
4 11. a. If attempts to negotiate reimbursement for services
5 between an out-of-network health care provider and a member of a
6 self-funded plan that does not elect to be subject to the provision of
7 section 9 of this act do not result in a resolution of the payment
8 dispute within 30 days after the plan member is sent a bill for the
9 services, the plan member or out-of-network health care provider
10 may initiate binding arbitration to determine payment for the
11 services. Unless negotiations for reimbursement result in an
12 agreement between the provider and the plan member within the 30
13 days, a provider shall not collect or attempt to collect
14 reimbursement, including initiation of any collection proceedings,
15 until the provider files a request for arbitration with the department
16 pursuant to this section.

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

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

23 (2) The arbitrator with which the department contracts pursuant
24 to section 10 of this act shall conduct the arbitration pursuant to this
25 section;

26 (3) The arbitrator shall consider information supplied by both
27 parties; and

28 (4) The arbitrator's decision shall include written findings,
29 including a final binding amount that the arbitrator determines is
30 reasonable for the service, which shall include a non-binding
31 recommendation to the entity providing or administering the self-
32 funded health benefits plan of an amount that would be reasonable
33 for the entity to contribute to payment for the service, and shall be
34 issued within ¹~~45~~ 30¹ days after the request is filed with the
35 department.

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

42 d. ¹~~In~~ making a determination pursuant to subsection b. of this
43 section, the arbitrator shall consider:

44 (1) the level of training, education, and experience of the health
45 care professional;

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

- 1 (3) the circumstances and complexity of the particular case,
2 including the time and place of the service;
- 3 (4) individual patient characteristics;
- 4 (5) as certified by an independent actuary:
 - 5 (a) the average in-network amount paid for the service by that
6 self-funded plan; and
 - 7 (b) the average amount paid for that service to other out-of-
8 network providers by that self-funded plan; and
- 9 (6) the out-of-network benefit design of the member's health
10 plan and the amount the entity providing or administering the self-
11 funded health benefits plan contributes, if anything, to the cost of
12 the service.

13 e.]¹ This section shall not apply to a covered person who
14 knowingly, voluntarily, and specifically selected an out-of-network
15 provider for health care services.

16

17 12. On or before January 31 of each calendar year, the
18 commissioner shall consult with the Department of the Treasury,
19 the relevant professional and occupational licensing boards within
20 the Division of Consumer Affairs in the Department of Law and
21 Public Safety, and the Department of Health, to obtain information
22 to compile and make publicly available, on the department's
23 website:

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

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

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

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

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

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

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

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

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

46 d. The number of and description of claims received by the
47 State Health Benefits Program and the School Employees' Health

1 Benefits Program for in-State emergency out-of-network health care
2 and inadvertent out-of-network health care.

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

7 f. The number of physician specialists practicing in the State in
8 a particular specialty and whether they are in-network or out-of-
9 network with respect to the carriers that administer the State Health
10 Benefits Program, the School Employees' Health Benefits Program,
11 the qualified health plans in the federally run health exchange in the
12 State, and other health benefits plans offered in the State.

13 g. The results of the network audit required pursuant to section
14 16 of this act.

15 h. ¹A summary of the information submitted to the department
16 pursuant to subsection f. of section 6 of this act concerning the
17 number of claims submitted by health care providers to carriers
18 which are denied or down coded by the carrier and the reasons for
19 the denials or down coding determinations.

20 i.¹ Any other benchmarks or information obtained pursuant to
21 this act that the commissioner deems appropriate to make publicly
22 available to further the goals of the act.

23

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

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

39

40 14. ¹a. A carrier shall calculate, as part of rate filings required
41 to be filed under New Jersey law, the savings that result from a
42 reduction in out-of-network claims payments pursuant to the
43 provisions of this act. The department shall include that
44 information in the information provided on the department's
45 website pursuant to section 12 of this act.

46 ¹b. The department shall report to the Governor, and to the
47 Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1),
48 no later than 12 months after the effective date of this act and

1 annually thereafter, on the savings to policyholders and the
2 healthcare system that result from the provisions of this act. The
3 report shall contain an analysis of the information compiled
4 pursuant to section 12 of this act.¹
5

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

16 b. This section shall not apply to any waiver, rebate, gift,
17 payment, or offer that falls within a safe harbor under federal laws
18 related to fraud and abuse concerning patient cost-sharing, including,
19 but not limited to, anti-kickback, self-referral, false claims, and civil
20 monetary penalties, including any advisory opinions issued by the
21 Centers for Medicare and Medicaid Services or the Office of Inspector
22 General pertaining to those laws.
23

24 16. A carrier which offers a managed care plan shall provide for
25 an annual audit of its provider network by an independent private
26 auditing firm. The audit shall be at the expense of the carrier and the
27 carrier shall submit the audit findings to the commissioner. The
28 commissioner shall make the results of the audit available on the
29 department's website. If the audit contains a determination that a
30 carrier has failed to maintain an adequate network of providers in
31 accordance with applicable federal or State law, in addition to any
32 other penalties or remedies available under federal or State law, it shall
33 be a violation of this act and the commissioner may initiate such action
34 as the commissioner deems appropriate to ensure compliance with this
35 act and network adequacy laws.
36

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

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

1 (2) A person or entity not covered by paragraph (1) of this
2 subsection that violates the requirements of this act shall be liable to a
3 penalty of not more than \$100 for each violation. Every day upon
4 which a violation occurs shall be considered a separate violation, but
5 no person or entity shall be liable to a penalty greater than \$2,500 for
6 each occurrence.

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

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

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

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

19

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

27

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

33

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

39

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

45

46

47 "Out-of-network Consumer Protection, Transparency, Cost
48 Containment and Accountability Act."