[First Reprint]

SENATE, No. 485

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

Co-Sponsored by:
Senator Ruiz

SYNOPSIS

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

CURRENT VERSION OF TEXT

As reported by the Senate Commerce Committee on April 5, 2018, with amendments.

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

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

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

1. This act shall be known and may be cited as the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act."

2. The Legislature finds and declares that:

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

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

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

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

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

f. Health care providers and hospitals report that inadequate reimbursement from carriers and government payers is causing

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:
[1]Senate SCM committee amendments adopted April 5, 2018.

financial stress on safety net hospitals, deteriorating morale among providers and reduced quality of care for consumers;

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

3. As used in this act:

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

"Department" means the Department of Banking and Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) the covered person may have a financial responsibility applicable to health care services provided by an out-of-network provider, 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 the person's self-funded health benefits plan; and

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

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

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

(b) the covered person may have a financial responsibility applicable to health care services provided at an out-of-network 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

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

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

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

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

(2) a statement that:

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

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

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

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

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

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

d. If, between the time the notice required pursuant to subsection a. of this section is provided to the covered person and the time the procedure takes place, the network status of the facility changes as it relates to the covered person's health benefits plan, the facility shall notify the covered person promptly.

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

5. a. Except as provided in subsection f. of this section, 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, the health care professional shall, in terms the covered person typically understands:

(1) Prior to scheduling a non-emergency procedure 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 for the service and the Current Procedural Terminology (CPT) codes associated with that service, disclose to the covered person in writing the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

(3) Inform the covered person that the covered person will 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 who is a physician shall provide the covered person, to the extent the information is available, with the name, practice name, mailing address, and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office for the covered person or coordinated or referred by the physician for the covered person at the time of referral to, or coordination of, services with that provider. The physician shall provide instructions as to how to determine the health benefits plans in which the health care provider participates and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

c. A physician shall, for a covered person's scheduled facility admission or scheduled outpatient facility services, provide the covered person and the facility with the name, practice name, mailing address, and telephone number of any other physician 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, and 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.

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

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

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

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

6. a. A carrier shall update the carrier's website within 20 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, provided that in the case of a change in affiliation the carrier has had notice of such change.

b. 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 the allowed amount for out-of-network services;

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

(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 carrier 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) 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

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

c. 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.

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

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

[1]f. A carrier shall include in the carrier's annual public regulatory filings, and in a manner to be determined by the Department of Banking and Insurance, the number of claims submitted by health care providers to the carrier which are denied or

down coded by the carrier and the reason for the denial or down coding determination.[1]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) The arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers and shall be binding on both parties. The decision of the arbitrator shall include written findings and shall be issued within [1][45] 30[1] days after the request is filed with the department. The arbitrator's expenses and fees shall be split equally among the parties except in situations in which the arbitrator determines that the payment made by the carrier was not made in good faith, in which case the carrier shall be responsible for all of the arbitrator's expenses and fees. Each party shall be responsible for its own costs and fees, including legal fees if any.

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

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

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

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

(4) individual patient characteristics; and

(5) as certified by an independent actuary:

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

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

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

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

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

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

[1]**[**g.**]** f.[1] In the event an entity providing or administering a self-funded health benefits plan elects to be subject to the provisions of section 9 of this act, as provided in subsection d. of that section, the provisions of this section shall apply to a self-funded plan in the same manner as the provisions of this section apply to a carrier. If a self-funded plan does not elect to be subject to the provision of section 9 of this act, a member of that plan may initiate binding arbitration as provided in section 11 of this act.

11. a. If attempts to negotiate reimbursement for services between an out-of-network health care provider and a member of a self-funded plan that does not elect to be subject to the provision of section 9 of this act do not result in a resolution of the payment dispute within 30 days after the plan member is sent a bill for the services, the plan member or out-of-network health care provider

may initiate binding arbitration to determine payment for the services. Unless negotiations for reimbursement result in an agreement between the provider and the plan member within the 30 days, a provider shall not collect or attempt to collect reimbursement, including initiation of any collection proceedings, until the provider files a request for arbitration with the department pursuant to this section.

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

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

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

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

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

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

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

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

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

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

(4) individual patient characteristics;

(5) as certified by an independent actuary:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. The number of physician specialists practicing in the State in a particular specialty and whether they are in-network or out-of-network with respect to the carriers that administer the State Health

Benefits Program, the School Employees' Health Benefits Program, the qualified health plans in the federally run health exchange in the State, and other health benefits plans offered in the State.

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

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

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

13. a. 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.

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

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

[1]b. The department shall report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), no later than 12 months after the effective date of this act and annually thereafter, on the savings to policyholders and the healthcare system that result from the provisions of this act. The report shall contain an analysis of the information compiled pursuant to section 12 of this act.[1]

15. a. It shall be a violation of this act if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all

or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. As the commissioner shall prescribe by regulation, a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement for the purposes of this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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