SENATE, No. 4249

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED NOVEMBER 18, 2019

Sponsored by:
Senator VIN GOPAL
District 11 (Monmouth)

SYNOPSIS

Requires DOBI to provide certain information concerning self-funded health benefits plans and out-of-network services.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning self-funded health benefits plans and amending P.L.2018, c.32.

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

1. Section 6 of P.L.2018, c.32 (C.26:2SS-6) is amended to read as follows:

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

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

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

(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**]** P.L.2018, c.32 (26:2SS-9), 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 to section 9 of **[**this act**]** P.L.2018, c.32 (26:2SS-9), whether the plan is self-funded and whether the plan has elected **[**is**]** to be subject to **[**this act**]** P.L.2018, c.32 (26:2SS-1 et seq.).

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**]** department, 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.

g. The department shall post on its website, in a prominent, easily-accessible location, and regularly update, a list of any self-funded health benefits plans that have not elected to be subject to P.L.2018, c.32 (26:2SS-1 et seq.).

(cf: P.L.2018, c.32, s.6.)

2. This act shall take effect on the 90th day next following enactment.

STATEMENT

This bill requires the Department of Banking and Insurance to post on its website, in a prominent, easily-accessible location, and regularly update, a list of any self-funded health benefits plans that have not elected to be subject to the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act."

Under current law, if a self-funded plan elects to be subject to the out-of-network law, it must comply with the requirements of that law, such as participating in the out-of-network arbitration process with providers and providing certain disclosures to providers and covered persons. The law requires self-funded plans to provide covered persons with health insurance identification cards that indicate that the plan has elected to be subject to the out-of-network law. This bill requires the department to post on its website a list of any self-funded plans that do not elect to be subject to the law, so that providers and covered persons have more certainty concerning the applicability of the law.