ASSEMBLY, No. 547

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:
Assemblyman ROBERT AUTH
District 39 (Bergen and Passaic)

SYNOPSIS

"Health Care Consumer's Out-of-Network Protection, Transparency, Cost Containment and Accountability Act."

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

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 "Health Care Consumer's Out-of-Network Protection, Transparency, Cost Containment and Accountability Act."

2. The Legislature finds and declares that:

a. The health care delivery system in this State requires reforms that will enhance consumer protections, create a system to resolve certain health care billing disputes, contain rising costs, and measure success in achieving 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 problems for health care consumers in New Jersey. Many consumers are surprised to find bills for hospital emergency room procedures or for charges by providers that they 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. 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, insurance, and self-insured employers costs, and imposes hardships on health care consumers;

e. Health care providers and hospitals report that inadequate reimbursement from carriers and other payers is causing financial stress on safety net hospitals, deteriorating morale among providers and reduced quality of care for consumers;

f. Approximately 70 percent of individuals with health benefits are in self-funded plans, in which the employer pays the claims directly without shifting the risk to insurance companies. Most employers work through licensed third party administrators, which disburse the funds to pay claims. Third party administrators have their own networks, whether preferred provider organizations or exclusive provider organizations, with which they contract in order

to receive a more favorable rate for their clients. Physicians and facilities, however, do not necessarily know what employer is affiliated with any given network that they are in; therefore, it is necessary for the physicians and health care facilities to know if they are in a network utilized by a particular employer when a patient presents himself for health care services and the identification card contains the name of the employer rather than a recognizable insurer. Therefore, a physician or health care facility cannot give proper notification to a patient. It is therefore necessary that physicians and healthcare facilities have full knowledge of the network arrangements of third party administrators or employers that pay claims directly in order that physicians and health care facilities can comply with the provisions of this act;

g. It is, therefore, in the public interest to reform the economics of 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. For the purposes of this act:

"Carrier" means an insurer licensed to write health insurance in this State under Title 17 of the Revised Statutes or Title 17B of the New Jersey Statutes and a health maintenance organization licensed pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or a carrier acting as a third party administrator on behalf of an employer or other entity under a self-funded plan.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier, an employer, or a third party administrator 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.

"Employer" means and includes a self-funded business or other entity that pays claims directly without using a licensed third party administrator.

"Facility-based provider" means a physician or other provider who provides health care services to patients who are in an inpatient or ambulatory care facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an inpatient or ambulatory care facility setting, which services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility's general business operations, wherein a covered person or the covered person's health benefits plan generally does not specifically

select or have a choice of providers from which to receive the service within the facility.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits and other health care services for covered services, and is delivered or issued for delivery in this State by or through a carrier, or an employer or third party administrator that pays hospital and medical benefits. 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" or "facility" means a general acute care hospital, satellite emergency department, a hospital-based off-site ambulatory care facility in which ambulatory surgical services are performed, or an ambulatory surgery facility, licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Knowingly selected a non-participating provider" means that a covered person chose the services of a specific provider, with full knowledge that the physician or health care facility is non-participating or 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 physician or facility's network status shall not render a covered person's decision to proceed with treatment from that physician or facility a choice made "knowingly" pursuant to this definition.

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

"Geographic region" means a group of counties as follows:

(1) Essex, Hudson, and Union counties;

(2) Bergen and Passaic counties;

(3) Monmouth, Morris, Sussex, and Warren counties;

(4) Hunterdon, Middlesex, and Somerset counties;

(5) Burlington, Camden, and Mercer counties; and

(6) Atlantic, Cape May, Ocean, Salem, Cumberland, and Gloucester counties.

"Non-participating physician" means a physician that is not in the network of a covered person's health benefits plan.

"Self-funded health benefits plan" means a health benefits plan in which payment to providers of health services is paid directly to providers on behalf of covered persons from an employer's or other entity's funds, either by the employer directly or through the use of

a licensed third party administrator, with no transfer of risk to a carrier or other party.

"Third party administrator" means an entity licensed pursuant to P.L.2001, c.267 (C.17B:27B-1 et seq.) that disburses payment for health benefits to providers for covered services on behalf of a self-funded health benefits plan.

4. At the time a non-emergency medical procedure or other health care service is scheduled for a covered person, a physician shall disclose to the patient whether or not the physician is a participating physician in the health benefits plan in which the covered person is a member. The covered person shall also have a responsibility to confirm that fact through a carrier, employer or employer's third party administrator, as the case may be. If the physician is a non-participating physician, the patient shall have the option of either finding an alternative physician or selecting the non-participating physician. If the patient knowingly selects a non-participating physician, the physician shall provide a written estimate of the probable cost of the procedure or service, absent unforeseen medical circumstances that may arise when the procedure is provided and shall secure the written assent of the patient to pay any balance due to the physician that is in excess of the amount paid by the covered person's health benefits plan and shall inform the covered person that he will have a financial responsibility with respect to health care services provided by the non-participating physician. The non-participating physician shall notify the covered person to contact the covered person's insurer, employer, or third party administrator, as the case may be, for further consultation on those costs.

5. a. A physician shall, at the time a covered person's non-emergency facility admission or outpatient procedure or service is scheduled, provide the covered person with the name, practice name, mailing address, and telephone number of any other physician or group of physicians whose ancillary services are to be utilized by the physician in connection with the procedure or service to be performed and shall recommend that the covered person contact: (1) any such physician or group of physicians; or (2) the covered person's insurer, employer, or third party administrator of the person's health benefits plan to determine whether physicians performing such ancillary services are participating physicians in the covered person's plan. If the covered person elects to utilize such ancillary services to be performed by a non-participating physician, the covered person shall provide written assent to the use of the non-participating physician and shall agree to pay any balance due that is in excess of the amount paid by the covered person's health benefits plan.

b. The receipt or acknowledgement by any covered person of any disclosure required pursuant to this act 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. 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 or health care service takes place, the network status of a physician changes as it relates to the covered person's health benefits plan, the physician shall notify the covered person promptly. In the case of a primary care physician performing an unscheduled procedure in that physician's office, the notice required under this section may be made verbally at the time of the service. The Department of Banking and Insurance shall specify in further detail the content and design of the disclosure form and the manner in which the form is to be provided.

6. Prior to scheduling an admission or appointment for an out-patient procedure or health service to be performed on a non-emergency basis, a health care facility shall:

a. 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;

b. advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is an in-network participating physician or out-of-network non-participating physician with respect to the covered person's health benefits plan; and

c. advise the covered person that if the health care facility is in-network with respect to the person's health benefits plan that: (1) the covered person will have a financial responsibility with respect to the person's copayment, deductible, or coinsurance as provided in the person's health benefits plan and that the person will not incur any out of pocket costs in excess of the charges applicable to an in-network procedure; and (2) that any bills, charges, or attempts to collect by the facility in excess of the covered person's copayment, deductible, or coinsurance, excluding any facility-based providers not in the covered person's plan, should be reported to the covered person's carrier or plan third party administrator.

7. If a health care facility is out-of-network with respect to a covered person's health benefits plan and the covered person knowingly elects to use the facility on a non-emergency basis, the covered person's assent shall be made in writing, and the following conditions shall be disclosed to the patient prior to the scheduling of an admission or an appointment for an outpatient procedure or health service:

a. the covered person will have a financial responsibility applicable to health care services provided at the out-of-network facility in excess of the covered person's copayment, deductible, or coinsurance and the covered person will be responsible for any costs in excess of those allowed by the person's health benefits plan;

b. the covered person should contact the covered person's carrier, employer, or third party administrator, as the case may be, for further consultation on those costs;

c. the covered person has the option to reschedule the admission or appointment for an outpatient procedure at a facility that is in the covered person's network; and

d. physician services provided in the facility are not included in the facility's charges or, as the case may be, that certain facility-based providers' charges, including staff physician charges, may be included in the facility's charges.

8. In a form that is consistent with federal guidelines, a non-participating or out-of-network facility shall make available to the covered person a list of the facility's standard charges for items and services to be provided by the facility, in accordance with regulations established by the commissioner by regulation. If requested by a covered person, a facility that is out-of-network shall disclose to the covered person in writing the amount or estimated amount that the facility will bill the covered person.

9. At the time an in-network health care facility schedules a procedure or seeks prior authorization from a carrier or third party administrator for the provision of non-emergency services to a covered person, the facility shall provide the covered person with a written disclosure that states that certain facility-based providers may be called upon to render care to the covered person during the course of treatment. This disclosure shall include:

a. a statement that these facility-based providers may not be participating physicians in the covered person's health benefits plan and are therefore considered to be out-of-network, and that in which case the services will be provided on an out-of-network basis;

b. a notification that the covered person may either agree to accept and pay the balance of the charges attributable to non-participating facility-based providers, that the covered person may contact his health benefits plan for additional assistance, or that he may rely on other rights and remedies that may be available under State or federal law; and

c. a statement that the covered person may obtain a list of facility-based providers from his health benefits plan that are participating providers and that the covered person may request those participating facility-based providers.

The written disclosure statement provided by the facility pursuant to this section shall be signed by the covered person or the covered person's representative, acknowledging that the covered person received the disclosure statement prior to the time of admission.

10. a. In order that a physician or health care facility can properly notify a covered person in accordance with the disclosure provisions of this act, if it is in the employer's or administrator's network, every employer paying claims directly and every licensed third party administrator of a health benefits plan licensed in New Jersey, and which contracts with physicians, facilities, preferred provider organizations or exclusive provider organizations to form a network shall:

(1) provide all employees of an employer or other organization with which it contracts to administer a health benefits plan with a list of all physicians and health care facilities which are in the employer's or third party administrator's network;

(2) provide all licensed physicians and health care facilities, which are in a network or networks of the employer or administrator, with a list of the employers or other organizations with which it contracts and which have covered persons in New Jersey. The list shall be updated as necessary when the employer or administrator acquires a new client business or organization or terminates a contract with a client; and

(3) include on any health benefits plan identification card the name, address, and telephone number of the third party administrator, as applicable.

b. Every carrier shall post the names, addresses and telephone numbers of physicians and health care facilities that are in its network or networks and shall update the carrier's website within 20 days of the addition or termination of a physician or a health care facility, or a change in a physician's affiliation with a facility, provided that in the case of a change of affiliation the carrier has had notice of such change.

11. a. In the event that medically necessary out-of-network emergency services are provided, a non-participating facility-based physician shall not attempt to collect a bill from the covered person, except for applicable deductible, copayment or coinsurance amounts that would apply if the covered person utilized a participating physician or in-network health care facility. The non-participating physician shall include a statement on any billing notice sent to the covered person for services that have been provided, informing the covered person that the covered person has no legal obligation to pay the remaining balance. The statement shall also inform the covered person of his obligation to forward the bill to the covered person's health benefits plan. A carrier,

employer, or third party administrator shall provide the non-participating physician or out-of-network health care facility with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

b. In a non-emergency situation, if a covered person who does not knowingly select, as evidenced by no written assent by the covered person, a non-participating physician or health care facility, but receives treatment from such physician or facility and assigns benefits to the physician or facility, the health benefits plan shall pay the non-participating physician either the billed amount or an amount the health benefits plan determines is reasonable for the health care services rendered, except for the covered person's copayment, coinsurance, or deductible.

c. If a covered person who does not knowingly select, as evidenced by no written assent by the covered person, a non-participating physician or facility but receives treatment from such physician or facility and does not assign benefits to the physician or facility, the covered person shall submit the bill to his health benefits plan. The health benefits plan shall pay the non-participating physician or facility the billed amount or an amount the health benefits plan determines is a usual, customary, and reasonable fee for the health services rendered, excluding the covered person's copayment, coinsurance, or deductible.

12. In the event a negotiation regarding any balance due in any case in which a covered person:

a. has not agreed to be treated by a non-participating physician, or health care facility in a non-emergency situation; or

b. has knowingly selected a non-participating provider and the procedure or health care service exceeds the physician or health care facility's estimate by at least $500, exclusive of any deductibles, copayments, or coinsurance applicable to the health benefits plan,

the dispute may be referred by a covered person or a health benefits plan to a peer review panel by a health benefits plan or an individual as provided in this act. In the case of an emergency, a carrier, employer, or third party administrator, as the case may be, shall notify a covered person that the covered person has the right to access the peer review process himself if the difference in the billed charge and the health benefit plan's allowable amount exceeds $500. Nothing in this section shall preclude a covered person from agreeing to accept and pay the charges for the out-of-network services himself rather than use the peer review process.

13. a. There is established a Physicians' Medical Bill Dispute Resolution Review Program in the State Board of Medical Examiners for the purpose of reviewing and settling disputes

regarding balance billing by non-participating physicians and non-participating facility-based physicians. The Physicians' Medical Bill Dispute Resolution Review Program shall be comprised of 21 physicians licensed by the State Board of Medical Examiners. The physicians on the board of the program, who shall be in active practice, shall be appointed by the Governor, in consultation with the Medical Society of New Jersey, and shall represent a broad range of specialties. Of the members of the program board first appointed after the effective date of this act, seven shall serve for a term of one year, seven shall serve for a term of two years, and seven shall serve for a term of three years. Thereafter, all members shall serve for a term of three years. Physicians may be reappointed by the Governor for subsequent terms.

b. Persons applying for peer review with respect to disputed bills pursuant to section 12 of this act shall submit their request for review to the State Board of Medical Examiners, which shall appoint individual case peer review panels comprised of three members of the Physicians' Medical Bill Dispute Resolution Review Program Board to each case, which members shall be practicing in the same or similar specialty as the physician who is the subject of the case being heard. In exceptional or unusual cases, the program board may appoint a specialty physician who is not a member of the program board appointed by the Governor. Each panel member hearing a disputed case shall receive a stipend of $250 per hearing, the cost of which shall be divided between the parties to the hearing.

14. a. The peer review panel in a disputed case shall have the authority to determine whether the balance of the physician's bill not reimbursed by the patient's health benefits plan was excessive in view of the medical procedure or procedures performed by the physician or that certain treatments or services were not medically necessary. This review as to medical necessity shall be in addition to and independent of any other remedy to determine or challenge medical necessity afforded by law.

b. In determining whether the bill submitted by the physician is excessive, the peer review panel shall take into account, as guidelines:

(1) the usual, customary, and reasonable charges normally charged for the same or similar procedures or services in the geographic region where they were performed;

(2) whether there is a gross disparity between the fee charged by the physician for services rendered as compared to the fees paid to the physician for the same services rendered to other patients in health benefits plans in which the physician is participating;

(3) the level of training, education, and experience of the provider;

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

(5) individual patient characteristics;

(6) fees paid by the health benefits plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health benefits plan;

(7) the physician's usual charge for comparable services with regard to patients in health benefits plans in which the provider is not participating;

(8) the average reimbursement accepted by the physician from that carrier or third party administrator in the past 12 months;

(9) the Medicare rate paid in the same region to the same type of physician for the same classification of health care facility in which the service took place; and

(10) the billed amount for the same type of procedure as reported by a recognized health claims data base for all geographic areas of the State, as determined by the commissioner; or a non-profit or commercial fee schedule data base provider. No such data base provider shall have an ownership or controlling interest in, or be an affiliate of any entity with a pecuniary interest in the application of the database, including an insurer, physician group, holding company of an insurer, or health insurance trade association. The panel shall also have, if warranted, the authority to review the patient's treatment to determine whether or not the treatment provided was appropriate and medically necessary.

15. a. There is established a Health Care Facilities Medical Bill Dispute Resolution Program for the purpose of reviewing and settling disputes regarding the balance billing of covered persons who utilize a non-network facility on a non-emergency basis pursuant to section 12 of this act. The program shall be comprised of a board of 11 members representing health care facilities located in this State, who shall be appointed by the Governor, in consultation with the New Jersey Hospital Association. The members shall serve for a term of three years. Of the members first appointed, three shall serve a one-year term, four shall serve a two-year term, and four shall serve a term of three years. Thereafter, all members shall serve for a term of three years. Representatives of health care facilities may be reappointed by the Governor for subsequent terms.

b. Persons applying for peer review regarding health care facility disputed bills shall submit them to the Commissioner of Banking and Insurance, who shall appoint individual panels of representatives of three facilities, provided that those selected to adjudicate a disputed facility bill shall not be members of, or affiliated with, the same health care facility or system as the facility whose bill is disputed.

16. The peer review panel appointed pursuant to subsection b. of section 15 of this act may consider whether there is a significant disparity between the fees charged by the facility for services rendered as compared to fees paid to participating facilities for the same service or fees charged by the facility to health benefits plans in which it is a participating provider. The panel may also consider whether a service or services were deemed to be medically necessary in accordance with normal practice, given the covered person's circumstances and condition. This review as to medical necessity shall be in addition to and independent of any other remedy to determine or challenge medical necessity afforded by law. In the case of health care facilities, a peer review panel may take into consideration the facility's actual cost in providing the services, as demonstrated by the facility, and whether that cost is consonant with the actual services rendered and the demographics of the population served by that facility.

17. a. When a decision is made by the appropriate peer review panel pursuant to section 14 or section 16 of this act, the panel, by majority vote, shall establish a reasonable reimbursement amount of the balance due to be paid by the covered person or the health benefits plan, or both, as the case may be, or deny payment of any balance due if the balance does not meet the criteria established by this act. The decision of the peer review panel shall be determinative.

b. Any interest charges for overdue payments shall not apply during the pendency of a decision by a peer review panel and any interest due to a physician or facility shall not accrue until after 20 days following the panel's decision, but in no circumstances longer than 150 days from the date that the physician or health care facility billed the carrier, employer or third party administrator for services rendered, unless both parties agree to a longer period of time.

18. On or before January 31 of each calendar year, the commissioner shall obtain information to compile and make publicly available on the department's website:

a. A list of all peer review applications filed pursuant to this act between January 1 and December 31 of the previous calendar year, including the percentage of all claims that were reviewed.

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

(a) an indication of whether the decision was in favor of the carrier, employer, third party administrator, or the non-participating physician or out-of-network health care facility;

(b) any reimbursement offers by either side and the award amount;

(c) the category and practice specialty of each non-participating physician involved in a peer review decision, as applicable; and

(d) a description of the health care service or services that were provided and billed for.

(2) The list of peer review decisions shall not include any information specifically identifying the provider, carrier, employer, third party administrator or covered person involved in each peer review decision.

b. The percentage of health care facilities and facility-based physicians, by specialty, that are participating physicians for each carrier in this State.

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

d. 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.

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

19. a. A carrier, employer, and third party administrator shall provide a written notice to each covered person, in a form and manner to be prescribed by the commissioner, 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 a 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 peer reviews filed pursuant to this act.

20. a. It shall be a violation of this act for an out-of-network health care provider, directly or indirectly related to a claim, to knowingly waive, rebate, give, pay, or offer 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.

21. This bill shall take effect on the 60th day next following enactment, but the Governor, the State Board of Medical Examiners, and the Department of Banking and Insurance may take such anticipatory action prior to that time as deemed necessary to effectuate the provisions of the act.

STATEMENT

This bill is intended to provide remedies for individuals who are treated by physicians and treated in facilities that do not belong to a provider network used by the individual's health benefits plan and who are consequently billed for the balance of charges that are not paid for by their health benefits plan.

In order to provide such services and to provide transparency in the health care system, the bill requires that at the time a non-emergency medical procedure or other health care service is scheduled for a covered person, a physician must disclose to the patient whether or not he is a participating physician in the health benefits plan in which the covered person is a member. If the physician is a non-participating physician, the covered person will have the option of either finding an alternative physician or selecting the non-participating physician. If the patient knowingly selects a non-participating physician, the physician would be required to provide a written estimate of the probable cost of the procedure or service, not including unforeseen medical circumstances that may arise when the procedure or service is provided. The non-participating physician must secure the written assent of the patient to pay any balance that is in excess of the amount paid by the person's health benefits plan. The covered person must be informed that he will have a financial responsibility with respect to the services that are provided. The physician also has to provide the covered person with information regarding any other physician or group of physicians whose ancillary services are to be utilized by the attending physician, as well as information as to how the patient can determine whether the ancillary physician or physicians are in the patient's network, thus avoiding what has been called "surprise" balance billing. The same requirements would apply to hospitals, which would have to inform patients that their facility-based physicians, including staff physicians, radiologists, and anesthesiologists who bill separately, may not be in the patient's health benefits plan network.

The disclosure provisions will not apply in any case in which the treatment takes place on an emergency or urgent basis; in that case the physician or hospital cannot require the patient to pay any amount in excess of whatever reimbursement was made by his health benefits plan.

While physicians and health care facilities clearly know if they are in a network organized by an insurance carrier, nearly 70 percent of individuals covered by health benefits plans in the State are in self-insured plans, in which their employers are paying the claims out of its own funds, assuming all of the risk themselves. Self-insured plans are almost always administered by licensed third party administrators, although a few employers process the claims themselves. These administrators contract with networks of physicians and health care facilities, including preferred provider organizations, to provide health care services at a reduced rate, much as health insurers do with their networks. Because of this, a physician or health care facility would not necessarily know if they are a member of a network used by an independent third party administrator; often the health benefits card carries the name of the employer rather than a recognizable insurance company or third party administrator. Because the bill requires disclosure of network status by all physicians and health care facilities, it requires third party administrators to notify every physician or facility that is in a network that they use with the name of the administrator's employer clients so that a physician or facility will be alerted that they are in a network of a health benefits plan of a patient working for a specific employer.

In the event that a patient or insurer or third party administrator receives a balance bill from a physician or facility, the bill provides two peer review mechanisms – one for physicians and one for health care facilities. The physicians' peer review panel, established in the Physicians' Medical Bill Dispute Resolution Review Program and located in the State Board of Medical Examiners, consists of 21 physicians of different specialties, appointed by the Governor. The health care facilities peer review panel, the Health Care Facilities Medical Bill Dispute Resolution Program, will be comprised of a board of 11 members representing health care facilities located in this State, who shall be appointed by the Governor in consultation with the New Jersey Hospital Association. A panel of three physicians or facilities will be assigned to each case. The bill does not provide for so-called "baseball-style arbitration," in which an all-or-nothing award is made relative to a disputed amount, but rather sets forth a number of criteria that should be considered by the peer review panel, and permits the panel to award any amount it would determine to be fair. The decision of the panel would be determinative.