

ASSEMBLY, No. 1239

STATE OF NEW JERSEY 219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:

Assemblyman GARY S. SCHAER

District 36 (Bergen and Passaic)

SYNOPSIS

"Healthcare Disclosure and Transparency Act."

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 **AN ACT** concerning health benefits plans, amending P.L.1997,
2 c.192 and supplementing Title 26 of the Revised Statues.

3

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

6

7 1. (New section) Sections 1 through 5 of this act shall be
8 known and may be cited as the "Healthcare Disclosure and
9 Transparency Act."

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11 2. (New section) As used in sections 3 through 5 of this act:

12 "Carrier" means an insurance company, health service
13 corporation, hospital service corporation, medical service
14 corporation or health maintenance organization authorized to issue
15 health benefits plans in this State.

16 "Covered person" means a person on whose behalf a carrier or
17 entity providing a self-funded health benefits plan is obligated to
18 pay benefits or provide services pursuant to the health benefits plan.

19 "Health benefits plan" means a benefits plan which pays or
20 provides hospital and medical expense benefits for covered
21 services, and is: (1) delivered or issued for delivery in this State by
22 or through a carrier; or (2) offered in this State by an entity
23 providing a self-funded health benefits plan. Health benefits plan
24 includes, but is not limited to, Medicare supplement coverage and
25 risk contracts to the extent not otherwise prohibited by federal law.
26 For the purposes of this act, health benefits plan shall not include
27 the following plans, policies or contracts: accident only, credit,
28 disability, long-term care, TRICARE supplement coverage,
29 coverage arising out of a workers' compensation or similar law,
30 automobile medical payment insurance, personal injury protection
31 insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), and
32 hospital confinement indemnity coverage.

33 "Health care facility" means a hospital or other health care
34 facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

35 "Physician" means a physician licensed by the State Board of
36 Medical Examiners to practice medicine and surgery pursuant to
37 chapter 9 of Title 45 of the Revised Statutes.

38

39 3. (New section) a. A carrier which offers a health benefits plan
40 or an entity which offers a self-funded health benefits plan shall
41 disclose in writing to a covered person, at the time of enrollment in
42 the plan and upon request thereafter, the reimbursement
43 methodology that the carrier or entity uses to determine amounts of
44 reimbursement for out-of-network health care services; 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 thus is new matter.

1 b. A carrier which offers a health benefits plan or an entity
2 which offers a self-funded health benefits plan shall establish and
3 maintain a website to serve as an information clearinghouse for
4 covered persons to obtain information to assist them in their health
5 care needs. The link to the website shall be prominently displayed
6 on the back of each health benefits card issued to a covered person.
7 For the purposes of this section, a “health benefits card” means a
8 card issued to a covered person for the limited purpose of obtaining
9 health care services under a health benefits plan. The website shall
10 be updated regularly and shall include, but not be limited to:

11 (1) links to quality rankings that are produced, audited, and
12 publicly reported by State and federal agencies for physicians,
13 which rankings shall be provided in a manner to be prescribed by
14 the Department of Banking and Insurance, in consultation with the
15 State Board of Medical Examiners, the Division of Consumer
16 Affairs, and the Department of Health;

17 (2) for each health benefits plan offered in this State:

18 (a) a clear and understandable description of the plan’s out-of-
19 network health care benefits, including a covered person’s financial
20 responsibility for those benefits;

21 (b) the reimbursement methodology of the carrier or entity, and
22 based on the reimbursement methodology, the amount that the plan
23 generally reimburses for each procedure or treatment for which
24 coverage is provided as an out-of- network health care service; and

25 (3) such other information as the Department of Banking and
26 Insurance determines appropriate and necessary to ensure that a
27 covered person receives sufficient information necessary to make a
28 well-informed health care decision.

29 c. The website shall contain links to the information set forth in
30 subsection b. of this section. Each link shall be prominently
31 displayed on the website in at least 14 point font to ensure each link
32 is easily accessible by covered persons and those seeking the
33 information set forth in subsection b. on the website.

34 d. The provisions of this section shall not apply to a health
35 maintenance organization with respect to its contract with
36 Medicaid.

37 e. A carrier that fails to comply with this section is liable to a
38 penalty of not more than \$1,000 for each violation. The penalty
39 shall be collected by the Commissioner of Banking and Insurance in
40 a summary proceeding in accordance with the “Penalty
41 Enforcement Law of 1999,” P.L.1999, c.274 (C.2A:58-10 et seq.).
42

43 4. (New section) a. Prior to scheduling an appointment with a
44 covered person for a non-emergency or elective procedure, and at
45 least three days prior to the procedure, a health care facility shall
46 provide a written disclosure form to the covered person on which
47 the health care facility shall make the following disclosures, as
48 applicable to each covered person’s health benefits plan, in clear

1 and understandable terms and in a language the covered person
2 understands:

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

5 (2) if the health care facility is in-network with respect to the
6 person's health benefits plan, and the health care facility will ensure
7 that the covered person will only receive health care services from
8 health care providers that are in-network with respect to the covered
9 person's health benefits plan, the health care facility shall disclose
10 that:

11 (a) all of the health care services received at the facility will be
12 provided on an in-network basis; and

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

17 (3) if the health care facility is in-network, but a covered person
18 may receive health care services in that facility from health care
19 providers that are out-of-network with respect to the covered
20 person's health benefits plan, the health care facility shall:

21 (a) disclose that the health care services associated with the
22 facility will be provided on an in-network basis, but other health
23 care services, including services of certain physicians, may be
24 provided on an out-of-network basis;

25 (b) disclose that the covered person may have a financial
26 responsibility applicable to certain out-of-network health care
27 services, in excess of the covered person's copayment, deductible,
28 or coinsurance as provided for in the covered person's health
29 benefits plan, and that the covered person should contact his health
30 insurance carrier for further consultation on those costs; and

31 (c) provide the covered person with a list of the three health
32 care facilities located closest to the health care facility that are in-
33 network with respect to that person's health benefits plan.

34 (4) if the health care facility is out-of-network with respect to
35 the covered person's health benefits plan, the health care facility
36 shall:

37 (a) disclose that certain health care services will be provided on
38 an out-of-network basis, including those health care services
39 associated with the health care facility;

40 (b) disclose that the covered person will have a financial
41 responsibility applicable to health care services provided at an out-
42 of-network facility, in excess of the covered person's copayment,
43 deductible, or coinsurance as provided for in the covered person's
44 health benefits plan, and that the covered person should contact his
45 health insurance carrier for further consultation on those costs; and

46 (c) provide the covered person with a list of the three health
47 care facilities located closest to the health care facility that are in-
48 network with respect to that person's health benefits plan.

1 b. A health care facility shall, prior to the performance of the
2 procedure, ensure that the covered person signs and returns the
3 disclosure form to the health care facility.

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

7 d. A health care facility that fails to comply with this section is
8 liable for action by the Department of Health pursuant to section 13
9 of P.L.1971, c.136 (C.26:2H-13).

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11 5. (New section) a. A physician shall, when scheduling an
12 appointment with a covered person to provide health care services,
13 disclose to that person whether the physician is in-network or out-
14 of-network with respect to the person's health benefits plan.

15 b. The disclosure required pursuant to subsection a. of this
16 section shall inform the covered person that the covered person may
17 have a financial responsibility, including any applicable
18 deductibles, copayments, and coinsurance, for the receipt of health
19 care services under the terms of the covered person's health benefits
20 plan.

21 c. A physician delivering out-of-network health care services
22 for any non-emergency or elective procedure shall, prior to
23 delivering the health care services and in terms the covered person
24 typically understands, provide the covered person receiving those
25 services with a clear and understandable: (1) description of the
26 procedure; (2) estimate of the costs for those services to be charged
27 by that physician; and (3) notice to the covered person to contact
28 the covered person's health insurance carrier for further
29 consultation on the costs of the procedure.

30 d. The State Board of Medical Examiners may specify the
31 manner in which the description of the procedure and the cost
32 estimate required by subsection c. of this section shall be provided.

33 e. A physician who fails to comply with this section is liable
34 for action by the State Board of Medical Examiners pursuant to R.S.
35 45:9-1 et seq.

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37 6. Section 8 of P.L.1997, c.192 (C.26:2S-8) is amended to read
38 as follows:

39 8. A carrier which offers a managed care plan shall establish a
40 policy governing removal of health care providers from the provider
41 network which includes the following:

42 a. The carrier shall inform a participating health care provider
43 of the carrier's removal policy at the time the carrier contracts with
44 the health care provider to participate in the provider network, and
45 at each renewal thereof.

46 b. If a licensed health care professional's participation will be
47 terminated prior to the date of the termination of the contract, the
48 carrier shall provide the health care professional with 90 days'

1 written notice of the termination and notice of a right to a hearing.
2 If requested by the health care professional, the carrier shall provide
3 the reasons for the termination in writing, and shall hold a hearing
4 within 30 days of the date of the request. The hearing shall be
5 conducted by a panel appointed by the carrier, which panel shall be
6 comprised of a minimum of three persons, at least one of whom is a
7 clinical peer in the same discipline and the same or similar specialty
8 as the health care professional being reviewed. The panel shall
9 make a decision that: (1) the health care professional shall be
10 terminated, or (2) the health care professional shall be reinstated or
11 provisionally reinstated, subject to conditions set forth by the panel.
12 The panel's determination shall be in writing and shall be made in a
13 timely manner. Participation in this process shall not be deemed to
14 be an abrogation of the health care professional's legal rights.

15 The notice required and opportunity for a hearing pursuant to
16 this subsection shall not apply in those cases when the contract
17 expires and is not renewed, the termination is for breach of contract,
18 in the opinion of the medical director, the health care professional
19 represents an imminent danger to an individual patient or the public
20 health, safety or welfare, or there is a determination of fraud.

21 c. If the carrier finds that a health care professional represents
22 an imminent danger to an individual patient or to the public health,
23 safety or welfare, the medical director shall promptly notify the
24 appropriate professional State licensing board **【**. Notification to the
25 State Board of Medical Examiners shall be subject **】** pursuant to the
26 provisions of **【**section 5 of P.L.1989, c.300 (C.45:9-19.5)**】** the
27 "Health Care Professional Responsibility and Reporting
28 Enhancement Act," P.L.2005, c.83 (C.45:1-33 et seq.).

29 d. The carrier shall not terminate participation of a health care
30 provider based on a determination that the provider referred a
31 covered person to an out-of-network health care provider, except
32 that this restriction shall not apply to a health maintenance
33 organization with respect to a Medicaid contract.

34 (cf: P.L.1997, c.192, s.8)

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36 7. This act shall take effect on the 90th day next following
37 enactment.

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STATEMENT

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42 This bill is designated the "Healthcare Disclosure and
43 Transparency Act" and requires providers of health benefits plans
44 to:

45 (1) disclose in writing to a covered person, at the time of
46 enrollment in the plan and upon request thereafter, the
47 reimbursement methodology that the carrier or entity uses to

1 determine amounts of reimbursement for out-of-network services;
2 and

3 (2) establish and maintain a website to serve as an information
4 clearinghouse for covered persons to obtain information to assist
5 them in their health care needs.

6 A link to the website must be featured and prominently displayed
7 on the back of each health benefits card issued to covered persons
8 to ensure that they are aware of the website. Specifically, the bill
9 requires the websites to have:

10 (1) links to quality rankings that are produced, audited, and
11 publicly reported by State and federal agencies for physicians,
12 which rankings shall be provided in a manner to be prescribed by
13 the Department of Banking and Insurance, in consultation with the
14 State Board of Medical Examiners, the Division of Consumer
15 Affairs, and the Department of Health;

16 (2) for each health benefits plan offered in this State, a clear and
17 understandable description of the plan's out-of-network health care
18 benefits, including a covered person's financial responsibility for
19 those benefits and, based on the reimbursement methodology of the
20 carrier or entity, the amount that the plan generally reimburses for
21 each procedure or treatment for which coverage is provided as an
22 out-of-network health care service; and

23 (3) any other information that the Department of Banking and
24 Insurance determines is appropriate and necessary to ensure that
25 covered persons receive sufficient information needed to make
26 well-informed health care decisions. The bill also prescribes a
27 minimum font size and location for each link featuring the
28 information prescribed.

29 The bill requires a health care facility, at least three days prior to
30 an elective procedure, to provide a written disclosure form to the
31 covered person on which the health care facility shall make certain
32 disclosures regarding whether the health care facility and physicians
33 providing services at the facility are in-network or out-of-network
34 with respect to the covered person's health benefits plan and
35 information concerning the financial responsibility of the covered
36 person with regard to services received at the facility. The health
37 care facility must, prior to the performance of the procedure, ensure
38 that the covered person signs and returns the disclosure form to the
39 health care facility.

40 The bill also requires a physician, when scheduling an
41 appointment with a covered person, to disclose whether the health
42 care services are in-network or out-of-network with respect to that
43 person's health benefits plan and that there may be a financial
44 responsibility of the covered person, including applicable
45 deductibles, copayments and coinsurance. The bill also requires the
46 physician, if providing out-of-network services, to provide to the
47 covered person, in a clear and understandable manner and in the
48 terms the covered person typically understands, the following:

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- 1 (1) a description of the procedure;
 - 2 (2) an estimate of the costs charged by the physician for those
 - 3 services; and
 - 4 (3) a notice to contact their insurance carrier for further
 - 5 consultation on the costs of the procedure.
- 6 The bill also amends the “Health Care Quality Act” by adding to
- 7 the current policies governing when a health insurance carrier can
- 8 remove a health care provider from a provider network. The bill
- 9 provides that the carrier shall not terminate participation of the
- 10 provider based on a determination that the provider referred a
- 11 covered person to an out-of-network health care provider.