SENATE, No. 3937

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED JUNE 15, 2021

Sponsored by:
Senator NELLIE POU
District 35 (Bergen and Passaic)

SYNOPSIS

Requires carriers to publish certain information concerning costs of coverage.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning insurance cost transparency and supplementing P.L.1997, c.192 (C.26:2S-1 et seq.).

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

1. a. A carrier shall make available on its internet website an interactive mechanism whereby any member of the public may:

(1) for each health benefit plan offered, compare the payment amounts accepted by in-network providers from the carrier for the provision of a particular health care service within the previous year;

(2) for each health benefit plan offered, obtain an estimate of the average amount accepted by in-network providers from the carrier for the provision of a particular health care service within the previous year;

(3) for each health benefit plan offered, obtain an estimate of the out-of-pocket costs that a covered person would owe a provider following the provision of a particular health care service;

(4) compare quality metrics applicable to in-network providers for major diagnostic categories with adjustments by risk and severity based upon the hierarchical condition category methodology or a nationally recognized health care quality reporting standard designated by the commissioner. Metrics shall be based on reasonably universal and uniform data bases with sufficient claim volume. If applicable to the provider, quality metrics shall include, but not be limited to:

(a) risk adjusted and absolute hospital readmission rates;

(b) risk adjusted and absolute hospitalization rates;

(c) admission volume;

(d) utilization volume;

(e) risk adjusted rates of adverse events; and

(f) risk adjusted and absolute relative total cost of care; and

(5) access any all-payer health claims data base which may be maintained by the department.

b. A carrier shall display, in a conspicuous location on its internet website, a notification that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforeseen costs that arise during the provision of that service.

c. Each estimate of out-of-pocket costs provided pursuant to paragraph (3) of subsection a. of this section shall provide:

(1) the out-of-pocket costs a covered person may owe if the covered person has exceeded the deductible; and

(2) the out-of-pocket costs a covered person may owe if the covered person has not exceeded the deductible.

d. A carrier may contract with a third party to comply with the provisions of this act.

e. Nothing in this act shall prohibit a carrier from charging a covered person cost sharing beyond that included in the estimate provided pursuant to paragraph (3) of subsection a. of this section if the additional cost sharing resulted from the unforeseen provision of additional health care services and the cost-sharing requirements of the unforeseen health care services were disclosed in the covered person's health benefits plan.

f. The requirements of this section, with the exception of paragraph (4) of subsection a. of this section, shall not apply to a health maintenance organization as defined in P.L.1973, c.337 (C.26:2J-1 et seq.).

g. As used in this section:

"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. “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.

“Emergency services” means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(1) placing the patient’s health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"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 a 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.

“Health care service” means:

(1) physical and occupational therapy services;

(2) obstetrical and gynecological services;

(3) radiology and imaging services;

(4) laboratory services;

(5) infusion therapy;

(6) inpatient or outpatient surgical procedures;

(7) outpatient nonsurgical diagnostic tests or procedures;

(8) any service determined by the Commissioner to be relevant to the provisions of this act.

“Hierarchical condition category methodology” means a coding system designed by the Centers for Medicare and Medicaid services to estimate future health care costs for patients.

2. This act shall take effect one year following the date of enactment.

STATEMENT

This bill requires a carrier to make available on its internet website an interactive mechanism whereby any member of the public may obtain certain information, including certain quality metrics and estimates of cost. Under the bill, a carrier is to display, in a conspicuous location on its internet website, a notification that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforeseen costs that arise during the provision of such service.

In addition, each estimate of out-of-pocket costs provided pursuant to the bill is to provide:

(1) the out-of-pocket costs a covered person may owe if the covered person has exceeded the deductible; and

(2) the out-of-pocket costs a covered person may owe if the covered person has not exceeded the deductible.

The bill does not prohibit a carrier from charging a covered person cost sharing beyond that included in the estimate provided pursuant to the bill if the additional cost sharing resulted from the unforeseen provision of additional health care services and the cost-sharing requirements of the unforeseen health care services were disclosed in the covered person's health benefits plan.