SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 20

STATE OF NEW JERSEY

Sponsored by Senator VITALE

AN ACT concerning health insurance, health care providers, and health care data 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 increase transparency in pricing for health care services, 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. Out-of-network benefits are a health insurance benefit enhancement for which insureds pay an additional premium, in recent years, out-of-network coverage has been used inappropriately as a means to diminish consumer's health insurance coverage, exposing consumers to additional costs;

d. Health insurers 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 collections, which contributes to the increasing costs of health care services and insurance and imposes hardships on health care consumers;

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

f. In order to collect necessary data to better implement reforms to the health care system to address these stated ills, it is necessary to establish a Healthcare Price Index system, or HPI, to collect data that can be used to fill critical information gaps as consumers, public policymakers, health care providers, researchers, quality improvement organizations, and carriers seek solutions for transforming health care delivery;

g. An HPI can systematically collect health care data to inform health policy initiatives and to further cost containment and quality improvement efforts;

h. An HPI would include medical, pharmacy, and behavioral health claims and be used to report cost, use, and quality information. To mask the identity of patients and ensure privacy, an HPI would be required to comply with the applicable provisions of the federal health privacy rule set forth in sections 160 and 164 of Title 45, Code of Federal Regulations, and with other proprietary requirements related to the collection and release of health care data;

i. By including all claims information into an HPI, New Jersey can gain a more complete picture of how much health care costs, how much providers receive for the same or similar services, the resources used to treat patients, and variations across the State, and among providers, in the total cost to treat an illness or medical event. In turn, businesses, consumers, providers, and policymakers can use the non-proprietary information to make better-informed decisions about cost-effectiveness and the quality of care;

j. An HPI is also an important source of information for designing and implementing a variety of payment and delivery system reforms, such as pay-for-performance, episode-of-care payments, global payments, medical homes, reference based pricing, and accountable care organizations;

k. Studies confirm that the United States spends significantly more on health care than other countries but, on the whole, does not produce better results for patients and does not receive equivalent value for each health care dollar spent;

l. The Institute of Medicine of the National Academy of Sciences has estimated that up to 30 percent of spending on health care in the United States is wasted; however, without comprehensive data on the costs, components, results, and demographics of care, it is difficult to identify and eliminate waste; and, without reliable information about how and where health care dollars are spent and how patients move through the system, states

cannot design effective programs to address both unnecessary and inadequate care; and

m. It is, therefore, in the public interest to create the consumer protections provided for in this act and to establish an HPI and increase transparency in health care cost and utilization patterns in New Jersey to provide consumers, policymakers, providers, researchers, quality improvement organizations, and carriers with the information needed to support necessary health care reforms that will lead to a more cost-effective, high-quality health care system that benefits the citizens of this State.

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; an entity providing or administering a self-funded health benefits plan; an entity under contract with the State Health Benefits Program and the School Employees’ Health Benefits Program to administer a health benefits plan; or any other entity providing a 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.

"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 data” means data from a reporting entity relating to the provision, financing, and administration of health care, as applicable. Health care data shall include, but not be limited to, information regarding: medical, pharmacy, and behavioral health claims; health care utilization; health care safety and quality; health outcomes; health care providers; and costs.

"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 professional" includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes.

"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.

"Index" or "HPI" means the Healthcare Price Index system established pursuant to this act.

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

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

"Region" means a group of counties as follows:

a. Essex, Hudson, and Union counties;

b. Bergen and Passaic counties;

c. Monmouth, Morris, Sussex, and Warren counties;

d. Hunterdon, Middlesex, and Somerset counties;

e. Burlington, Camden, and Mercer counties; and

f. Atlantic, Cape May, Ocean, Salem, Cumberland, and Gloucester counties.

"Reporting entity" means a carrier, but shall not include entities providing or administering a self-funded health benefits plan. "Reporting entity" shall include an entity under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan under those programs.

4. a. Prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, and at least 30 days prior to the procedure, or upon scheduling the appointment if the procedure is scheduled to occur in less than 30 days, and in terms the covered person typically understands, a health care facility shall:

(1) disclose 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;

(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; and

(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

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

(b) the covered person will 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 establish, update, and make public through posting on the facility's website 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; and

(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;

(3) As applicable, the name, mailing address, and telephone number of the physician groups that the facility has contracted with to provide services including anesthesiology, pathology, or 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 heath 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. A health care professional shall disclose to a covered persons 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) At least 30 days prior to a non emergency procedure, or upon scheduling the appointment if the non emergency procedure is scheduled to occur in less than 30 days, 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, disclose to the covered person in writing the amount or estimated amount that the health care professional will bill the covered person 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) the covered person should 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 health care professional who is 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, 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 heath benefits plan, the professional shall notify the covered person promptly.

f. 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 reporting entity shall update the entity's website within 20 days of the addition or termination of a provider from the entity's network or a change in a physician's affiliation with a facility.

b. With respect to out-of-network services, for each health benefits plan offered, a reporting entity 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 reimbursement for out-of-network services;

(2) the amount the plan will reimburse under that methodology;

(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 entity 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) the approximate dollar amount that the entity will pay for a specific out-of-network service; and

(7) 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.

c. If a reporting entity 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 reporting entity shall notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the reporting entity 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.

7. a. If a covered person receives medically necessary services at any health care facility on an emergency or urgent basis, 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, and the carrier and facility cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or health care facility may initiate binding arbitration pursuant to section 13 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 urgent basis accept reimbursement rates in accordance with section 8 of this act.

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:

(1) the health benefits plans with which the facility has an agreement to be in-network;

(2) the number of health care professionals, by specialty, that provide services in the facility and whether those professionals participate in the same health benefits networks as the facility; and

(3) if any health care professionals that provide services in the facility are not in-network with respect to any health benefits plan in which the facility is in-network, confirmation that the facility has an agreement in place for professionals providing services in the facility to otherwise comply with section 8 of this act.

e. 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, the health care professional performing those services 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 the carrier and the professional cannot agree on a reimbursement rate for the services provided pursuant to subsection a. of this section within 30 days after the carrier is billed for the service, the carrier or professional may initiate binding arbitration pursuant to section 13 of this act.

9. a. The Commissioner of Banking and Insurance shall select an organization to maintain the Healthcare Price Index, in accordance with the terms of a written agreement which shall be entered into between the department and the organization, as further described in this act. The commissioner shall select an organization

that possesses the capabilities to develop and implement policies and procedures for the collection, processing, storage, protection, management and analysis of health care data in accordance with this act. The organization, at the commissioner's direction, shall:

(1) collect the health care data from reporting entities;

(2) if directed by the commissioner, incorporate other health care data sets such as Medicaid, Medicare or Hospital Discharge Data with the data collected and held by the organization;

(3) determine the standards and methods necessary for collecting health care data in a manner that minimizes the cost and administrative burden on carriers and utilizes uniform reporting systems for the collection of data on a scheduled basis;

(4) comply with the applicable provisions of the federal health privacy rule set forth in sections 160 and 164 of Title 45, Code of Federal Regulations, and with other proprietary requirements related to the collection and release of health care data;

(5) electronically publish on the department's website a list of average paid in-network claims which will be utilized to support the arbitration for any amount billed by an out-of-network health care provider and reimbursed by a carrier pursuant to section 11 of this act; and

(6) allow access to state entities and not for profit researchers that execute data use agreements with the department, which agreement shall be subject to review and approval by the commissioner, to utilize the non-proprietary portions of the index to measure trends and identify outliers within the State health care system related to: health care safety and quality; health care utilization; health outcomes; costs; efficiency and other areas in the public interest as identified by the commissioner.

b. The commissioner may solicit, receive, and accept grants, funds, or anything of value from any public or private entity and receive and accept fees or contributions of money, property, labor, or any other thing of value from any legitimate source to support the operation of the index, provided that: (1) the commissioner does not have reason to believe that the entity may have a vested interest in the decisions of the commissioner or the organization concerning the operation of the index; and (2) any funds received are disclosed on the department's website.

c. The purpose of the index shall be to serve as a source for useful, objective, reliable, and comprehensive health information designed to:

(1) identify and electronically publish annually the list of average in-network paid commercial claims; and

(2) make health care data available to the State and to researchers to improve health care quality, reduce health care costs, and increase pricing transparency.

d. Reporting entities shall, and entities providing or administering a self funded plan may, file that health care data determined by the commissioner to be necessary to carry out the purposes of this act. The form, medium, content, and frequency of the reporting shall be established by the commissioner but shall be reported not less than annually. Upon request by the commissioner, reporting entities shall report 2014 data to the department to be shared with the organization to effectuate the purposes of this act as soon as practicable upon the effective date of this act.

e. Each reporting entity shall submit a completed health care claims data set for all covered persons who are New Jersey residents in accordance with the requirements of this section. Each reporting entity shall also be responsible for the submission of health care claims processed by any subcontractor on its behalf. The health care claims data set to be reported shall include, but not be limited to, the following files, as applicable: a medical claims file; a pharmacy claims file; a behavioral health claims file; a provider file; and a covered person eligibility file containing records associated with each of the claims files reported. The completed health care claims data set shall also include, but not be limited to, a record of all claims, including the amount billed for by the provider and the amount paid by the carrier, for which information is submitted to the commissioner by carriers pursuant to sections 5 and 6 of P.L.1999, c.155 (C.17B:30-30 and 17B:30-31).

10. a. The agreement between the department and the organization shall specify the form, medium, content, and frequency of reporting of the health care data, consistent with the provisions of section 9 of this act, to the organization by reporting entities as determined by the commissioner to be necessary to effectuate the purposes of this act. The agreement shall be considered a contract for professional services pursuant to section 8 of P.L.2005, c.336 (C.52:34-10.8) due to the advanced actuarial and health care cost expertise and knowledge required of the organization.

b. The agreement between the department and the organization shall require the organization to submit sufficient information about the index and its use to enable the department to produce reports utilizing the data contained within the index, as the commissioner determines to be in furtherance of the purposes of this act.

c. The department shall, within 30 days of the date of enactment of this act, select a data storage contractor. The data storage contractor shall: (1) house and ensure the security of the data collected pursuant to this act; and (2) identify the format in which the data should be collected and analyzed to effectuate the purposes of this act. The data storage contractor shall be either: (1) an existing State entity that has the capacity to store and secure the

data; or (2) selected pursuant to an existing State contract for data warehousing.

11. The agreement between the department and the organization shall require the organization, upon review and analysis of the health care data submitted for the purposes of the Healthcare Price Index, to establish a list of average in-network commercial paid claims, by region, for health care services in New Jersey. The organization shall update the list annually and the department shall publish it on its website.

12. 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.

b. 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, the benefits 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:

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

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

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 attempt to negotiate reimbursement with the out-of-network health care provider.

13. a. If attempts to negotiate reimbursement for services provided by an out-of-network health care provider, pursuant to subsection c. of section 12 of this act, do not result in a resolution

of the payment dispute within 30 days after the carrier is billed for the services by the out-of-network health care provider, 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. In response to this notice, the nonrequesting party shall inform the requesting party 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, 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 30 days after the request is filed with the department. The arbitrator's expenses and fees shall be paid as provided in the decision. Each party shall be responsible for its own costs and fees, including legal fees if any.

c. 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 carrier: (b) the average amount paid for that service to other out-of-network providers by that carrier: and (c) the average reimbursement accepted by the provider from that carrier for the service in the past 12 months; and

(6) (a) the Medicare rate paid in the same region to the same type of health care provider for the same classification of health care facility in which the service took place; (b) the billed amount for the same type of procedure as reported by Fair Health, Inc.; and (c) when available, the average in-network commercial paid claim as reported by the HPI for that service to the same type of provider, including in the case of a facility the classification of the facility in which the service took place, in the same region.

d. 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 under P.L.1999, c.154 (C.17B:30-23 et al.) shall not accrue until after 30 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.

e. 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.

f. This section shall not apply to a covered person who knowingly, voluntarily, and specifically chooses an out-of-network provider for health care services.

14. 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 13 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 list of the 50 most common average paid in-network procedures as established by the HPI pursuant to section 11 of this act, with a method for consumers to estimate the costs for those procedures for each facility in the State.

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

e. 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.

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

g. The number of physician specialists practicing in the State in a particular specialty and whether they are in 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.

h. 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.

15. a. There is established in the Department of the Treasury a nonlapsing revolving fund to be known as the "Healthcare Price Index Trust Fund." This fund shall be the repository for monies collected pursuant to subsection c. of this section and other monies received as grants or otherwise appropriated for the purposes of the index. The monies in the fund shall be used only to pay for administrative and operational expenses that the department incurs in order to carry out its responsibilities pursuant to this act, including funding the organization pursuant to the agreement between the department and the organization, and shall be specifically dedicated and utilized exclusively for this purpose.

b. The State Treasurer shall be the custodian of the fund, and all disbursements from the fund shall be made by the State

Treasurer upon vouchers signed by the commissioner or the commissioner's designee. The monies in the fund shall be invested and reinvested by the Director of the Division of Investment in the Department of the Treasury as are other trust funds in the custody of the State Treasurer in the manner provided by law. Interest received on the monies in the fund shall be credited to the fund.

c. (1) The commissioner shall apply, and periodically revise as necessary, an annual surcharge to all reporting entities in the State, on a pro rata basis according to the number of covered persons in each health benefits plan, as the commissioner determines necessary to effectuate the purposes of this act.

(2) Any surcharges or assessments applied by the commissioner pursuant to paragraph (1) of this subsection shall not be fixed at a level that would generate revenue in excess of amounts necessary to effectuate the purposes of this act.

(3) The department and organization may charge a reasonable user fee to state entities and not for profit researchers for the right to access and use the data contained within the index; however, the fee may be reduced or waived for users that demonstrate a plan to use the data in research of general value to the public health or an inability to pay the scheduled fee, as provided in rules to be adopted by the commissioner.

(4) The department or organization may provide technical assistance to other public or private entities, for a fee, utilizing data released for the purposes of the index.

(5) The proceeds collected pursuant to this subsection shall be deposited into the fund.

(6) Information concerning monies collected pursuant to this subsection, including other monies received as grants or otherwise appropriated for the purposes of the index, and any fees collected for the right to access and use the data contained within the index, shall be disclosed and made available on the department website. The information shall be updated at least every 60 days.

d. The penalties collected pursuant to section 20 of this act shall be deposited into the fund.

16. a. A reporting entity 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 reporting entity'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 and information on how consumers

can report and file complaints with the department or the appropriate regulatory agency relating to any out-of-network charges.

17. 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 14 of this act.

18. a. It shall be a violation of this act if a 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.

19. A reporting entity 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 reporting entity and the entity 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 entity 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.

20. 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) In addition to any other existing penalties for such acts, a person or entity that receives data under the terms and conditions of this act and intentionally or knowingly uses, sells, or transfers the data for commercial advantage, pecuniary gain, personal gain, or malicious harm, in violation of rules which the commissioner shall adopt, shall be liable to a penalty of not more than $500,000 for each violation.

(3) A person or entity not covered by paragraphs (1) or (2) 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.

21. 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.

22. 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.

23. This act shall take on the first day of the fourth month next following the date of 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.

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