SUMMARY OF "OUT OF NETWORK" LEGISLATION
September 2018

MSNJ has worked for years to protect patients and find compromise on insurance network laws and policies in the state. We achieved a great victory 8 years ago with New Jersey's Assignment of Benefits law, which requires insurers to pay out of network physicians directly for their care.
http://www.state.nj.us/dobi/bulletins/blt10_36.pdf

Since then, health insurers have sought ways to reduce out of network payments and lower costs. The insurers narrowed networks and unilaterally terminated physicians without cause, generating national headlines. They also created tiered networks, a clever way to include physicians in network, while avoiding steerage and payments to those in lower tiers. At the same time, MSNJ has worked to increase network adequacy and sought fair contracts and payments so that patients get the coverage they pay for. We also sought better explanations by insurers about benefits, liabilities and coverage. Health literacy is key with high deductible and other new plan models.

The "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act" was signed by the Governor on June 1st. It takes effect on **September 1st.** In general, the bill applies to emergency and "inadvertent" care, meaning care provided by out-of-network physicians in in-network settings (i.e. hospital-based physicians).

The bill applies to state-regulated insurance plans. The bill does not apply to federally regulated self-funded plans (about 70% of New Jersey's insurance market), UNLESS a self-funded plan opts in to participate in the arbitration program. If it does, then the hold harmless patient protection and the assignment of benefits rule are also triggered. *The bill only applies to patients with federally-regulated plans that do NOT opt in by allowing them to bring physicians to arbitration to dispute charges. (Read more below on this below.)

Disclosure and Hold Harmless

The bill achieves the transparency goals we sought. Physicians, hospitals and insurers all have to do a better job explaining costs, processes and network status to patients. The bill also codifies the State regulation that provides a prohibition on balance billing beyond a patient's in network rate.

> Current regulation: That a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is a network or out-of-network provider and the covered person and/or provider has complied with all required preauthorization or notice requirements, shall be limited to the copayment, deductible and/or coinsurance applicable to network services. *N.J.A.C. 11:22-5.8*

Network Adequacy

The bill also addresses a key MSNJ concern by requiring insurers to share network adequacy audits with the State. The insurers have opposed this requirement for years, even though we clearly have network adequacy issues, with shortages in specialties from primary care to psychiatry to hospital specialists. We have always said we have an in-network problem, not an out-of-network problem. The requirement will hopefully shed light on contracting issues and improve access for patients.

Arbitration
MSNJ fought hard to find balance in the arbitration system, which now closely resembles the existing one. The new system uses a baseball style (the arbitrator must choose between the physician's charge and the insurer's offer of payment) when the difference between the charge and the offer is greater than $1000. There are no statutory criteria required for arbitrators to consider. There are no caps on payments.

The current arbitration system is deemed to be fair by most. We anticipate that the new system will be similarly administered by the same vendor. Of note, the arbitration costs of the "new" program are split, just like the current program, so there should be no great incentive for insurers to tie physicians up with arbitration. In fact, the sponsors of the legislation hoped arbitration will be used as infrequently as it is used today. Please see the FAQ on the existing program as a reminder of its structure and rules:
http://www.state.nj.us/dobi/chap352/352appealqanda.html

Around 10 years ago, the out of network payment landscape changed when a court found that payers were illegally depressing payments, using Ingenix, an insurance company-controlled database, which skewed payments down. Since then, we have advocated for the use of Fair Health or other independent databases as claim payment benchmarks. Currently, New Jersey's arbitration program uses Fair Health as a benchmark. The State also uses Fair Health to benchmark out of network payments for patients covered by the state health benefits programs.

Waiver
The part of the bill that MSNJ will watch closely is the prohibition of **patterns** of waiver of copays or other patient liabilities: "It shall be a violation of this act if an out-of-network 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."

We hope that regulators will not apply this law unfairly and that insurers do not use it to initiate or amplify frivolous fraud investigations. We urge members to advise us if this happens. With requirements for insurers to provide better explanations of patient liabilities, the sticker shock of deductibles will hopefully go down. But, since financial hardships will remain, evidence of true, intended patterns of inducement must be required.

Preemption
The bill triggers analysis under the Supremacy Clause and whether federal laws (ERISA or Taft Hartley) preempt the opt-in allowance. There is an abundance of case law on the issue. We believe this issue will be litigated, causing uncertainty of the viability of the law.

Patient Arbitration
The bill creates an arbitration system for patients who have federally-regulated health plans to fight physician bills. The arbitration process is binding in determining what the physician may collect and provides a non-binding recommendation of what the patient's insurance should pay. This is problematic, as it will create tension between physicians and patients and may also raise preemption issues. We hope that existing State laws on excessive billing and federal rules for patient complaints (e.g. U.S. Department of Labor) will be honored.
NOTE: Unless negotiations for reimbursement result in an agreement between the provider and the plan member within the 30 days, a provider shall not collect or attempt to collect reimbursement, including initiation of any collection proceedings, until the provider files a request for arbitration.

*This process is NOT allowed for voluntary services or for patients with health plans that opt-in to the law.

MSNJ will watch the implementation of this law closely. We will continue to monitor physician and patient complaints under current laws as well. We expect the Department of Banking and Insurance to continue its focus on network adequacy and to stop and correct insurers when they violate laws and policies.

Issue	Current law	S485 (Vitale)/A2039 (Coughlin)
Hold harmless: limit patient liability to in-network rates if the patient has a state-regulated plan	Yes	Yes -also applies to patients with plans that opt-in, if those provisions withstands legal challenge (see below)
Arbitration between providers and insurers	Yes, traditional arbitration with a cap (90th percentile of Fair Health) -$1000 minimum claim (aggregated) as trigger -fees are split	Yes, baseball style arbitration -$1000 difference between charge and offer as trigger -fees are split -insurer must take last, best offer into arbitration -includes hospitals *current process also stays in place
Arbitration option for patients	No, they are held harmless, under State plans so it is not needed	Yes, for members of self-funded plans (if it withstands legal challenge)
Disclosure by hospitals, doctors and insurers	No	Yes, but for insurers, it is only for state-regulated plans (about 30% of NJ patients)
Preemption issues	No	Yes – the "opt in" (allowing federally-regulated plans to use state arbitration) raises federal preemption issues
Punishing providers for waiving copays	No	Yes, section 15 prohibits waivers of patient liability (copay, deductible etc)
Network audits	No	Yes, the bill requires insurers to submit audits of network adequacy status to the State

SPECIFIC DETAILS OF THE BILL

DISCLOSURE REQUIREMENTS

HOSPITALS

Section 4

a. Prior to scheduling an appointment with a covered person for a non-emergency or elective procedure and in terms the covered person typically understands, a health care facility shall:

(1) 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;

(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 and provide information about how to determine the health plans participated in by any physician who is reasonably anticipated to provide services to the covered person;

(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;

(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) should be reported to the covered person's carrier and the relevant regulatory entity; and

(d) that if the covered person's coverage is provided through an entity providing or administering a self-funded health benefits plan that does not elect to be subject to the provisions of this act, that:

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

(ii) the covered person may have a financial responsibility applicable to health care services provided by an out-of-network provider, 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 the person's self-funded health benefits plan; and

(iii) the covered person should contact the covered person's self-funded health benefits plan sponsor for further consultation on those costs; 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 may be provided on an out-of-network basis;

(b) the covered person may 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 make available to the public 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;

(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; and

(d) the covered person should contact their carrier for further consultation on those costs;

(3) as applicable, the name, mailing address, and telephone number of the hospital-based physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, and 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 health benefits plan, the facility shall notify the covered person promptly.

Section 7

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 inadvertent basis are provided notification of the provisions of this act and information as to each health benefits plan with which the facility has a contract to be in-network.

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 the health benefits plans with which the facility has an agreement to be in-network.

MSNJ MEDICAL SOCIETY OF NEW JERSEY Est. 1766

PHYSICIANS

Section 5

a. A health care professional shall disclose to a covered person 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) Prior to scheduling a non-emergency procedure 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 for the service, disclose to the covered person in writing the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, 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) Advise the covered person to 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 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, and 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 health benefits plan, the professional shall notify the covered person promptly.

EXCEPTION: f. In the case of a primary care physician or internist performing an unscheduled procedure in that provider's office, the notice required pursuant this section may be made verbally at the time of the service.

INSURERS

Section 6

a. A carrier shall update the carrier's website within 20 days of the addition or termination of a provider from the carrier's network or a change in a physician's affiliation with a facility, provided that in the case of a change in affiliation the carrier has had notice of such change.

b. With respect to out-of-network services, for each health benefits plan offered, a carrier shall, consistent with State and federal law, provide a covered person with:

(1) a clear and understandable description of the plan's out-of-network health care benefits, including the methodology used by the entity to determine the allowed amount for out-of-network services;

(2) the allowed amount the plan will reimburse under that methodology and, in situations in which a covered person requests allowed amounts associated with a specific Current Procedural Terminology code, the portion of the allowed amount the plan will reimburse and the portion of the allowed amount that the covered person will pay, including an explanation that the covered person will be required to pay the difference between the allowed amount as defined by the carrier's plan and the charges billed by an out-of-network provider;

(3) examples of anticipated out-of-pocket costs for frequently billed out-of-network services;

(4) information in writing and through an internet website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services;

(5) …(6) …and

(7) access to a telephone hotline that shall be operated no less than 16 hours per day for consumers to call with questions about network status and out-of-pocket costs.

c. If a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed, the carrier shall notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

d. A carrier shall incorporate into the Explanation of Benefits and all reimbursement correspondence to the consumer and the provider clear and concise notification that inadvertent and involuntary out-of-network charges are not subject to balance billing above and beyond the financial responsibility incurred under the terms of the contract for in-network service. Any attempt by the provider to collect, bill, or invoice funds should be promptly reported to the carrier's customer service department at the phone number that the carrier shall provide on the Explanation of Benefits and all reimbursement correspondence to the consumer.

OPT IN: e. A carrier, and any other entity providing or administering a self-funded health benefits plan that elects to be subject to this act, shall issue a health insurance identification card to the primary insured under a health benefits plan that indicates whether the plan is insured or, in the case of self-funded plans that elect to be subject of this act.

f. A carrier shall include in the carrier's annual public regulatory filings, and in a manner to be determined by the Department of Banking and Insurance, the number of claims submitted by health care providers to the carrier which are denied or down coded by the carrier and the reason for the denial or down coding determination.

Section 13

a. A carrier 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 carrier's website.

Section 14
14. a. 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.

DEPARTMENT OF BANKING AND INSURANCE
Section 12
The Department is required to published detailed information about arbitrations, including bids, winners, and description of services.

The Department is required to list the percentage of facilities and hospital-based physicians that are in-network for each carrier.

The Department is required to track out of network services for state employees and premium rates, as well as patient complaints.

Section 13
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 arbitrations filed pursuant to section 11 of this act.

Section 14
b. The department shall report to the Governor, and to the Legislature, no later than 12 months after the effective date of this act and annually thereafter, on the savings to policyholders and the healthcare system that result from the provisions of this act.

MSNJ MEDICAL SOCIETY OF NEW JERSEY EST. 1766

PATIENT HOLD HARMLESS

Section 7 (applies to state-regulated plans, codifying current law)

a. If a covered person receives medically necessary services at any health care facility on an emergency or urgent basis as defined by the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160 (C.26:2H-18.64), 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.

*This section also applies to self-funded plans that opt-in.

Section 8 (applies to state-regulated plans, codifying current law)

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 as defined by the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. s.1395dd et seq. and section 14 of P.L.1992, c.160 (C.26:2H-18.64), the health care professional performing those services shall:

(1) in the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount; and

(2) in the case of emergency and urgent services, 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.

*This section also applies to self-funded plans that opt-in.

Section 9

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. In the case of services provided to a member of a self-funded plan that does not elect to be subject to the provisions of this section, the provider shall be permitted to bill the covered person in excess of the applicable deductible, copayment, or coinsurance amounts.

ASSIGNMENT OF BENEFITS (codifies current law)

Section 9

b. (1) 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, benefits provided by a carrier 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:

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

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

*This section also applies to self-funded plans that opt-in.

ARBITRATION

Section 9 (first step: payment negotiation)

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 the carrier shall determine within 20 days from the date of the receipt of the claim for the services whether the carrier considers the claim to be excessive, and if so, the carrier shall notify the provider of this determination within 20 days of the receipt of the claim. If the carrier provides this notification, the carrier and the provider shall have 30 days from the date of this notification to negotiate a settlement.
- The carrier may attempt to negotiate a final reimbursement amount with the out-of-network health care provider which differs from the amount paid by the carrier pursuant to this subsection. If there is no settlement reached after the 30 days, the carrier shall pay the provider their final offer for the services.
- If the carrier and provider cannot agree on the final offer as a reimbursement rate for these services, the carrier, provider, or covered person, as applicable, may initiate binding arbitration within 30 days of the final offer, pursuant to section 10 or 11 of this act.
- In addition, in the event that arbitration is initiated pursuant to section 10 of this act, the payment shall be subject to the binding arbitration provisions of paragraphs (4) and (5) of subsection b. of section 10 of this act.

*This section also applies to self-funded plans that opt-in.

*Note: this program includes hospitals, unlike other state arbitration programs (notably, New York, on which much of this new law was based).

Section 10 (arbitration)

a. If attempts to negotiate reimbursement for services provided by an out-of-network health care provider, pursuant to subsection c. of section 9 of this act, do not result in a resolution of the payment dispute, and the difference between the carrier's and the provider's final offers is not less than $1,000, 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, which in the case of the carrier shall be the amount paid pursuant to subsection c. of section 9 of this act. In response to this notice, the out-of-network provider shall inform the carrier 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 made pursuant to subsection c. of section 9 of this act 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 split equally among the parties except in situations in which the arbitrator determines that the payment made by the carrier was not made in good faith, in which case the carrier shall be responsible for all of the arbitrator's expenses and fees. Each party shall be responsible for its own costs and fees, including legal fees.

c. (1) The amount awarded by the arbitrator that is in excess of any payment already made pursuant to subsection c. of section 9 shall be paid within 20 days of the arbitrator's decision as provided in subsection b. of this section.
(2) The interest charges for overdue payments shall not apply during the pendency of a decision under subsection b. of this section and any interest required to be paid a provider shall not accrue until after 20 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, unless both parties agree to a longer period of time.

EXCEPTIONS/RULES
d. 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.
e. This section shall not apply to a covered person who knowingly, voluntarily, and specifically selected an out-of-network provider for health care services.

*This section also applies to self-funded plans that opt-in.

PATIENT ARBITRATION
Section 11
a. If attempts to negotiate reimbursement for services between an out-of-network health care provider and a member of a self-funded plan that does not elect to be subject to this act do not result in a resolution of the payment dispute within 30 days after the plan member is sent a bill for the services, the plan member or out-of-network health care provider may initiate binding arbitration. Unless negotiations for reimbursement result in an agreement between the provider and the plan member within the 30 days, a provider shall not collect or attempt to collect reimbursement, until the provider files a request for arbitration with the department.

b. The binding arbitration shall adhere to the following requirements:
(1) Arbitration shall be initiated by filing a request with the department.
(2) The arbitrator with which the department contracts pursuant to section 10 of this act shall conduct the arbitration pursuant to this section;
(3) The arbitrator shall consider information supplied by both parties; and
(4) The arbitrator's decision shall include written findings, including a final binding amount that the arbitrator determines is reasonable for the service, which shall include a non-binding recommendation to the entity providing or administering the self-funded health benefits plan of an amount that would be reasonable for the entity to contribute to payment for the service, and shall be issued within 30 days.

c. The arbitrator's expenses and fees shall be divided equally among the parties, unless the payment would pose a financial hardship to the plan member, in which case the department shall establish an agreement with the arbitrator to waive any part or all of the cost of arbitration. Each party shall be responsible for its own costs and fees, including legal fees, if any.

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

WAIVER OF PATIENT LIABILITIES

Section 15

a. It shall be a violation of this act if an out-of-network 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.

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.

NETWORK ADEQUACY

Section 16

A carrier 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 carrier and the carrier 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 carrier 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.

PENALTIES

Section 17

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.

(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) A person or entity not covered by paragraph (1) 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.

EFFECTIVE DATE

Section 21

This act takes effect on September 1st (three months after the Governor's signature), but there will likely be a delay in implementation, since we await the promulgation of regulations. MSNJ will keep members informed.