

**SYNOPSIS OF PROPOSED NEW RULES AND AMENDMENTS TO IMPLEMENT  
N.J.S.A 26:2SS-1 TO -20, OUT-OF-NETWORK CONSUMER PROTECTION,  
TRANSPARENCY, COST CONTAINMENT AND ACCOUNTABILITY ACT**

On June 1, 2018, the Out-Of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act, N.J.S.A. 26:2SS-1 to -20, (“Act”), was enacted and became effective on August 30, 2018. This Act enhances consumer protections from surprise bills for inadvertent and emergency or urgent out-of-network health care services (“inadvertent and/or involuntary out-of-network services”), in addition to making changes to several elements of New Jersey’s health care delivery system. These improvements include transparency and consumer disclosure requirements, the creation of an arbitration system, and cost containment for inadvertent and involuntary out-of-network services.

On November 20, 2018, the Department of Banking and Insurance (“Department”) issued guidance in the form of Bulletin No. 18-14 to carriers, as defined under the Act, health care providers, and other interested parties to help those entities meet their obligations under the Act, pending the adoption of rules. The Department intends to proceed with proposing new rules and amendments to existing rules to implement the Act and codify Bulletin No. 18-14 incorporating changes, which are based upon feedback from interested parties and information obtained through the application of the guidance contained in the Bulletin. Accordingly, the Department is providing advance notice of the intended rulemaking action and is seeking your input on the proposed new rules and amendments, as summarized below.

**Proposed New Rule N.J.A.C. 11:24D**

This proposed new rule will define terms; specify required transparency disclosures regarding out-of-network services; establish consumer protections from billing for inadvertent and/or involuntary out-of-network services above the covered person’s network level cost-sharing;

prohibit the waiver of cost-sharing; specify the procedure for the processing of claims for inadvertent and/or emergency out-of-network services prior to arbitration; specify the procedure for the arbitration of claims for inadvertent and/or involuntary out-of-network services; and specify the procedure for arbitration of claims for inadvertent and/or involuntary out-of-network services where a self-funded health benefits plan does not elect to be subject to the arbitration and claims processing provisions of the Act. The proposed new rule will expressly address the topics summarized below.

N.J.A.C. 11:24D-1.1: Purpose and Scope:

Proposed new rule N.J.A.C. 11:24D-1.1 provides that a carrier, which is a defined term, must comply with the proposed new rules as they relate to health benefits plans that the carrier delivers or issues for delivery in New Jersey, and that a carrier and third-party administrator are subject to the rules when self-funded health benefits plans that they administer elect to participate in the claims processing and arbitration provisions of the proposed new rules. Additionally, the proposed new rules apply to any services or functions of a carrier that the carrier may subcontract to another entity or otherwise engage.

The transparency provisions in the proposed new rule apply to all carriers, which includes self-funded multiple employer welfare arrangements (“MEWAs”) subject to N.J.S.A. 17B:27C-1 to -12, that issue health benefits plans in New Jersey. Self-funded plans that elect to participate in the claims processing and arbitration requirements of the proposed new rules are not subject to the transparency requirements of the proposed new rules.

The proposed new rules apply to health benefits plans in New Jersey without regard to whether the plan contains coverage for voluntary out-of-network benefits. The claims processing and arbitration provisions of the proposed new rules apply when out-of-network services are

rendered on an inadvertent and/or involuntary basis in New Jersey by a New Jersey licensed or certified health care provider to a person covered under a health benefits plan issued in New Jersey.

With respect to self-funded health benefits plans that choose to be subject to the claims processing and arbitration provisions of the proposed new rules, these rules will apply without regard to the principle location of the sponsor of the self-funded health benefits plan and how many covered persons reside in New Jersey, provided that the out-of-network services were rendered on an inadvertent and/or involuntary basis in New Jersey, by a New Jersey licensed or certified health care provider to a covered person who was a resident of New Jersey on the date of service.

Covered persons cannot waive their rights under the provisions of the proposed new rules unless the waiver is both knowing and voluntary and the covered person specifically selected the out-of-network health care provider. The waiver and the circumstances of its execution must demonstrate that the covered person chose the services of a specific provider, with full knowledge that the provider is out-of-network and the covered person had the opportunity to be serviced by an in-network provider and instead, selected the out-of-network health care provider. Additionally, waivers that are required from covered persons in order to receive inadvertent and/or involuntary out-of-network services will not remove those services from the purview of the provisions the proposed new rules.

N.J.A.C. 11:24D-1.2 Definitions:

In addition to terms defined already defined under New Jersey law, proposed new rule N.J.A.C. 11:24D-1.2 defines the following:

- “Allowed charge,” means the allowed amount or the allowance for the service as determined by the carrier;
- “Cost-sharing,” means the deductible, copayment, or coinsurance that are the responsibility of the covered person for services rendered by a network provider

under the health benefits plan. For tiered health benefits plans, the cost-sharing applied for inadvertent and/or involuntary out-of-network health care services shall be the cost-sharing for the most preferred, lowest cost tier. Cost-sharing refers to the network deductible, copayment, or coinsurance as applied to the allowed charge. Total member cost-sharing liability for inadvertent and/or involuntary out-of-network services is calculated based upon either the amount accepted by the out-of-network health care provider or the final amount paid by the carrier to the out-of-network health care provider before any arbitration. "Cost-sharing" does not refer to a specific dollar amount;

- "Emergency or urgent basis" means all emergency and urgent care, including services to treat a medical condition manifesting itself in acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of a bodily organ or part. With respect to a pregnant woman having contractions, an emergency exists where: there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the unborn child. "Emergency or urgent basis" also includes coverage for all medical services and supplies needed to treat a non-life-threatening condition that requires care by a provider within 24 hours; "Involuntary out-of-network services" meaning medically necessary health care services that are covered under a managed care plan and are provided by an out-of-network health care provider due to the emergency or urgent basis of the medical condition;
- "Inadvertent and/or involuntary out-of-network claim(s)" means claims for any and all services rendered by the same out-of-network health care provider for the same covered person during the same in-patient admission at an in-network facility and/or emergent or urgent visit during which inadvertent and/or involuntary out-of-network services are provided, including any in-patient facility stays that result from an emergent or urgent visit. In the case of out-of-network laboratory services, "inadvertent and/or involuntary out-of-network claim(s)" means claims for out-of-network laboratory testing and/or analysis on all specimens taken during the same office or facility visit;
- "Voluntary Out-of-Network Treatment" means that the covered person knowingly, voluntarily, and specifically selects an out-of-network health care provider to render treatment.

Proposed new rule N.J.A.C. 11:24D-1.3(a) requires that carriers provide covered persons with clear and understandable descriptions of the coverage that is provided under a specific health benefits plan when services are rendered by out-of-network health care providers, describing coverage for such services when rendered on an emergency or urgent basis, for inadvertent out-of-network services, and for voluntary out-of-network treatment.

Proposed new rule N.J.A.C. 11:24D-1.3(a)1 provides that the issuance or renewal of a plan and upon request from a covered person, carriers must issue transparency disclosures by using the template provided by the Department titled “Disclosures to Covered Persons Regarding Out-of-Network Treatment,” which should be customized based upon the terms of the specific health benefits plan applicable to the covered person receiving the disclosure. A draft template is attached. The template contains the following transparency disclosures required under the Act: (1) How the plan covers medically necessary treatment on an emergency or urgent basis by out-of-network health care providers; (2) How the plan covers treatment by an out-of-network health care provider when a covered person uses an in-network health care facility and, for any reason, health care services are unavailable from an in-network health care provider or are rendered by an out-of-network health care provider in that in-network health care facility, including when a specimen for laboratory testing is taken by an in-network provider in their office or in an in-network health care facility but the testing is performed by an out-of-network bio-analytical laboratory; (3) That a covered person’s cost-sharing for inadvertent and/or involuntary out-of-network services is limited to the network level cost-sharing under the plan; (4) A description of the ability of carriers to negotiate and settle with out-of-network health care providers to pay less than the amount billed for inadvertent and/or involuntary out-of-network services, and how that settlement may increase the covered person’s cost-sharing liability above the amount indicated in

the initial Explanation of Benefits; (5) A description of the right of carriers and out-of-network health care providers to enter into binding arbitration for inadvertent and/or involuntary out-of-network services to determine the amount to be paid by the carrier for the medical services, where an agreement cannot be reached through negotiation and the out-of-network health care provider does not accept the payment amount shown on a subsequent or revised Explanation of Benefits. The description shall include disclosure that the arbitration award will not increase the covered person's cost-sharing liability above the amount shown on a subsequent or revised Explanation of Benefits; (6) How all plans cover treatment from out-of-network health care providers if in-network health care providers are not available in accordance with the applicable network adequacy standards and the opportunity to access a provider through a request for an in-plan exception, which, if denied, is an adverse benefit determination subject to internal and external appeals; (7) For a plan that provides benefits when a covered person voluntarily uses and out of-network provider, such as a preferred provider organization plan or point of service plan, the out-of-network cost-sharing requirements and the standards the carrier uses to determine the allowed charge; (8) How to obtain more information from the carrier regarding whether a provider is in-network, examples of out-of-network costs, and how to estimate costs for out-of-network services for specific Current Procedural Terminology ("CPT") codes; and (9) The website address(es) and telephone hotline number maintained by the carrier to provide information on out-of-network coverage and issues.

N.J.A.C. 11:24D-1.3(a)2 requires that carriers maintain a website page that provides transparency information for each health benefits plan the carrier offers in New Jersey. The website page must also include the following: (1) A clear and prominent disclaimer that any estimates or examples provided by the carrier for out-of-network costs do not take into account

the amounts that the covered person may have already paid that accumulated toward the maximum out-of-pocket limit under their plan; (2) A clear and prominent disclaimer that out-of-network arbitration is only available with respect to out-of-network services that were rendered on an inadvertent and/or involuntary basis in New Jersey by a New Jersey licensed or certified health care provider; and (3) For a preferred provider organization plan or point of service plan, information that enables prospective covered persons to calculate the anticipated out-of-pocket costs for voluntary out-of-network services in a geographical region or zip code. However, CPT code specific disclosures of out-of-network allowed charges will only be required for inforce covered persons and may be placed on members-only portions of the carrier's website.

Proposed new rule N.J.A.C. 11:24D-1.3(a)3 requires that carriers maintain a telephone hotline that is operated for at least 16 hours per day and staffed with live representatives that are capable of responding to questions about network status and out-of-pocket costs.

N.J.A.C. 11:24D-1.4 Billing for Inadvertent and/or Involuntary Out-of-Network Services Above the Covered Person's Network Level Cost-Sharing:

Proposed new rule N.J.A.C. 11:24D-1.4 provides that covered persons must not be billed by any health provider for inadvertent and/or involuntary out-of-network services above the network level cost-sharing for the service(s). Any health care provider that bills covered persons for inadvertent and/or involuntary out-of-network services above the network level cost-sharing for those services do so in violation of the express prohibition set forth in the Act and may be referred to the appropriate licensing board or other regulatory body for the out-of-network health care provider and be subject to the imposition of monetary penalties.

N.J.A.C. 11:24D-1.5 Prohibition on Waiver of Cost-Sharing:

Proposed new rule N.J.A.C. 11:24D-1.5 provides that an out-of-network health care provider is prohibited in most instances from knowingly waiving, rebating, giving, paying, or offering to waive, rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan as an inducement for the covered person to seek services from the out-of-network health care provider. A pattern of waiving, rebating, giving, or payment all or part of the deductible, copayment, or coinsurance by a provider will be considered an inducement. Out-of-network health care providers found to have violated the above waiver provisions will be subject to penalties.

However, an out-of-network health care provider may waive, rebate, give, pay, or offer to waive, rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the covered person's health benefits plan if (1) the waiver, rebate, gift, payment, or offer falls within the safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including as provided in any advisory opinions issued by the Centers for Medicare and Medicaid Services or the Office of Inspector General relating thereto; or (2) the waiver, rebate, gift, payment, or offer thereof is not offered as part of any advertisement or solicitation; the out-of-network health care provider does not routinely waive, rebate, give, pay, or offer to waive, rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan; and the out-of-network health care provider either (i) waives, rebates, gives, pays, or offers to waive, rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan after determining in good faith that the covered person is in financial need; or (ii) fails to collect the covered person's deductible, copayment or coinsurance after making reasonable collection efforts,



which reasonable efforts does not necessarily include initiating collection proceedings. Additionally, an out-of-network health care provider may waive, rebate, give, pay, or offer to waive, rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan as provided in 42 CFR 1001.952(k).

N.J.A.C. 11:24D-2.1 Processing Claims for Inadvertent and/or Involuntary Out-of-Network Services Prior to Arbitration:

Proposed new rule N.J.A.C. 11:24D-2.1(a) provides that all claims for inadvertent and/or involuntary out-of-network services with dates of service on and after August 30, 2018, under health benefits plans issued by carriers in New Jersey, and to self-funded health benefits plans issued in New Jersey that elect to participate in the out-of-network arbitration are subject to the rules contained in the proposed new rules. For claims with multiple dates of service submitted on one claim, the proposed new rules only apply if the initial date of service is on or after August 30, 2018. The proposed new rules do not apply to voluntary out-of-network services or out-of-network services obtained through an in-plan exception.

Proposed new rule N.J.A.C. 11:24D-2.1(b) states that carriers and self-funded health benefits plans that elects to participate in the out-of-network arbitration must process all claims for inadvertent and/or involuntary out-of-network services in accordance with the Act and the provisions of the proposed new rules. Carriers that issue fully-insured health benefits plans must comply with the provisions regarding the prompt payment of claims in processing claims for inadvertent and/or involuntary out-of-network services.

Proposed new rule N.J.A.C. 11:24D-2.1(c) provides that upon the receipt of a claim for inadvertent and/or involuntary out-of-network services, carriers must either: (1) pay the charges as billed by the out-of-network health care provider; or (2) determine and provide notice to the out-of-network health care provider within 20 days of the receipt of the claim that the provider's

billed charges exceed the amount initially determined to be the allowed charge for the services. Upon making the determination that the out-of-network health care provider's billed charges exceed the initially determined allowed charge, the rule will require carriers to immediately issue a written notice to the out-of-network health care provider that details: (i) information to identify the covered person, impacted inadvertent and/or involuntary out-of-network claim(s), and specific services that have been determined to exceed the initially determined allowed charge for those services, including the allowed charges for each impacted service; (ii) that the claim is for inadvertent and/or involuntary out-of-network services, that the carrier has concluded that the billed charges exceed the initially determined allowed charge for those services, and the methods to initiate negotiation, which must include certified mail, email, and online form submission; (iii) that the carrier is not paying the out-of-network health care provider's billed charges, and instead, is paying its portion of the initially determined allowed charge; (iv) that if the out-of-network health care provider does not accept the carrier's payment based on the initially determined allowed charge as payment in full, the out-of-network health care provider has the right to negotiate with the carrier for 30 days from the date of the receipt of the notification that the carrier deemed that the out-of-network health care provider's billed charges exceed the initially determined allowed charge for those services; (v) that to exercise the right to negotiate, the out-of-network health care provider must advise the carrier of its rejection of the carrier's payment based on the initially determined allowed charge as payment in full within 30 days of the receipt of the notification that the provider's billed charges exceed the initially determined allowed charge for those services, and must follow the directions given by the carrier to do so, which must include options for certified mail, email, and online submission; and (vi) that if the out-of-network health care provider does not contact the carrier within 30 days of the receipt of the notification that the

provider's billed charges exceed the initially determined allowed charge for those services, the out-of-network health care provider foregoes, and will not be permitted to seek, redress through the arbitration process set forth in the Act and the proposed new rules.

Carriers must issue the above notice immediately upon the determination that the out-of-network health care provider's billed charges exceed the initially determined allowed charge, but in no event later than 20 days of the receipt of the claim for inadvertent and/or involuntary out-of-network services. A carrier may elect to issue payment its portion of the initially determined allowed charge to the out-of-network health care provider with the issuance of this notice within the 20-day timeframe; however, a carrier that issues fully-insured health benefits plans must remit payment for its portion of the initially determined allowed charge in compliance with the provisions for the prompt payment of claims.

Upon issuance of the payment for its portion of the initially determined allowed charge to the out-of-network health care provider, the carrier must provide notice to the covered person, which must be the issuance of an Explanation of Benefits to the covered person, and all notices must include text, or be accompanied by a separate document if needed, that details the following: (A) the out-of-network claim is for inadvertent and/or involuntary out-of-network services, and the carrier has determined that the billed charges exceed the initially determined allowed charge for those services; (B) the carrier is not paying the out-of-network health care provider's billed charges, and is paying its portion of the initially determined allowed charge; (C) the out-of-network health care provider may reject the payment based upon the initially determined allowed charge as payment in full; (D) if the payment based on the initially determined allowed charge is rejected by the out-of-network health care provider as insufficient reimbursement, the amount of the allowed charge may be subject to negotiation between the carrier and the out-of-network health care

provider; (E) if negotiation is pursued and results in an agreement, the amount of the allowed charge may increase, which may result in the carrier paying more and may increase the covered person's cost-sharing liability for the out-of-network claim; (F) if negotiation does not result in an agreement, both the carrier and the out-of-network health care provider can seek to enter into binding arbitration; (G) if negotiation is not pursued by the provider, the initial Notice/Explanation of Benefits becomes final and indicates what the covered person's final cost-sharing liability is for the inadvertent and/or involuntary out-of-network services; and (H) the covered person must not be billed by the out-of-network health care provider for the inadvertent and/or involuntary out-of-network services above the covered person's network level cost-sharing liability, as set forth in the initial Notice/Explanation of Benefits or subsequent Notice/Explanations of Benefits. Any attempts by the out-of-network health care provider to bill the covered person above the covered person's network level cost-sharing liability should be reported to the carrier and a complaint should be filed with the appropriate licensing board or other regulatory body for the out-of-network health care provider.

Proposed new rule N.J.A.C. 11:24D-2.1(d) provides that if the out-of-network health care provider rejects the initially determined allowed charge and elects to negotiate, the parties have 30 days from the provider's receipt of the carrier's notification that the billed charges exceed the initially determined allowed charge to negotiate.

Proposed new rule N.J.A.C. 11:24D-2.1(e) provides that an out of-network health care provider seeking to reject the initially determined allowed charge and negotiate must advise the carrier of its rejection of the initially determined allowed charge as payment in full within the 30-day negotiation period as set forth in proposed new rule N.J.A.C. 11:24D-2.1(d). If a negotiated settlement as to the allowed charge is reached within the 30-day negotiation period, the carrier

must: (1) remit payment for the additional liability for its portion of the negotiated allowed charge, as agreed to during negotiation, to the out-of-network health care provider within 30 days of the date of negotiated settlement; and (2) issue remittance advice, which may be accompanied by a separate document, if needed, to the out-of-network health care provider, and a notice to the covered person through the issuance of an Explanation of Benefits, which may be accompanied by a separate document, if needed, that includes text that details the following: (i) the amount of the allowed charge has been negotiated, and this negotiated amount is being accepted by the provider as payment in full for the claim for inadvertent and/or involuntary out-of-network services; (ii) the amounts of the initially determined allowed charge, initial carrier payment, and the covered person's cost-sharing liability based on each of those amounts; (iii) the amounts of: the negotiated allowed charge, revised carrier payment; the increase in the covered person's cost-sharing liability based upon new negotiated allowed charge; and the covered person's final total cost-sharing liability for the claim for inadvertent and/or involuntary out-of-network services as of the time of reprocessing based upon the new negotiated allowed charge; (iv) the additional amount paid by the carrier, calculated as the difference between the initial carrier payment and the revised carrier payment; (v) the covered person must not be billed by the out-of-network health care provider for the inadvertent and/or involuntary out-of-network services above the covered person's network level cost-sharing liability, as set forth in this revised Notice/Explanation of Benefits.

Proposed new rule N.J.A.C. 11:24D-2.1(f) provides that if a negotiated settlement is not reached, the carrier must, within seven days of the expiration of the 30-day negotiation period: (1) notify the out-of-network health care provider of the carrier's final offer allowed charge; (2) remit additional payment of its portion of the final offer allowed charge to the out-of-network health care provider; (3) provide a notice to the covered person through the issuance of an Explanation

of Benefits, which may be accompanied by a separate document, and remittance advice or a similar notice, which may be accompanied by a separate document, if needed, to the out-of-network health care provider that sets forth the following: (i) the carrier and the out-of-network health care provider have not reached a negotiated settlement of the allowed charge; (ii) the amounts of the initially determined allowed charge, initial carrier payment, and the covered person's cost-sharing liability based on those amounts; (iii) the amounts of the final offer allowed charge, revised carrier payment, and the covered person's final cost-sharing liability for the claim for inadvertent and/or involuntary out-of-network services as of the time of reprocessing; (iv) if the carrier's final offer allowed charge is higher than the initially determined allowed charge, the carrier must state that the amount of the carrier's allowed charge has increased and that the covered person's total cost-sharing liability either has or has not increased, depending on whether the covered person satisfied the maximum out-of-pocket before claim reprocessing, and the amount of any applicable increase in the covered person's cost-sharing liability under the final offer allowed charge versus the initially determined allowed charge; (v) the additional amount paid by the carrier, calculated as the difference between the initial carrier payment and the revised carrier payment; (vi) notice that the covered person's cost-sharing liability will not increase again, even if the carrier or out-of-network health care provider request to enter into arbitration or subsequently reach a settlement for a different allowed charge amount; and (vii) the covered person must not be billed by the out-of-network health care provider for the inadvertent and/or involuntary out-of-network services above the covered person's network level cost-sharing liability, as set forth in this revised Notice/Explanation of Benefits.

N.J.A.C. 11:24D-2.2: Arbitration of Claims for Inadvertent and/or Involuntary Out-of-Network Services:

Proposed new rule N.J.A.C. 11:24D-2.2(a) provides that for inadvertent and/or involuntary out-of-network claims that are not resolved pursuant to the claims and negotiation processes above, the carrier, which includes self-funded health benefits plans that elect to be subject to the claims processing and negotiation provisions of the chapter, or an out-of-network health care provider may request to enter into binding arbitration within 30 days of the out-of-network health care provider's receipt of the carrier's notification that sets forth the carrier's final offer provided that: (1) the difference between the carrier's final offer allowed charge and the final offer of the out-of-network health care provider for the inadvertent and/or involuntary out-of-network claim is \$1,000 or higher; (2) all applicable preauthorization or notice requirements of the health benefits plan were complied with; and (3) the matter does not involve a dispute eligible for submission to the Independent Health Care Appeals Program or external appeal under the Patient Protection and Affordable Care Act, such as disputes as to whether a treatment or services is: (i) medically necessary; (ii) experimental or investigation; (iii) cosmetic; (iv) medical or dental; or (v) a service for which the carrier should have authorized services to be performed by an out-of-network health care provider through an in-plan exception because the carrier's network lacks a provider who is accessible and possesses the requisite skill and expertise to perform the needed services.

Aggregation of claims to determine whether the dispute equals or exceeds \$1,000 is permitted for each inadvertent and/or involuntary out-of-network claim, as defined in the proposed new rules, provided that the services were rendered by the same provider to the same patient. For all inadvertent and/or involuntary out of-network claims where the dispute does not equal or exceed \$1,000, the initiating party may file for arbitration under the New Jersey Program for

Independent Claims Payment Arbitration established by the Health Claims Authorization, Processing and Payment Act, provided that the claim is otherwise eligible for, and the initiating party complies with the applicable rules of, arbitration under the New Jersey Program for Independent Claims Payment Arbitration.

Proposed new rule N.J.A.C. 11:24D-2.2(b) provides that instructions as to how to file out-of-network arbitration requests are available on the website of the arbitration vendor conducting the arbitrations.

Proposed new rule N.J.A.C. 11:24D-2.2(c) requires that both the requesting and the responding parties to the arbitration provide copies of all submissions, including but not limited to the application, any responses thereto and all supporting documentation, to the other party upon filing with the arbitrator, and that failure to do may subject the non-compliant party to penalties, including, but not limited to, default award in favor of the party compliant with this provision. Additionally, submissions to carriers must be made via same method and/or address to which an out-of-network health care provider rejects the carrier's payment based upon the initially determined allowed charge.

Proposed new rule N.J.A.C. 11:24D-2.2(d) provides that within seven business days of the receipt of an out-of-network arbitration application, the arbitration vendor will acknowledge receipt of the out-of-network arbitration application to the parties and will promptly review the request to determine whether it is eligible for arbitration and for completeness of the out-of-network arbitration application, which may include issuance of notices of deficiency in the application or eligibility information to the parties. The arbitration vendor will accept for processing a complete application that meets the following criteria: (1) the covered person's health benefits plan was delivered, or issued for delivery, in New Jersey and is not an out-of-state plan, a



Federal plan, or Managed Medicaid, or the covered person's self-funded health benefits plan has elected to participate in the out-of-network arbitration; (2) the covered person was covered under the health benefits plan at the time that the inadvertent and/or involuntary out-of-network services were rendered; (3) the out-of-network health care provider is licensed or certified in New Jersey and rendered a covered service to a covered person in New Jersey under a health benefits plan and that service meets the definitions of inadvertent and/or involuntary out-of-network services, as set forth in the chapter. For laboratory testing by a laboratory licensed in New Jersey, this includes when tests are ordered by an in-network health care provider and any necessary services for the test are rendered to the covered person in New Jersey without regard to the situs of the laboratory performing the testing, such as laboratory testing ordered by an in-network provider and performed by an out-of-network bio-analytical laboratory, whether such services are performed in a health care facility or at a health care professional's office; (4) the difference between the carrier's and out-of-network health care provider's final offers is \$1,000 or more; (5) the initiating party's and the responding party's final offer for the allowed charge is specified in the request. With respect to a carrier, the final offer amount must be the amount set forth in the pre-arbitration Notice/Explanation of Benefits; (6) the out-of-network arbitration application includes, or the covered person has previously submitted, a fully-executed "Consent to Representation in Appeals of Utilization Management Determinations and Authorizations for Release of Medical Records in UM Appeals and Independent Arbitration of Claims" form in the event that the covered person's confidential information accompanies the arbitration request; and (7) the party initiating the arbitration request has submitted to the arbitration vendor all necessary information requested by the arbitration vendor with the out-of-network application and applicable fee.

Proposed new rule N.J.A.C. 11:24D-2.2(e) provides that the arbitration vendor will reject an out-of-network arbitration application received in excess of 30 days after the provider's receipt of the carrier's notification of its final offer allowed charge.

Proposed new rule N.J.A.C. 11:24D-2.2(f) provides that the arbitration vendor will reject an out-of-network arbitration application if the carrier demonstrates that the provider did not notify the carrier of the provider's rejection of the initially determined allowed charge within 30 days of the receipt of the notification.

Proposed new rule N.J.A.C. 11:24D-2.2(g) provides that if the matter is deemed eligible for arbitration by the arbitration vendor, the vendor will request a substantive response from the responding party to the arbitration.

Proposed new rule N.J.A.C. 11:24D-2.2(h) provides the following procedures related to the timeliness of post-application submissions: (1) all post-application submissions to the arbitrator are due within the timeframes provided in the arbitrator's request, but no later than 15 days from the date of the request; (2) if the initiating party fails to respond to or to correct any deficiencies within 15 days from the date of the arbitration vendor's request, the out-of-network arbitration application will be deemed withdrawn; and (3) if the responding party fails to respond to or to correct any deficiencies within 15 days from the date of the arbitration vendor's request and the initiating party has complied with all requests from the arbitration vendor, the arbitration vendor will provide notice to all parties of the responding parties' opportunity to cure the remaining issues within 72 business hours, which notice must also provide that the award will be issued for the initiating party if no cure or correction is provided.

Proposed new rule N.J.A.C. 11:24D-2.2(i) provides that if an out-of-network arbitration application is rejected based upon information submitted with the out-of-network arbitration

application, the arbitration vendor will retain the initiating party's review fee and refund the arbitration fee. If the out-of-network arbitration application is initially accepted, but later rejected as ineligible based upon information submitted in whole or in part by the non-initiating party, the arbitration vendor will retain the review fees of both parties and refund the arbitration fees.

Proposed new rule N.J.A.C. 11:24D-2.2(j) provides that the arbitrator will review the documents submitted to, requested by, and accepted by the arbitration vendor from the parties in dispute, and no in-person or telephonic testimony will be permitted during the arbitration proceeding.

Proposed new rule N.J.A.C. 11:24D-2.2(k) provides that within 30 days of the receipt of a complete out-of-network arbitration application and accompanying documents, the arbitrator will apply the arbitrator's experience in health care pricing and issue a decision subject to the following: (1) the decision must be in writing, issued by the arbitrator, and must explain the reasoning for selection of the prevailing final offer; (2) the decision must select either the final offer of the out-of-network health care provider or the carrier as the award amount; (3) the decision must split the costs of the arbitration between the parties to the arbitration, unless the carrier is found to not have acted in good faith; (4) the decision must not award legal fees or costs; and (5) the decision must be binding on all parties.

Proposed new rule N.J.A.C. 11:24D-2.2(l) provides that if the out-of-network health care provider prevails in the arbitration, the carrier must remit payment of the difference between its portion of its final offer allowed charge and the arbitration award within 20 days of the date of the arbitration decision. Additionally, the carrier must pay the difference between the arbitration award and any prior payments it has made without any increase in the covered person's cost-sharing liability. If the carrier fails to remit payment within 20 days of the date of the arbitration

decision, interest of 12 percent per annum will accrue, starting interest on the 21<sup>st</sup> day after the date of the arbitration decision pursuant to Health Claims Authorization, Processing and Payment Act. The interest will terminate on the date of payment, but no later than 150 days after the date of the claim receipt, unless the parties agree to a longer period of time.

Proposed new rule N.J.A.C. 11:24D-2.2(m) requires the carrier to notify the covered person of the results of the arbitration award upon payment of an arbitration award, if applicable, but no later than 30 days from the date of the arbitration decision. The notification must be provided through the issuance of a final Explanation of Benefits, that includes text, or is accompanied by a separate document, if needed, which advises of the following: (1) the arbitration decision has been issued; (2) the amount of the arbitration award for the final allowed charge; any revised carrier payment based on the arbitrator's award, if applicable; and the covered person's final cost-sharing liability for the claim as of the time of reprocessing, which must not be greater than the covered person's cost-sharing liability based upon the carrier's final offer allowed charge, as disclosed in the pre-arbitration Notice/Explanation of Benefits; (3) the amount, if any, paid by the carrier based upon the difference between the final offer allowed charge and the arbitration award; (4) this notice is provided only for the information of the covered person, and that the covered person is not responsible for any increased cost-sharing liability as a result of the arbitration award; and the covered person must not be billed by the out-of-network health care provider for the inadvertent and/or involuntary out-of-network services above the covered person's network level cost-sharing liability, as set forth in the pre-arbitration and final Notice/Explanation of Benefits.

N.J.A.C. 11:24D-2.3 Self-Funded Health benefits plans – Out-of-Network Arbitration Without Plan Opt-In:

Proposed new rule N.J.A.C. 11:24D-2.3(a) provides that for self-funded health benefits plans covering New Jersey residents that do not elect to participate in the out-of-network arbitration program, a member of a self-funded health benefits plan or the out-of-network health care provider may request binding arbitration for claims for inadvertent and/or involuntary out-of-network services provided that: (1) there is no resolution of a payment dispute within 30 days after the member is sent a bill for the services; (2) the member was a New Jersey resident when the inadvertent and/or involuntary out-of-network services were rendered; and (3) the inadvertent and/or involuntary out-of-network services were rendered in New Jersey by a New Jersey licensed or certified health care provider.

Proposed new rule N.J.A.C.11:24D-2.3(b) provides that an out-of-network health care provider may bill the member once upon the initial adjudication of the claim for inadvertent and/or involuntary out-of-network services by a self-funded health benefits plan. After the covered person is billed for the inadvertent and/or involuntary out-of-network services, a 30-day negotiation period between the out-of-network health care provider and the member is commenced, during which time, the out-of-network health care provider is not permitted to collect or attempt to collect reimbursement from the member, including through the initiation of collection proceedings. After the expiration of the 30-day negotiation period, either the out-of-network health care provider or the member may initiate arbitration.

Proposed new rule N.J.A.C. 11:24D-2.3(c) provides that the out-of-network health care provider may not then subsequently bill the member or initiate collection activity until the provider has filed a request for arbitration pursuant to this section.

Proposed new rule N.J.A.C. 11:24D-2.3(d) provides that voluntary out-of-network claims are not eligible for arbitration.

Proposed new rule N.J.A.C. 11:24D-2.3(e) provides that arbitrations without plan opt-in will be administered by the Department's out-of-network arbitration vendor.

Proposed new rule N.J.A.C. 11:24D-2.3(f) provides that out-of-network arbitration may be requested by submitting a completed out-of-network arbitration application directly to the arbitration vendor.

Proposed new rule N.J.A.C. 11:24D-2.3(g) provides that upon receipt of a request, the arbitration vendor will promptly review the request to determine whether it is eligible for arbitration and the completeness of the out-of-network arbitration application. The arbitration vendor will accept for processing a complete application that meets the following criteria: (1) the health benefits plan at issue is a self-funded health benefits plan that has not elected to participate in the out-of-network arbitration program; (2) the self-funded health benefits plan covers emergency or urgent services rendered by an out-of-network health care provider; (3) the member was a New Jersey resident on the date of service and was covered under a self-funded health benefits plan at the time that the inadvertent and/or involuntary out-of-network services were rendered; (4) the member has been billed by an out-of-network health care provider for the inadvertent and/or involuntary out-of-network services that were rendered in New Jersey by a New Jersey licensed provider; (5) the out-of-network arbitration application includes, or the member has previously submitted, a fully-executed "Consent to Representation in Appeals of Utilization Management Determinations and Authorizations for Release of Medical Records in UM Appeals and Independent Arbitration of Claims" form in the event that the member's confidential information accompanies the arbitration request; and (6) the party initiating the arbitration request

has submitted all necessary information requested by the vendor with the out-of-network arbitration application and the applicable fee.

Proposed new rule N.J.A.C. 11:24D-2.3(h) provides that the arbitration vendor will not accept the request unless 30 days have elapsed from issuance of the out-of-network health care provider's bill to the member.

Proposed new rule N.J.A.C. 11:24D-2.3(i) provides that the arbitration proceeding will be conducted pursuant to the procedures applicable to fully-insured plans.

Proposed new rule N.J.A.C. 11:24D-2.3(j) provides that within 30 days of the receipt of a complete out-of-network arbitration application and accompanying documents, the arbitrator will apply the arbitrator's experience in health care pricing and issue a decision subject to the following: (1) the decision must be in writing and issued by the arbitrator; (2) the decision must award an amount that the arbitrator determines is reasonable for the inadvertent and/or involuntary out-of-network services; (3) the decision must split the costs of the arbitration between the parties to the arbitration, unless the payment would pose a financial hardship to the member, which can be demonstrated by total family income below 250% of the Federal Poverty Level; (4) the decision must not award legal fees or costs; and (5) the decision must be binding on the member and the out-of-network health care provider and must include a non-binding recommendation to the entity providing or administering the self-funded health benefits plan of an amount that would be reasonable to contribute to payment for the inadvertent and/or involuntary out-of-network services.

### **Proposed Amendments to N.J.A.C. 11:2-17**

#### **N.J.A.C. 11:2-17.9 Rules for Fair and Equitable Settlements Application to Life and Health Insurance**

N.J.A.C. 11:2-17.9 will be amended to prohibit carriers, that issue health benefits plans in New Jersey with voluntary out-of-network benefits, from setting the initially determined allowed charge for inadvertent and/or involuntary out-of-network services at an amount that is less than the allowed charge for the same out-of-network services rendered on a voluntary basis under that same health benefits plan.

### **Proposed Amendments to N.J.A.C. 11:22-1**

#### **N.J.A.C. 11:22-1.2 Definitions:**

N.J.A.C. 11:22-1.2 will be amended to provide the definitions of “cost-sharing”; “health care facility”; “inadvertent out-of-network services”; and “involuntary out-of-network services”; which are consistent with the definitions under New Jersey law and discussed above.

#### **N.J.A.C. 11:22-1.5 Prompt Payment of Claims**

N.J.A.C. 11:22-1.5 will be amended to prohibit carriers or their agents from denying, delaying, or pending payment of a claim solely on the basis that the services are inadvertent and/involuntary out-of-network services, and that carriers must process claims in accordance with the proposed new rules discussed above and existing regulations.

#### **N.J.A.C. 11:22-1.6 Denied and Disputed Claims:**

N.J.A.C. 11:22-1.6(a)4 will be amended to include circumstances where the carrier or its agent disputes the amount of the claim for inadvertent and/or involuntary out-of-network services as required by the proposed new rules discussed above.

#### **N.J.A.C. 11:22-1.14 Reporting Requirements:**



N.J.A.C. 11:22-1.14(a) will be amended to include the number of claims that are denied and downcoded and the reasons for the downcoding in a carrier's or ODS's quarterly and annual report on the timeliness of claims payments.

N.J.A.C. 11:22-1.14(b) will be amended to include denials and downcoding and the reasons for downcoding in the annual report on timeliness of claims payments.

N.J.A.C. 11:22-1.16 Explanation of Benefits:

N.J.A.C. 11:22-1.16(b) will be amended to provide that the explanation of benefits for claims for inadvertent and/or involuntary out-of-network services, must set forth the disclosures in the form and manner required by proposed new rules discussed above, and a notice that advises that: (1) charges for inadvertent and/or involuntary out-of-network services, including charges for services provided on an emergency or urgent basis, are not subject to billing above the cost-sharing applicable to network level services; and (2) that any attempts by the out-of-network health care provider to bill, collect, or invoice funds from the covered person above the covered person's cost-sharing applicable to network level services should be promptly reported to the carrier, at the phone number that the carrier must provide on the Explanation of Benefits and all reimbursement correspondence to the consumer, and a complaint should be filed with the appropriate licensing board or other regulatory body for the out-of-network health care provider.

**Proposed Amendments to N.J.A.C. 11:22-8**

N.J.A.C. 11:22-8.1 Purpose and Scope:

N.J.A.C. 11:22-8.1 will be amended to provide that the rule applies to all insurance companies, health service corporations, hospital service corporations, medical service corporations, and health maintenance organizations authorized to issue insured health benefits

plans in New Jersey and to all third-party administrators licensed or registered in New Jersey that are administering insured health benefits plans in New Jersey.

N.J.A.C. 11:22-8.2 Definitions:

N.J.A.C. 11:22-8.2 will be amended to revise the definition of “health benefits plan” or “plan” to include “other insured plan for medical care delivered or issued for delivery in New Jersey”.

N.J.A.C. 11:22-8.3 Requirement to Issue Identification Cards

N.J.A.C. 11:22-8.3(a) will be amended to include third-party administrators with carriers in the requirement to remain responsible for the proper issuance of the identification cards and for their compliance with the subchapter.

N.J.A.C. 11:22-8.3(b) will require that the word “INSURED” appear on the front of all health benefits plan identification cards in upper-case text.

**Proposed New Rule N.J.A.C. 11:22-8A**

N.J.A.C. 11:22-8A.1 Purpose and Scope:

Proposed new rule N.J.A.C. 11:22-8A.1 provides that this new rule will establish standards and criteria regarding information contained on identification cards for certain self-funded health benefits plan that will apply to all multiple employer welfare arrangements, carriers, third-party administrators, or other entities that administers a self-funded health benefits plan in New Jersey.

N.J.A.C. 11:22-8A.2 Definitions:

Proposed new rule N.J.A.C. 11:24D-1.2 defines terms such as “card,” “health plan identification card,” or “identification card”; “carrier”; “Commissioner”; “Department”; “group

number”; “identification number” or “ID”; “covered person”; “multiple employer welfare arrangement” or “MEWA”; “primary covered person”; “self-funded health benefits plan” or “self-funded plan” or “plan”; and “third-party administrator”.

N.J.A.C. 11:22-8A.3 Requirements to Issue Identification Cards:

Proposed new rule N.J.A.C. 11:22-8A.3(a) requires that all carriers, third-party administrators, multiple employer welfare arrangements, or other entities, that provide or administer a self-funded health benefits plan in New Jersey issue a health plan identification card to the primary covered person under a self-funded health benefits plan, and that additional identification cards may be issued to other persons included under the primary covered person’s plan. The carrier, third-party administrator, multiple employer welfare arrangement, or other entity may contract with an administrator, agent, contractor, or other vendor to issue the identification cards; however, the entity responsible for administration of the self-funded health benefits plan that is licensed in New Jersey must remain responsible for the proper issuance of the identification cards and for their compliance with the subchapter.

Proposed new rule N.J.A.C. 11:22-8A.3(b) requires that the following information appear on the identification cards in a readily identifiable manner: (1) the name of the carrier, third-party administrator, multiple employer welfare arrangement, or other entity administering the self-funded health benefits plan; (2) upper-case text as follows on the front of the identification card: “SELF-FUNDED”; (3) the covered person’s name; (4) the covered person’s identification number and/or the group number, if applicable; (5) the name of the primary care provider for each covered person, if such selection is required under the plan; (6) a phone number or electronic address for authorization and admission certifications, if required under the plan; (7) in-network cost-sharing information, including amounts applicable to primary care provider visits, specialist visits,

emergency room visits, and hospital stays; and (8) for all multiple employer welfare associations subject to the provisions of N.J.S.A. 17B:27C-1 et seq. and for self-funded health benefits plans, as defined in the proposed new rules discussed above, that elect to participate in the out-of-network arbitration program, pursuant to the Act, text located on the front of the identification card below or adjacent to “SELF-FUNDED” that states: “NJ Arbitration — Yes as of [effective date (after which all claims for inadvertent and/or involuntary out-of-network services incurred are subject to arbitration) that is at least two weeks after the mailing of the identification card].”

N.J.A.C. 11:22-8A.4 Time Limits:

Proposed new rule N.J.A.C. 11:22-8A.4(a) requires that as of its operative date, a health plan’s identification card be provided to covered persons of self-funded health benefits plans in New Jersey pursuant to the terms of the self-funded health benefits plan documents and/or contract; however, noncomplying identification cards must be replaced with complying identification cards by all licensed and/or registered carriers, third-party administrators, multiple employer welfare arrangements, or other entities upon issuance of a new plan or upon renewal of an existing plan. The effective date of the plan’s opt-in status regarding out-of-network arbitration, as indicated on the plan’s identification card, must be no less than two weeks after the date that the new identification cards are mailed to members indicating the plan’s opt-in status, and the plan’s opt-in status must not be effective unless new identification cards have been mailed to members and an informational filing has been made with the Department. Additionally, if a plan has opted into out-of-network arbitration, this information along with the effective date of the plan’s opt-in status, must be prominently displayed on the publicly accessible website, if any, of the carrier, third-party administrator, multiple employer welfare arrangement, or other entity

administering the self-funded health benefits plan at the same time the identification cards indicating such opt-in status are sent to plan members.

N.J.A.C. 11:22-8A.5 Informational Filings:

Proposed new rule N.J.A.C. 11:22-8A.5(a) provides that every entity that provides or administers a self-funded health benefits plan that elects to be subject to out-of-network arbitration pursuant to the Act must make informational filings on a quarterly basis of each year as follows: March 15<sup>th</sup>, June 15<sup>th</sup>, September 15<sup>th</sup>, and December 15<sup>th</sup>, of the form of the identification card(s) for the self-funded health benefits plans electing to participate in out-of-network arbitration. If a self-funded health benefits plan later withdraws from participation in out-of-network arbitration, the plan administrator must notify the Department in writing, including the date of withdrawal. The same information included in the informational filing to the Department, including the effective date of the opt-in or withdraw from participation in out-of-network arbitration, must be prominently displayed and updated on the publicly accessible website, if any, of the carrier, third-party administrator, multiple employer welfare arrangement, or other entity administering the self-funded health benefits plan that opts in to out-of-network arbitration.

Proposed new rule N.J.A.C. 11:22-8A.5(b) provides that every carrier, third-party administrator, or other entity that provides or administers a self-funded health benefits plan in New Jersey must be prepared to produce a sample identification card for any or all of those self-funded health benefits plans upon the Department's request.

Proposed new rule N.J.A.C. 11:22-8A.5(c) provides that informational filings, including information that identifies the name of the plan sponsor if such is not stated on the identification

card, must be made by the entity that issues the identification card and same must be submitted to the Department's Life and Health Division.

**Proposed New Rule N.J.A.C. 11:24-6.4**

Proposed new rule N.J.A.C. 11:24-6.4 requires that carriers annually obtain independent verification of the adequacy of the carrier's provider network, which includes a review and confirmation that the network meets all of the time and distance standards described N.J.A.C. 11:24-6.2 to -6.3. The independent entity performing the verification must submit a report to the Department's Consumer Protection Services in a format set forth by order, or similar means, and/or posted on the Department's website. For the first year of reporting, the report will be due on the date directed by the Department, and for each year thereafter, the report will be due on May 1.

**Proposed Amendments N.J.A.C. 11:24-8**

**N.J.A.C. 11:24-8.3 Utilization Management Determinations:**

N.J.A.C. 11:24-8.3 will be amended to provide that where a carrier authorizes a health care service to be performed by a network health care provider and the provider becomes an out-of-network health care provider while the authorization is in effect but prior to the provision of the service, the carrier must notify the covered person of the change in participation status as soon as practicable. If the notice is provided less than 30 days prior to provision of the service, the covered person's responsibility must be limited to that which would have applied had the health care provider been in-network on the date of service, except as follows: if the change in participation status is due to the health care provider's termination, based upon the opinion of the carrier's medical director that the health care provider represents an imminent danger to an individual

patient or the public health, safety, or welfare, the carrier must assist the covered person in finding another in-network health care provider to provide the service in accordance with the medical exigencies of the diagnosis and service no later than 30 days from the issuance of the notice of change in provider status.

N.J.A.C. 11:24-9.1 Member Rights and Responsibilities: Disclosure to Consumers

N.J.A.C. 11:24-9.1 will be amended to require that HMOs maintain accurate and accessible health care provider directions in accordance with N.J.A.C. 11:24C-4.5 to -4.6.

N.J.A.C. 11:24-9.1 will additionally be amended to recodify existing subsections (c) through (d) as new subsections (d) through (e) with the following proposed changes to text:

Recodified N.J.A.C. 11:24-9.1(e)9 will be amended to include inadvertent and/or involuntary out-of-network services by out-of-network health care providers and for services provided by an out-of-network health care provider for whom the covered person has been granted an in-plan exception in the statement of the member's rights to be free from balance billing by providers;

Recodified N.J.A.C. 11:24-9.1(e)12 will be amended to add the requirement that any other applicable laws and regulations be included;

Recodified N.J.A.C. 11:24-9.1(e)13 will be amended to add the requirement that timeframes applicable under specific laws or regulations be included;

Recodified N.J.A.C. 11:24-9.1(e) will be amended to require that the statement of member's rights must include the right to a prompt response to a request as to whether a provider is an in-network health care provider;

Recodified N.J.A.C. 11:24-9.1(e) will be amended to require that the statement of member's rights must include the right to access a telephone hotline that is operated for at least 16

hours per day and staffed with live representatives that are capable of responding to questions about network status; and

Recodified N.J.A.C. 11:24-9.1(e) will be amended to require that the statement of member's rights must include the right to obtain notice of the out-of-network transparency disclosures required by proposed new rule above.

### **Proposed Amendments N.J.A.C. 11:24A**

#### **N.J.A.C. 11:24A-2.3 Disclosure Requirements:**

N.J.A.C. 11:24A-2.3(a)1iii will be amended to provide that with the exception of Medicaid, Medicare Advantage, and Medicare supplement coverage, the policies and procedures must also describe the billing, notice requirements, and arbitration provisions applicable to the involuntary treatment of emergency or urgent care services by out-of-network health care providers as required by the proposed new rules discussed above.

N.J.A.C. 11:24A-2.3(a)2i will be amended to include the disclosures as set forth in the proposed new rule discussed above.

N.J.A.C. 11:24A-2.3(a)2iii will be amended to provide that what the carriers determine is the customary and reasonable charge is referred to the allowed charge, and to provide that the services that are covered under the plan or contract where services are rendered by an out-of-network provider is referred to as the voluntary use of an out-of-network provider.

#### **N.J.A.C. 11:24A-2.5 Other Rights of Covered Persons:**

N.J.A.C. 11:24A-2.5(b)2 will be amended to provide that with the exception of Medicaid, Medicare Advantage, and Medicare supplement coverage, the policies and procedures must also describe the billing, notice requirements, and arbitration provisions applicable to the involuntary



treatment of emergency or urgent care services by out-of-network health care providers as required by the proposed new rules discussed above.

N.J.A.C. 11:24A-2.5(b) will be amended to provide that with the exception for Medicaid, Medicare Advantage, and Medicare supplement coverage, the carriers' policies and procedures must address the right of the covered person to (1) request and obtain information from the carrier as to whether a provider is an in-network health care provider and (2) call a telephone hotline operated for at least 16 hours per day and staffed with live representatives that are capable of responding to questions about network status and out-of-pocket costs for out-of-network services.

N.J.A.C. 11:24A-2.6 Emergency and Urgent Care Services:

N.J.A.C. 11:24A-2.6(b) will be amended to include reference to other qualified or licensed urgent care facility.

N.J.A.C. 11:24A-2.6 will be amended to require the carrier to pay for coverage of, and limit the responsibility for, the provisions of medically necessary emergency or urgent care services by out-of-network health care providers in accordance the provisions of the proposed new rules discussed above.

N.J.A.C. 11:24A-3.4 Utilization Management Program

N.J.A.C. 11:24A-3.4 will be amended to provide that where a carrier authorizes a health care service to be performed by a network health care provider and the provider becomes an out-of-network health care provider while the authorization is in effect but prior to the provision of the service, the carrier must notify the covered person of the change in participation status as soon as practicable. If the notice is provided less than 30 days prior to provision of the service, the covered person's responsibility must be limited to that which would have applied had the health care

provider been in-network on the date of service, except as follows: if the change in participation status is due to the health care provider's termination, based upon the opinion of the carrier's medical director that the health care provider represents an imminent danger to an individual patient or the public health, safety, or welfare, the carrier must assist the covered person in finding another in-network health care provider to provide the service in accordance with the medical exigencies of the diagnosis and service no later than 30 days from the issuance of the notice of change in provider status.

N.J.A.C. 11:24A-4.2 Disclosures to Covered Persons:

N.J.A.C. 11:24A-4.2(a) will be amended provide that the notice must also state that the covered person can request directly from the carrier information as to whether a particular health care provider is participating in-network or is out-of-network and how to make the request, including, but not limited to, a telephone hotline operated for at least 16 hours per day.

N.J.A.C. 11:24A-4.3 will be amended to require that the carrier must provide information to consumers to allow an estimate of out-of-pocket costs for out-of-network services to be calculated, as required by proposed new rules discussed above.

N.J.A.C. 11:24A-4.10 Network Adequacy:

N.J.A.C. 11:24A-4.10 will be amended to require that carriers annually obtain independent verification of the adequacy of the carrier's provider network, which includes a review and confirmation that the network meets all of the time and distance standards described in N.J.A.C. 11:24A-4.10. The independent entity performing the verification must submit a report to the Department's Consumer Protection Services in a format set forth by order, or similar means, and/or

posted on the Department's website. For the first year of reporting, the report will be due on the date directed by the Department, and for each year thereafter, the report will be due on May 1.

**Amendments to N.J.A.C. 11:24C**

**N.J.A.C. 11:24C-4.6 Standards for Accuracy of Provider Directory Information:**

N.J.A.C. 11:24C-4.6(c) will be amended to require that carriers update electronic directories 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 had notice of such change.

N.J.A.C. 11:24C-4.6 will also be amended to include a new provision that requires that carriers annually obtain independent verification of the accuracy of the provider directory, subject to the following requirements: (1) the verification must include testing of the directory entries for primary care providers, specialist providers, and facilities; (2) the testing must be of the accuracy of the data elements required by N.J.A.C. 11:24C-4.5(b); (3) the verification is to be performed by direct contact with the provider's office and not by the use of third-party data; and (4) the independent entity performing the verification must submit a report to the Department's Consumer Protection Services in a format set forth by order or similar means, and/or posted on the Department's website. The new provision will also provide that for the first year of reporting, the report will be due on the date directed by the Department, and for each year thereafter, the report will be due on May 1.

Please provide any feedback you wish the Department to consider on the proposed new rules and amendments by e-mail to [Advancenotice@dobi.nj.gov](mailto:Advancenotice@dobi.nj.gov) by November 29, 2019. Thank you for your participation in this important component of the rulemaking process.

