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ASSEMBLY, No. 235

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Sponsored by:
Assemblyman GARY S. SCHAER
District 36 (Bergen and Passaic)

SYNOPSIS

The "Health Care Provider Network Transparency Act"; establishes requirements for granting access to certain health care provider discounts.

CURRENT VERSION OF TEXT

As reported by the Assembly Financial Institutions and Insurance Committee on June 7, 2012, with amendments.

AN ACT concerning certain health care provider networks, and supplementing chapter 30 of Title 17B of the New Jersey Statutes.

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

1. This act shall be known and may be cited as the "Health Care Provider Network Transparency Act."

2. As used in this act:

"Contracting entity" means any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business.

"Covered person" means an individual who is covered under a health insurance plan.

"Discount medical plan organization" means an entity that, in exchange for fees, dues, charges or other consideration, provides to its members access to providers of medical services and the right to receive medical services from those providers at a discount.

"Electronic claims transport" means accepting and digitizing claims already digitized, placing those claims into a format that complies with the electronic transaction standards issued by the United States Department of Health and Human Services under subtitle F of title II of the federal "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (42 U.S.C. s. 1320d et seq.) as those electronic standards are applicable to the parties, and electronically transmitting those claims to the appropriate contracting entity, payer, or third party administrator.

"Health care services" means services for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

"Health insurance plan" means any hospital and medical expense incurred policy, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise. "Health insurance plan" shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and private passenger automobile insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage similar to the foregoing as specified in federal regulations issued pursuant to the federal "Health

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Assembly AFI committee amendments adopted June 7, 2012.

Insurance Portability and Accountability Act of 1996," P.L.104-191 (29 U.S.C. s.1181 et al.), under which benefits for medical care are secondary or incidental to other insurance benefits; dental or vision benefits; benefits for long-term care, nursing home care, home health care, or community-based care; specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or such other similar, limited benefits as are specified in regulations; Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act Pub.L.74-271 (42 U.S.C. s.1395ss(g)(1)); coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (10 U.S.C. s.1071 et seq.); or other similar limited benefit supplemental coverages.

"Payer" means a carrier, organized delivery system, or any other person who undertakes to provide and assumes financial risk for the payment of health benefits, and is obligated to pay claims for health benefits on behalf of a covered person to a provider or other claimant.

"Provider" means a physician licensed pursuant to Title 45 of the Revised Statutes, [1]a general acute care facility licensed by the Commissioner of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), including rehabilitation, psychiatric and long-term acute facilities,[1] a physician organization, a physician hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. "Provider" shall not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

"Provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and providing for the delivery of and payment for health care services to covered persons.

"Third party" means a person or entity that enters into a contract with a contracting entity or with another third party to gain access to a provider network contract.

"Third party administrator" means "third party administrator" as defined by section 1 of P.L.2001, c.267 (C.17B:27B-1).

3. This act shall not apply to:

a. A provider network contract for services provided to beneficiaries of the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), the Medicare program established pursuant to the federal Social Security Act, Pub.L.74-271 (42 U.S.C. s.1395 et seq.), or the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.);

b. Situations in which access to a provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity; and

c. A contract between a contracting entity and a discount medical plan organization.

4. a. Any person conducting business as a contracting entity in this State on the effective date of this act shall register with the Department of Banking and Insurance within 90 days of the effective date of this act unless the person is licensed by the department as an insurer. Any person that commences business as a contracting entity in this State on or after the effective date of the act shall register with the department within 30 days of commencing business unless the person is licensed by the department as an insurer.

b. Registration shall consist of the submission to the department of the following information:

(1) the official name of the contracting entity and any other names under which the contracting entity does business or was formerly known;

(2) the mailing address and main telephone number for the contracting entity's main headquarters;

(3) the name and telephone number of the contracting entity's representative who serves as the primary contact with the department; and

(4) any other information deemed to be necessary by the department.

c. The information required by this section shall be submitted in written or electronic format, as prescribed by the department through regulation.

d. The department may collect a reasonable fee for the purpose of administering the registration process, as prescribed by the department through regulation.

5. A contracting entity shall not grant to a third party access to a provider network contract unless the third party accessing the provider network contract is:

a. A payer or third party administrator or other entity that administers or processes claims on behalf of the payer;

b. A preferred provider organization or preferred provider network, including a physician organization or physician-hospital organization; or

c. An entity engaged in the business of providing electronic claims transport between the contracting entity and the payer, that does not provide access to the provider's health care services and contractual discounts to any other third party.

6. A contracting entity shall not grant to a third party access to a provider's health care services and contractual discounts pursuant to a provider network contract unless:

a. The provider network contract specifically states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity; and

b. The third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.

7. a. A contracting entity that grants to a third party access to a provider's health care services and contractual discounts pursuant to a provider network contract shall, at the time a provider network contract is entered into with a provider:

(1) identify and provide to the provider upon request, a written or electronic list of all third parties known at the time of contracting, to which the contracting entity has or will grant access to the provider's health care services and contractual discounts pursuant to a provider network contract; and

(2) maintain an Internet website or other readily available mechanism, such as a toll-free telephone number, through which a provider may obtain a listing, updated at least every 90 days, of the third parties with which the contracting entity or another third party has executed contracts to grant access to the provider's health care services and contractual discounts pursuant to a provider network contract.

b. A contracting entity that grants to a third party access to a provider's health care services and contractual discounts pursuant to a provider network contract shall, at the time that access is provided to the third party:

(1) provide the third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract; and

(2) require that the third party identify the contracting entity that is the source of the contractual discount taken by the third party on each remittance advice or explanation of payment furnished to a provider when the discount is pursuant to the contracting entity's provider network contract.

8. a. A contracting entity that grants to a third party access to a provider's health care services and contractual discounts pursuant to a provider network contract shall, in situations in which the provider network contract is terminated:

(1) provide notice to the third party of the termination of the provider network contract no later than 60 days prior to the effective date of the termination of the provider network contract, which notice may be provided through any reasonable means, including but not limited to, written notice, electronic communication, or an update to an electronic database or other provider listing; and

(2) require all persons that are by contract eligible to claim the right to access a provider's discounted rates to cease claiming entitlement to those rates or other contracted rights or obligations for services rendered after termination of the provider network contract.

b. In situations in which a provider network contract is terminated, subject to any applicable continuity of care requirements, agreements, or contractual provisions:

(1) the right of a third party to access a provider's health care services and contractual discounts pursuant to a provider network contract shall terminate on the termination date of the provider network contract;

(2) claims for health care services performed after the termination date of the provider network contract shall not be eligible for processing and payment in accordance with the terms of the provider network contract; and

(3) claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, shall be eligible for processing and payment in accordance with the terms of the provider network contract.

9. a. All information made available by a contracting entity to a provider in accordance with the requirements of this act shall be confidential and the provider shall not disclose the information to any person or entity not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity.

b. Nothing contained in this act shall be construed to prohibit a contracting entity from requiring a provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's practice or the administration thereof.

10. A third party that has been granted access to a provider's health care services and contractual discounts pursuant to a provider network contract and that grants access to a subsequent third party shall comply with the requirements imposed on a contracting entity

pursuant to sections 5, 6, 7, 8, and 9 of this act, as if the third party were the contracting entity.

11. a. In situations in which a third party has been granted access to a provider's health care services and contractual discounts pursuant to a provider network contract, the contracting entity and third party shall disclose, on each remittance advice or explanation of payment furnished to a provider, the entity that is the source of the contractual discount.

b. Except as provided in subsection c. of this section, a provider shall have the right to refuse to accept a discounted amount as the appropriate reimbursement amount under a provider network contract, and the provider shall have the right to require payment of the charge with no discount applied, if:

(1) a remittance advice or explanation of payment furnished by a contractual entity or third party fails to comply with subsection a. of this section; or

(2) the contractual discount is not exercised pursuant to a network provider contract that is in compliance with the provisions of this act.

c. In situations in which a provider refuses to accept a discounted amount pursuant to paragraph (1) of subsection b. of this section, a provider shall notify the contracting entity or third party of the apparent violation in writing. If the contracting entity or third party, within 30 days of receipt of notice of the apparent violation, notifies the provider that the apparent violation resulted from an administrative oversight or other unintentional error and submits to the provider a corrected remittance advice or explanation of benefits with documentation demonstrating eligibility for the discount applied, the discount shall be applied and the provider shall not have a right to refuse to accept the discounted amount.

12. a. Any person who violates any provision of this act shall be liable to a civil penalty in an amount of not less than $500, or more than $10,000, for each violation. A penalty shall be collected and enforced by a summary proceeding brought by the Commissioner of Banking and Insurance pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

b. In addition to any penalty pursuant to subsection a. of this section, it shall be an unfair trade practice pursuant to the provisions of N.J.S.17B:30-1 et seq. and a violation of that act for any person to knowingly access or utilize a provider's contractual discount pursuant to a provider network contract without a contractual relationship with the provider, contracting entity, or third party.

13. The Commissioner of Banking and Insurance shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purpose of this act.

14. This act shall take effect on the 90th day following enactment and shall apply to all provider network contracts that are delivered, issued, executed or renewed in this State, on or after the effective date.