[First Reprint]

ASSEMBLY, No. 3860

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED FEBRUARY 27, 2024

Sponsored by:
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SYNOPSIS

Establishes certain medical billing requirements concerning specific nature of charges or expenses for health care services.

CURRENT VERSION OF TEXT

As amended but not reported by the Assembly Financial Institutions and Insurance Committee on May 20, 2024.

(Sponsorship Updated As Of: 2/27/2024)

AN ACT concerning medical billing requirements and supplementing Title 45 of the Revised Statutes.

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

1. a. As used in this section:

"Carrier" means an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefits plan, including: an insurance company authorized to issue health benefits plans; a health maintenance organization; a health, hospital, or medical service corporation; a multiple employer welfare arrangement; the State Health Benefits Program and the School Employees' Health Benefits Program; or any other entity providing a health benefits plan. Except as provided under the provisions of this act, "carrier" shall not include any other entity providing or administering a self-funded health benefits plan.

"Episode of care" means the medical care ordered to be provided for a specific medical procedure, condition, or illness.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, "health benefits plan" shall not include the following plans, policies or contracts: Medicaid, Medicare, Medicare Advantage, accident only, credit, disability, long-term care, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), a dental plan as defined pursuant to section 1 of P.L.2014, c.70 (C.26:2S-26) and hospital confinement indemnity coverage.

"Health care facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et al.)

"Health care professional" means an individual, acting within the scope of the individual's licensure or certification, who provides professional services in, or under contract with, a health care facility.

"Health care provider" or "provider" means a health care professional or health care facility.

"Health care service" means the preadmission, outpatient, inpatient, and post discharge care provided in or by a health care facility, and such other items or services as are necessary for such care, including but not limited to medical devices, which are provided for the purpose of health maintenance, diagnosis, or treatment of human disease, pain, injury, disability, deformity, or physical condition,

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 May 20, 2024.

including, but not limited to, nursing service, home care nursing, and other paramedical service, ambulance service, dental and vision services, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, including services provided by a health care professional in private practice.

"Self-funded health benefits plan" or "self-funded plan" means a self-insured health benefits plan governed by the provisions of the federal "Employee Retirement Income Security Act of 1974," 29 U.S.C. s.1001 et seq.

b. (1) A health care provider shall, within 30 days after a patient's discharge or release or within seven days after receiving a written request, provide to the patient or to the patient's survivor or legal guardian, as appropriate, a consolidated, itemized statement or bill detailing the specific nature of the charges or expenses for the health care services the patient received from the provider. The description of billed charges shall be in plain language that is comprehensible to an ordinary layperson but may include technical terms to describe the health care services if the technical terms are defined using limited medical nomenclature as permitted under the rules adopted pursuant to this section.

(2) The itemized statement or bill required by this section shall:

(a) not describe a billed charge using only a medical billing code or a general term such as "miscellaneous charges," "supply charges," or "other charges";

(b) list the specific services received and expenses incurred by date and health care provider, enumerating in detail the constituent components of the services received within each department of a health care facility and including unit price data on rates charged by a health care facility;

(c) identify each item as paid, assigned to a third-party payer, or chargeable directly to the patient, including the amount due and the due date for any amount expected from the patient;

(d) not refer to drug code numbers without also using the appropriate brand name or generic name for each drug;

(e) include the services provided by hospital-based physicians and other health care providers who cannot bill separately;

(f) specifically identify physical, rehabilitative, occupational, or speech therapy treatment by date, type, and length of treatment; **[1]**[and]**[1]**

(g) conspicuously display the telephone number of the health care facility's patient liaison responsible for expediting the resolution of any billing dispute between the patient, or the patient's survivor or legal guardian in accordance with subsection c. of this section**[1]**; and

(h) provide information on free or reduced cost financial assistance health care programs available to patients, distributed through a paper copy of the application for each program, unless the patient has opted

to receive communications exclusively through electronic means; and, if available, provide a link to the online application for each program[1].

(3) After delivery of the initial statement or bill, any subsequent statement or bill provided to a patient or to the patient's survivor or legal guardian, as appropriate, relating to the same episode of care shall include all the information required by paragraph (2) of this subsection, with any revisions clearly delineated.

(4) A health care provider shall:

(a) transmit the itemized statement or bill by [1]**[**secure e-mail, via a secure online portal, or, upon request, by**]**[1] mail [1]or, upon request, by secure e-mail, via a secure online portal[1]; and

(b) not bill or otherwise charge a patient for preparation of an itemized statement or bill required by this section.

c. Each health care facility shall establish policies and procedures for reviewing and responding to questions from a patient concerning the patient's consolidated itemized statement or bill. A response shall be provided no more than [1]**[**seven**]** 10[1] business days after the date a question is received.

d. The Board of Medical Examiners, in consultation with the Department of Banking and Insurance and the Division of Consumer Affairs in the Department of Law and Public Safety, shall adopt rules that specify the requirements for health care providers licensed by the board to develop and provide plain-language billing statements in accordance with this section. The Board of Medical Examiners shall ensure that the rules are consistent with P.L.2018, c.32 (C.26:2SS-1 et seq.). The rules shall specify, at a minimum, the following:

(1) the contents of the statements, including the patient's rights and payment obligations pursuant to the patient's health benefit plan;

(2) disclosure requirements specific to health care facilities, including the terms used to differentiate in-network and out-of-network services and health care providers; and

(3) requirements to ensure that carriers, health care facilities, and health care providers use language that is consistent with the disclosures required by P.L.2018, c.32 (C.26:2SS-1 et seq.).

e. The Department of Health, in consultation with the Department of Banking and Insurance and the Division of Consumer Affairs in the Department of Law and Public Safety, shall adopt rules that specify the requirements for health care facilities to develop and provide plain-language billing statements in accordance with this section. The Department of Health shall ensure that the rules are consistent with P.L.2018, c.32 (C.26:2SS-1 et seq.). The rules shall specify, at a minimum, the following:

(1) the contents of the statements, including the patient's rights and payment obligations pursuant to the patient's health benefit plan;

(2) disclosure requirements specific to health care facilities, including the terms used to differentiate in-network and out-of-network services and health care providers; and

(3) requirements to ensure that carriers, health care facilities, and health care providers use language that is consistent with the disclosures required by P.L.2018, c.32 (C.26:2SS-1 et seq.).

2. This act shall take effect immediately and shall apply to health care services performed on and after the first day of the 24th month next following the date of enactment.