The following is a summary of the provisions of P.L. 2018, c. 32 which apply to all health care professionals and the provisions that apply specifically to physicians. This summary is provided as an unofficial interpretation by the Division of Consumer Affairs. Health care professionals should consult with their legal representatives to determine the impact P.L. 2018, c. 32 will have on their individual practices.

Health care professionals are required to make two disclosures of the health benefits plans in which the health care professional participates and facilities with which the health care professional is affiliated:

1. Prior to provision of non-emergency services, in writing or through a website; and

2. At the time of an appointment, in writing or verbally.

If a health care professional does not participate in a covered person's plan, the health care professional must:

1. Prior to scheduling non-emergency procedure, inform the person that the health care professional is out-of-network and that the amount, or estimated amount, the health care professional will bill for the procedure is available upon request;

2. Upon request, disclose to the covered person in writing the amount or estimated amount that will be billed for the procedure and the associated Current Procedural Terminology (CPT) codes for the service;

3. Inform the covered person that he or she will be financially responsible for services provided out-of-network in excess of copayment, deductible, or coinsurance and that he or she may be responsible for costs in excess of those allowed by a health benefits plan; and

4. Advise the covered person to contact their health benefits plan for consultation on costs.

A physician is required to provide a covered person the name, practice name, mailing address, and telephone number, to the extent information is available, for a health care provider providing services in conjunction with those provided by the physician when that health care provider is providing the following services:

Anesthesiology;

Laboratory;

Pathology;

Radiology; or

Assistant surgeon services.

Health care providers are required to tell a covered person how to determine the health benefits plans in which the health care provider participates and recommend that the covered person contact their health benefits plan for consultation on costs.

When scheduling facility admission or outpatient facility services, a physician is required to:

1. Provide a covered person and facility with the name, practice name, mailing address, and telephone number of any other physician whose services are scheduled at the time of pre-admission, testing, registration, or admission when non-emergency services are scheduled;

2. Provide information on how to determine the health benefits plans in which the other physician participates; and

3. Recommend that the covered person contact his or her health benefits plan for consultation on costs.

If the network status of a health care professional changes between the time of the disclosures and the provision of the procedure, the health care professional shall notify the covered person.

If a primary care physician or internist performs an unscheduled procedure in his or her office, the required disclosures may be made verbally at time of service.

If a health care professional does not participate in a covered person's health benefits plan and he or she provides services in an in-network health care facility when in-network services are unavailable in the facility, the health care professional shall not bill the person in excess of any deductible, copayment, or coinsurance amount.

If a health care professional provides medically necessary services on an emergency or urgent basis, the health care professional shall not bill a covered person in excess of any deductible, copayment, or coinsurance amount for in-network services pursuant to the covered person's health benefits plan.