

ASSEMBLY, No. 589

STATE OF NEW JERSEY 214th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2010 SESSION

Sponsored by:

Assemblyman JOSEPH CRYAN

District 20 (Union)

Assemblywoman VALERIE VAINIERI HUTTLE

District 37 (Bergen)

SYNOPSIS

Concerns the delivery and oversight of coverage under certain health benefits plans; establishes Health Care Patient Ombudsperson.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel



1 AN ACT concerning the delivery and oversight of coverage under
2 certain health benefits plans, and supplementing and amending
3 various parts of the statutory law.
4

5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:
7

8 1. (New section) a. A carrier, multiple employer welfare
9 arrangement or other health benefits plan provider, or its agent,
10 contractor, or administrator, including but not limited to a third
11 party administrator for a self-insured health benefits plan, shall
12 issue or require the issuance of a health benefits plan identification
13 card to at least the primary covered person under the health benefits
14 plan.

15 b. The health benefits plan identification card shall, at a
16 minimum, include the following information, which shall be
17 presented in a readily identifiable manner on the card or,
18 alternatively, embedded on the card and available through
19 electronic extraction using a magnetic stripe or other means:

20 (1) the primary covered person's name and health benefits plan
21 identification number;

22 (2) the contract holder's name and health benefits plan
23 identification number, if different than the name and identification
24 number of the primary covered person;

25 (3) the health benefits plan group number, if applicable;

26 (4) the name of the issuing carrier, multiple employer welfare
27 arrangement or other health benefits plan provider, or the agent,
28 contractor or administrator that is administering the plan;

29 (5) the effective date of the health benefits plan coverage;

30 (6) the appropriate mailing address or Internet website address
31 for filing any claim pursuant to the provisions of P.L.1999, c.154
32 (C.17B:30-23 et al.);

33 (7) a covered person's copayment obligations, for at least the
34 following:

35 (a) a primary care office visit;

36 (b) a specialty care office visit; and

37 (c) an emergency room visit; and

38 (8) the phone number or Internet website address for a covered
39 person or health care provider to obtain the following:

40 (a) confirmation of the effective date of health benefits plan
41 coverage;

42 (b) verification of a particular benefit provided under the health
43 benefits plan coverage;

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.

1 (c) prior authorization, as provided for pursuant to section 5 of
2 P.L.2005, c.352 (C.17B:30-52) or as otherwise provided pursuant to
3 the terms of the health benefits plan; and

4 (d) contact information for health care providers participating in
5 the health benefits plan network, if applicable.

6 c. The health benefits plan identification card shall be designed
7 so that whenever the card is photocopied or electronically scanned,
8 the resulting image is clearly legible.

9
10 2. Section 9 of P.L.1997, c.192 (C.26:2S-9) is amended to read
11 as follows:

12 9. The Commissioner of Banking and Insurance, in
13 consultation with representatives of managed care plans and health
14 care providers as the commissioner deems appropriate, shall
15 establish by regulation a universal contract for participation form,
16 for use by any carrier which offers a managed care plan, consistent
17 with the provisions of this section, for the purposes of establishing
18 and renewing health care provider participation in that plan. The
19 commissioner shall revise the universal contract form, as necessary,
20 to conform with any available industry-wide, national standards for
21 managed care plan participation. Nothing herein shall be construed
22 to prevent a carrier from supplementing the universal contract form
23 with additional contractual provisions, so long as the additional
24 provisions do not duplicate or contradict the provisions set forth in
25 the universal contract form.

26 A carrier which offers a managed care plan shall contract with a
27 participating health care provider only after: providing that health
28 care provider an opportunity to review the proposed contract for
29 participation, presented on the universal contract form, as well as a
30 summary disclosure form for that contract which sets forth the
31 compensation terms, treatment policies, protocols, quality assurance
32 activities, and utilization management systems related to the
33 managed care plan and the health care provider's participation in
34 the managed care plan as set forth in section 3 of P.L. c. (C.)
35 (pending before the Legislature as this bill); and, if applicable, the
36 health care provider submits, and the carrier accepts, the universal
37 physician application for participation form or renewal form
38 established pursuant to P.L.2001, c.88 (C.26:2S-7.1 et seq.).

39 The contract between a participating health care provider and a
40 carrier which offers a managed care plan:

41 a. Shall state that the health care provider shall not be
42 penalized or the contract terminated by the carrier because the
43 health care provider acts as an advocate for the patient in seeking
44 appropriate, medically necessary health care services;

45 b. Shall not provide financial incentives to the health care
46 provider for withholding covered health care services that are
47 medically necessary as determined in accordance with section 6 of

- 1 this act, except that nothing in this subsection shall be construed to
2 limit the use of capitated payment arrangements between a carrier
3 and a health care provider; **[and]**
- 4 c. Shall protect the ability of a health care provider to
5 communicate openly with a patient about all appropriate diagnostic
6 testing and treatment options;
- 7 d. Shall not require the participation of the health care provider
8 in any managed care plan other than the one or more specified
9 under the terms of the contract, and shall not include participation
10 in any future managed care plan to be offered by the carrier as a
11 condition of participating in the one or more managed care plans
12 specified under the contract;
- 13 e. Shall not prohibit the health care provider from entering into
14 a contract to be a participating health care provider with any other
15 carrier;
- 16 f. Shall not prohibit the contracting carrier from contracting
17 with any other health care provider to also be a participating health
18 care provider;
- 19 g. Shall not contain any provision, commonly referred to as a
20 “most favored nation” clause, that: (1) prohibits, or grants the
21 carrier the option to prohibit, the health care provider from
22 contracting with another carrier for less compensation than that
23 provided by the compensation terms specified under the contract;
24 (2) requires, or grants the carrier the option to require, the health
25 care provider to accept lower compensation in the event the health
26 care provider contracts with another carrier for less compensation
27 than that provided by the compensation terms specified under the
28 contract; (3) requires, or grants the carrier the option to require,
29 termination or renegotiation of the contract if the health care
30 provider contracts with another carrier for less compensation than
31 that provided by the compensation terms specified under the
32 contract; or (4) requires the health care provider to disclose the
33 provider’s compensation terms with any other carrier with which
34 the provider contracts. The provisions of this subsection shall not
35 apply to any contract between a carrier and a health care provider
36 that is a hospital licensed pursuant to Title 26 of the Revised
37 Statutes;
- 38 h. Shall not be amended by the carrier without proper notice to
39 the health care provider.
- 40 (1) Whenever the carrier seeks to make a material amendment to
41 the contract, which shall include any amendment that changes
42 administrative procedures under the contract in a way that may
43 reasonably be expected to significantly increase the health care
44 provider’s administrative expenses, or adds or removes a managed
45 care plan or network subject to the contract, the carrier shall send a
46 written request to the health care provider or appropriate contact
47 person as designated in the contract detailing the proposed material

1 amendment by certified mail, return receipt requested or by a secure
2 electronic mail transmission. The written request shall be delivered
3 not less than 90 calendar days prior to the proposed effective date of
4 the amendment. The health care provider may accept or reject the
5 proposed amendment in writing at any time prior to the proposed
6 effective date of the amendment, and:

7 (a) if it is accepted as evidenced by a written confirmation, the
8 amendment shall be incorporated into the contract and take effect as
9 provided by the amendment;

10 (b) if it is rejected as evidenced by a written confirmation, the
11 amendment shall not be incorporated into the contract; or

12 (c) if it is not accepted or rejected by a written confirmation, the
13 amendment shall be deemed rejected and not incorporated into the
14 contract.

15 (2) Whenever the carrier seeks to make an amendment that is
16 not a material amendment as set forth in paragraph (1) of this
17 subsection, the carrier shall send a written request to the health care
18 provider or appropriate contact person as designated in the contract
19 detailing the proposed amendment by regular mail or by a secure
20 electronic mail transmission. The written request shall be delivered
21 not less than 15 calendar days prior to the proposed effective date of
22 the amendment. The health care provider may accept or reject the
23 proposed amendment in writing at any time prior to the proposed
24 effective date of the amendment, following the same procedure for
25 accepting or rejecting a proposed material amendment set forth in
26 paragraph (1) of this subsection.

27 i. (1) Shall remain in effect for a specific duration, as
28 specified in the contract, and shall not automatically renew unless
29 the health care provider and carrier agree to the automatic renewal
30 of the contract as evidenced by a separately signed clear and
31 conspicuous automatic renewal provision in the contract, or a
32 separately signed document concerning the automatic renewal of
33 the contract; and

34 (2) Shall remain in effect for the specific duration specified in
35 the contract, notwithstanding the carrier's participation in any
36 merger, consolidation, or other acquisition of another carrier or
37 entity, or another managed care plan; and

38 j. (1) Shall provide for a binding arbitration mechanism, as
39 established by the Commissioner of Banking and Insurance
40 pursuant to this subsection, concerning contractual disputes
41 involving any contract established pursuant to this section and the
42 rights conferred therein. The commissioner shall contract with a
43 nationally recognized, independent organization that specializes in
44 arbitration to conduct the arbitration proceedings.

45 (2) Any party to the contract may initiate an arbitration
46 proceeding. The arbitrator may award reasonable attorney's fees
47 and costs to the prevailing party in the arbitration proceeding.

1 (3) Any dispute pertaining to medical necessity which is eligible
2 to be submitted to the Independent Health Care Appeals Program
3 established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)
4 shall not be the subject of arbitration pursuant to this subsection.

5 (cf: P.L.1997, c.192, s.9)

6
7 3. (New section) a. A carrier which offers a managed care
8 plan shall, in an offer to contract with a participating health care
9 provider, include a summary disclosure form for that contract.

10 b. The summary disclosure form shall include the following,
11 with specific cross-references to the location of the provisions
12 within the actual contract being offered from which the summary is
13 based:

14 (1) information, consistent with section 1 of P.L.2005, c.286
15 (C.26:2S-9.2) if applicable, that is sufficient to allow the
16 participating health care provider to determine the compensation
17 terms, indicating the applicable predetermined fees or
18 reimbursement rates for covered services agreed to be performed by
19 the participating health care provider, or the methodology agreed to
20 for determining the fees or reimbursement rates through a generally
21 recognized method of payment or mode of classification, including
22 fee-for-service, resource-based relative value schedule, per diem,
23 diagnosis-related group, capitation, the Current Procedural
24 Terminology codes developed and maintained by the American
25 Medical Association, or the Healthcare Common Procedure Coding
26 System utilized by the Centers for Medicare and Medicaid Services.
27 The carrier shall indicate the effect, if any, on compensation for a
28 covered service provided if more than one procedural code or other
29 classification applies to that covered service;

30 (2) the type and number of managed care plans for which the
31 contract shall apply, and the number of networks within which the
32 health care provider shall participate;

33 (3) the term of the contract and a list of addenda, if any, to the
34 contract;

35 (4) contact information for the carrier or administrator
36 responsible for processing claims pursuant to P.L.1999, c.154
37 (C.17B:30-23 et al.);

38 (5) the application of any internal processing edits to claims,
39 including, if applicable, the editing product software name, version,
40 and version update; and

41 (6) a summary of the internal appeals mechanism established to
42 resolve disputes raised by a health care provider under the contract
43 pursuant to subsection e. of sections 2 through 7 and section 10 of
44 P.L.1999, c.154 (C.17:48-8.4, C.17:48A-7.12, C.17:48E-10.1,
45 C.17B:26-9.1, C.17B:27-44.2, C.26:2J-8.1 and C.17:48F-13.1).

- 1 c. In addition to the summarization of contract provisions
2 provided pursuant to subsection b. of this section, the summary
3 disclosure form shall indicate:
- 4 (1) reading the summary disclosure form shall not be a
5 substitute for reading the entire contract;
- 6 (2) the summary disclosure form is an overview to the actual
7 contract offered to the participating health care provider, and the
8 terms and conditions stated in that contract constitute the exclusive
9 contractual rights of the parties;
- 10 (3) by agreeing to and signing the contract, the participating
11 health care provider shall be bound by the terms and conditions
12 stated in that contract;
- 13 (4) nothing within the summary disclosure form shall create any
14 additional rights or causes of action for any contracting party; and
- 15 (5) the terms and conditions of the contract are subject to
16 amendment pursuant to the process set forth under subsection h. of
17 section 9 of P.L.1997, c.192 (C.26:2S-9), and recommend that the
18 participating health care provider always review and deliberately
19 consider any proposed amendments.

20
21 4. Section 1 of P.L.2005, c.286 (C.26:2S-9.2) is amended to
22 read as follows:

- 23 1. a. A carrier which offers a managed care plan that
24 negotiates with a health care provider to become a participating
25 provider, who is reimbursed per procedure under the plan, shall, by
26 January 1 of each calendar year for a health care provider under an
27 existing contract applicable for the previous calendar year, and
28 otherwise within 15 days upon request, furnish the health care
29 provider with a written fee schedule, or in an electronic format if
30 agreed upon by both parties, showing the specifically defined
31 compensation terms or generally recognized method of payment or
32 mode of classification for determining the fees for that health care
33 provider, and the fees for [the 20 most common] all evaluation and
34 management codes and [the 20 most common office-based or
35 hospital-based] in-network services for the health care provider's
36 specialty or sub-specialty, to be provided by the health care
37 provider under the plan pursuant to the proposed or existing
38 contract between the carrier and health care provider. If the carrier
39 negotiates with the health care provider to become a participating
40 provider under more than one managed care plan offered by the
41 carrier, the carrier shall provide the applicable fee schedule for each
42 plan. If the carrier negotiates a fee schedule with the health care
43 provider that is specific to that health care provider, the carrier shall
44 provide only the applicable fee schedule for that health care
45 provider. **[If the rate that the health care provider will be paid is a**
46 **percentage of another rate, it shall be sufficient for the carrier to**
47 **provide that formula to the health care provider. The carrier shall**

1 furnish the fee schedule pursuant to this subsection within 15 days
2 of the request of the provider.】

3 The fee schedule provided to the health care provider by the
4 carrier is proprietary and shall be confidential. Unauthorized
5 distribution of the fee schedule may result in the health care
6 provider's termination from the network 【in accordance with the
7 provisions of N.J.A.C. 8:38-1.1 et seq】 as provided by regulation of
8 the Commissioner of Banking and Insurance.

9 b. The carrier shall reimburse the health care provider in
10 accordance with the annual fee schedule provided to the health care
11 provider pursuant to the contract, and the carrier shall not amend
12 this fee schedule during the calendar year for which the fee
13 schedule is applicable. 【The carrier may revise the fee schedule
14 upon providing the health care provider with written notice of the
15 change and, upon request, a copy of the revised fee schedule】 The
16 carrier shall deliver written notice of any amendment to the fee
17 schedule to the health care provider not less than 90 calendar days
18 prior to providing the health care provider a new annual fee
19 schedule, by January 1 as required pursuant to subsection a. of this
20 section, to apply to the calendar year next following.

21 c. Nothing in this section shall be construed to limit the ability
22 of a carrier to make payments under a managed care plan based on
23 its claims payment policies.

24 (cf: P.L.2005, c.286, s.1)

25

26 5. (New section) As used in sections 5 through 9 of this act:

27 “Benefits payer” means a carrier, organized delivery system,
28 employer, or any other person who undertakes to provide and
29 assumes financial risk for the payment of health benefits, and is
30 obligated to pay claims for health benefits on behalf of a covered
31 person to a health care provider or other claimant.

32 “Carrier” means an insurance company, health service
33 corporation, hospital service corporation, medical service
34 corporation, health maintenance organization, or prepaid
35 prescription service organization authorized to issue any health
36 benefits plan in this State.

37 “Covered person” means a person on whose behalf a benefits
38 payer is obligated to pay benefits pursuant to a health benefits plan.

39 “Covered service” means a service provided by a health care
40 provider or organized delivery system to a covered person under a
41 health benefits plan for which a benefits payer is obligated to pay
42 benefits.

43 “Health benefits plan” means any hospital or medical expense
44 insurance policy, health service corporation contract, hospital
45 service corporation contract, medical service corporation contract,
46 health maintenance organization contract, or other contract, policy,
47 or plan that pays or provides hospital or medical expense benefits

1 for covered services, and is delivered or issued for delivery in this
2 State by or through a benefits payer. Health benefits plan includes,
3 but is not limited to, the following contracts, policies, and plans:
4 accident only or disability income insurance, or any combination
5 thereof; liability insurance, including general liability insurance and
6 motor vehicle liability insurance; workers' compensation or similar
7 insurance; and motor vehicle medical payment insurance or
8 personal injury protection coverage provided by a motor vehicle or
9 automobile insurance policy issued pursuant to Subtitle 3 of Title
10 17 of the Revised Statutes (R.S.17:17-1 et seq.) or P.L.1972, c.70
11 (C.39:6A-1 et seq.).

12 "Health care provider" means an individual or entity, which
13 while acting within the scope of the individual's or entity's
14 licensure or certification, provides a covered service defined by a
15 health benefits plan. Health care provider includes, but is not
16 limited to, a physician or any other health care professional licensed
17 or certified pursuant to Title 45 of the Revised Statutes, or a
18 hospital or any other health care facility licensed pursuant to
19 P.L.1971, c.136 (C.26:2H-1 et seq.).

20 "Network" means one or more health care providers which enter
21 into a selective contracting arrangement with a benefits payer.

22 "Organized delivery system" means "organized delivery system"
23 as defined in section 1 of P.L.1999, c.409 (C.17:48H-1).

24 "Selective contracting arrangement" means an arrangement in
25 which a benefits payer participates in selective contracting with one
26 or more participating health care providers or organized delivery
27 systems, and which arrangement contains reasonable benefit
28 differentials, including, but not limited to, predetermined fee or
29 reimbursement rates for covered services applicable to participating
30 and nonparticipating health care providers and organized delivery
31 systems.

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

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

36

37 6. (New section) A person or entity, other than a benefits payer,
38 carrier, organized delivery system, health care provider, or third
39 party administrator or billing service, as set forth in section 7 of this
40 act, shall not sell, lease, transfer, assign, or otherwise disclose any
41 predetermined fee or reimbursement rate for covered services
42 agreed to in any selective contracting arrangement.

43

44 7. (New section) a. Except as otherwise provided by this
45 section: (1) a benefits payer which enters into, or proposes to enter
46 into, a selective contracting arrangement; (2) a third party
47 administrator for that benefits payer; (3) a carrier or organized

1 delivery system participating or proposing to participate in the
2 selective contracting arrangement; (4) a health care provider
3 participating or proposing to participate in the selective contracting
4 arrangement; or (5) a third party billing service for that health care
5 provider, shall not sell, lease, transfer, assign, or otherwise disclose
6 any predetermined fee or reimbursement rate for covered services
7 agreed to in the selective contracting arrangement.

8 b. Notwithstanding the provisions of subsection a. of this
9 section, the benefits payer, carrier or organized delivery system
10 proposing to participate in a selective contracting arrangement with
11 a health care provider may disclose any predetermined fee or
12 reimbursement rate pursuant to the provisions of section 1 of
13 P.L.2005, c.286 (C.26:2S-9.2) for the purpose of negotiation
14 between the parties with respect to the terms of the selective
15 contracting arrangement.

16 c. Notwithstanding the provisions of subsection a. of this
17 section, the benefits payer, or a carrier or organized delivery system
18 participating in the selective contracting arrangement, may disclose
19 any predetermined fee or reimbursement rate, for the purpose of
20 administering the payment of a claim for a covered service, to: (1)
21 a third party administrator for that benefits payer; (2) a carrier or
22 organized delivery system participating in the selective contracting
23 arrangement; (3) a health care provider participating in the selective
24 contracting arrangement; (4) a third party billing service for that
25 health care provider; or (5) a covered person.

26 d. Notwithstanding the provisions of subsection a. of this
27 section, the benefits payer, or a carrier or organized delivery system
28 participating in the selective contracting arrangement, may disclose
29 any predetermined fee or reimbursement rate, for the purpose of
30 providing an incentive to utilize a network or organized delivery
31 system participating in the selective contracting arrangement, to: (1)
32 the benefits payer; (2) a carrier or organized delivery system
33 participating in the selective contracting arrangement; or (3) a
34 covered person. For the purposes of this subsection, "incentive"
35 means reduced copayments, reduced deductibles, or premium
36 discounts attributable to the use of a health care provider in a
37 network or organized delivery system for any covered service, or a
38 financial penalty attributable to the use of any health care provider
39 not participating in that network or organized delivery system.

40
41 8. (New section) A benefits payer, carrier, organized delivery
42 system, or health care provider that does not participate in a
43 selective contracting arrangement, or a third party administrator or
44 billing service acting on behalf of a benefits payer or health care
45 provider that does not participate in the selective contracting
46 arrangement, shall not calculate or pay any fee or reimbursement
47 rate for covered services by using any negotiated, predetermined fee

1 or reimbursement rate agreed to in the selective contracting
2 arrangement.

3
4 9. (New section) Any benefits payer, carrier, organized
5 delivery system, health care provider, third party administrator or
6 billing service, or other person or entity, which violates any
7 provision of sections 5 through 9 of this act shall be ordered to pay
8 restitution to any person aggrieved by the violation, and shall be
9 liable to a civil penalty in an amount not less than \$500, or more
10 than \$10,000, for each violation. A penalty shall be collected and
11 enforced by summary proceedings pursuant to the provisions of the
12 "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10
13 et seq.).

14
15 10. Section 3 of P.L.2001, c.14 (C.26:2S-21) is amended to read
16 as follows:

17 3. a. (1) There is established the Managed Health Care
18 Consumer Assistance Program in the Department of Health and
19 Senior Services. The commissioner shall make agreements to
20 operate the program as necessary, in consultation with the
21 Commissioner of Human Services and the Commissioner of
22 Banking and Insurance, to assure that citizens have reasonable
23 access to services in all regions of the State.

24 (2) This program, as transferred to the Department of Banking
25 and Insurance pursuant to the Governor's Reorganization Plan No.
26 005-2005, and consolidated and reorganized as part of the
27 department's Office of Insurance Claims Ombudsman, shall be
28 transferred to the Department of the Public Advocate and continued
29 under the Health Care Patient Ombudsperson as set forth in sections
30 11 and 12 of P.L. , c. (C.) (pending before the Legislature
31 as this bill).

32 b. The program shall:

33 (1) create and provide educational materials and training to
34 consumers regarding their rights and responsibilities as enrollees in
35 managed care plans, including materials and training specific to
36 Medicaid, NJ FamilyCare, Medicare and commercial managed care
37 plans;

38 (2) assist and educate individual enrollees about the functions of
39 the State and federal agencies that regulate managed care products,
40 assist and educate enrollees about the various complaint, grievance
41 and appeal processes, including State fair hearings, provide
42 assistance to individuals in determining which process is most
43 appropriate for the individual to pursue when necessary, maintain
44 and provide to individual enrollees the forms that may be necessary
45 to submit a complaint, grievance or appeal with the State or federal
46 agencies, and provide assistance to individual enrollees in
47 completion of the forms, if necessary;

- 1 (3) maintain and provide information to individuals upon
2 request about advocacy groups, including legal services programs
3 Statewide and in each county that may be available to assist
4 individuals, and maintain lists of State and Congressional
5 representatives and the means by which to contact representatives,
6 for distribution upon request;
 - 7 (4) maintain a toll-free telephone number for consumers to call
8 for information and assistance. The number shall be accessible to
9 the deaf and hard of hearing, and staff or translation services shall
10 be available to assist non-English proficient individuals who are
11 members of language groups that meet population thresholds
12 established by the department;
 - 13 (5) ensure that individuals have timely access to the services of,
14 and receive timely responses from, the program;
 - 15 (6) provide feedback to managed care plans, beneficiary
16 advisory groups and employers regarding enrollees' concerns and
17 problems;
 - 18 (7) provide nonpartisan information about federal and State
19 activities relative to managed care, and provide assistance to
20 individuals in obtaining copies of pending legislation, statutes and
21 regulations; and
 - 22 (8) develop and maintain a data base monitoring the degree of
23 each type of service provided by the program to individual
24 enrollees, the types of concerns and complaints brought to the
25 program and the entities about which complaints and concerns are
26 brought.
- 27 c. In order to meet its objectives, the program shall have access
28 to:
- 29 (1) the medical and other records of an individual enrollee
30 maintained by a managed care plan, upon the specific written
31 authorization of the enrollee or his legal representative;
 - 32 (2) the administrative records, policies, and documents of
33 managed care plans to which individuals or the general public have
34 access; and
 - 35 (3) all licensing, certification, and data reporting records
36 maintained by the State or reported to the federal government by the
37 State that are not proprietary information or otherwise protected by
38 law, with copies thereof to be supplied to the program by the State
39 upon the request of the program.
- 40 d. The program shall take such actions as are necessary to
41 protect the identity and confidentiality of any complainant or other
42 individual with respect to whom the program maintains files or
43 records. Any medical or personally identifying information received
44 or in the possession of the program shall be considered confidential
45 and shall be used only by the department, the program and such
46 other agencies as the commissioner designates and shall not be
47 subject to public access, inspection or copying under P.L.1963, c.73

1 (C.47:1A-1 et seq.) or the common law concerning access to public
2 records. This subsection shall not be construed to limit the ability
3 of the program to compile and report non-identifying data pursuant
4 to paragraph (8) of subsection b. of this section.

5 e. The program shall seek to coordinate its activities with
6 consumer advocacy organizations, legal assistance providers
7 serving low-income and other vulnerable health care consumers,
8 managed care and health insurance counseling assistance programs,
9 and relevant federal and State agencies to assure that the
10 information and assistance provided by the program are current and
11 accurate.

12 f. Until such time as the program is developed, the
13 commissioner shall make agreements with two independent, private
14 nonprofit consumer advocacy organizations, which shall be the
15 Community Health Law Project and New Jersey Protection and
16 Advocacy, Inc. to operate the program on an interim basis. The
17 interim program shall be in effect for one year from the effective
18 date of this act. Any appropriation in this act for the program may
19 be allocated for the interim program.

20 (cf: P.L.2001, c.14, s.3)

21

22 11. (New section) There is hereby established in the Division of
23 Citizen Relations in the Department of Public Advocate a Health
24 Care Patient Ombudsperson. The Health Care Patient
25 Ombudsperson shall be appointed by the Public Advocate and shall
26 serve at the pleasure of the Public Advocate during the Public
27 Advocate's term of office.

28

29 12. (New section) a. All functions, powers, and duties now
30 vested under the Managed Health Care Consumer Assistance
31 Program, as referenced in section 3 of P.L.2001, c.14 (C.26:2S-21),
32 transferred to the Department of Banking and Insurance pursuant to
33 the Governor's Reorganization Plan No. 005-2005, and
34 consolidated and reorganized as part of the department's Office of
35 Insurance Claims Ombudsman, are hereby transferred to and
36 assumed by the Health Care Patient Ombudsperson in the Division
37 of Citizen Relations in the Department of the Public Advocate.

38 b. The Health Care Patient Ombudsperson shall coordinate
39 functions and duties, as appropriate, with the Director of the
40 Division of Mental Health Advocacy established pursuant to section
41 29 of P.L.2005, c.155 (C.52:27EE-29) and the Director of the
42 Division of Advocacy for the Developmentally Disabled established
43 pursuant to section 38 of P.L.2005, c.155 (C.52:27EE-38).

44 c. Whenever, in any law, rule, regulation, order, reorganization
45 plan, contract, document, judicial or administrative proceeding, or
46 otherwise, reference is made to the Managed Health Care Consumer
47 Assistance Program, prior to and including its transfer to the

1 Department of Banking and Insurance as part of the department's
2 Office of Insurance Claims Ombudsman, the same shall mean and
3 refer to the Health Care Patient Ombudsperson in the Division of
4 Citizen Relations in the Department of the Public Advocate.

5
6 13. This act shall take effect on the first day of the seventh
7 month next following enactment, and shall apply to all health
8 benefits plans that are delivered, issued, executed or renewed, or
9 approved for issuance or renewal in this State, on or after the
10 effective date; but the Commissioner of Banking and Insurance and
11 the Public Advocate may take any anticipatory administrative action
12 in advance thereof as shall be necessary for the implementation of
13 this act.

14
15
16 STATEMENT
17

18 This bill concerns the delivery and oversight of coverage under
19 various health benefits plans by mandating the issuance of
20 identification cards, standardizing contract forms and enhancing
21 contractual obligations between carriers and health care providers
22 participating in plans, and establishing a Health Care Patient
23 Ombudsperson in the Department of the Public Advocate.

24 First, the bill requires the issuance of a health benefits plan
25 identification card to at least the primary covered person under the
26 health benefits plan. The card shall include information, either
27 presented in a readily identifiable manner on the card or embedded
28 on the card and available through electronic extraction. The
29 information included on the card shall include, but not be limited to:
30 the primary covered person's name and identification number; the
31 contract holder's name and identification number, if different than
32 the primary covered person; the name of the issuing health benefits
33 plan provider, or the agent, contractor or administrator that is
34 administering the plan; contact information for filing benefits
35 claims and obtaining other information about coverage; and a
36 covered person's copayment obligations.

37 Second, the bill requires the Commissioner of Banking and
38 Insurance, in consultation with representatives of managed care
39 plans and health care providers, to establish by regulation a
40 universal contract for participation form, for use by any carrier
41 which offers a managed care plan for the purpose of establishing
42 and renewing health care provider participation in that plan.
43 Notwithstanding the adoption of a universal contract form, nothing
44 in the bill shall be construed to prevent a carrier from
45 supplementing the form with additional contractual provisions, so
46 long as the additional provisions do not duplicate or contradict the
47 provisions set forth in the universal contract form.

1 The contract between the carrier and the participating health care
2 provider shall include certain provisions, primarily intended to
3 protect the health care provider. These provisions: shall not require
4 participation in any managed care plan other than the one or more
5 specified under the terms of the contract; shall not include
6 participation in any future managed care plan to be offered by the
7 carrier as a condition of participating in the one or more managed
8 care plans specified under the contract; shall not prohibit the health
9 care provider from entering into a contract with any other carrier;
10 shall not contain any provision, commonly referred to as a “most
11 favored nation” clause, which impacts a health care provider who
12 contracts with another carrier for less compensation than that
13 provided by the compensation terms under the contract; sets forth
14 notice and written acceptance requirements for making material and
15 non-material amendments to the contract; and requires the use of an
16 independent, binding arbitration process, contracted by the
17 Commissioner of Banking and Insurance, to resolve contractual
18 disputes.

19 A carrier which offers a managed care plan shall only contract
20 with a participating health care provider after: (1) the health care
21 provider submits, and the carrier accepts, the universal physician
22 application for participation form or renewal form established
23 pursuant to P.L.2001, c.88 (C.26:2S-7.1 et seq.), if applicable; and
24 (2) the health care provider is given an opportunity to review the
25 proposed contract for participation, presented on the universal
26 contract form, as well as a summary disclosure form for that
27 contract. The summary disclosure form shall detail the
28 compensation terms, treatment policies, protocols, quality assurance
29 activities, and utilization management systems related to the
30 managed care plan and the health care provider’s participation in
31 that plan. The summary disclosure form shall also indicate specific
32 cross-references to the location of the provisions within the actual
33 contract being offered by the carrier from which the summary is
34 based.

35 Additionally, a carrier shall, by January 1 of each calendar year
36 for health care providers under existing contracts, and otherwise
37 within 15 days upon request, furnish a fee schedule, showing the
38 specifically defined compensation terms, or generally recognized
39 method of payment or mode of classification for determining fees,
40 and the fees for all codes and in-network services. This annual fee
41 schedule shall not be amended during the calendar year for which it
42 is applicable, and the carrier shall provide adequate notice, not less
43 than 90 days, concerning any amendment to the fee schedule to
44 apply in a subsequent calendar year.

45 Third, the bill regulates the disclosure and use of privately
46 negotiated in-network fees and reimbursement rates agreed to
47 between health care providers and carriers and other payers, for use

1 by these parties, and their third party administrators and billing
2 services, in administering the payment of claims for services
3 provided pursuant to managed care plans and other health benefits
4 plans.

5 With respect to a selective contracting arrangement under a
6 health benefits plan, the bill provides that: (1) a benefits payer
7 which enters into, or proposes to enter into, such an arrangement;
8 (2) a third party administrator for that benefits payer; (3) a carrier or
9 organized delivery system participating or proposing to participate
10 in the selective contracting arrangement; (4) a health care provider
11 participating or proposing to participate in the selective contracting
12 arrangement; or (5) a third party billing service for that health care
13 provider, shall not sell, lease, transfer, assign, or otherwise disclose
14 any predetermined fee or reimbursement rate for covered services
15 agreed to in the selective contracting arrangement.

16 Notwithstanding this blanket prohibition, the bill establishes
17 several disclosure exceptions for the participating parties to the
18 selective contracting arrangement. First, the benefits payer, carrier
19 or organized delivery system, proposing to participate in a selective
20 contracting arrangement with a health care provider may disclose
21 any predetermined fee or reimbursements rate pursuant to the
22 provisions of section 1 of P.L.2005, c.286 (C.26:2S-9.2) for the
23 purpose of negotiation between the parties with respect to the terms
24 of the selective contracting arrangement. Second, the benefits
25 payer, or a participating carrier or organized delivery system, may
26 disclose any predetermined fee or reimbursement rate, for the
27 purpose of administering the payment of a claim, to: (1) a third
28 party administrator for that benefits payer; (2) a participating carrier
29 or organized delivery system; (3) a participating health care
30 provider; (4) a third party billing service for that health care
31 provider; or (5) a covered person. Additionally, the benefits payer,
32 carrier or organized delivery system may disclose any
33 predetermined fee or reimbursement rate, in order to provide an
34 incentive to utilize a contracted provider network or organized
35 delivery system, to: (1) the benefits payer; (2) a participating carrier
36 or organized delivery system; or (3) a covered person.

37 Any person or entity that is not a party to the selective
38 contracting arrangement as described above shall not sell, lease,
39 transfer, assign, or otherwise disclose any predetermined fee or
40 reimbursement rate for covered services agreed to in that selective
41 contracting arrangement.

42 Also, the bill provides that a benefits payer, carrier, organized
43 delivery system, or health care provider that does not participate in
44 the selective contracting arrangement, or a third party administrator
45 or billing service acting on behalf of a benefits payer or health care
46 provider that does not participate in the selective contracting
47 arrangement, shall not calculate or pay any fee or reimbursement

1 rate for covered services by using any negotiated, predetermined fee
2 or reimbursement rate agreed to in that selective contracting
3 arrangement.

4 Any benefits payer, carrier, organized delivery system, health
5 care provider, third party administrator or billing service, or other
6 person or entity which violates any applicable provisions of the bill
7 concerning in-network fee and reimbursement rate disclosures shall
8 be ordered to pay restitution to any person aggrieved by the
9 violation, and shall be liable to a civil penalty in an amount not less
10 than \$500, or more than \$10,000, for each violation. Any penalty
11 shall be collected and enforced by summary proceedings pursuant
12 to the provisions of the "Penalty Enforcement Law of 1999,"
13 P.L.1999, c.274 (C.2A:58-10 et seq.).

14 Finally, the bill establishes a Health Care Patient Ombudsperson,
15 in the Division of Citizen Relations in the Department of the Public
16 Advocate. The Health Care Patient Ombudsperson shall be
17 appointed by the Public Advocate and shall serve at the pleasure of
18 the Public Advocate during the Public Advocate's term of office.

19 All function, powers, and duties now vested under the Managed
20 Health Care Consumer Assistance Program, as referenced in section
21 3 of P.L.2001, c.14 (C.26:2S-21), transferred to the Department of
22 Banking and Insurance pursuant to the Governor's Reorganization
23 Plan No. 005-2005, and consolidated and reorganized as part of the
24 department's Office of Insurance Claims Ombudsman, are
25 transferred by the bill and assumed by the Health Care Patient
26 Ombudsperson. Additionally, the ombudsperson shall coordinate
27 functions and duties, as appropriate, with the Director of the
28 Division of Mental Health Advocacy and the Director of the
29 Division of Advocacy for the Developmentally Disabled, both of
30 which are divisions within the Department of the Public Advocate.