ASSEMBLY, No. 2061

STATE OF NEW JERSEY

INTRODUCED JUNE 3, 1996

By Assemblyman JONES

AN ACT regulating managed care and other health benefits plans, supplementing Titles 26 and 17 of the Revised Statutes and Title 17B of the New Jersey Statutes and amending P.L.1973, c.337.

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

1. (New section) The Legislature finds and declares that, given the rapidly accelerating spread of managed care plan coverage throughout New Jersey and the associated problems that have attended this development, it is manifestly in the public interest to provide for the effective and fair regulation of managed care plans in this State to protect patients and providers, and to assure high quality, affordable health care for the residents of this State.

2. (New section) As used in sections 1 through 17 of this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Commissioner" means the Commissioner of Health.

"Covered person" means a person on whose behalf a carrier or other entity offering the plan is obligated to pay benefits pursuant to the health benefits plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier or other entity offering the plan is obligated to pay benefits.

"Department" means the Department of Health.

"Emergency services" means health care services provided after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, psychiatric disturbances or symptoms of substance abuse, such that the absence of immediate attention could reasonably be expected to result in: placing that person's health in serious jeopardy, or with

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

Matter underlined thus is new matter.

respect to a pregnant woman, the health of the woman or her child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits for covered services and is delivered or issued for delivery in this State by or through a carrier or any other entity. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, 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.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan. Health care provider includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Independent utilization review organization" means an independent, nonprofit entity comprised of physicians and other health care professionals who are representative of the active practitioners in the area in which the organization will operate and which is under contract with the department to provide medical necessity or appropriateness of services appeal reviews pursuant to this act.

"Managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan. A managed care plan may be issued by or through a carrier which assumes financial risk for the plan or any other entity that provides and finances health benefits for a covered person.

"Network contractor" means an entity that enters into a contractual arrangement with a health care provider to form a network of providers to deliver a comprehensive package of health care services, which includes hospital and medical services, to residents of this State and contracts with a payer for access to the network for the payer's managed care plan. A network contractor does not assume financial risk for the health care services provided by the network for a managed care plan. A network contractor may contract with payers

to provide utilization management and quality assurance programs and other related services. Network contractor shall not include an entity that operates under an exclusive contract with one or more health maintenance organizations which hold a certificate of authority pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.).

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures and retrospective review.

3. (New section) a. A managed care plan in effect on the effective date of this act which provides benefits to residents of this State shall file a registration form with the department within 90 days of the effective date of this act. A managed care plan established after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the plan will begin to provide benefits to residents of this State. The registration form shall be valid for two years, but the managed care plan shall notify the department within 10 business days of any change in information provided on the registration form.

b. A carrier which offers an individual or group health benefits plan to residents of this State on an indemnity basis on the effective date of this act shall file a registration form with the department within 90 days of the effective date of this act. A carrier authorized to issue health benefits plans in this State after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the carrier will begin to offer a health benefits plan to residents of this State. The registration form shall be valid for two years, but the carrier shall notify the department within 10 business days of any change in information provided on the registration form.

c. A network contractor in operation on the effective date of this act shall file a registration form with the department within 90 days of the effective date of this act. A network contractor established after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the entity will begin to offer its services in this State. The registration form shall be valid for two years, but the network contractor shall notify the department

within 10 business days of any change in information provided on the registration form.

d. The commissioner shall establish a registration form for managed care plans, indemnity carriers and network contractors which shall request, at a minimum, the official address and telephone number of the place of business of the managed care plan, carrier or network contractor.

e. The filing of a registration form by a managed care plan, indemnity carrier or network contractor with the department pursuant to this act is for informational purposes only in order to enable the department to carry out the provisions of this act. The registration required pursuant to this act shall not be construed to authorize the department to regulate managed care plans, carriers or network contractors in any manner not otherwise provided by law.

f. A managed care plan, indemnity carrier or network contractor filing a registration form with the department pursuant to this act shall pay a biennial registration fee of $200.

g. A health maintenance organization which holds a certificate of authority pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be exempt from the registration requirements of this section but shall comply with the provisions of sections 2 and 4 through 17 of this act.

A health maintenance organization shall be required to comply with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this act conflict with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.), the provisions of this act shall supercede the provisions of P.L.1973, c.337

h. A carrier which issues health benefit plans utilizing a selective contracting arrangement pursuant to section 22 of P.L.1993, c.162 (C.17B:27A-54) shall be exempt from the registration requirements of this section with respect to the selective contracting arrangement, but shall comply with the provisions of sections 2 and 4 through 25 of this act.

A carrier shall be required to comply with the provisions of section 22 of P.L.1993, c.162 (C.17B:27A-54) and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this act conflict with the provisions of section 22 of P.L.1993, c.162 (C.17B:27A-54), the provisions of this act shall supercede the provisions of P.L.1993, c.162.

4. (New section) A managed care plan or indemnity carrier, as appropriate, shall disclose in writing, in easily understandable language, to a subscriber, insured or enrollee, as the case may be, the terms and conditions of its health benefits plan, and shall promptly provide the subscriber, insured or enrollee with written notification of any change in the terms and conditions prior to the effective date of

the change. The managed care plan or indemnity carrier shall provide the required information at the time of enrollment and annually thereafter.

a. The information required to be disclosed pursuant to this section shall include a description of:

(1) covered services and benefits to which the subscriber, insured or enrollee is entitled;

(2) treatment policies and restrictions or limitations on covered services and benefits, including, but not limited to, physical and occupational therapy services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health services;

(3) financial responsibility of the subscriber, insured or enrollee, including copayments and deductibles;

(4) prior authorization and any other review requirements with respect to accessing covered services;

(5) where and in what manner covered services may be obtained;

(6) changes in covered benefits, including any addition, reduction or elimination of specific benefits;

(7) the subscriber's, insured's or enrollee's right to appeal and the procedure for initiating an appeal of a utilization management decision made by or on behalf of the managed care plan or carrier with respect to the denial, reduction or termination of a covered health care benefit or the denial of payment for a health care service;

(8) the procedure to initiate an appeal under the Independent Health Benefits Plan Appeals Program established pursuant to section 12 of this act; and

(9) such other information as the commissioner shall require.

b. The carrier or managed care plan shall file the information required pursuant to this section with the department.

5. (New section) a. In addition to the disclosure requirements provided in section 4 of this act, a managed care plan shall disclose to a prospective subscriber, insured or enrollee, as the case may be, in writing, in easily understandable language, the following information:

(1) A participating provider directory providing information on a covered person's access to primary care physicians and specialists, including the number of available participating physicians, by provider category or specialty, and their professional office addresses, telephone numbers and hospital affiliations. The managed care plan shall promptly notify a subscriber, insured or enrollee, who is affected, of any changes in the list of primary care physicians;

(2) General information about the financial incentives between participating physicians under contract with the managed care plan or network contractor, as applicable, and other participating health care providers and facilities to which the participating physicians refer their

managed care patients;

(3) The percentage of the managed care plan's network physicians who are board certified; and

(4) The managed care plan's standard for customary waiting times for appointments for urgent and routine care.

The managed care plan shall provide the information required in this subsection at the time of enrollment and annually thereafter.

b. Upon the request of a current or prospective subscriber, insured or enrollee, a managed care plan shall promptly provide that person with information on the following:

(1) whether a particular network physician is board certified;

(2) whether a particular network physician is currently accepting new patients;

(3) a description of the procedures followed to determine whether a drug, device or treatment is excluded from coverage on the basis of being experimental or investigational and the criteria used for that determination;

(4) any prescription drug formulary used by the plan;

(5) a description of quality assurance procedures, including the results of any survey by an independent accrediting organization, a copy of which shall be filed with the commissioner and with the Commissioner of Insurance;

(6) the percentage of premium income expended on health care services for subscribers, insureds or enrollees and on administration, respectively;

(7) the number of complaints received by participating providers and subscribers, insureds or enrollees each year broken down by specific category;

(8) procedures and terms by which a subscriber, insured or enrollee may select and change that person's primary care practitioner or specialist;

(9) the written application procedures and qualification requirements for a health care provider to be considered for participation in the managed care plan;

(10) procedures utilized to ensure the confidentiality of health care information records of covered persons;

(11) telephone numbers for obtaining information about the managed care plan; and

(12) the members of the governing body of the managed care entity, its officers, senior administrative staff, and a description of the entity's ownership, including the identity of any person or entity owning at least 5% of the managed care entity's equity and whether the entity is owned and operated as a for profit or a nonprofit organization.

c. The managed care plan shall file the information required pursuant to this section with the department.

d. The managed care plan shall file a copy of the most recent annual certified financial statement with the commissioner and with the Commissioner of Insurance upon their request.

6. (New section) a. A managed care plan shall designate a New Jersey licensed physician to serve as medical director of the plan. The medical director, or his designee, shall be designated to serve as the medical director for medical services provided to the managed care plan's covered persons in the State and shall be licensed to practice medicine in New Jersey.

The medical director shall be responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan. The treatment policies, protocols, quality assurance program and utilization management decisions of the plan shall be based on nationally recognized standards of health care practice. The quality assurance and utilization management programs shall be in accordance with standards adopted by regulation of the department pursuant to this act.

b. A network contractor shall maintain quality assurance and utilization management programs for the network. The quality assurance and utilization management programs shall be in accordance with standards adopted by regulation of the department pursuant to this act. The network contractor may contract with a payer for use of the quality assurance and utilization management programs for the payer's managed care plan.

The network contractor shall designate a licensed physician to serve as medical director of the network. The medical director, or his designee, shall be designated to serve as the medical director for medical services provided by the network to covered persons in the State and shall be licensed to practice medicine in New Jersey. The medical director shall be responsible for quality assurance activities and utilization management decisions of the network. The quality assurance activities and utilization management decisions shall be based on nationally recognized standards of health care practice.

c. The medical director of the plan or network shall ensure that:

(1) Any utilization management decision to deny, reduce or terminate a health care benefit or to deny payment for a health care service, because that service is not medically necessary, shall be made by a physician with knowledge in the area of the health care practice. In the case of a health care service prescribed or provided by a dentist, the decision shall be made by a dentist with knowledge in the area of the health care practice;

(2) A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the plan or network, as appropriate, for those services, unless the approval was based upon

fraudulent information submitted by the covered person or the participating provider;

(3) A procedure is implemented whereby participating physicians and dentists have an opportunity to review and comment on all medical and surgical and dental protocols, respectively, of the plan;

(4) The utilization management program is available on a 24-hour basis to respond to authorization requests for emergency services and is available, at a minimum, during normal working hours for inquiries and authorization requests for nonemergency health care services;

(5) No prior authorization shall be required for emergency services rendered outside of the geographic service area of the plan or network; and

(6) A medical screening examination of a subscriber, insured or enrollee upon arrival in a hospital, as required under federal law and as specified by regulation of the department, which is necessary to determine that person’s medical need for emergency services, shall be a covered service to the same extent as any emergency service.

7. (New section) Each application for credentialing or participation, as appropriate, to a managed care plan or network contractor shall be reviewed by a committee of the plan or contractor that includes appropriate representation of health care professionals with knowledge in the applicant's scope of professional practice.

8. (New section) A managed care plan or network contractor shall establish a policy governing removal of health care providers from the plan or network which includes the following:

a. The plan or contractor shall inform all participating health care providers of the plan's or contractor's removal policy at the time the plan or contractor contracts with the health care providers to participate in the plan or network, and at each renewal thereof.

b. If a health care provider's credentialing will be withdrawn or participation terminated prior to the date of termination of the contract, the plan or contractor shall provide the provider with 90-days notice of the withdrawal or termination, unless the withdrawal or termination is for breach of contract or because, in the opinion of the medical director, the health care provider represents an imminent danger to an individual patient or to the public health, safety or welfare.

c. If the plan or contractor finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety or welfare, the plan or contractor shall promptly notify the appropriate professional State licensing board or State licensing authority, as appropriate.

9. (New section) A managed care plan's or network contractor's contract with a participating health care provider:

a. Shall state that the health care provider shall not be penalized or the contract terminated by the managed care plan or network contractor because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary covered health care services;

b. Shall not provide financial incentives to the health care provider for withholding covered health care services that are medically necessary, in the opinion of the medical director;

c. Shall protect the ability of a health care provider to communicate openly with a patient about all appropriate diagnostic testing and treatment options; and

d. Shall not transfer liability to a health care provider for the actions or omissions of the managed care plan or network contractor.

10. (New section) Notwithstanding the provisions of any law to the contrary, if a managed care plan or network contractor terminates its contract with a participating provider at the plan's or contractor's initiative, a covered person who has selected that provider to receive covered services may continue to receive covered services from that provider, at the covered person's option, until the end of the covered person's period of enrollment, or for up to one year of treatment, whichever date is later, in the case of post-operative follow-up care, oncological treatment and psychiatric treatment, or for up to 120 calendar days in other cases where it is medically necessary for the covered person to continue treatment with that physician, or, in the case of obstetrical care, through the duration of a pregnancy, and up to six weeks after childbirth; and, during that period, those health care services shall be covered by the managed care plan under the same terms and conditions as they were covered while the provider was participating in the managed care plan.

11. (New section) A managed care plan, indemnity carrier or network contractor that violates a provision of sections 1 through 10 of this act shall be liable to a civil penalty of not less than $250 and not greater than $10,000 for each day the plan, carrier or contractor is in violation of the act if reasonable notice in writing is given of the intent to levy the penalty and the managed care plan, indemnity carrier or network contractor has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with "the penalty enforcement law," N.J.S.2A:58-1 et seq.

12. (New section) There is established the Independent Health Benefits Plan Appeals Program in the Department of Health. The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by health benefits plans to deny, reduce or terminate covered benefits in the event the final decision is contested by the covered person. The appeal review shall not include any decisions regarding pharmaceutical products or benefits not covered by the health benefits plan.

13. (New section) A covered person may apply to the Independent Health Benefits Plan Appeals Program for a review of a decision to deny, reduce or terminate a covered benefit other than pharmaceutical products if the person has already completed the health benefits plan's appeals process, if any, and the person contests the final decision by the health benefits plan. The person shall apply to the program within 30 days of the date the final decision was issued by the health benefits plan, in a manner determined by the commissioner.

As part of the application, the covered person shall provide the program with:

a. The name and business address of the health benefits plan;

b. A brief description of the covered person's medical condition for which covered benefits were denied, reduced or terminated;

c. A copy of any information provided by the health benefits plan regarding its decision to deny, reduce or terminate the benefit; and

d. A written consent to obtain any necessary medical records from the health benefits plan and, in the case of a managed care plan, any other out-of-network physician the person may have consulted on the matter.

The covered person shall pay the department an application processing fee of $25, except that the commissioner may waive the fee in the case of financial hardship.

14. (New section) a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any health benefits plan and shall not have any private arrangement with an individual health care facility, health care provider or supplier whose services may be subject to review within the area in which the organization shall operate. The commissioner may establish additional requirements and standards consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Benefits Plan Appeals Program.

b. The commissioner shall establish procedures for transmitting the completed application for an appeal review to the independent utilization review organization.

c. The independent utilization review organization shall review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on available practice guidelines developed by professional medical societies, boards or associations.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the health benefits plan's denial, reduction or termination of benefits arbitrarily deprived the covered person of medically necessary services covered by the health benefits plan. If the organization determines that the denial, reduction or termination of benefits arbitrarily deprived the person of necessary, covered services, it shall make a recommendation to the covered person and health benefits plan regarding the appropriate, medically necessary health care services the person should receive. The recommendation of the organization shall be binding on the health benefits plan, which shall promptly make arrangements to provide the recommended health care services, if any. If the covered person is not in agreement with the organization's findings and recommendation, the person may seek the desired health care services outside of the health benefits plan, at his own expense.

d. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a health benefits plan denial, reduction or termination of a covered benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

e. The covered person's medical records provided to the Independent Health Benefits Plan Appeals Program and the independent utilization review organization and the findings and recommendations of the organization made pursuant to this act are confidential and shall be used only by the department, the organization and the affected health benefits plan for the purposes of this act. The medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

f. The commissioner shall establish a reasonable, per case reimbursement schedule for the independent utilization review organization.

15. (New section) a. An employee of the department who participates in the Independent Health Benefits Plan Appeals Program shall not be liable in any action for damages to any person for any action taken within the scope of his function in the Independent Health Benefits Plan Appeals Program. The Attorney General shall defend

the person in any civil suit and the State shall provide indemnification for any damages awarded.

b. The health benefits plan that is the subject of a review shall not be liable in any action for damages to any person for any action taken to implement a recommendation of the independent utilization review organization pursuant to this act.

16. (New section) The commissioner shall assess a health benefits plan a fee based on the number of appeals filed against the plan. The commissioner shall use the revenues from the fees to support the cost of the Independent Health Benefits Plan Appeals Program reviews.

17. (New section) The commissioner shall enforce the provisions of sections 1 through 17 of this act and adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to carry out those provisions.

18. (New section) Notwithstanding the provisions of chapter 26 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

19. (New section) Notwithstanding the provisions of chapter 27 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

20. (New section) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

21. (New section) Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

22. (New section) Notwithstanding the provisions of P.L.1938, c.366 (C.17:48-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the

effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

23. (New section) Notwithstanding the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

24. (New section) Notwithstanding the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

25. (New section) Notwithstanding the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this act unless the health maintenance organization meets the requirements of P.L. , c. (C.) (pending before the Legislature as this bill).

26. Section 24 of P.L.1973, c. 337 (C.26:2J-24) is amended to read as follows:

24. Penalties and Enforcement a. The commissioner may, in lieu of suspension or revocation of a certificate of authority under section 18 hereof, levy an administrative penalty in an amount not less than **[**$100.00**]** $250 nor more than**[**$1,000.00**]** $10,000 for each day the health maintenance organization is in violation of P.L.1973, c.337 (C.26:2J-1 et seq.), if reasonable notice in writing is given of the intent to levy the penalty **[**and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation, and fails to do so within said time**]** and the health maintenance organization has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the defect in its operations which gave rise to the penalty citation, and fails to do so within the time allowed. Any such penalty may be recovered in a summary proceeding pursuant to **[**the Penalty Enforcement Law (N.J.S.2A:58-1 et seq.)**]** "the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. Any person who violates this act is a disorderly person and shall be prosecuted and punished pursuant to the "disorderly persons law" subtitle 12 of Title 2A of the New Jersey Statutes.

c. (1) If the commissioner or the Commissioner of Insurance shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner or Commissioner of

Insurance may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection c. shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner or the Commissioner of Insurance may deem appropriate under the circumstances.

d. (1) The commissioner or the Commissioner of Insurance may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.

(2) Within 20 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. Such hearings shall be conducted pursuant to the Administrative Procedure Act, P.L.1968, c. 410 (C. 52:14B-1 et seq.) and judicial review shall be available as provided therein.

e. In the case of any violation of the provisions of this act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection d. of this section, the commissioner may institute a proceeding to obtain injunctive relief, in accordance with the applicable Court Rules.

(cf: P.L.1973, c.337, s.24)

27. This act shall take effect on the 180th day after enactment.

STATEMENT

This bill provides various consumer safeguards with respect to health insurance and the operation of managed care plans.

Specifically, the bill:

• requires managed care plans, indemnity carriers and network contractors (entities, such as preferred provider organizations or PPOs, that establish health care provider networks for managed care plans) to register with the Department of Health;

• requires managed care plans and indemnity carriers to disclose to covered persons, in writing, in easily understandable language, at the time of enrollment and annually thereafter, the terms and conditions of

the health benefits plan. The information shall include a description of:

- covered services and benefits to which the covered person is entitled;

- treatment policies and restrictions or limitations on covered services and benefits, including, but not limited to, physical and occupational therapy services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health services;

- financial responsibility of the covered person, including copayments and deductibles;

- prior authorization and any other review requirements with respect to accessing covered services;

- where and in what manner services or benefits may be obtained;

- changes in covered benefits, including any addition, reduction or elimination of specific benefits;

- the covered person's right to appeal and the procedure for initiating an appeal of a utilization management decision made by or on behalf of the managed care plan or carrier with respect to the denial, reduction or termination of a covered health care benefit or the denial of payment for a health care service;

- the procedure to initiate an appeal under the Independent Health Benefits Plan Appeals Program established by this bill; and

- such other information as the Commissioner of Health shall require.

• requires managed care plans to also disclose to a prospective covered person, in writing, in easily understandable language, the following information at the time of enrollment and annually thereafter:

- a participating provider directory providing information on a covered person's access to primary care physicians and specialists, including the number of available participating physicians, by provider category or specialty, and their professional office addresses, telephone numbers and hospital affiliations;

- general information about the financial incentives between participating physicians under contract with the managed care plan and other participating health care providers and facilities to which the participating physicians refer their managed care patients;

- the percentage of the managed care plan's network physicians who are board certified; and

- the managed care plan's standard for customary waiting times for appointments for urgent and routine care.

Also, upon request of a current or prospective covered person, a managed care plan shall promptly provide information on the following:

- whether a particular network physician is board certified;

- whether a particular network physician is currently accepting new

patients;

- a description of the procedures followed to determine whether a drug, device or treatment is excluded from coverage on the basis of being experimental or investigational and the criteria used for that determination;

- any prescription drug formulary used by the plan;

- a description of quality assurance procedures;

- the percentage of premium income expended on health care services for subscribers, insureds or enrollees and on administration, respectively;

- the number of complaints received by participating providers and covered persons each year broken down by specific category;

- procedures and terms by which a covered person may select and change that person's primary care practitioner or specialist;

- the written application procedures and qualification requirements for a health care provider to be considered for participation in the plan;

- procedures utilized to ensure the confidentiality of health care information records of covered persons;

- telephone numbers for obtaining information about the managed care plan; and

- the members of the governing body of the managed care entity, its officers, senior administrative staff, and a description of the entity's ownership.

• requires managed care plans and network contractors to have a medical director who is a licensed physician and who is responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan, in the case of a managed care plan, and quality assurance activities and utilization management decisions, in the case of a network contractor. The medical director, or his designee, shall be a New Jersey licensed physician and shall be designated to serve as the medical director for medical services provided to covered persons in the State. Also, quality assurance and utilization management programs shall be in accordance with standards adopted by the Department of Health;

• requires network contractors to maintain quality assurance and utilization management programs and provides that the network contractor may contract with payers for use of the programs for their managed care plans;

• requires managed care plans and network contractors to establish a policy governing the removal of health care providers which provides 90-days' notice for withdrawal of credentialing (if the withdrawal of credentialing occurs prior to the date of termination of the contract), unless there is a breach of contract or, in the opinion of the medical director, the health care provider represents an imminent danger to an individual patient or to the public health, safety or welfare;

• provides that a participating health care provider shall not be penalized or have his contract terminated because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary covered health care benefits, and prohibits any provision in a provider's contract that provides financial incentives for withholding covered health care services that are medically necessary, in the opinion of the medical director. Also, the contract shall protect the ability of a health care provider to communicate openly with a patient about all appropriate diagnostic testing and treatment options;

• provides that if a managed care plan or network contractor terminates its contract with a participating provider at the plan's or contractor's initiative, a covered person who has selected that provider to receive covered services may continue to receive covered services from that provider, at the covered person's option, until the end of the covered person's period of enrollment, or for up to one year of treatment, whichever date is later, in the case of post-operative follow-up care, oncological treatment and psychiatric treatment, or for up to 120 calendar days in other cases where it is medically necessary for the covered person to continue treatment with that physician, or, in the case of obstetrical care, through the duration of a pregnancy, and up to six weeks after childbirth; and, during that period, those health care services shall be covered by the managed care plan under the same terms and conditions as they were covered while the provider was participating in the managed care plan; and

• provides that the penalty for violations of the bill shall be between $250 and $10,000 for each day the violation continues and increases the penalties in the law governing health maintenance organizations, P.L.1973, c.337, to these same amounts.

In addition, the bill establishes an Independent Health Benefits Plan Appeals Program in the Department of Health, in order to provide an independent medical necessity or appropriateness of services review of final decisions by health benefits plans to deny, reduce or terminate covered benefits in the event the final decision is contested by the covered person. Under this program, the Commissioner of Health would contract with one or more independent utilization review organizations in the State to conduct the appeal reviews. The independent utilization review organization is to be independent of any health benefits plan and shall not have any private arrangement with an individual health care facility, health care provider or supplier whose services may be subject to review within the area in which the organization shall operate.

Regulates managed care health plans.