

[Third Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 2420, 2623 and 2668

STATE OF NEW JERSEY

ADOPTED MARCH 13, 1997

Sponsored by Assemblywoman VANDERVALK, Assemblymen
COHEN, DiGAETANO, DORIA, Assemblywoman WRIGHT,
Assemblymen KRAMER, Felice, Blee, Assemblywomen
Quigley, Weinberg, Assemblymen Azzolina, Zecker, Caraballo,
Dalton, Geist, Greenwald, R. Smith, Zisa, Assemblywoman
Heck, Assemblyman LeFevre, Assemblywomen Buono,
Murphy, Assemblymen Bagger and Barnes

1 AN ACT concerning patient protections under health benefits plans,
2 supplementing Titles 26, 17 and 34 of the Revised Statutes and
3 Title 17B of the New Jersey Statutes, amending and supplementing
4 P.L.1973, c.337 and amending P.L.1992, c.160.

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

8
9 1. This act shall be known and may be cited as the "Health Care
10 Quality Act."

11
12 2. (New section) As used in sections 2 through 19 of this act:
13 "Carrier" means an insurance company, health service corporation,
14 hospital service corporation, medical service corporation or health
15 maintenance organization authorized to issue health benefits plans in
16 this State.

17 "Commissioner" means the Commissioner of Health and Senior
18 Services.

19 "Contract holder" means an employer or organization that
20 purchases a contract for services.

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Assembly floor amendments adopted May 22, 1997.

² Assembly floor amendments adopted June 5, 1997.

³ Assembly floor amendments adopted June 19, 1997.

1 "Covered person" means a person on whose behalf a carrier
2 offering the plan is obligated to pay benefits or provide services
3 pursuant to the health benefits plan.

4 "Covered service" means a health care service provided to a
5 covered person under a health benefits plan for which the carrier is
6 obligated to pay benefits or provide services.

7 "Department" means the Department of Health and Senior
8 Services.

9 "Health benefits plan" means a benefits plan which pays or
10 provides hospital and medical expense benefits for covered services,
11 and is delivered or issued for delivery in this State by or through a
12 carrier. Health benefits plan includes, but is not limited to, Medicare
13 supplement coverage and risk contracts to the extent not otherwise
14 prohibited by federal law. For the purposes of this act, health benefits
15 plan shall not include the following plans, policies or contracts:
16 accident only, credit, disability, long-term care, CHAMPUS
17 supplement coverage, coverage arising out of a workers' compensation
18 or similar law, automobile medical payment insurance, personal injury
19 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et
20 seq.) or hospital confinement indemnity coverage.

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

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

34 "Managed care plan" means a health benefits plan that integrates
35 the financing and delivery of appropriate health care services to
36 covered persons by arrangements with participating providers, who are
37 selected to participate on the basis of explicit standards, to furnish a
38 comprehensive set of health care services and financial incentives for
39 covered persons to use the participating providers and procedures
40 provided for in the plan.

41 "Subscriber" means, in the case of a group contract, a person
42 whose employment or other status, except family status, is the basis
43 for eligibility for enrollment by the carrier or, in the case of an
44 individual contract, the person in whose name the contract is issued.

45 "Utilization management" means a system for reviewing the
46 appropriate and efficient allocation of health care services under a

1 health benefits plan according to specified guidelines, in order to
2 recommend or determine whether, or to what extent, a health care
3 service given or proposed to be given to a covered person should or
4 will be reimbursed, covered, paid for, or otherwise provided under the
5 health benefits plan. The system may include: preadmission
6 certification, the application of practice guidelines, continued stay
7 review, discharge planning, preauthorization of ambulatory care
8 procedures and retrospective review.

9

10 3. (New section) a. A carrier which offers a health benefits plan
11 to residents of this State on the effective date of this act, shall file a
12 form, as prescribed by the commissioner, with the department within
13 90 days of the effective date of this act and file a copy of the form with
14 the Department of Banking and Insurance. A carrier authorized to
15 issue health benefits plans in this State after the effective date of this
16 act shall file a form with the department at least 30 days prior to the
17 date the carrier will begin to offer a health benefits plan to residents of
18 this State. The carrier shall file a copy of the form with the
19 Department of Banking and Insurance. A carrier shall notify the
20 department within 10 business days of any change in information
21 provided on the form.

22 b. The commissioner shall establish a form for carriers which shall
23 request, at a minimum:

24 (1) the official address and telephone number of the place of
25 business of the carrier; and

26 (2) a description of the carrier's internal patient appeals process
27 available to covered persons to contest a denial, reduction or
28 termination of benefits, if any.

29 c. A health maintenance organization which holds a certificate of
30 authority pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be
31 exempt from the filing requirements of this section but shall comply
32 with the provisions of this act.

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

39 d. A carrier which issues health benefits plans utilizing a selective
40 contracting arrangement pursuant to section 22 of P.L.1993, c.162
41 (C.17B:27A-54) shall be required to comply with the provisions of
42 section 22 of P.L.1993, c.162 and any rules and regulations adopted
43 pursuant thereto, except that in the event that the provisions of this act
44 conflict with the provisions of section 22 of P.L.1993, c.162, the
45 provisions of this act shall supercede the provisions of section 22 of
46 P.L.1993, c.162.

1 4. (New section) A carrier shall disclose in writing to a
2 subscriber, in a manner consistent with the "Life and Health Insurance
3 Policy Language Simplification Act," P.L.1979, c.167 (C.17B:17-17
4 et seq.), the terms and conditions of its health benefits plan, and shall
5 promptly provide the subscriber with written notification of any
6 change in the terms and conditions prior to the effective date of the
7 change. The carrier shall provide the required information at the time
8 of enrollment and upon request thereafter.

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

11 (1) covered services and benefits to which the subscriber or other
12 covered person is entitled;

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

18 (3) financial responsibility of the covered person, including
19 copayments and deductibles;

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

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

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

25 (7) the covered person's right to appeal and the procedure for
26 initiating an appeal of a utilization management decision made by or
27 on behalf of the carrier with respect to the denial, reduction or
28 termination of a health care benefit or the denial of payment for a
29 health care service;

30 (8) the procedure to initiate an appeal through the Independent
31 Health Care Appeals Program established pursuant to this act; and

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

33 b. The carrier shall file the information required pursuant to this
34 section with the department.

35

36 5. (New section) a. In addition to the disclosure requirements
37 provided in section 4 of this act, a carrier which offers a managed care
38 plan shall disclose to a subscriber, in writing, in a manner consistent
39 with the "Life and Health Insurance Policy Language Simplification
40 Act," P.L.1979, c.167 (C.17B:17-17 et seq.), the following
41 information at the time of enrollment and annually thereafter:

42 (1) A current participating provider directory providing
43 information on a covered person's access to primary care physicians
44 and specialists, including the number of available participating
45 physicians, by provider category or specialty and by county. The
46 directory shall include the professional office address of a primary care

1 physician and any hospital affiliation the primary care physician has.
2 The directory shall also provide information about participating
3 hospitals.

4 The carrier shall promptly notify each covered person prior to the
5 termination or withdrawal from the carrier's provider network of the
6 covered person's primary care physician;

7 (2) General information about the financial incentives between
8 participating physicians under contract with the carrier and other
9 participating health care providers and facilities to which the
10 participating physicians refer their managed care patients;

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

13 (4) The carrier's managed care plan's standard for customary
14 waiting times for appointments for urgent and routine care; and

15 (5) The availability through the department, upon request of a
16 member of the general public, of independent consumer satisfaction
17 survey results and an analysis of quality outcomes of health care
18 services of managed care plans in the State.

19 The carrier shall provide a prospective subscriber with information
20 about the provider network, including hospital affiliations, and other
21 information specified in this subsection, upon request.

22 b. Upon request of a covered person, a carrier shall promptly
23 inform the person:

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

25 (2) whether a particular network physician is currently accepting
26 new patients.

27 c. The carrier shall file the information required pursuant to this
28 section with the department.

29

30 6. (New section) a. A carrier which offers a managed care plan
31 or uses a utilization management system in any of its health benefits
32 plans shall designate a licensed physician to serve as medical director.
33 The medical director, or his designee, shall be designated to serve as
34 the medical director for medical services provided to covered persons
35 in the State and shall be licensed to practice medicine in New Jersey.

36 The medical director shall be responsible for treatment policies,
37 protocols, quality assurance activities and utilization management
38 decisions of the carrier. The treatment policies, protocols, quality
39 assurance program and utilization management decisions of the carrier
40 shall be based on generally accepted standards of health care practice.
41 The quality assurance and utilization management programs shall be
42 in accordance with standards adopted by regulation of the department
43 pursuant to this act.

44 b. The medical director shall ensure that:

45 (1) Any utilization management decision to deny, reduce or
46 terminate a health care benefit or to deny payment for a health care

1 service, because that service is not medically necessary, shall be made
2 by a physician. In the case of a health care service prescribed or
3 provided by a dentist, the decision shall be made by a dentist;

4 (2) A utilization management decision shall not retrospectively
5 deny coverage for health care services provided to a covered person
6 when prior approval has been obtained from the carrier for those
7 services, unless the approval was based upon fraudulent information
8 submitted by the covered person or the participating provider;

9 (3) In the case of a managed care plan, a procedure is
10 implemented whereby participating physicians and dentists have an
11 opportunity to review and comment on all medical and surgical and
12 dental protocols, respectively, of the carrier;

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

18 (5) In the case of a managed care plan, a covered person is
19 permitted to: choose or change a primary care physician from among
20 participating providers in the provider network, and, when
21 appropriate, choose a specialist from among participating network
22 providers following an authorized referral, if required by the carrier,
23 and subject to the ability of the specialist to accept new patients.

24

25 7. (New section) Each application for participation ¹ by a licensed
26 health care professional that is submitted¹ to a carrier which offers a
27 managed care plan shall be reviewed by a committee of the carrier that
28 includes appropriate representation of health care professionals with
29 knowledge in the applicant's scope of professional practice.

30

31 8. (New section) A carrier which offers a managed care plan shall
32 establish a policy governing removal of health care providers from the
33 provider network which includes the following:

34 a. The carrier shall inform a participating health care provider of
35 the carrier's removal policy at the time the carrier contracts with the
36 health care provider to participate in the provider network, and at each
37 renewal thereof.

38 b. If a licensed health care professional's participation will be
39 terminated prior to the date of the termination of the contract, the
40 carrier shall provide the health care professional with 90-days written
41 notice of the termination and notice of a right to a hearing. If
42 requested by the health care professional, the carrier shall provide the
43 reasons for the termination in writing, and shall hold a hearing within
44 30 days of the date of the request. The hearing shall be conducted by
45 a panel appointed by the carrier, which panel shall be comprised of a
46 minimum of three persons, at least one of whom is a clinical peer in

1 the same discipline and the same or similar specialty as the health care
2 professional being reviewed. The panel shall make a decision that: (1)
3 the health care professional shall be terminated, or (2) the health care
4 professional shall be reinstated or provisionally reinstated, subject to
5 conditions set forth by the panel. The panel's determination shall be
6 in writing and shall be made in a timely manner. Participation in this
7 process shall not be deemed to be an abrogation of the health care
8 professional's legal rights.

9 The notice required and opportunity for a hearing pursuant to this
10 subsection shall not apply in those cases when the contract expires and
11 is not renewed, the termination is for breach of contract, in the opinion
12 of the medical director, the health care professional represents an
13 imminent danger to an individual patient or the public health, safety or
14 welfare, or there is a determination of fraud.

15 c. If the carrier finds that a health care professional represents an
16 imminent danger to an individual patient or to the public health, safety
17 or welfare, the medical director shall promptly notify the appropriate
18 professional State licensing board. Notification to the State Board of
19 Medical Examiners shall be subject to the provisions of section 5 of
20 P.L.1989, c.300 (C.45:9-19.5).

21

22 9. (New section) The contract between a participating health care
23 provider and a carrier which offers a managed care plan:

24 a. Shall state that the health care provider shall not be penalized
25 or the contract terminated by the carrier because the health care
26 provider acts as an advocate for the patient in seeking appropriate,
27 medically necessary ¹[covered]¹ health care services;

28 b. Shall not provide financial incentives to the health care provider
29 for withholding covered health care services that are medically
30 necessary ¹[, in the opinion of the medical director]¹ ²as determined
31 in accordance with section 6 of this act, except that nothing in this
32 subsection shall be construed to limit the use of capitated payment ³[or
33 reimbursement]³ arrangements between a carrier and a health care
34 provider²; and

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

38

39 10. (New section) a. A carrier which offers a managed care plan
40 shall offer a point-of-service plan ¹[rider]¹ to every contract holder
41 which would allow a covered person to receive covered services from
42 out-of-network health care providers without having to obtain a
43 referral or prior authorization from the carrier. The point-of-service
44 plan ¹[rider]¹ may require that a subscriber pay a higher deductible or
45 copayment and higher premium for the plan¹[rider]¹, pursuant to limits
46 established by the department, in consultation with the Department of

1 Banking and Insurance, by regulation.

2 b. A carrier shall provide each subscriber in a plan whose contract
3 holder elects the point-of-service plan ¹[rider]¹, with the opportunity,
4 at the time of enrollment and during the annual open enrollment
5 period, to enroll in the point-of-service plan option. The carrier shall
6 provide written notice of the point-of-service plan ¹[rider]¹ to each
7 subscriber in a plan whose contract holder elects the point-of-service
8 ¹[rider] plan¹ and shall include in that notice a detailed explanation of
9 the financial costs to be incurred by a subscriber who selects that plan
10 ¹[rider]¹.

11 c. The requirements of this section shall not apply to a carrier
12 contract which offers a managed care plan that provides health care
13 services to Medicaid recipients pursuant to P.L.1968, c.413 (C.30:4D-
14 1 et seq.), or a ¹[carrier which offers a managed care plan that has
15 been in operation in this State for less than three years]federally
16 qualified, nonprofit health maintenance organization¹.

17 ¹d. A carrier which offers a managed care plan utilizing a selective
18 contracting arrangement approved in accordance with N.J.A.C.11:4-37
19 et seq. that provides benefits for out-of-network providers shall be
20 deemed to be in compliance with this section.

21 e. A health maintenance organization affiliated with an insurance
22 company authorized to issue health benefits plans in this State that
23 offers point-of-service benefits exclusively through a point-of-service
24 plan provided by the affiliated insurance company using a selective
25 contracting arrangement approved in accordance with N.J.A.C.11:4-
26 37.1 et seq., shall be deemed to be in compliance with this section if
27 the point-of-service plan is offered pursuant to the requirements of
28 subsections a. and b.of this section.¹

29
30 11. (New section) There is established the Independent Health
31 Care Appeals Program in the department.

32 The purpose of the appeals program is to provide an independent
33 medical necessity or appropriateness of services review of final
34 decisions by carriers to deny, reduce or terminate benefits in the event
35 the final decision is contested by the covered person. The appeal
36 review shall not include any decisions regarding ¹[pharmaceutical
37 products or]¹ benefits not covered by the covered person's health
38 benefits plan.

39 a. A covered person may apply to the Independent Health Care
40 Appeals Program for a review of a decision to deny, reduce or
41 terminate a benefit ¹[other than pharmaceutical products]¹ if the
42 person has already completed the carrier's appeals process, if any, and
43 the person contests the final decision by the carrier. The person shall
44 apply to the department within 60 days of the date the final decision
45 was issued by the carrier, in a manner determined by the
46 commissioner.

1 b. As part of the application, the covered person shall provide the
2 department with:

3 (1) The name and business address of the carrier;

4 (2) A brief description of the covered person's medical condition
5 for which benefits were denied, reduced or terminated;

6 (3) A copy of any information provided by the carrier regarding
7 its decision to deny, reduce or terminate the benefit; and

8 (4) A written consent to obtain any necessary medical records
9 from the carrier and, in the case of a carrier which offers a managed
10 care plan, any other out-of-network physician the person may have
11 consulted on the matter.

12 c. The covered person shall pay the department an application
13 processing fee of \$25, except that the commissioner may reduce or
14 waive the fee in the case of financial hardship.

15

16 12. (New section) a. The commissioner shall contract with one or
17 more independent utilization review organizations in the State that
18 meet the requirements of this act to conduct the appeal reviews. The
19 independent utilization review organization shall be independent of any
20 carrier. The commissioner may establish additional requirements,
21 including conflict of interest standards, consistent with the purposes
22 of this act that an organization shall meet in order to qualify for
23 participation in the Independent Health Care Appeals Program.

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

27 c. The independent utilization review organization shall promptly
28 review the pertinent medical records of the covered person to
29 determine the appropriate, medically necessary health care services the
30 person should receive, based on ¹[available] applicable, generally
31 accepted¹ practice guidelines ¹[, including those]¹ developed by ¹ the
32 federal government, national or¹ professional medical societies, boards
33 or associations ¹and any applicable clinical protocols or practice
34 guidelines developed by the carrier¹. The organization shall complete
35 its review and make its determination within 90 days of receipt of a
36 completed application for an appeal review or within less time, as
37 prescribed by the commissioner.

38 Upon completion of the review, the organization shall state its
39 findings in writing and make a determination of whether the carrier's
40 denial, reduction or termination of benefits deprived the covered
41 person of medically necessary services covered by the person's health
42 benefits plan. If the organization determines that the denial, reduction
43 or termination of benefits deprived the person of medically necessary
44 covered services, it shall make a recommendation to the covered
45 person and carrier regarding the appropriate, medically necessary
46 health care services the person should receive. Upon receiving the

1 organization's recommendation, the carrier shall promptly notify the
2 covered person and the commissioner about what action the carrier
3 will take with respect to the recommendation. If the covered person
4 is not in agreement with the organization's findings and
5 recommendation or the carrier's action on the recommendation, the
6 person may seek the desired health care services outside of his health
7 benefits plan, at his own expense.

8 d. If the commissioner determines that a carrier exhibits a pattern
9 of noncompliance with the findings and recommendations of an
10 independent utilization review organization, the commissioner shall
11 review the carrier's utilization management program to ensure that the
12 carrier is in compliance with all relevant State laws and regulations,
13 including utilization management standards. If the commissioner
14 determines that the carrier is in violation of patient rights and other
15 applicable regulations, the commissioner may impose such penalties
16 and sanctions on the carrier, as provided by regulation, as the
17 commissioner deems appropriate.

18 e. The commissioner shall require the independent utilization
19 review organization to establish procedures to provide for an
20 expedited review of a carrier's denial, reduction or termination of a
21 benefit decision when a delay in receipt of the service could seriously
22 jeopardize the health or well-being of the covered person.

23 f. The covered person's medical records provided to the
24 Independent Health Care Appeals Program and the independent
25 utilization review organization and the findings and recommendations
26 of the organization made pursuant to this act are confidential and shall
27 be used only by the department, the organization and the affected
28 carrier for the purposes of this act. The medical records and findings
29 and recommendations shall not otherwise be divulged or made public
30 so as to disclose the identity of any person to whom they relate, and
31 shall not be included under materials available to public inspection
32 pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

33 g. The commissioner shall establish a reasonable, per case
34 reimbursement schedule for the independent utilization review
35 organization.

36 h. The cost of the appeal review shall be borne by the carrier
37 pursuant to a schedule of fees established by the commissioner.

38
39 13. (New section) a. An employee of the department who
40 participates in the Independent Health Care Appeals Program shall not
41 be liable in any action for damages to any person for any action taken
42 within the scope of his function in the Independent Health Care
43 Appeals Program. The Attorney General shall defend the person in
44 any civil suit and the State shall provide indemnification for any
45 damages awarded.

46 b. The carrier that is the subject of a review shall not be liable in
47 any action for damages to any person for any action taken to

1 implement a recommendation of the independent utilization review
2 organization pursuant to this act.

3

4 14. (New section) The commissioner shall report every six
5 months to the Senate and General Assembly standing reference
6 committees on health and insurance and to the Governor on the status
7 of the Independent Health Care Appeals Program. The report shall
8 include a summary of the number of reviews conducted and medical
9 specialties affected, a summary of the findings and recommendations
10 made by the independent utilization review organization, any actions
11 taken by the commissioner against a carrier pursuant to subsection d.
12 of section 12 of this act and any other information and
13 recommendations deemed appropriate by the commissioner.

14

15 15. (New section) a. A carrier which offers a managed care plan
16 shall comply with department reporting requirements with respect to
17 quality outcomes measures of health care services and independent
18 consumer satisfaction surveys.

19 b. The department shall make available to members of the general
20 public, upon request, the results of the independent consumer
21 satisfaction survey and the analysis of quality outcomes measures of
22 health care services provided by managed care plans in the State,
23 prepared by the department.

24

25 16. (New section) a. A carrier that violates any provision of this
26 act shall be liable to a civil penalty of not less than \$250 and not
27 greater than \$10,000 for each day that the carrier is in violation of the
28 act if reasonable notice in writing is given of the intent to levy the
29 penalty and, at the discretion of the commissioner, the carrier has 30
30 days, or such additional time as the commissioner shall determine to
31 be reasonable, to remedy the condition which gave rise to the
32 violation, and fails to do so within the time allowed. The penalty shall
33 be collected by the commissioner in the name of the State in a
34 summary proceeding in accordance with "the penalty enforcement
35 law," N.J.S.2A:58-1 et seq.

36 b. (1) The commissioner or the Commissioner of Banking and
37 Insurance may issue an order directing a carrier or a representative of
38 a carrier to cease and desist from engaging in any act or practice in
39 violation of the provisions of this act.

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

46 c. In the case of any violation of the provisions of this act, if the

1 commissioner elects not to issue a cease and desist order, or in the
2 event of noncompliance with a cease and desist order issued pursuant
3 to subsection b. of this section, the commissioner may institute a
4 proceeding to obtain injunctive relief in accordance with the applicable
5 Court Rules.

6
7 17. (New section) The commissioner and the Commissioner of
8 Banking and Insurance shall develop recommendations for legislative
9 action to address the issue of regulating health care or managed care
10 entities that seek to contract directly with employers or other
11 purchasers on a risk-assuming basis. The recommendations shall
12 identify the type of health care or managed care entities and the scope
13 of activities of these entities that should be subject to regulation by the
14 State. In preparing the recommendations, the commissioners shall
15 consider the current State statutory and regulatory requirements for
16 health maintenance organizations and insurance companies issuing
17 health benefits plans in the State, as well as federal legislation and laws
18 and court rulings to determine how these health care and managed care
19 entities that assume risk should be regulated.

20 The commissioners shall report their recommendations to the
21 Senate and General Assembly standing reference committees on health
22 and insurance and to the Governor within one year of the effective
23 date of this act.

24
25 18. (New section) An employer who provides a comprehensive
26 self-funded health benefits plan to his employees or their dependents
27 in this State shall annually, and upon request of an employee at other
28 times during the year, notify his employees that they are covered by a
29 self-insured plan that is not subject to regulation by the State of New
30 Jersey, and specify which mandated health insurance benefits,
31 established by statute, are not covered by the self-insured plan. The
32 Commissioner of Health and Senior Services shall notify the
33 Commissioner of Labor of any health insurance mandates enacted into
34 law, and the Commissioner of Labor shall notify employers in a timely
35 manner of the health insurance mandates subject to the provisions of
36 this section.

37
38 19. (New section) The commissioner shall enforce the provisions
39 of this act.

40 Within six months of the effective date of this act, in consultation
41 with the Commissioner of Banking and Insurance, the commissioner
42 shall adopt rules and regulations, pursuant to the "Administrative
43 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to
44 carry out the purposes of this act. The regulations shall establish
45 consumer protection and quality standards governing carriers which
46 offer a managed care plan or use a utilization management system that

1 are consistent with the standards governing health maintenance
2 organizations in the State.

3 The regulations shall include standards for: a quality management
4 program; provider participation in a network; adequacy of the provider
5 network with respect to the scope and type of health care benefits
6 provided by the carrier, the geographic service area covered by the
7 provider network and access to medical specialists, when appropriate;
8 utilization management as required in this act; a covered person
9 complaint system; a patient appeals system as required in this act; the
10 establishment of consumer rights of covered persons; carrier disclosure
11 as required in this act; and outcomes and data reporting requirements
12 as required in this act.

13

14 20. (New section) The Commissioner of Banking and Insurance
15 may conduct an examination of a health maintenance organization as
16 often as he deems necessary in order to protect the interests of
17 providers, contract holders, members, and the residents of this State.
18 An organization shall make its relevant books and records available for
19 examination by the Commissioner of Banking and Insurance, and
20 retain its records in accordance with a schedule established by the
21 Commissioner of Banking and Insurance by regulation. The
22 reasonable expenses of the examination shall be borne by the
23 organization being examined. In lieu of such examination, the
24 Commissioner of Banking and Insurance may accept the report of an
25 examination made by the commissioner of another state.

26

27 21. (New section) Notwithstanding the provisions of chapter 26
28 of Title 17B of the New Jersey Statutes to the contrary, no policy shall
29 be delivered, issued, executed or renewed on or after the effective
30 date of this act unless the policy meets the requirements of P.L. , c.
31 (C.)(pending before the Legislature as this bill) and regulations
32 adopted thereto. The provisions of this section shall apply to all
33 policies in which the insurer has reserved the right to change the
34 premium.

35

36 22. (New section) Notwithstanding the provisions of chapter 27
37 of Title 17B of the New Jersey Statutes to the contrary, no policy shall
38 be delivered, issued, executed or renewed on or after the effective date
39 of this act unless the policy meets the requirements of P.L. , c.
40 (C.)(pending before the Legislature as this bill) and regulations
41 adopted thereto. The provisions of this section shall apply to all
42 policies in which the insurer has reserved the right to change the
43 premium.

44

45 23. (New section) Notwithstanding the provisions of P.L.1992,
46 c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract

1 shall be delivered, issued, executed or renewed on or after the
2 effective date of this act unless the policy or contract meets the
3 requirements of P.L. , c. (C.)(pending before the Legislature as
4 this bill) and regulations adopted thereto. The provisions of this
5 section shall apply to all policies or contracts in which the carrier has
6 reserved the right to change the premium.

7
8 24. (New section) Notwithstanding the provisions of P.L.1992,
9 c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract
10 shall be delivered, issued, executed or renewed on or after the
11 effective date of this act unless the policy or contract meets the
12 requirements of P.L. , c. (C.)(pending before the Legislature as
13 this bill) and regulations adopted thereto. The provisions of this
14 section shall apply to all policies or contracts in which the carrier has
15 reserved the right to change the premium.

16
17 25. (New section) Notwithstanding the provisions of P.L.1938,
18 c.366 (C.17:48-1 et seq.) to the contrary, no individual or group
19 contract shall be delivered, issued, executed or renewed on or after the
20 effective date of this act unless the contract meets the requirements of
21 P.L. , c. (C.)(pending before the Legislature as this bill) and
22 regulations adopted thereto. The provisions of this section shall apply
23 to all contracts in which the hospital service corporation has reserved
24 the right to change the premium.

25
26 26. (New section) Notwithstanding the provisions of P.L.1940,
27 c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group
28 contract shall be delivered, issued, executed or renewed on or after the
29 effective date of this act unless the contract meets the requirements of
30 P.L. , c. (C.)(pending before the Legislature as this bill) and
31 regulations adopted thereto. The provisions of this section shall apply
32 to all contracts in which the medical service corporation has reserved
33 the right to change the premium.

34
35 27. (New section) Notwithstanding the provisions of P.L.1985,
36 c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group
37 contract shall be delivered, issued, executed or renewed on or after the
38 effective date of this act unless the contract meets the requirements of
39 P.L. , c. (C.)(pending before the Legislature as this bill) and
40 regulations adopted thereto. The provisions of this section shall apply
41 to all contracts in which the health service corporation has reserved
42 the right to change the premium.

43
44 28. (New section) Notwithstanding the provisions of P.L.1973,
45 c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to
46 establish and operate a health maintenance organization in this State

1 shall not be issued or continued on or after the effective date of this
2 act unless the health maintenance organization meets the requirements
3 of P.L. , c. (C.) (pending before the Legislature as this bill) and
4 regulations adopted thereto. The provisions of this section shall apply
5 to all enrollee agreements in which the health maintenance
6 organization has reserved the right to change the schedule of charges.

7

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

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

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

29 c. (1) If the commissioner or the Commissioner of Banking and
30 Insurance shall for any reason have cause to believe that any violation
31 of this act has occurred or is threatened, the commissioner or
32 Commissioner of Banking and Insurance may give notice to the health
33 maintenance organization and to the representatives, or other persons
34 who appear to be involved in such suspected violation, to arrange a
35 conference with the alleged violators or their authorized
36 representatives for the purpose of attempting to ascertain the facts
37 relating to such suspected violation, and, in the event it appears that
38 any violation has occurred or is threatened, to arrive at an adequate
39 and effective means of correcting or preventing such violation.

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

44 d. (1) The commissioner or the Commissioner of Banking and
45 Insurance may issue an order directing a health maintenance
46 organization or a representative of a health maintenance organization

1 to cease and desist from engaging in any act or practice in violation of
2 the provisions of this act.

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

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

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

16

17 30. Section 12 of P.L.1992, c.160 (C.26:2H-18.62) is amended to
18 read as follows:

19 12. a. The monies in the hospital and other health care initiatives
20 account are appropriated for the establishment of a program which will
21 assist hospitals and other health care facilities in the underwriting of
22 innovative and necessary health care services and provide funding for
23 public or private health care programs, which may include any
24 program funded pursuant to section 25 of P.L.1991, c.187
25 (C.26:2H-18.47), managed care regulation and oversight pursuant to
26 P.L. , c. (C.)(pending before the Legislature as this bill), and for
27 such other programs that the commissioner deems necessary or
28 appropriate to carry out the provisions of section 5 of P.L.1992, c.160
29 (C.26:2H-18.55).

30 The commissioner shall develop equitable regulations regarding
31 eligibility for and access to the financial assistance, within six months
32 of the effective date of this act.

33 b. Such funds as may be necessary shall be transferred by the
34 department from the fund to the Division of Medical Assistance and
35 Health Services in the Department of Human Services for payment to
36 disproportionate share hospitals.

37 c. Notwithstanding any law to the contrary, each hospital whose
38 revenue cap was established by the Hospital Rate Setting Commission
39 in 1993 pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) shall pay
40 .53% of its total operating revenue to the department for deposit in the
41 Health Care Subsidy Fund, except that the amount to be paid by a
42 hospital in a given year shall be prorated by the department so as not
43 to exceed the \$40 million limit set forth in this subsection. The
44 hospital shall make monthly payments to the department beginning
45 July 1, 1993, except that the total amount paid into the Health Care
46 Subsidy Fund plus interest shall not exceed \$40 million per year. The

1 commissioner shall determine the manner in which the payments shall
2 be made.

3 For the purposes of this subsection, "total operating revenue" shall
4 be defined by the department in accordance with financial reporting
5 requirements established pursuant to N.J.A.C.8:31B-3.3.

6 d. The monies paid by the hospitals shall be credited to the
7 hospital and other health care initiatives account.

8 (cf: P.L.1995,c.133, s.8)

9

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

11

12

13

14

15 Designated the "Health Care Quality Act."