ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

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

STATE OF NEW JERSEY

DATED: MARCH 13, 1997

The Assembly Health Committee favorably reports an Assembly Committee Substitute for Assembly Bill Nos. 2420, 2623 and 2668.

This substitute, which is designated the "Health Care Quality Act," provides comprehensive consumer safeguards with respect to health insurance and the operation of health maintenance organizations.

Specifically, the substitute:

• requires carriers (insurance companies, health, hospital and medical service corporations and health maintenance organizations) to disclose to a subscriber (typically an employee or individual who purchases a health benefits plan), in writing, in easily understandable language, at the time of enrollment and upon request thereafter, the terms and conditions of the health benefits plan, which information shall include a description of:

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

- restrictions or limitations on covered services and benefits;

- 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 covered services may be obtained;

- changes in covered services or benefits, including any addition, reduction or elimination of specific services or 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 carrier with respect to the denial, reduction or termination of a benefit or the denial of payment for a health care service; and

- the procedure to initiate an appeal through the Independent Health Care Appeals Program in the Department of Health and Senior Services that is created in the substitute;

• requires carriers which offer managed care plans to also disclose to a subscriber, in writing, in easily understandable language, the following information at the time of enrollment and annually thereafter:

- a current 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 by county. The information shall include the primary care physicians' professional office addresses and any hospital affiliation the physician has. The directory also shall provide information about participating hospitals;

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

- the percentage of the carrier's network physicians who are board certified;

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

- the availability, through the Department of Health and Senior Services, of independent consumer satisfaction survey results and an analysis of quality outcomes of health care services of managed care plans in the State.

Also, upon request of a covered person, a carrier shall promptly inform the person whether a particular network physician is board certified and whether a particular network physician is currently accepting new patients;

• requires carriers which offer a managed care plan 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 carrier.

• requires that each application from a provider for participation to a carrier which offers a managed care plan shall be reviewed by a committee of the carrier that includes appropriate representation of providers with knowledge in the applicant's scope of professional practice;

• requires carriers to establish a policy governing the removal of health care providers. In the case of licensed health care professionals, the policy shall provide 90-days written notice of termination (if the termination occurs prior to the date of termination of the contract), unless there is a breach of contract, the health care professional represents an imminent danger to an individual patient or to the public health, safety or welfare, or there is a determination of fraud. Upon request of the professional, the carrier is required to give the professional the reasons for the termination and an opportunity for a hearing before a three-member panel appointed by the carrier, at least one member of which is a clinical peer in the same discipline and same or similar specialty as the health care professional being reviewed;

• 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 services, 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;

• requires carriers which offer a managed care plan to offer a point-of-service plan rider to all contract holders (typically an employer or purchaser of a health benefits plan) which would allow a covered person to receive covered health care services from out-of-network providers without having to obtain a referral or prior authorization from the carrier. The subscriber may be required to pay a higher deductible or copayment and higher premium for the rider;

• establishes the Independent Health Care Appeals Program in the Department of Health and Senior Services to ensure that carriers which are under increasing pressure to contain costs, do not achieve their cost containment goals by providing less care than is medically appropriate. The program will provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person. Under the program, the Commissioner of Health and Senior Services will contract with one or more independent utilization review organizations in the State that meet the requirements of this substitute to conduct the appeal reviews. All carriers would be required to provide the department with a description of the carrier’s internal patient appeals process available to covered persons to contest a denial, reduction or termination of benefits.

The appeals program will not require carriers to provide services not otherwise covered under the health benefits plan, and the program will not consider appeals about coverage of particular pharmaceutical products; it will focus only on covered services. The program would be funded by the carriers based on a schedule of fees established by the commissioner;

• requires a carrier which offers a managed care plan to comply with department reporting requirements with respect to quality outcomes measures of health care services and independent consumer satisfaction surveys. The department will make results of the surveys and its analysis of the quality outcomes measures available to the public to enable consumers to choose the most appropriate health benefits plan. Funding for department oversight and administration of the provisions of the substitute and the independent consumer satisfaction surveys and analyses of outcome measures will come from the hospital and other health care initiatives account in the Health Care Subsidy Fund pursuant to section 12 of P.L.1992, c.160 (C.26:2H-18.62);

• provides that the penalty for violations of the substitute shall be between $250 and $10,000 for each day that the violation continues, and increases the penalties in the "Health Maintenance Organizations

Act," P.L.1973, c.337 (C.26:2J-1 et seq.), to these same amounts. The substitute also provides that reasonable notice in writing be given to the carrier of the intent to levy the penalty and, at the discretion of the commissioner, the carrier would have 30 days or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation;

• supplements the "Health Maintenance Organizations Act" to authorize the Commissioner of Banking and Insurance to conduct an examination of a health maintenance organization as often as he deems necessary in order to protect the interests of providers, contract holders, members, and the residents of this State;

• requires employers in the State who provide a comprehensive self-funded health benefits plan to their employees to annually notify the employees that they are covered by a self-insured plan that is not subject to regulation by the State, and specify which mandated health insurance benefits, such as a minimum of 48 or 96 hours inpatient care following childbirth and benefits for treatment of diabetes, are covered by the self-insured plan; and

• directs the Commissioners of Health and Senior Services and Banking and Insurance to develop recommendations and report to the Legislature and Governor within one year on the issue of regulating health care or managed care entities that seek to contract directly with employees or other purchasers on a risk-assuming basis.

As reported by the committee, this substitute is identical to the Senate Committee Substitute for Senate Bill No. 269 (1R) (Sinagra/Matheussen), which was reported by the Senate Health Committee on March 10, 1997 and is currently pending before the Senate.