ASSEMBLY, No. 2623

STATE OF NEW JERSEY

INTRODUCED DECEMBER 19, 1996

By Assemblymen DiGAETANO and DORIA

AN ACT concerning managed care health benefits plans, amending P.L.1973, c.337 and supplementing various parts of the statutory law.

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

1. (New section) This act shall be known and may be cited as the "New Jersey Consumer Health Act of 1997."

2. (New section) The Legislature finds and declares that:

a. Under the current managed care systems operating in the State of New Jersey including, but not limited to, health maintenance organizations, preferred provider organizations, networks, panels and other such ventures, the medical needs and rights of individuals have become secondary to and are in conflict with the cost containment mechanisms routinely utilized by such systems.

b. Routine denial of care is becoming more and more prevalent under managed care, with authorization for hospital admissions, referrals to specialists, surgeries, and tests now subject to a gatekeeping process, often without a physical examination of the individual.

c. No health maintenance organization or other managed care entity should be able to prevent health care professionals from disclosing to an individual any information the health care professional determines to be relevant to the individual's health care.

d. The only effective way to ensure health care provider accountability and high quality care is to promote the ability of individuals to freely select providers, and for providers to maintain ongoing professional relationships with their patients regardless of network or panel affiliation.

e. The primary concern of the public, identified by numerous public opinion surveys, is the right to choose one's health care provider.

f. The citizens of this State are in need of patient advocacy.

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 <u>thus</u> is new matter.

g. It is therefore in the public interest to establish a framework to permit health care providers and individuals to readily obtain information concerning health care management guidelines and policies that affect coverage and payment for health care items and services; assure an opportunity for health care providers and interested individuals to request revisions in such care management guidelines; establish a common basis for making decisions regarding the medical necessity of particular health care items and services covered by a managed care health benefits plan; and assure the availability of a swift appeals process for individuals who believe that the use of health care management guidelines have denied them access to medically necessary care.

3. (New section) As used in sections 3 through 9 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 and Senior Services.

"Covered person" means a person on whose behalf a carrier or other entity is obligated to pay benefits pursuant to a 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 and Senior Services.

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

"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.).

"Point-of-service plan option" means an option in a managed care plan which allows a covered person under the plan to use a health care provider which is not a member of the managed care plan's network of providers.

"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

4. (New section) a. A managed care plan shall provide each covered person with the opportunity, at the time of enrollment and during a one-month period in each subsequent year, to enroll in a point-of-service plan option, subject to the provisions of subsection b. of this section. The managed care plan shall provide written notice of the point-of-service plan option to each covered person upon enrollment and annually thereafter, and shall include in that notice a detailed explanation of the financial costs to be incurred by a covered person who selects that option.

b. A covered person who enrolls in a point-of-service plan option may receive a covered service from a health care provider who is not a participating provider, but the covered person may be required to pay a higher annual premium which reflects the actuarial value of this expanded coverage, or an annual deductible plus a coinsurance charge which shall not exceed 20% of the cost of the service provided, or both.

5. (New section) a. A managed care plan shall provide an opportunity for any health care provider doing business within the managed care plan's geographic service area to apply to be a participating provider in its plan if :

(1) the health care provider is willing to meet the terms and conditions of the plan;

(2) the health care provider meets the provider credentialing requirements of the plan; and

(3) the managed care plan has determined that there is a need to include the health care services provided by the provider, in accordance with standards to be developed by the commissioner. A managed care plan shall not exclude any specific health care provider class.

The managed care plan shall make available to a provider applicant upon request a copy of the criteria used by the plan to accept or deny his application to be a participating provider.

b. A managed care plan shall establish procedures for the review of a provider application which shall include, but not be limited to, review by a committee that includes appropriate representation of health care professionals with knowledge in the applicant's scope of professional practice and written notification to the applicant within 30 days of receipt of the provider application, of the acceptance or denial of the application.

c. A managed care plan shall not deny an application to enter into a provider contract with a prospective participating provider, unless the provider is provided with written notice of the reasons for denial or termination, as applicable. The managed care plan shall establish an appeals process for health care providers to contest the denial of their provider application.

d. The managed care plan shall establish a mechanism to ensure that participating providers are able to participate in the development of policies and procedures governing health care services delivery by a managed care plan, including, but not limited to: provider credentialing requirements; coverage of new technology and procedures; quality assurance and improvement; and health care management procedures.

6. (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 participation will be terminated prior to the date of termination of the contract, the plan or contractor shall provide the provider with 90-days notice of the termination, unless the 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.

A plan or contractor shall not terminate a contract with a provider unless the plan or contractor provides the provider with written notice of the reasons for termination.

Any challenge brought by a provider to his termination shall be subject to a binding alternative dispute resolution process conducted by a neutral and professional arbitration service selected either by the plan or contractor or under the terms of the provider's contract with the plan or contractor. The costs of conducting the alternative dispute resolution process shall be borne by the provider unless the arbitration service determines that the termination was made in bad faith.

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.

7. (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 a covered person 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; and

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

8. (New section) a. A managed care plan shall include a utilization management program overseen by a medical director responsible for all decisions made by the program, who shall be a physician licensed

by the State Board of Medical Examiners to practice medicine and surgery.

b. The criteria and procedures used by the utilization management program shall be developed in consultation with participating providers, shall be based upon nationally recognized standards, shall be updated annually and shall be disseminated to each participating provider, and to a covered person upon his request.

c. The utilization management program shall respond to inquiries regarding, or requests for prior authorization for, nonemergency health care services from participating providers or covered persons within four business days, and shall be available on a 24-hour basis to respond to prior authorization requests for emergency services.

d. The utilization management program shall not take an adverse utilization management action unless: (1) the proposed adverse action is reviewed and approved by a health care professional who is competent and legally authorized to perform the health care service that is the subject of the adverse action; and (2) the utilization management program establishes a procedure whereby any covered person subjected to an adverse utilization management action may appeal that adverse action.

e. The utilization management program shall not affirm an adverse utilization management action which is appealed by a covered person unless the appellate review of the action is conducted by a health care professional who was not involved in approving the adverse action, is competent to provide the health care service that is the subject of the adverse action, and is a member of the same health care profession as, or of a health care profession that requires the same level of education as, or a higher level of education than, the covered person's provider of record.

f. The utilization management program shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the program for those services, unless the approval was based upon fraudulent information submitted by the covered person or the participating provider.

g. No prior authorization shall be required for emergency services rendered outside of the geographic service area of a managed care plan.

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

9. (New section) A managed care plan, carrier or network contractor that violates any provision 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, 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.

10. (New section) The commissioner shall enforce the provisions 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 the provisions of this act.

11. (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 P.L. , c. (C.)(pending before the Legislature as this bill) unless the policy meets the requirements of that act.

12. (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 P.L. , c. (C.)(pending before the Legislature as this bill) unless the policy meets the requirements of that act

13. (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 P.L. , c. (C.)(pending before the Legislature as this bill) unless the policy or contract meets the requirements of that act.

14. (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 P.L. , c. (C.)(pending before the Legislature as this bill) unless the policy or contract meets the requirements of that act.

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

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

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

18. (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 P.L. , c. (C.) (pending before the Legislature as this bill) unless the health maintenance organization meets the requirements of that act.

19. 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**]** 30 days, or such additional time as the commissioner shall determine to be 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**]** 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 Banking and 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 Banking and 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 Banking and Insurance may deem appropriate under the circumstances.

d. (1) The commissioner or the Commissioner of Banking and 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 Governing the Courts of the State of New Jersey.

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

20. This act shall take effect on the 180th day after the date of enactment, but the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

STATEMENT

This bill, designated "The New Jersey Consumer Health Act of 1997," provides various consumer and health care provider safeguards with respect to health insurance and the operation of managed care plans.

Specifically, the bill:

• requires a managed care plan to offer a point-of-service option rider to all policy or contract holders which would allow a covered person to receive covered health care benefits from out-of-network providers without having to obtain a referral or prior authorization from the managed care entity. The covered person may be required to pay a higher deductible or copayment and higher premium for the plan

option;

• provides that a managed care plan shall provide an opportunity for any health care provider doing business within the plan's geographic service area to apply to be a participating provider in its managed care plan if: the provider is willing to meet the terms and conditions of the plan and meets the provider credentialing requirements of the plan; and if the entity has determined that there is a need for the plan to include the health care services provided by the provider, in accordance with standards developed by the commissioner;

• provides that a managed care plan shall not deny an application to enter into a contract with a prospective participating provider unless the plan provides written notice of the reasons for denial or termination;

•provides that the managed care plan shall establish a mechanism to ensure that participating providers are able to participate in the development of policies and procedures governing health care services delivery;

• requires managed care plans and network contractors to establish a policy governing the removal of health care providers which provides 90-days' notice for 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 managed care plan or contractor shall not terminate a contract with a provider unless the plan or contractor gives the provider written notice of the reasons for termination, and that any challenge brought by a provider to his termination shall be subject to a binding alternative dispute resolution process conducted by a neutral and professional arbitration service selected either by the plan or contractor or under the terms of the provider's contract with the plan or contractor; and

• 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.

The bill further requires, with respect to a utilization review program operated by a certified managed care plan, that:

• the program be overseen by a licensed physician;

• the criteria and procedures used by the program be developed in consultation with participating providers, be based upon nationally recognized standards, and be disseminated to each participating

provider, and to a covered person upon his request;

• the program respond to inquiries regarding, or requests for prior authorization for, health care services from participating providers or covered persons within four business days, and be available on a 24-hour basis to respond to prior authorization requests for emergency services;

• the program not retrospectively deny coverage for health care services when prior approval has been obtained for those services, unless the approval was based upon fraudulent information;

• no prior authorization be required for emergency services rendered outside a plan's geographic service, or for screening by a health care provider to determine a covered person’s medical need for emergency services, which shall be a covered service; and

• a medical screening examination upon arrival in a hospital which is necessary to determine a covered person’s medical need for emergency services be covered to the same extent as any emergency service.

In addition, the bill 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 to these same amounts. The bill also provides that reasonable notice in writing be given to the managed care plan, network contractor, or health maintenance organization of the intent to levy the penalty and the managed care plan, carrier, network contractor or health maintenance organization 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.

"New Jersey Consumer Health Act of 1997."