ASSEMBLY, No. 2668

STATE OF NEW JERSEY

INTRODUCED JANUARY 23, 1997

By Assemblywoman WRIGHT and Assemblyman KRAMER

AN ACT concerning managed health care plans and supplementing Title 26 of the Revised Statutes.

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

1. This act shall be known and may be cited as the "Managed Health Care Consumer Protection Act."

2. The Legislature finds and declares that it is necessary and in the public interest to enact this act in order to ensure generally that persons enrolled in each managed health care plan which is offered or operated in this State receive adequate health care services, and specifically to ensure that:

a. enrollees have full and timely access to clinically and culturally appropriate health care personnel and facilities;

b. enrollees have adequate choice among health care professionals who are accessible and qualified;

c. there is open communication between health care professionals and enrollees;

d. enrollees have access to comprehensive pharmaceutical services;

e. enrollees have access to information regarding limits on coverage of experimental treatments;

f. there is high quality of care within each managed health care plan;

g. medical decisions are made by appropriate medical personnel within the managed health care plan;

h. health care professionals within a managed health care plan are legally authorized practitioners in good standing;

i. managed health care plan data are available to the public, as appropriate;

j. there is full public access to information regarding health care service delivery within a managed health care plan;

k. the State has authority to oversee all managed health care plans;

l. there is a fair mechanism for resolving enrollee complaints within a managed health care plan; and

m. each managed health care plan provides for a timely resolution of enrollee grievances and appeals.

3. As used in this act:

"Appeal" means a formal process whereby an enrollee, whose care has been reduced, denied, or terminated, or who deems the care inappropriate, can contest an adverse grievance decision by a managed health care plan.

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

"Emergency" means a medical condition, the onset of which is sudden and unexpected, that manifests itself by symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably assume that the condition requires immediate medical treatment, and could expect the absence of medical attention to result in serious impairment to bodily functions or place the person's health in serious jeopardy.

"Enrollee" means a person who is enrolled in a managed health care plan.

"Experimental treatment" means treatment that, while not commonly used for a particular condition or illness, nevertheless is recognized for treatment of the particular condition or illness when there is no clearly superior, non-experimental treatment alternative available to an enrollee.

"Grievance" means a written complaint submitted by or on behalf of an enrollee.

"Health care facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Health care practitioner" means a physician or other health care professional providing health care services.

"Health care provider" means a clinic, hospital, physician organization, preferred provider organization, independent practice association, or other appropriately licensed provider of health care services or supplies.

"Health care services" means services for the diagnosis, prevention or treatment of a health condition, illness, injury or disease.

"Managed care entity" means a person or entity, including a licensed insurance company; health, hospital or medical service corporation; health maintenance organization; limited health services organization; preferred provider organization or third party administrator, that establishes, operates or maintains a network of participating health care providers and practitioners.

"Managed health care plan" means a plan operated by a managed care entity that provides for the financing and delivery of comprehensive health care services to persons enrolled in the plan, with financial incentives for persons enrolled in the plan to use the

participating health care providers and practitioners and the health care services covered by the plan.

"Participating health care provider" means a health care provider which has entered into an agreement with a managed care entity to provide health care services to an enrollee in its managed health care plan.

"Participating practitioner" means a health care practitioner who has entered into an agreement with a managed care entity to provide health care services to an enrollee in its managed health care plan.

"Primary care practitioner" means a participating practitioner who has been designated by the managed health care plan to coordinate, supervise or provide ongoing care to an enrollee.

"Prudent layperson" is a person without specific medical training for the illness or condition in question who acts as a reasonable person would under similar circumstances.

"Quality assurance" means the ongoing evaluation by a managed health care plan of the quality of health care services provided to its enrollees.

4. a. The provisions of this act shall apply to each managed care entity operating in this State.

b. A managed health care plan shall not be offered or operated in this State one year after the effective date of this act unless it is authorized by the commissioner, and the commissioner shall have all necessary authority to oversee each managed health care plan. The commissioner shall provide by regulation for a process of required application for authorization to offer or operate a managed health care plan pursuant to this act.

b. 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 this act.

b. 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.

5. a. A managed health care plan shall include a sufficient number and type of primary care practitioners and specialists throughout the plan's service area to meet the needs of enrollees and to provide meaningful choice. Each managed health care plan shall demonstrate that it offers:

(1) an adequate number of accessible acute care hospital services

within a reasonable distance and travel time;

(2) an adequate number of accessible primary care practitioners within a reasonable distance and travel time, including family practice and general practice physicians, internists, obstetrician/gynecologists and pediatricians;

(3) an adequate number of accessible specialists and sub-specialists within a reasonable distance and travel time, and that when the type of medical specialist needed for a specific condition is not represented on the plan's list of participating specialists, enrollees have access to non-participating health care practitioners; and

(4) the availability of specialty medical services, including physical therapy, occupational therapy, and rehabilitation services.

b. If a managed health care plan terminates the participation of an enrollee's primary care practitioner, the plan shall provide for the enrollee's continuity of care with an alternative primary care practitioner. The plan shall allow an enrollee, at no additional out-of-pocket cost, to continue to receive services from a primary care practitioner whose contract with the plan is terminated without cause, for a period of 60 days, when the enrollee requests this continued care.

c. A managed health care plan shall provide telephone access to the plan for a sufficient period of time during both business and evening hours to ensure enrollee access for routine care, and 24-hour telephone access to either the plan or a participating health care provider or practitioner for emergency care or authorization for care.

d. A managed health care plan shall establish reasonable standards for waiting times to obtain appointments, except as provided for emergency care. The standards shall include appointment scheduling guidelines based on the type of health care service, including prenatal care appointments, well-child visits and immunizations, routine physical examinations, follow-up appointments for chronic conditions, and urgent care.

e. A managed health care plan shall be required to cover and reimburse expenses for emergency care obtained, without prior authorization, in situations in which a prudent layperson could reasonably believe the person's condition required immediate attention at the nearest health care facility.

f. A managed health care plan shall demonstrate that it has developed an access plan to meet the needs of vulnerable under-served populations.

(1) The plan shall provide culturally appropriate services to the greatest extent possible.

(2) When a significant number of enrollees in the plan speaks a first language other than English, the plan shall provide access to personnel fluent in languages other than English, to the greatest extent possible.

(3) The plan shall develop standards for continuity of care following enrollment, including sufficient information on how to access health

care services within the plan.

g. Each managed health care plan shall hold harmless enrollees against claims from participating health care providers and practitioners in the managed health care plan for payment of the cost of covered health care services.

6. a. An enrollee shall have adequate choice among participating practitioners in a managed health care plan who are accessible and qualified.

b. A managed health care plan shall permit enrollees to choose their own primary care practitioner from a list of health care practitioners within the plan. This list shall be updated as health care practitioners are added or removed and shall include:

(1) a sufficient number of primary care practitioners who are accepting new enrollees; and

(2) a sufficient mix of primary care practitioners that reflects a diversity that is adequate to meet the needs of the enrolled population's varied characteristics, including age, gender, race and health status.

c. A managed health care plan shall develop a system to permit an enrollee to use a medical specialist as the enrollee's primary care practitioner when the enrollee's medical condition warrants it. This may include enrollees suffering from chronic diseases as well as those with other special needs.

d. A managed health care plan shall provide continuity of care and appropriate referral to specialists within the plan when specialty care is warranted.

(1) Enrollees shall have access to medical specialists on a timely basis.

(2) Enrollees shall be provided with a choice of specialists when a referral is made.

e. A managed health care plan shall offer a point-of-service option to permit an enrollee to receive health care services from a non-participating health care provider or practitioner. The point-of-service option may require that the enrollee in the plan pay a reasonable portion of the costs of the out-of-plan care.

f. A managed health care plan shall provide an enrollee with access to a consultation with a health care practitioner for a second opinion.

7. a. A managed health care plan may not contract with a health care practitioner to limit the practitioner's disclosure to an enrollee, or to another person on behalf of an enrollee, of any information relating to the enrollee's medical condition or treatment options.

b. A health care practitioner shall not be penalized, or his contract with a managed health care plan terminated, because the practitioner offers a referral to, or discusses medically necessary or appropriate

care with, an enrollee or another person on behalf of an enrollee.

(1) The health care practitioner may not be prohibited by the plan from discussing all treatment options with the enrollee.

(2) Other information determined by the health care practitioner to be in the best interests of the enrollee may be disclosed by the practitioner to the enrollee, or to another person on behalf of an enrollee.

c. (1) A health care practitioner shall not be penalized for discussing financial incentives and financial arrangements between the practitioner and the managed care entity with an enrollee.

(2) A managed health care plan shall inform its enrollees in writing of the financial arrangements between the plan and participating practitioners if those arrangements include an incentive or bonus for restricting the amount of health care services provided to the enrollee.

8. a. A managed health care plan shall provide coverage for any drug or device approved by the federal Food and Drug Administration, whether or not the drug or device has been approved for the enrollee's specific condition or illness, so long as the primary care practitioner or specialist treating the enrollee determines the drug or device is medically necessary and appropriate for the enrollee's condition or illness.

b. A managed health care plan shall include a drug utilization review program, the primary emphasis of which shall be to enhance quality of care for enrollees by assuring appropriate drug therapy, that includes the following:

(1) retrospective review of prescription drugs furnished to enrollees;

(2) education of physicians, enrollees and pharmacists regarding the appropriate use of prescription drugs; and

(3) ongoing periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees.

c. The drug utilization review program shall utilize the following to effectuate the purposes of subsection b. of this section:

(1) relevant clinical criteria and standards for drug therapy;

(2) nonproprietary criteria and standards developed and revised through an open, professional consensus process;

(3) intervention which focuses on improving therapeutic outcomes; and

(4) measures to ensure the confidentiality of the relationship between an enrollee and health care practitioner.

d. The managed health care plan may only deny coverage for a drug or device, based upon a prospective review of drug therapy, in cases of enrollee ineligibility, coverage limitations or fraud.

e. The prescribing health care practitioner shall determine the

appropriate drug therapy for an enrollee, and no substitutions shall be made without the direct approval of the prescriber.

9. a. A managed health care plan which limits coverage for an experimental treatment, procedure, drug or device shall define the limitation and disclose the limits in any agreement or certificate of coverage. This disclosure shall include:

(1) the person who is authorized to make such a determination; and

(2) the criteria the plan uses to determine whether a service is experimental.

b. A managed health care plan that denies coverage for an experimental treatment, procedure, drug or device for an enrollee who has a terminal condition or illness shall provide the enrollee with a denial letter within 20 working days of the submitted request for such coverage. The letter shall include:

(1) the name and title of the person making the decision;

(2) a statement setting forth the specific medical and scientific reasons for denying coverage;

(3) a description of alternative treatment, services, or supplies covered by the plan, if any; and

(4) a copy of the plan's grievance and appeal procedure.

10. a. A managed health care plan shall appoint a medical director who is a physician licensed to practice in New Jersey, and who shall be responsible for the treatment policies, protocols, quality assurance activities and utilization management decisions of the plan.

b. A managed health care plan shall develop comprehensive quality assurance standards adequate to identify, evaluate and remedy problems relating to access, continuity and quality of health care services. These standards shall include:

(1) an ongoing written, internal quality assurance program;

(2) specific written guidelines for quality of care studies and monitoring, including attention to vulnerable populations;

(3) performance and clinical outcomes-based criteria;

(4) a procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(5) a plan for data gathering and assessment pursuant to section 11 of this act; and

(6) a peer review process.

c. Each managed health care plan shall have a process for the selection of health care practitioners who will be on the plan's list of participating practitioners, with written policies and procedures for review and approval used by the plan.

(1) The plan shall establish minimum professional requirements for participating health care practitioners.

(2) The plan shall demonstrate that it has consulted with

appropriately qualified health care practitioners to establish the minimum professional requirements.

(3) The plan's selection process shall include verification of each health care practitioner's license, history of license suspension or revocation, and liability claims history.

(4) A managed health care plan shall establish a formal written, ongoing process for the re-evaluation of each participating health care practitioner within a specified number of years after the practitioner's initial acceptance into the plan. The re-evaluation shall include an update of the previous review criteria and an assessment of the practitioner's performance pattern based on criteria that include enrollee clinical outcomes, number of complaints and malpractice actions.

d. A managed health care plan shall not use a health care practitioner beyond, or outside of, the practitioner's legally authorized scope of practice.

11. a. A managed health care plan shall provide information on the plan's structure, decision-making process, health care benefits and exclusions, cost and cost-sharing requirements, list of participating health care providers and practitioners, and grievance and appeal procedures to all potential enrollees, all enrollees covered by the plan, and to the commissioner, on a form and in a manner prescribed by the commissioner.

b. The managed health care plan shall collect and report annually to the commissioner all data specified by the commissioner, on a form and in a manner prescribed by the commissioner, including, but not limited to, the following:

(1) gross outpatient and hospital utilization data;

(2) enrollee clinical outcome data;

(3) the number and types of enrollee grievances or complaints during the year, the status of decisions, and the average time required to reach a decision; and

(4) the number, amount and disposition of malpractice claims resolved during the year by the managed health care plan and any of its participating health care practitioners.

c. The managed health care plan shall make all data specified in subsections a. and b. of this section available to the public on a timely basis, on a form and in a manner prescribed by the commissioner.

d. The managed health care plan shall establish written policies and procedures for the handling of medical records and enrollee communications to ensure enrollee confidentiality.

e. The managed health care plan shall ensure the confidentiality of specified enrollee information, including, but not limited to, prior medical history, medical record information and claims information, except when a disclosure of this information is required by law.

f. The managed health care plan shall be prohibited from releasing an enrollee's patient record information unless the release is authorized in writing by the enrollee.

12. a. A managed health care plan shall provide written notification to each enrollee, in a language the enrollee understands, regarding the right to file a grievance. At a minimum, this notification shall be given:

(1) prior to enrollment in the plan; and

(2) at the time health care services are denied or limited under the plan.

b. The notification provided to an enrollee at the time of a denial of health care services pursuant to subsection a. of this section shall include: the reason for denial, the name of the person responsible for the decision, the criteria for the determination, and the enrollee's right to file a grievance.

c. The grievance procedure shall include:

(1) identification of the reviewing body and an explanation of the process of review;

(2) an initial investigation and review;

(3) notification to the enrollee within a reasonable amount of time of the outcome of the grievance; and

(4) an appeal procedure.

d. The managed health care plan shall set reasonable time limits for each part of the review process, but in no case shall the review extend beyond a 30-day period.

e. The managed health care plan shall provide for the expedited review of grievances in cases involving an imminent, emergent or serious threat to the health of the enrollee, in which case the plan:

(1) shall immediately inform the enrollee of his right to an expedited review; and

(2) shall provide the enrollee with a written statement of the disposition or pending status of the grievance within 72 hours of the commencement of the review process.

13. a. The commissioner shall perform an audit of each managed health care plan on an annual basis, for the purpose of reviewing enrollee clinical outcome data, enrollee service data, operational and other financial data.

b. Nothing in this act shall preclude the commissioner from investigating complaints, grievances or appeals on behalf of enrollees or health care practitioners.

c. The commissioner shall develop standards for the compliance of managed health care plans with the requirements of this act, and shall establish by regulation penalties for violations of the provisions of this act.

14. The commissioner shall enforce the provisions of this act, in consultation with the Commissioner of Banking and Insurance, and shall 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.

15. This act shall take effect on the 180th day after the date of enactment, except that the commissioner may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

STATEMENT

This bill, which is designated the "Managed Health Care Consumer Protection Act," provides for the regulation of all managed health care plans in the State by the Department of Health and Senior Services (DHSS) with respect to key consumer protection issues, including both health maintenance organizations (HMO's) which are currently regulated under P.L.1973, c.337 (C.26:2J-1 et seq.) and non-HMO comprehensive managed health care plans which are not currently subject to DHSS regulation.

With respect to HMO's, the bill stipulates that:

- a certificate of authority to establish and operate an HMO in this State shall not be issued or continued on or after the effective date of this bill unless the HMO meets the requirements of this bill; and
- an HMO shall be required to comply with the provisions of P.L.1973, c.337 and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this bill conflict with the provisions of P.L.1973, c.337, the provisions of this bill shall supercede the provisions of P.L.1973, c.337.

The bill requires that a managed health care plan which is offered or operated in this State be authorized by the Commissioner of Health and Senior Services. The commissioner is provided with statutory authority in this bill to promulgate regulations for managed health care plans including network adequacy, member and provider rights, quality assurance, utilization management, complaints and patient appeals and data reporting.

With respect to any financial incentives which may be utilized by a managed health care plan, the bill stipulates that:

- a health care practitioner shall not be penalized for discussing financial incentives and financial arrangements between the practitioner and the managed care entity with an enrollee; and
- a managed health care plan shall inform its enrollees in writing of the financial arrangements between the plan and participating practitioners if those arrangements include an incentive or bonus for

restricting the amount of health care services provided to the enrollee.

The bill also requires that a managed health care plan provide coverage for any drug or device approved by the federal Food and Drug Administration, whether or not the drug or device has been approved for the enrollee's specific condition or illness, so long as the primary care practitioner or specialist treating the enrollee determines the drug or device is medically necessary and appropriate for the enrollee's condition or illness. A managed health care plan shall include a drug utilization review program, the primary emphasis of which shall be to enhance quality of care for enrollees by assuring appropriate drug therapy.

The bill takes effect on the 180th day after the date of enactment, except that the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the bill.

"Managed Health Care Consumer Protection Act."