Title 26.
Chapter 2S (New)
Health Care Quality
§§ 1-17,19
C. 26:2S-1 To
26:2S-18
§18 C. 34:11A-14
§20 C. 26:2J-18.1
§21 C. 17B:26-2.1n
§22 C. 17B:27-46.1q
§23
C. 17B:27A-19.5
§24 C. 17B:27A-7.3
§25 C. 17:48-6r
§26 C. 17:48A-7p
§27 C. 17:48E-35.15
§28 C. 26:2J-4.16
§31 Note To §§1-30

P.L. 1997, CHAPTER 192, ***approved August 8, 1997***
Senate Committee Substitute ***(Second Reprint)*** for
Senate, No. 269
(CORRECTED COPY)

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

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 "Health Care Quality Act."

2. (New section) As used in sections 2 through 19 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.

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

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide 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] Senate floor amendments adopted May 22, 1997.
[2] Assembly floor amendments adopted June 19, 1997.

pursuant to the health benefits plan.

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

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

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

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

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

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

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

"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 care procedures and retrospective review.

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

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

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

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

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

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

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

4. (New section) A carrier shall disclose in writing to a

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

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

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

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

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

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

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

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

(7) 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 health care benefit or the denial of payment for a health care service;

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

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

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

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

(1) 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 directory shall include the professional office address of a primary care physician and any hospital affiliation the primary care physician has.

The directory shall also provide information about participating hospitals.

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

(2) 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 managed care patients;

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

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

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

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

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

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

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

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

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

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

b. The medical director shall ensure that:

(1) Any utilization management decision to deny, reduce or terminate a health care benefit or to deny payment for a health care service, because that service is not medically necessary, shall be made

by a physician. In the case of a health care service prescribed or provided by a dentist, the decision shall be made by a dentist;

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

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

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

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

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

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

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

b. If a licensed health care professional’s participation will be terminated prior to the date of the termination of the contract, the carrier shall provide the health care professional with 90-days written notice of the termination and notice of a right to a hearing. If requested by the health care professional, the carrier shall provide the reasons for the termination in writing, and shall hold a hearing within 30 days of the date of the request. The hearing shall be conducted by a panel appointed by the carrier, which panel shall be comprised of a minimum of three persons, at least one of whom is a clinical peer in the same discipline and the same or similar specialty as the health care

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

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

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

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

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

b. Shall not provide financial incentives to the health care provider for withholding covered health care services that are medically necessary [1]**[**, in the opinion of the medical director**]**[1] [2]<u>as determined in accordance with section 6 of this act, except that nothing in this subsection shall be construed to limit the use of capitated payment arrangements between a carrier and a health care provider</u>[2]; and

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

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

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

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

[1]d. A carrier which offers a managed care plan utilizing a selective contracting arrangement approved in accordance with N.J.A.C.11:4-37.1 et seq. that provides benefits for out-of-network providers shall be deemed to be in compliance with this section.

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

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

The purpose of the appeals program is to 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. The appeal review shall not include any decisions regarding [1][pharmaceutical products or][1] benefits not covered by the covered person's health benefits plan.

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

b. As part of the application, the covered person shall provide the

department with:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16. (New section) a. A carrier 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 that the carrier is in violation of the act if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the carrier 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.

b. (1) The commissioner or the Commissioner of Banking and Insurance may issue an order directing a carrier or a representative of a carrier 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. The hearing 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.

c. 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 b. of this section, the commissioner may institute a proceeding to obtain injunctive relief in accordance with the applicable Court Rules.

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

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

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

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

Within six months of the effective date of this act, in consultation with the Commissioner of Banking and Insurance, the commissioner 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 purposes of this act. The regulations shall establish consumer protection and quality standards governing carriers which offer a managed care plan or use a utilization management system that

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

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

20. (New section) The Commissioner of Banking and Insurance may 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. An organization shall make its relevant books and records available for examination by the Commissioner of Banking and Insurance, and retain its records in accordance with a schedule established by the Commissioner of Banking and Insurance by regulation. The reasonable expenses of the examination shall be borne by the organization being examined. In lieu of such examination, the Commissioner of Banking and Insurance may accept the report of an examination made by the commissioner of another state.

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

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

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

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

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

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

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

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

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

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

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

24. 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 that the health maintenance organization is in violation of P.L.1973, c.337 (C.26:2J-1 et seq.), if reasonable notice in writing is given of the intent to levy the penalty **[**and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation, and fails to do so within said time**]**and, at the discretion of the commissioner, the health maintenance organization has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the conditions which gave rise to the violation, and fails to do so within the time allowed. Any such penalty may be recovered in a summary proceeding pursuant to **[**the Penalty Enforcement Law (N.J.S.2A:58-1 et seq.)**]** "the penalty enforcement law," N.J.S.2A:58-1 et seq.

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

c. (1) If the commissioner or the Commissioner of 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.

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

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

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

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

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

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

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

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

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

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

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

Designated the "Health Care Quality Act."