SENATE, No. 266

STATE OF NEW JERSEY

Introduced Pending Technical Review by Legislative Counsel

PRE-FILED FOR INTRODUCTION IN THE 1996 SESSION

By Senators SINAGRA and INVERSO

AN ACT concerning health benefits 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. As used in this act:

"Carrier" means any 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.

"Covered person" means a person on whose behalf the carrier or other entity delivering or issuing the health benefits plan is obligated to pay benefits pursuant to the health benefits plan.

"Covered service" means a service provided to a covered person under a health benefits plan for which the carrier or other entity delivering or issuing the plan is obligated to pay benefits.

"Department" means the Department of Health.

"Health benefits plan" means a policy, contract or other agreement delivered or issued for delivery in this State by a carrier or other entity paying benefits for covered services, and includes indemnity and managed care plans.

"Independent utilization review organization" means an independent, nonprofit 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 selected providers 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. Managed care includes, but is not limited to,

a health maintenance organization or HMO, a preferred provider organization or PPO, an exclusive provider organization or EPO, a point-of-service plan or POS, or any other similar health benefits delivery system, whether issued by or through a carrier, multiple employer arrangement, out-of-State trust, professional, business or other association, employer or any other entity and whether self-insured or insured under a plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees of two or more employers and their dependents, whether self-insured, or insured under a plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, and shall include, but is not limited to, a multiple employer arrangement or MEWA, multiple employer trust or other form of benefit trust.

2. a. A managed care plan in effect on the effective date of this act which provides benefits to residents of this State shall file a registration form with the department within 90 days of the effective date of this act. A managed care plan established after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the plan will begin to provide benefits to residents of this State. The registration form shall be valid for two years, but the managed care plan shall notify the department within 10 business days of any change in information provided on the registration form.

b. A carrier which offers an individual or group health benefits plan to residents of this State on an indemnity basis on the effective date of this act shall file a registration form with the department within 90 days of the effective date of this act. A carrier authorized to issue health benefits plans in this State after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration 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 registration form shall be valid for two years, but the carrier shall notify the department within 10 business days of any change in information provided on the registration form.

c. The commissioner shall establish a registration form for managed care plans and indemnity carriers which shall request, at a minimum, the following information:

(1) The official address and telephone number of the place of business of the managed care plan or carrier; and

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

d. The filing of a registration form by a managed care plan or indemnity carrier with the department pursuant to this act is for informational purposes only in order to enable the department to carry out the provisions of this act. The registration required pursuant to this act shall not be construed to authorize the department to regulate managed care plans or carriers in any manner not otherwise provided by law.

e. A managed care plan or indemnity carrier filing a registration form with the department pursuant to this act shall pay a biennial registration fee of $200.

3. There is established the Statewide Independent Health Benefits Plan Appeals Program in the Department of Health.

The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by health benefits plans to deny, reduce or terminate covered benefits in the event the final decision is contested by the covered person. The appeal review shall not include any decisions regarding pharmaceutical products or benefits not covered by the health benefits plan.

4. A covered person may apply to the Statewide Independent Health Benefits Plan Appeals Program for a review of a decision to deny, reduce or terminate a covered benefit other than pharmaceutical products if the person has already completed the health benefits plan's appeals process, if any, and the person contests the final decision by the health benefits plan. The person shall apply to the program within 30 days of the date the final decision was issued by the health benefits plan, in a manner determined by the commissioner.

As part of the application, the covered person shall provide the program with:

a. The name and business address of the health benefits plan;

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

c. A copy of any information provided by the health benefits plan regarding its decision to deny, reduce or terminate the benefit; and

d. A written consent to obtain any necessary medical records from the health benefits plan and, in the case of a managed care plan, any other out-of-network physician the person may have consulted on the matter.

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

5. 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 health benefits plan and shall not have any private arrangement with an individual health care facility, health care provider or supplier whose services may be subject to review within the area in which the organization shall operate. The commissioner may establish additional requirements and standards consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Statewide Independent Health Benefits Plan 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 review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on available practice guidelines developed by professional medical societies, boards or associations.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the health benefits plan's denial, reduction or termination of benefits arbitrarily deprived the covered person of medically necessary services covered by the health benefits plan. If the organization determines that the denial, reduction or termination of benefits arbitrarily deprived the person of necessary, covered services, it shall make a recommendation to the covered person and health benefits plan regarding the appropriate, medically necessary health care services the person should receive. The recommendation of the organization shall be binding on the health benefits plan, which shall promptly make arrangements to provide the recommended health care services, if any. If the covered person is not in agreement with the organization's findings and recommendation, the person may seek the desired health care services outside of the health benefits plan, at his own expense.

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

e. The covered person's medical records provided to the Statewide Independent Health Benefits Plan 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 health benefits plan 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.).

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

6. a. An employee of the department who participates in the Statewide Independent Health Benefits Plan 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 Statewide Independent Health Benefits Plan 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 health benefits plan 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.

7. The commissioner shall assess a health benefits plan a fee based on the number of appeals filed against the plan. The commissioner shall use the revenues from the fees to support the cost of the Health Benefits Plan Appeals Program reviews.

8. The commissioner shall report annually to the Senate and General Assembly standing reference committees on health and insurance and to the Governor on the status of the Statewide Independent Health Benefits Plan 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, and any other information and recommendations deemed appropriate by the commissioner.

9. A managed care plan which contracts with an out-of-State health care facility to provide a covered service to covered persons in this State, shall offer a covered person who is referred to the out-of-State facility the option of obtaining the service in this State if a comparable service with comparable quality is provided by a health care facility in this State.

10. This act shall take effect on the 120th day after enactment.

STATEMENT

This bill establishes a Statewide Independent Health Benefits Plan Appeals Program in the Department of Health. The purpose of the program is to provide an independent medical necessity or appropriateness of services review of final decisions by health benefits plans to deny, reduce or terminate covered benefits in the event the final decision is contested by the covered person.

The Commissioner of Health shall contract with one or more independent utilization review organizations in the State that meet the requirements of this bill to conduct the appeal reviews. The independent utilization review organization shall be independent of any health benefits plan and shall not have any private arrangement with an individual health care facility, health care provider or supplier whose services may be subject to review within the area in which the organization shall operate. The commissioner may establish additional requirements and standards consistent with the purposes of this bill that an organization shall meet in order to qualify for participation in the Statewide Independent Health Benefits Plan Appeals Program.

The bill would require all managed care plans and indemnity carriers that provide benefits to residents of the State to file a registration form with the Department of Health, which will be valid for two years. The form will request the official address and telephone number of the place of business of the managed care plan or carrier and a description of the managed care plan's or carrier's internal patient appeals process available to covered persons to contest a denial, reduction or termination of covered benefits. This basic information about the managed care plan or carrier will be needed by the department to carry out the purposes of the bill and will not be used by the department to regulate managed care plans or carriers in any manner not otherwise provided by law.

The intent of the bill is to provide a measure of consumer protection with respect to health care services in the State, by ensuring that managed care plans and indemnity carriers which are under increasing pressure to contain costs, do not achieve their cost containment goals by providing less care than is medically appropriate. The bill does not require managed care plans or carriers to provide services not otherwise covered under the contract or policy, and the appeals program will not consider appeals about coverage of particular pharmaceutical products; it will focus only on covered benefits. An employee of the Department of Health who participates in the program would be given immunity from civil liability for actions taken as members of the program. The appeals program would be funded by assessments on the health benefits plans. The bill would cover all health benefits plans (insured and self-insured) that provide benefits to residents of the State.

Additionally, the bill provides immunity to the health benefits plan that is the subject of a review for any actions taken by that plan to implement a recommendation of a reviewing physician. The bill includes a provision that would require a managed care plan which contracts with an out-of-State health care facility for the provision of certain health care services to offer covered persons the option of obtaining the health care service at a facility in this State, rather than going out of State, if a comparable service with comparable quality is available in this State.

Establishes Statewide Independent Health Benefits Plan Appeals Program in DOH.