SENATE HEALTH COMMITTEE

STATEMENT TO

# SENATE, No. 269

with committee amendments

# STATE OF NEW JERSEY

DATED: MARCH 14, 1996

The Senate Health Committee reports favorably Senate Bill No. 269 with committee amendments.

As amended by committee, this bill, which is designated the "Health Care Quality Act," provides various consumer safeguards with respect to health insurance and the operation of managed care plans.

Specifically, the bill:

• requires managed care plans, indemnity carriers and network contractors (entities, such as preferred provider organizations or PPOs, that establish health care provider networks for managed care plans) to register with the Department of Health;

• requires managed care plans and indemnity carriers to disclose to covered persons, in writing, in easily understandable language, at the time of enrollment and annually thereafter, the terms and conditions of the health benefits plan, which information shall include a description of:

a. covered services and benefits to which the covered person is entitled;

b. treatment policies and 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;

c. financial responsibility of the covered person, including copayments and deductibles;

d. prior authorization and any other review requirements with respect to accessing covered services;

e. where and in what manner services or benefits may be obtained;

f. changes in covered benefits, including any addition, reduction or elimination of specific benefits;

g. 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 managed care plan or carrier with respect to the denial, reduction or termination of a covered health care benefit or the denial of payment for a health care service;

h. the procedure to initiate an appeal pursuant to the provisions of Senate Bill No. 266 of 1996 which establishes the Statewide Independent Health Benefits Plan Appeals Program in the Department of Health; and

i. such other information as the commissioner shall require.

• requires managed care plans to also disclose to a prospective covered person, in writing, in easily understandable language, the following information at the time of enrollment and annually thereafter:

a. a 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 their professional office addresses;

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

c. The percentage of the managed care plan's network physicians who are board certified; and

d. The managed care plan's standard for customary waiting times for appointments for urgent and routine care.

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

• requires managed care plans and network contractors to have a medical director who is a licensed physician and who is responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan, in the case of a managed care plan, and quality assurance activities and utilization management decisions, in the case of a network contractor. The medical director, or his designee, shall be a New Jersey licensed physician and shall be designated to serve as the medical director for medical services provided to covered persons in the State. Also, quality assurance and utilization management programs shall be in accordance with standards adopted by the Department of Health;

• requires network contractors to maintain quality assurance and utilization management programs and provides that the network contractor may contract with payers for use of the programs for their managed care plans;

• requires managed care plans and network contractors to establish a policy governing the removal of health care providers which provides 90-days' notice for withdrawal of credentialing (if the withdrawal of credentialing occurs prior to the date of 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 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;

• 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 plan. The covered person may be required to pay a higher deductible or copayment and higher premium for the plan option; and

• 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, P.L.1973, c.337, to these same amounts. The bill also provides that reasonable notice in writing be given to the managed care plan, network contractor, indemnity carrier or health maintenance organization of the intent to levy the penalty and the managed care plan, indemnity 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.

The committee amended the bill to:

- clarify the definition of "network contractor;"

- require that the managed care plan's or carrier's disclosure information for covered persons be written in easily understandable language and clarify when the information shall be provided to covered persons;

- delete the requirement that the plans disclose the percentage breakdown of premium dollars spent on benefits and on administration;

- add additional disclosure requirements concerning participating providers that must be provided to covered persons, including the percentage of the managed care plan's physicians who are board certified and the plan's standard for customary waiting times for appointments for urgent and routine care. Also, upon request, a plan will be required to inform a covered person whether a particular network physician is board certified or is currently accepting new patients;

- clarify that the medical director, or his designee, shall be a New Jersey licensed physician and shall be designated to serve as the medical director for medical services provided to residents of this State;

- require that quality assurance and utilization management programs shall be in accordance with standards adopted by the

Department of Health;

- clarify that utilization management decisions to deny, reduce or terminate a health care benefit shall be made by a physician with knowledge in the area of the health care practice, rather than the health care service, as the bill originally provided;

- provide that a managed care plan or network contractor establish a policy governing removal of health care providers, which includes hospitals and other health care facilities, as well as health care professionals. The bill originally provided that the policy cover only health care professionals;

- provide that contracts with participating providers also protect the ability of health care providers to communicate openly with patients about all appropriate testing and treatment options;

- clarify, regarding the point of service requirement, that a managed care plan shall offer the option as a rider to the basic managed care plan and exempt managed care plans that have been in operation for less than three years from the requirement to offer the point of service option; and

- provide managed care plans, network contractors, indemnity carriers and health maintenance organizations with notice of violations and 30 days to remedy the defect before a fine is levied by the Commissioner of Health.

This bill was prefiled for introduction in the 1996-97 session pending technical review. As reported, the bill includes the changes required by technical review which has been performed.