SENATE, No. 574

STATE OF NEW JERSEY

INTRODUCED JANUARY 29, 1996

By Senator BASSANO

AN ACT allowing certain organizations to enter into preferred provider arrangements and supplementing Chapter 17 of Title 17B of the New Jersey 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 "New Jersey Preferred Provider Arrangement Act."

2. The purpose of this act is to encourage health care cost containment while preserving the quality of care by allowing organizations to enter into preferred provider arrangements and by establishing minimum standards for preferred provider arrangements and the health benefit plans associated with those arrangements.

3. As used in this act:

"Commissioner" means the Commissioner of Insurance.

"Covered service" means a health care service which an organization is obligated to pay for or provide under a health benefit plan.

"Covered person" means a person on whose behalf the organization is obligated to pay for or provide a health care service.

"Emergency care" means a covered service provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in: serious impairment of bodily function; serious dysfunction of any bodily organ or part; or placing the patient's health in serious jeopardy.

"Health benefit plan" means a health insurance policy or subscriber contract between the covered person, subscriber or policyholder and an organization which defines the covered services and benefit levels available.

"Health care provider" means a provider of health care services.

"Health care service" means a service or product sold by a health care provider and includes, but is not limited to, hospital, medical,

surgical, dental, vision and pharmaceutical services or products.

"Organization" means an insurer doing the business of health insurance, as defined in N.J.S.17B:17-4, and operating pursuant to Title 17B of the New Jersey Statutes; a hospital service corporation operating pursuant to P.L.1938, c.366 (C.17:48-1 et seq.); a medical service corporation operating pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.); a health service corporation operating pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.); or a fraternal benefit society operating pursuant to P.L.1959, c.167 (C.17:44A-1 et seq.).

"Preferred provider" means a heath care provider or group of health care providers who have contracted to provide specified covered services.

"Preferred provider arrangement" means a contract between or on behalf of an organization and a preferred provider.

4. Notwithstanding any provision of law to the contrary, any organization may enter into preferred provider arrangements and may issue health benefit plans associated with those arrangements. Those arrangements shall:

a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers;

b. Include mechanisms which are designed to minimize the cost of a health benefit plan. These mechanisms may include among others:

(1) The review or control of utilization of health care services; and

(2) A procedure for determining whether health care services rendered are medically necessary; and

c. Assure reasonable access to covered services available to covered persons under the preferred provider arrangement and an adequate number of preferred providers to render those health care services.

5. a. Organizations may issue health benefit plans which provide for incentives for covered persons who use the health care services of preferred providers. Such health benefit plans shall contain at least the following provisions:

(1) A provision that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, that emergency care shall be reimbursed as though the covered person had been treated by a preferred provider; and

(2) A provision which clearly identifies the differential in benefit levels for health care services of preferred providers and benefit levels for health care services of health care providers who are not preferred providers.

b. (1) Except as provided pursuant to paragraph (2) of this

subsection, if a health benefit plan provides differences in benefit levels payable to preferred providers compared to other health care providers, such differences shall be no greater than 40%, excluding deductibles, copayments, and coinsurance.

(2) With the approval of the commissioner, greater differences in benefit levels than those provided in paragraph (1) of this subsection may be permitted for mental health, substance abuse, and prescription drug benefits, and for other like benefits.

c. Health benefit plans using preferred providers shall specify in writing the procedure for resolving complaints and grievances of covered persons.

6. Organizations may place reasonable limits on the number or classes of preferred providers but there shall be no discrimination against providers on the basis of religion, race, color, national origin, age, sex or marital status.

7. Organizations complying with this act shall:

a. Be required to comply with all other applicable laws, rules and regulations of this State; and

b. Provide a quality assurance program which is appropriate to the scope of the preferred provider arrangement.

8. If an entity enters into a contract or agreement providing covered services with a health care provider, but is not engaged in activities which would require it to be licensed or to obtain a certificate of authority as an organization, as defined in this act, that entity shall file with the commissioner information describing its activities and a description of the contract or agreement it has entered into with the health care providers. The provisions of this section shall not apply to employers or to the administrators of employers' self-funded plans, who enter into contracts or agreements with health care providers for the exclusive benefit of their employees and dependents.

9. Nothing contained in any provision of this act shall be deemed to impair or otherwise affect any contractual agreements and forms which have been filed and approved by the commissioner and are in effect before the effective date of this act.

10. The commissioner may promulgate rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to enforce and administer this act.

11. This act shall take effect immediately.

STATEMENT

This bill allows insurers to enter into preferred provider arrangements with physicians, hospitals and other health care providers to lower the cost of health care services while preserving the quality of care provided. Currently, some 30 states permit preferred provider arrangements.

Allows insurers to establish preferred provider arrangements.