SENATE, No. 1439

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 19, 1996

By Senators CARDINALE, SINAGRA, Singer and Matheussen

AN ACT concerning limited health service organizations 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:

"Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the limited health service organization.

"Certified limited health service organization" means a limited health service organization that undertakes to provide or arrange for the provision of one or more limited health services or benefits to enrollees or contract holders and which is compensated on a basis that does not entail the assumption of financial risk by the organization.

"Consumer Price Index" means the medical component of the Consumer Price Index for All Urban Consumers, as reported by the United States Department of Labor, shown as an average index for the New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton region combined.

"Contract holder" means the person or organization which contracts with the limited health service organization.

"Enrollee" means a person and his dependents who are entitled to benefits provided under a limited health service organization contract.

"Evidence of coverage" means the certificate, agreement or contract issued pursuant to this act which sets forth the services or benefits to which the enrollee or contract holder is entitled.

"Licensed limited health service organization" means a limited health service organization that undertakes to provide or arrange for the provision of one or more limited health services or benefits to enrollees or contract holders and that is compensated on a basis which entails the assumption of financial risk by the organization, as defined by the Commissioner of Banking and Insurance by regulation. A licensed limited health service organization shall not include: an entity otherwise authorized or licensed pursuant to the laws of this State to provide a limited health service on a prepayment or other basis in connection with a health benefits plan; or an insurer licensed under

Title 17 of the Revised Statutes or Title 17B of the New Jersey Statutes to do the business of Banking and Insurance in this State.

"Limited health service" means a health service or benefit that may be or is provided to an enrollee or contract holder including, but not limited to, substance abuse services, vision care services, mental health services, pharmaceutical services, podiatric care services, chiropractic services, case management services, employee assistance plan services or rehabilitation services. Limited health service shall not include hospital, medical, surgical or emergency services except those provided in connection with the limited health services which are the subject of the contract or agreement with the provider.

"Net equity" means the excess of total assets over total liabilities, excluding liabilities that have been subordinated in a manner acceptable to the Commissioner of Banking and Insurance.

"Provider" means a physician, health care professional, health care facility or any other person or institution which provides services or benefits under a limited health service contract.

"Tangible net equity" means net equity reduced by the value assigned to intangible assets, including, but not limited to, goodwill, going concern value, organizational expense, start-up costs, long-term prepayments of deferred charges, nonreturnable deposits, and obligations of officers, directors, owners or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due.

2. Any person offering limited health services in a manner substantially provided for in this act shall be presumed to be subject to the provisions of the act unless the person is otherwise regulated under P.L.1973, c.337 (C.26:2J-1 et seq.), Title 17 of the Revised Statutes and Title 17B of the New Jersey Statutes.

3. a. Beginning one year after the date of enactment of this act, no person, corporation, partnership, or other entity shall operate a limited health service organization in this State which receives compensation on a basis that does not entail the assumption of financial risk, and no person shall sell, offer to sell or solicit offers to purchase or receive advance or periodic consideration for such limited health services without obtaining certification from the Commissioner of Health and Senior Services pursuant to this act.

b. A limited health service organization operating in this State on the effective date of this act which receives compensation on a basis that does not entail the assumption of financial risk, shall submit an application for certification to the commissioner within nine months of the date of enactment of this act. The organization may continue to operate during the pendency of its application, but in no case longer

than 18 months after the date of enactment of this act. In the event the application is denied, the applicant shall then be treated as a limited health service organization whose certification has been revoked pursuant to section 10 of this act. Nothing in this subsection shall operate to impair any contract which was entered into before the effective date of this act.

c. The certification shall be valid for a period of three years. An organization shall apply to the Department of Health and Senior Services for renewal of its certification in accordance with regulations adopted by the commissioner.

4. Each application for certification to operate a limited health service organization shall be made to the Commissioner of Health and Senior Services on a form prescribed by the commissioner, shall be certified by an officer or authorized representative of the applicant and shall include the following:

a. A copy of the applicant's basic organizational document, such as the articles of incorporation, if a corporation, articles of association, partnership agreement, management agreement, trust agreement, or other applicable documents and all amendments to such documents;

b. A copy of the executed bylaws, rules and regulations, or similar documents, regulating the conduct of the applicant's internal affairs;

c. A list, in a form approved by the commissioner, of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to, the members of the board of directors, executive committee or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire 10% or more of the voting securities of the applicant; in the case of a partnership or association, the names of the partners or members; each person who has loaned funds to the applicant for the operation of its business; and a statement of any criminal convictions or enforcement or regulatory action taken against any person who is a member of the board, the executive committee or other governing board or committee, or the principal officers;

d. A statement generally describing the applicant, its facilities, personnel, and the limited health services to be offered by the organization;

e. A copy of the standard form of any contract made or to be made between the applicant and any providers relative to the provision of limited health services to enrollees or contract holders;

f. A copy of the form of any contract made or to be made between the applicant and contract holders;

g. A copy of the applicant's most recent financial statements audited by an independent certified public accountant;

h. A list of the persons who are to provide the limited health services, and the geographical area in which they are located and in which the services are to be performed;

i. A list of any affiliate of the applicant which provides services to the applicant in this State and a description of any material transaction between the affiliate and the applicant;

j. A description of the services or benefits to be offered or proposed to be offered by the organization;

k. A description of the proposed method of marketing;

l. A description of the complaint and appeals procedures instituted by the applicant;

m. A description of the quality assurance and utilization review procedures established by the applicant;

n. A description of the means which will be utilized to assure the availability and accessibility of health services to the enrollees;

o. A statement setting forth the means by which the organization is to be compensated for its services; and

p. Such other information as may be required by the commissioner.

5. Following receipt of an application for certification, the Commissioner of Health and Senior Services shall review it in consultation with the Commissioner of Banking and Insurance and notify the applicant of any deficiencies contained therein.

a. The Commissioner of Health and Senior Services shall issue a certification to a limited health service organization in a timely manner, if the commissioner finds that the organization meets the standards provided for in this act, including, but not limited to:

(1) All of the material required by section 4 of this act has been filed;

(2) The persons responsible for conducting the applicant’s affairs are competent, trustworthy and possess good reputations, and have had appropriate experience, training and education;

(3) The persons who are to perform the health care services are properly qualified;

(4) The organization has demonstrated the potential ability to assure that limited health services will be provided in a manner which will assure the availability and accessibility of the services;

(5) The standard forms of provider agreements to be used by the organization are acceptable;

(6) The organization has adequate arrangements for an ongoing quality assurance program;

(7) The organization has adequate procedures established to develop, compile, evaluate and report statistics, patterns of utilization and the availability and accessibility of its services, as required by the commissioner by regulation; and

(8) The organization's contracts to provide services do not entail

or will not result in the assumption of financial risk by the organization.

b. If certification is denied, the commissioner shall notify the applicant and shall set forth the reasons for the denial in writing. The applicant may request a hearing by notice to the commissioner within 30 business days of receiving the notice of denial. Upon such denial, the applicant shall submit to the commissioner a plan for bringing the limited health service organization into compliance or providing for the closing down of its business.

6. a. A certified limited health service organization, unless otherwise provided for in this act, shall not materially modify any matter or document furnished to the Commissioner of Health and Senior Services pursuant to section 4 of this act, unless the organization files with the commissioner at least 60 days prior to use or adoption of the change, a notice of the change or modification, together with such information as may be required by the commissioner to explain the change or modification. If the commissioner fails to affirmatively approve or disapprove the change or modification within 60 days of submission of the notice, the notice of modification shall be deemed approved. The commissioner may extend the 60-day review period for not more than an additional 30 days by giving written notice of the extension before the expiration of the 60-day period. If a change or modification is disapproved, the commissioner shall notify the organization in writing and specify the reason for the disapproval.

b. Prior to entering into any contract with a contract holder, an organization shall file with the commissioner, for his approval, any benefits which are offered or proposed to be offered under the plan, as well as any modifications which may be made thereto. The filing shall be made no later than 60 days prior to the date that the benefits are intended to be in force. If the benefits are not disapproved prior to the effective date by the commissioner, the benefits shall be deemed approved.

7. A certified limited health service organization may contract with any person to provide some or all of the services it normally performs in providing limited health services and supplemental services to its enrollees and contract holders, but no such contract shall be made effective until it has been approved by the Commissioner of Health and Senior Services. The organization may contract for construction or use of facilities, marketing, enrollment, administration and for services from additional providers.

Before entering into a contract, the organization shall provide the commissioner with notice of the contract and such supporting documentation as the commissioner determines necessary. If the

commissioner does not affirmatively approve or disapprove the contract within 60 days of the date of submission, the contract shall be deemed approved. The commissioner may extend the 60-day review period for not more than 30 additional days by giving written notice of the extension before the expiration of the initial 60-day period. If the contract is disapproved, the commissioner shall notify the organization in writing and specify the reasons for disapproval.

8. Every contract holder and enrollee shall be issued an evidence of coverage by the certified limited health service organization, which shall contain a clear and complete statement of:

a. The limited health services to which each enrollee is entitled;

b. Any limitation to which the services or benefits are subject, including, but not limited to, exclusions or other charges, if applicable;

c. Where information is available as to where and how health services may be obtained; and

d. The method for resolving complaints by enrollees and contract holders.

If any part of the services or benefits offered under the contract are subcontracted, the document issued to the contract holder and enrollee by the organization may contain the information required herein on behalf of the subcontractor.

9. A certified limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints which are initiated by enrollees, contract holders and providers, in accordance with minimum standards established by the Commissioner of Health and Senior Services by regulation. The complaint procedure shall be in writing and filed with the commissioner, and shall be made available to providers as well as contract holders and enrollees as provided for in this act.

10. The Commissioner of Health and Senior Services may suspend or revoke a certification issued to a limited health service organization pursuant to this act upon his determination that:

a. The organization is operating significantly in contravention of its basic organizational document;

b. The organization has failed to provide the services for which it has been certified or which are in contravention of the contract or contracts filed with the commissioner;

c. The organization is unable to maintain the standards of care as set forth by the commissioner by regulation;

d. The organization has failed to implement in a reasonable manner the complaint system required to be established by this act;

e. The continued operation of the organization would be hazardous to the health and welfare of its enrollees; or

f. The organization has otherwise failed to comply with this act.

11. If the Commissioner of Health and Senior Services has cause to believe that grounds exist for the suspension or revocation of the certification issued to a limited health service organization, he shall notify the organization in writing, specifically stating the grounds for suspension or revocation and fixing a time for a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). If the certification is revoked, the organization shall submit a plan to the commissioner within 15 days of the revocation, for the winding up of its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of its business. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

12. A certified limited health service organization shall pay to the Commissioner of Health and Senior Services such application and annual fees as established by the commissioner by regulation.

13. a. The Commissioner of Health and Senior Services may, upon notice and hearing, levy an administrative penalty in an amount not less than $1,000 nor more than $30,000 for each violation, per contract or enrollee, by a certified limited health service organization. Penalties imposed by the commissioner pursuant to this section may be in lieu of, or in addition to, suspension or revocation of a certification pursuant to this act. A penalty may be recovered in a summary proceeding pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. If the commissioner believes that any violation of this act has occurred or is threatened, the commissioner may give notice to the organization, its representatives, or any other persons who appear to be involved in the alleged violation. The commissioner may arrange a conference with the alleged violators or their authorized representatives to ascertain the facts relating to the alleged violation. In the event that it appears that a violation has occurred or is threatened, the commissioner may implement the necessary measures to correct or prevent the violation. Appeals under this section shall be conducted pursuant to the "Administrative Procedure Act." P.L.1968, c.410 (C.52:14B-1 et seq.)

14. a. The Commissioner of Health and Senior Services may issue an order directing a certified limited health service organization to cease and desist from engaging in any act or practice which is in violation of the provisions of this act. The order shall be subject to

review pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

b. In the event of noncompliance with a cease and desist order issued pursuant to subsection a. of this section, or if the commissioner elects not to issue a cease and desist order in the case of a violation of any provision of this act, the commissioner may institute a proceeding to obtain injunctive relief, in accordance with the applicable procedures provided in the Rules of Court.

15. a. Beginning one year after the date of enactment of this act, no person, corporation, partnership, or other entity shall operate a limited health service organization in this State which receives compensation on a basis that entails the assumption of financial risk, and no person shall sell, offer to sell or solicit offers to purchase or receive advance or periodic consideration for such limited health services without obtaining a license from the Commissioner of Banking and Insurance pursuant to this act.

b. A limited health service organization operating in this State on the effective date of this act which receives compensation on a basis that entails the assumption of financial risk, shall submit an application for licensure to the Commissioner of Banking and Insurance within nine months of the date of enactment of this act. The organization may continue to operate during the pendency of its application, but in no case longer than 18 months after the date of enactment of this act. In the event the application is denied, the applicant shall then be treated as a limited health service organization whose license has been revoked pursuant to section 31 of this act. Nothing in this subsection shall operate to impair any contract which was entered into before the effective date of this act.

16. An application for a license to operate a limited health service organization shall be made both to the Commissioner of Banking and Insurance and the Commissioner of Health and Senior Services on a form prescribed by regulation, shall be certified by an officer or authorized representative of the applicant, and shall include the following:

a. A copy of the applicant’s basic organizational document, such as the articles of incorporation, if a corporation, articles of association, partnership agreement, management agreement, trust agreement, or other applicable documents and all amendments to such documents;

b. A copy of the executed bylaws, rules and regulations, or similar documents, regulating the conduct of the applicant’s internal affairs;

c. A list, in a form established by regulation, of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to, the members of the board of directors, executive

committee or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire 10% or more of the voting securities of the applicant; in the case of a partnership or association, the names of the partners or members; each person who has loaned funds to the applicant for the operation of its business; and a statement of any criminal convictions or enforcement or regulatory action taken against any person who is a member of the board, the executive committee or other governing board or committee, or the principal officers;

d. A statement generally describing the applicant, its facilities, personnel, and the limited health services to be offered by the organization;

e. A copy of the standard form of any contract made or to be made between the applicant and any providers relative to the provision of limited health services to enrollees or contract holders;

f. A copy of the form of any contract made or to be made between the applicant and contract holders or prospective contract holders;

g. A copy of the applicant’s most recent financial statements audited by an independent certified public accountant. If the financial affairs of the applicant's parent company are audited by an independent certified public accountant, but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, shall satisfy this requirement unless the Commissioner of Banking and Insurance determines that additional or more recent financial information is required for the proper administration of this act;

h. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital and any other sources of funding and provisions for contingencies;

i. A list of any affiliate of the applicant which provides services to the applicant in this State and a description of any material transaction between the affiliate and the applicant;

j. The means by which the organization is to be compensated for its services and benefits and a schedule of rates and charges;

k. A description of the proposed method of marketing;

l. A description of the complaint and appeals procedures instituted by the applicant;

m. A description of the quality assurance and utilization review procedures established by the applicant;

n. A power of attorney, duly executed by the applicant, if not domiciled in this State, appointing the Commissioner of Banking and Insurance and his successors in office as the true and lawful attorney of the applicant in and for this State upon whom all lawful process in

any legal action or proceeding against the organization on a cause of action arising in this State may be served;

o. A description of the means which will be utilized to assure the availability and accessibility of the health services to enrollees.

p. A plan, in the event of insolvency, for continuation of the services to be provided for under the contract;

q. A list of the persons who are to provide the limited health services, and the geographical area in which they are located and in which the services are to be performed;

r. A description of the services or benefits to be offered or proposed to be offered by the organization; and

s. Such other information as may be required by the Commissioner of Banking and Insurance or the Commissioner of Health and Senior Services.

17. Following receipt of an application, the Commissioner of Banking and Insurance shall review it in consultation with the Commissioner of Health and Senior Services and notify the applicant of any deficiencies contained therein.

a. The Commissioner of Banking and Insurance shall issue a license to a limited health service organization in a timely manner, if the commissioner finds that the organization meets the standards provided for in this act, including, but not limited to:

(1) All of the material required by section 16 of this act has been filed;

(2) The persons responsible for conducting the applicant's affairs are competent, trustworthy and possess good reputations, and have had appropriate experience, training and education;

(3) The applicant is financially sound and may reasonably be expected to meet its obligations to enrollees and the contract holder. In making this determination, the commissioner shall consider:

(a) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments and other enrollee charges used in connection therewith;

(b) The adequacy of working capital, other sources of funding and provisions for contingencies;

(c) Whether any deposit of cash or securities, or any other evidence of financial protection submitted meets the requirements set forth in this act or by the commissioner; and

(d) The applicant's rates and rating methodology;

(4) Any deficiencies identified by the commissioner have been corrected; and

(5) Any other factors determined by the commissioner to be relevant have been addressed to the satisfaction of the commissioner.

b. The Commissioner of Banking and Insurance shall refer all standard forms of provider agreements and quality assurance programs

to be used by the licensed limited health service organization to the Commissioner of Health and Senior Services for review and approval. The Commissioner of Insurance shall rely principally upon the decision of the Commissioner of Health and Senior Services regarding provider agreements and quality assurance programs in determining whether the applicant for a license:

(1) Has demonstrated the potential ability to assure that limited health services will be provided in a manner that will assure the availability and accessibility of the services;

(2) Has adequate arrangements for an ongoing quality assurance program;

(3) Has established acceptable standard forms for provider agreements to be used by the organization;

(4) Has demonstrated that the persons who are to perform the health care services are properly qualified; and

(5) Has adequate procedures established to develop, compile, evaluate and report statistics, patterns of utilization and the availability and accessibility of its services, as required by the commissioner by regulation.

c. If the license is denied, the commissioner shall notify the applicant and shall set forth the reasons for the denial in writing. The applicant may request a hearing by notice to the commissioner within 30 business days of receiving the notice of denial. Upon such denial, the applicant shall submit to the commissioner a plan for bringing the limited health service organization into compliance or providing for the closing down of its business.

18. a. A licensed limited health organization, unless otherwise provided for in this act, shall not materially modify any matter or document furnished to the Commissioner of Banking and Insurance pursuant to section 16 of this act, including any change in rates or charges offered or to be offered under the contract, unless the organization files with the commissioner at least 60 days prior to use or adoption of the change, a notice of the change or modification, together with such information as may be required by the commissioner to explain the change or modification. If the commissioner fails to affirmatively approve or disapprove the change or modification within 60 days of submission of the notice, the notice of modification shall be deemed approved. The commissioner may extend the 60-day review period for not more than an additional 30 days by giving written notice of the extension before the expiration of the 60-day period. If a change or modification is disapproved, the commissioner shall notify the organization in writing and specify the reason for the disapproval.

b. Charges under any contract shall be established in accordance with sound actuarial principles and shall not be excessive, inadequate,

or unfairly discriminatory. If at any time the commissioner finds that the rates or benefits offered under the plan are inadequate, excessive, or unfairly discriminatory, he may order that they be rescinded or modified. If the commissioner orders that the plans be rescinded or modified, he shall notify the organization and specify the reasons for the order. The organization may, within 30 business days of receiving the order, request a hearing, which shall be held no later than 45 days after the receipt of the request by the commissioner.

c. Prior to entering into any contract with a contract holder, an organization shall file with the commissioner, for his approval, any services or benefits which are offered or proposed to be offered under the plan, as well as any modifications which may be made thereto. The filing shall be made no later than 60 days prior to the date that the services or benefits are intended to be in force. The commissioner shall either approve the services or benefits or state in writing his reasons for their disapproval within 60 days of receipt of the filing.

19. Any insurer, hospital, medical or health service corporation or health maintenance organization which is not otherwise authorized to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the Commissioner of Banking and Insurance such information as shall be required by the commissioner pursuant to section 16 of this act.

20. A licensed limited health service organization may:

a. Purchase, lease, construct, renovate, operate and maintain such facilities, ancillary equipment and property which may be required for its principal office or for any other purposes deemed necessary in the business transactions of the organization;

b. Borrow money;

c. Loan funds to any person for the purpose of acquiring or constructing facilities or in furtherance of a program providing services to enrollees, or for any other purpose reasonably related to the business of the organization;

d. Furnish limited health services to enrollees or contract holders through providers who are under contract with or employed by the organization;

e. Contract with any person for the performance of certain functions such as marketing, enrollment and administration;

f. Contract with an insurer licensed in this State for the provision of Banking and Insurance, indemnity coverage, or reimbursement against the cost of services provided by the organization; and

g. In addition to basic services provided by the organization to contract holders and enrollees, may provide:

(1) Additional services as approved by the Commissioner of Banking and Insurance, in consultation with the Commissioner of

Health and Senior Services;

(2) Indemnity benefits covering urgent care or emergency services;

(3) Coverage for services from providers other than participating providers, when referred in accordance with the terms of the contract; and

(4) Any other function provided by law, in the organization's articles of incorporation or in the license.

21. A licensed limited health service organization may contract with any person to provide some or all of the services it normally performs in providing limited health services and supplemental services to its enrollees and contract holders, but no such contract shall be made effective until it has been approved by the Commissioner of Banking and Insurance. The services may include consultative and administrative services. In granting approval, the commissioner may impose any limitations he deems necessary for the protection of the organization's enrollees and contract holders, and the actual and potential effect of providing such services on the financial condition of the organization. Before entering into such a contract, the organization shall provide the commissioner with notice of the contract and such supporting documentation as the commissioner determines necessary. If the commissioner does not affirmatively approve or disapprove the contract within 60 days of the date of submission, the contract shall be deemed approved. The commissioner may extend the 60-day review period for not more than 30 additional days by giving written notice of the extension before the expiration of the initial 60-day period. If the contract is disapproved, the commissioner shall notify the organization in writing and specify the reasons for disapproval.

22. Every contract holder and enrollee shall be issued an evidence of coverage by the licensed limited health service organization, which shall contain a clear and complete statement of:

a. The limited health services or benefits to which each enrollee is entitled;

b. Any limitation to which the services are subject, including, but not limited to, exclusions, deductibles, copayments or other charges;

c. Where information is available as to where and how health services may be obtained; and

d. The method for resolving complaints by enrollees and contract holders.

If any part of the services or benefits offered under the contract are subcontracted, the document issued to the contract holder and enrollee by the organization may contain the information required herein on behalf of the subcontractor.

23. A licensed limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints which are initiated by enrollees, contract holders and providers, in accordance with minimum standards established by the Commissioner of Banking and Insurance by regulation. The complaint procedure shall be in writing and filed with the commissioner, and shall be made available to providers as well as contract holders and enrollees as provided for in this act.

24. a. A licensed limited health service organization which is organized under the laws of this State shall be treated as a domestic insurer for the purposes of P.L.1970, c.22 (C.17:27A-1 et seq.).

b. An organization shall be subject to the provisions of N.J.S.17B:30-1 et seq.

c. The capital, surplus and other funds of an organization shall be invested in accordance with the provisions of N.J.S.17B:20-1 et seq. and guidelines established by the commissioner by regulation.

25. The Commissioner of Banking and Insurance may conduct an examination of a licensed limited health service organization as often as he deems necessary in order to protect the interests of providers, contract holders, enrollees, and the residents of this State. An organization shall make its relevant books and records available for examination by the commissioner, and retain its records in accordance with a schedule established by the commissioner by regulation. The reasonable expenses of the examination shall be borne by the organization being examined. In lieu of such examination, the commissioner may accept the report of an examination made by the commissioner of another state.

26. All licensed limited health service organization contracts with providers or with entities which subcontract for the provision of limited health services shall contain the following terms and conditions:

a. In the event that the organization fails to pay for limited health services for any reason whatsoever, including, but not limited to, insolvency or breach of contract, neither the contract holder nor the enrollee shall be liable to the provider for any sums owed to the provider under the contract.

b. No provider, agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the contract holder or enrollee sums owed to the provider by the organization, but this shall not be construed to prohibit collection of uncovered charges consented to or lawfully owed to providers by a contract holder or enrollee.

27. a. Except as provided in subsection b. of this section, each

licensed limited health service organization shall, at all times, have and maintain tangible net equity as established by the Commissioner of Banking and Insurance by regulation, which amount may vary in accordance with the size of the organization, the services provided by the organization and the financial liabilities of the organization.

b. An organization which has uncovered expenses in excess of $50,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity in an amount established by the commissioner by regulation, in addition to the tangible net equity required by subsection a. of this section.

c. The commissioner may adjust the amounts required in subsection b. of this section annually, by regulation, in accordance with changes in the Consumer Price Index.

28. a. A licensed limited health service organization shall deposit with the Commissioner of Banking and Insurance or with an entity or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner in an amount established by the commissioner, by regulation, which amount shall be adjusted annually by the commissioner, by regulation, in accordance with changes in the Consumer Price Index, plus 25% of the tangible net equity required by section 27 of this act; except that the deposit shall not be required to exceed $100,000, which amount may be adjusted by the commissioner annually in accordance with changes in the Consumer Price Index. The deposit shall be deemed an admitted asset of the organization in the determination of tangible net equity.

b. All income from deposits shall be an asset of the organization. An organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value, except that a security may not be substituted unless it has been approved by the commissioner.

c. Amounts on deposit shall be used to protect the interests of the organization's enrollees in the State and to assure continuation of limited health services to enrollees of an organization which is in rehabilitation or liquidation. If an organization is placed in rehabilitation or liquidation, the deposit shall be treated as an asset subject to the provisions of N.J.S.17B:32-1 et seq.

d. The commissioner may, by regulation, adjust the amount of required net worth that an organization may have in order to provide adequate protection against contingencies affecting the organization's financial position which are not fully covered by reserves and other liabilities and supporting assets.

29. A licensed limited health service organization shall maintain in

force a fidelity bond in its own name on its officers and employees, in an amount established by the Commissioner of Banking and Insurance by regulation. In lieu of the bond, the organization may deposit with the commissioner cash or securities or other investments approved by the commissioner.

30. A licensed limited health service organization shall file an annual report with the Commissioner of Banking and Insurance, on or before March 1 of each year, attested to by at least two principal officers, which covers the preceding calendar year. The report shall be on a form prescribed by the commissioner and shall include:

a. A financial statement of the organization, including its balance sheet, income statement and statement of changes in financial position for the preceding year, certified by an independent public accountant, or a consolidated audited financial statement of its parent company certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the organization;

b. The number of enrollees at the beginning of the year, the number of enrollees as of the end of the year, and the number of enrollments during the year;

c. At the discretion of the commissioner, a statement by a qualified actuary setting forth his opinion as to the adequacy of reserves; and

d. Any other information relating to the performance of the organization as may be required by the commissioner.

The commissioner may assess a fine of up to $100 per day for each day a required report is late. The commissioner may require the submission of additional reports from time to time, as he deems necessary.

31. The Commissioner of Banking and Insurance may suspend or revoke the license issued to a limited health service organization pursuant to this act upon his determination that:

a. The organization is operating significantly in contravention of its basic organizational document;

b. The organization has issued an evidence of coverage or used rates or charges which do not comply with the requirements of this act;

c. The organization is unable to fulfill its obligations to enrollees or prospective enrollees;

d. The tangible net equity of the organization is less than that required by this act, or the organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

e. The organization has failed to implement in a reasonable manner the complaint system required to be established by this act;

f. The continued operation of the organization would be hazardous to the health and welfare of its enrollees;

g. The organization has failed to file any report required pursuant to this act;

h. The organization has failed to provide the services for which it has been licensed or which are in contravention of the contract or contracts filed with the commissioner;

i. The organization is unable to maintain the standards of care as set forth by regulation; or

j. The organization has otherwise failed to comply with this act.

32. If the Commissioner of Banking and Insurance has cause to believe that grounds exist for the suspension or revocation of a license, he shall notify the licensed limited health service organization in writing, specifically stating the grounds for suspension or revocation and fixing a time for a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). If a license is revoked, the organization shall submit a plan to the commissioner within 15 days of the revocation, for the winding up of its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of its business. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

33. The Commissioner of Banking and Insurance may require, in connection with the plan for insolvency required pursuant to subsection p. of section 16 of this act, that a licensed limited health service organization maintain insurance to cover the expenses to be paid for continued benefits following a determination of insolvency, or make other arrangements to ensure that benefits are continued for the period determined in the insolvency plan.

34. Any rehabilitation, liquidation or conservation of a licensed limited health service organization shall be subject to the provisions of N.J.S.17B:32-1 et seq. and shall be conducted under the supervision of the Commissioner of Banking and Insurance; except that the commissioner shall have the authority to regulate any licensed limited health service organization doing business in this State as a domestic insurer. The commissioner may apply for an order directing him to rehabilitate, liquidate, reorganize or conserve an organization upon any one or more applicable grounds as stated for insurers in N.J.S.17B:32-1 et seq. or any other provision of Title 17B of the New Jersey Statutes or when in his opinion the organization fails to satisfy the requirements for the issuance of a license relating to solvency or the requirements for solvency protection as set forth in this act.

35. If an order of rehabilitation issued pursuant to this act directs or provides for the continued operation of the licensed limited health service organization, including the receipt of payments from, and the provision of limited health services to enrollees, the order may authorize the rehabilitator to make the payments necessary for continued operation, including those expenses necessary for the conduct of the rehabilitation.

36. In the event that an order of rehabilitation or liquidation is granted, the order may enjoin providers from billing enrollees and their beneficiaries for health care services provided. In the course of a rehabilitation proceeding, the court may allow reformation of enrollee and provider contracts, or other restructuring of outstanding liabilities, or transfer of the business to another licensed limited health service organization. A primary goal of the restructuring or transfer shall be the provision of uninterrupted services to enrollees of the organization. In the course of a rehabilitation proceeding, a plan for settling the claims of general creditors shall not be deemed to be inequitable or to constitute preferential treatment if the amount of reimbursement for an outstanding claim depends, in part, on the estimated increase or decrease in future or prior claims of the creditor.

37. A licensed limited health service organization shall not be subject to the "New Jersey Life and Health Insurance Guaranty Association Act," P.L.1991, c.208 (C.17B:32A-1 et seq.), and the New Jersey Life and Health Insurance Guaranty Association established pursuant to that act shall not provide protection to any individuals entitled to receive limited health services from a licensed limited health service organization.

38. A licensed limited health service organization shall pay to the Commissioner of Banking and Insurance such application, examination and annual fees as established by the commissioner by regulation.

39. a. The Commissioner of Banking and Insurance may, upon notice and hearing, levy an administrative penalty in an amount not less than $1,000 nor more than $30,000 for each violation per contract or enrollee by a licensed limited health service organization. Penalties imposed by the commissioner pursuant to this section may be in lieu of, or in addition to, suspension or revocation of a license pursuant to this act. A penalty may be recovered in a summary proceeding pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. If the commissioner believes that any violation of this act has occurred or is threatened, the commissioner may give notice to the licensed limited health service organization, its representatives, or any other persons who appear to be involved in the alleged violation. The

commissioner may arrange a conference with the alleged violators or their authorized representatives to ascertain the facts relating to the alleged violation. In the event that it appears that a violation has occurred or is threatened, the commissioner may implement the necessary measures to correct or prevent the violation. Appeals under this section shall be conducted pursuant to the "Administrative Procedure Act." P.L.1968, c.410 (C.52:14B-1 et seq.)

40. a. The Commissioner of Banking and Insurance may issue an order directing a licensed limited health service organization to cease and desist from engaging in any act or practice which is in violation of the provisions of this act. The order shall be subject to review pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

b. In the event of noncompliance with a cease and desist order issued pursuant to subsection a. of this section, or if the commissioner elects not to issue a cease and desist order in the case of a violation of any provision of this act, the commissioner may institute a proceeding to obtain injunctive relief, in accordance with the applicable procedures provided in the Rules of Court.

41. Any data or information relating to the diagnosis, treatment or health of an enrollee or prospective enrollee obtained by a certified or licensed limited health service organization from the contract holder, enrollee, prospective enrollee or any provider shall be confidential and shall not be disclosed to any person except:

a. To the extent that it may be necessary to carry out the purposes of this act;

b. Upon the express consent of the enrollee or prospective enrollee;

c. Pursuant to statute or court order for the production of evidence or the discovery thereof; or

d. In the event of a claim or litigation between an enrollee or a prospective enrollee and the organization wherein such data or information is relevant. An organization shall be entitled to claim any statutory privilege against disclosure which the provider who furnished the information to the organization is entitled to claim.

42. The Commissioner of Health and Senior Services and the Commissioner of Banking and Insurance shall consult with the Commissioner of Human Services with respect to the certification or licensure, as the case may be, of any limited health service organization which contracts with or is to contract with the Department of Human Services for the provision of limited health services.

43. Any certified limited health services organization which intends to change the means by which it receives compensation so that it will be compensated on a basis that entails the assumption of financial risk, shall notify the Commissioner of Health and Senior Services and make application for licensure to the Commissioner of Banking and Insurance.

44. The Commissioner of Banking and Insurance shall retain all the powers granted to him by Title 17 of the Revised Statutes and Title 17B of the New Jersey Statutes with respect to the licensure and regulation of limited health service organizations.

45. The Commissioners of Health and Senior Services and Banking and Insurance, respectively, shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.

46. This act shall take effect 180 days after enactment, but the Commissioners of Health and Senior Services and Banking and Insurance may take such anticipatory administrative action in advance of the effective date as shall be necessary for the implementation of the act.

STATEMENT

This bill provides for the regulation by the Departments of Health and Senior Services and Banking and Insurance of limited health service organizations.

A limited health service organization is an entity that undertakes to provide or arrange for the provision of one or more limited health services or benefits to enrollees or contract holders. The organization may be compensated on a basis that does not entail the assumption of financial risk by the organization or on a basis which entails the assumption of financial risk by the organization, as defined by the Commissioner of Banking and Insurance by regulation. The bill provides that those organizations that do not assume financial risk shall obtain certification from the Department of Health and Senior Services and those organizations that do assume financial risk shall be licensed by the Department of Banking and Insurance and treated as a domestic insurer.

The bill defines "limited health service" as a health service or benefit including, but not limited to, substance abuse services, vision care services, mental health services, pharmaceutical services, podiatric care services, chiropractic services, case management services, employee assistance plan services or rehabilitation services. Limited

health service does not include hospital, medical, surgical or emergency services except those provided in connection with the limited health services which are the subject of the contract or agreement with the provider.

Regulates limited health service organizations.