SENATE, No. 1929

STATE OF NEW JERSEY

INTRODUCED MARCH 20, 1997

By Senators SINGER and RICE

AN ACT providing for patient access to emergency health care and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that federal Medicare law requires emergency physicians and other health care providers to evaluate, treat, and stabilize a person seeking treatment in a hospital emergency department, and specifically prohibits these providers from delaying this treatment in order to determine the person's health insurance coverage; however, some managed care plans regularly deny coverage for emergency health care provided to covered persons because of a failure to obtain prior authorization for the care from the managed care plan or based upon a retrospective determination that the medical condition identified through the federally required evaluation did not constitute an emergency medical condition, and these denials impose a significant financial burden on the covered person as well as the providers of emergency health care.

2. As used in this act:

"Carrier" means an insurance company, health, hospital or medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State.

"Covered person" means a person on whose behalf a managed care plan is required to pay benefits under the terms and conditions of the plan.

"Emergency medical condition" means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing that person's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"Emergency health care" means health care items and services furnished in a hospital emergency department and ancillary services routinely available to that department, to the extent that they are

required to evaluate and treat an emergency medical condition until the condition is stabilized.

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits for covered services and is delivered or issued for delivery in this State by or through a carrier or another entity.

"Managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care to covered persons by arrangements with participating health care 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. A managed care plan may be issued by or through a carrier which assumes financial risk for the plan or another entity that provides and finances health benefits for a covered person.

"Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before a person can be transferred in compliance with the provisions of section 1867 of the federal Social Security Act (42 U.S.C. §1395dd).

3. A managed care plan shall be required to cover emergency health care provided to a covered person:

a. without regard to whether or not the health care provider providing the emergency health care has a contractual or other arrangement with the managed care plan to provide the care to the covered person; and

b. without regard to whether the managed care plan has approved a request for prior authorization for the emergency health care.

4. a. If a covered person receives emergency health care from a hospital emergency department pursuant to a screening evaluation conducted by a treating physician or other emergency department personnel, and, as a result of the screening evaluation, the treating physician or other emergency department personnel identify other health care items or services that are promptly needed by the covered person, the managed care plan shall provide immediate availability for the treating physician or other emergency department personnel to obtain prior authorization by phone, seven days a week, 24 hours a day, for the provision of those health care items or services.

b. A managed care plan shall be deemed to have approved a request for a prior authorization for promptly needed health care items and services if:

(1) the treating physician or other personnel have attempted to contact the designated person at the managed care plan to obtain prior authorization to provide, or to provide a referral for, the health care items and services to the covered person, and access to the designated

person has not been provided as required in subsection a. of this section; or

(2) the designated person has not denied the request for prior authorization within 30 minutes after the time that the request was made.

c. If a participating physician at the managed care plan or another person authorized by the plan to make prior authorization determinations for the plan refers a covered person to a hospital emergency department for evaluation or treatment, the managed care plan shall be deemed to have approved a request for prior authorization of the health care items and services reasonably provided to the covered person pursuant to the referral.

d. Approval of a request for a prior authorization, including a deemed approval pursuant to subsections a., b. and c. of this section, shall be treated as an approval of any health care items and services required to treat the medical condition which is identified pursuant to an emergency screening evaluation. A managed care plan shall not subsequently deny or reduce payment for an item or service provided pursuant to the approval unless the approval was based on fraudulent information about the covered person's medical condition.

5. a. A managed care plan shall determine and make prompt payment in a reasonable and appropriate amount for emergency health care provided to a covered person, including services required under section 1867 of the federal Social Security Act (42 U.S.C. §1395dd).

b. A managed care plan shall not impose a cost-sharing obligation on a covered person for emergency health care that is provided in a hospital emergency department which requires the covered person to pay out-of-pocket a greater portion of the cost for the emergency health care than for comparable health care items and services which are provided in a different setting.

c. Notwithstanding the provisions of subsection b. of this section to the contrary, a managed care plan may impose a reasonable copayment on a covered person for the purpose of deterring inappropriate use of a hospital emergency department, as determined in accordance with regulations adopted by the Commissioner of Health and Senior Services.

6. a. A managed care plan that violates the provisions of this act shall be liable to a civil penalty in an amount to be determined by the Commissioner of Health and Senior Services, up to a maximum of the following:

(1) $10,000 for each violation;

(2) three times the amount that the managed care plan would have paid for health care items and services if the plan had not violated the provisions of this act; or

(3) $1,000,000, in the case of repeated and substantial violations of the provisions of this act.

The penalty shall be sued for and collected in the name of the commissioner pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. In determining the civil penalty to be imposed pursuant to subsection a. of this section, the commissioner shall consider whether a managed care plan has taken corrective action with respect to its violation of the provisions of this act, such as making a payment for health care items and services for which coverage or payment was denied in violation of section 4 of this act, or establishing policies and procedures to prevent a recurrence of the violation.

c. The commissioner may make a payment to a covered person or health care provider, as appropriate, from a penalty collected pursuant to subsection a. of this section, in an amount equal to the amount that the managed care plan would have paid for a health care item or service if the managed care plan had not denied coverage or payment for the health care item or service in violation of the provisions of this act.

7. The Commissioner of Health and Senior Services, in consultation with the Commissioner of Banking and Insurance and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to carry out the provisions of this act.

8. This act shall take effect on the 180th day after the date of enactment, except that the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

STATEMENT

This bill establishes a uniform definition of an emergency medical condition that is based upon the prudent layperson standard for all managed care plans in this State. The bill is intended to prevent managed care plans from denying coverage for legitimate emergency health care after the fact.

The bill requires that a managed care plan:

-- cover emergency health care provided to a covered person without regard to whether or not the provider providing the emergency health care has a contractual or other arrangement with the managed care plan to provide the care to the covered person, and without regard to whether the managed care plan has approved a request for prior authorization for the emergency health care;

-- determine and make prompt payment in a reasonable and appropriate amount for emergency health care, including services required to be provided in accordance with section 1867 of the federal Social Security Act (42 U.S.C. §1395dd); and

-- provide immediate availability for hospital emergency department personnel to obtain prior authorization by phone, seven days a week, 24 hours a day, for the provision of health care items and services identified by the physician or other emergency department personnel, other than emergency health care, that are promptly needed by the covered person.

Under this bill, a managed care plan is deemed to have approved a request for a prior authorization for promptly needed health care items and services if:

-- the treating physician or other personnel have attempted to contact the designated person at the managed care plan to obtain prior authorization to provide, or to provide a referral for, the health care items and services to the covered person, and access to the designated person has not been provided as required in the bill, or

-- the designated person has not denied the request for prior authorization within 30 minutes after the time the request was made.

The bill further provides that if a participating physician at the managed care plan or another person authorized by the managed care plan to make prior authorization determinations for the plan refers a covered person to a hospital emergency department for evaluation or treatment, the managed care plan shall be deemed to have approved a request for prior authorization of the health care items and services reasonably provided to the covered person pursuant to the referral. Approval of a request for a prior authorization, including a deemed approval, shall be treated as an approval of any health care items and services required to treat the medical condition identified pursuant to an emergency screening evaluation. A managed care plan shall not subsequently deny or reduce payment for a health care item or service provided pursuant to the approval unless the approval was based on fraudulent information about the covered person's medical condition.

The bill provides for a civil penalty for violations of the bill and authorizes the Commissioner of Health and Senior Services to make a payment, from any penalty collected, to a covered person or health care provider, as appropriate, in an amount equal to the amount the managed care plan would have paid for a health care item or service if the plan had not denied coverage or payment for the health care item or service in violation of the bill.

The bill prohibits a managed care plan from imposing a cost-sharing obligation on a covered person for emergency health care that is provided in a hospital emergency department which requires the covered person to pay out-of-pocket a greater portion of the cost for the emergency health care than for comparable health care items and

services which are provided in a different setting; however, a managed care plan may impose a reasonable copayment on a covered person for the purpose of deterring inappropriate use of a hospital emergency department, as determined in accordance with regulations adopted by the Commissioner of Health and Senior Services.

The bill takes effect on the 180th day after the date of enactment, except that the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance as shall be necessary to implement the bill.

Prohibits managed care plans from retrospectively denying coverage for legitimate emergency health care.