26:2H-18.24

LEGISLATIVE HISTORY CHECKLIST
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NJSA: 26:2H-18.24 et al (Health care cost containment)

LAWS OF: 1991 **CHAPTER:** 187

Bill No: S3251

Sponsor(s): Codey

Date Introduced: January 24, 1991

Committee: **Assembly:** Appropriations

Senate: Institutions, Health & Welfare

Amended during passage: Yes Amendments during passage denoted by asterisks.

Date of Passage: **Assembly:** June 20, 1991

Senate: May 9, 1991

Date of Approval: July 1, 1991

Following statements are attached if available:

Sponsor statement: Yes Also attached: statements (2) with floor amendments.

Committee Statement: **Assembly:** Yes

Senate: Yes

Fiscal Note: No

Veto Message: No

Message on signing: Yes

Following were printed:

Reports: Yes

Hearings: Yes

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(over)

26.24-18.27

974.90
159
1990 New Jersey. Governor's Commission on Health Care Costs.
Cost, accessibility, responsibility, efficiency
for New Jersey. October 1, 1990.

974.90
159
1990c New Jersey. Legislature. Senate. Institutions, Health and Welfare
Committee
Public hearing on review...recommendation of the Governor's
Commission on Health Care Costs, held 11-14-90. Trenton, 1990

Clippings Attached:

"Assembly OKs bill for health care," [New Brunswick] Home News, 6-21-91.

"Assembly OKs indigent health-care fund," The Record [Bergen County], 6-21-91.

"Health care reforms clear the Assembly," [Newark] Star-Ledger, 6-21-91.

"NJ Health care law to aid poor," Phila. Inquirer, 7-2-91/

KBG/SLJ

P.L.1991, CHAPTER 187, *approved July 1, 1991*

1991 Senate No. 3251 *(Fourth Reprint)*

1 *AN ACT* concerning health care cost containment and revising
2 parts of statutory law.
3
4 BE IT ENACTED *by the Senate and General Assembly of the*
5 *State of New Jersey:*
6 [4]1. (New section) The Legislature finds and declares that:
7 a. Access to quality health care shall not be denied to
8 residents of the State because of their inability to pay for the
9 care; there are many residents of the State, particularly those
10 with incomes below the federal poverty level, who cannot pay for
11 needed hospital care and in order to ensure that these persons
12 have equal access to hospital care it is necessary to maintain a
13 mechanism which will ensure payment of uncompensated hospital
14 care; and to protect the fiscal solvency of the State's general
15 hospitals, as provided for in P.L.1971, c.136 (C.26:2H-1 et al.), it
16 is necessary that all payers of health care services share equally
17 in the payment of uncompensated care on a Statewide basis.
18 b. The "New Jersey Uncompensated Care Trust Fund," created
19 pursuant to P.L.1986, c.204, and continued pursuant to P.L.1989,
20 c.1 (C.26:2H-18.4 et seq.), which law expired on December 31,
21 1990, by which hospitals were able to collect their reasonable
22 cost of approved uncompensated care, resulted in unobstructed
23 access to health care for residents without insurance who
24 otherwise are unable to afford care.
25 c. Having received and thoroughly reviewed the reports issued
26 by the Commissioner of Health and the Governor's Commission
27 on Health Care Costs on uncompensated care, its economic
28 implications and various means of financing uncompensated care,
29 it is evident that provision for a trust fund is necessary, with
30 modifications, to ensure access to hospital care for those who
31 cannot afford to pay and the fiscal solvency of hospitals. At the
32 same time, the State should take further actions to: provide
33 more comprehensive Medicaid coverage for the medically
34 indigent, reduce the rate of increase in health insurance
35 premiums and explore and implement various initiatives to reduce
36 the amount of uncompensated care in this State without
37 impairing access to care.[4]
38 [4]2. (New section) As used in sections 1 through 26 of P.L. ,

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
1 Senate SIH committee amendments adopted March 11, 1991.
2 Senate floor amendments adopted March 25, 1991.
3 Senate floor amendments adopted March 25, 1991.
4 Assembly AAP committee amendments adopted June 13, 1991.

c. (C.)(now pending before the Legislature as this bill):

"Assessment" means monies that are required to be remitted to the fund by hospitals pursuant to this act.

"Commission" means the Hospital Rate Setting Commission established pursuant to section 5 of P.L.1978, c.83 (C.26:2H-4.1).

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Disproportionate share hospital" means a hospital designated by the Commissioner of Human Services pursuant to Pub.L.89-97 (42 U.S.C.§1396a et seq.)

"Fund" means the "New Jersey Health Care Trust Fund" established pursuant to this act.

"Hospital" means a general acute care hospital whose schedule of rates is approved by the commission pursuant to section 11 of P.L.1978, c.83 (C.26:2H-18.1).

"Medicaid" means the New Jersey Medical Assistance and Health Services Program in the Department of Human Services established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Payer" means a governmental or nongovernmental third party payer or any purchaser of hospital services whose hospital reimbursement rates are established by the commission pursuant to P.L.1971, c.136 (C.26:2H-1 et al.), but shall not include the Medicaid program and the Medicare program established pursuant to Pub.L.89-97 (42 U.S.C. §1395 et seq.), except as provided for in subsection a. of section 5 of this act.

"Uncompensated care" means inpatient and outpatient care provided to medically indigent persons and bad debts as defined by regulation of the department pursuant to P.L.1971, c.136 (C.26:2H-1 et al.).[4]

[4]3. (New section) The commission is authorized to approve a hospital's rates to achieve an equitable collection and distribution mechanism among hospitals in the State for payment of uncompensated care pursuant to the provisions of this act.[4]

[4]4. (New section) There is established the "New Jersey Health Care Trust Fund" in the Department of Health.

a. The fund shall be comprised of assessments remitted by hospitals pursuant to this act and any other monies appropriated thereto to carry out the purposes of this act.

The fund shall be a nonlapsing fund dedicated for use by the State: (1) to distribute payments for the cost of uncompensated care in the State, (2) to subsidize a pilot health insurance program for small business employees, (3) to fund the reasonable cost of administering the fund, (4) to fund the reasonable cost of preparing and disseminating health insurance information to employers pursuant to section 17 of P.L. , c. (C.)(now pending before the Legislature as this bill) and (5) to fund primary health care provided by community health centers, on a pilot basis, pursuant to section 23 of P.L. , c. (C.)(now pending before the Legislature as this bill); except that, monies remitted by hospitals pursuant to this act shall not be used for the purpose

of subsidizing pilot health insurance programs for small business employees. Interest earned on monies deposited in the fund shall be credited to the fund.

b. The fund shall be administered by a person appointed by the commissioner.

The administrator of the fund is responsible for overseeing and coordinating the collection and disbursement of fund monies. The administrator is responsible for promptly informing the commission and the Commissioners of Health and Human Services if monies are not or are not reasonably expected to be collected or disbursed or if the fund's reserve as established in subsection c. of this section falls below the required level.

c. The fund shall maintain a reserve in an amount not to exceed $25 million. The commissioner shall adopt rules and regulations to govern the use of the reserve and to ensure the integrity of the fund, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[4]

[4]5. (New section) a. For the periods beginning January or July of the hospitals' rate year, the department shall determine a uniform Statewide uncompensated care add-on. The commission shall approve the add-on before it is included in hospital rates.

The add-on shall be determined by dividing the Statewide amount of approved uncompensated care plus an amount adequate to fund the reasonable cost of administering the fund pursuant to subsection a. of section 4 of P.L. , c. (C.)(now pending before the Legislature as this bill) and to maintain the reserve pursuant to subsection c. of section 4 of P.L. , c. (C.)(now pending before the Legislature as this bill), by the Statewide amount of approved revenue for all payers and approved revenue for medically indigent persons less the Statewide amount of approved uncompensated care.

The Medicaid program shall provide its share of the uncompensated care add-on, as determined by the commission, through a direct contribution to the fund of an amount equal to the Medicaid program's State share of the uncompensated care add-on.

The add-on and any increases made to the add-on are an allowable cost and shall be included as part of the hospital's rates as established by the commission.

b. The amount of money raised by the uniform Statewide uncompensated care add-on, as a percentage of all governmental and nongovernmental approved revenue, shall not exceed 13%, except that the add-on shall not exceed 19.7%.

c. The uniform Statewide uncompensated care add-on for patients whose hospital bills are paid by a health maintenance organization or other payer which has negotiated a discounted rate of payment with the hospital shall be based on the full rate of reimbursement for the services provided by the hospital to the patient under the hospital reimbursement system established pursuant to P.L.1978, c.83, rather than on the discounted rate of

1 payment.
2 d. No provision of this section shall be construed to preclude
3 the commission from approving individual hospital rate increases
4 for uncompensated care in addition to the add-on. Such
5 increases, however, shall not be paid from the moneys in the
6 Health Care Trust Fund.[4]
7 [4]6. (New section) a. The commission shall approve each
8 hospital's reasonable uncompensated care costs and shall ensure
9 that uncompensated care services financed pursuant to this act
10 are provided in the most appropriate and cost-effective manner
11 which the commission determines hospitals can reasonably be
12 required to achieve. The commission shall reduce a hospital's
13 reasonable uncompensated care costs by the amount of
14 overpayment for patient care services, if any, by the Medicare
15 program established pursuant to Pub.L.89-97 (42 U.S.C. § 1395 et
16 seq.), the Medicaid program, or any payer or purchaser of hospital
17 services whose hospital reimbursement rates are not established
18 by the commission pursuant to P.L.1971, c.136 (C.26:2H-1 et
19 al.). For the purposes of this section, "overpayment" means
20 reimbursement in excess of that allowed by section 5 of P.L.1978,
21 c.83 (C.26:2H-4.1).
22 The commission shall require a hospital which engages in
23 inefficient or inappropriate provision of uncompensated care
24 services to submit to the commission a cost reduction plan. The
25 commission may prospectively reduce the hospital's
26 uncompensated care payments for failure to submit or implement
27 a cost reduction plan that has been approved by the commission.
28 b. The hospital mandatory assessment shall be funded by the
29 uniform Statewide uncompensated care add-on determined
30 pursuant to section 5 of P.L. , c. (C.)(now pending before the
31 Legislature as this bill) which is charged by the hospital to all
32 payers.
33 A hospital shall collect all monies received from the
34 uncompensated care add-on pursuant to subsection a. of section 5
35 of P.L. , c. (C.)(now pending before the Legislature as this
36 bill) and remit all such monies to the fund as the hospital's
37 mandatory assessment.
38 Such funds as may be necessary from the assessment shall be
39 appropriated from the fund to the Division of Medical Assistance
40 and Health Services in the Department of Human Services for
41 payment to disproportionate share and non-disproportionate share
42 hospitals for payments of approved uncompensated care costs.
43 The commission shall determine the amount that the Division
44 of Medical Assistance and Health Services in the Department of
45 Human Services shall pay to each hospital.
46 The Commissioner of Human Services shall adopt rules and
47 regulations pursuant to the "Administrative Procedure Act,"
48 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of
49 this subsection.[4]
50 [4]7. (New section) a. A hospital shall remit the mandatory

1 assessment to the fund at the end of every month, for 12 months,
2 except that, a hospital shall remit the first payment under this
3 act by August 30, 1991.
4 b. If a hospital is delinquent in its payment of the mandatory
5 assessment to the fund, the commission may, pursuant to rules
6 and regulations adopted by the commissioner, remove from that
7 hospital's schedule of rates the uniform Statewide
8 uncompensated care add-on or levy a reasonable penalty on the
9 hospital. The penalty shall be recovered in a summary civil
10 proceeding brought in the name of the State in the Superior Court
11 pursuant to "the penalty enforcement law" (N.J.S.2A:58-1 et
12 seq.). Penalties collected pursuant to this section shall be
13 deposited in the fund established pursuant to this act.
14 c. A hospital authorized to receive payments from the Division
15 of Medical Assistance and Health Services in the Department of
16 Human Services pursuant to subsection b. of section 6 of P.L. ,
17 c. (C.)(now pending before the Legislature as this bill), shall
18 receive the payments on a monthly basis. A hospital shall receive
19 12 monthly payments and the first payment shall be made within
20 45 days of the effective date of this section.[4]
21 [4]8. (New section) a. A hospital shall not be reimbursed for
22 the cost of uncompensated care unless the commissioner certifies
23 to the commission that the hospital has followed the procedures
24 pursuant to this section and section 11 of P.L. , c. (C.)(now
25 pending before the Legislature as this bill). For the purposes of
26 this section and section 11 of P.L. , c. (C.)(now pending
27 before the Legislature as this bill), "designated hospital
28 employee" means an employee of the hospital who has received
29 training in the collection of patient financial data and
30 identification of third party coverage and in assessing a patient's
31 eligibility for public assistance; and "responsible party" means
32 any person who is responsible for paying a patient's hospital bill.
33 b. A designated hospital employee shall interview a patient
34 upon the patient's initial request for care. If the emergent
35 nature of the patient's required health care makes the immediate
36 patient interview impractical, the designated hospital employee
37 shall interview the patient's family member, responsible party or
38 guardian, as appropriate, but if there is no family member,
39 responsible party or guardian, the designated hospital employee
40 shall interview the patient within five working days of the
41 patient's admission into the hospital or prior to discharge,
42 whichever date is sooner.
43 c. A patient interview shall, at a minimum, include the
44 following inquiries, except as provided in paragraph (5) of this
45 subsection:
46 (1) The designated hospital employee shall obtain
47 documentation of proper identification of the patient.
48 Documentation of proper identification may include, but shall not
49 be limited to, a driver's license, a voter registration card, an
50 alien registry card, a birth certificate, an employee identification

card, a union membership card, an insurance or welfare plan identification card or a Social Security card. Proper identification of the patient may also be provided by personal recognition by a person not associated with the patient. For the purposes of this paragraph, "proper identification" means the patient's name, mailing address, residence telephone number, date of birth, Social Security number, and place and type of employment, employment address and employment telephone number, as applicable.

(2) The designated hospital employee shall inquire of the patient, family member, responsible party or guardian, as appropriate, whether the patient is covered by health insurance, and if so, shall request documentation of the evidence of health insurance coverage. Documentation may include, but shall not be limited to, a government sponsored health plan card or number, a group sponsored or direct subscription health plan card or number, a commercial insurance identification card or claim form or a union welfare plan identification card or claim form.

(3) If evidence of health insurance coverage for the patient is not documented or if evidence of health insurance coverage is documented but the patient's health insurance coverage is unlikely to provide payment in full for the patient's account at the hospital, the designated hospital employee shall make an initial determination of whether the patient is eligible for participation in a public assistance program. If the employee concludes that the patient may be eligible for a public assistance program, the employee shall so advise the patient, family member, responsible party or guardian, as appropriate. The employee, either directly or through the hospital's social services office, shall give the patient, family member, responsible party or guardian, as appropriate, the name, address and phone number of the public assistance office that can assist in enrolling the patient in the program. The employee, or the social services office of the hospital, shall also advise the public assistance office of the patient's possible eligibility, including possible retroactive or presumptive eligibility, for the program.

Notwithstanding the provisions of this paragraph to the contrary, if a county welfare agency employee is assigned to the hospital pursuant to section 9 of P.L. , c. (C.)(now pending before the Legislature as this bill) the designated hospital employee shall refer the patient, family member, responsible party or guardian, as appropriate, to the county welfare agency employee who shall determine if the patient is eligible for Medicaid.

(4) If evidence of health insurance coverage for the patient is not documented or if evidence of health insurance coverage is documented but the patient's health insurance coverage is unlikely to provide payment in full for the patient's account at the hospital, and the patient does not appear to be eligible for public assistance, the designated hospital employee shall

1 determine if the patient is eligible for charity care pursuant to
2 regulations adopted by the commissioner. If the patient does not
3 qualify for charity care, the designated hospital employee shall
4 request from the patient, family member, responsible party or
5 guardian, as appropriate, the patient's or responsible party's
6 place of employment, income, real property and durable personal
7 property owned by the patient or responsible party and bank
8 accounts possessed by the patient or responsible party, along with
9 account numbers and the name and location of the bank.

10 (5) In the case of a patient seeking outpatient services, the
11 designated hospital employee shall make the inquiries and obtain
12 the documentation required pursuant to paragraphs (1) and (2) of
13 this subsection. If the patient provides the required
14 documentation, the designated hospital employee is not required
15 to make further inquiries, but if the patient cannot provide the
16 required documentation, the designated hospital employee shall
17 follow the procedures required pursuant to paragraphs (3) and (4)
18 of this subsection.

19 d. The provisions of this section shall not apply to a patient
20 who is investigated by a county adjuster and found to be indigent
21 by a court of competent jurisdiction pursuant to the provisions of
22 chapter 4 of Title 30 of the Revised Statutes. A patient so found
23 shall qualify for charity care under rules and regulations adopted
24 by the commissioner.[4]

25 [4]9. (New section) The Commissioner of Health, in
26 consultation with the Commissioner of Human Services, shall
27 designate those hospitals at which an employee from the county
28 welfare agency shall be stationed, on either a full or part-time
29 basis, as appropriate, to perform eligibility determinations for
30 the Medicaid program pursuant to P.L.1968, c.413 (C.30:4D-1 et
31 seq.).

32 A designated hospital shall reimburse the county welfare
33 agency for the nonfederal share of costs associated with the
34 county welfare agency employee, as certified by the
35 Commissioner of Human Services. The Commissioner of Human
36 Services shall bill the hospital quarterly for the nonfederal share
37 of costs and reimburse the county welfare agency upon receipt of
38 payment from the hospital.

39 A hospital shall be fully reimbursed for the nonfederal share of
40 costs associated with a county welfare agency employee
41 stationed at the hospital through the reimbursement rates of the
42 hospital, as established by the commission.[4]

43 [4]10. (New section) The Commissioner of Human Services shall
44 require that a county welfare agency provide adequate employees
45 to determine Medicaid eligibility to any hospital in the county
46 that has been designated by the Commissioner of Health pursuant
47 to section 9 of P.L. , c. (C.)(now pending before the
48 Legislature as this bill).

49 The Commissioner of Human Services shall bill the designated
50 hospital quarterly for the nonfederal share of costs associated

1 with a county welfare agency employee stationed at the hospital,
2 and reimburse the county welfare agency upon receipt of
3 payment from the hospital.[4]
4 [4]11. (New section) a. If, upon the discharge of a patient from
5 the hospital, the patient's account has not been paid in full by
6 the patient or responsible party or by health insurance, or it is
7 unlikely that the patient's account will be paid in full by the
8 patient or responsible party or by health insurance, as identified
9 pursuant to paragraphs (2) and (3) of subsection c. of section 8 of
10 P.L. , c. (C.)(now pending before the Legislature as this
11 bill), and the patient or responsible party is likely to have assets
12 such as those identified pursuant to paragraph (4) of subsection c.
13 of section 8 of P.L. , c. (C.)(now pending before the
14 Legislature as this bill), a hospital shall follow the collection
15 procedure pursuant to this section unless the patient's aggregate
16 outstanding balance is less than $250 or unless and until the cost
17 of collecting the account exceeds the patient's outstanding
18 balance.
19 b. The hospital shall commence the collection procedure
20 within two weeks after a patient's discharge from the hospital or
21 date of service at the hospital.
22 The collection procedure shall include:
23 (1) At least three billing statements, each sent at intervals of
24 no longer than four weeks, shall be sent to the patient's or
25 responsible party's mailing address.
26 At least two collection follow-up letters shall follow the three
27 billing statements. The collection follow-up letters shall be sent
28 to the patient's or responsible party's mailing address at an
29 interval of no longer than three weeks. Each collection follow-up
30 letter shall state the amount due and owing, the collection
31 history on the account and the hospital's intention to proceed
32 with legal action if the outstanding balance is not paid in full or,
33 in the alternative, the patient or responsible party fails to enter
34 into payment arrangements with the hospital. Each collection
35 follow-up letter shall request a partial payment of the
36 outstanding balance in the patient's account as the minimum
37 amount due and shall offer to establish a payment schedule for
38 the remainder of the outstanding balance in the patient's account
39 based upon the patient's or responsible party's ability to pay.
40 The letter shall clearly indicate the name of a person for the
41 patient or responsible party to contact, and a telephone number
42 for the patient or responsible party to call, in order to arrange
43 such a payment schedule.
44 A hospital is not required to comply with the requirements of
45 sending a third billing statement or two collection follow-up
46 letters if mail has twice been returned to the hospital, and
47 hospital personnel, despite reasonable efforts, are unable to
48 determine a new mailing address for the patient or responsible
49 party;
50 (2) At least three attempts to reach the patient or responsible

1 party by telephone shall be made if hospital personnel have
2 determined a residence or business telephone number for the
3 patient or responsible party. If hospital personnel are not able to
4 make telephone contact with the patient or responsible party
5 after three attempts, the hospital shall send a collection
6 telegram;
7 (3) Legal action to collect the amount due and owing on the
8 patient's account shall be taken; and
9 (4) The hospital shall request the department, on behalf of the
10 fund, to request the Department of the Treasury to apply or
11 cause to be applied the income tax refund or homestead rebate
12 due the patient or responsible party, or both the income tax
13 refund and homestead rebate, or so much of either or both as is
14 necessary to recover the amount due and owing on the patient's
15 account, pursuant to section 1 of P.L.1981, c.239 (C.54A:9-8.1),
16 for which purpose the patient's outstanding balance shall be
17 considered a debt to the fund and the fund shall be considered an
18 agency of State government.
19 c. Unless the cost of completing the procedure, in part or in
20 its entirety, exceeds the outstanding balance on a patient's
21 account, a hospital shall complete the procedures in paragraphs
22 (1) and (2) of subsection b. of this section before submitting
23 appropriate documentation and requesting from the commissioner
24 that the hospital be reimbursed on a delinquent account from the
25 fund.
26 If any payment on a delinquent account is received as a result
27 of compliance with the procedures in subsection b. of this section
28 and the hospital has already received payment from the fund, the
29 amount of money the hospital is entitled to receive from the fund
30 shall be adjusted pursuant to procedures established by the
31 commission.
32 d. This section shall not apply to a patient who: qualifies for
33 charity care pursuant to rules and regulations adopted by the
34 commissioner; is found to be indigent by a court of competent
35 jurisdiction pursuant to the provisions of chapter 4 of Title 30 of
36 the Revised Statutes; or qualifies for care under the federal
37 Hill-Burton program pursuant to 42 U.S.C. § 291 et seq.
38 e. The commissioner shall adopt rules and regulations to
39 effectuate the purposes of this section and section 8 of P.L. ,
40 c. (C.)(now pending before the Legislature as this bill);
41 except that nothing in this section or section 8 of P.L. , c.
42 (C.)(now pending before the Legislature as this bill) shall be
43 construed to prohibit the commissioner from adopting rules and
44 regulations that are more stringent than the provisions of this
45 section and section 8 of P.L. , c. (C.)(now pending before
46 the Legislature as this bill).[4]
47 [4]12. (New section) a. The department shall annually provide
48 for an audit of each hospital's uncompensated care within a time
49 frame established by rules and regulations adopted by the
50 commissioner.

1 b. Prior to the department's final approval of the audit, the
2 results of the audit shall be reviewed with the hospital. If a
3 hospital disputes an audit adjustment, the hospital may appeal the
4 adjustment to the commission. The commission shall resolve the
5 dispute within 90 calendar days of the date on which the hospital
6 appealed the adjustment.
7 c. Upon receipt and acceptance of the final audit, the
8 commission, within 90 calendar days, shall adjust a hospital's
9 schedule of rates so that the rates reflect the audit adjustment.[4]
10 [4]13. (New section) The department shall, for the purpose of
11 developing patient profiles, require a hospital to report the
12 following information about any patient who was served on an
13 inpatient basis or on any patient served on an outpatient basis
14 with an account balance greater than $125, whose account has
15 been referred to a collection agency or for legal action pursuant
16 to paragraph (3) of subsection b. of section 10 of P.L.1989, c.1
17 (C.26:2H-18.13) or to paragraph (3) of subsection b. of section 11
18 of P.L. , c. (C.)(now pending before the Legislature as this
19 bill): the patient's age; sex; marital status; employment status
20 and if employed, whether the employment is full or part-time;
21 type of health insurance coverage, and if the patient is a child
22 under 18 years of age who does not have health insurance
23 coverage or a married person who does not have health insurance
24 coverage, whether the child's parent or the married person's
25 spouse, as the case may be, has health insurance coverage.
26 The hospital shall also include a copy of any billing information
27 about the patient's account, at the point of write-off as a bad
28 debt, which is provided to a collection agency or any other person
29 for legal action, including whether the amount due and owing
30 represents the patient or responsible party's failure to pay a full
31 hospital bill, a partial hospital bill, or an insurance copayment or
32 deductible.
33 The hospital shall provide the information to the department on
34 a quarterly basis, on a form developed by the department, in
35 consultation with the New Jersey Hospital Association.[4]
36 [4]14. (New section) The Department of the Treasury shall
37 compile and submit to the Department of Health information
38 about the income of persons whose income tax refund or
39 homestead rebate was applied to recover the amount due and
40 owing on a patient's account pursuant to paragraph (4) of
41 subsection b. of section 10 of P.L.1989, c.1 (C.26:2H-18.13) or to
42 paragraph (4) of subsection b. of section 11 of P.L. , c.
43 (C.)(now pending before the Legislature as this bill).
44 The information compiled by the department shall identify the
45 number of persons whose annual income for 1990 is: below
46 $10,000; between $10,000 and $20,000; between $20,001 and
47 $40,000; between $40,001 and $60,000; between $60,001 and
48 $80,000; and greater than $80,000.[4]
49 [4]15. (New section) The State Auditor shall conduct quality
50 control reviews of the audits of hospital uncompensated care for

1 calendar years 1989 and 1990 that are required pursuant to
2 section 11 of P.L.1989, c.1 (C.26:2H-18.14). The State Auditor
3 shall select a representative sample of hospital audits to
4 complete the reviews, except that each year's review shall
5 include, at a minimum, the audits from the 20 hospitals with the
6 highest uncompensated care costs in the State.
7 The State Auditor shall report to the chairmen of the Senate
8 Institutions, Health and Welfare and General Assembly Health
9 and Human Services Committees and the Commissioner of Health
10 on the results of the reviews and make any recommendations
11 necessary to improve the system for monitoring compliance with
12 the patient interview and collection procedures required pursuant
13 to this act.
14 The Department of Health shall promptly provide the State
15 Auditor with a copy of the completed audits of each hospital's
16 uncompensated care for 1989, and the completed audits for 1990,
17 as soon as they are available, for the purpose of conducting the
18 reviews.[4]
19 [4]16. (New section) The commission shall adjust a hospital's
20 schedule of rates to ensure that services which are provided to
21 emergency room patients who do not require those services on an
22 emergency basis are reimbursed at a rate appropriate for primary
23 care, according to regulations adopted by the commissioner.
24 Nothing in this section shall be construed to restrict the right of
25 the commission to increase a hospital's schedule of rates for
26 required emergency services, except that the increase shall not
27 be solely to offset a reduction in hospital revenue as a result of
28 reduced rates for primary care provided in the emergency room.
29 Nothing in this section shall be construed to permit a hospital
30 to refuse to provide emergency room services to a patient who
31 does not require the services on an emergency basis.[4]
32 [4]17. (New section) Any employer in this State who does not
33 provide health insurance coverage to its employees is required to
34 provide employer assistance and to inform all of its current and
35 prospective employees about the importance of having health
36 insurance coverage. The employer shall also make a good faith
37 effort to assist any employee who wishes to purchase health
38 insurance from a health insurance carrier.
39 For the purposes of this section, "employer assistance" means
40 the dissemination to all current and prospective employees of
41 information obtained from the department on health insurance
42 products available in the State for employees and their
43 dependents.
44 The department, in consultation with the Department of
45 Insurance, shall prepare and have ready for dissemination to
46 employers information on health insurance products available in
47 the State.[4]
48 [4]18. (New section) The monies remaining in the
49 "Uncompensated Care Reduction--Pilot Program" account of the
50 New Jersey Uncompensated Care Trust Fund established pursuant

1 to P.L.1989, c.1 (C.26:2H-18.4 et seq.) on December 31, 1990
2 shall be used to subsidize or otherwise provide financial
3 assistance for a health insurance pilot program for small business
4 employees; except that the monies, and any interest earned
5 thereon, shall remain in the account until such time as a law is
6 enacted which establishes the health insurance pilot program for
7 small business employees and which appropriates the monies in
8 the account.[4]
9 [4]19. (New section) A hospital shall not advertise by any means
10 the availability of uncompensated care that is provided at the
11 hospital pursuant to this act. Nothing in this section shall be
12 construed to prohibit a hospital from advertising its requirement
13 to provide charity care under the federal Hill-Burton program
14 pursuant to 42 U.S.C. § 291 et seq.[4]
15 [4]20. (New section) A hospital that does not claim any
16 deduction for bad debt for the purpose of the department's
17 determination of that hospital's uncompensated care factor
18 pursuant to N.J.A.C.8:31B-4.39, is eligible for full reimbursement
19 for charity care, as provided pursuant to N.J.A.C.8:31B-4.37, for
20 all eligible patients regardless of a patient's state of residence;
21 except that this section shall not apply in the case of a patient
22 who is not a resident of the United States.[4]
23 [4]21. (New section) a. The cost of advanced life support
24 services provided pursuant to P.L.1984, c.146 (C.26:2K-7 et seq.)
25 to medically indigent persons incurred through a hospital's
26 provision of advanced life support services shall be compensated
27 pursuant to this act. The commission shall, by regulation,
28 establish a schedule of reimbursement rates for advanced life
29 support services. Reimbursement for mobile intensive care unit
30 uncompensated care shall only include those uninsured patients
31 who are classified as charity care pursuant to regulations
32 promulgated by the commissioner. Reimbursement shall exclude
33 bad debt, the difference in a contractual allowance, or any
34 medical denials for a service.
35 b. The cost of advanced life support services provided by the
36 University of Medicine and Dentistry of New Jersey University
37 Hospital to uninsured patients who are classified as charity care
38 shall be uncompensated care, except that such uncompensated
39 care shall be exempt from any reimbursement limitations for
40 uncompensated care that apply to University Hospital.
41 Reimbursement for advanced life support services uncompensated
42 care for University Hospital shall not be paid from the fund, but
43 shall be paid through the reimbursement rates of University
44 Hospital as established by the commission.[4]
45 [4]22. (New section) For all periods for which an audit for
46 reimbursement for uncompensated care through the
47 Uncompensated Care Trust Fund established pursuant to
48 P.L.1989, c.1 (C.26:2H-18.4 et seq.) shall be conducted, the
49 requirements regarding the determination of eligibility for
50 charity care pursuant to sections 9 and 10 of P.L.1989, c.1

1 (C.26:2H-18.12 and 18.13) shall not apply to a patient who is
2 investigated by a county adjuster and found to be indigent by a
3 court of competent jurisdiction pursuant to the provisions of
4 chapter 4 of Title 30 of the Revised Statutes. A patient so found
5 shall qualify for charity care.[4]
6 [4]23. (New section) a. The commissioner shall establish a pilot
7 program to create a partnership between urban hospitals with
8 high uncompensated care costs and community health centers in
9 order to provide primary health care in the most appropriate
10 community setting. The commissioner shall select one hospital
11 with high uncompensated care costs in the northern, central and
12 southern regions of the State, respectively, to participate in the
13 program. The commissioner shall establish the program by
14 September 1, 1991.
15 b. Each hospital selected to participate in the program shall
16 establish a formal agreement with a community health center
17 located near the hospital, in which the hospital agrees to refer
18 emergency room patients who are not in need of emergency care,
19 but require primary care, to the community health center for the
20 needed medical services. The agreement shall stipulate that if
21 the patient who is referred to the community health center
22 cannot afford to pay for the health care services provided at the
23 center and qualifies for charity care pursuant to requirements
24 established by the commissioner, the center shall submit the bill
25 to the referring hospital and the hospital shall include the amount
26 of the bill in its uncompensated care costs. The hospital shall
27 reimburse the center for the approved charity care provided
28 pursuant to this pilot program. The agreement shall also
29 stipulate that the community health center shall operate at hours
30 that reflect the needs of the community and shall provide an
31 emergency contact during nonoperating hours.[4]
32 [4]24. (New section) The commissioner shall report to the
33 Governor, the presiding officers of the Senate and the General
34 Assembly, and the chairmen of the Senate Institutions, Health
35 and Welfare Committee and the General Assembly Health and
36 Human Services Committee, six and 11 months after the
37 effective date of this act on the status of the fund.
38 a. The commissioner shall include in the first report a
39 summary of the findings of the 1990 annual audit of each
40 hospital's uncompensated care conducted pursuant to section 12
41 of P.L. , c. (C.)(now pending before the Legislature as this
42 bill). The summary shall include the percentage of
43 uncompensated care for each hospital that is classified as charity
44 care and as bad debt, respectively. The report shall also include
45 a compilation of the information collected pursuant to section 13
46 of P.L. , c. (C.)(now pending before the Legislature as this
47 bill).
48 b. The commissioner shall include in the second report a
49 compilation of the information collected pursuant to section 13
50 of P.L. , c. (C.)(now pending before the Legislature as this

1 bill) and provided by the Department of the Treasury pursuant to
2 section 14 of P.L. , c. (C.)(now pending before the
3 Legislature as this bill).[4]
4 [4]25. (New section) a. There is established in the Department
5 of Health a special fund to be known as the "Health Care Cost
6 Reduction Fund."
7 The monies in the Health Care Cost Reduction Fund are hereby
8 appropriated for the purposes and in amounts not to exceed the
9 amounts specified in this subsection:
10 (1) Local health planning - $3 million per year;
11 (2) Demographic study of hospital patients whose accounts are
12 classified as bad debts - $50,000;
13 (3) Primary Care Physician and Dentist Loan Redemption
14 Program - $1 million per year;
15 (4) Provision of funds to community health centers funded
16 under sections 329 or 330 of the "Public Health Service Act," (42
17 U.S.C. § 254b, 254c) or which have been designated by the Health
18 Resources and Services Administration in the United States
19 Public Health Service as a Federally Qualified Health Center, to
20 enable these centers to expand their hours of operation to
21 evenings and weekends, and to enhance and advertise their
22 primary health care services as an alternative to hospital
23 emergency rooms - $10 million per year;
24 (5) Expansion of eligibility for the Medicaid program to 185%
25 of the poverty level for pregnant women and infants up to one
26 year of age;
27 (6) Establishment of a "HealthStart Plus" program for pregnant
28 women and infants up to age one whose income is between 185%
29 and 300% of the poverty level - $8 million per year;
30 (7) Establishment of the "Competitive Initiatives Fund" to
31 strengthen relationships between hospitals and community health
32 centers - $6 million per year; and
33 (8) Other reform measures established by law which are
34 designed to contain the cost of uncompensated care.
35 The department shall maintain a separate account for each of
36 the reform measures funded by the Health Care Cost Reduction
37 Fund.
38 b. Notwithstanding any law to the contrary, each hospital
39 whose rates are established by the commission pursuant to
40 P.L.1978, c.83 (C.26:2H-1 et al.) shall pay .53% of its approved
41 revenue base for 1991 to the Department of Health for deposit in
42 the Health Care Cost Reduction Fund. The hospital shall make
43 monthly payments to the department for a period of 24 months
44 beginning on the first month following the date of enactment of
45 this act, except that the total amount paid into the Health Care
46 Cost Reduction Fund plus interest shall not exceed $40 million
47 per year. The commissioner shall determine the manner in which
48 the payments shall be made.
49 c. The commissioner shall report to the Senate Institutions,
50 Health and Welfare Committee and the General Assembly Health

1 and Human Services Committee quarterly on the status of the
2 Health Care Cost Reduction Fund. The report shall specify the
3 amount of revenues received by the fund and the specific
4 expenditures made, and proposed to be made, from the fund.[4]
5 [4]26. (New section) The employees, appropriations and other
6 moneys, files, books, papers, records, equipment and other
7 property of the "New Jersey Uncompensated Care Trust Fund"
8 and the "Uncompensated Care Trust Fund Advisory Committee,"
9 established pursuant to P.L.1986, c.204, and continued pursuant
10 to P.L.1989, c.1 (C.26:2H-18.4 et seq.), which law expired on
11 December 31, 1990, are transferred, pursuant to the "State
12 Agency Transfer Act," P.L.1971, c.375 (C.52:14D-1 et seq.) to
13 the "New Jersey Health Care Trust Fund" established pursuant to
14 this act.[4]
15 [4][1.] 27.[4] Section 1 of P.L.1971, c.136 (C.26:2H-1) is amended
16 to read as follows:
17 1. It is hereby declared to be the public policy of the State
18 that hospital and related health care services of the highest
19 quality, of demonstrated need, efficiently provided and properly
20 utilized at a reasonable cost are of vital concern to the public
21 health. In order to provide for the protection and promotion of
22 the health of the inhabitants of the State, promote the financial
23 solvency of hospitals and similar health care facilities and
24 contain the rising cost of health care services, the State
25 Department of Health[, which has been designated as the sole
26 agency in this State for comprehensive health planning under the
27 "National Health Planning and Resources Development Act of
28 1974" (Federal Law 93-641), as amended and supplemented,] shall
29 have the central, comprehensive responsibility for the
30 development and administration of the State's policy with
31 respect to health planning, hospital and related health care
32 services and health care facility cost containment programs, and
33 all public and private institutions, whether State, county,
34 municipal, incorporated or not incorporated, serving principally
35 as residential health care facilities, nursing or maternity homes
36 or as facilities for the prevention, diagnosis, or treatment of
37 human disease, pain, injury, deformity or physical condition, shall
38 be subject to the provisions of this act.
39 (cf: P.L.1979, c.496, s.19)
40 [4][2.] 28.[4] Section 2 of P.L.1971, c.136 (C.26:2H-2) is amended
41 to read as follows:
42 2. The following words or phrases, as used in this act, shall
43 have the following meanings, unless the context otherwise
44 requires:
45 a. "Health care facility" means the facility or institution
46 whether public or private, engaged principally in providing
47 services for health maintenance organizations, diagnosis of
48 treatment of human disease, pain, injury, deformity or physical
49 condition, including, but not limited to, a general hospital, special
50 hospital, mental hospital, public health center, diagnostic center,

1 treatment center, rehabilitation center, extended care facility,
2 skilled nursing home, nursing home, intermediate care facility,
3 tuberculosis hospital, chronic disease hospital, maternity hospital,
4 outpatient clinic, dispensary, home health care agency,
5 residential health care facility and bioanalytical laboratory
6 (except as specifically excluded hereunder) or central services
7 facility serving one or more such institutions but excluding
8 institutions that provide healing solely by prayer and excluding
9 such bioanalytical laboratories as are independently owned and
10 operated, and are not owned, operated, managed or controlled, in
11 whole or in part, directly or indirectly by any one or more health
12 care facilities, and the predominant source of business of which is
13 not by contract with health care facilities within the State of
14 New Jersey and which solicit or accept specimens and operate
15 predominantly in interstate commerce.

16 b. "Health care service" means the preadmission, outpatient,
17 inpatient and postdischarge care provided in or by a health care
18 facility, and such other items or services as are necessary for
19 such care, which are provided by or under the supervision of a
20 physician for the purpose of health maintenance organizations,
21 diagnosis or treatment of human disease, pain, injury, disability,
22 deformity or physical condition, including, but not limited to,
23 nursing service, home care nursing and other paramedical service,
24 ambulance service, service provided by an intern, resident in
25 training or physician whose compensation is provided through
26 agreement with a health care facility, laboratory service,
27 medical social service, drugs, biologicals, supplies, appliances,
28 equipment, bed and board, but excluding services provided by a
29 physician in his private practice, except as provided in section 7
30 of P.L.1971, c.136 (C.26:2H-7), or by practitioners of healing
31 solely by prayer, and services provided first aid, rescue and
32 ambulance squads as defined in the "New Jersey Highway Safety
33 Act of 1971," P.L.1971, c.351 (C.27:5F-1 et seq.).

34 c. "Construction" means the erection, building, or substantial
35 acquisition, alteration, reconstruction, improvement, renovation,
36 extension or modification of a health care facility, including its
37 equipment, the inspection and supervision thereof; and the
38 studies, surveys, designs, plans, working drawings, specifications,
39 procedures, and other actions necessary thereto.

40 d. "Board" means the Health Care Administration Board
41 established pursuant to this act.

42 e. "Commission" means the Hospital Rate Setting Commission
43 established pursuant to this act.

44 f. "Government agency" means a department, board, bureau,
45 division, office, agency, public benefit or other corporation, or
46 any other unit, however described, of the State or political
47 subdivision thereof.

48 g. ["Statewide Health Coordinating Council" means the
49 Statewide Health Coordinating Council formed under the
50 provisions of Federal Law 93-641, as amended and supplemented.]

1 (Deleted by amendment, P.L. , c.)
2 h. ["Health Systems Agency" means an officially recognized
3 health systems agency formed under the provisions of Federal
4 Law 93-641 as amended and supplemented.] (Deleted by
5 amendment, P.L. , c.)
6 i. "Department" means the State Department of Health.
7 j. "Commissioner" means the State Commissioner of Health.
8 k. "Preliminary cost base" means that proportion of a
9 hospital's current cost which may reasonably be required to be
10 reimbursed to a properly utilized hospital for the efficient and
11 effective delivery of appropriate and necessary health care
12 services of high quality required by such hospital's mix of
13 patients. The preliminary cost base initially may include costs
14 identified by the commissioner and approved or adjusted by the
15 commission as being in excess of that proportion of a hospital's
16 current costs identified above, which excess costs shall be
17 eliminated in a timely and reasonable manner prior to
18 certification of the revenue base. The preliminary cost base shall
19 be established in accordance with regulations proposed by the
20 commissioner and approved by the board.
21 l. "Certified revenue base" means the preliminary cost base
22 adjusted by the commission, as appropriate and necessary
23 pursuant to regulations proposed by the commissioner and
24 approved by the board, to provide for the financial solvency of a
25 hospital which is properly utilized and which delivers, effectively
26 and efficiently, appropriate and necessary health care services of
27 a high quality required by its mix of patients.
28 m. "Provider of health care" means an individual (1) who is a
29 direct provider of health care service in that the individual's
30 primary activity is the provision of health care services to
31 individuals or the administration ~~of health care facilities in which~~
32 such care is provided and, when required by State law, the
33 individual has received professional training in the provision of
34 such services or in such administration and is licensed or certified
35 for such provision or administration; or (2) who is an indirect
36 provider of health care in that the individual (a) holds a fiduciary
37 position with, or has a fiduciary interest in, any entity described
38 in subparagraph b(ii) or subparagraph b(iv); provided, however,
39 that a member of the governing body of a county or any elected
40 official shall not be deemed to be a provider of health care unless
41 he is a member of the board of trustees of a health care facility
42 or a member of a board, committee or body with authority
43 similar to that of a board of trustees, or unless he participates in
44 the direct administration of a health care facility; or (b)
45 received, either directly or through his spouse, more than
46 one-tenth of his gross annual income for any one or more of the
47 following;
48 (i) Fees or other compensation for research into or instruction
49 in the provision of health care services;
50 (ii) Entities engaged in the provision of health care services or

1 in research or instruction in the provision of health care services;
2 (iii) Producing or supplying drugs or other articles for
3 individuals or entities for use in the provision of or in research
4 into or instruction in the provision of health care services;
5 (iv) Entities engaged in producing drugs or such other articles.
6 n. "Private long-term health care facility" means a nursing
7 home, skilled nursing home or intermediate care facility
8 presently in operation and licensed as such prior to the adoption
9 of the 1967 Life Safety Code by the State Department of Health
10 in 1972 and which has a maximum 50-bed capacity and which
11 does not accommodate Medicare or Medicaid patients.
12 o. "Local advisory board" means an independent, private
13 nonprofit corporation which is not a health care facility, a
14 subsidiary thereof or an affiliated corporation of a health care
15 facility, that is designated by the Commissioner of Health to
16 serve as the regional health planning agency for a designated
17 region in the State.
18 p. "State Health Planning Board" means the board established
19 pursuant to section [4][10] 33[4] of P.L. , c. (C.) (now pending
20 before the Legislature as this bill) to prepare and review the
21 State Health Plan and to conduct certificate of need review
22 activities.
23 (cf: P.L.1980, c.105, s.5)
24 [4][3.] 29.[4] Section 5 of P.L.1978, c.83 (C.26:2H-4.1) is amended
25 to read as follows:
26 5. a. There is hereby established in the State Department of
27 Health a Hospital Rate Setting Commission which shall consist of
28 five members[, three of whom] who shall be appointed by the
29 Governor with the advice and consent of the Senate for terms of
30 [4] four years. Of the [initial] appointees added pursuant to P.L. ,
31 c. (C.) (pending before the Legislature as this bill), one
32 shall serve for a term of [2] two years and one for a term of [3]
33 three years. No member shall be eligible for appointment for
34 more than two full consecutive terms. [Two] Three of the
35 members appointed by the Governor shall be consumers of health
36 care services who are not providers of health care services, one
37 shall represent either business or organized labor as a purchaser
38 of health care services and one shall have experience in hospital
39 administration or finance[1], but shall not be an employee of a
40 hospital[1]. [The Commissioners of the State Departments of
41 Health and Insurance or their designated representatives, who
42 shall be officials with the rank of deputy or assistant
43 commissioner, shall serve as ex-officio voting members of the
44 commission.] The commission shall annually select a chairman
45 from among its members. Three members of the commission
46 shall constitute a quorum and no action of the commission shall
47 be taken except upon the affirmative vote of a majority of its
48 members.
49 The [appointed] members of the commission shall each receive
50 compensation at $150.00 per day. The commission members shall

1 also be entitled to reasonable expenses incurred in the
2 performance of their duties. Any such member may be removed
3 from office by the Governor, for good cause shown. Any vacancy
4 occurring in the membership of the commission for any cause
5 shall be filled in the same manner as the original appointment but
6 for the unexpired term only. A member shall otherwise continue
7 to serve after expiration of his term until a new appointment is
8 made.
9 The commission shall select an executive secretary and the
10 commissioner shall provide to the commission such clerical staff,
11 supplies and equipment as may be necessary for it to faithfully
12 discharge its duties.
13 The commission shall be established and its members appointed
14 by January 1, 1979.
15 b. The commissioner shall determine the order in which
16 hospitals shall have their preliminary cost base and appropriate
17 schedule of rates approved by the commission. The commissioner
18 shall propose and the commission approve or adjust the
19 preliminary cost base, and the commission shall approve an
20 appropriate schedule of rates for all hospitals by January 1,
21 1983. The schedule of rates shall be reasonable and sufficient to
22 provide the revenue requirements of the preliminary cost base
23 and shall be adjusted from time to time, as appropriate, to reach
24 the certified revenue base.
25 The commission shall certify the revenue base, provided the
26 conditions described in subsections k. and l. of section 2 of this
27 act have been met, and shall perform such other duties as are
28 specified elsewhere in this act.
29 A hospital shall continue to be reimbursed under the rate
30 setting system in effect on the day preceding the effective date
31 of this act, except as said system is amended by regulation, until
32 the commission approves the hospital's preliminary cost base.
33 (cf: P.L.1978, c.83, s.5)
34 [4][4.] 30.[4] Section 7 of P.L.1971, c.136 (C.26:2H-7) is amended
35 to read as follows:
36 7. No health care facility shall be constructed or expanded,
37 and no new health care [1][services] service[1] shall be instituted
38 after the effective date of [this act] P.L.1971, c.136 (C.26:2H-1
39 et seq.) except upon application for and receipt of a certificate
40 of need as provided by [this act] P.L.1971, c.136 (C.26:2H-1 et
41 seq.). No agency of the State or of any county or municipal
42 government shall approve any grant of funds for, or issue any
43 license to, a health care facility which is constructed or
44 expanded, or which institutes a new health care service, in
45 violation of the provisions of [4][this act] P.L.1971, c.136
46 (C.26:2H-1 et seq.)[4].
47 The provisions of this section shall apply to [1][any purchase of
48 major moveable equipment whose total cost is over $1 million and
49 any modernization, renovation or construction project whose
50 total cost is over $1 million.]:

a. The initiation of any health care service as provided in section 2 of P.L.1971, c.136 (C.26:2H-2);

b. The initiation by any person of a health care service which is the subject of a health planning regulation adopted by the Department of Health;

c. The purchase by any person of major moveable equipment whose total cost is over $1 million;

d. The expenditure by a licensed health care facility of over $1 million for modernization or renovation of its physical plant, or for construction of a new health care facility; and

e. The modernization, renovation or construction of a facility by any person, whose total project cost exceeds $1 million, if the facility-type is the subject of a health planning regulation adopted by the Department of Health.[1]

The commissioner may periodically increase the monetary thresholds established in this section, by regulation, to reflect inflationary increases in the costs of health care equipment or construction.

For the purposes of this section, "health care service" shall include any service which is the subject of a health planning regulation adopted by the Department of Health [1][and any service or acquisition, including a service provided by, or acquisition of, a physician in the physician's private practice, with a total project cost that is greater than $1 million], and "person" shall include a corporation, company, association, society, firm, partnership and joint stock company, as well as an individual[1].

[4]A physician who initiates a health care service which is the subject of a health planning regulation or purchases major moveable equipment pursuant to subsection b. or c. of this section, may apply to the commissioner for a waiver of the certificate of need requirement if: the equipment or health care service is such an essential, fundamental and integral component of the physician's practice specialty, that the physician would be unable to practice his specialty according to the acceptable medical standards of that specialty without the health care service or equipment; the physician bills at least 75% of his total amount of charges in the practice specialty which uses the health care service or equipment; and the health care service or equipment is not otherwise available and accessible to patients, pursuant to standards established by the commissioner, by regulation. The commissioner shall make a determination about whether to grant or deny the waiver, within 120 days from the date the request for the waiver is received by the commissioner and shall so notify the physician who requested the waiver. If the request is denied, the commissioner shall include in that notification the reason for the denial. If the request is denied, the initiation of a health care service or the purchase of major moveable equipment shall be subject to the certificate of need requirements pursuant to this section.

A health maintenance organization which furnishes at least basic comprehensive care health services on a prepaid basis to enrollees either through providers employed by the health maintenance organization or through a medical group or groups which contract directly with the health maintenance organization, which initiates a health care service, or modernizes, renovates or constructs a health care facility pursuant to subsections a., b., d. or e. of this section, may apply to the commissioner for a waiver of the certificate of need requirement if: the initiation of the health care service or the modernization, renovation or construction is in the best interests of State health planning; and the health maintenance organization is in compliance with the provisions of P.L.1973, c.337 (C. 26:2J-1 et seq.) and complies with the provisions of subsection d. of section 3 of P.L.1973, c.337 (C. 26:2J-3) regarding notification to the commissioner. The commissioner shall make a determination about whether to grant or deny the waiver within 45 days from the date the request for the waiver is received by the commissioner and shall so notify the health maintenance organization. If the request for a waiver is denied on the basis that the request would not be in the best interests of State health planning, the commissioner shall state in that notification the reason why the request would not be in the best interests of State health planning. If the request for a waiver is denied, the health maintenance organization's initiation of a health care service or modernization, renovation or construction project shall be subject to the certificate of need requirements pursuant to this section.

The requirement to obtain a certificate of need for major moveable equipment pursuant to subsection c. of this section shall not apply if a contract to purchase that equipment was entered into prior to July 1, 1991.[4]

(cf: P.L.1971, c.136, s.7)

[4][5.] 31.[4] Section 8 of P.L.1971, c.136 (C.26:2H-8) is amended to read as follows:

8. No certificate of need shall be issued unless the action proposed in the application for such certificate is consistent with the health care needs identified in the State Health Plan and the action is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, will not have an adverse economic or financial impact on the delivery of health care services in the region or Statewide, and will contribute to the orderly development of adequate and effective health care services. In making such determinations there shall be taken into consideration (a) the availability of facilities or services which may serve as alternatives or substitutes, (b) the need for special equipment and services in the area, (c) the possible economies and improvement in services to be anticipated from the operation of joint central services, (d) the adequacy of financial resources and sources of present and future revenues, (e) the availability of sufficient manpower in the several

1 professional disciplines, and (f) such other factors as may be
2 established by regulation. [The commissioner shall cause
3 appropriate surveys and studies to be made concerning the need
4 for health care facilities and keep current records and statistics
5 thereon by designated areas or regions of the State.]
6 In the case of an application by a health care facility
7 established or operated by any recognized religious body or
8 denomination the needs of the members of such religious body or
9 denomination for care and treatment in accordance with their
10 religious or ethical convictions may be considered to be public
11 need.
12 (cf: P.L.1971, c.138, s.1)
13 [4][6.] 32.[4] Section 9 of P.L.1971, c.136 (C.26:2H-9) is amended
14 to read as follows:
15 9. Certificates of need shall be issued by the commissioner in
16 accordance with the provisions of [this act] P.L.1971, c.136
17 (C.26:2H-1 et seq.) and the State Health Plan and based upon
18 criteria and standards therefor promulgated by the
19 commissioner. [The commissioner shall establish minimum
20 requirements and maximum needs for health care facilities in
21 each area or region of the State, taking into consideration the
22 recommendations of the health systems agencies and the
23 Statewide Health Coordinating Council.
24 No such certificate shall be denied without the approval of the
25 board and prior to the determination by the board, the applicant
26 shall have been granted opportunity for hearing and the
27 commissioner or his designee shall have furnished the board in
28 writing his recommendations and reasons therefor; and no] The
29 commissioner may approve or deny an application for a
30 certificate of need if the approval or denial is consistent with the
31 State Health Plan. If an application is denied, the applicant may
32 appeal the decision to the board. No decision shall be made by
33 the commissioner contrary to the recommendations of the
34 [Statewide Health Coordinating Council or the Health Systems
35 Agency] State Health Planning Board or the local advisory board
36 concerning a certificate of need application or any other matter,
37 unless the [council and the Health Systems Agency] State Health
38 Planning Board and the applicant shall have been granted
39 opportunity for hearing. Requests for a fair hearing shall be
40 made to the Department of Health within 30 days of receipt of
41 notification of the commissioner's action. The department shall
42 arrange within 60 days of a request, for fair hearings on all such
43 cases and after such hearing the commissioner or his designee
44 shall furnish the board, the [council, the Health Systems Agency]
45 State Health Planning Board and the applicant in writing the
46 hearing examiner's recommendations and reasons therefor. The
47 board within 30 days of receiving all appropriate hearing records
48 or, in the absence of a request for a hearing within 30 days of
49 receiving the denial recommendations of the commissioner, shall
50 make its determination.

1 [1]For the three-year period beginning January 1, 1992 through
2 December 31, 1994, the commissioner shall limit approval of
3 certificates of need for capital construction projects for hospitals
4 that would be financed by the New Jersey Health Care Facilities
5 Financing Authority pursuant to P.L.1972, c.29 (C.26:2I-1 et
6 seq.), to a Statewide total of [4][$275] $225[4] million per year for
7 all projects, exclusive of the refinancing of approved projects.[1]
8 [4]For the purposes of this section, capital construction project
9 shall include the purchase of any major moveable equipment as
10 well as any modernization, construction, or renovation project.[4]
11 If the commissioner intends to approve or deny an application
12 for a certificate of need contrary to the State Health Plan, the
13 commissioner shall submit to the board the entire record of the
14 application, including the recommendations of the local advisory
15 board and the State Health Planning Board and the
16 commissioner's specific reasons for his intention to act contrary
17 to the State Health Plan. [1][The board is authorized to make the
18 final decision regarding the application.][1] If the board agrees
19 with the commissioner, it shall [1]request the commissioner to hold
20 the affected application and[1] direct the State Health Planning
21 Board to amend the State Health Plan to reflect its
22 determination. [1]Upon the effective date of the amendment to
23 the State Health Plan, the commissioner shall reconsider the
24 application.[1]
25 (cf: P.L.1978, c.83, s.6)
26 [4]33. (New section) There is established in the Department of
27 Health a State Health Planning Board. The members of the board
28 shall include: the Commissioners of Health and Human Services,
29 or their designees, who shall serve as ex officio, nonvoting
30 members; the chairmen of the Health Care Administration Board,
31 the Hospital Rate Setting Commission and the Public Health
32 Council, or their designees, who shall serve as ex officio
33 members; one representative from each of the local advisory
34 boards; and five public members appointed by the Governor with
35 the advice and consent of the Senate, three of whom are
36 consumers of health care services who are neither providers of
37 health care services or persons with a fiduciary interest in a
38 health care service.
39 Of the public members first appointed, two shall serve for a
40 term of two years, two shall serve for a term of three years and
41 one shall serve for a term of four years. Following the expiration
42 of the original terms, the public members shall serve for a term
43 of four years and are eligible for reappointment. Any vacancy
44 shall be filled in the same manner as the original appointment,
45 for the unexpired term. Public members shall continue to serve
46 until their successors are appointed. The public members shall
47 serve without compensation but may be reimbursed for
48 reasonable expenses incurred in the performance of their duties,
49 within the limits of funds available to the board.
50 a. A member or employee of the State Health Planning Board

1 shall not, by reason of his performance of any duty, function or
2 activity required of, or authorized to be undertaken by the board,
3 be held civilly or criminally liable if that person acted within the
4 scope of his duty, function or activity as a member or employee
5 of the board, without gross negligence or malice toward any
6 person affected thereby.
7 b. A member of the State Health Planning Board shall not vote
8 on any matter before the board concerning an individual or entity
9 with which the member has, or within the last 12 months has had,
10 any substantial ownership, employment, medical staff, fiduciary,
11 contractual, creditor or consultative relationship. A member who
12 has or has had such a relationship with an individual or entity
13 involved in any matter before the board shall make a written
14 disclosure of the relationship before any action is taken by the
15 board with respect to the matter and shall make the relationship
16 public in any meeting in which action on the matter is to be
17 taken.[4]
18 [4]34. (New section) a. The State Health Planning Board shall
19 prepare and revise annually, a State Health Plan. The State
20 Health Plan shall identify the unmet health care needs in an area
21 by service and location and it shall serve as the basis upon which
22 all certificate of need applications shall be approved. The plan
23 shall be effective beginning January 1, 1992.
24 The State Health Planning Board shall consider the
25 recommendations of the local advisory boards in preparing and
26 revising the plan to incorporate specific regional and geographic
27 considerations of access to, and delivery of, health care services
28 at a reasonable cost. The State Health Planning Board shall
29 incorporate the recommendations of the local advisory boards
30 into the plan unless the recommendations are in conflict with the
31 best interests of Statewide health planning.
32 For each unmet health care service identified in the plan, the
33 plan shall specify the period of time for which a certificate of
34 need for that service shall be valid.
35 The plan shall be adopted by the Commissioner of Health
36 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
37 (C.52:14B-1 et seq.), subject to the approval of the Health Care
38 Administration Board.
39 b. The State Health Planning Board shall review applications
40 for certificates of need and make recommendations to the
41 Commissioner of Health in accordance with the State Health
42 Plan.[4]
43 [4]35. (New section) There is established a program to provide
44 local health planning on a Statewide basis in a minimum of five
45 specific geographic regions to be designated by the Governor, in
46 consultation with the Commissioner of Health. Each region shall,
47 to the extent possible, include sufficient resources to provide a
48 comprehensive range of health care facilities and services and
49 the designation of each region shall take into account the
50 compatibility of social, economic, transportation and geographic

1 characteristics.
2 a. Local health planning in each region shall be conducted by a
3 local advisory board approved by the Commissioner of Health,
4 which shall be organized as a nonprofit corporation.
5 The commissioner shall establish requirements for the
6 composition of the governing body of each corporation and shall
7 specify, under the terms of an agreement with the corporation
8 for the awarding of a grant pursuant to this section, those
9 functions which the board, at a minimum, shall perform. The
10 commissioner shall award to each corporation a grant of such
11 monies as shall be determined by the commissioner.
12 The membership of the governing body of the corporation
13 approved as a local advisory board shall be composed of
14 consumers and providers of health care who reside or have their
15 principal place of business within the geographic region
16 designated by the commissioner, except that no less than 51% but
17 no more than 60% of the members shall be persons who are not
18 providers of health care.
19 b. The local advisory board shall conduct local health planning
20 for its designated region and make recommendations at least
21 annually to the State Health Planning Board for incorporation
22 into the State Health Plan. The local advisory board shall also
23 review certificate of need applications for any proposed project
24 in its region and make recommendations to the Commissioner of
25 Health in accordance with the State Health Plan.
26 c. A member of the governing body or employee of the
27 corporation shall not, by reason of his performance of any duty,
28 function or activity required of, or authorized to be undertaken
29 by the corporation, be held civilly or criminally liable if that
30 person acted within the scope of his duty, function or activity as
31 a member of the governing body or employee of the corporation
32 and without gross negligence or malice toward any person
33 affected thereby.
34 A corporation shall not, by reason of the performance of any
35 duty, function or activity required of, or authorized to be
36 undertaken by the corporation, be held civilly or criminally liable
37 if the member of the governing body or the employee of the
38 corporation who acted on behalf of the corporation in the
39 performance of that duty, function, or activity acted within the
40 scope of his duty, function or activity as a member of the
41 governing body or employee of the corporation, exercised due
42 care and acted without gross negligence or malice toward any
43 person affected thereby.[4]
44 [4][7.] 36.[4] Section 10 of P.L.1971, c.136 (C.26:2H-10) is
45 amended to read as follows:
46 10. Application for a certificate of need shall be made to the
47 department, and shall be in such form and contain such
48 information as the department may prescribe. The department
49 shall charge a nonreturnable fee [1][of not more than $1,000.00][1]
50 for the filing of an application for a certificate of need [1][as it

1 shall from time to time fix in rules or regulations.]. The
2 minimum fee for the filing of an application shall be $5,000. For
3 a project whose total cost is greater than $1 million but less than
4 $10 million, the fee shall be $5,000 plus .05% of the total project
5 cost, and for a project whose total cost is $10 million or more,
6 the fee shall be $5,000 plus 1.0% of the total project cost[1] [4],
7 except that, the maximum fee for the filing of an application
8 shall be $100,000[4]. Upon receipt of an application, copies
9 thereof shall be referred by the department to the appropriate
10 [planning agencies or council] local advisory board and the State
11 Health Planning Board for review.
12 These appropriate [agencies and council] boards shall provide
13 adequate mechanisms for full consideration of each application
14 submitted to them and for developing recommendations thereon.
15 Such recommendations, whether favorable or unfavorable, shall
16 be forwarded to the commissioner within 90 days of the date of
17 referral of the application. A copy of the recommendations made
18 shall be forwarded to the applicant.
19 Recommendations concerning certificates of need shall be
20 governed and based upon the principles and considerations set
21 forth in section 8 [hereof] of P.L.1971, c.136 (C.26:2H-8).
22 No member, officer or employee of any planning body shall be
23 subject to civil action in any court as the result of any act done
24 or failure to act, or of any statement made or opinion given,
25 while discharging his duties under this act as such member,
26 officer, or employee, provided he acted in good faith with
27 reasonable care and upon proper cause.
28 (cf: P.L.1978, c.83, s.7)
29 [4]37. (New section) a. Notwithstanding the provisions of section
30 10 of P.L.1971, c.136 (C.26:2H-10) to the contrary:
31 (1) If at least 25% of the quorum of voting members at a
32 meeting of a local advisory board votes affirmatively to approve
33 a certificate of need application, regardless of whether the local
34 advisory board's recommendation is to approve or deny the
35 application, the application shall be forwarded to the State
36 Health Planning Board for its review of the application. If the
37 application does not receive the required minimum number of
38 affirmative votes, the application shall not be submitted to the
39 State Health Planning Board or the Commissioner of Health for
40 their reviews, respectively.
41 (2) If at least 25% of the quorum of voting members at a
42 meeting of the State Health Planning Board votes affirmatively
43 to approve a certificate of need application, regardless of
44 whether the State Health Planning Board's recommendation is to
45 approve or deny the application, the application shall be
46 forwarded to the Commissioner of Health for his review of the
47 application. If the application does not receive the required
48 minimum number of affirmative votes, the application shall not
49 be submitted to the commissioner for his review.
50 b. If an application which is consistent with the State Health

1 Plan does not receive the required minimum number of
2 affirmative votes by either a local advisory board or the State
3 Health Planning Board, respectively, the applicant may request a
4 fair hearing to permit the application to move to the next level
5 for review. The request for a fair hearing shall be made to the
6 Commissioner of Health within 30 days of the vote by the local
7 advisory board or State Health Planning Board, as applicable.
8 The fair hearing shall be held within 60 days of the request. If
9 the hearing examiner determines that the application should be
10 reviewed by the next level for review, the applicant shall be so
11 notified and the State Health Planning Board or the
12 commissioner, as applicable, shall review the application in the
13 manner provided pursuant to section 10 of P.L.1971, c.136
14 (C.26:2H-10).[4]
15 [4][8.] 38.[4] Section 12 of P.L.1971, c.136 (C.26:2H-12) is
16 amended to read as follows:
17 12. a. No health care facility shall be operated unless it shall:
18 (1) possess a valid license issued pursuant to this act, which
19 license shall specify the kind or kinds of health care services the
20 facility is authorized to provide; (2) establish and maintain a
21 uniform system of cost accounting approved by the commissioner;
22 (3) establish and maintain a uniform system of reports and audits
23 meeting the requirements of the commissioner; (4) prepare and
24 review annually a long range plan for the provision of health care
25 services, which plan shall be compatible with the State Health
26 Plan [established pursuant to the "National Health Planning and
27 Resources Development Act of 1974" (Federal Law 93-641)] as
28 related to medical health services, health care services, and
29 health manpower; and (5) establish and maintain a centralized,
30 coordinated system of discharge planning which assures every
31 patient a planned program of continuing care and which meets
32 the requirements of the commissioner which requirements shall,
33 where feasible, equal or exceed those standards and regulations
34 established by the Federal Government for all federally-funded
35 health care facilities but shall not require any person who is not
36 in receipt of State or Federal assistance to be discharged against
37 his will.
38 b. (1) Application for a license for a health care facility shall
39 be made upon forms prescribed by the department. The
40 department shall charge such nonrefundable fees for the filing of
41 an application for a license and any renewal thereof, as it shall
42 from time to time fix in rules or regulations; provided, however,
43 that no such fee shall exceed $2,000.00. The application shall
44 contain the name of the health care facility, the kind or kinds of
45 health care service to be provided, the location and physical
46 description of the institution, and such other information as the
47 department may require. (2) A license shall be issued by the
48 department upon its findings that the premises, equipment,
49 personnel, including principals and management, finances, rules
50 and bylaws, and standards of health care service are fit and

1 adequate and there is reasonable assurance the health care
2 facility will be operated in the manner required by this act and
3 rules and regulations thereunder.
4 c. A license issued before the effective date of this act to a
5 health care facility for its operation, upon the first renewal date
6 thereafter, may be extended for a 1 year period of time, provided
7 the facility then meets the requirements for licensure at the time
8 said license was issued and submits an acceptable plan to meet
9 current requirements at the end of said period of time.
10 d. The commissioner may amend a facility's license to reduce
11 that facility's licensed bed capacity to reflect actual utilization
12 at the facility if the commissioner determines that [4][one] 10[4] or
13 more licensed beds in the health care facility have not been used
14 for at least the last two succeeding years [4][[1], except that, the
15 provisions of this subsection shall not apply in those cases in
16 which a licensed bed has not been used for at least the last two
17 succeeding years in order to comply with a patient's or
18 resident's request to reduce the number of beds in that patient's
19 or resident's room at the facility during the time the patient or
20 resident occupies the room[1]][4]. For the purposes of this
21 subsection, the commissioner may retroactively review
22 utilization at a facility for a two year period beginning on [4][July
23 1, 1989] January 1, 1990[4].
24 (cf: P.L.1978, c.83, s.8)
25 [4]39. (New section) a. If a hospital enters into a contract or
26 any other form of agreement with a health care benefits
27 provider, insurance plan or any other third party to charge a
28 discounted or reduced rate for health care services rendered at
29 the hospital for that provider's, insurance plan's or third party's
30 subscribers, enrollees, members or beneficiaries, as the case may
31 be, the hospital shall notify the Hospital Rate Setting
32 Commission in writing within 30 days of the date that the
33 contract or agreement is entered into.
34 A hospital shall not be entitled to recover through its schedule
35 of rates the loss in revenue incurred by the hospital as a result of
36 the discounted or reduced rate.
37 b. Upon request of the commission and in a manner specified
38 by the commission, the hospital shall provide the commission with
39 information about the number of patients whose rates were
40 discounted or reduced and the loss in revenue incurred by the
41 hospital as a result of the contract or agreement.[4]
42 [4][9.] 40.[4] Section 11 of P.L.1978, c.83 (C.26:2H-18.1) is
43 amended to read as follows:
44 11. a. The commission shall make the determinations and hear
45 appeals provided for in this act in a timely manner pursuant to
46 regulations proposed by the commissioner and approved by the
47 board. Such regulations shall be presented to the Standing
48 Legislative Committees on Institutions, Health and Welfare for
49 final approval within 1 year following establishment of the
50 commission pursuant to the provisions of this act, and shall

1 remain in effect in the form proposed by the commissioner and
2 approved by the board until the provisions of such regulations are
3 enacted into law as amendments to this act. Such regulations
4 shall require that in the event the commission does not perform
5 its duties within the time period specified therein the commission
6 may permit a hospital to make a temporary reasonable change in
7 rates which shall be effective immediately, when it deems it in
8 the public interest to do so. Notwithstanding such temporary
9 change in rates, the review procedure set forth in this section
10 shall be conducted by the commission as soon thereafter as is
11 possible.
12 b. Pursuant to regulations proposed by the commissioner and
13 approved by the board, the commissioner shall propose and the
14 commission shall make automatic periodic adjustments to each
15 preliminary cost base or certified revenue base for changes in
16 economic factors reasonably calculated to provide for the effects
17 of general economic inflation or deflation; for industrywide
18 changes in the efficiency of delivering health care services; and
19 for each hospital's actual changes in volume and case-mix, which
20 are necessary and appropriate. The commission shall approve an
21 appropriate change in the schedule of rates to reflect these
22 adjustments.
23 c. Pursuant to regulations proposed by the commissioner and
24 approved by the board, the commission shall consider adjustments
25 to the certified revenue bases and schedules of rates, provided
26 such adjustments: (1) result from changes in statutes [and] or
27 regulations affecting the delivery of health care; and (2) may
28 affect one or more hospitals. Such adjustments shall take into
29 account the effectiveness and efficiency of the health care
30 delivery system as a whole. Where appropriate the commission
31 may sit en banc and hold public hearings in order to obtain the
32 evidence required to support its conclusions and determinations.
33 In the case of such hearings the commission shall provide actual
34 notice to the affected planning and licensing authorities and
35 hospitals, and to the commissioner and the Public Advocate.
36 d. Pursuant to regulations proposed by the commissioner and
37 approved by the board, all [other] changes in [the commission's
38 determinations] a hospital's preliminary cost base or certified
39 revenue base and schedule of rates other than those provided for
40 in subsections b. and c. of this section, shall require a review by
41 the commission in a public hearing of the entire preliminary cost
42 base or certified revenue base and schedule of rates.
43 Determinations of the commission may be appealed by hospitals,
44 the commissioner, the Public Advocate, affected planning,
45 licensing or inspection agencies and payors, and other affected
46 parties, and shall be conducted as contested proceedings under
47 the Administrative [Procedures] Procedure Act, P.L.1968, c.410
48 (C.52:14B-1 et seq.). During the pendency of any appeal, the
49 schedule of rates approved by the commission pursuant to
50 [sections 5 and 10 of this act] section 5 of P.L.1978, c.83

1 (C.26:2H-4.1) and section 18 of P.L.1971, c.136 (C.26:2H-18)
2 shall remain in effect.
3 In all appeals, the burden of proof shall be on the petitioner.
4 All determinations rendered hereunder shall be consistent with
5 regulations and shall set forth in detail the commission's
6 reasoning and conclusions regarding the parties and
7 considerations specified in this act.
8 (cf: P.L.1978, c.83, s.11)
9 [4][10. (New section) There is established in the Department of
10 Health a State Health Planning Board. The members of the board
11 shall include: the Commissioners of Health and Human Services,
12 or their designees, who shall serve as ex officio, nonvoting
13 members; the chairmen of the Health Care Administration Board,
14 the Hospital Rate Setting Commission and the Public Health
15 Council, or their designees, who shall serve as ex officio
16 members; one representative from each of the local advisory
17 boards; and five public members appointed by the Governor with
18 the advice and consent of the Senate, three of whom are
19 consumers of health care services who are neither providers of
20 health care services or persons with a fiduciary interest in a
21 health care service.
22 Of the public members first appointed, two shall serve for a
23 term of two years, two shall serve for a term of three years and
24 one shall serve for a term of four years. Following the expiration
25 of the original terms, the public members shall serve for a term
26 of four years and are eligible for reappointment. Any vacancy
27 shall be filled in the same manner as the original appointment,
28 for the unexpired term. Public members shall continue to serve
29 until their successors are appointed. The public members shall
30 serve without compensation but may be reimbursed for
31 reasonable expenses incurred in the performance of their duties,
32 within the limits of funds available to the board.
33 a. A member or employee of the State Health Planning Board
34 shall not, by reason of his performance of any duty, function or
35 activity required of, or authorized to be undertaken by the board,
36 be held civilly or criminally liable if that person acted within the
37 scope of his duty, function or activity as a member or employee
38 of the board, without gross negligence or malice toward any
39 person affected thereby.
40 b. A member of the State Health Planning Board shall not vote
41 on any matter before the board concerning an individual or entity
42 with which the member has, or within the last 12 months has had,
43 any substantial ownership, employment, medical staff, fiduciary,
44 contractual, creditor or consultative relationship. A member who
45 has or has had such a relationship with an individual or entity
46 involved in any matter before the board shall make a written
47 disclosure of the relationship before any action is taken by the
48 board with respect to the matter and shall make the relationship
49 public in any meeting in which action on the matter is to be
50 taken.][4]

1 4[11. (New section) a. The State Health Planning Board shall
2 prepare and revise annually, a State Health Plan. The State
3 Health Plan shall identify the unmet health care needs in an area
4 by service and location and it shall serve as the basis upon which
5 all certificate of need applications shall be approved. The plan
6 shall be effective beginning January 1, 1992.
7 The State Health Planning Board shall consider the
8 recommendations of the local advisory boards in preparing and
9 revising the plan to incorporate specific regional and geographic
10 considerations of access to, and delivery of, health care services
11 1at a reasonable cost1. The State Health Planning Board shall
12 incorporate the recommendations of the local advisory boards
13 into the plan unless the recommendations are in conflict with the
14 best interests of Statewide health planning.
15 1[The plan shall establish an annual limit for major capital
16 construction projects that would be authorized to be financed by
17 the New Jersey Health Care Facilities Financing Authority
18 pursuant to P.L.1972, c.29 (C.26:2I-1 et seq.),except that for the
19 five-year period beginning January 1, 1992 through December 31,
20 1996, the annual limit shall be $200 million.]1
21 For each unmet health care service identified in the plan, the
22 plan shall specify the period of time for which a certificate of
23 need for that service shall be valid.
24 The plan shall be adopted by the Commissioner of Health
25 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
26 (C.52:14B-1 et seq.), subject to the approval of the Health Care
27 Administration Board.
28 b. The State Health Planning Board shall review applications
29 for certificates of need and make recommendations to the
30 Commissioner of Health in accordance with the State Health
31 Plan.]4
32 4[12. (New section) There is established a program to provide
33 local health planning on a Statewide basis in a minimum of five
34 specific geographic regions to be designated by the Governor, in
35 consultation with the Commissioner of Health. Each region shall,
36 to the extent possible, include sufficient resources to provide a
37 comprehensive range of health care facilities and services and
38 the designation of each region shall take into account the
39 compatibility of social, economic, transportation and geographic
40 characteristics.
41 a. Local health planning in each region shall be conducted by a
42 local advisory board approved by the Commissioner of Health,
43 which shall be organized as a nonprofit corporation.
44 The commissioner shall establish requirements for the
45 composition of the governing body of each corporation and shall
46 specify, under the terms of an agreement with the corporation
47 for the awarding of a grant pursuant to this section, those
48 functions which the board, at a minimum, shall perform. The
49 commissioner shall award to each corporation a grant of such
50 monies as shall be determined by the commissioner.

1 The membership of the governing body of the corporation
2 approved as a local advisory board shall be composed of
3 consumers and providers of health care who reside or have their
4 principal place of business within the geographic region
5 designated by the commissioner, except that no less than 51% but
6 no more than 60% of the members shall be persons who are not
7 providers of health care.
8 b. The local advisory board shall conduct local health planning
9 for its designated region and make recommendations at least
10 annually to the State Health Planning Board for incorporation
11 into the State Health Plan. The local advisory board shall also
12 review certificate of need applications for any proposed project
13 in its region and make recommendations to the Commissioner of
14 Health in accordance with the State Health Plan.
15 c. A member of the governing body or employee of the
16 corporation shall not, by reason of his performance of any duty,
17 function or activity required of, or authorized to be undertaken
18 by the corporation, be held civilly or criminally liable if that
19 person acted within the scope of his duty, function or activity as
20 a member of the governing body or employee of the corporation
21 and without gross negligence or malice toward any person
22 affected thereby.
23 A corporation shall not, by reason of the performance of any
24 duty, function or activity required of, or authorized to be
25 undertaken by the corporation, be held civilly or criminally liable
26 if the member of the governing body or the employee of the
27 corporation who acted on behalf of the corporation in the
28 performance of that duty, function, or activity acted within the
29 scope of his duty, function or activity as a member of the
30 governing body or employee of the corporation, exercised due
31 care and acted without gross negligence or malice toward any
32 person affected thereby.][4]
33 [4][[1]13. (New section) a. Notwithstanding the provisions of
34 section 10 of P.L.1971, c.136 (C.26:2H-10) to the contrary:
35 (1) If at least 25% of the quorum of voting members at a
36 meeting of a local advisory board votes affirmatively to approve
37 a certificate of need application, regardless of whether the local
38 advisory board's recommendation is to approve or deny the
39 application, the application shall be forwarded to the State
40 Health Planning Board for its review of the application. If the
41 application does not receive the required minimum number of
42 affirmative votes, the application shall not be submitted to the
43 State Health Planning Board or the Commissioner of Health for
44 their reviews, respectively.
45 (2) If at least 25% of the quorum of voting members at a
46 meeting of the State Health Planning Board votes affirmatively
47 to approve a certificate of need application, regardless of
48 whether the State Health Planning Board's recommendation is to
49 approve or deny the application, the application shall be
50 forwarded to the Commissioner of Health for his review of the

application. If the application does not receive the required minimum number of affirmative votes, the application shall not be submitted to the commissioner for his review.

b. If an application which is consistent with the State Health Plan does not receive the required minimum number of affirmative votes by either a local advisory board or the State Health Planning Board, respectively, the applicant may request a fair hearing to permit the application to move to the next level for review. The request for a fair hearing shall be made to the Commissioner of Health within 30 days of the vote by the local advisory board or State Health Planning Board, as applicable. The fair hearing shall be held within 60 days of the request. If the hearing examiner determines that the application should be reviewed by the next level for review, the applicant shall be so notified and the State Health Planning Board or the commissioner, as applicable, shall review the application in the manner provided pursuant to section 10 of P.L.1971, c.136 (C.26:2H-10).[1]]4

1[13.] 4[14.1] 41.4 Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read as follows:

3. Definitions. As used in this act, and unless the context otherwise requires:

a. "Applicant" means any person who has made application for purposes of becoming a "qualified applicant."

b. "Commissioner" means the Commissioner of the Department of Human Services.

c. "Department" means the Department of Human Services, which is herein designated as the single State agency to administer the provisions of this act.

d. "Director" means the Director of the Division of Medical Assistance and Health Services.

e. "Division" means the Division of Medical Assistance and Health Services.

f. "Medicaid" means the New Jersey Medical Assistance and Health Services Program.

g. "Medical assistance" means payments on behalf of recipients to providers for medical care and services authorized under this act.

h. "Provider" means any person, public or private institution, agency or business concern approved by the division lawfully providing medical care, services, goods and supplies authorized under this act, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

i. "Qualified applicant" means a person who is a resident of this State and is determined to need medical care and services as provided under this act, and who:

(1) Is a recipient of Aid to Families with Dependent Children;

(2) Is a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act;

1 (3) Is an "ineligible spouse" of a recipient of Supplemental
2 Security Income for the Aged, Blind and Disabled under Title XVI
3 of the Social Security Act, as defined by the federal Social
4 Security Administration;
5 (4) Would be eligible to receive public assistance under a
6 categorical assistance program except for failure to meet an
7 eligibility condition or requirement imposed under such State
8 program which is prohibited under Title XIX of the federal Social
9 Security Act such as a durational residency requirement, relative
10 responsibility, consent to imposition of a lien;
11 (5) Is a child between 18 and 21 years of age who would be
12 eligible for Aid to Families with Dependent Children, living in the
13 family group except for lack of school attendance or pursuit of
14 formalized vocational or technical training;
15 (6) Is an individual under 21 years of age who qualifies for
16 categorical assistance on the basis of financial eligibility, but
17 does not qualify as a dependent child under the State's program
18 of Aid to Families with Dependent Children (AFDC), or groups of
19 such individuals, including but not limited to, children in foster
20 placement under supervision of the Division of Youth and Family
21 Services whose maintenance is being paid in whole or in part from
22 public funds, children placed in a foster home or institution by a
23 private adoption agency in New Jersey or children in
24 intermediate care facilities, including institutions for the
25 mentally retarded, or in psychiatric hospitals;
26 (7) Meets the standard of need applicable to his circumstances
27 under a categorical assistance program or Supplemental Security
28 Income program, but is not receiving such assistance and applies
29 for medical assistance only.
30 [1][A person shall not be considered a qualified applicant if,
31 within 24 months of becoming or making application to become a
32 qualified applicant, he has made a voluntary assignment or
33 transfer of real or personal property, or any interest or estate in
34 property, for less than adequate consideration. Such voluntary
35 assignment or transfer of property shall be deemed to have been
36 made for the purpose of becoming a qualified applicant in the
37 absence of evidence to the contrary supplied by the applicant.
38 This requirement shall not be applicable to Supplemental Security
39 Income applicants or aged, blind or disabled applicants for
40 Medicaid only unless authorized by federal law. Implementation
41 of this requirement shall conform with the provisions of section
42 132 of Pub.L. 97-248 (42 U.S.C.§ 1396 p. (c));][1]
43 (8) Is determined to be medically needy and meets all the
44 eligibility requirements described below:
45 (a) The following individuals are eligible for services, if they
46 are determined to be medically needy:
47 (i) Pregnant women;
48 (ii) Dependent children under the age of 21;
49 (iii) Individuals who are 65 years of age and older; and
50 (iv) Individuals who are blind or disabled pursuant to either 42

C.F.R. 435.530 et seq. or 42 C.F.R. 435.540 et seq., respectively.

(b) The following income standard shall be used to determine medically needy eligibility:

(i) For one person and two person households, the income standard shall be the maximum allowable under federal law, but shall not exceed 133 1/3% of the State's payment level to two person households eligible to receive assistance pursuant to P.L.1959, c.86 (C.44:10-1 et seq.); and

(ii) For households of three or more persons, the income standard shall be set at 133 1/3% of the State's payment level to similar size households eligible to receive assistance pursuant to P.L.1959, c.86 (C.44:10-1 et seq.).

(c) The following resource standard shall be used to determine medically needy eligibility:

(i) For one person households, the resource standard shall be 200% of the resource standard for recipients of Supplemental Security Income pursuant to 42 U.S.C.§ 1382(1)(B);

(ii) For two person households, the resource standard shall be 200% of the resource standard for recipients of Supplemental Security Income pursuant to 42 U.S.C.§ 1382(2)(B); and

(iii) For households of three or more persons, the resource standard in subparagraph (c)(ii) above shall be increased by $100.00 for each additional person.

(iv) The resource standards established in (i), (ii), and (iii) are subject to federal approval and the resource standard may be lower if required by the federal Department of Health and Human Services.

(d) Individuals whose income exceeds those established in subparagraph (b) of paragraph (8) of this subsection may become medically needy by incurring medical expenses as defined in 42 C.F.R. 435.831(c) which will reduce their income to the applicable medically needy income established in subparagraph (b) of paragraph (8) of this subsection.

(e) A six month period shall be used to determine whether an individual is medically needy.

(f) Eligibility determinations for the medically needy program shall be administered as follows:

(i) County welfare agencies are responsible for determining and certifying the eligibility of pregnant women and dependent children. The division shall reimburse county welfare agencies for 100% of the reasonable costs of administration which are not reimbursed by the federal government for the first 12 months of this program's operation. Thereafter, 75% of the administrative costs incurred by county welfare agencies which are not reimbursed by the federal government shall be reimbursed by the division;

(ii) The division is responsible for certifying the eligibility of individuals who are 65 years of age and older and individuals who are blind or disabled. The division may enter into contracts with county welfare agencies to determine certain aspects of

1 eligibility. In such instances the division shall provide county
2 welfare agencies with all information the division may have
3 available on the individual.
4 The division shall notify all eligible recipients of the
5 Pharmaceutical Assistance to the Aged and Disabled program,
6 P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the
7 medically needy program and the program's general
8 requirements. The division shall take all reasonable
9 administrative actions to ensure that Pharmaceutical Assistance
10 to the Aged and Disabled recipients, who notify the division that
11 they may be eligible for the program, have their applications
12 processed expeditiously, at times and locations convenient to the
13 recipients; and
14 (iii) The division is responsible for certifying incurred medical
15 expenses for all eligible persons who attempt to qualify for the
16 program pursuant to subparagraph (d) of paragraph (8) of this
17 subsection;
18 (9)(a) [Is a pregnant woman, or is] Is a child who is [under one
19 year of age, or, on and after October 1, 1987, is a child under
20 two] at least one year of age and under six years of age; and
21 (b) Is a member of a family whose income does not exceed
22 133% of the poverty level and who meets the federal Medicaid
23 eligibility requirements set forth in section 9401 of Pub.L. 99-509
24 (42 U.S.C.§ 1396a)[, except that a pregnant woman who is
25 determined to be a qualified applicant shall, notwithstanding any
26 change in the income of the family of which she is a member,
27 continue to be deemed a qualified applicant until the end of the
28 60 day period beginning on the last day of her pregnancy];
29 (10) Is a pregnant woman who is determined by a provider to
30 be presumptively eligible for medical assistance based on criteria
31 established by the commissioner, pursuant to section 9407 of
32 Pub.L.99-509 (42 U.S.C.§ 1396a(a)); [or]
33 (11) Is an individual 65 years of age and older, or an individual
34 who is blind or disabled pursuant to section 301 of Pub.L. 92-603
35 (42 U.S.C.§ 1382c), whose income does not exceed 100% of the
36 poverty level, adjusted for family size, and whose resources do
37 not exceed 100% of the resource standard used to determine
38 medically needy eligibility pursuant to paragraph (8) of this
39 subsection[1][.];[1]
40 (12) [1]Is a qualified disabled and working individual pursuant to
41 section 6408 of Pub.L.101-239 (42 U.S.C. §1396d) whose income
42 does not exceed 200% of the poverty level and whose resources
43 do not exceed 200% of the resource standard used to determine
44 eligibility under the Supplemental Security Income Program,
45 P.L.1973, c.256 (C.44:7-85 et seq.); or
46 (13)[1] Is a pregnant woman or is a child who is under one year
47 of age and is a member of a family whose income does not exceed
48 185% of the poverty level and who meets the federal Medicaid
49 eligibility requirements set forth in section 9401 of Pub.L.99-509
50 (42 U.S.C. §1396a), except that a pregnant woman who is

determined to be a qualified applicant shall, notwithstanding any change in the income of the family of which she is a member, continue to be deemed a qualified applicant until the end of the 60 day period beginning on the last day of her pregnancy.

[1]An individual who has, within 30 months of applying to be a qualified applicant for Medicaid services in a nursing facility or a medical institution, or for home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. §1396n(c)), disposed of resources for less than fair market value shall be ineligible for assistance for nursing facility services, an equivalent level of services in a medical institution, or home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. §1396n(c)). The period of the ineligibility shall be the lesser of 30 months or the number of months resulting from dividing the uncompensated value of the transferred resources by the average monthly private payment rate for nursing facility services in the State as determined annually by the commissioner.[1]

j. "Recipient" means any qualified applicant receiving benefits under this act.

k. "Resident" means a person who is living in the State voluntarily with the intention of making his home here and not for a temporary purpose. Temporary absences from the State, with subsequent returns to the State or intent to return when the purposes of the absences have been accomplished, do not interrupt continuity of residence.

l. "State Medicaid Commission" means the Governor, the Commissioner of Human Services, the President of the Senate and the Speaker of the General Assembly, hereby constituted a commission to approve and direct the means and method for the payment of claims pursuant to this act.

m. "Third party" means any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

n. "Governmental peer grouping system" means a separate class of skilled nursing and intermediate care facilities administered by the State or county governments, established for the purpose of screening their reported costs and setting reimbursement rates under the Medicaid program that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated State or county skilled nursing and intermediate care facilities.

o. "Comprehensive maternity or pediatric care provider" means any person or public or private health care facility that is a provider and that is approved by the commissioner to provide comprehensive maternity care or comprehensive pediatric care as defined in subsection b. (18) and (19) of section 6 of P.L.1968,

1 c.413 (C.30:4D-6b. (18) and (19)).
2 p. "Poverty level" means the official poverty level based on
3 family size established and adjusted under Section 673(2) of
4 Subtitle B, the "Community Services Block Grant Act," of
5 Pub.L.97-35 (42 U.S.C.§ 9902(2)).
6 (cf: P.L.1987, c.349, s.1)
7 1[14.] 4[15.1] 42.4 (New section) 1[Within five years of the
8 effective date of P.L. , c. (C.)(pending before the
9 Legislature as this bill), the Commissioner of Human Services
10 shall ensure that all recipients of medical assistance pursuant to
11 P.L.1968, c.413 (C.30:4D-1 et seq.) are given the option of
12 participating in a managed care plan] The Commissioner of
13 Human Services shall prepare a five-year plan to develop a
14 Statewide network of managed care providers for Medicaid
15 recipients pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.)1. A
16 managed care plan may include, but is not limited to, the Garden
17 State Health Plan, or its successor, any other State approved or
18 federally qualified health maintenance organization, or any other
19 cost effective health plan, prepaid or otherwise, that is under
20 contract with the Division of Medical Assistance and Health
21 Services in the Department of Human Services to provide
22 managed care services to 1Medicaid1 recipients 1[of medical
23 assistance]1.
24 1The commissioner shall prepare the plan within one year of
25 the effective date of P.L. , c. (C.)(pending before the
26 Legislature as this bill) and submit the plan to the Governor and
27 the Chairmen of the Senate Institutions, Health and Welfare and
28 General Assembly Health and Human Services Committees.1
29 4[116.] 43.4 (New section) Within one year of the effective
30 date of P.L. , c. (C.)(pending before the Legislature as this
31 bill), every State approved or federally qualified health
32 maintenance organization in the State shall submit a plan to the
33 Commissioner of Human Services to enroll Medicaid recipients
34 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.). The plan shall
35 include the terms and conditions for enrolling Medicaid
36 recipients, including the number of recipients that can reasonably
37 be enrolled, the health care services that will be offered, and an
38 estimate of the per capita cost for enrollment of these persons.
39 The commissioner shall provide a health maintenance
40 organization, upon written request, with any nonidentifying
41 information about Medicaid recipients that is necessary to assist
42 the health maintenance organization in preparing its plan.1
43 4[117.] 44.4 (New section) Within six months of the effective
44 date of P.L. , c. (C.)(pending before the Legislature as this
45 bill), the Commissioner of Human Services shall report to the
46 Governor and the Chairmen of the Senate Institutions, Health and
47 Welfare and General Assembly Health and Human Services
48 Committees on ways: to increase the number of providers in the
49 Medicaid program pursuant to P.L.1968, c.413 (C.30:4D-1 et
50 seq.); to improve Medicaid provider relations with the Medicaid

1 program; to reduce administrative burdens encountered by
2 Medicaid providers; and to streamline Statewide administration
3 of the Medicaid program.1
4 1[15.] 4[18.1] 45.4 (New section) a. Any person who is not
5 eligible for medical assistance pursuant to P.L.1968, c.413
6 (C.30:4D-1 et seq.) who is employed full-time or part-time and
7 does not have health insurance coverage provided by his employer
8 or by his spouse's employer, if any, or who cannot afford to
9 purchase health insurance coverage that may be offered by his
10 employer or his spouse's employer, if any, shall be eligible to
11 purchase health care coverage through the Garden State Health
12 Plan operated by the Division of Medical Assistance and Health
13 Services in the Department of Human Services.
14 b. A small employer, as defined by the Commissioner of
15 Human Services, who has not provided or offered to provide
16 health insurance coverage anytime during the 12-month period
17 immediately preceeding the effective date of coverage pursuant
18 to this section, shall be eligible to purchase health care coverage
19 for its employees through the Garden State Health Plan operated
20 by the Division of Medical Assistance and Health Services in the
21 Department of Human Services.
22 c. The Commissioner of Human Services shall design one or
23 more plans of benefits for employees and small employers who
24 wish to purchase health care coverage through the Garden State
25 Health Plan. The commissioner shall establish a schedule of
26 premiums for enrollment in the plan, which shall ensure that the
27 premiums charged are adequate to fund the costs of the benefits
28 provided by the plan to persons not otherwise eligible for medical
29 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.).
30 d. The commissioner shall make the purchase of health care
31 coverage through the Garden State Health Plan available to
32 employees and small employers within one year of the effective
33 date of P.L. , c. (C.) (pending before the Legislature as
34 this bill).
35 1e. Nothing in this section shall be construed to include the
36 Garden State Health Plan as a health maintenance organization in
37 any other provision of law regarding the offering or availability
38 of coverage by a health maintenance organization.1
39 1[16.] 4[19.1 Section 2 of P.L.1959, c.90 (C.2A:53A-8) is
40 amended to read as follows:
41 2. Notwithstanding the provisions of the foregoing paragraph,
42 any nonprofit corporation, society or association organized
43 exclusively for hospital purposes shall be liable to respond in
44 damages to such beneficiary who shall suffer damage from the
45 ~~negligence of such corporation, society or association or of its~~
46 agents or servants [to an amount not exceeding $10,000.00,
47 together with interest and costs of suit, as the result of any 1
48 accident and to the extent to which such damage, together with
49 ~~interest and costs of suit, shall exceed the sum of $10,000.00 such~~
50 nonprofit corporation, society or association organized

1 exclusively for hospital purposes shall not be liable therefor].
2 (cf: P.L.1959, c.90, s.2)][4]
3 [1][17.] [4][20.][1] Section 8 of P.L.1977, c.240 (C.24:6E-7) is
4 amended to read as follows:
5 8. Every prescription blank shall [be imprinted with the words,
6 "substitution permissible" and "do not substitute" and shall
7 contain space for the physician's or other authorized prescriber's
8 initials next to the chosen option. Notwithstanding any other
9 law, unless the physician or other authorized prescriber explicitly
10 states that there shall be no substitution when transmitting an
11 oral prescription or, in the case of a written prescription,
12 indicates that there shall be no substitution by initialing the
13 prescription blank next to "do not substitute," a different brand
14 name or nonbrand name drug product of the same established
15 name shall be dispensed by a pharmacist] [3]be imprinted with the
16 words, "brand necessary" and shall contain a box for the
17 physician's or other authorized prescriber's initials next to the
18 imprinted words. The prescription blank shall[3] contain one
19 signature line for the physician's or other authorized prescriber's
20 signature [3]at the bottom of the blank[3]. The prescriber's
21 signature shall validate the prescription and, unless the prescriber
22 [3][handwrites [1]["brand necessary" or] "brand necessary,"[1] "brand
23 medically necessary," [1]or words of similar meaning which express
24 a medical necessity for the brand name drug product, the
25 signature[1]] initials the box next to the words "brand necessary,"
26 the prescriber's signature[3] shall designate approval of
27 substitution of a drug by a pharmacist pursuant to this act if such
28 different brand name or nonbrand name drug product shall reflect
29 a lower cost to the consumer and is contained in the latest list of
30 interchangeable drug products published by the council; provided,
31 however, where the prescriber [indicates "substitution
32 permissible and] requests the pharmacist to notify him of the
33 substitution,["] the pharmacist shall transmit notice, either orally
34 or by written notice to be mailed no later than the end of the
35 business day, to the prescriber specifying the drug product
36 actually dispensed and the name of the manufacturer thereof.
37 [However,] Notwithstanding any other law to the contrary, unless
38 the physician or other authorized prescriber explicitly states that
39 a brand name drug product is necessary when transmitting an oral
40 prescription by using the phrase [1]["brand necessary" or "brand
41 medically necessary",] "brand necessary," [3]["brand medically
42 necessary," or words of similar meaning which express a medical
43 necessity for the brand name drug product,[1]][3] a different brand
44 name or nonbrand name drug product of the same established
45 name shall be dispensed by a pharmacist, however, no drug
46 interchange shall be made unless a savings to the consumer
47 results, and the pharmacist passes such savings on to the
48 consumer in full by charging no more than the regular and
49 customary retail price for the drug to be substituted. For
50 prescriptions filled other than by mail, [1][the consumer may, if a

1 substitution is indicated and prior to having his prescription
2 filled, request] if substitution is indicated[1] the pharmacist or his
3 agent [1][to inform him] , prior to filling the prescription, shall
4 inform the consumer[1] of the price savings that would result from
5 substitution. If the consumer is not satisfied with said price
6 savings he may, upon request, be dispensed the drug product
7 prescribed by the physician. The pharmacist shall make a
8 notation of such request upon the prescription blank.
9 (cf: P.L.1977, c.240, s.8)][4]
10 [1][18.] [4][21.[1] (New section) The Drug Utilization Review
11 Council established pursuant to section 6 of P.L.1977, c.240
12 (C.24:6E- 5) shall send written notice within 30 days, and again
13 within 60 days, after the effective date of P.L. , c. (C.)
14 (pending before the Legislature as this bill) to each duly licensed
15 physician, dentist, veterinarian and other practitioner licensed in
16 this State to write prescriptions intended for the treatment or
17 prevention of disease in man or animals, hereinafter referred to
18 as a prescriber, which shall:
19 a. Inform a prescriber of the provisions of [1][P.L. , c. (C.)
20 (pending before the Legislature as this bill)] section 8 of
21 P.L.1977, c.240 (C.24:6E-7)[1]; and
22 b. Inform a prescriber that the enactment of this act does not
23 preclude a prescriber from prescribing a brand name drug if, in
24 his opinion, the use of the brand name drug is in the best medical
25 interest of the patient.][4]
26 [1][19.] [4][22.[1]] 46.[4] (New section) A physician shall not dispense
27 more than a [4][four-day] seven-day[4] supply of drugs or medicines
28 to any patient[4][, unless the] . The[4] drugs or medicines [4][are]
29 shall be[4] dispensed at or below the cost the physician has paid for
30 the particular drug or medicine [4], plus an administrative cost not
31 to exceed 10% of the cost of the drug or medicine[4].
32 The provisions of this section shall not apply to a physician:
33 a. who dispenses drugs or medicines in [4]a hospital emergency
34 room, a student health center at an institution of higher
35 education, or[4] a publicly subsidized [4]community health center,[4]
36 family planning [4]clinic[4] or prenatal clinic, if the drugs or
37 medicines that are dispensed are directly related to the services
38 provided at the [4][clinic] facility[4];
39 b. whose practice is situated 10 miles or more from a licensed
40 pharmacy;
41 c. when he dispenses allergenic extracts and injectables; [4][or][4]
42 d. when he dispenses drugs pursuant to an oncological or AIDS
43 protocol[4]; or
44 e. when he dispenses salves, ointments or drops[4].
45 [1][20.] [4][23.[1] (New section) Sections [1][20 through 37] 23
46 through 40[1] of P.L. , c. (C.) (pending before the Legislature
47 as this bill) shall be known and may be cited as the "Primary Care
48 Physician [1]and Dentist[1] Loan Redemption Program Act."][4]
49 [1][21.] [4][24.[1] (New section) As used in sections [1][20 through 37]
50 23 through 40[1] of P.L. , c. (C.) (pending before the

1 Legislature as this bill):
2 "Eligible student loan expenses" means the cumulative total of
3 the annual student loans covering the cost of attendance at an
4 undergraduate institution of medical [1]or dental[1] education.
5 Interest paid or due on student loans that an applicant has taken
6 out for use in paying the costs of undergraduate medical [1]or
7 dental[1] education shall be considered eligible for reimbursement
8 under the program. The Chancellor of Higher Education may
9 establish a limit on the total amount of student loans which may
10 be redeemed for participants under the program, provided that
11 the total redemption of student loans does not exceed [1][$40,000]
12 $70,000[1].
13 "Medically underserved area" means an urban or rural area
14 which need not conform to the geographic boundaries of a
15 political subdivision within the State but which shall be defined in
16 terms of census tracts, if possible, which is a rational area for
17 the delivery of health services and which has a medical [1]or
18 dental[1] manpower shortage as determined by the Commissioner
19 of Health; or a population group which the commissioner
20 determines has a medical [1]or dental[1] manpower shortage; or a
21 public or nonprofit private health care facility or other facility
22 which is so designated.
23 "Primary care" includes the practice of family medicine,
24 general internal medicine, general pediatrics, general obstetrics,
25 gynecology, and any other areas of medicine which the
26 Commissioner of Health may define as primary care. [1]Primary
27 care also includes the practice of general dentistry and
28 pedodontics.[1]
29 "Primary Care Physician [1]and Dentist[1] Loan Redemption
30 Program" means a program which provides for the redemption of
31 the eligible student loan expenses of its participants.
32 "Undergraduate medical [1]or dental[1] education" means the
33 period of time between entry into medical [1]or dental[1] school and
34 the award of the medical (M.D., D.O.) degree [1]or dental (D.M.D.)
35 degree, respectively[1].][4]
36 [1][22.] [4][25.[1] (New section) There is established a Primary
37 Care Physician [1]and Dentist[1] Loan Redemption Program within
38 the Department of Higher Education. The program shall provide
39 for the redemption of a portion of the eligible student loan
40 expenses of program participants for each year of service in a
41 medically underserved area of the State as designated by the
42 Commissioner of Health.][4]
43 [1][23.] [4][26.[1] (New section) To be eligible to participate in the
44 Primary Care Physician [1]and Dentist[1] Loan Redemption
45 Program, an applicant shall:
46 a. Be a resident of the State;
47 b. Be a graduate of a medical school approved by the State
48 Board of Medical Examiners for the purpose of licensure and
49 receive a recommendation from the school's medical staff
50 concerning participation in the loan redemption program [1]in the

1 case of a physician, or be a graduate of a dental school approved
2 by the New Jersey State Board of Dentistry for the purpose of
3 licensure and receive a recommendation from the school's dental
4 staff concerning participation in the loan redemption program in
5 the case of a dentist[1];
6 c. [1][Have] In the case of a physician, have[1] completed a
7 professional residency training program and receive a
8 recommendation from the medical staff of the training program
9 concerning participation in the loan redemption program; and,
10 d. Agree to practice medicine [1]or dentistry, as appropriate,[1]
11 in a medically underserved area of the State.][4]
12 [1][24.] [4][27.[1] (New section) The Commissioner of Health, after
13 consultation with the Commissioner of Corrections and the
14 Commissioner of Human Services, shall designate and establish a
15 ranking of medically underserved areas of the State. The criteria
16 used by the Commissioner of Health in designating underserved
17 areas shall include, but not be limited to:
18 a. the ratio of the supply of primary care physicians [1]and
19 dentists[1] by relative specialty to the population under
20 consideration with a goal of meeting current standards for
21 physician [1]and dentist[1] to population ratios in primary care
22 medical [1]and dental[1] specialties;
23 b. the financial resources of the population under
24 consideration;
25 c. the population's access to medical [1]and dental[1] services;
26 and,
27 d. appropriate physician [1]and dentist[1] staffing ratios in State,
28 county, municipal and private nonprofit health care facilities.
29 The commissioner shall annually transmit the list of medically
30 underserved areas and the number of positions needed in each
31 area to the Chancellor of Higher Education.][4]
32 [1][25.] [4][28.[1] (New section) A medical [1]or dental[1] student who
33 is eligible and interested in participating in the loan redemption
34 program shall sign a nonbinding agreement with the Department
35 of Higher Education upon completion of the final year of
36 undergraduate medical [1]or dental[1] training [1], as appropriate[1].
37 At the end of the final year of residency training [1]in the case of
38 a physician, and at the end of the final year of undergraduate
39 dental training or residency training if such training is required in
40 a primary care dental specialty in the case of a dentist[1], the
41 applicant shall sign a contractual agreement with the Department
42 of Higher Education. The agreement shall specify the applicant's
43 length of required service and the total amount of eligible
44 student loan expenses to be redeemed by the State in return for
45 service. The agreement shall also stipulate that the applicant has
46 knowledge of and agrees to the six month probationary period
47 required prior to final acceptance into the program pursuant to
48 section [1][27] 30[1] of P.L. , c. (C.) (pending before the
49 Legislature as this bill).][4]
50 [1][26.] [4][29.[1] (New section) Maximum redemption of loans

1 under the loan redemption program shall amount to [1][25%] 15%[1]
2 of principal and interest of eligible student loan expenses in
3 return for one full year of service in a designated medically
4 underserved area of the State, an additional [1][35%] 20%[1] for a
5 second full year of service, [1][and][1] an additional [1][40%] 25%[1] for
6 a third full year of service [1]and an additional 40% for a fourth
7 full year of service[1] for a total redemption of eligible student
8 loan expenses of up to, but not to exceed, [1][$40,000] $70,000[1].
9 Service in a medically underserved area shall begin immediately
10 upon completion of the medical residency training program [1]in
11 the case of a physician, and immediately upon completion of
12 undergraduate dental training or residency training if such
13 training is required in a primary care dental specialty in the case
14 of a dentist[1].][4]
15 [1][27.] [4][30.[1] (New section) Each program participant shall
16 serve a six month probationary period upon initial placement in a
17 service site within the medically underserved area. During that
18 period, the medical [1]or dental[1] staff of the service site [1], as
19 appropriate,[1] shall evaluate the suitability of the placement for
20 the participant. At the end of the probationary period, the
21 medical [1]or dental[1] staff shall recommend the continuation of
22 the program participant's present placement, a change in
23 placement, or its determination that the participant is an
24 unsuitable candidate for the loan redemption program. If the
25 medical [1]or dental[1] staff of the service site recommends a
26 change in placement, then the chancellor shall place the program
27 participant in an alternate placement within a medically
28 underserved area. If the medical [1]or dental[1] staff determines
29 that the program participant is not a suitable candidate for the
30 program, then the chancellor shall take this recommendation into
31 consideration in regard to the participant's final acceptance into
32 the program. No loan redemption payment shall be made during
33 the six month probationary period, however, a program
34 participant shall receive credit for this six month period in
35 calculating the first year of required service under the loan
36 redemption contract.][4]
37 [1][28.] [4][31.[1] (New section) The Chancellor of Higher
38 Education, in consultation with the Commissioner of Health, shall
39 match program participants to medically underserved areas based
40 upon the ranking of the underserved areas established by the
41 commissioner and on the basis of participant preference.][4]
42 [1][29.] [4][32.[1] (New section) The Chancellor of Higher
43 Education shall annually determine the number of program
44 positions available on the basis of the need for primary care
45 physicians [1]and dentists[1] in medically underserved areas of the
46 State as determined by the Commissioner of Health and the State
47 and federal funds available for the program. Once the number of
48 program positions has been determined, the chancellor shall
49 select the program participants from among those students who
50 have applied to the program and who meet the criteria

1 established pursuant to section [1][23] 26[1] of P.L. , c. (C.)
2 (pending before the Legislature as this bill). In selecting program
3 participants, the chancellor shall accord priority to applicants in
4 the following manner:
5 a. First, to any applicant who is completing a [1]fourth,[1] third
6 or second year of a loan redemption contract;
7 b. Second, to any applicant whose residence in the State at the
8 time of entry into post secondary education was within a
9 medically underserved area; and,
10 c. Third, to any applicant according to the severity of the
11 physician [1]or dentist[1] shortage in the area selected by the
12 applicant.
13 In the event that there are more applicants who have the same
14 priority than there are program positions, the chancellor shall
15 select participants by means of a lottery or other form of random
16 selection.][4]
17 [1][30.] [4][33.[1] (New section) A physician [1]or dentist[1] who has
18 previously entered into a contract with the Department of Higher
19 Education may nullify the agreement by notifying the
20 Department of Higher Education in writing and assuming full
21 responsibility for repayment of principal and interest at the
22 appropriate market rate of the full amount of the eligible student
23 loan expenses or that portion of the loan which has not been
24 redeemed by the State in return for partial fulfillment of the
25 contract. In no event shall service in a medically underserved
26 area for less than the full calendar year of each period of service
27 entitle the participant to any benefits under the loan redemption
28 program. A participant seeking to nullify the contract shall be
29 required to pay the unredeemed portion of indebtedness in not
30 more than 10 years following termination of the contract minus
31 the years of service already served under the contract.][4]
32 [1][31.] [4][34.[1] (New section) In case of a program participant's
33 death or total or permanent disability, the Chancellor of Higher
34 Education shall nullify the service obligation of the student
35 thereby terminating the student's obligation to repay the unpaid
36 balance of the redeemable portion of the loan and the accrued
37 interest thereon, or where continued enforcement of the contract
38 may result in extreme hardship, the chancellor may nullify or
39 suspend the service obligation of the student.][4]
40 [1][32.] [4][35.[1] (New section) In case of a program participant's
41 conviction of a felony or misdemeanor or an act of gross
42 negligence in the performance of service obligations or where the
43 license to practice has been suspended or revoked, the Chancellor
44 of Higher Education shall have the authority to terminate the
45 participant's service in the program and request repayment of
46 the outstanding debt.][4]
47 [1][33.] [4][36.[1] (New section) A student who is participating in a
48 federal program of a similar nature, which [1][provide] provides[1]
49 financial support for students in return for service in underserved
50 areas of the nation, shall not be eligible for participation in the

1 Primary Care Physician [1]and Dentist[1] Loan Redemption Program
2 unless after review and consideration the Chancellor of Higher
3 Education finds that the student has extraordinary financial
4 responsibilities making it essential for the student to use the loan
5 resources of both federal and State programs. These cases shall
6 be reviewed and approved by the chancellor on an individual
7 basis. In these cases, the period of service to the State of New
8 Jersey may be served simultaneously with the federal service
9 obligation if that obligation is being discharged by service within
10 this State.][4]
11 [1][34.] [4][37.[1] (New section) Prior to repayment of the annual
12 amount eligible for redemption, each program participant shall
13 report to the Department of Higher Education, in such manner
14 and form as it shall prescribe, information on the participant's
15 performance of service in the medically underserved area as
16 required under the contract.][4]
17 [1][35.] [4][38.[1] (New section) The Chancellor of Higher
18 Education and the Commissioner of Health shall jointly establish
19 a procedure for the recruitment of program applicants at
20 medical [1]and dental[1] schools and health centers. The procedure
21 shall provide for the participation of the medical [1]and dental[1]
22 staff [1],as appropriate,[1] of those facilities in the selection of
23 appropriate applicants for the program.][4]
24 [1][36.] [4][39.[1] (New section) The Department of Higher
25 Education shall annually apply for any federal funds which may be
26 available to implement the provisions of this act.][4]
27 [1][37.] [4][40.[1] (New section) The State Board of Higher
28 Education shall adopt rules and regulations pursuant to the
29 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
30 seq.) as may be necessary to implement the provisions of this
31 act.][4]
32 [4][[1]41. Section 2 of P.L.1989, c.19 (C.45:9-22.5) is amended to
33 read as follows:
34 2. a. A practitioner shall not refer a patient or direct an
35 employee of the practitioner to refer a patient to a health care
36 service in which the practitioner, or the practitioner's immediate
37 family, or the practitioner in combination with practitioner's
38 immediate family has a significant beneficial interest [unless the
39 practitioner] ; except that, in the case of a practitioner, a
40 practitioner's immediate family or a practitioner in combination
41 with the practitioner's immediate family who had the significiant
42 beneficial interest prior to the effective date of P.L. , c.
43 (C.)(pending before the Legislature as this bill), the
44 practitioner may continue to refer a patient or direct an
45 employee to do so if that practitioner discloses the significant
46 beneficial interest to the patient.
47 [The] b. If a practitioner is permitted to refer a patient to a
48 health care service pursuant to subsection a. of this section, the
49 practitioner shall provide the patient with a written disclosure
50 form, prepared pursuant to section 3 of [this act] P.L.1989, c.19

1 (C.45:9-22.6), and post a copy of this disclosure form in a
2 conspicuous public place in the practitioner's office.
3 c. The restrictions on referral of patients established in this
4 section shall not apply to a health care service that is provided at
5 the practitioner's medical office and for which the patient is
6 billed directly by the practitioner.[1]
7 (cf: P.L.1989, c.19, s.2)][4]
8 [4][[1]42. (New section) The Commissioner of Health, in
9 consultation with the Commissioner of Human Services, shall
10 designate those hospitals at which an employee from the county
11 welfare agency shall be stationed, on either a full or part-time
12 basis, as appropriate, to perform eligibility determinations for
13 the Medicaid program pursuant to P.L.1968, c.413 (C.30:4D-1 et
14 seq.).
15 The county welfare agency shall be responsible for the
16 nonfederal share of salary and employee benefit costs associated
17 with the county welfare agency employee.[1]][4]
18 [4][[1]43. (New section) The Commissioner of Human Services
19 shall require that a county welfare agency provide adequate
20 employees to determine Medicaid eligibility to any hospital in the
21 county that has been designated by the Commissioner of Health
22 pursuant to section 42 of P.L. , c. (C.)(pending before the
23 Legislature as this bill).[1]][4]
24 [4]47. Section 2 of P.L.1989, c.19 (C.45:9-22.5) is amended to
25 read as follows:
26 2. a. A practitioner shall not refer a patient or direct an
27 employee of the practitioner to refer a patient to a health care
28 service in which the practitioner, or the practitioner's immediate
29 family, or the practitioner in combination with practitioner's
30 immediate family has a significant beneficial interest [unless the
31 practitioner] ; except that, in the case of a practitioner, a
32 practitioner's immediate family or a practitioner in combination
33 with the practitioner's immediate family who had the significiant
34 beneficial interest prior to the effective date of P.L. , c.
35 (C.)(now pending before the Legislature as this bill), the
36 practitioner may continue to refer a patient or direct an
37 employee to do so if that practitioner discloses the significant
38 beneficial interest to the patient.
39 [The] b. If a practitioner is permitted to refer a patient to a
40 health care service pursuant to subsection a. of this section, the
41 practitioner shall provide the patient with a written disclosure
42 form, prepared pursuant to section 3 of [this act] P.L.1989, c.19
43 (C.45:9-22.6), and post a copy of this disclosure form in a
44 conspicuous public place in the practitioner's office.
45 c. The restrictions on referral of patients established in this
46 section shall not apply to:
47 (1) a health care service that is provided at the practitioner's
48 medical office and for which the patient is billed directly by the
49 practitioner; and
50 (2) radiation therapy pursuant to an oncological protocol,

1 lithotripsy and renal dialysis.[4]
2 (cf: P.L.1989, c.19, s.2)
3 [4]48. Section 2 of P.L.1959, c.90 (C.2A:53A-8) is amended to
4 read as follows:
5 2. Notwithstanding the provisions of the foregoing paragraph,
6 any nonprofit corporation, society or association organized
7 exclusively for hospital purposes shall be liable to respond in
8 damages to such beneficiary who shall suffer damage from the
9 negligence of such corporation, society or association or of its
10 agents or servants to an amount not exceeding [$10,000.00]
11 $250,000, together with interest and costs of suit, as the result of
12 any [1] one accident and to the extent to which such damage,
13 together with interest and costs of suit, shall exceed the sum of
14 [$10,000.00] $250,000 such nonprofit corporation, society or
15 association organized exclusively for hospital purposes shall not
16 be liable therefor.[4]
17 (cf: P.L.1959, c.90, s.2)
18 [4]49. (New section) The Legislature finds that many residents
19 of New Jersey either cannot afford health insurance coverage at
20 the levels currently offered in the marketplace, or cannot afford
21 it at all. Sections 50 through 59 of P.L. , c. (C.)(now pending
22 before the Legislature as this bill) provide affordable health
23 insurance coverage as to the amount and cost of coverage by
24 requiring health insurers and health maintenance organizations to
25 offer health care coverage with minimal basic benefits or
26 services at the lowest possible cost as determined by the
27 Commissioner of Insurance.[4]
28 [4]50. (New section) Every hospital service corporation
29 authorized to do business in this State shall offer for sale
30 individual and group basic health care contracts in accordance
31 with accepted underwriting standards for payment of benefits to
32 each person covered thereunder.[4]
33 [4]51. (New section) a. A basic health care contract offered
34 pursuant to section 50 of P.L. , c. (C.)(now pending before
35 the Legislature as this bill) shall provide:
36 (1) Basic hospital expense coverage for a period of 21 days in a
37 benefit year for each covered person for expenses incurred for
38 medically necessary treatment and services rendered as a result
39 of injury or sickness, including:
40 (a) Daily hospital room and board, including general nursing
41 care and special diets;
42 (b) Miscellaneous hospital services, including expenses incurred
43 for charges made by the hospital for services and supplies which
44 are customarily rendered by the hospital and provided for use
45 only during any period of confinement;
46 (c) Hospital outpatient services consisting of hospital services
47 on the day surgery is performed; hospital services rendered within
48 72 hours after accidental injury; and x-ray and laboratory tests to
49 the extent that benefits for such services would have been
50 provided if rendered to an inpatient of the hospital;

1 (2) Basic medical-surgical expense coverage for each covered
2 person for expenses incurred for medically necessary services for
3 treatment of injury or sickness for the following:
4 (a) Surgical services;
5 (b) Anesthesia services consisting of administration of
6 necessary general anesthesia and related procedures in
7 connection with covered surgical services rendered by a physician
8 other than the physician performing the surgical services;
9 (c) In-hospital services rendered to a person who is confined to
10 a hospital for treatment of injury or sickness other than that for
11 which surgical care is required;
12 (3) Maternity benefits, including cost of delivery and prenatal
13 care;
14 (4) Out-of-hospital physical examination, including related
15 x-rays and diagnostic tests, on the following basis:
16 (a) For covered minors of less than two years of age, up to six
17 examinations during the first two years of life; for covered
18 minors of two years of age or older, one examination at age 3, 6,
19 9, 12, 15 and 18 years;
20 (b) For covered adults of less than 40 years of age, one
21 examination every five years; for covered adults 40 or more years
22 of age but less than 60 years of age, one examination every three
23 years; and for covered adults 60 years of age or older, one
24 examination every two years.
25 Notwithstanding the provisions of this section to the contrary,
26 a hospital service corporation may provide alternative benefits or
27 services from those required by this subsection if they are
28 approved by the Commissioner of Insurance and are within the
29 intent of this act.
30 b. (1) No person who is eligible for coverage under Medicare
31 pursuant to Pub. L. 89-97 (42 U.S.C. §1395 et seq.) shall be a
32 covered person under a contract required to be offered pursuant
33 to section 50 of P.L. , c. (C.)(now pending before the
34 Legislature as this bill).
35 (2) A hospital service corporation shall not sell a contract
36 required to be offered pursuant to section 50 of P.L. , c.
37 (C.)(now pending before the Legislature as this bill) to a group
38 which was covered by health benefits or health insurance any
39 time during the 12-month period immediately preceding the
40 effective date of coverage.
41 c. (1) Contracts required to be offered pursuant to section 50
42 of P.L. , c. (C.)(now pending before the Legislature as this
43 bill) may contain or provide for coinsurance or deductibles, or
44 both; except that no deductible shall be payable in excess of a
45 total of $250 by an individual or family unit during any benefit
46 year, no coinsurance shall be payable in excess of a total of $500
47 by an individual or family unit during any benefit year, and
48 neither coinsurance nor deductibles shall apply to physical
49 examinations or maternity benefits covered pursuant to
50 paragraphs (3) or (4) of subsection a. of this section.

1 (2) Managed care systems may be utilized for coverages
2 required to be offered pursuant to this section, subject to the
3 review and approval of the Commissioner of Insurance.
4 d. Notwithstanding any other law to the contrary, a hospital
5 service corporation shall file copies of all forms of contracts
6 required to be offered pursuant to section 50 of P.L. , c.
7 (C.)(now pending before the Legislature as this bill) for
8 approval with the Commissioner of Insurance at least 60 days
9 prior to becoming effective. Unless disapproved by the
10 commissioner prior to its effective date specifying in what
11 respects the form is not in compliance with the standards set
12 forth in this subsection, any such contract form filed with the
13 commissioner shall be deemed approved as of its effective date,
14 provided, however, that contract forms shall be effective only
15 with respect to those contract form filings which are
16 accompanied by an explanation and identification of the changes
17 being made on a form prescribed by the commissioner. In his
18 discretion, the commissioner may waive the 60-day waiting
19 period or any portion thereof.
20 Contract forms shall not be unfair, inequitable, misleading or
21 contrary to law, nor shall they produce rates that are excessive,
22 inadequate or unfairly discriminatory.
23 e. Notwithstanding any other law to the contrary, a hospital
24 service corporation shall file all rates and supplementary rate
25 information and all changes and amendments thereof for the
26 contracts required to be offered pursuant to section 50 of P.L. ,
27 c. (C.)(now pending before the Legislature as this bill) for
28 approval with the commissioner at least 60 days prior to
29 becoming effective. Unless disapproved by the commissioner
30 prior to their effective date specifying in what respects the filing
31 is not in compliance with the standards set forth in this
32 subsection, any such rates, supplementary rate information,
33 changes or amendments filed with the commissioner shall be
34 deemed approved as of their effective date. In his discretion, the
35 commissioner may waive the 60-day waiting period or any portion
36 thereof.
37 Rates shall not be excessive, inadequate or unfairly
38 discriminatory.
39 f. The commissioner shall issue regulations to establish
40 minimum standards for loss ratios under contracts required to be
41 offered pursuant to section 50 of P.L. , c. (C.)(now
42 pending before the Legislature as this bill).
43 g. Notwithstanding any provision of law to the contrary, a
44 hospital service corporation shall not be required, in regard to
45 contracts required to be offered pursuant to section 50 of P.L. ,
46 c. (C.)(now pending before the Legislature as this bill), to
47 provide mandatory health care benefits or provide benefits for
48 services rendered by providers of health care services as
49 otherwise required by law.
50 h. The commissioner shall, pursuant to the provisions of the

1 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1
2 et seq.), adopt rules and regulations necessary to effectuate the
3 purposes of this section and section 50 of P.L. , c. (C.)(now
4 pending before the Legislature as this bill), including standards
5 for terms and conditions of contracts required to be offered
6 pursuant to this section and section 50 of P.L. , c. (C.)(now
7 pending before the Legislature as this bill) and schedules of
8 benefits for coverages provided for in subsection a. of this
9 section.
10 i. Every hospital service corporation shall report annually on
11 or before March 1 to the Department of Insurance the number of
12 individual and group contracts required to be offered pursuant to
13 section 50 of P.L. , c. (C.)(now pending before the
14 Legislature as this bill) that were sold in the preceding calendar
15 year and the number of persons covered under each type of
16 contract. The department shall compile and analyze this
17 information and shall report annually on or before July 1 its
18 findings and any recommendations it may have to the Governor
19 and the Legislature.[4]
20 [4]52. (New section) Every medical service corporation
21 authorized to do business in this State shall offer for sale
22 individual and group basic health care contracts in accordance
23 with accepted underwriting standards for payment of benefits to
24 each person covered thereunder.[4]
25 [4]53. (New section) a. A basic health care contract offered
26 pursuant to section 52 of P.L. , c. (C.)(now pending before
27 the Legislature as this bill) shall provide:
28 (1) Basic hospital expense coverage for a period of 21 days in a
29 benefit year for each covered person for expenses incurred for
30 medically necessary treatment and services rendered as a result
31 of injury or sickness, including:
32 (a) Daily hospital room and board, including general nursing
33 care and special diets;
34 (b) Miscellaneous hospital services, including expenses incurred
35 for charges made by the hospital for services and supplies which
36 are customarily rendered by the hospital and provided for use
37 only during any period of confinement;
38 (c) Hospital outpatient services consisting of hospital services
39 on the day surgery is performed; hospital services rendered within
40 72 hours after accidental injury; and x-ray and laboratory tests to
41 the extent that benefits for such services would have been
42 provided if rendered to an inpatient of the hospital;
43 (2) Basic medical-surgical expense coverage for each covered
44 person for expenses incurred for medically necessary services for
45 treatment of injury or sickness for the following:
46 (a) Surgical services;
47 (b) Anesthesia services consisting of administration of
48 necessary general anesthesia and related procedures in
49 connection with covered surgical services rendered by a physician
50 other than the physician performing the surgical services;

1 (c) In-hospital services rendered to a person who is confined to
2 a hospital for treatment of injury or sickness other than that for
3 which surgical care is required;
4 (3) Maternity benefits, including cost of delivery and prenatal
5 care;
6 (4) Out-of-hospital physical examination, including related
7 x-rays and diagnostic tests, on the following basis:
8 (a) For covered minors of less than two years of age, up to six
9 examinations during the first two years of life; for covered
10 minors of two years of age or older, one examination at age 3, 6,
11 9, 12, 15 and 18 years;
12 (b) For covered adults of less than 40 years of age, one
13 examination every five years; for covered adults 40 or more years
14 of age but less than 60 years of age, one examination every three
15 years; and for covered adults 60 years of age or older, one
16 examination every two years.
17 Notwithstanding the provisions of this section to the contrary,
18 a medical service corporation may provide alternative benefits or
19 services from those required by this subsection if they are
20 approved by the Commissioner of Insurance and are within the
21 intent of this amendatory and supplementary act.
22 b. (1) No person who is eligible for coverage under Medicare
23 pursuant to Pub. L. 89-97 (42 U.S.C. §1395 et seq.) shall be a
24 covered person under a contract required to be offered pursuant
25 to section 52 of P.L. , c. (C.)(now pending before the
26 Legislature as this bill).
27 (2) A medical service corporation shall not sell a contract
28 required to be offered pursuant to section 52 of P.L. , c.
29 (C.) (now pending before the Legislature as this bill) to a group
30 which was covered by health benefits or health insurance any
31 time during the 12-month period immediately preceeding the
32 effective date of coverage.
33 c. (1) Contracts required to be offered pursuant to section 52
34 of P.L. , c. (C.)(now pending before the Legislature as this
35 bill) may contain or provide for coinsurance or deductibles, or
36 both; except that no deductible shall be payable in excess of a
37 total of $250 by an individual or family unit during any benefit
38 year, no coinsurance shall be payable in excess of a total of $500
39 by an individual or family unit during any benefit year, and
40 neither coinsurance nor deductibles shall apply to physical
41 examinations or maternity benefits covered pursuant to
42 paragraphs (3) or (4) of subsection a. of this section.
43 (2) Managed care systems may be utilized for coverages
44 required to be offered pursuant to this section, subject to the
45 review and approval of the Commissioner of Insurance.
46 d. Notwithstanding any other law to the contrary, a medical
47 service corporation shall file copies of all forms of contracts
48 required to be offered pursuant to section 52 of P.L. , c.
49 (C.)(now pending before the Legislature as this bill) for
50 approval with the Commissioner of Insurance at least 60 days

1 prior to becoming effective. Unless disapproved by the
2 commissioner prior to its effective date specifying in what
3 respects the form is not in compliance with the standards set
4 forth in this subsection, any such contract form filed with the
5 commissioner shall be deemed approved as of its effective date,
6 provided, however, that contract forms shall be effective only
7 with respect to those contract form filings which are
8 accompanied by an explanation and identification of the changes
9 being made on a form prescribed by the commissioner. In his
10 discretion, the commissioner may waive the 60-day waiting
11 period or any portion thereof.
12 Contract forms shall not be unfair, inequitable, misleading or
13 contrary to law, nor shall they produce rates that are excessive,
14 inadequate or unfairly discriminatory.
15 e. Notwithstanding any other law to the contrary, a medical
16 service corporation shall file all rates and supplementary rate
17 information and all changes and amendments thereof for the
18 contracts required to be offered pursuant to section 52 of P.L. ,
19 c. (C.)(now pending before the Legislature as this bill) for
20 approval with the commissioner at least 60 days prior to
21 becoming effective. Unless disapproved by the commissioner
22 prior to their effective date specifying in what respects the filing
23 is not in compliance with the standards set forth in this
24 subsection, any such rates, supplementary rate information,
25 changes or amendments filed with the commissioner shall be
26 deemed approved as of their effective date. In his discretion, the
27 commissioner may waive the 60-day waiting period or any portion
28 thereof.
29 Rates shall not be excessive, inadequate or unfairly
30 discriminatory.
31 f. The commissioner shall issue regulations to establish
32 minimum standards for loss ratios under contracts required to be
33 offered pursuant to section 52 of P.L. , c. (C.)(now pending
34 before the Legislature as this bill).
35 g. Notwithstanding any provision of law to the contrary, a
36 medical service corporation shall not be required, in regard to
37 contracts required to be offered pursuant to section 52 of P.L. ,
38 c. (C.)(now pending before the Legislature as this bill), to
39 provide mandatory health care benefits or provide benefits for
40 services rendered by providers of health care services as
41 otherwise required by law.
42 h. The commissioner shall, pursuant to the provisions of the
43 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1
44 et seq.), adopt rules and regulations necessary to effectuate the
45 purposes of this section and section 52 of P.L. , c. (C.)(now
46 pending before the Legislature as this bill), including standards
47 for terms and conditions of contracts required to be offered
48 pursuant to this section and section 52 of P.L. , c. (C.)(now
49 pending before the Legislature as this bill) and schedules of
50 benefits for coverages provided for in subsection a. of this

1 section.
2 i. Every medical service corporation shall report annually on
3 or before March 1 to the Department of Insurance the number of
4 individual and group contracts required to be offered pursuant to
5 section 52 of P.L. , c. (C.)(now pending before the
6 Legislature as this bill) that were sold in the preceding calendar
7 year and the number of persons covered under each type of
8 contract. The department shall compile and analyze this
9 information and shall report annually on or before July 1 its
10 findings and any recommendations it may have to the Governor
11 and the Legislature.[4]
12 [4]54. (New section) Every health service corporation authorized
13 to do business in this State shall offer for sale individual and
14 group basic health care contracts in accordance with accepted
15 underwriting standards for payment of benefits to each person
16 covered thereunder.[4]
17 [4]55. (New section) a. A basic health care contract offered
18 pursuant to section 54 of P.L. , c. (C.)(now pending before
19 the Legislature as this bill) shall provide:
20 (1) Basic hospital expense coverage for a period of 21 days in a
21 benefit year for each covered person for expenses incurred for
22 medically necessary treatment and services rendered as a result
23 of injury or sickness, including:
24 (a) Daily hospital room and board, including general nursing
25 care and special diets;
26 (b) Miscellaneous hospital services, including expenses incurred
27 for charges made by the hospital for services and supplies which
28 are customarily rendered by the hospital and provided for use
29 only during any period of confinement;
30 (c) Hospital outpatient services consisting of hospital services
31 on the day surgery is performed; hospital services rendered within
32 72 hours after accidental injury; and x-ray and laboratory tests to
33 the extent that benefits for such services would have been
34 provided if rendered to an inpatient of the hospital;
35 (2) Basic medical-surgical expense coverage for each covered
36 person for expenses incurred for medically necessary services for
37 treatment of injury or sickness for the following:
38 (a) Surgical services;
39 (b) Anesthesia services consisting of administration of
40 necessary general anesthesia and related procedures in
41 connection with covered surgical services rendered by a physician
42 other than the physician performing the surgical services;
43 (c) In-hospital services rendered to a person who is confined to
44 a hospital for treatment of injury or sickness other than that for
45 which surgical care is required;
46 (3) Maternity benefits, including cost of delivery and prenatal
47 care;
48 (4) Out-of-hospital physical examination, including related
49 x-rays and diagnostic tests, on the following basis:
50 (a) For covered minors of less than two years of age, up to six

1 examinations during the first two years of life; for covered
2 minors of two years of age or older, one examination at age 3, 6,
3 9, 12, 15 and 18 years;
4 (b) For covered adults of less than 40 years of age, one
5 examination every five years; for covered adults 40 or more years
6 of age but less than 60 years of age, one examination every three
7 years; and for covered adults 60 years of age or older, one
8 examination every two years.
9 Notwithstanding the provisions of this section to the contrary,
10 a health service corporation may provide alternative benefits or
11 services from those required by this subsection if they are
12 approved by the Commissioner of Insurance and are within the
13 intent of this amendatory and supplementary act.
14 b. (1) No person who is eligible for coverage under Medicare
15 pursuant to Pub. L. 89-97 (42 U.S.C. §1395 et seq.) shall be a
16 covered person under a contract required to be offered pursuant
17 to section 54 of P.L. , c. (C.)(now pending before the
18 Legislature as this bill).
19 (2) A health service corporation shall not sell a contract
20 required to be offered pursuant to section 54 of P.L. , c.
21 (C.)(now pending before the Legislature as this bill) to a group
22 which was covered by health benefits or health insurance any
23 time during the 12-month period immediately preceeding the
24 effective date of coverage.
25 c. (1) Contracts required to be offered pursuant to section 54
26 of P.L. , c. (C.)(now pending before the Legislature as this
27 bill) may contain or provide for coinsurance or deductibles, or
28 both; except that no deductible shall be payable in excess of a
29 total of $250 by an individual or family unit during any benefit
30 year, no coinsurance shall be payable in excess of a total of $500
31 by an individual or family unit during any benefit year, and
32 neither coinsurance nor deductibles shall apply to physical
33 examinations or maternity benefits covered pursuant to
34 paragraphs (3) or (4) of subsection a. of this section.
35 (2) Managed care systems may be utilized for coverages
36 required to be offered pursuant to this section, subject to the
37 review and approval of the Commissioner of Insurance.
38 d. Notwithstanding any other law to the contrary, a health
39 service corporation shall file copies of all forms of contracts
40 required to be offered pursuant to section 54 of P.L. , c.
41 (C.)(now pending before the Legislature as this bill) for
42 approval with the Commissioner of Insurance at least 60 days
43 prior to becoming effective. Unless disapproved by the
44 commissioner prior to its effective date specifying in what
45 respects the form is not in compliance with the standards set
46 forth in this subsection, any such contract form filed with the
47 commissioner shall be deemed approved as of its effective date,
48 provided, however, that contract forms shall be effective only
49 with respect to those contract form filings which are
50 accompanied by an explanation and identification of the changes

1 being made on a form prescribed by the commissioner. In his
2 discretion, the commissioner may waive the 60-day waiting
3 period or any portion thereof.
4 Contract forms shall not be unfair, inequitable, misleading or
5 contrary to law, nor shall they produce rates that are excessive,
6 inadequate or unfairly discriminatory.
7 e. Notwithstanding any other law to the contrary, a health
8 service corporation shall file all rates and supplementary rate
9 information and all changes and amendments thereof for the
10 contracts required to be offered pursuant to section 54 of P.L. ,
11 c. (C.)(now pending before the Legislature as this bill) for
12 approval with the commissioner at least 60 days prior to
13 becoming effective. Unless disapproved by the commissioner
14 prior to their effective date specifying in what respects the filing
15 is not in compliance with the standards set forth in this
16 subsection, any such rates, supplementary rate information,
17 changes or amendments filed with the commissioner shall be
18 deemed approved as of their effective date. In his discretion, the
19 commissioner may waive the 60-day waiting period or any portion
20 thereof.
21 Rates shall not be excessive, inadequate or unfairly
22 discriminatory.
23 f. The commissioner shall issue regulations to establish
24 minimum standards for loss ratios under contracts required to be
25 offered pursuant to section 54 of P.L. , c. (C.)(now pending
26 before the Legislature as this bill).
27 g. Notwithstanding any provision of law to the contrary, a
28 health service corporation shall not be required, in regard to
29 contracts required to be offered pursuant to section 54 of P.L. ,
30 c. (C.)(now pending before the Legislature as this bill), to
31 provide mandatory health care benefits or provide benefits for
32 services rendered by providers of health care services as
33 otherwise required by law.
34 h. The commissioner shall, pursuant to the provisions of the
35 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1
36 et seq.), adopt rules and regulations necessary to effectuate the
37 purposes of this section and section 54 of P.L. , c. (C.)(now
38 pending before the Legislature as this bill), including standards
39 for terms and conditions of contracts required to be offered
40 pursuant to this section and section 54 of P.L. , c. (C.)(now
41 pending before the Legislature as this bill) and schedules of
42 benefits for coverages provided for in subsection a. of this
43 section.
44 i. Every health service corporation shall report annually on or
45 before March 1 to the Department of Insurance the number of
46 individual and group contracts required to be offered pursuant to
47 section 54 of P.L. , c. (C.)(now pending before the
48 Legislature as this bill) that were sold in the preceding calendar
49 year and the number of persons covered under each type of
50 contract. The department shall compile and analyze this

1 information and shall report annually on or before July 1 its
2 findings and any recommendations it may have to the Governor
3 and the Legislature.[4]
4 [4]56. (New section) Every health insurer authorized to do
5 business in this State which delivers or issues for delivery policies
6 in accordance with the provisions of chapter 26 of Title 17B of
7 the New Jersey Statutes shall offer for sale individual basic
8 health care policies in accordance with accepted underwriting
9 standards for payment of benefits to each person covered
10 thereunder.
11 Every health insurer authorized to do business in this State
12 which delivers or issues for delivery policies in accordance with
13 the provisions of chapter 27 of Title 17B of the New Jersey
14 Statutes shall offer for sale group basic health care policies in
15 accordance with accepted underwriting standards for payment of
16 benefits to each person covered thereunder.[4]
17 [4]57. (New section) a. A basic health care policy offered
18 pursuant to section 56 of P.L. , c. (C.)(now pending before
19 the Legislature as this bill) shall provide:
20 (1) Basic hospital expense coverage for a period of 21 days in a
21 benefit year for each covered person for expenses incurred for
22 medically necessary treatment and services rendered as a result
23 of injury or sickness, including:
24 (a) Daily hospital room and board, including general nursing
25 care and special diets;
26 (b) Miscellaneous hospital services, including expenses incurred
27 for charges made by the hospital for services and supplies which
28 are customarily rendered by the hospital and provided for use
29 only during any period of confinement;
30 (c) Hospital outpatient services consisting of hospital services
31 on the day surgery is performed; hospital services rendered within
32 72 hours after accidental injury; and x-ray and laboratory tests to
33 the extent that benefits for such services would have been
34 provided if rendered to an inpatient of the hospital;
35 (2) Basic medical-surgical expense coverage for each covered
36 person for expenses incurred for medically necessary services for
37 ~~treatment of injury or sickness for the following:~~
38 (a) Surgical services;
39 (b) Anesthesia services consisting of administration of
40 necessary general anesthesia and related procedures in
41 connection with covered surgical services rendered by a physician
42 other than the physician performing the surgical services;
43 (c) In-hospital services rendered to a person who is confined to
44 a hospital for treatment of injury or sickness other than that for
45 which surgical care is required;
46 (3) Maternity benefits, including cost of delivery and prenatal
47 care;
48 (4) Out-of-hospital physical examination, including related
49 x-rays and diagnostic tests, on the following basis:
50 (a) For covered minors of less than two years of age, up to six

1 examinations during the first two years of life; for covered
2 minors of two years of age or older, one examination at age 3, 6,
3 9, 12, 15 and 18 years;
4 (b) For covered adults of less than 40 years of age, one
5 examination every five years; for covered adults 40 or more years
6 of age but less than 60 years of age, one examination every three
7 years; and for covered adults 60 years of age or older, one
8 examination every two years.
9 Notwithstanding the provisions of this section to the contrary,
10 a health insurer may provide alternative benefits or services from
11 those required by this subsection if they are approved by the
12 Commissioner of Insurance and are within the intent of this
13 amendatory and supplementary act.
14 b. (1) No person who is eligible for coverage under Medicare
15 pursuant to Pub. L. 89-97 (42 U.S.C. §1395 et seq.) shall be a
16 covered person under a policy required to be offered pursuant to
17 section 56 of P.L. , c. (C.)(now pending before the
18 Legislature as this bill).
19 (2) A health insurer shall not sell a policy required to be
20 offered pursuant to section 56 of P.L. , c. (C.)(now pending
21 before the Legislature as this bill) to a group which was covered
22 by health benefits or health insurance any time during the
23 12-month period immediately preceeding the effective date of
24 coverage.
25 c. (1) Policies required to be offered pursuant to section 56 of
26 P.L. , c. (C.)(now pending before the Legislature as this bill)
27 may contain or provide for coinsurance or deductibles, or both;
28 except that no deductible shall be payable in excess of a total of
29 $250 by an individual or family unit during any benefit year, no
30 coinsurance shall be payable in excess of a total of $500 by an
31 individual or family unit during any benefit year, and neither
32 coinsurance nor deductibles shall apply to physical examinations
33 or maternity benefits covered pursuant to paragraphs (3) or (4) of
34 subsection a. of this section.
35 (2) Managed care systems may be utilized for coverages
36 required to be offered pursuant to this section, subject to the
37 review and approval of the Commissioner of Insurance.
38 d. Notwithstanding any other law to the contrary, a health
39 insurer shall file copies of all forms of policies required to be
40 offered pursuant to section 56 of P.L. , c. (C.)(now pending
41 before the Legislature as this bill) for approval with the
42 Commissioner of Insurance at least 60 days prior to becoming
43 effective. Unless disapproved by the commissioner prior to its
44 effective date specifying in what respects the form is not in
45 compliance with the standards set forth in this subsection, any
46 such policy form filed with the commissioner shall be deemed
47 approved as of its effective date, provided, however, that policy
48 forms shall be effective only with respect to those policy form
49 filings which are accompanied by an explanation and
50 identification of the changes being made on a form prescribed by

1 the commissioner. In his discretion, the commissioner may waive
2 the 60-day waiting period or any portion thereof.
3 Policy forms shall not be unfair, inequitable, misleading or
4 contrary to law, nor shall they produce rates that are excessive,
5 inadequate or unfairly discriminatory.
6 e. Notwithstanding any other law to the contrary, a health
7 insurer shall file all rates and supplementary rate information and
8 all changes and amendments thereof for the policies required to
9 be offered pursuant to section 56 of P.L. , c. (C.)(now
10 pending before the Legislature as this bill) for approval with the
11 commissioner at least 60 days prior to becoming effective.
12 Unless disapproved by the commissioner prior to their effective
13 date specifying in what respects the filing is not in compliance
14 with the standards set forth in this subsection, any such rates,
15 supplementary rate information, changes or amendments filed
16 with the commissioner shall be deemed approved as of their
17 effective date. In his discretion, the commissioner may waive
18 the 60-day waiting period or any portion thereof.
19 Rates shall not be excessive, inadequate or unfairly
20 discriminatory.
21 f. The commissioner shall issue regulations to establish
22 minimum standards for loss ratios under policies required to be
23 offered pursuant to section 56 of P.L. , c. (C.)(now pending
24 before the Legislature as this bill).
25 g. Notwithstanding any provision of law to the contrary, a
26 health insurer shall not be required, in regard to policies required
27 to be offered pursuant to section 56 of P.L. , c. (C.)(now
28 pending before the Legislature as this bill), to provide mandatory
29 health care benefits or provide benefits for services rendered by
30 providers of health care services as otherwise required by law.
31 h. The commissioner shall, pursuant to the provisions of the
32 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1
33 et seq.), adopt rules and regulations necessary to effectuate the
34 purposes of this section and section 56 of P.L. , c. (C.)(now
35 pending before the Legislature as this bill), including standards
36 for terms and conditions of policies required to be offered
37 pursuant to this section and section 56 of P.L. , c. (C.)(now
38 pending before the Legislature as this bill) and schedules of
39 benefits for coverages provided for in subsection a. of this
40 section.
41 i. Every health insurer shall report annually on or before
42 March 1 to the Department of Insurance the number of individual
43 and group policies required to be offered pursuant to section 56
44 of P.L. , c. (C.)(now pending before the Legislature as this
45 bill) that were sold in the preceding calendar year and the number
46 of persons covered under each type of policy. The department
47 shall compile and analyze this information and shall report
48 annually on or before July 1 its findings and any recommendations
49 it may have to the Governor and the Legislature.[4]
50 [4]58. (New section) Notwithstanding any provision of law to the

1 contrary, a certificate of authority to establish and operate a
2 health maintenance organization in this State shall not be issued
3 or continued by the Commissioner of Health on or after the
4 effective date of this section unless the health maintenance
5 organization offers for sale, on an individual and group basis, and
6 in accordance with accepted underwriting standards, coverages
7 for basic health services for each enrollee covered thereunder.[4]
8 [4]59. (New section) a. The coverages for basic health care
9 services offered pursuant to section 58 of P.L. , c. (C.)(now
10 pending before the Legislature as this bill) shall be limited to the
11 following services:
12 (1) Basic hospital expense coverage for a period of 21 days in a
13 benefit year for each enrollee for services provided for medically
14 necessary treatment and services rendered as a result of injury or
15 sickness, including:
16 (a) Daily hospital room and board, including general nursing
17 care and special diets;
18 (b) Miscellaneous hospital services, including services and
19 supplies which are customarily rendered by the hospital and
20 provided for use only during any period of confinement;
21 (c) Hospital outpatient services consisting of hospital services
22 on the day surgery is performed; hospital services rendered within
23 72 hours after accidental injury; and x-ray and laboratory tests to
24 the extent that benefits for such services would have been
25 provided if rendered to an inpatient of the hospital;
26 (2) Basic medical-surgical services for each enrollee for
27 medically necessary services for treatment of injury or sickness
28 for the following:
29 (a) Surgical services;
30 (b) Anesthesia services consisting of administration of
31 necessary general anesthesia and related procedures in
32 connection with covered surgical services rendered by a physician
33 other than the physician performing the surgical services;
34 (c) In-hospital services rendered to a person who is confined to
35 a hospital for treatment of injury or sickness other than that for
36 which surgical care is required;
37 (3) Maternity services, including delivery and prenatal care;
38 (4) Out-of-hospital physical examination, including related
39 x-rays and diagnostic tests, on the following basis:
40 (a) For enrollees who are less than two years of age, up to six
41 examinations during the first two years of life; for enrollees who
42 are minors of two years of age or older, one examination at age
43 3, 6, 9, 12, 15 and 18 years;
44 (b) For enrollees who are adults less than 40 years of age, one
45 examination every five years; for enrollees who are 40 or more
46 years of age but less than 60 years of age, one examination every
47 three years; and for enrollees who are 60 years of age or older,
48 one examination every two years.
49 Notwithstanding the provisions of this section to the contrary,
50 a health maintenance organization may provide alternative

1 coverage for services from those required by this subsection if
2 they are approved by the Commissioner of Insurance and are
3 within the intent of this amendatory and supplementary act.
4 b. (1) No person who is eligible for coverage under Medicare
5 pursuant to Pub. L. 89-97 (42 U.S.C. §1395 et seq.) shall be an
6 enrollee under coverage required to be offered pursuant to
7 section 58 of P.L. , c. (C.)(now pending before the
8 Legislature as this bill).
9 (2) A health maintenance organization shall not provide
10 coverage for services required to be offered pursuant to section
11 58 of P.L. , c. (C.)(now pending before the Legislature as this
12 bill) to a group which was covered by health benefits or health
13 insurance any time during the 12-month period immediately
14 preceeding the effective date of coverage.
15 c. (1) Coverage for services required to be offered pursuant to
16 section 58 of P.L. , c. (C.)(now pending before the
17 Legislature as this bill) may contain or provide coinsurance or
18 deductibles, or both; except that no deductible shall be payable in
19 excess of a total of $250 by an individual or family unit during
20 any benefit year, no coinsurance shall be payable in excess of a
21 total of $500 by an individual or family unit during any benefit
22 year, and neither coinsurance nor deductibles shall apply to
23 physical examinations or maternity services covered pursuant to
24 paragraphs (3) or (4) of subsection a. of section 58 of P.L. , c.
25 (C.)(now pending before the Legislature as this bill).
26 (2) Managed care systems may be utilized for coverage of
27 services required to be offered pursuant to section 58 of P.L. ,
28 c. (C.)(now pending before the Legislature as this bill), subject
29 to the review and approval of the Commissioner of Insurance.
30 d. Notwithstanding any other law to the contrary, a health
31 maintenance organization shall file copies of all forms for
32 coverages required to be offered pursuant to section 58 of P.L. ,
33 c. (C.)(now pending before the Legislature as this bill) for
34 approval with the Commissioner of Insurance at least 60 days
35 prior to becoming effective. Unless disapproved by the
36 commissioner prior to its effective date specifying in what
37 respects the form is not in compliance with the standards set
38 forth in this subsection, any such coverage form filed with the
39 commissioner shall be deemed approved as of its effective date,
40 provided, however, that coverage forms shall be effective only
41 with respect to those coverage form filings which are
42 accompanied by an explanation and identification of the changes
43 being made on a form prescribed by the commissioner. In his
44 discretion, the commissioner may waive the 60-day waiting
45 period or any portion thereof.
46 These forms shall not be unfair, inequitable, misleading or
47 contrary to law, nor shall they produce rates that are excessive,
48 inadequate or unfairly discriminatory.
49 e. Notwithstanding any other law to the contrary, a health
50 maintenance organization shall file all rates and supplementary

rate information and all changes and amendments thereof for the coverages required to be offered pursuant to section 58 of P.L. , c. (C.)(now pending before the Legislature as this bill) for approval with the Commissioner of Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive such 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The Commissioner of Insurance shall issue regulations to establish minimum standards for loss ratios under coverages required to be offered pursuant to section 58 of P.L. , c. (C.)(now pending before the Legislature as this bill).

g. Notwithstanding any provision of law to the contrary, a health maintenance organization shall not be required, in regard to coverages required to be offered pursuant to section 58 of P.L. , c. (C.)(now pending before the Legislature as this bill), to provide mandatory health care benefits or services or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The Commissioner of Insurance and the Commissioner of Health shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 58 of P.L. , c. (C.)(now pending before the Legislature as this bill), including standards for terms and conditions of health care service coverages required to be offered pursuant to this section and section 58 of P.L. , c. (C.)(now pending before the Legislature as this bill) and schedules of benefits for coverage of services provided for in subsection a. of this section.

i. Every health maintenance organization shall report annually on or before March 1 to the Department of Insurance the number of individual and group coverages required to be offered pursuant to section 58 of P.L. , c. (C.)(now pending before the Legislature as this bill) that were sold in the preceding calendar year and the number of enrollees under each type of coverage. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

j. A health maintenance organization which complies with the basic health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub.L. 93-222 (42 U.S.C. §300e et seq.), shall be deemed in

1 compliance with this section and section 58 of P.L. , c, (C.
2) (now pending before the Legislature as this bill).[4]
3 [4]60. (New section) As used in sections 60 through 76 of P.L. ,
4 c. (C.) (now pending before the Legislature as this bill):
5 "Eligible student loan expenses" means the cumulative total of
6 the annual student loans covering the cost of attendance at an
7 undergraduate institution of medical or dental education.
8 Interest paid or due on student loans that an applicant has taken
9 out for use in paying the costs of undergraduate medical or dental
10 education shall be considered eligible for reimbursement under
11 the program. The Chancellor of Higher Education may establish
12 a limit on the total amount of student loans which may be
13 redeemed for participants under the program, provided that the
14 total redemption of student loans does not exceed $70,000.
15 "Medically underserved area" means an urban or rural area
16 which need not conform to the geographic boundaries of a
17 political subdivision within the State but which shall be defined in
18 terms of census tracts, if possible, which is a rational area for
19 the delivery of health services and which has a medical or dental
20 manpower shortage as determined by the Commissioner of
21 Health; or a population group which the commissioner determines
22 has a medical or dental manpower shortage; or a public or
23 nonprofit private health care facility or other facility which is so
24 designated.
25 "Primary care" includes the practice of family medicine,
26 general internal medicine, general pediatrics, general obstetrics,
27 gynecology, and any other areas of medicine which the
28 Commissioner of Health may define as primary care. Primary
29 care also includes the practice of general dentistry and
30 pedodontics.
31 "Primary Care Physician and Dentist Loan Redemption
32 Program" means a program which provides for the redemption of
33 the eligible student loan expenses of its participants.
34 "Undergraduate medical or dental education" means the period
35 of time between entry into medical or dental school and the
36 award of the medical (M.D., D.O.) degree or dental (D.M.D.,
37 D.D.S.) degree, respectively.[4]
38 [4]61. (New section) There is established a Primary Care
39 Physician and Dentist Loan Redemption Program within the
40 Department of Higher Education. The program shall provide for
41 the redemption of a portion of the eligible student loan expenses
42 of program participants for each year of service in a medically
43 underserved area of the State as designated by the Commissioner
44 of Health.[4]
45 [4]62. (New section) To be eligible to participate in the Primary
46 Care Physician and Dentist Loan Redemption Program, an
47 applicant shall:
48 a. Be a resident of the State;
49 b. Be a graduate of a medical school approved by the State
50 Board of Medical Examiners for the purpose of licensure and

receive a recommendation from the school's medical staff concerning participation in the loan redemption program in the case of a physician, or be a graduate of a dental school approved by the New Jersey State Board of Dentistry for the purpose of licensure and receive a recommendation from the school's dental staff concerning participation in the loan redemption program in the case of a dentist;

c. In the case of a physician, have completed a professional residency training program and received a recommendation from the medical staff of the training program concerning participation in the loan redemption program; and,

d. Agree to practice medicine or dentistry, as appropriate, in a medically underserved area of the State.[4]

[4]63. (New section) The Commissioner of Health, after consultation with the Commissioner of Corrections and the Commissioner of Human Services, shall designate and establish a ranking of medically underserved areas of the State. The criteria used by the Commissioner of Health in designating underserved areas shall include, but not be limited to:

a. the ratio of the supply of primary care physicians and dentists by relative specialty to the population under consideration with a goal of meeting current standards for physician and dentist to population ratios in primary care medical and dental specialties;

b. the financial resources of the population under consideration;

c. the population's access to medical and dental services; and,

d. appropriate physician and dentist staffing ratios in State, county, municipal and private nonprofit health care facilities.

The commissioner shall annually transmit the list of medically underserved areas and the number of positions needed in each area to the Chancellor of Higher Education.[4]

[4]64. (New section) A medical or dental student who is eligible and interested in participating in the loan redemption program shall sign a nonbinding agreement with the Department of Higher Education upon completion of the final year of undergraduate medical or dental training, as appropriate. At the end of the final year of residency training in the case of a physician, and at the end of the final year of undergraduate dental training or residency training if such training is required in a primary care dental specialty in the case of a dentist, the applicant shall sign a contractual agreement with the Department of Higher Education. The agreement shall specify the applicant's length of required service and the total amount of eligible student loan expenses to be redeemed by the State in return for service. The agreement shall also stipulate that the applicant has knowledge of and agrees to the six month probationary period required prior to final acceptance into the program pursuant to section 66 of P.L. , c. (C.) (now pending before the Legislature as this bill).[4]

1 [4]65. (New section) Maximum redemption of loans under the
2 loan redemption program shall amount to 15% of principal and
3 interest of eligible student loan expenses in return for one full
4 year of service in a designated medically underserved area of the
5 State, an additional 20% for a second full year of service, an
6 additional 25% for a third full year of service and an additional
7 40% for a fourth full year of service for a total redemption of
8 eligible student loan expenses of up to, but not to exceed,
9 $70,000. Service in a medically underserved area shall begin
10 immediately upon completion of the medical residency training
11 program in the case of a physician, and immediately upon
12 completion of undergraduate dental training or residency training
13 if such training is required in a primary care dental specialty in
14 the case of a dentist.[4]
15 [4]66. (New section) Each program participant shall serve a six
16 month probationary period upon initial placement in a service site
17 within the medically underserved area. During that period, the
18 medical or dental staff of the service site, as appropriate, shall
19 evaluate the suitability of the placement for the participant. At
20 the end of the probationary period, the medical or dental staff
21 shall recommend the continuation of the program participant's
22 present placement, a change in placement, or its determination
23 that the participant is an unsuitable candidate for the loan
24 redemption program. If the medical or dental staff of the service
25 site recommends a change in placement, then the Chancellor of
26 Higher Education shall place the program participant in an
27 alternate placement within a medically underserved area. If the
28 medical or dental staff determines that the program participant
29 is not a suitable candidate for the program, then the chancellor
30 shall take this recommendation into consideration in regard to
31 the participant's final acceptance into the program. No loan
32 redemption payment shall be made during the six month
33 probationary period, however, a program participant shall receive
34 credit for this six month period in calculating the first year of
35 required service under the loan redemption contract.[4]
36 [4]67. (New section) The Chancellor of Higher Education, in
37 consultation with the Commissioner of Health, shall match
38 program participants to medically underserved areas based upon
39 the ranking of the underserved areas established by the
40 commissioner and on the basis of participant preference.[4]
41 [4]68. (New section) The Chancellor of Higher Education shall
42 annually determine the number of program positions available on
43 the basis of the need for primary care physicians and dentists in
44 medically underserved areas of the State as determined by the
45 Commissioner of Health and the State and federal funds available
46 for the program. Once the number of program positions has been
47 determined, the chancellor shall select the program participants
48 from among those students who have applied to the program and
49 who meet the criteria established pursuant to section 62 of P.L. ,
50 c. (C.) (now pending before the Legislature as this

bill). In selecting program participants, the Chancellor of Higher Education shall accord priority to applicants in the following manner:

a. First, to any applicant who is completing a fourth, third or second year of a loan redemption contract;

b. Second, to any applicant whose residence in the State at the time of entry into post secondary education was within a medically underserved area; and,

c. Third, to any applicant according to the severity of the physician or dentist shortage in the area selected by the applicant.

In the event that there are more applicants who have the same priority than there are program positions, the Chancellor of Higher Education shall select participants by means of a lottery or other form of random selection.[4]

[4]69. (New section) A physician or dentist who has previously entered into a contract with the Department of Higher Education may nullify the agreement by notifying the Department of Higher Education in writing and assuming full responsibility for repayment of principal and interest at the appropriate market rate of the full amount of the eligible student loan expenses or that portion of the loan which has not been redeemed by the State in return for partial fulfillment of the contract. In no event shall service in a medically underserved area for less than the full calendar year of each period of service entitle the participant to any benefits under the loan redemption program. A participant seeking to nullify the contract shall be required to pay the unredeemed portion of indebtedness in not more than 10 years following termination of the contract minus the years of service already served under the contract.[4]

[4]70. (New section) In case of a program participant's death or total or permanent disability, the Chancellor of Higher Education shall nullify the service obligation of the student thereby terminating the student's obligation to repay the unpaid balance of the redeemable portion of the loan and the accrued interest thereon, or where continued enforcement of the contract may result in extreme hardship, the chancellor may nullify or suspend the service obligation of the student.[4]

[4]71. (New section) In case of a program participant's conviction of a felony or misdemeanor or an act of gross negligence in the performance of service obligations or where the license to practice has been suspended or revoked, the Chancellor of Higher Education shall have the authority to terminate the participant's service in the program and request repayment of the outstanding debt.[4]

[4]72. (New section) A student who is participating in a federal program of a similar nature, which provides financial support for students in return for service in underserved areas of the nation, shall not be eligible for participation in the Primary Care Physician and Dentist Loan Redemption Program unless after review and consideration the Chancellor of Higher Education

1 finds that the student has extraordinary financial responsibilities
2 making it essential for the student to use the loan resources of
3 both federal and State programs. These cases shall be reviewed
4 and approved by the chancellor on an individual basis. In these
5 cases, the period of service to the State of New Jersey may be
6 served simultaneously with the federal service obligation if that
7 obligation is being discharged by service within this State.[4]

8 [4]73. (New section) Prior to repayment of the annual amount
9 eligible for redemption, each program participant shall report to
10 the Department of Higher Education, in such manner and form as
11 it shall prescribe, information on the participant's performance
12 of service in the medically underserved area as required under
13 the contract.[4]

14 [4]74. (New section) The Chancellor of Higher Education and
15 the Commissioner of Health shall jointly establish a procedure for
16 the recruitment of program applicants at medical and dental
17 schools and health centers. The procedure shall provide for the
18 participation of the medical and dental staff, ~~as appropriate~~, of
19 those facilities in the selection of appropriate applicants for the
20 program.[4]

21 [4]75. (New section) The Department of Higher Education shall
22 annually apply for any federal funds which may be available to
23 implement the provisions of this act.[4]

24 [4]76. (New section) The State Board of Higher Education shall
25 adopt rules and regulations pursuant to the "Administrative
26 Procedure Act," P.L.1968, c.410 (C.52:~~14B-1~~ et seq.) as may be
27 necessary to implement the provisions of sections 60 through 75
28 of P.L. , c. (C.)(now pending before the Legislature as this
29 bill).[4]

30 [4][[1]44.] 77.[4] (New section) a. Every student enrolled as a
31 full-time student at a public or private institution of higher
32 education in this State shall maintain health insurance coverage
33 which provides basic hospital benefits. The coverage shall be
34 maintained throughout the period of the student's enrollment.

35 b. Every student enrolled as a full-time student shall present
36 evidence of the health insurance coverage required by subsection
37 a. of this section to the institution at least annually, in a manner
38 prescribed by the institution.

39 c. The State Board of Higher Education shall require all public
40 and private institutions of higher education in this State to offer
41 health insurance coverage on a group or individual basis for
42 purchase by students who are required to maintain the coverage
43 pursuant to this section.

44 [4]d.[4] The State Board of Higher Education shall adopt rules and
45 regulations pursuant to the "Administrative Procedure Act,"
46 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of
47 subsections a., b. and c. of this section.

48 [4][d.] e.[4] The Student Assistance Board in the Department of
49 Higher Education shall adopt rules and regulations to require that
50 a public or private institution of higher education in this State

1 consider the coverage required pursuant to this section as an
2 educational cost for purposes of determining a student's
3 eligibility for financial aid.
4 [4][e.] f.[4] Nothing in this section shall be construed to permit a
5 hospital in this State to deny access to hospital care to a
6 full-time student whose health insurance coverage required by
7 this section lapses for any reason.
8 [4][f.] g.[4] The provisions of this section shall not apply to a
9 person who is a participant in the REACH program established
10 pursuant to P.L.1987, c.282 (C.44:10-9 et seq.).[1]
11 [4][[1]45. (New section) a. There is established in the Department
12 of Health a special fund to be known as the "Health Care Cost
13 Reduction Fund."
14 The monies in the fund are hereby appropriated for the
15 purposes and in amounts not to exceed the amounts specified in
16 this subsection:
17 (1) Local health planning - $3 million;
18 (2) Demographic study of hospital patients whose accounts are
19 classified as bad debts - $50,000;
20 (3) Primary Care Physician and Dentist Loan Redemption
21 Program - $1 million;
22 (4) Provision of funds to eight community health centers funded
23 under section 330 of the "Public Health Service Act," (42 U.S.C.
24 §254c.), to enable these centers to expand their hours of
25 operation to evenings and weekends, and to enhance and advertise
26 their primary health care services as an alternative to hospital
27 emergency rooms - $10 million;
28 (5) Expansion of eligibility for the Medicaid program to 185%
29 of the poverty level for pregnant women and infants up to one
30 year of age;
31 (6) Establishment of a "HealthStart Plus" program for pregnant
32 women and infants up to age one whose income is between 185%
33 and 300% of the poverty level - $8 million;
34 (7) Establishment of the "Competitive Initiatives Fund" - $6
35 million; and
36 (8) Other reform measures established by law which are
37 designed to contain the cost of uncompensated care.
38 The department shall maintain a separate account for each of
39 the reform measures funded by the fund.
40 b. Notwithstanding any law to the contrary, each hospital
41 whose rates are established by the Hospital Rate Setting
42 Commission pursuant to P.L.1978, c.83 (C.26:2H-1 et al.) shall
43 pay .53% of its approved revenue base for 1991 to the
44 Department of Health for deposit in the Health Care Cost
45 Reduction Fund. The hospital shall make monthly payments to
46 the department for a period of 24 months beginning on the first
47 month following the date of enactment of this act, except that
48 the total amount paid into the fund plus interest shall not exceed
49 $40 million per year. The Commissioner of Health shall
50 determine the manner in which the payments shall be made.

1 c. The commissioner shall report to the Senate Institutions,
2 Health and Welfare Committee and the General Assembly Health
3 and Human Services Committee quarterly on the status of the
4 fund. The report shall specify the amount of revenues received
5 by the fund and the specific expenditures made, and proposed to
6 be made, from the fund.[1]][4]
7 [4][[2]46. For all periods for which an audit for reimbursement for
8 uncompensated care through the Uncompensated Care Trust Fund
9 established pursuant to P.L.1989, c.1 (C.26:2H-18.4 et seq.) shall
10 be conducted, the requirements regarding the determination of
11 eligibility for charity care pursuant to sections 9 and 10 of
12 P.L.1989, c.1 (C.26:2H-18.12 and 18.13) shall not apply to a
13 patient who is investigated by a county adjuster and found to be
14 indigent by a court of competent jurisdiction pursuant to the
15 provisions of chapter 4 of Title 30 of the Revised Statutes. A
16 patient so found shall qualify for charity care.[2]][4]
17 [4]78. (New section) a. A health insurer shall reimburse all
18 claims or any portion of any claim from an insured or an
19 insured's assignee, for payment under a health insurance policy,
20 within 60 days after receipt of the claim by the health insurer. If
21 a claim or a portion of a claim is contested by the health insurer,
22 the insured or the insured's assignee shall be notified in writing
23 within 45 days after receipt of the claim by the health insurer,
24 that the claim is contested or denied; except that, the
25 uncontested portion of the claim shall be paid within 60 days
26 after receipt of the claim by the health insurer. The notice that
27 a claim is contested shall identify the contested portion of the
28 claim and the reasons for contesting the claim.
29 A health insurer, upon receipt of the additional information
30 requested from the insured or the insured's assignee shall pay or
31 deny the contested claim or portion of the contested claim,
32 within 90 days.
33 Payment shall be treated as being made on the date a draft or
34 other valid instrument which is equivalent to payment was placed
35 in the United States mail in a properly addressed, postpaid
36 envelope or, if not so posted, on the date of delivery.
37 b. An overdue payment shall bear simple interest at the rate
38 of 10% per year.
39 c. For the purposes of this section, "health insurer" means an
40 insurer authorized to provide health insurance on an individual
41 basis pursuant to chapter 26 of Title 17B of the New Jersey
42 Statutes.
43 d. The Department of Insurance shall adopt rules and
44 regulations pursuant to the "Administrative Procedure Act,"
45 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of
46 this section.[4]
47 [4]79. (New section) a. A health insurer shall reimburse all
48 claims or any portion of any claim from an insured or an
49 insured's assignee, for payment under a health insurance policy,
50 within 60 days after receipt of the claim by the health insurer. If

1 a claim or a portion of a claim is contested by the health insurer,
2 the insured or the insured's assignee shall be notified in writing
3 within 45 days after receipt of the claim by the health insurer,
4 that the claim is contested or denied; except that, the
5 uncontested portion of the claim shall be paid within 60 days
6 after receipt of the claim by the health insurer. The notice that
7 a claim is contested shall identify the contested portion of the
8 claim and the reasons for contesting the claim.
9 A health insurer, upon receipt of the additional information
10 requested from the insured or the insured's assignee shall pay or
11 deny the contested claim or portion of the contested claim,
12 within 90 days.
13 Payment shall be treated as being made on the date a draft or
14 other valid instrument which is equivalent to payment was placed
15 in the United States mail in a properly addressed, postpaid
16 envelope or, if not so posted, on the date of delivery.
17 b. An overdue payment shall bear simple interest at the rate
18 of 10% per year.
19 c. For the purposes of this section, "health insurer" means an
20 insurer authorized to provide health insurance on a group basis
21 pursuant to chapter 27 of Title 17B of the New Jersey Statutes.
22 d. The Department of Insurance shall adopt rules and
23 regulations pursuant to the "Administrative Procedure Act,"
24 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of
25 this section.[4]
26 [4]80. (New section) a. A health maintenance organization shall
27 reimburse all claims or any portion of any claim from an enrollee
28 or an enrollee's assignee, for payment under health maintenance
29 organization coverage, within 60 days after receipt of the claim
30 by the health maintenance organization. If a claim or a portion
31 of a claim is contested by the health maintenance organization,
32 the enrollee or the enrollee's assignee shall be notified in writing
33 within 45 days after receipt of the claim by the health
34 maintenance organization, that the claim is contested or denied;
35 except that, the uncontested portion of the claim shall be paid
36 within 60 days after receipt of the claim by the health
37 maintenance organization. The notice that a claim is contested
38 shall identify the contested portion of the claim and the reasons
39 for contesting the claim.
40 A health maintenance organization, upon receipt of the
41 additional information requested from the enrollee or the
42 enrollee's assignee shall pay or deny the contested claim or
43 portion of the contested claim, within 90 days.
44 Payment shall be treated as being made on the date a draft or
45 other valid instrument which is equivalent to payment was placed
46 in the United States mail in a properly addressed, postpaid
47 envelope or, if not so posted, on the date of delivery.
48 b. An overdue payment shall bear simple interest at the rate
49 of 10% per year.
50 c. For the purposes of this section, "health maintenance

1 organization" means a health maintenance organization
2 authorized pursuant to the provisions of P.L.1973, c.337
3 (C.26:2J-1 et seq.).
4 d. The Department of Health shall adopt rules and regulations
5 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
6 (C.52:14B-1 et seq.) to carry out the provisions of this section.[4]
7 [4]81. (New section) The Commissioner of Health shall, to the
8 extent possible and reasonable within the Department of Health's
9 responsibilities under P.L.1971, c.136 (C.26:2H-1 et seq.),
10 coordinate its annual inspection of a hospital with the triennial
11 inspection conducted by the Joint Commission for the
12 Accreditation of Healthcare Organizations to prevent duplication
13 during the inspection process.[4]
14 [4]82. (New section) a. There is created a Health Care Cost
15 Reduction Advisory Committee. The members shall include: the
16 Commissioners of Health, Human Services and Insurance and the
17 Public Advocate, or their designees who shall serve ex officio;
18 two members of the Senate to be appointed by the President
19 thereof, no more than one of whom shall be of the same political
20 party, and two members of the General Assembly to be appointed
21 by the Speaker thereof, no more than one of whom shall be of the
22 same political party; two public members who have professional
23 expertise in the area of health care financing, one each to be
24 appointed by the President of the Senate and the Speaker of the
25 General Assembly; and nine members appointed by the Governor
26 as follows: one person who represents the Office of the Governor
27 who shall serve ex officio and eight public members who include
28 three persons who represent payers, one to be appointed upon the
29 recommendation of Blue Cross and Blue Shield of New Jersey,
30 Inc., one upon the recommendation of the Health Insurance
31 Association of America and one upon the recommendation of the
32 New Jersey Health Maintenance Association; one person who
33 represents hospitals in the State, to be appointed upon the
34 recommendation of the New Jersey Hospital Association; one
35 person who represents business and industry in this State, to be
36 appointed upon the recommendation of the New Jersey Business
37 and Industry Association; one person who represents organized
38 labor in this State, to be appointed upon the recommendation of
39 the New Jersey State AFL-CIO; and two persons who are
40 consumers of health care.
41 The public members shall serve for a term of two years and be
42 eligible for reappointment for an additional two-year term,
43 except that of the public members first appointed, four shall be
44 appointed for a term of two years and four for a term of one
45 year. Vacancies in the advisory committee shall be filled in the
46 same manner as the original appointments were made for the
47 unexpired term.
48 The advisory committee shall organize as soon as practicable
49 after the appointment of its members and shall select a
50 chairperson from among its public members. Members of the

advisory committee shall serve without compensation but shall be reimbursed for the necessary expenses incurred in the performance of their duties as members of the advisory committee.

b. The advisory committee shall:

(1) Review and assess the effectiveness of the health care reform initiatives provided for in this act which are designed to reduce uncompensated care and health care costs, and expand health insurance coverage in the State, and make such recommendations to the Governor and the Legislature as the advisory committee deems necessary;

(2) Make recommendations to the Commissioner of Health on the procedures that shall be used to audit uncompensated care at the hospitals, including methods of indigent care cost recovery and bad debt collection by the hospitals; and

(3) Make recommendations to the Governor and the Legislature on additional methods of funding uncompensated care that may be used to supplement or replace funding methods already implemented.

c. There is created within the advisory committee a five-member subcommittee to review the existing funding and technical support for the Hospital Rate Setting Commission.

The subcommittee members shall be appointed by the Governor and shall include: one person who represents hospitals in the State, to be appointed upon the recommendation of the New Jersey Hospital Association; one person who represents business and industry in this State, to be appointed upon the recommendation of the New Jersey Business and Industry Association; one person who represents organized labor in this State, to be appointed upon the recommendation of the New Jersey State AFL-CIO; and two persons who are consumers of health care.

The members of the subcommittee may be members of the advisory committee. The members of the subcommittee shall serve for a term of 12 months. Vacancies in the subcommittee shall be filled in the same manner as the original appointments were made for the unexpired term.

The subcommittee shall organize as soon as practicable after the appointment of its members and shall select a chairperson from among its members. Members of the subcommittee shall serve without compensation but shall be reimbursed for necessary expenses incurred in the performance of their duties as members of the subcommittee.

The subcommittee shall report its findings and recommendations to the Commissioner of Health and the chairmen of the Senate Institutions, Health and Welfare Committee and the Assembly Health and Human Services Committee no later than three months after the effective date of this act.[4]

[4]83. Section 1 of P.L.1989, c.19 (C.45:9-22.4) is amended to

1 read as follows:
2 1. For the purposes of this act:
3 "Health care service" means a business entity which provides
4 on an inpatient or outpatient basis: testing for or diagnosis or
5 treatment of human disease or dysfunction; or dispensing of drugs
6 or medical devices for the treatment of human disease or
7 dysfunction. Health care service includes, but is not limited to, a
8 bioanalytical laboratory, pharmacy, home health care agency,
9 rehabilitation facility, nursing home, hospital, or a facility which
10 provides radiological or other diagnostic imagery services,
11 physical therapy, ambulatory surgery, or ophthalmic services.
12 "Immediate family" means the practitioner's spouse and
13 children, the practitioner's siblings and parents, the
14 practitioner's spouse's siblings and parents, and the spouses of
15 the practitioner's children.
16 "Practitioner" means a physician, chiropractor or podiatrist
17 licensed pursuant to Title 45 of the Revised Statutes.
18 "Significant beneficial interest" means any financial interest
19 [that is equal to or greater than the lesser of: (1) 5% of the whole
20 or (2) $5,000.00]; but does not include ownership of a building
21 wherein the space is leased to a person at the prevailing rate
22 under a straight lease agreement, or any interest held in publicly
23 traded securities.4
24 (cf: P.L.1989, c.19, s.1)
25 1[38.] 2[46.1] 4[47.2] 84.4 The following are repealed:
26 Sections 3, 6 and 11 of P.L.1971, c.136 (C.26:2H-3, C.26:2H-6
27 and C.26:2H-11);
28 P.L.1987, c.118 (C.26:2H-5.2 through 5.6, inclusive); 4[and]4
29 P.L.1979, c.272 (C.18A:72D-1 through 18A:72D-11, inclusive)4;
30 ~~and P.L.1989, c.1 (C.26:2H-18.4 et al.)~~4.
31 485. This amendatory and suplementary act shall be known and
32 may be cited as the "Health Care Cost Reduction Act."4
33 1[39.] 2[47.1] 4[48.2] 86.4 This act shall take effect on the 30th
34 day after enactment, except that sections 4[5 and 6] 1 through
35 26, inclusive, shall take effect on July 1, 1991, sections 1 through
36 8 and 11 through 24, inclusive, and section 26 shall expire on June
37 30, 1992, section 29 shall take effect on the 120th day after
38 enactment, sections 31 and 324 shall take effect on January 1,
39 1992 4and sections 50, 52, 54, 56 and 58 shall take effect on the
40 90th day after enactment4.
41
42
43 HEALTH
44
45 Designated the "Health Care Cost Reduction Act" and
46 implements recommendations of the Governor's Commission on
47 Health Care Costs.

1 the Department of Higher Education, in such manner and form as
2 it shall prescribe, information on the participant's performance
3 of service in the medically underserved area as required under
4 the contract.
5 35. (New section) The Chancellor of Higher Education and the
6 Commissioner of Health shall jointly establish a procedure for the
7 recruitment of program applicants at medical schools and health
8 centers. The procedure shall provide for the participation of the
9 medical staff of those facilities in the selection of appropriate
10 applicants for the program.
11 36. (New section) The Department of Higher Education shall
12 annually apply for any federal funds which may be available to
13 implement the provisions of this act.
14 37. (New section) The State Board of Higher Education shall
15 adopt rules and regulations pursuant to the "Administrative
16 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) as may be
17 necessary to implement the provisions of this act.
18 38. The following are repealed:
19 Sections 3, 6 and 11 of P.L.1971, c.136 (C.26:2H-3, C.26:2H-6
20 and C.26:2H-11);
21 P.L.1987, c.118 (C.26:2H-5.2 through 5.6, inclusive); and
22 P.L.1979, c.272 (C.18A:72D-1 through 18A:72D-11, inclusive).
23 39. This act shall take effect on the 30th day after enactment,
24 except that sections 5 and 6 shall take effect on January 1, 1992.
25
26
27 Sponsor STATEMENT
28
29 This bill adopts major recommendations of the Governor's
30 Commission on Health Care Costs to reform the State's health
31 care system.
32 The bill makes significant changes in the certificate of need
33 and health planning process. The bill establishes a State Health
34 Planning Board which shall develop and annually review a State
35 Health Plan. The plan will be used as the basis for approving all
36 certificate of need applications. The bill also establishes a
37 system of local health planning whereby the Governor will
38 designate at least five local health planning regions. Each region
39 will establish a local advisory board, which shall be a nonprofit
40 corporation, to conduct local health planning and make
41 recommendations for the State Health Plan, and to perform
42 certificate of need reviews.
43 The bill changes the composition of the Hospital Rate Setting
44 Commission to remove the Commissioners of Health and
45 Insurance and replace them with two public members, one of
46 whom represents business or labor as a purchaser of health care
47 services.
48 The definition of "health care service" is broadened to include
49 any service which is the subject of a health planning regulation
50 adopted by the Department of Health and any service or

acquisition, including a service provided by, or acquisition of, a physician in the physician's private practice, with a total project cost that is greater than $1 million.

The bill expands the Medicaid eligibility level to cover pregnant women and children up to one year of age whose income is up to 185% of the federal poverty level. The bill also requires Medicaid to make the option of participating in a managed care health care program available to all Medicaid recipients within five years. Also, the bill expands the Medicaid program's Garden State Health Plan (a State-operated health maintenance organization) to permit individuals who do not have health care coverage and small businesses which do not provide health care coverage to their employees, to purchase coverage through the Garden State Health Plan. The premiums paid by these individuals and small businesses will be determined by the Commissioner of Human Services and will be sufficient to fund the cost of the benefits under the plan.

The bill amends section 2 of P.L.1959, c.90 (C.2A:53A-8) to eliminate the $10,000 limitation on liability for hospitals.

The bill amends section 8 of P.L.1977, c.240 (C.24:6E-7), the "Prescription Drug Price and Quality Stabilization Act," to allow one line prescription forms to be used by a physician, dentist, veterinarian or other authorized prescriber. The prescription form shall contain one signature line for the prescriber's signature, and unless the prescriber handwrites "brand necessary" or "brand medically necessary," the signature shall designate approval of generic substitution of a drug by a pharmacist. Unless the prescriber explicitly states that a brand name drug product is necessary when transmitting an oral prescription, by using the phrase "brand necessary" or "brand medically necessary," a different brand name or nonbrand name (generic) drug product shall be dispensed by the pharmacist.

The bill prohibits a physician from dispensing more than a four-day supply of drugs or medicines to a patient, for profit. However, the dispensing prohibition shall not apply to a physician: (a) who dispenses drugs or medicines in a publicly subsidized family planning or prenatal clinic, if the drugs or medicines that are dispensed are directly related to the services provided at the clinic; (b) whose practice is situated 10 miles or more from a licensed pharmacy; (c) when he dispenses allergenic extracts and injectables; or (d) when he dispenses drugs pursuant to an oncological or AIDS protocol.

Finally, this bill establishes a Primary Care Physician Loan Redemption Program in the Department of Higher Education. The program is to provide for the redemption of a portion of the eligible student loan expenses of program participants for each year of service in a medically underserved area of the State as designated by the Commissioner of Health.

To be eligible to participate in the program, an applicant shall:

a. Be a resident of the State;

1 b. Be a graduate of a medical school recognized by the State
2 Board of Medical Examiners for the purpose of licensure and
3 receive a recommendation from the school's medical staff in
4 regard to participation in the loan redemption program;
5 c. Have completed a professional residency training program
6 and receive a recommendation from the medical staff of the
7 training program in regard to participation in the loan redemption
8 program; and,
9 d. Agree to practice in a medically underserved area of the
10 State.
11 The bill establishes an order of priority for the selection of
12 eligible applicants for the program.
13 The maximum redemption of loans under the program shall be
14 25% of principal and interest of eligible student loan expenses in
15 return for one full year of service in a designated medically
16 underserved area of the State, an additional 35% for a second full
17 year of service, and an additional 40% for a third full year of
18 service for a total redemption of eligible student loan expenses of
19 up to, but not to exceed, $40,000.
20 The bill directs the Chancellor of Higher Education to annually
21 apply to the federal government for any federal funds which may
22 be available to implement the loan redemption program. The
23 federal Public Health Service Amendments Act of 1987
24 established new authority for the creation of federal and state
25 loan redemption programs for physicians and made federal
26 matching funds available for such state programs.
27 Finally, the bill repeals sections 3, 6 and 11 of P.L.1971, c.136
28 (C.26:2H-3, 6, 11), concerning the health planning process that
29 had been mandated by federal law. It also repeals P.L.1987,
30 c.118 (C.26:2H-5.2 through 5.6) which established local health
31 planning agencies. These provisions have been replaced by new
32 provisions applicable to the State health planning process
33 established in this bill. The bill also repeals P.L.1979, c.272
34 (C.18A:72D-1 et seq.) concerning a medical student loan
35 forgiveness program. This program was not successful in
36 attracting medical students to work in medically underserved
37 areas, and is replaced with a new program in this bill.
38
39
40 HEALTH
41
42 Implements recommendations of Governor's Commission on
43 Health Care Costs.

[CORRECTED COPY]

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[THIRD REPRINT]

SENATE, No. 3251

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: JUNE 13, 1991

The Assembly Appropriations Committee favorably reports Senate Bill No. 3251 (3R) with committee amendments.

As amended by committee, this bill adopts several major recommendations of the Governor's Commission on Health Care Costs to reform the State's health care system.

The amended bill creates the "New Jersey Health Care Trust Fund" to replace the "New Jersey Uncompensated Care Trust Fund" established pursuant to P.L.1989, c.1 (C.26:2H-18.4 et seq.), which expired on December 31, 1990. The New Jersey Health Care Trust Fund would be effective on July 1, 1991 and would expire 12 months later, on June 30, 1992.

The bill repeals P.L.1989, c.1 and re-enacts the substantive provisions of that law, except that the bill caps the uncompensated care add-on at 19.7%.

The bill links the New Jersey Health Care Trust Fund to the Medicaid program in order to enable the State to claim federal Medicaid matching funds for uncompensated care that is provided in "disproportionate share" hospitals (i.e., hospitals whose uncompensated care costs are equal to or above the median of those costs in the State).

The bill requires hospitals to submit to the Department of Health demographic and other pertinent information about patients whose accounts are classified as bad debts, so that more can be learned about the persons whose care is paid for through the New Jersey Health Care Trust Fund. Further, the State Treasurer is required to report to the department income information about those patients whose income tax refund or homestead rebate is withheld to pay for overdue hospital bills. The information from the demographic "audit" of the persons who use the fund will be included in the first of two reports to the Legislature and Governor on the status of the fund which the Commissioner of Health is required to make six and 11 months after the effective date of the bill, respectively.

The bill establishes a pilot program to fund primary care for indigent persons in three community health centers, rather than in hospital emergency rooms. The Commissioner of Health will select three hospitals, one each in the northern, central and southern regions of the State. Each of the hospitals will sign agreements

with a local community health center and agree to refer emergency room patients who do not need emergency medical care to the health centers for appropriate medical care. The health care of those patients referred to the health centers who qualify for charity care will be paid for through the trust fund.

In order to provide funding for various health care initiatives that should reduce the cost of uncompensated care in the State, the bill establishes the "Health Care Cost Reduction Fund" and requires each hospital to pay the Department of Health .53% of its approved revenue base for 1991, for the next 24 months, for deposit in the fund. The monies in this special fund shall be used for funding:

(1) Local health planning;

(2) A demographic study of hospital patients whose accounts are classified as bad debts;

(3) The Primary Care Physician and Dentist Loan Redemption Program (established in this bill);

(4) The provision of funds to certain federally funded community health centers, to enable these centers to expand their hours of operation to evenings and weekends, and to advertise their primary health care services as an alternative to hospital emergency rooms;

(5) The expansion of eligibility for the Medicaid program to 185% of the poverty level for pregnant women and infants up to one year of age;

(6) Establishment of a "HealthStart Plus" program for pregnant women and infants up to age one whose income is between 185% and 300% of the poverty level;

(7) Establishment of the "Competitive Initiatives Fund" to strengthen relationships between hospitals and community health centers; and

(8) Other reform measures established by law which are designed to contain the cost of uncompensated care.

The bill revamps the certificate of need and health planning process by establishing a State Health Planning Board to develop and annually revise a State Health Plan. The planning board will replace the current Statewide Health Coordinating Council, or SHCC. The State Health Plan will be used as the basis for approving all certificate of need applications. The bill also establishes a system of local health planning whereby the Governor will designate at least five local health planning regions. Each region will establish a local advisory board, which shall be a nonprofit corporation, to conduct local health planning and make recommendations for the State Health Plan, and to perform certificate of need reviews. The five local advisory boards will replace the current three health systems agencies, or HSAs.

The bill changes the composition of the five-member Hospital Rate Setting Commission to remove the Commissioners of Health and Insurance and replace them with two public members, one of whom represents business or labor as a purchaser of health care services. The bill also specifies that the member who has

experience in hospital administration or finance shall not be an employee of a hospital.

For the purpose of requiring a certificate of need (CN), the bill specifies the types of services, equipment or facilities to which the CN requirement would apply, regardless of ownership. The requirement to obtain a CN would apply to:

a. The initiation of any health care service as provided in section 2 of P.L.1971, c.136 (C.26:2H-2);

b. The initiation by any person of a health care service which is the subject of a health planning regulation adopted by the Department of Health;

c. The purchase by any person of major moveable equipment whose total cost is over $1 million;

d. The expenditure by a licensed health care facility of over $1 million for modernization or renovation of its physical plant, or for construction of a new health care facility; and

e. The modernization, renovation or construction of a facility by any person, whose total project cost exceeds $1 million, if the facility-type is the subject of a health planning regulation adopted by the Department of Health.

The commissioner may periodically increase the monetary thresholds established in the bill, by regulation, to reflect inflationary increases in the costs of health care equipment or construction. Also, the bill specifies that "person" includes a corporation, company, association, society, firm, partnership and joint stock company, as well as an individual. It is the intent of this bill, however, that the changes in the CN requirements shall not affect a physician who seeks to open or maintain a "traditional" type of office for the private practice of medicine.

The bill increases the fees for filing an application for a certificate of need. The bill establishes a minimum fee of $5,000 and provides that the fee for a project costing more than $1 million but less than $10 million will be $5,000 plus .05% of the total project cost, and the fee for a project costing $10 million or more will be $5,000 plus 1.0% of the total project cost, except that the maximum fee shall be $100,000.

The bill clarifies the hospital rate setting appeal process to limit individual hospital appeals (other than those resulting from changes in statutes and regulations or those changes affecting more than one hospital) to a review of a hospital's full revenue base. This should reduce the number of appeals for single items since a hospital's full revenue base would be subject to review for each appeal, rather than just that part of the revenue base related to the object of the appeal.

The bill adopts several reforms concerning the State Medicaid program.

- The Medicaid eligibility level is expanded to cover pregnant women and children up to one year of age whose income is up to 185% of the federal poverty level.

• Medicaid would be required to prepare a five-year plan to develop a Statewide network of managed care providers for Medicaid recipients.

• The Medicaid program's Garden State Health Plan (a State-operated health maintenance organization) is expanded to permit individuals who do not have health care coverage and small businesses which do not provide health care coverage to their employees, to purchase coverage through the Garden State Health Plan.

• All health maintenance organizations in the State would be required to submit a plan to the Commissioner of Human Services to enroll recipients of Medicaid.

• The Commissioner of Human Services will be required to report to the Governor and the Legislature on ways to increase the number of Medicaid providers, to improve Medicaid provider relations with the Medicaid program, to reduce administrative burdens encountered by Medicaid providers, and to streamline Statewide administration of the Medicaid program.

The bill prohibits a physician from dispensing more than a seven-day supply of drugs or medicines to a patient. However, the dispensing prohibition shall not apply to a physician: (a) who dispenses drugs or medicines in a hospital emergency room, a student health center at an institution of higher education, or a publicly subsidized family planning or prenatal clinic, if the drugs or medicines that are dispensed are directly related to the services provided at the clinic; (b) whose practice is situated 10 miles or more from a licensed pharmacy; (c) when he dispenses allergenic extracts and injectables; (d) when he dispenses drugs pursuant to an oncological or AIDS protocol; or (e) when he dispenses salves, ointments or drops.

Under the provisions of the bill, physicians, chiropractors, and podiatrists, or members of their family who own a "significant beneficial interest" in a health care service would be prohibited from referring patients to that service. This provision amends P.L.1989, c.19 (C.45:9-22.5), the law requiring a practitioner to disclose his significant beneficial interest to patients he refers to the service. The provisions of this bill "grandfather in" those practitioners who had a significant beneficial interest prior to the effective date of the bill, so that these practitioners would continue to be able to refer their patients so long as they disclose the financial interest. The prohibition on referrals shall not apply, however, to radiation therapy, lithotripsy or renal dialysis services.

The bill amends P.L.1959, c.90 (C.2A:53A-8) to raise the limitation on liability for hospitals from $10,000 to $250,000.

The bill requires hospital service corporations, medical service corporations, health service corporations, commercial insurers and certain health maintenance organizations to offer mini-health care coverages in accordance with accepted underwriting standards for benefits or services specified in the bill. The required coverage

would include for each covered insured:

1. Hospital inpatient care for a period of 21 days in a benefit year;

2. Hospital outpatient services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and hospital outpatient X-ray and laboratory tests that would have been provided if treated on an inpatient basis;

3. Medical-surgical services consisting of surgical services, anesthesia services and in-hospital services to nonsurgical patients;

4. Maternity benefits including cost of delivery and prenatal care; and

5. Out-of-hospital physical examinations on a schedule established in the bill.

The bill allows insurers and health maintenance organizations to provide alternative benefits or services to those specified above if they are approved by the Commissioner of Insurance and are within the intent of the bill.

The coverage required to be offered under the bill may be subject to coinsurance and deductibles. However, deductible payments may not exceed $250 by an individual or family unit; coinsurance payments may not exceed $500 by an individual or family unit; and neither deductibles nor coinsurance may apply to physical examinations or maternity benefits. The bill also provides that the provisions of current law which mandate benefits and providers would not be applicable to the coverages required to be offered under this bill and that managed care systems may be utilized subject to the review and approval of the Commissioner of Insurance. The bill prohibits insurers and health maintenance organizations from selling mini-coverages required to be offered by this bill to groups which were covered by health benefits within the preceding 12 months.

The bill establishes a Primary Care Physician and Dentist Loan Redemption Program in the Department of Higher Education. The program is to provide for the redemption of a portion of the eligible student loan expenses of qualified medical and dental students for each year of service in a medically underserved area of the State as designated by the Commissioner of Health. The maximum redemption of loans under the program shall be 15% of principal and interest of eligible student loan expenses in return for one full year of service in a designated medically underserved area of the State, an additional 20% for a second full year of service, an additional 25% for a third full year of service, and an additional 40% for a fourth full year of service, for a total redemption of eligible student loan expenses of up to, but not to exceed, $70,000. The bill directs the Chancellor of Higher Education to annually apply to the federal government for any federal funds which may be available to implement the loan redemption program. The federal Public Health Service Amendments Act of 1987 established new authority for the creation of federal and state loan redemption programs and made

federal matching funds available for such state programs.

The bill requires commercial health insurers and health maintenance organizations to reimburse all claims within 60 days after receipt of the claim by the insurer or health maintenance organization, unless the claim is contested.

The bill establishes a 19-member Health Care Cost Reduction Advisory Committee to review and assess the effectiveness of the health care reform initiatives provided for in the bill. The committee will report its recommendations to the Governor and Legislature. Also, the bill establishes a subcommittee of the advisory committee to review the existing funding and technical support for the Hospital Rate Setting Commission.

Finally, the bill repeals sections 3, 6 and 11 of P.L.1971, c.136 (C.26:2H-3, 6, 11), concerning the health planning process that had been mandated by federal law in 1971. It also repeals P.L.1987, c.118 (C.26:2H-5.2 through 5.6) which established local health planning agencies. These provisions have been replaced by new provisions applicable to the State health planning process established in this bill. The bill also repeals P.L.1979, c.272 (C.18A:72D-1 et seq.) concerning a medical and dental student loan forgiveness program. This program was not successful in attracting medical or dental students to work in medically underserved areas, and is replaced with a new program in the bill.

COMMITTEE AMENDMENTS:

The committee amendments make the following changes in the bill:

- Create the "New Jersey Health Care Trust Fund," which will replace the "New Jersey Uncompensated Care Trust Fund," and re-enact the substantive provisions of P.L.1989, c.1 (sections 1 through 24 and 26);
- Link the Health Care Trust Fund to the Medicaid program to enable the State to claim additional federal Medicaid funds for uncompensated care, in accordance with an option permitted states under the federal Omnibus Budget Reconciliation Act of 1990, Pub.L.101-508 (sections 1, 2, 4, 5, 6 and 7);
- Require each hospital to reimburse a county welfare agency for the nonfederal share of costs associated with the stationing of an employee of that agency at the hospital to perform Medicaid eligibility determinations, rather than the county welfare agency being responsible for those costs (sections 9 and 10);
- Provide that hospitals would not have to carry out the bad debt collection procedures for outstanding balances that are less than $250 (section 11);
- Provide for a demographic study of the people whose hospital accounts are classified as bad debts (section 13);
- Require that the information compiled by the Department of the Treasury about the income of persons whose income tax refund or homestead rebate was applied to recover an outstanding amount on

a hospital patient's account include an additional income category, to identify the numbers of persons whose income is below $10,000 and between $10,000 and $20,000 (section 14);

- Require the State Auditor to conduct quality control reviews of the Department of Health's annual audits of hospitals' uncompensated care (section 15);
- Change the date for the establishment of a pilot program for designated urban hospitals and community health centers from July 1 to September 1, 1991 (section 23);
- Insert additional language regarding the objects of expenditure from the Health Care Cost Reduction Fund to clarify which community health centers shall be eligible to receive monies from the fund, and indicate the purpose of the Competitive Initiatives Fund (section 25);
- Exempt purchases of major moveable equipment contracted for prior to July 1, 1991 from the certificate of need requirement and provide that certain physicians and health maintenance organizations may seek a waiver from the certificate of need process, under certain circumstances (section 30);
- Include major moveable equipment in the definition of capital construction projects for the purposes of the three-year cap on hospital capital construction projects (section 32);
- Establish a maximum certificate of need application fee of $100,000 (section 36);
- Change from one to 10 the number of unused health care facility beds based upon which the Commissioner of Health may reduce a facility's licensed bed capacity, and changes the beginning date for the two-year period of the commissioner's review of utilization at a facility from July 1, 1989 to January 1, 1990 (section 38);
- Require a hospital to notify the Hospital Rate Setting Commission about any discounted payment rate arrangement with a third party payer, and prohibit the hospital from recovering revenue lost through such an arrangement through its rates (section 39);
- Prohibit a physician from dispensing more than a seven-day supply of drugs or medicines to a patient. The bill previously prohibited the dispensing of more than a four day supply, for profit, but allowed dispensing for any period of time if the drugs were provided at or below cost. Amendments also add salves, ointments and drops to the exceptions to this requirement (section 46);
- Exempt certain therapeutic health care services from the restrictions on physician referral of patients (section 47);
- Require health insurers and certain health maintenance organizations to offer mini-health care (bare bones) coverages (sections 49 through 59);
- Mandate claim payment deadlines for individual and group health insurers and HMO's (sections 78, 79 and 80);
- Provide for coordinated health care facility inspections by the Department of Health and the Joint Commission for the Accreditation of Healthcare Organizations (section 81);

- Establish a Health Care Cost Reduction Advisory Committee (section 82); and
- Amend the definition of "significant beneficial interest" in P.L.1989, c.19 (C.45:9-22.4) to delete the dollar threshold (section 83).

As amended by the committee, this bill is identical to Assembly Bill No. 5000 ACA, which the committee also reported favorably on this date.

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

STATEMENT TO

SENATE, No. 3251

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 11, 1991

The Senate Institutions, Health and Welfare Committee favorably reports Senate Bill No. 3251 with committee amendments.

As amended by committee, this bill adopts several major recommendations of the Governor's Commission on Health Care Costs to reform the State's health care system.

The bill revamps the certificate of need and health planning process by establishing a State Health Planning Board to develop and annually revise a State Health Plan. The planning board will replace the current Statewide Health Coordinating Council, or SHCC. The State Health Plan will be used as the basis for approving all certificate of need applications. The bill also establishes a system of local health planning whereby the Governor will designate at least five local health planning regions. Each region will establish a local advisory board, which shall be a nonprofit corporation, to conduct local health planning and make recommendations for the State Health Plan, and to perform certificate of need reviews. The five local advisory boards will replace the current three health systems agencies, or HSAs.

The bill changes the composition of the five-member Hospital Rate Setting Commission to remove the Commissioners of Health and Insurance and replace them with two public members, one of whom represents business or labor as a purchaser of health care services. The bill also specifies that the member who has experience in hospital administration or finance shall not be an employee of a hospital.

For the purpose of requiring a certificate of need (CN), the bill specifies the types of services, equipment or facilities to which the CN requirement would apply, regardless of ownership. The requirement to obtain a CN would apply to:

a. The initiation of any health care service as provided in section 2 of P.L.1971, c.136 (C.26:2H-2);

b. The initiation by any person of a health care service which is the subject of a health planning regulation adopted by the Department of Health;

c. The purchase by any person of major moveable equipment whose total cost is over $1 million;

d. The expenditure by a licensed health care facility of over $1 million for modernization or renovation of its physical plant, or for construction of a new health care facility; and

e. The modernization, renovation or construction of a facility by any person, whose total project cost exceeds $1 million, if the facility-type is the subject of a health planning regulation adopted by the Department of Health.

The commissioner may periodically increase the monetary thresholds established in the bill, by regulation, to reflect inflationary increases in the costs of health care equipment or construction. Also, the bill specifies that "person" includes a corporation, company, association, society, firm, partnership and joint stock company, as well as an individual.

The bill increases the fees for filing an application for a certificate of need. The bill establishes a minimum fee of $5,000 and provides that the fee for a project costing more than $1 million but less than $10 million will be $5,000 plus .5% of the total project cost, and the fee for a project costing $10 million or more will be $5,000 plus 1.0% of the total project cost.

The bill clarifies the hospital rate setting appeal process to limit individual hospital appeals (other than those resulting from changes in statutes and regulations or those changes affecting more than one hospital) to a review of a hospital's full revenue base. This should reduce the number of appeals for single items since a hospital's full revenue base would be subject to review for each appeal, rather than just that part of the revenue base related to the object of the appeal.

The bill adopts several reforms concerning the State Medicaid program.

- The Medicaid eligibility level is expanded to cover pregnant women and children up to one year of age whose income is up to 185% of the federal poverty level.
- Medicaid would be required to prepare a five-year plan to develop a Statewide network of managed care providers for Medicaid recipients. The plan would be prepared within one year and submitted to the Governor and the Legislature.
- The Medicaid program's Garden State Health Plan (a State-operated health maintenance organization) is expanded to permit individuals who do not have health care coverage and small businesses which do not provide health care coverage to their employees, to purchase coverage through the Garden State Health Plan. The premiums paid by these individuals and small businesses will be determined by the Commissioner of Human Services and will be sufficient to fund the cost of the benefits under the plan.
- All health maintenance organizations in the State would be required to submit a plan to the Commissioner of Human Services to enroll recipients of Medicaid. The plan would include the terms and conditions for enrolling Medicaid recipients, including the number of recipients that can be enrolled, the health care services that will be offered, and an estimate of the per capita cost for enrollment of these persons.
- The Commissioner of Human Services will be required to report to the Governor and the Legislature on ways to increase the

number of Medicaid providers, to improve Medicaid provider relations with the Medicaid program, to reduce administrative burdens encountered by Medicaid providers, and to streamline Statewide administration of the Medicaid program.

The bill amends P.L.1959, c.90 (C.2A:53A-8) to eliminate the $10,000 limitation on liability for hospitals.

The bill amends section 8 of P.L.1977, c.240 (C.24:6E-7), the "Prescription Drug Price and Quality Stabilization Act," to allow one line prescription forms to be used by a physician, dentist, veterinarian or other authorized prescriber. The prescription form shall contain one signature line for the prescriber's signature, and unless the prescriber handwrites "brand necessary," "brand medically necessary," or words of similar meaning which express a medical necessity for the brand name drug product, the signature shall designate approval of generic substitution of a drug by a pharmacist. The bill also provides that whenever substitution is indicated, the pharmacist shall inform the consumer of the price savings that would result from generic substitution. Presently, the law requires the pharmacist to inform the consumer of the price savings at the consumer's request.

The bill prohibits a physician from dispensing more than a four-day supply of drugs or medicines to a patient, for profit. However, the dispensing prohibition shall not apply to a physician: (a) who dispenses drugs or medicines in a publicly subsidized family planning or prenatal clinic, if the drugs or medicines that are dispensed are directly related to the services provided at the clinic; (b) whose practice is situated 10 miles or more from a licensed pharmacy; (c) when he dispenses allergenic extracts and injectables; or (d) when he dispenses drugs pursuant to an oncological or AIDS protocol.

The bill establishes a Primary Care Physician and Dentist Loan Redemption Program in the Department of Higher Education. The program is to provide for the redemption of a portion of the eligible student loan expenses of qualified medical and dental students for each year of service in a medically underserved area of the State as designated by the Commissioner of Health. The maximum redemption of loans under the program shall be 15% of principal and interest of eligible student loan expenses in return for one full year of service in a designated medically underserved area of the State, an additional 20% for a second full year of service, an additional 25% for a third full year of service, and an additional 40% for a fourth full year of service, for a total redemption of eligible student loan expenses of up to, but not to exceed, $70,000. The bill directs the Chancellor of Higher Education to annually apply to the federal government for any federal funds which may be available to implement the loan redemption program. The federal Public Health Service Amendments Act of 1987 established new authority for the creation of federal and state loan redemption programs and made federal matching funds available for such state programs.

Under the provisions of the bill, physicians, chiropractors, and podiatrists, or members of their family who own a "significant beneficial interest" in a health care service would be prohibited from referring patients to that service. This provision amends P.L.1989, c.19 (C.45:9-22.5), the law requiring a practitioner to disclose his significant beneficial interest to patients he refers to the service. The provisions of this bill "grandfather in" those practitioners who had a significant beneficial interest prior to the effective date of the bill, so that these practitioners would continue to be able to refer their patients so long as they disclose the financial interest.

The bill directs the Commissioner of Health to designate hospitals in which an employee from the county welfare agency shall be stationed to make eligibility determinations for the Medicaid program. This on-site Medicaid employee should be able to promptly enroll those patients who qualify for Medicaid. This bill provides that the county welfare agency which assigns the worker to the hospital, would be responsible for the salary and employee benefits costs; however, the federal government will reimburse the counties for 50% of the costs.

The bill continues the requirement that was contained in section 14 of P.L.1989, c.1 (the law establishing the Uncompensated Care Trust Fund) which expired on December 31, 1990, that every student enrolled as a full-time student at a public or private institution of higher education in this State shall maintain health insurance coverage which provides basic hospital benefits. The coverage shall be maintained throughout the period of the student's enrollment.

In order to provide funding for various health care initiatives that should reduce the cost of uncompensated care in the State, the bill establishes a Health Care Cost Reduction Fund and requires each hospital to pay the Department of Health .53% of its approved revenue base for 1991, for the next 24 months, for deposit in the fund. The monies in this special fund shall be used for funding:

(1) Local health planning;

(2) A demographic study of hospital patients whose accounts are classified as bad debts;

(3) The Primary Care Physician and Dentist Loan Redemption Program;

(4) The provision of funds to eight community health centers funded under section 330 of Part c of Title III of the "Public Health Service Act," Pub.L.94-63 (42 U.S.C. § 254c.), to enable these centers to expand their hours of operation to evenings and weekends, and to advertise their primary health care services as an alternative to hospital emergency rooms;

(5) The expansion of eligibility for the Medicaid program to 185% of the poverty level for pregnant women and infants up to one year of age;

(6) Establishment of a "HealthStart Plus" program for pregnant women and infants up to age one whose income is between 185% and 300% of the poverty level - $8 million;

(7) Establishment of the "Competitive Initiatives Fund" - $6 million; and

(8) Other reform measures established by law which are designed to contain the cost of uncompensated care.

Finally, the bill repeals sections 3, 6 and 11 of P.L.1971, c.136 (C.26:2H-3, 6, 11), concerning the health planning process that had been mandated by federal law in 1971. It also repeals P.L.1987, c.118 (C.26:2H-5.2 through 5.6) which established local health planning agencies. These provisions have been replaced by new provisions applicable to the State health planning process established in this bill. The bill also repeals P.L.1979, c.272 (C.18A:72D-1 et seq.) concerning a medical and dental student loan forgiveness program. This program was not successful in attracting medical or dental students to work in medically underserved areas, and is replaced with a new program in the bill.

The committee amendments:

- Clarify the definition of "health care service" for the purposes of obtaining a certificate of need and specify to whom and for what equipment and construction the requirement applies;

- Increase the filing fees for certificate of need applications;

- Specify that the Hospital Rate Setting Commission member experienced in hospital administration or finance shall not be an employee of a hospital;

- Delete the requirement that the cap on capital construction shall be in the proposed State Health Plan, and provide, instead, that for a three-year period beginning January 1, 1992, the Commissioner of Health may approve certificates of need for capital construction projects for hospitals up to an annual Statewide limit of $275 million for all projects, exclusive of refinancing;

- Clarify that the Commissioner of Health's authority to reduce a health care facility's licensed bed capacity shall not apply in those cases in which a licensed bed has not been used upon the request of a patient to reduce the number of beds in his room while he occupies the room;

- In order to ensure that certificate of need applications with very little or no support from either the local advisory board or State Health Planning Board do not proceed to the next level of review, the amendments require that an application receive affirmative votes from at least 25% of the quorum of voting members before it can proceed to the next level. The amendments also provide for an appeal process for those applicants who do not receive the minimum number of votes.

- Require the Commissioner of Human Services to prepare a five-year plan to develop a Statewide network of managed care providers for Medicaid recipients, rather than direct the commissioner to offer all Medicaid recipients the option to participate in a managed care plan within five years, as the bill originally provided;

- Require all health maintenance organizations in the State to submit a plan to the Commissioner of Human Services to enroll Medicaid recipients;

- Require the Commissioner of Human Services to report to the

Legislature and the Governor on ways to improve Medicaid provider relations and Statewide administration of the Medicaid program;

- Clarify that the expansion of the Garden State Health Plan to certain small employers and individuals shall not be construed to mean that any other reference in law regarding the offering or availability of coverage by a health maintenance organization shall apply to the Garden State Health Plan;

- Require a pharmacist, whenever generic drug substitution is indicated, to inform a consumer of the price savings that would result from substitution;

- Expand the Primary Care Physician Loan Redemption Program to include dentists, provide that the redemption of loans shall be over a four-year period instead of three years as the bill originally provided, and increase the maximum amount of eligible student loan expenses that can be redeemed from $40,000 to $70,000.

- Prohibit physicians, chiropractors and podiatrists, or members of their family who own a "significant beneficial interest" in a health care service, from referring patients to that service;

- Direct the Commissioner of Health to designate hospitals in which an employee from the county welfare agency shall be stationed to make eligibility determinations for the Medicaid program; and

- Establish a Health Care Cost Reduction Fund and require hospitals to pay a percentage of their approved revenue base for 1991 into the fund for the purpose of funding various health care initiatives which will reduce the cost of uncompensated care.

The committee also adopted technical amendments to section 3 of P.L.1968, c.413 (C.30:4D-3) to update the section to conform with changes made pursuant to P.L.1991, c.20.

ADOPTED
MAR 25 1991

SENATE Amendments
(Proposed by Senator Lesniak)

to

SENATE, No. 3251 (1R)

(Sponsored by Senator Codey)

REPLACE SECTION 20 TO READ:

[1][17.] 20.[1] Section 8 of P.L.1977, c.240 (C.24:6E-7) is amended to read as follows:

8. Every prescription blank shall [be imprinted with the words, "substitution permissible" and "do not substitute" and shall contain space for the physician's or other authorized prescriber's initials next to the chosen option. Notwithstanding any other law, unless the physician or other authorized prescriber explicitly states that there shall be no substitution when transmitting an oral prescription or, in the case of a written prescription, indicates that there shall be no substitution by initialing the prescription blank next to "do not substitute," a different brand name or nonbrand name drug product of the same established name shall be dispensed by a pharmacist] [2]be imprinted with the words, "brand necessary" and shall contain a box for the physician's or other authorized prescriber's initials next to the imprinted words. The prescription blank shall[2] contain one signature line for the physician's or other authorized prescriber's signature [2]at the bottom of the blank[2]. The prescriber's signature shall validate the prescription and, unless the prescriber [2][handwrites [1]["brand necessary" or] "brand necessary,"[1] "brand medically necessary," [1]or words of similar meaning which express a medical necessity for the brand name drug product, the signature[1]] initials the box next to the words "brand necessary," the prescriber's signature[2] shall designate approval of substitution of a drug by a pharmacist pursuant to this act if such different brand name or nonbrand name drug product shall reflect a lower cost to the consumer and is contained in the latest list of interchangeable drug products published by the council; provided, however, where the prescriber [indicates "substitution permissible and] requests the pharmacist to notify him of the substitution,["] the pharmacist shall transmit notice, either orally or by written notice to be mailed no later than the end of the business day, to the prescriber specifying the drug product actually dispensed and the name of the manufacturer thereof. [However,] Notwithstanding any other law to the contrary, unless the physician or other authorized prescriber explicitly states that a brand name drug product is necessary when transmitting an oral prescription by using the phrase [1]["brand necessary" or "brand medically necessary",] "brand necessary," [2]["brand

medically necessary," or words of similar meaning which express a medical necessity for the brand name drug product,[1]][2] a different brand name or nonbrand name drug product of the same established name shall be dispensed by a pharmacist, however, no drug interchange shall be made unless a savings to the consumer results, and the pharmacist passes such savings on to the consumer in full by charging no more than the regular and customary retail price for the drug to be substituted. For prescriptions filled other than by mail, [1][the consumer may, if a substitution is indicated and prior to having his prescription filled, request] if substitution is indicated[1] the pharmacist or his agent [1][to inform him] , prior to filling the prescription, shall inform the consumer[1] of the price savings that would result from substitution. If the consumer is not satisfied with said price savings he may, upon request, be dispensed the drug product prescribed by the physician. The pharmacist shall make a notation of such request upon the prescription blank.
(cf: P.L.1977, c.240, s.8)

STATEMENT

These amendments provide that a physician, dentist, veterinarian or other authorized prescriber shall use a revised prescription form regarding the use of generic drugs. The form shall be imprinted with the words, "brand necessary," and shall contain a box for the physician's or other authorized prescriber's initials next to the imprinted words. The form shall contain one signature line for the physician's or other authorized prescriber's signature at the bottom of the form, and unless the prescriber initials the box, the signature shall designate approval of generic drug substitution.

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TR 0065

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ADOPTED 3/25/91

SENATE Amendments
(Proposed by Senator Codey)

to

SENATE, No. 3251 (1R)

(Sponsored by Senator Codey)

INSERT NEW SECTION 46 TO READ:

[2]46. For all periods for which an audit for reimbursement for uncompensated care through the Uncompensated Care Trust Fund established pursuant to P.L.1989, c.1 (C.26:2H-18.4 et seq.) shall be conducted, the requirements regarding the determination of eligibility for charity care pursuant to sections 9 and 10 of P.L.1989, c.1 (C.26:2H-18.12 and 18.13) shall not apply to a patient who is investigated by a county adjuster and found to be indigent by a court of competent jurisdiction pursuant to the provisions of chapter 4 of Title 30 of the Revised Statutes. A patient so found shall qualify for charity care.[2]

RENUMBER SECTIONS 46 and 47 AS 47 and 48

STATEMENT

This amendment addresses a technical problem faced by Bergen Pines County Hospital, which is the only hospital in the State that participates in both the psychiatric cost sharing program and the Uncompensated Care Trust Fund.

The amendment provides that a patient who is investigated by a county adjuster and found to be indigent by a court of competent jurisdiction, shall also qualify for charity care under the provisions of the Uncompensated Care Trust Fund (P.L.1989, c.1). The county adjuster's investigation of a patient's financial status would serve as a substitute for the investigation required under the trust fund law; consequently, the amendment also provides that the hospital would not be required to undergo the interview and collection procedures required under P.L.1989, c.1 for such a patient. For the purposes of the Department of Health's audit of a hospital's reimbursement for trust fund monies, this exemption from the interview and collection procedures shall apply to the audit periods of 1989 and 1990.

This amendment will not have any cost impact on the Uncompensated Care Trust Fund.

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OFFICE OF THE GOVERNOR
NEWS RELEASE

CN-001 **TRENTON, N.J. 08625**

Contact: Emma Byrne
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Release: Monday
July 1, 1991

GOVERNOR FLORIO SIGNS MAJOR HEALTH CARE REFORM MEASURE

Law Works Toward Lowering Costs and Reducing Problems of Uninsured

New Jersey is leading the way in providing for universal health care in spite of a lack of leadership at the national level, Governor Jim Florio said today as he signed the "Health Care Cost Reduction Act" designed to make health care in the state more affordable and accessible.

"Maintaining access and quality in health care seems to be one of the great medical mysteries of our time. We've tackled that mystery and we've succeeded in ways that will mark a new beginning for health care in New Jersey and send a message far and wide," said Governor Florio. "The people of New Jersey can't afford to be financially strangled by wildly rising health care costs. Those costs must come down and this legislation will help in that effort."

"Health care is a national problem and it cries out for a national response. But New Jersey is not waiting for Washington anymore. Instead, we're showing the way," Governor Florio said. "We have the foundation for universal health care in New Jersey. Now, together, we must build on that foundation and at the same time, contain costs. We call our program "Real Care" -- because it's a real answer to a real problem. No more band-aids. No more stop-gap solutions."

The legislation enacts many of the recommendations set forth by the Governor's Commission on Health Care Costs last year following their intensive study and public debate on the issues confronting New Jersey's health care system. These reforms will:

- Reduce health care costs and decrease reliance on the Health Care Trust Fund. Enacts the Health Care Trust Fund for one year to finance hospital care for the uninsured while other meaningful reforms are put in place.
- Expand early care for children by expanding Medicaid which will decrease the number of uninsured who rely on the trust fund and will allow the state to obtain federal matching funds.
- Reduce uncompensated care and expand primary care.

- Require insurers to offer affordable "bare bone" health insurance policies
- Provide a framework for rational health planning and cost containment.
- Create a physician and dentist loan redemption program to encourage health care professions to serve in medically undeserved areas.

"I read the other day in the Wall Street Journal an apt description of Washington's response to the health care crisis: Take two aspirin and call us in a couple of years. This law says New Jersey's people can't wait another couple of years," said Governor Florio. "This is an important step toward reining in our out-of-control health care system. We're getting health care back to where the most important people are the patients."

The lack of leadership on the national level regarding health care has left a void that states are scrambling to fill, the Governor noted. Earlier this month, he signed legislation which will put a non-binding resolution on the November ballot on the question of a national health care policy.

"The high cost of health care is squeezing the middle class of our country dry. It used to be taken for granted that being an American meant receiving the best medical care in the world," said Governor Florio. "Now, we're faced with a cruel irony. The care's out there and we've managed to find cures for diseases that used to be death sentences. But too often we've replaced the heartbreak of illness with the heartbreak of bankruptcy."

"This is an important day -- a happy day. A day when we take a big step toward making sure New Jersey offers all of us, not only a future of opportunity, but of the good health that makes that opportunity possible."

# # #

"REAL CARE":
HEALTH CARE COST REDUCTION ACT

The Health Care Cost Reduction Act is a comprehensive, cost-effective reform measure aimed at making health care in New Jersey more affordable and more accessible. The legislation enacts many of the recommendations set forth by the Governor's Commission on Health Care Costs following their intensive study and public debate on the issues confronting New Jersey's health care system.

These reforms will reduce health care costs and decrease reliance on the Health Care Trust Fund. Expanding Medicaid alone will decrease the number of uninsured relying on the trust fund and will allow the state to obtain federal matching funds. It requires insurers to offer affordable "bare bone" health insurance policies and takes steps to divert patients from hospital emergency rooms to community health centers for less expensive care. It also strengthens the state's inadequate certificate of need procedure.

HIGHLIGHTS

- *HEALTH CARE TRUST FUND*

  The Health Care Trust Fund replaces the expired Uncompensated Care Trust Fund while enacting meaningful reforms that will bring down the costs of health care. The newly created trust fund begins on July 1, 1991 and expires on July 31, 1992. Hospitals would receive the first of twelve payments from the fund by August 15, 1991; hospitals would have to make their first of twelve payments into the fund by August 30, 1991. The Health Care Trust Fund differs from the expired trust fund in several important respects:
  - The uncompensated care add-on to all paying patients' hospital bills is capped at 19.7 percent.
  - Requires a hospital to pay all of the uncompensated care monies it receives every month (not just the difference between its actual uncompensated care costs and what it collects) into the fund as an assessment.
  - Caps the amount that must be maintained in the fund's reserve at $25 million.

- *REFORMS TO REDUCE UNCOMPENSATED CARE AND EXPAND PRIMARY CARE*

  - Expands Medicaid eligibility to cover children up to 6-years-old and pregnant women with family incomes up to 133 percent of the federal poverty level.

- Expands Medicaid eligibility to cover children up to age one and pregnant women with family incomes up to 185 percent of the federal poverty level.
- Requires the outstationing of Medicaid workers within 30 days at hospitals designated by the Health Commissioner to promote greater enrollment of eligible poor in Medicaid.
- Establishes a pilot project between three hospitals and three community health centers in order to divert non-emergent medical cases from emergency rooms to community health centers.
- Requires insurers to provide a limited "bare bones" health insurance policy for sale in the state to groups and individuals.
- Requires that all college students carry health insurance.
- Funds a demographic study of patients whose bills are classified as charity care and thus eligible for payment through the trust fund.
- Establishes a Competitive Initiatives Fund to provide a basis for hospitals and community health centers to work together so that non-emergent medical cases are treated at the community health center.
- Enacts a Health Start Plus program to provide prenatal, obstetrical and social service programs for pregnant, uninsured women and for children with incomes between 185 percent and 300 percent of the federal poverty level.

- ***HEALTH PLANNING AND COST CONTAINMENT***

  - Creates a state Health Planning Board to develop State Health Plan to be used as the basis for approval of all certificates of need. The State Health Plan will identify all unmet health care needs in the state and will be created by January 1, 1992. Creates at least five local advisory board to conduct local health planning to make recommendations regarding certificates of need and the State Health Plan.
  - Requires certificate of need applications for purchases and modernizations by any health care service or health care facility with a total cost greater than $1 million. Brings physicians under the certificate of need program.
  - Increases the minimum fee for filing a certificate of need from $1,000 to $5,000 plus a percentage of the project cost.
  - Provides funds to extend the hours of federally-funded community health centers to weekends and evenings to increase patient access.
  - Places a three-year capital construction cap of $225 million per year on all construction, including modernization or renovation at hospitals that would be financed by the New Jersey Health Care Financing Authority. The purchase of major movable equipment is included in the cap.

- *OTHER MAJOR MEASURES*

    - Creates the Primary Care Physician and Dentist Loan Redemption Program to encourage these health care professionals to serve in medically underserved areas in exchange for student loan forgiveness up to $70,000
    - Prohibits health care practitioners from referring patients to services in which the practitioner or members of their family have any financial interest. This bill exempts from the prohibition: services provided at the practitioner's medical offices; radiation therapy; lithotripsy, and renal dialysis. This bill grandfathers in all practitioners who currently have a financial interest so that these practitioners may continue to refer if they provide proper financial disclosure to their patients.
    - Prohibits doctors from dispensing more than a 7-day supply of prescription drugs. The physician may charge at or below the cost, plus an administrative fee not to exceed 10 percent of the cost of the drug. This limitation does not apply to allergy medicines, salves, ointments, drops or drugs dispensed pursuant to an oncological or AIDS protocol.
    - Requires the State Auditor to review the records of the 20 hospitals with the highest number of uninsured patients.
    - Removes the Commissioners of Health and Insurance from the five-member Hospital Rate Setting Commission and replaces them with two public members.
    - Allows the Health Commissioner to amend the license of a health care facility to reduce the number of beds if ten or more of its licensed beds have not been used in the last two years.
    - Raises the $10,000 limit on non-profit hospital liability to $250,000

- *HEALTH CARE COST REDUCTION FUND*

  To fund the reforms, all hospitals are required to pay 0.53 percent of their 1991 approved revenue into this newly established fund. Each hospital will be required to make equal monthly deposits for a period of 24 months. This will generate $74 million over the next two years. The amount collected from all of the hospitals is capped at $40 million per year.