26:2S-12

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 1

NJSA: 26:2S-12 (Independent Healthcare Appeals Program)

BILL NO: A322 (Substituted for S640)

SPONSORS: Vandervalk and Talarico

DATE INTRODUCED: Pre-filed

COMMITTEE: **ASSEMBLY:** Banking and Insurance; Health

SENATE: ----

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** May 11, 2000

SENATE: December 4, 2000

DATE OF APPROVAL: January 16, 2001

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (1st reprint enacted)

(Amendments during passage denoted by superscript numbers)

A322

SPONSORS STATEMENT: (Begins on page 3 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes 1/27/00 (Health)

2/10/00 (Banking & Ins)

SENATE: No

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

S640

SPONSORS STATEMENT: (Begins on page 3 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

"New law requires HMOs to accept appeal rulings," 1-17-2001 Star Ledger, p19

ASSEMBLY, No. 322

STATE OF NEW JERSEY

209th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblyman GUY F. TALARICO
District 38 (Bergen)

SYNOPSIS

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

AN ACT concerning the Independent Health Care Appeals Program and amending P.L.1997, c.192.

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

1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read as follows:

12. a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any carrier. The commissioner may establish additional requirements, including conflict of interest standards, consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Care Appeals Program.

b. The commissioner shall establish procedures for transmitting the completed application for an appeal review to the independent utilization review organization.

c. The independent utilization review organization shall promptly review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier. The organization shall complete its review and make its determination within 90 days of receipt of a completed application for an appeal review or within less time, as prescribed by the commissioner.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall **[**make a recommendation**]** convey to the covered person and carrier its decision regarding the appropriate, medically necessary health care services that the person should receive**[**. Upon receiving the organization's recommendation**]**, which shall be binding on the carrier **[**shall promptly notify the covered person and the commissioner about what action the carrier will take with respect to the recommendation**]**. If the covered person is not in

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

Matter underlined thus is new matter.

agreement with the organization's [findings and recommendation or the carrier's action on the recommendation] decision, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

d. If the commissioner determines that a carrier [exhibits a pattern of noncompliance] has failed to comply with the [findings and recommendations] decision of an independent utilization review organization[, the commissioner shall review the carrier's utilization management program to ensure that the carrier is in compliance with all relevant State laws and regulations, including utilization management standards. If the commissioner determines that the carrier] or is otherwise in violation of patient rights and other applicable regulations, the commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the commissioner deems appropriate.

e. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

f. The covered person's medical records provided to the Independent Health Care Appeals Program and the independent utilization review organization and the findings and recommendations of the organization made pursuant to this act are confidential and shall be used only by the department, the organization and the affected carrier for the purposes of this act. The medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

g. The commissioner shall establish a reasonable, per case reimbursement schedule for the independent utilization review organization.

h. The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the commissioner.

(cf: P.L.1997, c.192, s.12)

2. This act shall take effect immediately.

STATEMENT

This bill makes the decisions rendered by independent utilization review organizations under the Independent Health Care Appeals Program established pursuant to the "Health Care Quality Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance carriers against whom a covered person files an appeal under the program.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 322

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 27, 2000

The Assembly Health Committee reports favorably and with committee amendments Assembly Bill No. 322.

As amended by the committee, this bill makes the decisions rendered by independent utilization review organizations under the Independent Health Care Appeals Program established pursuant to the "Health Care Quality Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance carriers against which a covered person files an appeal under the program.

The committee amendments specify that if all or part of the independent utilization review organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services.

As reported by the committee, this bill is identical to Senate Bill No. 2123 (1R) of 1999 (Matheussen/Sinagra) which was reported by the Senate Health Committee during the prior session, and is similar to Assembly Bill No. 3319 of 1999 (Vandervalk/Talarico).

This bill was prefiled for introduction in the 2000-2001 session pending technical review. As reported, the bill includes the changes required by technical review which has been performed.

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 322

STATE OF NEW JERSEY

DATED: FEBRUARY 10, 2000

The Assembly Banking and Insurance Committee reports favorably Assembly Bill No. 322 (1R).

This bill makes the decisions rendered by independent utilization review organizations under the Independent Health Care Appeals Program established pursuant to the "Health Care Quality Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance carriers against whom a covered person files an appeal under the program. The bill further provides that if all or part of the independent utilization review organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services.

[First Reprint]

ASSEMBLY, No. 322

STATE OF NEW JERSEY

209th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblyman GUY F. TALARICO
District 38 (Bergen)

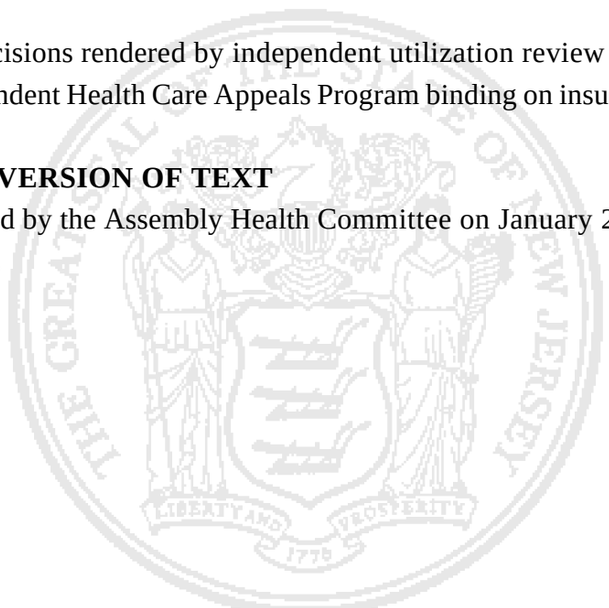
Co-Sponsored by:
Assemblywoman Crecco, Assemblymen LeFevre, Conaway, Gusciora, Garrett, Assemblywoman Greenstein, Assemblyman Thompson, Senators Matheussen, Sinagra, Gormley, Cafiero, Bennett, Bark, Robertson, Palaia, Kavanaugh, Bassano, McNamara, Allen, Inverso, Bucco, Singer, Kosco and Martin

SYNOPSIS

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on January 27, 2000, with amendments.



(Sponsorship Updated As Of: 12/5/2000)

AN ACT concerning the Independent Health Care Appeals Program and amending P.L.1997, c.192.

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

1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read as follows:

12. a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any carrier. The commissioner may establish additional requirements, including conflict of interest standards, consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Care Appeals Program.

b. The commissioner shall establish procedures for transmitting the completed application for an appeal review to the independent utilization review organization.

c. The independent utilization review organization shall promptly review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier. The organization shall complete its review and make its determination within 90 days of receipt of a completed application for an appeal review or within less time, as prescribed by the commissioner.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall **[**make a recommendation**]** convey to the covered person and carrier its decision regarding the appropriate, medically necessary health care services that the person should receive**[**. Upon receiving the organization's recommendation**]**, which shall be binding on the carrier **[**shall promptly notify the covered

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Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted January 27, 2000.

person and the commissioner about what action the carrier will take with respect to the recommendation**]**. [1]If all or part of the organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services.[1] If the covered person is not in agreement with the organization's **[**findings and recommendation or the carrier's action on the recommendation**]** decision, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

d. If the commissioner determines that a carrier **[**exhibits a pattern of noncompliance**]** has failed to comply with the **[**findings and recommendations**]** decision of an independent utilization review organization**[**, the commissioner shall review the carrier's utilization management program to ensure that the carrier is in compliance with all relevant State laws and regulations, including utilization management standards. If the commissioner determines that the carrier**]** or is otherwise in violation of patient rights and other applicable regulations, the commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the commissioner deems appropriate.

e. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

f. The covered person's medical records provided to the Independent Health Care Appeals Program and the independent utilization review organization and the findings and recommendations of the organization made pursuant to this act are confidential and shall be used only by the department, the organization and the affected carrier for the purposes of this act. The medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

g. The commissioner shall establish a reasonable, per case reimbursement schedule for the independent utilization review organization.

h. The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the commissioner.

(cf: P.L.1997, c.192, s.12)

2. This act shall take effect immediately.

SENATE, No. 640

STATE OF NEW JERSEY

209th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

SYNOPSIS

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

AN ACT concerning the Independent Health Care Appeals Program and amending P.L.1997, c.192.

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

1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read as follows:

12. a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any carrier. The commissioner may establish additional requirements, including conflict of interest standards, consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Care Appeals Program.

b. The commissioner shall establish procedures for transmitting the completed application for an appeal review to the independent utilization review organization.

c. The independent utilization review organization shall promptly review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier. The organization shall complete its review and make its determination within 90 days of receipt of a completed application for an appeal review or within less time, as prescribed by the commissioner.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall **[**make a recommendation**]** convey to the covered person and carrier its decision regarding the appropriate, medically necessary health care services that the person should receive**[**. Upon receiving the organization's recommendation**]**, which shall be binding on the carrier **[**shall promptly notify the covered person and the commissioner about what action the carrier will take with respect to the recommendation**]**. If all or part of the

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organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services. If the covered person is not in agreement with the organization's **[**findings and recommendation or the carrier's action on the recommendation**]** decision, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

d. If the commissioner determines that a carrier **[**exhibits a pattern of noncompliance**]** has failed to comply with the **[**findings and recommendations**]** decision of an independent utilization review organization**[**, the commissioner shall review the carrier's utilization management program to ensure that the carrier is in compliance with all relevant State laws and regulations, including utilization management standards. If the commissioner determines that the carrier**]** or is otherwise in violation of patient rights and other applicable regulations, the commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the commissioner deems appropriate.

e. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

f. The covered person's medical records provided to the Independent Health Care Appeals Program and the independent utilization review organization and the findings and recommendations of the organization made pursuant to this act are confidential and shall be used only by the department, the organization and the affected carrier for the purposes of this act. The medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

g. The commissioner shall establish a reasonable, per case reimbursement schedule for the independent utilization review organization.

h. The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the commissioner.

(cf: P.L.1997, c.192, s.12)

2. This act shall take effect immediately.

STATEMENT

This bill would make the decisions rendered by independent

utilization review organizations under the Independent Health Care Appeals Program established pursuant to the "Health Care Quality Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance carriers against whom a covered person files an appeal under the program.

The bill would specify that if all or part of the independent utilization review organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 640

STATE OF NEW JERSEY

DATED: MARCH 20, 2000

The Senate Health Committee reports favorably Senate Bill No. 640.

This bill would make the decisions rendered by independent utilization review organizations under the Independent Health Care Appeals Program established pursuant to the "Health Care Quality Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance carriers against whom a covered person files an appeal under the program.

The bill would specify that if all or part of the independent utilization review organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services.

In the 1998-1999 session, the committee reported favorably with amendments Senate Bill No. 2123, which is identical to this bill. This bill is also identical to Assembly Bill No. 322(1R) (Vandervalk/Talerico) which is pending before the General Assembly.

This bill was prefiled for introduction in the 2000-2001 session pending technical review. As reported, the bill includes the changes required by technical review which has been performed.

SENATE, No. 640

STATE OF NEW JERSEY

209th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

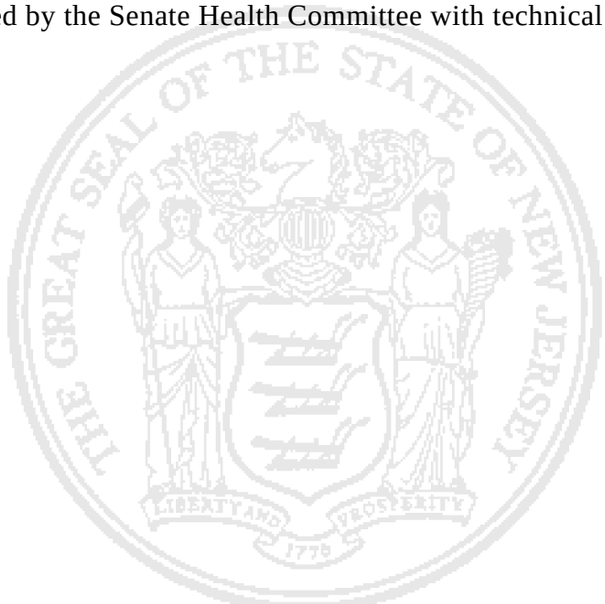
Co-Sponsored by:
Senators Gormley, Cafiero, Bennett, Bark, Robertson, Palaia, Kavanaugh, Bassano, McNamara, Allen, Inverso, Bucco, Singer, Kosco and Martin

SYNOPSIS

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

CURRENT VERSION OF TEXT

As reported by the Senate Health Committee with technical review.



(Sponsorship Updated As Of: 11/14/2000)

AN ACT concerning the Independent Health Care Appeals Program and amending P.L.1997, c.192.

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

1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read as follows:

12. a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any carrier. The commissioner may establish additional requirements, including conflict of interest standards, consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Care Appeals Program.

b. The commissioner shall establish procedures for transmitting the completed application for an appeal review to the independent utilization review organization.

c. The independent utilization review organization shall promptly review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier. The organization shall complete its review and make its determination within 90 days of receipt of a completed application for an appeal review or within less time, as prescribed by the commissioner.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall **[**make a recommendation**]** convey to the covered person and carrier its decision regarding the appropriate, medically necessary health care services that the person should receive**[**. Upon receiving the organization's recommendation**]**, which shall be binding on the carrier **[**shall promptly notify the covered person and the commissioner about what action the carrier will take with respect to the recommendation**]**. If all or part of the

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organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services. If the covered person is not in agreement with the organization's **[**findings and recommendation or the carrier's action on the recommendation**]** decision, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

d. If the commissioner determines that a carrier **[**exhibits a pattern of noncompliance**]** has failed to comply with the **[**findings and recommendations**]** decision of an independent utilization review organization**[**, the commissioner shall review the carrier's utilization management program to ensure that the carrier is in compliance with all relevant State laws and regulations, including utilization management standards. If the commissioner determines that the carrier**]** or is otherwise in violation of patient rights and other applicable regulations, the commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the commissioner deems appropriate.

e. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

f. The covered person's medical records provided to the Independent Health Care Appeals Program and the independent utilization review organization and the findings and recommendations of the organization made pursuant to this act are confidential and shall be used only by the department, the organization and the affected carrier for the purposes of this act. The medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

g. The commissioner shall establish a reasonable, per case reimbursement schedule for the independent utilization review organization.

h. The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the commissioner.

(cf: P.L.1997, c.192, s.12)

2. This act shall take effect immediately.

P.L. 2001, CHAPTER 1, ***approved January 16, 2001***
Assembly, No. 322 ***(First Reprint)***

AN ACT concerning the Independent Health Care Appeals Program and amending P.L.1997, c.192.

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

1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read as follows:

12. a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any carrier. The commissioner may establish additional requirements, including conflict of interest standards, consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Care Appeals Program.

b. The commissioner shall establish procedures for transmitting the completed application for an appeal review to the independent utilization review organization.

c. The independent utilization review organization shall promptly review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier. The organization shall complete its review and make its determination within 90 days of receipt of a completed application for an appeal review or within less time, as prescribed by the commissioner.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall **[**make a recommendation**]** convey to the covered person and carrier its decision regarding the appropriate, medically necessary health care services that the person should receive**[**. Upon receiving the organization's recommendation**]**, which shall be binding on the carrier **[**shall promptly notify the covered person and the commissioner about what action the carrier will take

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted January 27, 2000.

with respect to the recommendation]. [1]If all or part of the organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services.[1] If the covered person is not in agreement with the organization's [findings and recommendation or the carrier's action on the recommendation] decision, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

d. If the commissioner determines that a carrier [exhibits a pattern of noncompliance] has failed to comply with the [findings and recommendations] decision of an independent utilization review organization[, the commissioner shall review the carrier's utilization management program to ensure that the carrier is in compliance with all relevant State laws and regulations, including utilization management standards. If the commissioner determines that the carrier] or is otherwise in violation of patient rights and other applicable regulations, the commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the commissioner deems appropriate.

e. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

f. The covered person's medical records provided to the Independent Health Care Appeals Program and the independent utilization review organization and the findings and recommendations of the organization made pursuant to this act are confidential and shall be used only by the department, the organization and the affected carrier for the purposes of this act. The medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

g. The commissioner shall establish a reasonable, per case reimbursement schedule for the independent utilization review organization.

h. The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the commissioner.

(cf: P.L.1997, c.192, s.12)

2. This act shall take effect immediately.

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

CHAPTER 1

AN ACT concerning the Independent Health Care Appeals Program and amending P.L.1997, c.192.

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

1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read as follows:

C.26:2S-12 Contract to conduct appeal reviews; procedures.

12. a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any carrier. The commissioner may establish additional requirements, including conflict of interest standards, consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Care Appeals Program.

b. The commissioner shall establish procedures for transmitting the completed application for an appeal review to the independent utilization review organization.

c. The independent utilization review organization shall promptly review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier. The organization shall complete its review and make its determination within 90 days of receipt of a completed application for an appeal review or within less time, as prescribed by the commissioner.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall convey to the covered person and carrier its decision regarding the appropriate, medically necessary health care services that the person should receive, which shall be binding on the carrier. If all or part of the organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services. If the covered person is not in agreement with the organization's decision, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

d. If the commissioner determines that a carrier has failed to comply with the decision of an independent utilization review organization or is otherwise in violation of patient rights and other applicable regulations, the commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the commissioner deems appropriate.

e. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

f. The covered person's medical records provided to the Independent Health Care Appeals Program and the independent utilization review organization and the findings and recommendations of the organization made pursuant to this act are confidential and shall be used only by the department, the organization and the affected carrier for the purposes of this act. The medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

g. The commissioner shall establish a reasonable, per case reimbursement schedule for the independent utilization review organization.

h. The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the commissioner.

2. This act shall take effect immediately.

Approved January 16, 2001.

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Office of the Governor
NEWS RELEASE

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Whitman Signs HMO Patient Protection Into Law

Governor Christie Whitman today signed legislation that protects patients who appeal decisions made by health insurance companies. The bill makes decisions in appeals binding on insurance carriers.

"This bill helps ensure that patients always come first," said Whitman. "For too long the needs of consumers were not the priority. This bill makes sure that if any or all of a decision is in favor of the patient the insurance carrier must provide coverage for services found to be medically necessary. Throughout this administration, we have been committed to enacting strong HMO consumer protection measures, such as the HMO patient's bill of rights and the HMO report card. This measure extends our commitment and further places patient needs at the top of the list."

A-322, sponsored by Assembly Members Vandervalk (R-Bergen) and Talarico (R-Bergen) and Senators Matheussen (R-Camden/Gloucester) and Sinagra (R-Middlesex), makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.