

SENATE, No. 11

STATE OF NEW JERSEY 209th LEGISLATURE

INTRODUCED SEPTEMBER 14, 2000

Sponsored by:

Senator JACK SINAGRA

District 18 (Middlesex)

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Co-Sponsored by:

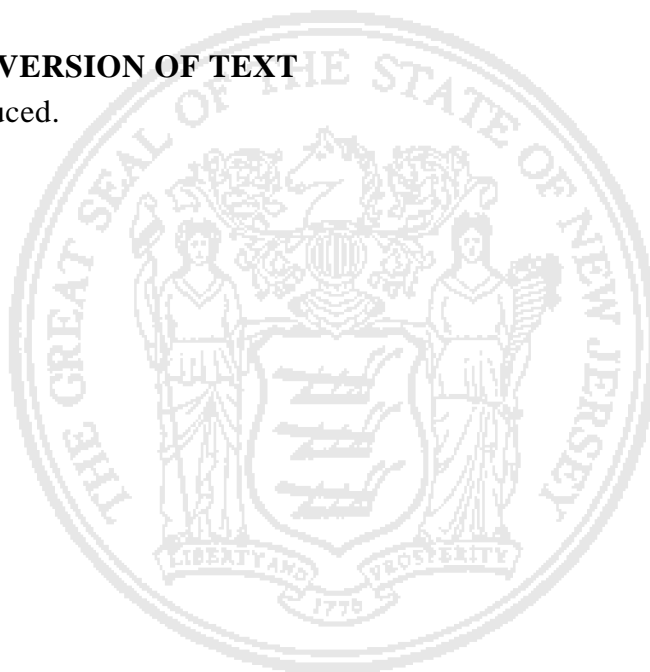
Senator Bucco, Allen, Kosco, Inverso, Singer, Robertson, Matheussen, Caffiero, Bennett, Bark, Palaia, Kavanaugh, Bassano, McNamara and Martin

SYNOPSIS

Requires managed care plans to pay in-network health care facilities full contractual rate regardless of whether treating practitioner is in-network or out-of-network provider.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 11/13/2000)

1 AN ACT concerning health benefits plans, amending and
2 supplementing P.L.1997, c.192 (C.26:2S-1 et seq.), and
3 supplementing Title 17 of the Revised Statutes, Title 17B of the
4 New Jersey Statutes and P.L.1973, c.337 (C.26:2J-1 et seq.).
5

6 **BE IT ENACTED** by the Senate and General Assembly of the State
7 of New Jersey:
8

9 1. Section 5 of P.L.1997, c.192 (C.26:2S-5) is amended to read as
10 follows:

11 5. a. In addition to the disclosure requirements provided in section
12 4 of this act, a carrier which offers a managed care plan shall disclose
13 to a subscriber, in writing, in a manner consistent with the "Life and
14 Health Insurance Policy Language Simplification Act," P.L.1979,
15 c.167 (C.17B:17-17 et seq.), the following information at the time of
16 enrollment and annually thereafter:

17 (1) A current participating provider directory providing
18 information on a covered person's access to primary care physicians
19 and specialists, including the number of available participating
20 physicians, by provider category or specialty and by county. The
21 directory shall include the professional office address of a primary care
22 physician and any hospital affiliation the primary care physician has.
23 The directory shall also provide information about participating
24 hospitals.

25 The carrier shall promptly notify each covered person prior to the
26 termination or withdrawal from the carrier's provider network of the
27 covered person's primary care physician;

28 (2) General information about the financial incentives between
29 participating physicians under contract with the carrier and other
30 participating health care providers and facilities to which the
31 participating physicians refer their managed care patients;

32 (3) The percentage of the carrier's managed care plan's network
33 physicians who are board certified;

34 (4) The carrier's managed care plan's standard for customary
35 waiting times for appointments for urgent and routine care; **[and]**

36 (5) The availability through the department, upon request of a
37 member of the general public, of independent consumer satisfaction
38 survey results and an analysis of quality outcomes of health care
39 services of managed care plans in the State; and

40 (6) The carrier's preauthorization and review requirements of the
41 health benefits plan regarding the determination of medical necessity
42 that apply to a covered person who is admitted to an in-network health
43 care facility, and the financial responsibility of the patient for the cost

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.

1 of services provided by an out-of-network admitting or attending
2 health care practitioner.

3 The carrier shall provide a prospective subscriber with information
4 about the provider network, including hospital affiliations, and other
5 information specified in this subsection, upon request.

6 b. Upon request of a covered person, a carrier shall promptly
7 inform the person:

8 (1) whether a particular network physician is board certified; and

9 (2) whether a particular network physician is currently accepting
10 new patients.

11 c. The carrier shall file the information required pursuant to this
12 section with the department.

13 (cf:P.L.1997,c.192,s.5)

14

15 2. (New section) a. With respect to a carrier which offers a
16 managed care plan that provides for both in-network and out-of-
17 network benefits, in the event that:

18 (1) a covered person is admitted by an out-of-network health care
19 provider to an in-network health care facility for covered, medically
20 necessary health care services, or

21 (2) the covered person receives covered, medically necessary health
22 care services from an out-of-network health care provider while the
23 covered person is a patient at an in-network health care facility and
24 was admitted to the health care facility by an in-network provider, the
25 carrier shall reimburse the health care facility for the services provided
26 by the facility at the carrier's full contracted rate without any penalty
27 for the patient's selection of an out-of-network provider, in accordance
28 with the in-network policies and in-network copayment, coinsurance
29 or deductible requirements of the managed care plan.

30 b. The provisions of this section shall apply only if the covered
31 person complies with the preauthorization or review requirements of
32 the health benefits plan regarding the determination of medical
33 necessity to access in-network inpatient benefits, as set forth in writing
34 pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

35

36 3. (New section) Notwithstanding the provisions of chapter 26 of
37 Title 17B of the New Jersey Statutes to the contrary, no policy shall
38 be delivered, issued, executed or renewed on or after the effective
39 date of this act unless the policy meets the requirements of P.L. ,
40 c. (C.)(pending before the Legislature as this bill). The provisions
41 of this section shall apply to all policies in which the insurer has
42 reserved the right to change the premium.

43

44 4. (New section) Notwithstanding the provisions of chapter 27 of
45 Title 17B of the New Jersey Statutes to the contrary, no policy shall
46 be delivered, issued, executed or renewed on or after the effective date

1 of this act unless the policy meets the requirements of P.L. ,
2 c. (C.)(pending before the Legislature as this bill). The provisions
3 of this section shall apply to all policies in which the insurer has
4 reserved the right to change the premium.

5
6 5. (New section) Notwithstanding the provisions of P.L.1992, c.162
7 (C.17B:27A-17 et seq.) to the contrary, no policy or contract shall be
8 delivered, issued, executed or renewed on or after the effective date
9 of this act unless the policy or contract meets the requirements of
10 P.L. , c. (C.)(pending before the Legislature as this bill). The
11 provisions of this section shall apply to all policies or contracts in
12 which the carrier has reserved the right to change the premium.

13
14 6. (New section) Notwithstanding the provisions of P.L.1992, c.161
15 (C.17B:27A-2 et seq.) to the contrary, no policy or contract shall be
16 delivered, issued, executed or renewed on or after the effective date
17 of this act unless the policy or contract meets the requirements of
18 P.L. , c. (C.)(pending before the Legislature as this bill). The
19 provisions of this section shall apply to all policies or contracts in
20 which the carrier has reserved the right to change the premium.

21
22 7. (New section) Notwithstanding the provisions of P.L.1938, c.366
23 (C.17:48-1 et seq.) to the contrary, no individual or group contract
24 shall be delivered, issued, executed or renewed on or after the
25 effective date of this act unless the contract meets the requirements of
26 P.L. , c. (C.)(pending before the Legislature as this bill). The
27 provisions of this section shall apply to all contracts in which the
28 hospital service corporation has reserved the right to change the
29 premium.

30
31 8. (New section) Notwithstanding the provisions of P.L.1940, c.74
32 (C.17:48A-1 et seq.) to the contrary, no individual or group contract
33 shall be delivered, issued, executed or renewed on or after the
34 effective date of this act unless the contract meets the requirements of
35 P.L. , c. (C.)(pending before the Legislature as this bill). The
36 provisions of this section shall apply to all contracts in which the
37 medical service corporation has reserved the right to change the
38 premium.

39
40 9. (New section) Notwithstanding the provisions of P.L.1985, c.236
41 (C.17:48E-1 et seq.) to the contrary, no individual or group contract
42 shall be delivered, issued, executed or renewed on or after the
43 effective date of this act unless the contract meets the requirements of
44 P.L. , c. (C.)(pending before the Legislature as this bill). The
45 provisions of this section shall apply to all contracts in which the

1 health service corporation has reserved the right to change the
2 premium.

3
4 10. (New section) Notwithstanding the provisions of P.L.1973,
5 c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to
6 establish and operate a health maintenance organization in this State
7 shall not be issued or continued on or after the effective date of this
8 act unless the health maintenance organization meets the requirements
9 of P.L. , c. (C.)(pending before the Legislature as this bill). The
10 provisions of this section shall apply to all enrollee agreements in
11 which the health maintenance organization has reserved the right to
12 change the schedule of charges.

13
14 11. This act shall take effect immediately.

15
16
17 STATEMENT

18
19 This bill requires a carrier which offers a managed care plan that
20 provides for both in-network and out-of-network benefits, to
21 reimburse a health care facility for the services provided by the facility
22 at the carrier's full contracted rate without any penalty for the patient's
23 selection of an out-of-network health care provider, in accordance
24 with the in-network policies and in-network copayment, coinsurance
25 or deductible requirements of the managed care plan, even if:

26 (1) a covered person is admitted by an out-of-network provider to
27 an in-network, health care facility for medically necessary health care
28 services, or

29 (2) the covered person receives covered, medically necessary health
30 care services from an out-of-network provider while the covered
31 person is a patient at an in-network health care facility and was
32 admitted to the health care facility by an in-network provider.

33 The bill also amends the "Health Care Quality Act" to require
34 carriers which offer a managed care plan to disclose to subscribers at
35 the time of enrollment and annually thereafter, the carrier's
36 preauthorization and review requirements of the health benefits plan
37 regarding the determination of medical necessity that apply to a
38 covered person who is admitted to an in-network health care facility,
39 and the financial responsibility of the patient for the cost of services
40 provided by an out-of-network admitting or attending health care
41 practitioner.

42 Health care facilities have negotiated steep discounts with managed
43 care plans in order to participate in the managed care plan's provider
44 network, yet the practice of some managed care plans is to not
45 reimburse the facility at the agreed upon in-network rate if the health
46 care provider who admits or attends to the patient is an out-of-

S11 SINAGRA, VITALE

6

1 network provider. The plans will often reimburse the facilities at the
2 discounted rate, less any out-of-network copayments or deductibles
3 that the covered person would be responsible for paying under the
4 plan. By treating an in-network health care facility as an out-of-
5 network provider (wherein patient copayments and deductibles apply),
6 when the patient's admitting or attending practitioner is an out-of-
7 network provider, and applying in-network rates that are reduced by
8 the applicable copayment and deductible amounts, the managed care
9 plans are unfairly penalizing the facilities by reimbursing them at rates
10 that are below the facilities' contractual amounts.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 11

STATE OF NEW JERSEY

DATED: SEPTEMBER 25, 2000

The Senate Health Committee reports favorably Senate Bill No. 11.

This bill requires a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits, to reimburse a health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network health care provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan, even if:

(1) a covered person is admitted by an out-of-network provider to an in-network health care facility for medically necessary health care services, or

(2) the covered person receives covered, medically necessary health care services from an out-of-network provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider.

The bill also amends the "Health Care Quality Act" to require carriers which offer a managed care plan to disclose to subscribers at the time of enrollment and annually thereafter, the carrier's preauthorization and review requirements of the health benefits plan regarding the determination of medical necessity that apply to a covered person who is admitted to an in-network health care facility, and the financial responsibility of the patient for the cost of services provided by an out-of-network admitting or attending health care practitioner.

The bill applies to all policies and contracts issued or renewed on or after the date of enactment of the bill.

Health care facilities have negotiated steep discounts with managed care plans in order to participate in the managed care plan's provider network, yet the practice of some managed care plans is to not reimburse the facility at the agreed upon in-network rate if the health care provider who admits or attends to the patient is an out-of-network provider. The plans will often reimburse the facilities at the discounted rate, less any out-of-network copayments or deductibles that the covered person would be responsible for paying under the plan. By treating an in-network health care facility as an out-of-network provider (wherein patient copayments and deductibles apply),

when the patient's admitting or attending practitioner is an out-of-network provider, and applying in-network rates that are reduced by the applicable copayment and deductible amounts, the managed care plans are unfairly penalizing the facilities by reimbursing them at rates that are below the facilities' contractual amounts.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 11

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Health Committee reports favorably and with committee amendments Senate Bill No. 11.

As amended by the committee, this bill requires a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits to reimburse a health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network health care provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan, even if:

- C a covered person is admitted by an out-of-network provider to an in-network health care facility for medically necessary health care services, or
- C the covered person receives covered, medically necessary health care services from an out-of-network provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider.

The bill also amends the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., to require carriers which offer a managed care plan to disclose to subscribers, at the time of enrollment and annually thereafter, the carrier's preauthorization and review requirements of the health benefits plan regarding the determination of medical necessity that apply to a covered person who is admitted to an in-network health care facility, and the financial responsibility of the patient for the cost of services provided by an out-of-network admitting or attending health care practitioner.

The bill applies to all policies and contracts issued or renewed on or after the date of enactment of the bill.

The committee amended the bill to apply its provisions to the State Health Benefits Plan by requiring that any contract purchased or renewed by the State Health Benefits Commission on or after the effective date of the bill, which provides hospital or medical expense benefits through a managed care plan, meet the requirements of the bill.

The committee amendments also make a technical change to section 1 of the bill, which amends N.J.S.A.26:2S-5, to reflect the provisions of section 7 of P.L.2001, c.14, by incorporating in that section the new paragraph (6) that was added by the latter statute.

As reported by the committee, this bill is identical to Assembly Bill No. 2827 ACA (Quigley/Greenstein), which the committee also reported on this date.

[First Reprint]

SENATE, No. 11

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED SEPTEMBER 14, 2000

Sponsored by:

Senator JACK SINAGRA

District 18 (Middlesex)

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Co-Sponsored by:

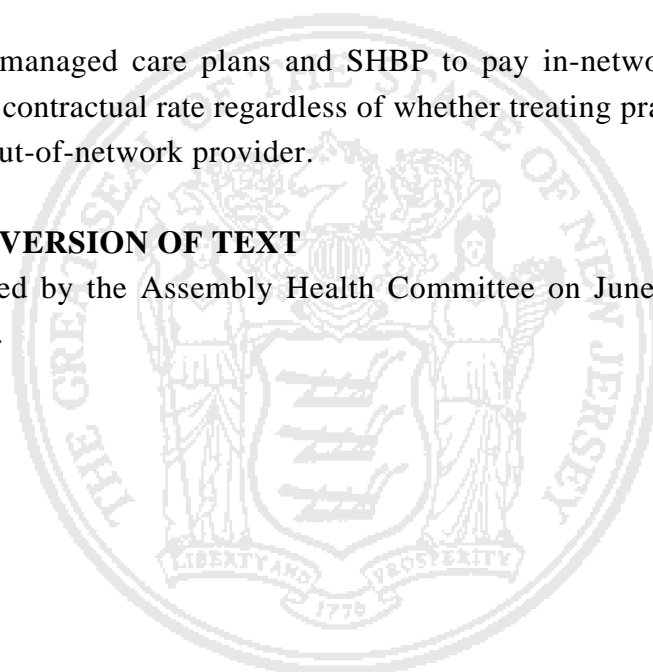
Senator Bucco, Allen, Kosco, Inverso, Singer, Robertson, Matheussen, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano, McNamara and Martin

SYNOPSIS

Requires managed care plans and SHBP to pay in-network health care facilities full contractual rate regardless of whether treating practitioner is in-network or out-of-network provider.

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on June 4, 2001, with amendments.



(Sponsorship Updated As Of: 11/13/2000)

1 AN ACT concerning health benefits plans, amending and
2 supplementing P.L.1997, c.192 ¹[(C.26:2S-1 et seq.)],¹ and
3 supplementing Title 17 of the Revised Statutes, Title 17B of the
4 New Jersey Statutes ¹[and],¹ P.L.1973, c.337 (C.26:2J-1 et seq.)
5 ¹and P.L.1961, c.49 (C.52:14-17.25 et seq.)¹.

6
7 **BE IT ENACTED** by the Senate and General Assembly of the State
8 of New Jersey:

9
10 1. Section 5 of P.L.1997, c.192 (C.26:2S-5) is amended to read as
11 follows:

12 5. a. In addition to the disclosure requirements provided in section
13 4 of this act, a carrier which offers a managed care plan shall disclose
14 to a subscriber, in writing, in a manner consistent with the "Life and
15 Health Insurance Policy Language Simplification Act," P.L.1979,
16 c.167 (C.17B:17-17 et seq.), the following information at the time of
17 enrollment and annually thereafter:

18 (1) A current participating provider directory providing
19 information on a covered person's access to primary care physicians
20 and specialists, including the number of available participating
21 physicians, by provider category or specialty and by county. The
22 directory shall include the professional office address of a primary care
23 physician and any hospital affiliation the primary care physician has.
24 The directory shall also provide information about participating
25 hospitals.

26 The carrier shall promptly notify each covered person prior to the
27 termination or withdrawal from the carrier's provider network of the
28 covered person's primary care physician;

29 (2) General information about the financial incentives between
30 participating physicians under contract with the carrier and other
31 participating health care providers and facilities to which the
32 participating physicians refer their managed care patients;

33 (3) The percentage of the carrier's managed care plan's network
34 physicians who are board certified;

35 (4) The carrier's managed care plan's standard for customary
36 waiting times for appointments for urgent and routine care; [and]

37 (5) The availability through the department, upon request of a
38 member of the general public, of independent consumer satisfaction
39 survey results and an analysis of quality outcomes of health care
40 services of managed care plans in the State¹[; and]¹

41 (6) ¹Information about the Managed Health Care Consumer

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 Assembly AHL committee amendments adopted June 4, 2001.

1 Assistance Program established pursuant to P.L.2001, c.14
2 (C.26:2S-19 et al.) as prescribed by regulation of the commissioner,
3 including the toll-free telephone number available to contact the
4 program; and

5 (7)¹ The carrier's preauthorization and review requirements of the
6 health benefits plan regarding the determination of medical necessity
7 that apply to a covered person who is admitted to an in-network health
8 care facility, and the financial responsibility of the patient for the cost
9 of services provided by an out-of-network admitting or attending
10 health care ¹[practitioner] practitioner¹.

11 The carrier shall provide a prospective subscriber with information
12 about the provider network, including hospital affiliations, and other
13 information specified in this subsection, upon request.

14 b. Upon request of a covered person, a carrier shall promptly
15 inform the person:

16 (1) whether a particular network physician is board certified; and

17 (2) whether a particular network physician is currently accepting
18 new patients.

19 c. The carrier shall file the information required pursuant to this
20 section with the department.

21 (cf: P.L.2001, c.14, s.7)

22

23 2. (New section) a. With respect to a carrier which offers a
24 managed care plan that provides for both in-network and out-of-
25 network benefits, in the event that:

26 (1) a covered person is admitted by an out-of-network health care
27 provider to an in-network health care facility for covered, medically
28 necessary health care services, or

29 (2) the covered person receives covered, medically necessary
30 health care services from an out-of-network health care provider while
31 the covered person is a patient at an in-network health care facility and
32 was admitted to the health care facility by an in-network provider, the
33 carrier shall reimburse the health care facility for the services provided
34 by the facility at the carrier's full contracted rate without any penalty
35 for the patient's selection of an out-of-network provider, in accordance
36 with the in-network policies and in-network copayment, coinsurance
37 or deductible requirements of the managed care plan.

38 b. The provisions of this section shall apply only if the covered
39 person complies with the preauthorization or review requirements of
40 the health benefits plan regarding the determination of medical
41 necessity to access in-network inpatient benefits, as set forth in writing
42 pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

43

44 3. (New section) Notwithstanding the provisions of chapter 26 of
45 Title 17B of the New Jersey Statutes to the contrary, no policy shall
46 be delivered, issued, executed or renewed on or after the effective

1 date of this act unless the policy meets the requirements of P.L. ,
2 c. (C.)(pending before the Legislature as this bill). The provisions
3 of this section shall apply to all policies in which the insurer has
4 reserved the right to change the premium.

5
6 4. (New section) Notwithstanding the provisions of chapter 27 of
7 Title 17B of the New Jersey Statutes to the contrary, no policy shall
8 be delivered, issued, executed or renewed on or after the effective date
9 of this act unless the policy meets the requirements of P.L. ,
10 c. (C.)(pending before the Legislature as this bill). The provisions
11 of this section shall apply to all policies in which the insurer has
12 reserved the right to change the premium.

13
14 5. (New section) Notwithstanding the provisions of P.L.1992,
15 c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract
16 shall be delivered, issued, executed or renewed on or after the
17 effective date of this act unless the policy or contract meets the
18 requirements of P.L. , c. (C.) (pending before the Legislature
19 as this bill). The provisions of this section shall apply to all policies or
20 contracts in which the carrier has reserved the right to change the
21 premium.

22
23 6. (New section) Notwithstanding the provisions of P.L.1992,
24 c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract
25 shall be delivered, issued, executed or renewed on or after the
26 effective date of this act unless the policy or contract meets the
27 requirements of P.L. , c. (C.) (pending before the
28 Legislature as this bill). The provisions of this section shall apply to
29 all policies or contracts in which the carrier has reserved the right to
30 change the premium.

31
32 7. (New section) Notwithstanding the provisions of P.L.1938,
33 c.366 (C.17:48-1 et seq.) to the contrary, no individual or group
34 contract shall be delivered, issued, executed or renewed on or after the
35 effective date of this act unless the contract meets the requirements of
36 P.L. , c. (C.)(pending before the Legislature as this bill). The
37 provisions of this section shall apply to all contracts in which the
38 hospital service corporation has reserved the right to change the
39 premium.

40
41 8. (New section) Notwithstanding the provisions of P.L.1940,
42 c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group
43 contract shall be delivered, issued, executed or renewed on or after the
44 effective date of this act unless the contract meets the requirements of
45 P.L. , c. (C.)(pending before the Legislature as this bill). The
46 provisions of this section shall apply to all contracts in which the

1 medical service corporation has reserved the right to change the
2 premium.

3

4 9. (New section) Notwithstanding the provisions of P.L.1985,
5 c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group
6 contract shall be delivered, issued, executed or renewed on or after the
7 effective date of this act unless the contract meets the requirements of
8 P.L. , c. (C.)(pending before the Legislature as this bill). The
9 provisions of this section shall apply to all contracts in which the
10 health service corporation has reserved the right to change the
11 premium.

12

13 10. (New section) Notwithstanding the provisions of P.L.1973,
14 c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to
15 establish and operate a health maintenance organization in this State
16 shall not be issued or continued on or after the effective date of this
17 act unless the health maintenance organization meets the requirements
18 of P.L. , c. (C.)(pending before the Legislature as this bill). The
19 provisions of this section shall apply to all enrollee agreements in
20 which the health maintenance organization has reserved the right to
21 change the schedule of charges.

22

23 ¹11. (New section) The State Health Benefits Commission shall
24 ensure that every contract purchased or renewed by the commission
25 on or after the effective date of P.L. , c. (C.)(pending before the
26 Legislature as this bill), which provides hospital or medical expense
27 benefits through a managed care plan as defined in section 2 of
28 P.L.1997, c.192 (C.26:2S-2), shall meet the requirements of section
29 2 of P.L. , c. (C.)(pending before the Legislature as this bill).¹

30

31 ¹[11.] 12.¹ This act shall take effect immediately.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 11

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: JUNE 25, 2001

The Assembly Appropriations Committee reports favorably Senate Bill No. 11 (1R) with committee amendments.

Senate Bill No. 11 (1R), as amended, requires a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits to reimburse a health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network health care provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan, even if:

- C a covered person is admitted by an out-of-network provider to an in-network health care facility for medically necessary health care services, or
- C the covered person receives covered, medically necessary health care services from an out-of-network provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider.

The bill also amends the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., to require carriers which offer a managed care plan to disclose to subscribers, at the time of enrollment and annually thereafter, the carrier's preauthorization and review requirements of the health benefits plan regarding the determination of medical necessity that apply to a covered person who is admitted to an in-network health care facility, and the financial responsibility of the patient for the cost of services provided by an out-of-network admitting or attending health care practitioner.

As amended and reported by the committee, this bill is identical to Assembly Bill No. 2827 (1R), also as amended and reported by the committee.

FISCAL IMPACT:

The Division of Pensions and Benefits has estimated a 0.5 percent increase in claims which would increase State costs by \$1.4 million and local costs by \$1.2 million.

COMMITTEE AMENDMENTS:

The amendments delay the effective date for 30 days after enactment.

FISCAL NOTE
[First Reprint]
SENATE, No. 11
STATE OF NEW JERSEY
209th LEGISLATURE

DATED: JULY 19, 2001

SUMMARY

- Synopsis:** Requires managed care plans and SHBP to pay in-network health care facilities full contractual rate regardless of whether treating practitioner is in-network or out-of-network provider.
- Type of Impact:** Increase in State General Fund expenditures. Increase in local government expenditures.
- Agencies Affected:** Department of Treasury, local government employers

Executive Estimate (in thousands)

Fiscal Impact	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
State Cost	\$1,351	\$1,486	\$1,635
Local Cost	\$1,199	\$1,319	\$1,451

- ! The Office of Legislative Services (OLS) **concurs** with the Executive estimate.
- ! Requires managed care plans, including the State Health Benefits Program (SHBP), to pay the full contracted rate of a covered patient's treatment at an in-network facility, even if the patient was admitted by or is receiving treatment from an out-of-network provider.
- ! The State's actuary estimates that State expenditures would increase by \$1.4 million and local expenditures for SHBP would increase by \$1.2 million in the first year of implementation.

BILL DESCRIPTION

Senate Bill No. 11 (1R) of 2001 requires health care carriers offering managed care plans to pay the full contracted rate of a covered patient's treatment at an in-network facility, even if the patient was admitted by or is receiving treatment from an out-of-network provider. The patient must be receiving medically necessary health care services, and must comply with the written preauthorization or review requirements of the health benefits plan regarding the determination of medical necessity.

The bill provides that an individual or group health care contract may not be delivered, executed, or renewed after the effective date of this legislation unless it meets the requirements specified above. In addition, a certificate of authority to establish or operate a health maintenance organization in New Jersey may not be issued or continued after the effective date of this legislation unless the above requirements are met.

FISCAL ANALYSIS

EXECUTIVE BRANCH

According to the Department of Treasury, the State's actuary projects that State and local government expenditures would increase by \$1.4 million and \$1.2 million, respectively, in the first year of implementation of the proposed legislation, as a result of a projected increase of 0.5 percent in total claims paid for SHBP managed care programs.

In cases where individuals enrolled in SHBP receive treatment at in-network facilities by out-of-network providers, full in-network coverage would be provided. The State or local government employer would be responsible for payment of the difference between the cost of in-network and out-of-network coverage which will vary based on the individual's managed care plan, the type of services (e.g., in-patient, out-patient, mental health), and the duration of treatment.

The department has assumed a 10 percent inflationary increase in out-year expenditures.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services concurs with the Executive estimate.

Section: *State Government*

Analyst: *Julie M. McDonnell*
Senior Fiscal Analyst

Approved: *Alan R. Kooney*
Legislative Budget and Finance Officer

This fiscal note has been prepared pursuant to P.L.1980, c.67.

[Second Reprint]
SENATE, No. 11

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED SEPTEMBER 14, 2000

Sponsored by:

Senator JACK SINAGRA

District 18 (Middlesex)

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Co-Sponsored by:

Senators Bucco, Allen, Kosco, Inverso, Singer, Robertson, Matheussen, Caffero, Bennett, Bark, Palaia, Kavanaugh, Bassano, McNamara, Martin, Assemblywomen Quigley, Greenstein, Weinberg and Assemblyman Gusciora

SYNOPSIS

Requires managed care plans and SHBP to pay in-network health care facilities full contractual rate regardless of whether treating practitioner is in-network or out-of-network provider.

CURRENT VERSION OF TEXT

As reported by the Assembly Appropriations Committee on June 25, 2001, with amendments.

(Sponsorship Updated As Of: 12/11/2001)

1 AN ACT concerning health benefits plans, amending and
2 supplementing P.L.1997, c.192 ¹[(C.26:2S-1 et seq.)], ¹and
3 supplementing Title 17 of the Revised Statutes, Title 17B of the
4 New Jersey Statutes ¹[and],¹ P.L.1973, c.337 (C.26:2J-1 et seq.)
5 ¹and P.L.1961, c.49 (C.52:14-17.25 et seq.)¹.

6
7 **BE IT ENACTED** by the Senate and General Assembly of the State
8 of New Jersey:

9
10 1. Section 5 of P.L.1997, c.192 (C.26:2S-5) is amended to read as
11 follows:

12 5. a. In addition to the disclosure requirements provided in section
13 4 of this act, a carrier which offers a managed care plan shall disclose
14 to a subscriber, in writing, in a manner consistent with the "Life and
15 Health Insurance Policy Language Simplification Act," P.L.1979,
16 c.167 (C.17B:17-17 et seq.), the following information at the time of
17 enrollment and annually thereafter:

18 (1) A current participating provider directory providing
19 information on a covered person's access to primary care physicians
20 and specialists, including the number of available participating
21 physicians, by provider category or specialty and by county. The
22 directory shall include the professional office address of a primary care
23 physician and any hospital affiliation the primary care physician has.
24 The directory shall also provide information about participating
25 hospitals.

26 The carrier shall promptly notify each covered person prior to the
27 termination or withdrawal from the carrier's provider network of the
28 covered person's primary care physician;

29 (2) General information about the financial incentives between
30 participating physicians under contract with the carrier and other
31 participating health care providers and facilities to which the
32 participating physicians refer their managed care patients;

33 (3) The percentage of the carrier's managed care plan's network
34 physicians who are board certified;

35 (4) The carrier's managed care plan's standard for customary
36 waiting times for appointments for urgent and routine care; [and]

37 (5) The availability through the department, upon request of a
38 member of the general public, of independent consumer satisfaction
39 survey results and an analysis of quality outcomes of health care
40 services of managed care plans in the State¹[; and]¹

41 (6) ¹Information about the Managed Health Care Consumer

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 Assembly AHL committee amendments adopted June 4, 2001.

² Assembly AAP committee amendments adopted June 25, 2001.

1 Assistance Program established pursuant to P.L.2001, c.14
2 (C.26:2S-19 et al.) as prescribed by regulation of the commissioner,
3 including the toll-free telephone number available to contact the
4 program; and

5 (7)¹ The carrier's preauthorization and review requirements of the
6 health benefits plan regarding the determination of medical necessity
7 that apply to a covered person who is admitted to an in-network health
8 care facility, and the financial responsibility of the patient for the cost
9 of services provided by an out-of-network admitting or attending
10 health care ¹[practitioner] practitioner¹.

11 The carrier shall provide a prospective subscriber with information
12 about the provider network, including hospital affiliations, and other
13 information specified in this subsection, upon request.

14 b. Upon request of a covered person, a carrier shall promptly
15 inform the person:

16 (1) whether a particular network physician is board certified; and

17 (2) whether a particular network physician is currently accepting
18 new patients.

19 c. The carrier shall file the information required pursuant to this
20 section with the department.

21 (cf: P.L.2001, c.14, s.7)

22

23 2. (New section) a. With respect to a carrier which offers a
24 managed care plan that provides for both in-network and out-of-
25 network benefits, in the event that:

26 (1) a covered person is admitted by an out-of-network health care
27 provider to an in-network health care facility for covered, medically
28 necessary health care services, or

29 (2) the covered person receives covered, medically necessary
30 health care services from an out-of-network health care provider while
31 the covered person is a patient at an in-network health care facility and
32 was admitted to the health care facility by an in-network provider, the
33 carrier shall reimburse the health care facility for the services provided
34 by the facility at the carrier's full contracted rate without any penalty
35 for the patient's selection of an out-of-network provider, in accordance
36 with the in-network policies and in-network copayment, coinsurance
37 or deductible requirements of the managed care plan.

38 b. The provisions of this section shall apply only if the covered
39 person complies with the preauthorization or review requirements of
40 the health benefits plan regarding the determination of medical
41 necessity to access in-network inpatient benefits, as set forth in writing
42 pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

43

44 3. (New section) Notwithstanding the provisions of chapter 26 of
45 Title 17B of the New Jersey Statutes to the contrary, no policy shall
46 be delivered, issued, executed or renewed on or after the effective

1 date of this act unless the policy meets the requirements of P.L. ,
2 c. (C.)(pending before the Legislature as this bill). The provisions
3 of this section shall apply to all policies in which the insurer has
4 reserved the right to change the premium.

5
6 4. (New section) Notwithstanding the provisions of chapter 27 of
7 Title 17B of the New Jersey Statutes to the contrary, no policy shall
8 be delivered, issued, executed or renewed on or after the effective date
9 of this act unless the policy meets the requirements of P.L. ,
10 c. (C.)(pending before the Legislature as this bill). The provisions
11 of this section shall apply to all policies in which the insurer has
12 reserved the right to change the premium.

13
14 5. (New section) Notwithstanding the provisions of P.L.1992,
15 c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract
16 shall be delivered, issued, executed or renewed on or after the
17 effective date of this act unless the policy or contract meets the
18 requirements of P.L. , c. (C.) (pending before the Legislature
19 as this bill). The provisions of this section shall apply to all policies or
20 contracts in which the carrier has reserved the right to change the
21 premium.

22
23 6. (New section) Notwithstanding the provisions of P.L.1992,
24 c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract
25 shall be delivered, issued, executed or renewed on or after the
26 effective date of this act unless the policy or contract meets the
27 requirements of P.L. , c. (C.) (pending before the
28 Legislature as this bill). The provisions of this section shall apply to
29 all policies or contracts in which the carrier has reserved the right to
30 change the premium.

31
32 7. (New section) Notwithstanding the provisions of P.L.1938,
33 c.366 (C.17:48-1 et seq.) to the contrary, no individual or group
34 contract shall be delivered, issued, executed or renewed on or after the
35 effective date of this act unless the contract meets the requirements of
36 P.L. , c. (C.)(pending before the Legislature as this bill). The
37 provisions of this section shall apply to all contracts in which the
38 hospital service corporation has reserved the right to change the
39 premium.

40
41 8. (New section) Notwithstanding the provisions of P.L.1940,
42 c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group
43 contract shall be delivered, issued, executed or renewed on or after the
44 effective date of this act unless the contract meets the requirements of
45 P.L. , c. (C.)(pending before the Legislature as this bill). The
46 provisions of this section shall apply to all contracts in which the

1 medical service corporation has reserved the right to change the
2 premium.

3

4 9. (New section) Notwithstanding the provisions of P.L.1985,
5 c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group
6 contract shall be delivered, issued, executed or renewed on or after the
7 effective date of this act unless the contract meets the requirements of
8 P.L. , c. (C.)(pending before the Legislature as this bill). The
9 provisions of this section shall apply to all contracts in which the
10 health service corporation has reserved the right to change the
11 premium.

12

13 10. (New section) Notwithstanding the provisions of P.L.1973,
14 c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to
15 establish and operate a health maintenance organization in this State
16 shall not be issued or continued on or after the effective date of this
17 act unless the health maintenance organization meets the requirements
18 of P.L. , c. (C.)(pending before the Legislature as this bill). The
19 provisions of this section shall apply to all enrollee agreements in
20 which the health maintenance organization has reserved the right to
21 change the schedule of charges.

22

23 ¹11. (New section) The State Health Benefits Commission shall
24 ensure that every contract purchased or renewed by the commission
25 on or after the effective date of P.L. , c. (C.)(pending before the
26 Legislature as this bill), which provides hospital or medical expense
27 benefits through a managed care plan as defined in section 2 of
28 P.L.1997, c.192 (C.26:2S-2), shall meet the requirements of section
29 2 of P.L. , c. (C.)(pending before the Legislature as this bill).¹

30

31 ¹[11.] 12.¹ This act shall take effect ²[immediately] on the first day
32 of the second month following enactment ².

ASSEMBLY, No. 2827

STATE OF NEW JERSEY 209th LEGISLATURE

INTRODUCED OCTOBER 12, 2000

Sponsored by:

Assemblywoman JOAN M. QUIGLEY

District 32 (Bergen and Hudson)

Assemblywoman LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

Co-Sponsored by:

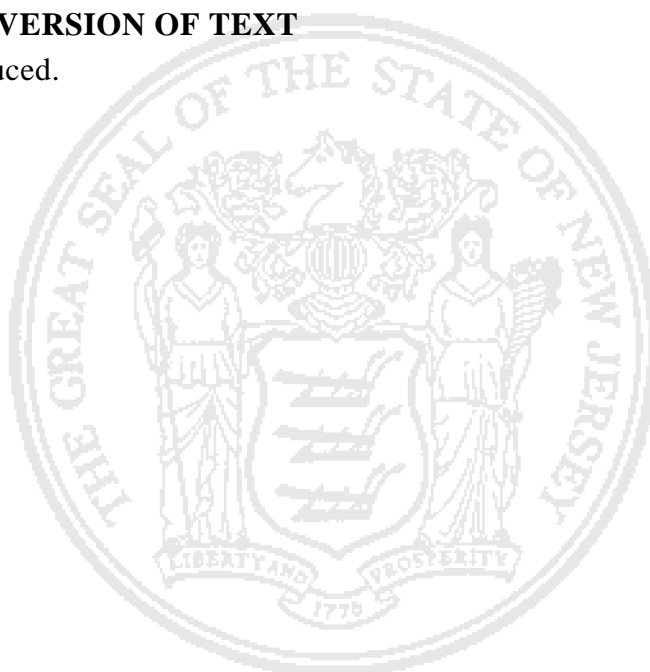
Assemblywoman Weinberg

SYNOPSIS

Requires managed care plans to pay in-network health care facilities full contractual rate regardless of whether treating practitioner is in-network or out-of-network provider.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning health benefits plans, amending and
2 supplementing P.L.1997, c.192 (C.26:2S-1 et seq.), and
3 supplementing Title 17 of the Revised Statutes, Title 17B of the
4 New Jersey Statutes and P.L.1973, c.337 (C.26:2J-1 et seq.).

5

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

8

9 1. Section 5 of P.L.1997, c.192 (C.26:2S-5) is amended to read as
10 follows:

11 5. a. In addition to the disclosure requirements provided in section
12 4 of this act, a carrier which offers a managed care plan shall disclose
13 to a subscriber, in writing, in a manner consistent with the "Life and
14 Health Insurance Policy Language Simplification Act," P.L.1979,
15 c.167 (C.17B:17-17 et seq.), the following information at the time of
16 enrollment and annually thereafter:

17 (1) A current participating provider directory providing
18 information on a covered person's access to primary care physicians
19 and specialists, including the number of available participating
20 physicians, by provider category or specialty and by county. The
21 directory shall include the professional office address of a primary care
22 physician and any hospital affiliation the primary care physician has.
23 The directory shall also provide information about participating
24 hospitals.

25 The carrier shall promptly notify each covered person prior to the
26 termination or withdrawal from the carrier's provider network of the
27 covered person's primary care physician;

28 (2) General information about the financial incentives between
29 participating physicians under contract with the carrier and other
30 participating health care providers and facilities to which the
31 participating physicians refer their managed care patients;

32 (3) The percentage of the carrier's managed care plan's network
33 physicians who are board certified;

34 (4) The carrier's managed care plan's standard for customary
35 waiting times for appointments for urgent and routine care; **[and]**

36 (5) The availability through the department, upon request of a
37 member of the general public, of independent consumer satisfaction
38 survey results and an analysis of quality outcomes of health care
39 services of managed care plans in the State; and

40 (6) The carrier's preauthorization and review requirements of the
41 health benefits plan regarding the determination of medical necessity
42 that apply to a covered person who is admitted to an in-network health
43 care facility, and the financial responsibility of the patient for the cost

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.

1 of services provided by an out-of-network admitting or attending
2 health care practitioner.

3 The carrier shall provide a prospective subscriber with information
4 about the provider network, including hospital affiliations, and other
5 information specified in this subsection, upon request.

6 b. Upon request of a covered person, a carrier shall promptly
7 inform the person:

8 (1) whether a particular network physician is board certified; and

9 (2) whether a particular network physician is currently accepting
10 new patients.

11 c. The carrier shall file the information required pursuant to this
12 section with the department.

13 (cf:P.L.1997,c.192,s.5)

14

15 2. (New section) a. With respect to a carrier which offers a
16 managed care plan that provides for both in-network and out-of-
17 network benefits, in the event that:

18 (1) a covered person is admitted by an out-of-network health care
19 provider to an in-network health care facility for covered, medically
20 necessary health care services, or

21 (2) the covered person receives covered, medically necessary health
22 care services from an out-of-network health care provider while the
23 covered person is a patient at an in-network health care facility and
24 was admitted to the health care facility by an in-network provider, the
25 carrier shall reimburse the health care facility for the services provided
26 by the facility at the carrier's full contracted rate without any penalty
27 for the patient's selection of an out-of-network provider, in accordance
28 with the in-network policies and in-network copayment, coinsurance
29 or deductible requirements of the managed care plan.

30 b. The provisions of this section shall apply only if the covered
31 person complies with the preauthorization or review requirements of
32 the health benefits plan regarding the determination of medical
33 necessity to access in-network inpatient benefits, as set forth in writing
34 pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

35

36 3. (New section) Notwithstanding the provisions of chapter 26 of
37 Title 17B of the New Jersey Statutes to the contrary, no policy shall
38 be delivered, issued, executed or renewed on or after the effective
39 date of this act unless the policy meets the requirements of P.L. , c.
40 (C.)(pending before the Legislature as this bill). The provisions of
41 this section shall apply to all policies in which the insurer has reserved
42 the right to change the premium.

43

44 4. (New section) Notwithstanding the provisions of chapter 27 of
45 Title 17B of the New Jersey Statutes to the contrary, no policy shall
46 be delivered, issued, executed or renewed on or after the effective date

1 of this act unless the policy meets the requirements of P.L. , c.
2 (C.)(pending before the Legislature as this bill). The provisions of
3 this section shall apply to all policies in which the insurer has reserved
4 the right to change the premium.

5
6 5. (New section) Notwithstanding the provisions of P.L.1992, c.162
7 (C.17B:27A-17 et seq.) to the contrary, no policy or contract shall be
8 delivered, issued, executed or renewed on or after the effective date
9 of this act unless the policy or contract meets the requirements
10 of P.L. , c. (C.)(pending before the Legislature as this bill). The
11 provisions of this section shall apply to all policies or contracts in
12 which the carrier has reserved the right to change the premium.

13
14 6. (New section) Notwithstanding the provisions of P.L.1992, c.161
15 (C.17B:27A-2 et seq.) to the contrary, no policy or contract shall be
16 delivered, issued, executed or renewed on or after the effective date
17 of this act unless the policy or contract meets the requirements
18 of P.L. , c. (C.)(pending before the Legislature as this bill). The
19 provisions of this section shall apply to all policies or contracts in
20 which the carrier has reserved the right to change the premium.

21
22 7. (New section) Notwithstanding the provisions of P.L.1938, c.366
23 (C.17:48-1 et seq.) to the contrary, no individual or group contract
24 shall be delivered, issued, executed or renewed on or after the
25 effective date of this act unless the contract meets the requirements of
26 P.L. , c. (C.)(pending before the Legislature as this bill). The
27 provisions of this section shall apply to all contracts in which the
28 hospital service corporation has reserved the right to change the
29 premium.

30
31 8. (New section) Notwithstanding the provisions of P.L.1940, c.74
32 (C.17:48A-1 et seq.) to the contrary, no individual or group contract
33 shall be delivered, issued, executed or renewed on or after the
34 effective date of this act unless the contract meets the requirements of
35 P.L. , c. (C.)(pending before the Legislature as this bill). The
36 provisions of this section shall apply to all contracts in which the
37 medical service corporation has reserved the right to change the
38 premium.

39
40 9. (New section) Notwithstanding the provisions of P.L.1985, c.236
41 (C.17:48E-1 et seq.) to the contrary, no individual or group contract
42 shall be delivered, issued, executed or renewed on or after the
43 effective date of this act unless the contract meets the requirements of
44 P.L. , c. (C.)(pending before the Legislature as this bill). The
45 provisions of this section shall apply to all contracts in which the
46 health service corporation has reserved the right to change the

1 premium.

2

3 10. (New section) Notwithstanding the provisions of P.L.1973,
4 c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to
5 establish and operate a health maintenance organization in this State
6 shall not be issued or continued on or after the effective date of this
7 act unless the health maintenance organization meets the requirements
8 of P.L. , c. (C.)(pending before the Legislature as this bill). The
9 provisions of this section shall apply to all enrollee agreements in
10 which the health maintenance organization has reserved the right to
11 change the schedule of charges.

12

13 11. This act shall take effect immediately.

14

15

16

STATEMENT

17

18 This bill requires a carrier which offers a managed care plan that
19 provides for both in-network and out-of-network benefits, to
20 reimburse a health care facility for the services provided by the facility
21 at the carrier's full contracted rate without any penalty for the patient's
22 selection of an out-of-network health care provider, in accordance
23 with the in-network policies and in-network copayment, coinsurance
24 or deductible requirements of the managed care plan, even if:

25 (1) a covered person is admitted by an out-of-network provider to
26 an in-network, health care facility for medically necessary health care
27 services, or

28 (2) the covered person receives covered, medically necessary health
29 care services from an out-of-network provider while the covered
30 person is a patient at an in-network health care facility and was
31 admitted to the health care facility by an in-network provider.

32 The bill also amends the "Health Care Quality Act" to require
33 carriers which offer a managed care plan to disclose to subscribers at
34 the time of enrollment and annually thereafter, the carrier's
35 preauthorization and review requirements of the health benefits plan
36 regarding the determination of medical necessity that apply to a
37 covered person who is admitted to an in-network health care facility,
38 and the financial responsibility of the patient for the cost of services
39 provided by an out-of-network admitting or attending health care
40 practitioner.

41 Health care facilities have negotiated steep discounts with managed
42 care plans in order to participate in the managed care plan's provider
43 network, yet the practice of some managed care plans is to not
44 reimburse the facility at the agreed upon in-network rate if the health
45 care provider who admits or attends to the patient is an out-of-
46 network provider. The plans will often reimburse the facilities at the

1 discounted rate, less any out-of-network copayments or deductibles
2 that the covered person would be responsible for paying under the
3 plan. By treating an in-network health care facility as an out-of-
4 network provider (wherein patient copayments and deductibles apply),
5 when the patient's admitting or attending practitioner is an out-of-
6 network provider, and applying in-network rates that are reduced by
7 the applicable copayment and deductible amounts, the managed care
8 plans are unfairly penalizing the facilities by reimbursing them at rates
9 that are below the facilities' contractual amounts.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2827

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Health Committee reports favorably and with committee amendments Assembly Bill No. 2827.

As amended by the committee, this bill requires a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits to reimburse a health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network health care provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan, even if:

- C a covered person is admitted by an out-of-network provider to an in-network health care facility for medically necessary health care services, or
- C the covered person receives covered, medically necessary health care services from an out-of-network provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider.

The bill also amends the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., to require carriers which offer a managed care plan to disclose to subscribers, at the time of enrollment and annually thereafter, the carrier's preauthorization and review requirements of the health benefits plan regarding the determination of medical necessity that apply to a covered person who is admitted to an in-network health care facility, and the financial responsibility of the patient for the cost of services provided by an out-of-network admitting or attending health care practitioner.

The bill applies to all policies and contracts issued or renewed on or after the date of enactment of the bill.

The committee amended the bill to apply its provisions to the State Health Benefits Plan by requiring that any contract purchased or renewed by the State Health Benefits Commission on or after the effective date of the bill, which provides hospital or medical expense benefits through a managed care plan, meet the requirements of the bill.

The committee amendments also make a technical change to section 1 of the bill, which amends N.J.S.A.26:2S-5, to reflect the provisions of section 7 of P.L.2001, c.14, by incorporating in that section the new paragraph (6) that was added by the latter statute.

As reported by the committee, this bill is identical to Senate Bill No. 11 ACA (Sinagra/Vitale), which the committee also reported on this date.

[First Reprint]

ASSEMBLY, No. 2827

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED OCTOBER 12, 2000

Sponsored by:

Assemblywoman JOAN M. QUIGLEY

District 32 (Bergen and Hudson)

Assemblywoman LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

Co-Sponsored by:

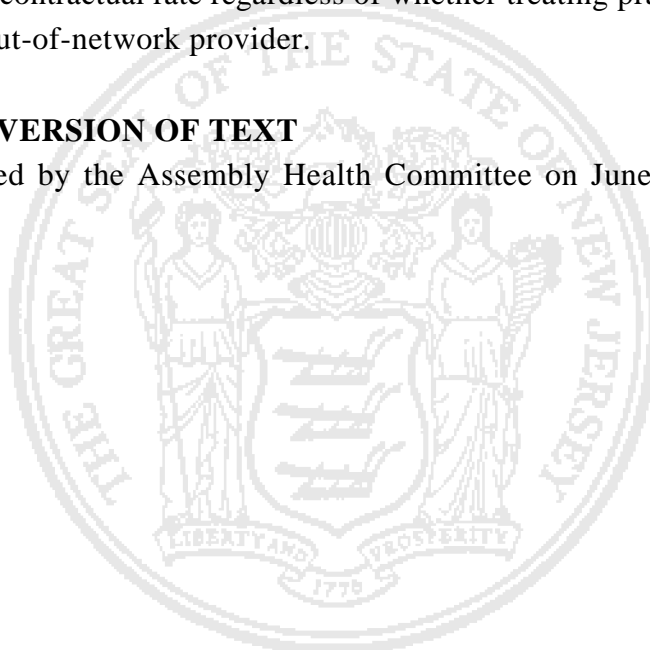
Assemblywoman Weinberg

SYNOPSIS

Requires managed care plans and SHBP to pay in-network health care facilities full contractual rate regardless of whether treating practitioner is in-network or out-of-network provider.

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on June 4, 2001, with amendments.



1 AN ACT concerning health benefits plans, amending and
2 supplementing P.L.1997, c.192 ¹[(C.26:2S-1 et seq.)]¹, and
3 supplementing Title 17 of the Revised Statutes, Title 17B of the
4 New Jersey Statutes ¹[and],¹ P.L.1973, c.337 (C.26:2J-1 et seq.)
5 ¹and P.L.1961, c.49 (C.52:14-17.25 et seq.)¹.

6

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

9

10 1. Section 5 of P.L.1997, c.192 (C.26:2S-5) is amended to read as
11 follows:

12 5. a. In addition to the disclosure requirements provided in section
13 4 of this act, a carrier which offers a managed care plan shall disclose
14 to a subscriber, in writing, in a manner consistent with the "Life and
15 Health Insurance Policy Language Simplification Act," P.L.1979,
16 c.167 (C.17B:17-17 et seq.), the following information at the time of
17 enrollment and annually thereafter:

18 (1) A current participating provider directory providing
19 information on a covered person's access to primary care physicians
20 and specialists, including the number of available participating
21 physicians, by provider category or specialty and by county. The
22 directory shall include the professional office address of a primary care
23 physician and any hospital affiliation the primary care physician has.
24 The directory shall also provide information about participating
25 hospitals.

26 The carrier shall promptly notify each covered person prior to the
27 termination or withdrawal from the carrier's provider network of the
28 covered person's primary care physician;

29 (2) General information about the financial incentives between
30 participating physicians under contract with the carrier and other
31 participating health care providers and facilities to which the
32 participating physicians refer their managed care patients;

33 (3) The percentage of the carrier's managed care plan's network
34 physicians who are board certified;

35 (4) The carrier's managed care plan's standard for customary
36 waiting times for appointments for urgent and routine care; [and]

37 (5) The availability through the department, upon request of a
38 member of the general public, of independent consumer satisfaction
39 survey results and an analysis of quality outcomes of health care
40 services of managed care plans in the State¹[; and]¹

41 (6) ¹Information about the Managed Health Care Consumer

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 Assembly AHL committee amendments adopted June 4, 2001.

1 Assistance Program established pursuant to P.L.2001, c.14
2 (C.26:2S-19 et al.) as prescribed by regulation of the commissioner,
3 including the toll-free telephone number available to contact the
4 program; and

5 (7)¹ The carrier's preauthorization and review requirements of the
6 health benefits plan regarding the determination of medical necessity
7 that apply to a covered person who is admitted to an in-network health
8 care facility, and the financial responsibility of the patient for the cost
9 of services provided by an out-of-network admitting or attending
10 health care ¹ [practitioner] practitioner ¹ .

11 The carrier shall provide a prospective subscriber with information
12 about the provider network, including hospital affiliations, and other
13 information specified in this subsection, upon request.

14 b. Upon request of a covered person, a carrier shall promptly
15 inform the person:

16 (1) whether a particular network physician is board certified; and

17 (2) whether a particular network physician is currently accepting
18 new patients.

19 c. The carrier shall file the information required pursuant to this
20 section with the department.

21 (cf: P.L.2001, c.14, s.7)

22

23 2. (New section) a. With respect to a carrier which offers a
24 managed care plan that provides for both in-network and out-of-
25 network benefits, in the event that:

26 (1) a covered person is admitted by an out-of-network health care
27 provider to an in-network health care facility for covered, medically
28 necessary health care services, or

29 (2) the covered person receives covered, medically necessary
30 health care services from an out-of-network health care provider while
31 the covered person is a patient at an in-network health care facility and
32 was admitted to the health care facility by an in-network provider, the
33 carrier shall reimburse the health care facility for the services provided
34 by the facility at the carrier's full contracted rate without any penalty
35 for the patient's selection of an out-of-network provider, in accordance
36 with the in-network policies and in-network copayment, coinsurance
37 or deductible requirements of the managed care plan.

38 b. The provisions of this section shall apply only if the covered
39 person complies with the preauthorization or review requirements of
40 the health benefits plan regarding the determination of medical
41 necessity to access in-network inpatient benefits, as set forth in writing
42 pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

43

44 3. (New section) Notwithstanding the provisions of chapter 26 of
45 Title 17B of the New Jersey Statutes to the contrary, no policy shall
46 be delivered, issued, executed or renewed on or after the effective

1 date of this act unless the policy meets the requirements of P.L. , c.
2 (C.)(pending before the Legislature as this bill). The provisions of
3 this section shall apply to all policies in which the insurer has reserved
4 the right to change the premium.

5
6 4. (New section) Notwithstanding the provisions of chapter 27 of
7 Title 17B of the New Jersey Statutes to the contrary, no policy shall
8 be delivered, issued, executed or renewed on or after the effective date
9 of this act unless the policy meets the requirements of P.L. , c.
10 (C.)(pending before the Legislature as this bill). The provisions of
11 this section shall apply to all policies in which the insurer has reserved
12 the right to change the premium.

13
14 5. (New section) Notwithstanding the provisions of P.L.1992,
15 c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract
16 shall be delivered, issued, executed or renewed on or after the
17 effective date of this act unless the policy or contract meets the
18 requirements of P.L. ,c. (C.)(pending before the Legislature as this
19 bill). The provisions of this section shall apply to all policies or
20 contracts in which the carrier has reserved the right to change the
21 premium.

22
23 6. (New section) Notwithstanding the provisions of P.L.1992,
24 c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract
25 shall be delivered, issued, executed or renewed on or after the
26 effective date of this act unless the policy or contract meets the
27 requirements of P.L. ,c. (C.)(pending before the Legislature as this
28 bill). The provisions of this section shall apply to all policies or
29 contracts in which the carrier has reserved the right to change the
30 premium.

31
32 7. (New section) Notwithstanding the provisions of P.L.1938,
33 c.366 (C.17:48-1 et seq.) to the contrary, no individual or group
34 contract shall be delivered, issued, executed or renewed on or after the
35 effective date of this act unless the contract meets the requirements of
36 P.L. , c. (C.)(pending before the Legislature as this bill). The
37 provisions of this section shall apply to all contracts in which the
38 hospital service corporation has reserved the right to change the
39 premium.

40
41 8. (New section) Notwithstanding the provisions of P.L.1940,
42 c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group
43 contract shall be delivered, issued, executed or renewed on or after the
44 effective date of this act unless the contract meets the requirements of
45 P.L. , c. (C.)(pending before the Legislature as this bill). The
46 provisions of this section shall apply to all contracts in which the

1 medical service corporation has reserved the right to change the
2 premium.

3

4 9. (New section) Notwithstanding the provisions of P.L.1985,
5 c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group
6 contract shall be delivered, issued, executed or renewed on or after the
7 effective date of this act unless the contract meets the requirements of
8 P.L. , c. (C.)(pending before the Legislature as this bill). The
9 provisions of this section shall apply to all contracts in which the
10 health service corporation has reserved the right to change the
11 premium.

12

13 10. (New section) Notwithstanding the provisions of P.L.1973,
14 c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to
15 establish and operate a health maintenance organization in this State
16 shall not be issued or continued on or after the effective date of this
17 act unless the health maintenance organization meets the requirements
18 of P.L. , c. (C.)(pending before the Legislature as this bill). The
19 provisions of this section shall apply to all enrollee agreements in
20 which the health maintenance organization has reserved the right to
21 change the schedule of charges.

22

23 ¹11. (New section) The State Health Benefits Commission shall
24 ensure that every contract purchased or renewed by the commission
25 on or after the effective date of P.L. , c. (C.)(pending before the
26 Legislature as this bill), which provides hospital or medical expense
27 benefits through a managed care plan as defined in section 2 of
28 P.L.1997, c.192 (C.26:2S-2), shall meet the requirements of section
29 2 of P.L. , c. (C.)(pending before the Legislature as this bill).¹

30

31 ¹[11.] 12.¹ This act shall take effect immediately.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 2827

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: JUNE 25, 2001

The Assembly Appropriations Committee reports favorably Assembly Bill No. 2827 (1R) with committee amendments.

Assembly Bill No. 2827 (1R), as amended, requires a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits to reimburse a health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network health care provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan, even if:

- C a covered person is admitted by an out-of-network provider to an in-network health care facility for medically necessary health care services, or
- C the covered person receives covered, medically necessary health care services from an out-of-network provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider.

The bill also amends the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., to require carriers which offer a managed care plan to disclose to subscribers, at the time of enrollment and annually thereafter, the carrier's preauthorization and review requirements of the health benefits plan regarding the determination of medical necessity that apply to a covered person who is admitted to an in-network health care facility, and the financial responsibility of the patient for the cost of services provided by an out-of-network admitting or attending health care practitioner.

As amended and reported by the committee, this bill is identical to Senate Bill No. 11 (1R), also as amended and reported by the committee.

FISCAL IMPACT:

The Division of Pensions and Benefits has estimated a 0.5 percent increase in claims which would increase State costs by \$1.4 million and local costs by \$1.2 million.

COMMITTEE AMENDMENTS:

The amendments delay the effective date for 30 days after enactment.

FISCAL NOTE
[First Reprint]
ASSEMBLY, No. 2827
STATE OF NEW JERSEY
209th LEGISLATURE

DATED: JULY 11, 2001

SUMMARY

- Synopsis:** Requires managed care plans and SHBP to pay in-network health care facilities full contractual rate regardless of whether treating practitioner is in-network or out-of-network provider.
- Type of Impact:** Increase in State General Fund expenditures. Increase in local government expenditures.
- Agencies Affected:** Department of Treasury, local government employers

Executive Estimate (in thousands)

Fiscal Impact	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
State Cost	\$1,351	\$1,486	\$1,635
Local Cost	\$1,199	\$1,319	\$1,451

- ! The Office of Legislative Services (OLS) **concurs** with the Executive estimate.
- ! Requires managed care plans, including the State Health Benefits Program (SHBP), to pay the full contracted rate of a covered patient's treatment at an in-network facility, even if the patient was admitted by or is receiving treatment from an out-of-network provider.
- ! The State's actuary estimates that State expenditures would increase by \$1.4 million and local expenditures for SHBP would increase by \$1.2 million in the first year of implementation.

BILL DESCRIPTION

Assembly Bill No. 2827 (1R) of 2001 requires health care carriers offering managed care plans to pay the full contracted rate of a covered patient's treatment at an in-network facility, even if the patient was admitted by or is receiving treatment from an out-of-network provider. The patient must be receiving medically necessary health care services, and must comply with the written preauthorization or review requirements of the health benefits plan regarding the determination of medical necessity.

The bill provides that an individual or group health care contract may not be delivered,

executed, or renewed after the effective date of this legislation unless it meets the requirements specified above. In addition, a certificate of authority to establish or operate a health maintenance organization in New Jersey may not be issued or continued after the effective date of this legislation unless the above requirements are met.

FISCAL ANALYSIS

EXECUTIVE BRANCH

According to the Department of Treasury, the State's actuary projects that State and local government expenditures would increase by \$1.4 million and \$1.2 million, respectively, in the first year of implementation of the proposed legislation, as a result of a projected increase of 0.5 percent in total claims paid for SHBP managed care programs.

In cases where individuals enrolled in the State Health Benefits Program (SHBP) receive treatment at in-network facilities by out-of-network providers, full in-network coverage would be provided. The State or local government employer would be responsible for payment of the difference between the cost of in-network and out-of-network coverage which will vary based on the individual's managed care plan, the type of services (e.g., in-patient, out-patient, mental health), and the duration of treatment.

The department has assumed a 10 percent inflationary increase in out-year expenditures.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services concurs with the Executive estimate.

Section: *State Government*

Analyst: *Julie M. McDonnell*
Senior Fiscal Analyst

Approved: *Alan R. Kooney*
Legislative Budget and Finance Officer

This fiscal note has been prepared pursuant to P.L.1980, c.67.

[Second Reprint]

ASSEMBLY, No. 2827

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED OCTOBER 12, 2000

Sponsored by:

Assemblywoman JOAN M. QUIGLEY

District 32 (Bergen and Hudson)

Assemblywoman LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

Co-Sponsored by:

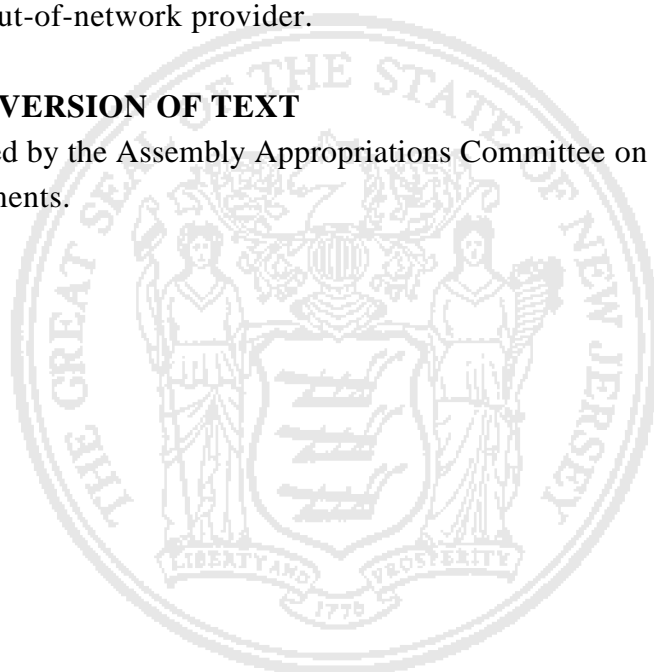
Assemblywoman Weinberg and Assemblyman Gusciora

SYNOPSIS

Requires managed care plans and SHBP to pay in-network health care facilities full contractual rate regardless of whether treating practitioner is in-network or out-of-network provider.

CURRENT VERSION OF TEXT

As reported by the Assembly Appropriations Committee on June 25, 2001, with amendments.



(Sponsorship Updated As Of: 12/11/2001)

1 AN ACT concerning health benefits plans, amending and
 2 supplementing P.L.1997, c.192 ¹[(C.26:2S-1 et seq.)]¹, and
 3 supplementing Title 17 of the Revised Statutes, Title 17B of the
 4 New Jersey Statutes ¹[and],¹ P.L.1973, c.337 (C.26:2J-1 et seq.)
 5 ¹and P.L.1961, c.49 (C.52:14-17.25 et seq.)¹.

6

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

9

10 1. Section 5 of P.L.1997, c.192 (C.26:2S-5) is amended to read as
 11 follows:

12 5. a. In addition to the disclosure requirements provided in section
 13 4 of this act, a carrier which offers a managed care plan shall disclose
 14 to a subscriber, in writing, in a manner consistent with the "Life and
 15 Health Insurance Policy Language Simplification Act," P.L.1979,
 16 c.167 (C.17B:17-17 et seq.), the following information at the time of
 17 enrollment and annually thereafter:

18 (1) A current participating provider directory providing
 19 information on a covered person's access to primary care physicians
 20 and specialists, including the number of available participating
 21 physicians, by provider category or specialty and by county. The
 22 directory shall include the professional office address of a primary care
 23 physician and any hospital affiliation the primary care physician has.
 24 The directory shall also provide information about participating
 25 hospitals.

26 The carrier shall promptly notify each covered person prior to the
 27 termination or withdrawal from the carrier's provider network of the
 28 covered person's primary care physician;

29 (2) General information about the financial incentives between
 30 participating physicians under contract with the carrier and other
 31 participating health care providers and facilities to which the
 32 participating physicians refer their managed care patients;

33 (3) The percentage of the carrier's managed care plan's network
 34 physicians who are board certified;

35 (4) The carrier's managed care plan's standard for customary
 36 waiting times for appointments for urgent and routine care; [and]

37 (5) The availability through the department, upon request of a
 38 member of the general public, of independent consumer satisfaction
 39 survey results and an analysis of quality outcomes of health care
 40 services of managed care plans in the State¹[; and]¹

41 (6) ¹Information about the Managed Health Care Consumer

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 Assembly AHL committee amendments adopted June 4, 2001.

² Assembly AAP committee amendments adopted June 25, 2001.

1 Assistance Program established pursuant to P.L.2001, c.14
2 (C.26:2S-19 et al.) as prescribed by regulation of the commissioner,
3 including the toll-free telephone number available to contact the
4 program; and

5 (7)¹ The carrier's preauthorization and review requirements of the
6 health benefits plan regarding the determination of medical necessity
7 that apply to a covered person who is admitted to an in-network health
8 care facility, and the financial responsibility of the patient for the cost
9 of services provided by an out-of-network admitting or attending
10 health care ¹ [practitioner] practitioner ¹ .

11 The carrier shall provide a prospective subscriber with information
12 about the provider network, including hospital affiliations, and other
13 information specified in this subsection, upon request.

14 b. Upon request of a covered person, a carrier shall promptly
15 inform the person:

16 (1) whether a particular network physician is board certified; and

17 (2) whether a particular network physician is currently accepting
18 new patients.

19 c. The carrier shall file the information required pursuant to this
20 section with the department.

21 (cf: P.L.2001, c.14, s.7)

22

23 2. (New section) a. With respect to a carrier which offers a
24 managed care plan that provides for both in-network and out-of-
25 network benefits, in the event that:

26 (1) a covered person is admitted by an out-of-network health care
27 provider to an in-network health care facility for covered, medically
28 necessary health care services, or

29 (2) the covered person receives covered, medically necessary
30 health care services from an out-of-network health care provider while
31 the covered person is a patient at an in-network health care facility and
32 was admitted to the health care facility by an in-network provider, the
33 carrier shall reimburse the health care facility for the services provided
34 by the facility at the carrier's full contracted rate without any penalty
35 for the patient's selection of an out-of-network provider, in accordance
36 with the in-network policies and in-network copayment, coinsurance
37 or deductible requirements of the managed care plan.

38 b. The provisions of this section shall apply only if the covered
39 person complies with the preauthorization or review requirements of
40 the health benefits plan regarding the determination of medical
41 necessity to access in-network inpatient benefits, as set forth in writing
42 pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

43

44 3. (New section) Notwithstanding the provisions of chapter 26 of
45 Title 17B of the New Jersey Statutes to the contrary, no policy shall
46 be delivered, issued, executed or renewed on or after the effective

1 date of this act unless the policy meets the requirements of P.L. , c.
2 (C.)(pending before the Legislature as this bill). The provisions of
3 this section shall apply to all policies in which the insurer has reserved
4 the right to change the premium.

5
6 4. (New section) Notwithstanding the provisions of chapter 27 of
7 Title 17B of the New Jersey Statutes to the contrary, no policy shall
8 be delivered, issued, executed or renewed on or after the effective date
9 of this act unless the policy meets the requirements of P.L. , c.
10 (C.)(pending before the Legislature as this bill). The provisions of
11 this section shall apply to all policies in which the insurer has reserved
12 the right to change the premium.

13
14 5. (New section) Notwithstanding the provisions of P.L.1992,
15 c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract
16 shall be delivered, issued, executed or renewed on or after the
17 effective date of this act unless the policy or contract meets the
18 requirements of P.L. ,c. (C.)(pending before the Legislature as this
19 bill). The provisions of this section shall apply to all policies or
20 contracts in which the carrier has reserved the right to change the
21 premium.

22
23 6. (New section) Notwithstanding the provisions of P.L.1992,
24 c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract
25 shall be delivered, issued, executed or renewed on or after the
26 effective date of this act unless the policy or contract meets the
27 requirements of P.L. ,c. (C.)(pending before the Legislature as this
28 bill). The provisions of this section shall apply to all policies or
29 contracts in which the carrier has reserved the right to change the
30 premium.

31
32 7. (New section) Notwithstanding the provisions of P.L.1938,
33 c.366 (C.17:48-1 et seq.) to the contrary, no individual or group
34 contract shall be delivered, issued, executed or renewed on or after the
35 effective date of this act unless the contract meets the requirements of
36 P.L. , c. (C.)(pending before the Legislature as this bill). The
37 provisions of this section shall apply to all contracts in which the
38 hospital service corporation has reserved the right to change the
39 premium.

40
41 8. (New section) Notwithstanding the provisions of P.L.1940,
42 c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group
43 contract shall be delivered, issued, executed or renewed on or after the
44 effective date of this act unless the contract meets the requirements of
45 P.L. , c. (C.)(pending before the Legislature as this bill). The
46 provisions of this section shall apply to all contracts in which the

1 medical service corporation has reserved the right to change the
2 premium.

3

4 9. (New section) Notwithstanding the provisions of P.L.1985,
5 c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group
6 contract shall be delivered, issued, executed or renewed on or after the
7 effective date of this act unless the contract meets the requirements of
8 P.L. , c. (C.)(pending before the Legislature as this bill). The
9 provisions of this section shall apply to all contracts in which the
10 health service corporation has reserved the right to change the
11 premium.

12

13 10. (New section) Notwithstanding the provisions of P.L.1973,
14 c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to
15 establish and operate a health maintenance organization in this State
16 shall not be issued or continued on or after the effective date of this
17 act unless the health maintenance organization meets the requirements
18 of P.L. , c. (C.)(pending before the Legislature as this bill). The
19 provisions of this section shall apply to all enrollee agreements in
20 which the health maintenance organization has reserved the right to
21 change the schedule of charges.

22

23 ¹11. (New section) The State Health Benefits Commission shall
24 ensure that every contract purchased or renewed by the commission
25 on or after the effective date of P.L. , c. (C.)(pending before the
26 Legislature as this bill), which provides hospital or medical expense
27 benefits through a managed care plan as defined in section 2 of
28 P.L.1997, c.192 (C.26:2S-2), shall meet the requirements of section
29 2 of P.L. , c. (C.)(pending before the Legislature as this bill).¹

30

31 ¹[11.] 12.¹ This act shall take effect ²[immediately] on the first
32 day of the second month following enactment².

§2 - C.26:2S-6.1
§3 - C.17B:26-2.1w
§4 -
C.17B:27-46.1aa
§5 -
C.17B:27A-19.10
§6 - C.17B:27A-7.8
§7 - C.17:48-6aa
§8 - C.17:48A-7z
§9 - C.17:48E-35.25
§10 - C.26:2J-4.26
§11 -
C.52:14-17.29h
§12 - Note to §§1-11

P.L. 2001, CHAPTER 367, *approved January 8, 2002*
Senate, No. 11 (*Second Reprint*)

1 AN ACT concerning health benefits plans, amending and
2 supplementing P.L.1997, c.192 ¹[(C.26:2S-1 et seq.)],¹ and
3 supplementing Title 17 of the Revised Statutes, Title 17B of the
4 New Jersey Statutes ¹[and],¹ P.L.1973, c.337 (C.26:2J-1 et seq.)
5 ¹and P.L.1961, c.49 (C.52:14-17.25 et seq.)¹.
6

7 **BE IT ENACTED** by the Senate and General Assembly of the State
8 of New Jersey:
9

10 1. Section 5 of P.L.1997, c.192 (C.26:2S-5) is amended to read as
11 follows:

12 5. a. In addition to the disclosure requirements provided in section
13 4 of this act, a carrier which offers a managed care plan shall disclose
14 to a subscriber, in writing, in a manner consistent with the "Life and
15 Health Insurance Policy Language Simplification Act," P.L.1979,
16 c.167 (C.17B:17-17 et seq.), the following information at the time of
17 enrollment and annually thereafter:

18 (1) A current participating provider directory providing
19 information on a covered person's access to primary care physicians
20 and specialists, including the number of available participating
21 physicians, by provider category or specialty and by county. The
22 directory shall include the professional office address of a primary care
23 physician and any hospital affiliation the primary care physician has.
24 The directory shall also provide information about participating
25 hospitals.

26 The carrier shall promptly notify each covered person prior to the
27 termination or withdrawal from the carrier's provider network of the
28 covered person's primary care physician;

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 Assembly AHL committee amendments adopted June 4, 2001.

² Assembly AAP committee amendments adopted June 25, 2001.

1 (2) General information about the financial incentives between
2 participating physicians under contract with the carrier and other
3 participating health care providers and facilities to which the
4 participating physicians refer their managed care patients;

5 (3) The percentage of the carrier's managed care plan's network
6 physicians who are board certified;

7 (4) The carrier's managed care plan's standard for customary
8 waiting times for appointments for urgent and routine care; [and]

9 (5) The availability through the department, upon request of a
10 member of the general public, of independent consumer satisfaction
11 survey results and an analysis of quality outcomes of health care
12 services of managed care plans in the State¹ [; and]¹

13 (6) ¹Information about the Managed Health Care Consumer
14 Assistance Program established pursuant to P.L.2001, c.14
15 (C.26:2S-19 et al.) as prescribed by regulation of the commissioner,
16 including the toll-free telephone number available to contact the
17 program; and

18 (7)¹ The carrier's preauthorization and review requirements of the
19 health benefits plan regarding the determination of medical necessity
20 that apply to a covered person who is admitted to an in-network health
21 care facility, and the financial responsibility of the patient for the cost
22 of services provided by an out-of-network admitting or attending
23 health care ¹ [practitioner] practitioner¹.

24 The carrier shall provide a prospective subscriber with information
25 about the provider network, including hospital affiliations, and other
26 information specified in this subsection, upon request.

27 b. Upon request of a covered person, a carrier shall promptly
28 inform the person:

29 (1) whether a particular network physician is board certified; and

30 (2) whether a particular network physician is currently accepting
31 new patients.

32 c. The carrier shall file the information required pursuant to this
33 section with the department.

34 (cf: P.L.2001, c.14, s.7)

35
36 2. (New section) a. With respect to a carrier which offers a
37 managed care plan that provides for both in-network and out-of-
38 network benefits, in the event that:

39 (1) a covered person is admitted by an out-of-network health care
40 provider to an in-network health care facility for covered, medically
41 necessary health care services, or

42 (2) the covered person receives covered, medically necessary
43 health care services from an out-of-network health care provider while
44 the covered person is a patient at an in-network health care facility and
45 was admitted to the health care facility by an in-network provider, the
46 carrier shall reimburse the health care facility for the services provided

1 by the facility at the carrier's full contracted rate without any penalty
2 for the patient's selection of an out-of-network provider, in accordance
3 with the in-network policies and in-network copayment, coinsurance
4 or deductible requirements of the managed care plan.

5 b. The provisions of this section shall apply only if the covered
6 person complies with the preauthorization or review requirements of
7 the health benefits plan regarding the determination of medical
8 necessity to access in-network inpatient benefits, as set forth in writing
9 pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

10
11 3. (New section) Notwithstanding the provisions of chapter 26 of
12 Title 17B of the New Jersey Statutes to the contrary, no policy shall
13 be delivered, issued, executed or renewed on or after the effective
14 date of this act unless the policy meets the requirements of P.L. ,
15 c. (C.)(pending before the Legislature as this bill). The provisions
16 of this section shall apply to all policies in which the insurer has
17 reserved the right to change the premium.

18
19 4. (New section) Notwithstanding the provisions of chapter 27 of
20 Title 17B of the New Jersey Statutes to the contrary, no policy shall
21 be delivered, issued, executed or renewed on or after the effective date
22 of this act unless the policy meets the requirements of P.L. ,
23 c. (C.)(pending before the Legislature as this bill). The provisions
24 of this section shall apply to all policies in which the insurer has
25 reserved the right to change the premium.

26
27 5. (New section) Notwithstanding the provisions of P.L.1992,
28 c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract
29 shall be delivered, issued, executed or renewed on or after the
30 effective date of this act unless the policy or contract meets the
31 requirements of P.L. , c. (C.) (pending before the Legislature
32 as this bill). The provisions of this section shall apply to all policies or
33 contracts in which the carrier has reserved the right to change the
34 premium.

35
36 6. (New section) Notwithstanding the provisions of P.L.1992,
37 c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract
38 shall be delivered, issued, executed or renewed on or after the
39 effective date of this act unless the policy or contract meets the
40 requirements of P.L. , c. (C.) (pending before the
41 Legislature as this bill). The provisions of this section shall apply to
42 all policies or contracts in which the carrier has reserved the right to
43 change the premium.

44
45 7. (New section) Notwithstanding the provisions of P.L.1938,
46 c.366 (C.17:48-1 et seq.) to the contrary, no individual or group

1 contract shall be delivered, issued, executed or renewed on or after the
2 effective date of this act unless the contract meets the requirements of
3 P.L. , c. (C.)(pending before the Legislature as this bill). The
4 provisions of this section shall apply to all contracts in which the
5 hospital service corporation has reserved the right to change the
6 premium.

7

8 8. (New section) Notwithstanding the provisions of P.L.1940,
9 c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group
10 contract shall be delivered, issued, executed or renewed on or after the
11 effective date of this act unless the contract meets the requirements of
12 P.L. , c. (C.)(pending before the Legislature as this bill). The
13 provisions of this section shall apply to all contracts in which the
14 medical service corporation has reserved the right to change the
15 premium.

16

17 9. (New section) Notwithstanding the provisions of P.L.1985,
18 c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group
19 contract shall be delivered, issued, executed or renewed on or after the
20 effective date of this act unless the contract meets the requirements of
21 P.L. , c. (C.)(pending before the Legislature as this bill). The
22 provisions of this section shall apply to all contracts in which the
23 health service corporation has reserved the right to change the
24 premium.

25

26 10. (New section) Notwithstanding the provisions of P.L.1973,
27 c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to
28 establish and operate a health maintenance organization in this State
29 shall not be issued or continued on or after the effective date of this
30 act unless the health maintenance organization meets the requirements
31 of P.L. , c. (C.)(pending before the Legislature as this bill). The
32 provisions of this section shall apply to all enrollee agreements in
33 which the health maintenance organization has reserved the right to
34 change the schedule of charges.

35

36 ¹11. (New section) The State Health Benefits Commission shall
37 ensure that every contract purchased or renewed by the commission
38 on or after the effective date of P.L. , c. (C.)(pending before the
39 Legislature as this bill), which provides hospital or medical expense
40 benefits through a managed care plan as defined in section 2 of
41 P.L.1997, c.192 (C.26:2S-2), shall meet the requirements of section
42 2 of P.L. , c. (C.)(pending before the Legislature as this bill).¹

43

44 ¹[11.] 12.¹ This act shall take effect ²[immediately] on the first day
45 of the second month following enactment ².

1

2

3 Requires managed care plans and SHBP to pay in-network health care

4 facilities full contractual rate regardless of whether treating

5 practitioner is in-network or out-of-network provider.

CHAPTER 367

AN ACT concerning health benefits plans, amending and supplementing P.L.1997, c.192, and supplementing Title 17 of the Revised Statutes, Title 17B of the New Jersey Statutes, P.L.1973, c.337 (C.26:2J-1 et seq.) and P.L.1961, c.49 (C.52:14-17.25 et seq.).

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

1. Section 5 of P.L.1997, c.192 (C.26:2S-5) is amended to read as follows:

C.26:2S-5 Additional disclosure requirements.

5. a. In addition to the disclosure requirements provided in section 4 of this act, a carrier which offers a managed care plan shall disclose to a subscriber, in writing, in a manner consistent with the "Life and Health Insurance Policy Language Simplification Act," P.L.1979, c.167 (C.17B:17-17 et seq.), the following information at the time of enrollment and annually thereafter:

(1) A current participating provider directory providing information on a covered person's access to primary care physicians and specialists, including the number of available participating physicians, by provider category or specialty and by county. The directory shall include the professional office address of a primary care physician and any hospital affiliation the primary care physician has. The directory shall also provide information about participating hospitals.

The carrier shall promptly notify each covered person prior to the termination or withdrawal from the carrier's provider network of the covered person's primary care physician;

(2) General information about the financial incentives between participating physicians under contract with the carrier and other participating health care providers and facilities to which the participating physicians refer their managed care patients;

(3) The percentage of the carrier's managed care plan's network physicians who are board certified;

(4) The carrier's managed care plan's standard for customary waiting times for appointments for urgent and routine care;

(5) The availability through the department, upon request of a member of the general public, of independent consumer satisfaction survey results and an analysis of quality outcomes of health care services of managed care plans in the State;

(6) Information about the Managed Health Care Consumer Assistance Program established pursuant to P.L.2001, c.14 (C.26:2S-19 et al.) as prescribed by regulation of the commissioner, including the toll-free telephone number available to contact the program; and

(7) The carrier's preauthorization and review requirements of the health benefits plan regarding the determination of medical necessity that apply to a covered person who is admitted to an in-network health care facility, and the financial responsibility of the patient for the cost of services provided by an out-of-network admitting or attending health care practitioner.

The carrier shall provide a prospective subscriber with information about the provider network, including hospital affiliations, and other information specified in this subsection, upon request.

b. Upon request of a covered person, a carrier shall promptly inform the person:

(1) whether a particular network physician is board certified; and

(2) whether a particular network physician is currently accepting new patients.

c. The carrier shall file the information required pursuant to this section with the department.

C.26:2S-6.1 Managed care plan to pay full contractual rate to out-of-network provider, certain circumstances.

2. a. With respect to a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits, in the event that:

(1) a covered person is admitted by an out-of-network health care provider to an in-network health care facility for covered, medically necessary health care services, or

(2) the covered person receives covered, medically necessary health care services from an out-of-network health care provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider, the carrier shall reimburse the health care facility for the services provided by the facility at the carrier's full

contracted rate without any penalty for the patient's selection of an out-of-network provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan.

b. The provisions of this section shall apply only if the covered person complies with the preauthorization or review requirements of the health benefits plan regarding the determination of medical necessity to access in-network inpatient benefits, as set forth in writing pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

C.17B:26-2.1w Policy issued under Chapter 26 of Title 17B required to cover certain out-of-network services.

3. Notwithstanding the provisions of chapter 26 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

C.17B:27-46.1aa Policy issued under Chapter 27 of Title 17B required to cover certain out-of-network services.

4. Notwithstanding the provisions of chapter 27 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

C.17B:27A-19.10 Policy, contract issued under C.17B:27A-17 et seq. required to cover certain out-of-network services.

5. Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

C.17B:27A-7.8 Policy, contract issued under C.17B:27A-2 et seq. required to cover certain out-of-network services.

6. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

C.17:48-6aa Contracts issued under C.17:48-1 et seq. required to cover certain out-of-network services.

7. Notwithstanding the provisions of P.L.1938, c.366 (C.17:48-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

C.17:48A-7z Contract issued under C.17:48A-1 et seq. required to cover certain out-of-network services.

8. Notwithstanding the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

C.17:48E-35.25 Contract issued under C.17:48E-1 et seq. required to cover certain out-of-network services.

9. Notwithstanding the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

C.26:2J-4.26 HMO required to cover certain out-of-network services.

10. Notwithstanding the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this act unless the health maintenance organization meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

C.52:14-17.29h State Health Benefits Commission contracts to cover certain out-of-network services.

11. The State Health Benefits Commission shall ensure that every contract purchased or renewed by the commission on or after the effective date of P.L.2001, c.367 (C.26:2S-6.1 et al.), which provides hospital or medical expense benefits through a managed care plan as defined in section 2 of P.L.1997, c.192 (C.26:2S-2), shall meet the requirements of section 2 of P.L.2001, c.367 (C.26:2S-6.1).

12. This act shall take effect on the first day of the second month following enactment

Approved January 8, 2002.