26:2S-5

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 367
NJSA: 26:2S-5 (Managed care plans—payments)
BILL NO: S11 (Substituted forA2827)
SPONSOR(S): Sinagra and Vitale
DATE INTRODUCED: September 14, 2000
COMMITTEE: **ASSEMBLY:** Health; Appropriations
SENATE: Health
AMENDED DURING PASSAGE: Yes
DATE OF PASSAGE: **ASSEMBLY:** December 10, 2001
SENATE: January 7, 2002
DATE OF APPROVAL: January 8, 2002
FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (2nd reprint enacted)
(Amendments during passage denoted by superscript numbers)

S11

SPONSORS STATEMENT: (Begins on page 5 of original bill) Yes
COMMITTEE STATEMENT: **ASSEMBLY**: Yes 6-4-2001(Health)
6-25-2001(Appropr.)
SENATE: Yes
FLOOR AMENDMENT STATEMENTS: No
LEGISLATIVE FISCAL NOTE: Yes

A2827

SPONSORS STATEMENT: (Begins on page 5 of original bill) Yes
Bill and Sponsors Statement identical to S11
COMMITTEE STATEMENT: **ASSEMBLY**: Yes 6-4-2001(Health)
6-25-2001(Appropr.)
Identical to Senate Statements to S11
SENATE: No
FLOOR AMENDMENT STATEMENTS: No
LEGISLATIVE FISCAL NOTE: Yes
FINAL VERSION (2nd reprint): Yes

VETO MESSAGE: No
GOVERNOR'S PRESS RELEASE ON SIGNING: No

FOLLOWING WERE PRINTED:

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REPORTS: No
HEARINGS: No
NEWSPAPER ARTICLES: No

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 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)

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

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; **[**and**]**

(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; and

(6) 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

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.

of services provided by an out-of-network admitting or attending health care practitoner.

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.

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

2. (New section) 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).

3. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

4. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

5. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

6. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

7. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

8. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

9. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the

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

10. (New section) 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. , c. (C.)(pending before the Legislature as this bill). 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.

11. This act shall take effect immediately.

STATEMENT

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 practitoner.

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.

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:

- 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
- 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)

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

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:

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; **[**and**]**

(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[1]**[**; and**]**[1]

(6) [1]Information 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.

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)[1] 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 [1][practitoner] practitioner[1].

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.

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

2. (New section) 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).

3. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

4. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

5. (New section) 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. , c. (C.) (pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

6. (New section) 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. , c. (C.) (pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

7. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

8. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the

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

9. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

10. (New section) 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. , c. (C.)(pending before the Legislature as this bill). 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.

[1]11. (New section) 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. , c. (C.)(pending before the Legislature as this bill), 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. , c. (C.)(pending before the Legislature as this bill).[1]

[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:

- 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
- 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	Year 1	Year 2	Year 3
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.

Office of Legislative Services
State House Annex
P.O. Box 068
Trenton, New Jersey 08625

Legislative Budget and Finance Office
Phone (609) 292-8030
Fax (609) 777-2442
www.njleg.state.nj.us

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, Cafiero, 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)

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

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:

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; **[**and**]**

(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[1]**[**; and**]**[1]

(6) [1]Information 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.

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)[1] 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 [1][practitoner] practitioner[1].

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.

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

2. (New section) 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).

3. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

4. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

5. (New section) 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. , c. (C.) (pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

6. (New section) 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. , c. (C.) (pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

7. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

8. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the

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

9. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

10. (New section) 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. , c. (C.)(pending before the Legislature as this bill). 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.

[1]11. (New section) 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. , c. (C.)(pending before the Legislature as this bill), 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. , c. (C.)(pending before the Legislature as this bill).[1]

[1][11.] 12.[1] This act shall take effect [2][immediately]on the first day 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.

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

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; **[**and**]**

(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; and

(6) 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

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.

of services provided by an out-of-network admitting or attending health care practitoner.

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.

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

2. (New section) 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).

3. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

4. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

5. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

6. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

7. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

8. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

9. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the

premium.

10. (New section) 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. , c. (C.)(pending before the Legislature as this bill). 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.

11. This act shall take effect immediately.

STATEMENT

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 practitoner.

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

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:

- 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
- 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.

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

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:

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; **[**and**]**

(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[1]**[**; and**]**[1]

(6) [1]Information 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.

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)[1] 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 [1][practitoner] practitioner[1] .

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.

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

2. (New section) 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).

3. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

4. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

5. (New section) 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. ,c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

6. (New section) 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. ,c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

7. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

8. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the

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

9. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

10. (New section) 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. , c. (C.)(pending before the Legislature as this bill). 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.

[1]11. (New section) 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. , c. (C.)(pending before the Legislature as this bill), 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. , c. (C.)(pending before the Legislature as this bill).[1]

[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:

- 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
- 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	Year 1	Year 2	Year 3
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)

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

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:

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; **[**and**]**

(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[1]**[**; and**]**[1]

(6) [1]Information 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.

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)[1] 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 [1][practitoner] practitioner[1] .

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.

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

2. (New section) 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).

3. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

4. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

5. (New section) 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. ,c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

6. (New section) 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. ,c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

7. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

8. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the

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

9. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

10. (New section) 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. , c. (C.)(pending before the Legislature as this bill). 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.

[1]11. (New section) 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. , c. (C.)(pending before the Legislature as this bill), 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. , c. (C.)(pending before the Legislature as this bill).[1]

[1][11.] 12.[1] This act shall take effect [2][immediately]on the first day of the second month following enactment[2].

§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)***

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

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:

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;

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.

(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; [and]

(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[1] [; and] [1]

(6) [1]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)[1] 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 [1][practitoner] practitioner[1].

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.

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

2. (New section) 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).

3. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

4. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

5. (New section) 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. , c. (C.) (pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

6. (New section) 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. , c. (C.) (pending before the Legislature as this bill). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

7. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

8. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

9. (New section) 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. , c. (C.)(pending before the Legislature as this bill). The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

10. (New section) 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. , c. (C.)(pending before the Legislature as this bill). 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.

[1]11. (New section) 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. , c. (C.)(pending before the Legislature as this bill), 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. , c. (C.)(pending before the Legislature as this bill).[1]

[1][11.] 12.[1] This act shall take effect [2][immediately]on the first day of the second month following enactment [2].

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.

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.