

# 26:2S-2

## LEGISLATIVE HISTORY CHECKLIST

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**LAWS OF:** 2005 **CHAPTER:** 172

**NJSA:** 26:2S-2 (Concerns managed behavioral health care services)

**BILL NO:** A2976 (Substituted for S1993)

**SPONSOR(S):** Weinberg and others

**DATE INTRODUCED:** May 27, 2004

**COMMITTEE:** **ASSEMBLY:** Health and Human Services  
**SENATE:** Health, Human Services and Senior Citizens

**AMENDED DURING PASSAGE:** Yes

**DATE OF PASSAGE:** **ASSEMBLY:** February 24, 2005

**SENATE:** June 20, 2005

**DATE OF APPROVAL:** August 5, 2005

**FOLLOWING ARE ATTACHED IF AVAILABLE:**

[FINAL TEXT OF BILL](#) (1<sup>st</sup> reprint enacted)

### A2976

[SPONSOR'S STATEMENT:](#) (Begins on page 7 of original bill) [Yes](#)

**COMMITTEE STATEMENT:** [ASSEMBLY:](#) [Yes](#)

[SENATE:](#) [Yes](#)

**FLOOR AMENDMENT STATEMENT:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

### S1993

[SPONSOR'S STATEMENT:](#) (Begins on page 7 of original bill) [Yes](#)

**COMMITTEE STATEMENT:** **ASSEMBLY:** No

[SENATE:](#) [Yes](#)

**FLOOR AMENDMENT STATEMENT:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

**VETO MESSAGE:** No

**GOVERNOR'S PRESS RELEASE ON SIGNING:** No

**FOLLOWING WERE PRINTED:**

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**HEARINGS:**

No

**NEWSPAPER ARTICLES:**

No

IS 9/5/07

P.L. 2005, CHAPTER 172, *approved August 5, 2005*  
Assembly, No. 2976 (*First Reprint*)

1 **AN ACT** concerning managed behavioral health care services and  
2 amending and supplementing P.L.1997, c.192.

3  
4 **BE IT ENACTED** by the Senate and General Assembly of the State  
5 of New Jersey:

6  
7 1. Section 2 of P.L.1997, c.192 (C.26:2S-2) is amended to read as  
8 follows:

9 2. As used in sections 2 through 19 of this act:

10 "Behavioral health care services" means procedures or services  
11 rendered by a health care provider for the treatment of mental illness,  
12 emotional disorders, or drug or alcohol abuse. "Behavioral health care  
13 services" does not include: any quality assurance or utilization  
14 management activities or treatment plan reviews conducted by a  
15 carrier, or a private entity on behalf of the carrier, pertaining to these  
16 services, whether administrative or clinical in nature; or any other  
17 administrative functions, including, but not limited to, accounting and  
18 financial reporting, billing and collection, data processing, debt or debt  
19 service, legal services, promotion and marketing, or provider  
20 credentialing.

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

25 "Commissioner" means the Commissioner of Health and Senior  
26 Services.

27 "Contract holder" means an employer or organization that  
28 purchases a contract for services.

29 "Covered person" means a person on whose behalf a carrier offering  
30 the plan is obligated to pay benefits or provide services pursuant to the  
31 health benefits plan.

32 "Covered service" means a health care service provided to a  
33 covered person under a health benefits plan for which the carrier is  
34 obligated to pay benefits or provide services.

35 "Department" means the Department of Health and Senior Services.

36 "Health benefits plan" means a benefits plan which pays or provides  
37 hospital and medical expense benefits for covered services, and is  
38 delivered or issued for delivery in this State by or through a carrier.  
39 Health benefits plan includes, but is not limited to, Medicare

**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:**

<sup>1</sup> Assembly AHH committee amendments adopted December 9, 2004.

1 supplement coverage and risk contracts to the extent not otherwise  
2 prohibited by federal law. For the purposes of this act, health benefits  
3 plan shall not include the following plans, policies or contracts:  
4 accident only, credit, disability, long-term care, CHAMPUS  
5 supplement coverage, coverage arising out of a workers' compensation  
6 or similar law, automobile medical payment insurance, personal injury  
7 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et  
8 seq.) or hospital confinement indemnity coverage.

9 "Health care provider" means an individual or entity which, acting  
10 within the scope of its licensure or certification, provides a covered  
11 service defined by the health benefits plan. Health care provider  
12 includes, but is not limited to, a physician and other health care  
13 professionals licensed pursuant to Title 45 of the Revised Statutes, and  
14 a hospital and other health care facilities licensed pursuant to Title 26  
15 of the Revised Statutes.

16 "Independent utilization review organization" means an independent  
17 entity comprised of physicians and other health care professionals who  
18 are representative of the active practitioners in the area in which the  
19 organization will operate and which is under contract with the  
20 department to provide medical necessity or appropriateness of services  
21 appeal reviews pursuant to this act.

22 "Managed behavioral health care organization" means an entity  
23 <sup>1</sup>[that], other than a carrier, which<sup>1</sup> contracts with a carrier to  
24 provide, undertake to arrange, or administer behavioral health care  
25 services to covered persons through health care providers employed  
26 by the managed behavioral health care organization or otherwise make  
27 behavioral health care services available to covered persons through  
28 contracts with health care providers. "Managed behavioral health care  
29 organization" does not include a person or entity that, for an  
30 administrative fee only, solely arranges a panel of health care providers  
31 for a carrier for the provision of behavioral health care services on a  
32 discounted fee-for-service basis.

33 "Managed care plan" means a health benefits plan that integrates the  
34 financing and delivery of appropriate health care services to covered  
35 persons by arrangements with participating providers, who are selected  
36 to participate on the basis of explicit standards, to furnish a  
37 comprehensive set of health care services and financial incentives for  
38 covered persons to use the participating providers and procedures  
39 provided for in the plan.

40 "Subscriber" means, in the case of a group contract, a person whose  
41 employment or other status, except family status, is the basis for  
42 eligibility for enrollment by the carrier or, in the case of an individual  
43 contract, the person in whose name the contract is issued.

44 "Utilization management" means a system for reviewing the  
45 appropriate and efficient allocation of health care services under a  
46 health benefits plan according to specified guidelines, in order to

1 recommend or determine whether, or to what extent, a health care  
2 service given or proposed to be given to a covered person should or  
3 will be reimbursed, covered, paid for, or otherwise provided under the  
4 health benefits plan. The system may include: preadmission  
5 certification, the application of practice guidelines, continued stay  
6 review, discharge planning, preauthorization of ambulatory care  
7 procedures and retrospective review.

8 (cf: P.L.1997, c.192, s.2)

9

10 2. Section 4 of P.L.1997, c.192 (C.26:2S-4) is amended to read as  
11 follows:

12 4. A carrier shall disclose in writing to a subscriber, in a manner  
13 consistent with the "Life and Health Insurance Policy Language  
14 Simplification Act," P.L.1979, c.167 (C.17B:17-17 et seq.), the terms  
15 and conditions of its health benefits plan, and shall promptly provide  
16 the subscriber with written notification of any change in the terms and  
17 conditions prior to the effective date of the change. The carrier shall  
18 provide the required information at the time of enrollment and upon  
19 request thereafter.

20 a. The information required to be disclosed pursuant to this section  
21 shall include a description of:

22 (1) covered services and benefits to which the subscriber or other  
23 covered person is entitled;

24 (2) restrictions or limitations on covered services and benefits,  
25 including, but not limited to, physical and occupational therapy  
26 services, clinical laboratory tests, hospital and surgical procedures,  
27 prescription drugs and biologics, radiological examinations and  
28 behavioral health care services;

29 (3) financial responsibility of the covered person, including  
30 copayments and deductibles;

31 (4) prior authorization and any other review requirements with  
32 respect to accessing covered services;

33 (5) where and in what manner covered services may be obtained;

34 (6) changes in covered services or benefits, including any addition,  
35 reduction or elimination of specific services or benefits;

36 (7) the covered person's right to appeal and the procedure for  
37 initiating an appeal of a utilization management decision made by or  
38 on behalf of the carrier with respect to the denial, reduction or  
39 termination of a health care benefit or the denial of payment for a  
40 health care service;

41 (8) the procedure to initiate an appeal through the Independent  
42 Health Care Appeals Program established pursuant to this act; and

43 (9) such other information as the commissioner shall require.

44 b. The carrier shall file the information required pursuant to this  
45 section with the department.

46 c. In the case of a carrier that owns, wholly or in part, or contracts

1 with a managed behavioral health care organization, the information  
2 required to be disclosed pursuant to this section shall include the  
3 following:

4 (1) the specific behavioral health care services covered and the  
5 specific exclusions that apply to the subscriber or other covered  
6 person;

7 (2) the covered person's responsibilities for obtaining behavioral  
8 health care services;

9 (3) the reimbursement methodology that the carrier and managed  
10 behavioral health care organization use to reimburse health care  
11 providers for behavioral health care services; and

12 (4) if the carrier offers a managed care plan that provides for both  
13 in-network and out-of-network benefits, the procedure that a covered  
14 person must utilize when attempting to obtain behavioral health care  
15 services from a health care provider who is not included in the  
16 network of providers used by the carrier or managed behavioral health  
17 care organization.

18 (cf: P.L.1997, c.192, s.4)

19

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

22 5. a. In addition to the disclosure requirements provided in section  
23 4 of this act, a carrier which offers a managed care plan shall disclose  
24 to a subscriber, in writing, in a manner consistent with the "Life and  
25 Health Insurance Policy Language Simplification Act," P.L.1979,  
26 c.167 (C.17B:17-17 et seq.), the following information at the time of  
27 enrollment and annually thereafter:

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

35 In the case of a carrier that owns, wholly or in part, or contracts  
36 with a managed behavioral health care organization, the directory shall  
37 include a list of participating providers of behavioral health care  
38 services with the address of each provider.

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

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

46 (3) The percentage of the carrier's managed care plan's network

1 physicians who are board certified;

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

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

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

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

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

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

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

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

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

29 (cf: P.L.2001, c.367, s.1)

30

31 4. (New section) a. A carrier that owns, wholly or in part, or  
32 contracts with a managed behavioral health care organization shall  
33 require the managed behavioral health care organization to provide the  
34 carrier and the commissioner with an annual report, no later than  
35 March 15th of each year and covering the preceding calendar year,  
36 which includes the following information:

37 (1) the payments made by the managed behavioral health care  
38 organization to health care providers for the provision of behavioral  
39 health care services to covered persons during the preceding calendar  
40 year, which shall be separately identified in the report from the other  
41 information that is required to be included pursuant to this subsection;

42 (2) the total expenses incurred by the managed behavioral health  
43 care organization for quality assurance and utilization management  
44 activities and treatment plan reviews, whether administrative or clinical  
45 in nature, during the preceding calendar year, which shall be separately  
46 identified in the report;

1 (3) the total expenses incurred by the managed behavioral health  
2 care organization for other administrative functions, including, but not  
3 limited to, accounting and financial reporting, billing and collection,  
4 data processing, debt or debt service, legal services, promotion and  
5 marketing, or provider credentialing, during the preceding calendar  
6 year, which shall each be separately identified in the report; and

7 (4) the amount of any premiums or other fees received by the  
8 managed behavioral health care organization during the preceding  
9 calendar year.

10 b. A carrier shall make available to a subscriber or other covered  
11 person, upon request, a copy of the report that is required pursuant to  
12 subsection a. of this section. The carrier may charge a fee, in an  
13 amount to be established by the commissioner, for furnishing a copy  
14 of the report or form to a subscriber or other covered person, which  
15 shall reasonably reflect the cost of preparation and the actual cost of  
16 postage and handling.

17  
18 5. This act shall take effect on the 60th day after enactment.  
19  
20

21 \_\_\_\_\_  
22  
23 Requires carriers that cover behavioral health care services to disclose  
24 certain information to their insureds.



# ASSEMBLY, No. 2976

## STATE OF NEW JERSEY 211th LEGISLATURE

INTRODUCED MAY 27, 2004

**Sponsored by:**

**Assemblywoman LORETTA WEINBERG**

**District 37 (Bergen)**

**Assemblyman LOUIS MANZO**

**District 31 (Hudson)**

**Assemblyman BRIAN P. STACK**

**District 33 (Hudson)**

**SYNOPSIS**

Requires carriers that cover behavioral health care services to disclose certain information to their insureds.

**CURRENT VERSION OF TEXT**

As introduced.



A2976 WEINBERG, MANZO

2

1 AN ACT concerning managed behavioral health care services and  
2 amending and supplementing P.L.1997, c.192.

3

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

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

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11 rendered by a health care provider for the treatment of mental illness,  
12 emotional disorders, or drug or alcohol abuse. "Behavioral health care  
13 services" does not include: any quality assurance or utilization  
14 management activities or treatment plan reviews conducted by a  
15 carrier, or a private entity on behalf of the carrier, pertaining to these  
16 services, whether administrative or clinical in nature; or any other  
17 administrative functions, including, but not limited to, accounting and  
18 financial reporting, billing and collection, data processing, debt or debt  
19 service, legal services, promotion and marketing, or provider  
20 credentialing.

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

25 "Commissioner" means the Commissioner of Health and Senior  
26 Services.

27 "Contract holder" means an employer or organization that  
28 purchases a contract for services.

29 "Covered person" means a person on whose behalf a carrier offering  
30 the plan is obligated to pay benefits or provide services pursuant to the  
31 health benefits plan.

32 "Covered service" means a health care service provided to a  
33 covered person under a health benefits plan for which the carrier is  
34 obligated to pay benefits or provide services.

35 "Department" means the Department of Health and Senior Services.

36 "Health benefits plan" means a benefits plan which pays or provides  
37 hospital and medical expense benefits for covered services, and is  
38 delivered or issued for delivery in this State by or through a carrier.  
39 Health benefits plan includes, but is not limited to, Medicare  
40 supplement coverage and risk contracts to the extent not otherwise  
41 prohibited by federal law. For the purposes of this act, health benefits  
42 plan shall not include the following plans, policies or contracts:  
43 accident only, credit, disability, long-term care, CHAMPUS

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

**Matter underlined thus is new matter.**

1 supplement coverage, coverage arising out of a workers' compensation  
2 or similar law, automobile medical payment insurance, personal injury  
3 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et  
4 seq.) or hospital confinement indemnity coverage.

5 "Health care provider" means an individual or entity which, acting  
6 within the scope of its licensure or certification, provides a covered  
7 service defined by the health benefits plan. Health care provider  
8 includes, but is not limited to, a physician and other health care  
9 professionals licensed pursuant to Title 45 of the Revised Statutes, and  
10 a hospital and other health care facilities licensed pursuant to Title 26  
11 of the Revised Statutes.

12 "Independent utilization review organization" means an independent  
13 entity comprised of physicians and other health care professionals who  
14 are representative of the active practitioners in the area in which the  
15 organization will operate and which is under contract with the  
16 department to provide medical necessity or appropriateness of services  
17 appeal reviews pursuant to this act.

18 "Managed behavioral health care organization" means an entity that  
19 contracts with a carrier to provide, undertake to arrange, or administer  
20 behavioral health care services to covered persons through health care  
21 providers employed by the managed behavioral health care  
22 organization or otherwise make behavioral health care services  
23 available to covered persons through contracts with health care  
24 providers. "Managed behavioral health care organization" does not  
25 include a person or entity that, for an administrative fee only, solely  
26 arranges a panel of health care providers for a carrier for the provision  
27 of behavioral health care services on a discounted fee-for-service basis.

28 "Managed care plan" means a health benefits plan that integrates the  
29 financing and delivery of appropriate health care services to covered  
30 persons by arrangements with participating providers, who are selected  
31 to participate on the basis of explicit standards, to furnish a  
32 comprehensive set of health care services and financial incentives for  
33 covered persons to use the participating providers and procedures  
34 provided for in the plan.

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36 employment or other status, except family status, is the basis for  
37 eligibility for enrollment by the carrier or, in the case of an individual  
38 contract, the person in whose name the contract is issued.

39 "Utilization management" means a system for reviewing the  
40 appropriate and efficient allocation of health care services under a  
41 health benefits plan according to specified guidelines, in order to  
42 recommend or determine whether, or to what extent, a health care  
43 service given or proposed to be given to a covered person should or  
44 will be reimbursed, covered, paid for, or otherwise provided under the  
45 health benefits plan. The system may include: preadmission  
46 certification, the application of practice guidelines, continued stay

1 review, discharge planning, preauthorization of ambulatory care  
2 procedures and retrospective review.

3 (cf: P.L.1997, c.192, s.2)

4

5 2. Section 4 of P.L.1997, c.192 (C.26:2S-4) is amended to read as  
6 follows:

7 4. A carrier shall disclose in writing to a subscriber, in a manner  
8 consistent with the "Life and Health Insurance Policy Language  
9 Simplification Act," P.L.1979, c.167 (C.17B:17-17 et seq.), the terms  
10 and conditions of its health benefits plan, and shall promptly provide  
11 the subscriber with written notification of any change in the terms and  
12 conditions prior to the effective date of the change. The carrier shall  
13 provide the required information at the time of enrollment and upon  
14 request thereafter.

15 a. The information required to be disclosed pursuant to this section  
16 shall include a description of:

17 (1) covered services and benefits to which the subscriber or other  
18 covered person is entitled;

19 (2) restrictions or limitations on covered services and benefits,  
20 including, but not limited to, physical and occupational therapy  
21 services, clinical laboratory tests, hospital and surgical procedures,  
22 prescription drugs and biologics, radiological examinations and  
23 behavioral health care services;

24 (3) financial responsibility of the covered person, including  
25 copayments and deductibles;

26 (4) prior authorization and any other review requirements with  
27 respect to accessing covered services;

28 (5) where and in what manner covered services may be obtained;

29 (6) changes in covered services or benefits, including any addition,  
30 reduction or elimination of specific services or benefits;

31 (7) the covered person's right to appeal and the procedure for  
32 initiating an appeal of a utilization management decision made by or  
33 on behalf of the carrier with respect to the denial, reduction or  
34 termination of a health care benefit or the denial of payment for a  
35 health care service;

36 (8) the procedure to initiate an appeal through the Independent  
37 Health Care Appeals Program established pursuant to this act; and

38 (9) such other information as the commissioner shall require.

39 b. The carrier shall file the information required pursuant to this  
40 section with the department.

41 c. In the case of a carrier that owns, wholly or in part, or contracts  
42 with a managed behavioral health care organization, the information  
43 required to be disclosed pursuant to this section shall include the  
44 following:

45 (1) the specific behavioral health care services covered and the  
46 specific exclusions that apply to the subscriber or other covered

1 person;

2 (2) the covered person's responsibilities for obtaining behavioral  
3 health care services;

4 (3) the reimbursement methodology that the carrier and managed  
5 behavioral health care organization use to reimburse health care  
6 providers for behavioral health care services; and

7 (4) if the carrier offers a managed care plan that provides for both  
8 in-network and out-of-network benefits, the procedure that a covered  
9 person must utilize when attempting to obtain behavioral health care  
10 services from a health care provider who is not included in the  
11 network of providers used by the carrier or managed behavioral health  
12 care organization.

13 (cf: P.L.1997, c.192, s.4)

14

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

17 5. a. In addition to the disclosure requirements provided in section  
18 4 of this act, a carrier which offers a managed care plan shall disclose  
19 to a subscriber, in writing, in a manner consistent with the "Life and  
20 Health Insurance Policy Language Simplification Act," P.L.1979,  
21 c.167 (C.17B:17-17 et seq.), the following information at the time of  
22 enrollment and annually thereafter:

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

30 In the case of a carrier that owns, wholly or in part, or contracts  
31 with a managed behavioral health care organization, the directory shall  
32 include a list of participating providers of behavioral health care  
33 services with the address of each provider.

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

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

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

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

45 (5) The availability through the department, upon request of a  
46 member of the general public, of independent consumer satisfaction

1 survey results and an analysis of quality outcomes of health care  
2 services of managed care plans in the State;

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

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

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

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

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

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

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

24 (cf: P.L.2001, c.367, s.1)

25

26 4. (New section) a. A carrier that owns, wholly or in part, or  
27 contracts with a managed behavioral health care organization shall  
28 require the managed behavioral health care organization to provide the  
29 carrier and the commissioner with an annual report, no later than  
30 March 15th of each year and covering the preceding calendar year,  
31 which includes the following information:

32 (1) the payments made by the managed behavioral health care  
33 organization to health care providers for the provision of behavioral  
34 health care services to covered persons during the preceding calendar  
35 year, which shall be separately identified in the report from the other  
36 information that is required to be included pursuant to this subsection;

37 (2) the total expenses incurred by the managed behavioral health  
38 care organization for quality assurance and utilization management  
39 activities and treatment plan reviews, whether administrative or clinical  
40 in nature, during the preceding calendar year, which shall be separately  
41 identified in the report;

42 (3) the total expenses incurred by the managed behavioral health  
43 care organization for other administrative functions, including, but not  
44 limited to, accounting and financial reporting, billing and collection,  
45 data processing, debt or debt service, legal services, promotion and  
46 marketing, or provider credentialing, during the preceding calendar

1 year, which shall each be separately identified in the report; and  
2 (4) the amount of any premiums or other fees received by the  
3 managed behavioral health care organization during the preceding  
4 calendar year.

5 b. A carrier shall make available to a subscriber or other covered  
6 person, upon request, a copy of the report that is required pursuant to  
7 subsection a. of this section. The carrier may charge a fee, in an  
8 amount to be established by the commissioner, for furnishing a copy  
9 of the report or form to a subscriber or other covered person, which  
10 shall reasonably reflect the cost of preparation and the actual cost of  
11 postage and handling.

12

13 5. This act shall take effect on the 60th day after enactment.

14

15

16

STATEMENT

17

18 This bill, which amends and supplements the "Health Care Quality  
19 Act," N.J.S.A.26:2S-1 et seq., is designed to make information about  
20 managed behavioral health care services provided directly by health  
21 insurance carriers in this State, or through carrier contracts with  
22 managed behavioral health care organizations, more widely available  
23 to other covered persons.

24 The bill defines:

25 - "behavioral health care services" to mean procedures or services  
26 rendered by a health care provider for the treatment of mental illness,  
27 emotional disorders, or drug or alcohol abuse; and

28 - "managed behavioral health care organization" to mean an entity  
29 that contracts with a carrier to provide, undertake to arrange, or  
30 administer behavioral health care services to covered persons through  
31 health care providers employed by the managed behavioral health care  
32 organization or otherwise make behavioral health care services  
33 available to covered persons through contracts with health care  
34 providers.

35 Specifically, the bill provides as follows:

36 --In the case of a carrier that owns, wholly or in part, or contracts  
37 with a managed behavioral health care organization, the information  
38 required to be disclosed to subscribers pursuant to N.J.S.A.26:2S-4 is  
39 to include the following:

40 \* the specific behavioral health care services covered and the  
41 specific exclusions that apply to the subscriber or other covered  
42 person;

43 \* the covered person's responsibilities for obtaining behavioral  
44 health care services;

45 \* the reimbursement methodology that the carrier and managed  
46 behavioral health care organization use to reimburse health care

1 providers for behavioral health care services; and

2 \* if the carrier offers a managed care plan that provides for both in-  
3 network and out-of-network benefits, the procedure that a covered  
4 person must utilize when attempting to obtain behavioral health care  
5 services from a health care provider who is not included in the  
6 network of providers used by the carrier or managed behavioral health  
7 care organization.

8 --In the case of a carrier that owns, wholly or in part, or contracts  
9 with a managed behavioral health care organization, the directory of  
10 health care providers participating in its network, which is furnished  
11 to subscribers pursuant to N.J.S.A.26:2S-5, is to include a list of  
12 participating providers of behavioral health care services with the  
13 address of each provider.

14 --A carrier that owns, wholly or in part, or contracts with a  
15 managed behavioral health care organization is to require the managed  
16 behavioral health care organization to provide the carrier and the  
17 Commissioner of Health and Senior Services with an annual report, no  
18 later than March 15th of each year and covering the preceding  
19 calendar year, which includes the following information:

20 \* the payments made by the managed behavioral health care  
21 organization to health care providers for the provision of behavioral  
22 health care services to covered persons during the preceding calendar  
23 year, which is to be separately identified in the report from the other  
24 information that is required to be included;

25 \* the total expenses incurred by the managed behavioral health care  
26 organization for quality assurance and utilization management  
27 activities and treatment plan reviews, whether administrative or clinical  
28 in nature, during the preceding calendar year, which are to be  
29 separately identified in the report;

30 \* the total expenses incurred by the managed behavioral health care  
31 organization for other administrative functions, including, but not  
32 limited to, accounting and financial reporting, billing and collection,  
33 data processing, debt or debt service, legal services, promotion and  
34 marketing, or provider credentialing, during the preceding calendar  
35 year, which are to each be separately identified in the report; and

36 \* the amount of any premiums or other fees received by the  
37 managed behavioral health care organization during the preceding  
38 calendar year.

39 --A carrier is to make available to a subscriber or other covered  
40 person, upon request, a copy of the report that is required pursuant to  
41 the bill. The carrier may charge a fee, in an amount to be established  
42 by the commissioner, for furnishing a copy of the report or form to a  
43 subscriber or other covered person, which is to reasonably reflect the  
44 cost of preparation and the actual cost of postage and handling.

45 The bill takes effect on the 60th day after enactment.



# ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

## STATEMENT TO

### ASSEMBLY, No. 2976

with committee amendments

# STATE OF NEW JERSEY

DATED: DECEMBER 6, 2004

The Assembly Health and Human Services Committee reports favorably and with committee amendments Assembly Bill No. 2976.

As amended by the committee, this bill, which amends and supplements the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., is designed to make information about managed behavioral health care services provided directly by health insurance carriers in this State, or through carrier contracts with managed behavioral health care organizations, more widely available to covered persons.

The bill defines:

-- "behavioral health care services" to mean procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, or drug or alcohol abuse; and

-- "managed behavioral health care organization" to mean an entity, other than a carrier, which contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to covered persons through health care providers employed by the managed behavioral health care organization or otherwise make behavioral health care services available to covered persons through contracts with health care providers.

Specifically, the bill provides as follows:

C In the case of a carrier that owns, wholly or in part, or contracts with a managed behavioral health care organization, the information required to be disclosed to subscribers pursuant to N.J.S.A.26:2S-4 is to include the following:

-- the specific behavioral health care services covered and the specific exclusions that apply to the subscriber or other covered person;

-- the covered person's responsibilities for obtaining behavioral health care services;

-- the reimbursement methodology that the carrier and managed behavioral health care organization use to reimburse health care providers for behavioral health care services; and

-- if the carrier offers a managed care plan that provides for both in-network and out-of-network benefits, the procedure that a covered person must utilize when attempting to obtain behavioral health care services from a health care provider who is not included in the

network of providers used by the carrier or managed behavioral health care organization.

C In the case of a carrier that owns, wholly or in part, or contracts with a managed behavioral health care organization, the directory of health care providers participating in its network, which is furnished to subscribers pursuant to N.J.S.A.26:2S-5, is to include a list of participating providers of behavioral health care services with the address of each provider.

C A carrier that owns, wholly or in part, or contracts with a managed behavioral health care organization is to require the managed behavioral health care organization to provide the carrier and the Commissioner of Health and Senior Services with an annual report, no later than March 15th of each year and covering the preceding calendar year, which includes the following information:

-- the payments made by the managed behavioral health care organization to health care providers for the provision of behavioral health care services to covered persons during the preceding calendar year, which is to be separately identified in the report from the other information that is required to be included;

-- the total expenses incurred by the managed behavioral health care organization for quality assurance and utilization management activities and treatment plan reviews, whether administrative or clinical in nature, during the preceding calendar year, which are to be separately identified in the report;

-- the total expenses incurred by the managed behavioral health care organization for other administrative functions, including, but not limited to, accounting and financial reporting, billing and collection, data processing, debt or debt service, legal services, promotion and marketing, or provider credentialing, during the preceding calendar year, which are to each be separately identified in the report; and

-- the amount of any premiums or other fees received by the managed behavioral health care organization during the preceding calendar year.

C A carrier is to make available to a subscriber or other covered person, upon request, a copy of the report that is required pursuant to the bill. The carrier may charge a fee, in an amount to be established by the commissioner, for furnishing a copy of the report or form to a subscriber or other covered person, which is to reasonably reflect the cost of preparation and the actual cost of postage and handling.

C The bill takes effect on the 60th day after enactment.

As reported by the committee, this bill is similar to Senate Bill No. 1993 (Coniglio), which is currently pending in the Senate Health, Human Services and Senior Citizens Committee.

#### COMMITTEE AMENDMENTS

The committee amendments to the bill revise the definition of a "managed behavioral health care organization" to clarify that it is an entity other than a carrier.

SENATE HEALTH, HUMAN SERVICES AND SENIOR  
CITIZENS COMMITTEE

STATEMENT TO

[First Reprint]

**ASSEMBLY, No. 2976**

**STATE OF NEW JERSEY**

DATED: MAY 5, 2005

The Senate Health, Human Services and Senior Citizens Committee reports favorably Assembly Bill No. 2976 (1R).

This bill, which amends and supplements the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., is designed to make information about managed behavioral health care services provided directly by health insurance carriers in this State, or through carrier contracts with managed behavioral health care organizations, more widely available to covered persons.

The bill defines:

-- "behavioral health care services" to mean procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, or drug or alcohol abuse; and

-- "managed behavioral health care organization" to mean an entity, other than a carrier, which contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to covered persons through health care providers employed by the managed behavioral health care organization or otherwise make behavioral health care services available to covered persons through contracts with health care providers.

Under the bill, a carrier that owns or contracts with a managed behavioral health care organization would be required to disclose to subscribers the following information: the specific behavioral health care services covered and the specific exclusions; the covered person's responsibilities for obtaining behavioral health care services; the reimbursement methodology used to reimburse health care providers for behavioral health care services; and the procedure that a covered person must use to obtain behavioral health care services from an out-of-network provider, if the plan provides for both in-network and out-of-network benefits.

The bill also provides that the carrier would be required to include a list of participating providers of behavioral health care services with each provider's address in the directory of in-network health care providers that is furnished to subscribers pursuant to N.J.S.A.26:2S-5.

In addition, the carrier is to require the managed behavioral health

care organization to provide the carrier and the Commissioner of Health and Senior Services with an annual report, no later than March 15th of each year and covering the preceding calendar year, which includes the following information:

- the payments made by the managed behavioral health care organization to health care providers for the provision of behavioral health care services to covered persons during the preceding calendar year, which is to be separately identified in the report from the other information that is required to be included;

- the total expenses incurred by the managed behavioral health care organization for quality assurance and utilization management activities and treatment plan reviews, whether administrative or clinical in nature, during the preceding calendar year, which are to be separately identified in the report;

- the total expenses incurred by the managed behavioral health care organization for other administrative functions, including accounting and financial reporting, billing and collection, data processing, debt or debt service, legal services, promotion and marketing, or provider credentialing, during the preceding calendar year, which are to each be separately identified in the report; and

- the amount of any premiums or other fees received by the managed behavioral health care organization during the preceding calendar year.

The carrier is to make available to a subscriber or other covered person, upon request, a copy of the report that is required pursuant to the bill, and may charge a fee, in an amount to be established by the commissioner that reasonably reflects the cost of preparation and the actual cost of postage and handling.

The bill takes effect on the 60th day after enactment.

This bill is identical to Senate Bill No. 1993 (Sca) (Coniglio/Vitale), which the committee also reported favorably on this date.

**SENATE, No. 1993**

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**STATE OF NEW JERSEY**  
**211th LEGISLATURE**

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INTRODUCED OCTOBER 25, 2004

**Sponsored by:**

**Senator JOSEPH CONIGLIO**

**District 38 (Bergen)**

**Senator JOSEPH F. VITALE**

**District 19 (Middlesex)**

**SYNOPSIS**

Requires carriers that cover behavioral health care services to disclose certain information to their insureds.

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 3/22/2005)**

S1993 CONIGLIO, VITALE

2

1 AN ACT concerning managed behavioral health care services and  
2 amending and supplementing P.L.1997, c.192.

3

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

6

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

9 2. As used in sections 2 through 19 of this act:

10 "Behavioral health care services" means procedures or services  
11 rendered by a health care provider for the treatment of mental illness,  
12 emotional disorders, or drug or alcohol abuse. "Behavioral health care  
13 services" does not include: any quality assurance or utilization  
14 management activities or treatment plan reviews conducted by a  
15 carrier, or a private entity on behalf of the carrier, pertaining to these  
16 services, whether administrative or clinical in nature; or any other  
17 administrative functions, including, but not limited to, accounting and  
18 financial reporting, billing and collection, data processing, debt or debt  
19 service, legal services, promotion and marketing, or provider  
20 credentialing.

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

25 "Commissioner" means the Commissioner of Health and Senior  
26 Services.

27 "Contract holder" means an employer or organization that  
28 purchases a contract for services.

29 "Covered person" means a person on whose behalf a carrier offering  
30 the plan is obligated to pay benefits or provide services pursuant to the  
31 health benefits plan.

32 "Covered service" means a health care service provided to a  
33 covered person under a health benefits plan for which the carrier is  
34 obligated to pay benefits or provide services.

35 "Department" means the Department of Health and Senior Services.

36 "Health benefits plan" means a benefits plan which pays or provides  
37 hospital and medical expense benefits for covered services, and is  
38 delivered or issued for delivery in this State by or through a carrier.  
39 Health benefits plan includes, but is not limited to, Medicare  
40 supplement coverage and risk contracts to the extent not otherwise  
41 prohibited by federal law. For the purposes of this act, health benefits  
42 plan shall not include the following plans, policies or contracts:  
43 accident only, credit, disability, long-term care, CHAMPUS

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

**Matter underlined thus is new matter.**

1 supplement coverage, coverage arising out of a workers' compensation  
2 or similar law, automobile medical payment insurance, personal injury  
3 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et  
4 seq.) or hospital confinement indemnity coverage.

5 "Health care provider" means an individual or entity which, acting  
6 within the scope of its licensure or certification, provides a covered  
7 service defined by the health benefits plan. Health care provider  
8 includes, but is not limited to, a physician and other health care  
9 professionals licensed pursuant to Title 45 of the Revised Statutes, and  
10 a hospital and other health care facilities licensed pursuant to Title 26  
11 of the Revised Statutes.

12 "Independent utilization review organization" means an independent  
13 entity comprised of physicians and other health care professionals who  
14 are representative of the active practitioners in the area in which the  
15 organization will operate and which is under contract with the  
16 department to provide medical necessity or appropriateness of services  
17 appeal reviews pursuant to this act.

18 "Managed behavioral health care organization" means an entity that  
19 contracts with a carrier to provide, undertake to arrange, or administer  
20 behavioral health care services to covered persons through health care  
21 providers employed by the managed behavioral health care  
22 organization or otherwise make behavioral health care services  
23 available to covered persons through contracts with health care  
24 providers. "Managed behavioral health care organization" does not  
25 include a person or entity that, for an administrative fee only, solely  
26 arranges a panel of health care providers for a carrier for the provision  
27 of behavioral health care services on a discounted fee-for-service basis.

28 "Managed care plan" means a health benefits plan that integrates the  
29 financing and delivery of appropriate health care services to covered  
30 persons by arrangements with participating providers, who are selected  
31 to participate on the basis of explicit standards, to furnish a  
32 comprehensive set of health care services and financial incentives for  
33 covered persons to use the participating providers and procedures  
34 provided for in the plan.

35 "Subscriber" means, in the case of a group contract, a person whose  
36 employment or other status, except family status, is the basis for  
37 eligibility for enrollment by the carrier or, in the case of an individual  
38 contract, the person in whose name the contract is issued.

39 "Utilization management" means a system for reviewing the  
40 appropriate and efficient allocation of health care services under a  
41 health benefits plan according to specified guidelines, in order to  
42 recommend or determine whether, or to what extent, a health care  
43 service given or proposed to be given to a covered person should or  
44 will be reimbursed, covered, paid for, or otherwise provided under the  
45 health benefits plan. The system may include: preadmission  
46 certification, the application of practice guidelines, continued stay

1 review, discharge planning, preauthorization of ambulatory care  
2 procedures and retrospective review.

3 (cf: P.L.1997, c.192, s.2)

4

5 2. Section 4 of P.L.1997, c.192 (C.26:2S-4) is amended to read as  
6 follows:

7 4. A carrier shall disclose in writing to a subscriber, in a manner  
8 consistent with the "Life and Health Insurance Policy Language  
9 Simplification Act," P.L.1979, c.167 (C.17B:17-17 et seq.), the terms  
10 and conditions of its health benefits plan, and shall promptly provide  
11 the subscriber with written notification of any change in the terms and  
12 conditions prior to the effective date of the change. The carrier shall  
13 provide the required information at the time of enrollment and upon  
14 request thereafter.

15 a. The information required to be disclosed pursuant to this section  
16 shall include a description of:

17 (1) covered services and benefits to which the subscriber or other  
18 covered person is entitled;

19 (2) restrictions or limitations on covered services and benefits,  
20 including, but not limited to, physical and occupational therapy  
21 services, clinical laboratory tests, hospital and surgical procedures,  
22 prescription drugs and biologics, radiological examinations and  
23 behavioral health care services;

24 (3) financial responsibility of the covered person, including  
25 copayments and deductibles;

26 (4) prior authorization and any other review requirements with  
27 respect to accessing covered services;

28 (5) where and in what manner covered services may be obtained;

29 (6) changes in covered services or benefits, including any addition,  
30 reduction or elimination of specific services or benefits;

31 (7) the covered person's right to appeal and the procedure for  
32 initiating an appeal of a utilization management decision made by or  
33 on behalf of the carrier with respect to the denial, reduction or  
34 termination of a health care benefit or the denial of payment for a  
35 health care service;

36 (8) the procedure to initiate an appeal through the Independent  
37 Health Care Appeals Program established pursuant to this act; and

38 (9) such other information as the commissioner shall require.

39 b. The carrier shall file the information required pursuant to this  
40 section with the department.

41 c. In the case of a carrier that owns, wholly or in part, or contracts  
42 with a managed behavioral health care organization, the information  
43 required to be disclosed pursuant to this section shall include the  
44 following:

45 (1) the specific behavioral health care services covered and the  
46 specific exclusions that apply to the subscriber or other covered



1 person;

2 (2) the covered person's responsibilities for obtaining behavioral  
3 health care services;

4 (3) the reimbursement methodology that the carrier and managed  
5 behavioral health care organization use to reimburse health care  
6 providers for behavioral health care services; and

7 (4) if the carrier offers a managed care plan that provides for both  
8 in-network and out-of-network benefits, the procedure that a covered  
9 person must utilize when attempting to obtain behavioral health care  
10 services from a health care provider who is not included in the  
11 network of providers used by the carrier or managed behavioral health  
12 care organization.

13 (cf: P.L.1997, c.192, s.4)

14

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

17 5. a. In addition to the disclosure requirements provided in section  
18 4 of this act, a carrier which offers a managed care plan shall disclose  
19 to a subscriber, in writing, in a manner consistent with the "Life and  
20 Health Insurance Policy Language Simplification Act," P.L.1979,  
21 c.167 (C.17B:17-17 et seq.), the following information at the time of  
22 enrollment and annually thereafter:

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

30 In the case of a carrier that owns, wholly or in part, or contracts  
31 with a managed behavioral health care organization, the directory shall  
32 include a list of participating providers of behavioral health care  
33 services with the address of each provider.

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

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

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

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

45 (5) The availability through the department, upon request of a  
46 member of the general public, of independent consumer satisfaction

1 survey results and an analysis of quality outcomes of health care  
2 services of managed care plans in the State;

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

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

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

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

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

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

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

24 (cf: P.L.2001, c.367, s.1)

25

26 4. (New section) a. A carrier that owns, wholly or in part, or  
27 contracts with a managed behavioral health care organization shall  
28 require the managed behavioral health care organization to provide the  
29 carrier and the commissioner with an annual report, no later than  
30 March 15th of each year and covering the preceding calendar year,  
31 which includes the following information:

32 (1) the payments made by the managed behavioral health care  
33 organization to health care providers for the provision of behavioral  
34 health care services to covered persons during the preceding calendar  
35 year, which shall be separately identified in the report from the other  
36 information that is required to be included pursuant to this subsection;

37 (2) the total expenses incurred by the managed behavioral health  
38 care organization for quality assurance and utilization management  
39 activities and treatment plan reviews, whether administrative or clinical  
40 in nature, during the preceding calendar year, which shall be separately  
41 identified in the report;

42 (3) the total expenses incurred by the managed behavioral health  
43 care organization for other administrative functions, including, but not  
44 limited to, accounting and financial reporting, billing and collection,  
45 data processing, debt or debt service, legal services, promotion and  
46 marketing, or provider credentialing, during the preceding calendar

1 year, which shall each be separately identified in the report; and  
2 (4) the amount of any premiums or other fees received by the  
3 managed behavioral health care organization during the preceding  
4 calendar year.

5 b. A carrier shall make available to a subscriber or other covered  
6 person, upon request, a copy of the report that is required pursuant to  
7 subsection a. of this section. The carrier may charge a fee, in an  
8 amount to be established by the commissioner, for furnishing a copy  
9 of the report or form to a subscriber or other covered person, which  
10 shall reasonably reflect the cost of preparation and the actual cost of  
11 postage and handling.

12

13 5. This act shall take effect on the 60th day after enactment.

14

15

16

#### STATEMENT

17

18 This bill, which amends and supplements the "Health Care Quality  
19 Act," N.J.S.A.26:2S-1 et seq., is designed to make information about  
20 managed behavioral health care services provided directly by health  
21 insurance carriers in this State, or through carrier contracts with  
22 managed behavioral health care organizations, more widely available  
23 to other covered persons.

24 The bill defines:

25 - "behavioral health care services" to mean procedures or services  
26 rendered by a health care provider for the treatment of mental illness,  
27 emotional disorders, or drug or alcohol abuse; and

28 - "managed behavioral health care organization" to mean an entity  
29 that contracts with a carrier to provide, undertake to arrange, or  
30 administer behavioral health care services to covered persons through  
31 health care providers employed by the managed behavioral health care  
32 organization or otherwise make behavioral health care services  
33 available to covered persons through contracts with health care  
34 providers.

35 Specifically, the bill provides as follows:

36 --In the case of a carrier that owns, wholly or in part, or contracts  
37 with a managed behavioral health care organization, the information  
38 required to be disclosed to subscribers pursuant to N.J.S.A.26:2S-4 is  
39 to include the following:

40 \* the specific behavioral health care services covered and the  
41 specific exclusions that apply to the subscriber or other covered  
42 person;

43 \* the covered person's responsibilities for obtaining behavioral  
44 health care services;

45 \* the reimbursement methodology that the carrier and managed  
46 behavioral health care organization use to reimburse health care

1 providers for behavioral health care services; and

2 \* if the carrier offers a managed care plan that provides for both in-  
3 network and out-of-network benefits, the procedure that a covered  
4 person must utilize when attempting to obtain behavioral health care  
5 services from a health care provider who is not included in the  
6 network of providers used by the carrier or managed behavioral health  
7 care organization.

8 --In the case of a carrier that owns, wholly or in part, or contracts  
9 with a managed behavioral health care organization, the directory of  
10 health care providers participating in its network, which is furnished  
11 to subscribers pursuant to N.J.S.A.26:2S-5, is to include a list of  
12 participating providers of behavioral health care services with the  
13 address of each provider.

14 --A carrier that owns, wholly or in part, or contracts with a  
15 managed behavioral health care organization is to require the managed  
16 behavioral health care organization to provide the carrier and the  
17 Commissioner of Health and Senior Services with an annual report, no  
18 later than March 15th of each year and covering the preceding  
19 calendar year, which includes the following information:

20 \* the payments made by the managed behavioral health care  
21 organization to health care providers for the provision of behavioral  
22 health care services to covered persons during the preceding calendar  
23 year, which is to be separately identified in the report from the other  
24 information that is required to be included;

25 \* the total expenses incurred by the managed behavioral health care  
26 organization for quality assurance and utilization management  
27 activities and treatment plan reviews, whether administrative or clinical  
28 in nature, during the preceding calendar year, which are to be  
29 separately identified in the report;

30 \* the total expenses incurred by the managed behavioral health care  
31 organization for other administrative functions, including, but not  
32 limited to, accounting and financial reporting, billing and collection,  
33 data processing, debt or debt service, legal services, promotion and  
34 marketing, or provider credentialing, during the preceding calendar  
35 year, which are to each be separately identified in the report; and

36 \* the amount of any premiums or other fees received by the  
37 managed behavioral health care organization during the preceding  
38 calendar year.

39 --A carrier is to make available to a subscriber or other covered  
40 person, upon request, a copy of the report that is required pursuant to  
41 the bill. The carrier may charge a fee, in an amount to be established  
42 by the commissioner, for furnishing a copy of the report or form to a  
43 subscriber or other covered person, which is to reasonably reflect the  
44 cost of preparation and the actual cost of postage and handling.

45 The bill takes effect on the 60th day after enactment.

SENATE HEALTH, HUMAN SERVICES AND SENIOR  
CITIZENS COMMITTEE

STATEMENT TO

**SENATE, No. 1993**

with committee amendments

**STATE OF NEW JERSEY**

DATED: MAY 5, 2005

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 1993.

As amended by the committee, this bill, which amends and supplements the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., is designed to make information about managed behavioral health care services provided directly by health insurance carriers in this State, or through carrier contracts with managed behavioral health care organizations, more widely available to covered persons.

The bill defines:

-- "behavioral health care services" to mean procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, or drug or alcohol abuse; and

-- "managed behavioral health care organization" to mean an entity, other than a carrier, which contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to covered persons through health care providers employed by the managed behavioral health care organization or otherwise make behavioral health care services available to covered persons through contracts with health care providers.

Under the bill, a carrier that owns or contracts with a managed behavioral health care organization would be required to disclose to subscribers the following information: the specific behavioral health care services covered and the specific exclusions; the covered person's responsibilities for obtaining behavioral health care services; the reimbursement methodology used to reimburse health care providers for behavioral health care services; and the procedure that a covered person must use to obtain behavioral health care services from an out-of-network provider, if the plan provides for both in-network and out-of-network benefits.

The bill also provides that the carrier would be required to include a list of participating providers of behavioral health care services with each provider's address in the directory of in-network health care

providers that is furnished to subscribers pursuant to N.J.S.A.26:2S-5.

In addition, the carrier is to require the managed behavioral health care organization to provide the carrier and the Commissioner of Health and Senior Services with an annual report, no later than March 15th of each year and covering the preceding calendar year, which includes the following information:

- the payments made by the managed behavioral health care organization to health care providers for the provision of behavioral health care services to covered persons during the preceding calendar year, which is to be separately identified in the report from the other information that is required to be included;

- the total expenses incurred by the managed behavioral health care organization for quality assurance and utilization management activities and treatment plan reviews, whether administrative or clinical in nature, during the preceding calendar year, which are to be separately identified in the report;

- the total expenses incurred by the managed behavioral health care organization for other administrative functions, including accounting and financial reporting, billing and collection, data processing, debt or debt service, legal services, promotion and marketing, or provider credentialing, during the preceding calendar year, which are to each be separately identified in the report; and

- the amount of any premiums or other fees received by the managed behavioral health care organization during the preceding calendar year.

The carrier is to make available to a subscriber or other covered person, upon request, a copy of the report that is required pursuant to the bill, and may charge a fee, in an amount to be established by the commissioner that reasonably reflects the cost of preparation and the actual cost of postage and handling.

The bill takes effect on the 60th day after enactment.

The committee amended the bill to revise the definition of a "managed behavioral health care organization" to clarify that it is an entity other than a carrier.

As amended by the committee, this bill is identical to Assembly Bill No. 2976 (1R) (Weinberg/Manzo/Stack), which the committee also reported favorably on this date.