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 (1st 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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IS 9/5/07

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

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

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

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

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

"Behavioral health care services" means procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, or drug or alcohol abuse. "Behavioral health care services" does not include: any quality assurance or utilization management activities or treatment plan reviews conducted by a carrier, or a private entity on behalf of the carrier, pertaining to these services, whether administrative or clinical in nature; or any 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.

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

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

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

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

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

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

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. 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:
[1] Assembly AHH committee amendments adopted December 9, 2004.

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

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

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

"Managed behavioral health care organization" means an entity [1][that], other than a carrier, which[1] 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. "Managed behavioral health care organization" does not include a person or entity that, for an administrative fee only, solely arranges a panel of health care providers for a carrier for the provision of behavioral health care services on a discounted fee-for-service basis.

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

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

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

recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.
(cf: P.L.1997, c.192, s.2)

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

4. A carrier shall disclose in writing to a subscriber, 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 terms and conditions of its health benefits plan, and shall promptly provide the subscriber with written notification of any change in the terms and conditions prior to the effective date of the change. The carrier shall provide the required information at the time of enrollment and upon request thereafter.

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

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

(2) restrictions or limitations on covered services and benefits, including, but not limited to, physical and occupational therapy services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health <u>care</u> services;

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

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

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

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

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

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

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

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

<u>c. In the case of a carrier that owns, wholly or in part, or contracts</u>

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

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

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

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

(4) 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.

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

3. 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.

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

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.

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

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

(1) 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 shall be separately identified in the report from the other information that is required to be included pursuant to this subsection;

(2) 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 shall be separately identified in the report;

(3) 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 shall each be separately identified in the report; and

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

b. A carrier shall make available to a subscriber or other covered person, upon request, a copy of the report that is required pursuant to subsection a. of this section. 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 shall reasonably reflect the cost of preparation and the actual cost of postage and handling.

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

Requires carriers that cover behavioral health care services to disclose 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.

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

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

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

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

"Behavioral health care services" means procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, or drug or alcohol abuse. "Behavioral health care services" does not include: any quality assurance or utilization management activities or treatment plan reviews conducted by a carrier, or a private entity on behalf of the carrier, pertaining to these services, whether administrative or clinical in nature; or any 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.

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

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

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

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

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

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Matter underlined thus is new matter.

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

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

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

"Managed behavioral health care organization" means an entity that 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. "Managed behavioral health care organization" does not include a person or entity that, for an administrative fee only, solely arranges a panel of health care providers for a carrier for the provision of behavioral health care services on a discounted fee-for-service basis.

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

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

review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.
(cf: P.L.1997, c.192, s.2)

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

4. A carrier shall disclose in writing to a subscriber, 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 terms and conditions of its health benefits plan, and shall promptly provide the subscriber with written notification of any change in the terms and conditions prior to the effective date of the change. The carrier shall provide the required information at the time of enrollment and upon request thereafter.

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

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

(2) restrictions or limitations on covered services and benefits, including, but not limited to, physical and occupational therapy services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health <u>care</u> services;

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

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

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

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

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

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

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

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

<u>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 pursuant to this section shall include the following:</u>

<u>(1) the specific behavioral health care services covered and the specific exclusions that apply to the subscriber or other covered</u>

person;

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

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

(4) 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.

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

3. 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.

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

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.

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

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

(1) 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 shall be separately identified in the report from the other information that is required to be included pursuant to this subsection;

(2) 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 shall be separately identified in the report;

(3) 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 shall each be separately identified in the report; and

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

b. A carrier shall make available to a subscriber or other covered person, upon request, a copy of the report that is required pursuant to subsection a. of this section. 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 shall reasonably reflect the cost of preparation and the actual cost of postage and handling.

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

STATEMENT

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 other 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 that 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:

--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.

--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.

--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.

--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.

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.

- 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.
- 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.

- 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.
- 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

STATE OF NEW JERSEY

211th LEGISLATURE

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)

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

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

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

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

"Behavioral health care services" means procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, or drug or alcohol abuse. "Behavioral health care services" does not include: any quality assurance or utilization management activities or treatment plan reviews conducted by a carrier, or a private entity on behalf of the carrier, pertaining to these services, whether administrative or clinical in nature; or any 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.

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

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

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

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

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

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

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: 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.

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

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

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

"Managed behavioral health care organization" means an entity that 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. "Managed behavioral health care organization" does not include a person or entity that, for an administrative fee only, solely arranges a panel of health care providers for a carrier for the provision of behavioral health care services on a discounted fee-for-service basis.

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

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

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

review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.
(cf: P.L.1997, c.192, s.2)

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

4. A carrier shall disclose in writing to a subscriber, 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 terms and conditions of its health benefits plan, and shall promptly provide the subscriber with written notification of any change in the terms and conditions prior to the effective date of the change. The carrier shall provide the required information at the time of enrollment and upon request thereafter.

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

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

(2) restrictions or limitations on covered services and benefits, including, but not limited to, physical and occupational therapy services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health <u>care</u> services;

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

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

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

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

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

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

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

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

<u>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 pursuant to this section shall include the following:</u>

<u>(1) the specific behavioral health care services covered and the specific exclusions that apply to the subscriber or other covered</u>

person;

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

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

(4) 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.

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

3. 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.

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

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.

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

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

(1) 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 shall be separately identified in the report from the other information that is required to be included pursuant to this subsection;

(2) 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 shall be separately identified in the report;

(3) 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 shall each be separately identified in the report; and

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

b. A carrier shall make available to a subscriber or other covered person, upon request, a copy of the report that is required pursuant to subsection a. of this section. 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 shall reasonably reflect the cost of preparation and the actual cost of postage and handling.

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

STATEMENT

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 other 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 that 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:

--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.

--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.

--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.

--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.

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 commitee 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.