26:2S-1

LEGISLATIVE HISTORY CHECKLIST
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(Health Care Quality Act)

NJSA: 26:2~~S~~-1 to 26:2~~S~~-18 et al

LAWS OF: 1997 **CHAPTER:** 192

BILL NO: S269

SPONSOR(S): Sinagra and Matheussen

DATE INTRODUCED: Pre-filed

COMMITTEE: **ASSEMBLY:** ---

SENATE: Health

AMENDED DURING PASSAGE: No Senate Committee Substitute enacted (2R)

DATE OF PASSAGE: **ASSEMBLY:** June 23, 1997

SENATE: May 22, 1996

DATE OF APPROVAL: August 7, 1997

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT: Yes Also attached: statements with floor amendments, adopted 5-22-97 & 6-19-97

COMMITTEE STATEMENT: **ASSEMBLY:** No

SENATE: Yes 3-14-96 & 3-10-97

FISCAL NOTE: No

VETO MESSAGE: No

MESSAGE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

See newspaper clippings--attached:
"A prescription for change," 8-8-97, Asbury Park Press.
"HMO law aids NJ patients," 8-8-97, Atlantic City Press.

KBP:pp

[Second Reprint]

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 269

STATE OF NEW JERSEY

ADOPTED MARCH 10, 1997

Sponsored by Senators SINAGRA, MATHEUSSEN, Singer, Bassano, Rice, Codey, MacInnes, LaRossa, Adler, Casey, McGreevey, McNamara, Kenny, Lynch, Zane, Inverso, Bennett, Ciesla, Cardinale, Bubba, Scott, Lesniak, Kosco and Cafiero

AN ACT concerning patient protections under health benefits plans, supplementing Titles 26, 17 and 34 of the Revised Statutes and Title 17B of the New Jersey Statutes, amending and supplementing P.L.1973, c.337 and amending P.L.1992, c.160.

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

1. This act shall be known and may be cited as the "Health Care Quality Act."

2. (New section) As used in sections 2 through 19 of this act:

"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

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] Senate floor amendments adopted May 22, 1997.
[2] Assembly floor amendments adopted June 19, 1997.

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 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 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.

3. (New section) a. A carrier which offers a health benefits plan to residents of this State on the effective date of this act, shall file a form, as prescribed by the commissioner, with the department within 90 days of the effective date of this act and file a copy of the form with the Department of Banking and Insurance. A carrier authorized to issue health benefits plans in this State after the effective date of this act shall file a form with the department at least 30 days prior to the date the carrier will begin to offer a health benefits plan to residents of this State. The carrier shall file a copy of the form with the Department of Banking and Insurance. A carrier shall notify the department within 10 business days of any change in information provided on the form.

b. The commissioner shall establish a form for carriers which shall request, at a minimum:

(1) the official address and telephone number of the place of business of the carrier; and

(2) a description of the carrier's internal patient appeals process available to covered persons to contest a denial, reduction or termination of benefits, if any.

c. A health maintenance organization which holds a certificate of authority pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be exempt from the filing requirements of this section but shall comply with the provisions of this act.

A health maintenance organization shall be required to comply with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this act conflict with the provisions of P.L.1973, c.337, the provisions of this act shall supercede the provisions of P.L.1973, c.337.

d. A carrier which issues health benefits plans utilizing a selective contracting arrangement pursuant to section 22 of P.L.1993, c.162 (C.17B:27A-54) shall be required to comply with the provisions of section 22 of P.L.1993, c.162 and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this act conflict with the provisions of section 22 of P.L.1993, c.162, the provisions of this act shall supercede the provisions of section 22 of P.L.1993, c.162.

4. (New section) 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 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.

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

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

The directory shall also provide information about participating hospitals.

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

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

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

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

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

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.

6. (New section) a. A carrier which offers a managed care plan or uses a utilization management system in any of its health benefits plans shall designate a licensed physician to serve as medical director. The medical director, or his designee, shall be designated to serve as the medical director for medical services provided to covered persons in the State and shall be licensed to practice medicine in New Jersey.

The medical director shall be responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the carrier. The treatment policies, protocols, quality assurance program and utilization management decisions of the carrier shall be based on generally accepted standards of health care practice. The quality assurance and utilization management programs shall be in accordance with standards adopted by regulation of the department pursuant to this act.

b. The medical director shall ensure that:

(1) Any utilization management decision to deny, reduce or terminate a health care benefit or to deny payment for a health care service, because that service is not medically necessary, shall be made

by a physician. In the case of a health care service prescribed or provided by a dentist, the decision shall be made by a dentist;

(2) A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the carrier for those services, unless the approval was based upon fraudulent information submitted by the covered person or the participating provider;

(3) In the case of a managed care plan, a procedure is implemented whereby participating physicians and dentists have an opportunity to review and comment on all medical and surgical and dental protocols, respectively, of the carrier;

(4) The utilization management program is available on a 24-hour basis to respond to authorization requests for emergency and urgent services and is available, at a minimum, during normal working hours for inquiries and authorization requests for nonurgent health care services; and

(5) In the case of a managed care plan, a covered person is permitted to: choose or change a primary care physician from among participating providers in the provider network, and, when appropriate, choose a specialist from among participating network providers following an authorized referral, if required by the carrier, and subject to the ability of the specialist to accept new patients.

7. (New section) Each application for participation [1]by a licensed health care professional that is submitted[1] to a carrier which offers a managed care plan shall be reviewed by a committee of the carrier that includes appropriate representation of health care professionals with knowledge in the applicant's scope of professional practice.

8. (New section) A carrier which offers a managed care plan shall establish a policy governing removal of health care providers from the provider network which includes the following:

a. The carrier shall inform a participating health care provider of the carrier's removal policy at the time the carrier contracts with the health care provider to participate in the provider network, and at each renewal thereof.

b. If a licensed health care professional's participation will be terminated prior to the date of the termination of the contract, the carrier shall provide the health care professional with 90-days written notice of the termination and notice of a right to a hearing. If requested by the health care professional, the carrier shall provide the reasons for the termination in writing, and shall hold a hearing within 30 days of the date of the request. The hearing shall be conducted by a panel appointed by the carrier, which panel shall be comprised of a minimum of three persons, at least one of whom is a clinical peer in the same discipline and the same or similar specialty as the health care

professional being reviewed. The panel shall make a decision that: (1) the health care professional shall be terminated, or (2) the health care professional shall be reinstated or provisionally reinstated, subject to conditions set forth by the panel. The panel's determination shall be in writing and shall be made in a timely manner. Participation in this process shall not be deemed to be an abrogation of the health care professional's legal rights.

The notice required and opportunity for a hearing pursuant to this subsection shall not apply in those cases when the contract expires and is not renewed, the termination is for breach of contract, in the opinion of the medical director, the health care professional represents an imminent danger to an individual patient or the public health, safety or welfare, or there is a determination of fraud.

c. If the carrier finds that a health care professional represents an imminent danger to an individual patient or to the public health, safety or welfare, the medical director shall promptly notify the appropriate professional State licensing board. Notification to the State Board of Medical Examiners shall be subject to the provisions of section 5 of P.L.1989, c.300 (C.45:9-19.5).

9. (New section) The contract between a participating health care provider and a carrier which offers a managed care plan:

a. Shall state that the health care provider shall not be penalized or the contract terminated by the carrier because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary [1]**[**covered**]**[1] health care services;

b. Shall not provide financial incentives to the health care provider for withholding covered health care services that are medically necessary [1]**[**, in the opinion of the medical director**]**[1] [2]<u>as determined in accordance with section 6 of this act, except that nothing in this subsection shall be construed to limit the use of capitated payment arrangements between a carrier and a health care provider</u>[2]; and

c. Shall protect the ability of a health care provider to communicate openly with a patient about all appropriate diagnostic testing and treatment options.

10. (New section) a. A carrier which offers a managed care plan shall offer a point-of-service plan [1]**[**rider**]**[1] to every contract holder which would allow a covered person to receive covered services from out-of-network health care providers without having to obtain a referral or prior authorization from the carrier. The point-of-service plan [1]**[**rider**]**[1] may require that a subscriber pay a higher deductible or copayment and higher premium for the plan[1]**[**rider**]**[1], pursuant to limits established by the department, in consultation with the Department of Banking and Insurance, by regulation.

b. A carrier shall provide each subscriber in a plan whose contract holder elects the point-of-service plan [1][rider][1], with the opportunity, at the time of enrollment and during the annual open enrollment period, to enroll in the point-of-service plan option. The carrier shall provide written notice of the point-of-service plan [1][rider][1] to each subscriber in a plan whose contract holder elects the point-of-service [1][rider] plan[1] and shall include in that notice a detailed explanation of the financial costs to be incurred by a subscriber who selects that plan [1][rider][1].

c. The requirements of this section shall not apply to a carrier contract which offers a managed care plan that provides health care services to Medicaid recipients pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or a [1][carrier which offers a managed care plan that has been in operation in this State for less than three years]federally qualified, nonprofit health maintenance organization[1].

[1]d. A carrier which offers a managed care plan utilizing a selective contracting arrangement approved in accordance with N.J.A.C.11:4-37.1 et seq. that provides benefits for out-of-network providers shall be deemed to be in compliance with this section.

e. A health maintenance organization affiliated with an insurance company authorized to issue health benefits plans in this State that offers point-of-service benefits exclusively through a point-of-service plan provided by the affiliated insurance company using a selective contracting arrangement approved in accordance with N.J.A.C.11:4-37.1 et seq., shall be deemed to be in compliance with this section if the point-of-service plan is offered pursuant to the requirements of subsections a. and b.of this section.[1]

11. (New section) There is established the Independent Health Care Appeals Program in the department.

The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person. The appeal review shall not include any decisions regarding [1][pharmaceutical products or][1] benefits not covered by the covered person's health benefits plan.

a. A covered person may apply to the Independent Health Care Appeals Program for a review of a decision to deny, reduce or terminate a benefit [1][other than pharmaceutical products][1] if the person has already completed the carrier's appeals process, if any, and the person contests the final decision by the carrier. The person shall apply to the department within 60 days of the date the final decision was issued by the carrier, in a manner determined by the commissioner.

b. As part of the application, the covered person shall provide the department with:

(1) The name and business address of the carrier;

(2) A brief description of the covered person's medical condition for which benefits were denied, reduced or terminated;

(3) A copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the benefit; and

(4) A written consent to obtain any necessary medical records from the carrier and, in the case of a carrier which offers a managed care plan, any other out-of-network physician the person may have consulted on the matter.

c. The covered person shall pay the department an application processing fee of $25, except that the commissioner may reduce or waive the fee in the case of financial hardship.

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

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

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

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

organization's recommendation, the carrier shall promptly notify the covered person and the commissioner about what action the carrier will take with respect to the recommendation. If the covered person is not in agreement with the organization's findings and recommendation or the carrier's action on the recommendation, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

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

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

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

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

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

13. (New section) a. An employee of the department who participates in the Independent Health Care Appeals Program shall not be liable in any action for damages to any person for any action taken within the scope of his function in the Independent Health Care Appeals Program. The Attorney General shall defend the person in any civil suit and the State shall provide indemnification for any damages awarded.

b. The carrier that is the subject of a review shall not be liable in

any action for damages to any person for any action taken to implement a recommendation of the independent utilization review organization pursuant to this act.

14. (New section) The commissioner shall report every six months to the Senate and General Assembly standing reference committees on health and insurance and to the Governor on the status of the Independent Health Care Appeals Program. The report shall include a summary of the number of reviews conducted and medical specialties affected, a summary of the findings and recommendations made by the independent utilization review organization, any actions taken by the commissioner against a carrier pursuant to subsection d. of section 12 of this act and any other information and recommendations deemed appropriate by the commissioner.

15. (New section) a. A carrier which offers a managed care plan shall comply with department reporting requirements with respect to quality outcomes measures of health care services and independent consumer satisfaction surveys.

b. The department shall make available to members of the general public, upon request, the results of the independent consumer satisfaction survey and the analysis of quality outcomes measures of health care services provided by managed care plans in the State, prepared by the department.

16. (New section) a. A carrier that violates any provision of this act shall be liable to a civil penalty of not less than $250 and not greater than $10,000 for each day that the carrier is in violation of the act if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the carrier has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with "the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. (1) The commissioner or the Commissioner of Banking and Insurance may issue an order directing a carrier or a representative of a carrier to cease and desist from engaging in any act or practice in violation of the provisions of this act.

(2) Within 20 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. The hearing shall be conducted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) and judicial review shall be available as provided therein.

c. In the case of any violation of the provisions of this act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection b. of this section, the commissioner may institute a proceeding to obtain injunctive relief in accordance with the applicable Court Rules.

17. (New section) The commissioner and the Commissioner of Banking and Insurance shall develop recommendations for legislative action to address the issue of regulating health care or managed care entities that seek to contract directly with employers or other purchasers on a risk-assuming basis. The recommendations shall identify the type of health care or managed care entities and the scope of activities of these entities that should be subject to regulation by the State. In preparing the recommendations, the commissioners shall consider the current State statutory and regulatory requirements for health maintenance organizations and insurance companies issuing health benefits plans in the State, as well as federal legislation and laws and court rulings to determine how these health care and managed care entities that assume risk should be regulated.

The commissioners shall report their recommendations to the Senate and General Assembly standing reference committees on health and insurance and to the Governor within one year of the effective date of this act.

18. (New section) An employer who provides a comprehensive self-funded health benefits plan to his employees or their dependents in this State shall annually, and upon request of an employee at other times during the year, notify his employees that they are covered by a self-insured plan that is not subject to regulation by the State of New Jersey, and specify which mandated health insurance benefits, established by statute, are not covered by the self-insured plan. The Commissioner of Health and Senior Services shall notify the Commissioner of Labor of any health insurance mandates enacted into law, and the Commissioner of Labor shall notify employers in a timely manner of the health insurance mandates subject to the provisions of this section.

19. (New section) The commissioner shall enforce the provisions of this act.

Within six months of the effective date of this act, in consultation with the Commissioner of Banking and Insurance, the commissioner shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to carry out the purposes of this act. The regulations shall establish consumer protection and quality standards governing carriers which

offer a managed care plan or use a utilization management system that are consistent with the standards governing health maintenance organizations in the State.

The regulations shall include standards for: a quality management program; provider participation in a network; adequacy of the provider network with respect to the scope and type of health care benefits provided by the carrier, the geographic service area covered by the provider network and access to medical specialists, when appropriate; utilization management as required in this act; a covered person complaint system; a patient appeals system as required in this act; the establishment of consumer rights of covered persons; carrier disclosure as required in this act; and outcomes and data reporting requirements as required in this act.

20. (New section) The Commissioner of Banking and Insurance may conduct an examination of a health maintenance organization as often as he deems necessary in order to protect the interests of providers, contract holders, members, and the residents of this State. An organization shall make its relevant books and records available for examination by the Commissioner of Banking and Insurance, and retain its records in accordance with a schedule established by the Commissioner of Banking and Insurance by regulation. The reasonable expenses of the examination shall be borne by the organization being examined. In lieu of such examination, the Commissioner of Banking and Insurance may accept the report of an examination made by the commissioner of another state.

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

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

23. (New section) Notwithstanding the provisions of P.L.1992,

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

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

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

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

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

28. (New section) Notwithstanding the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to

establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this act unless the health maintenance organization meets the requirements of P.L. , c. (C.) (pending before the Legislature as this bill) and regulations adopted thereto. The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

29. Section 24 of P.L.1973, c. 337 (C.26:2J-24) is amended to read as follows:

24. a. The commissioner may, in lieu of suspension or revocation of a certificate of authority under section 18 hereof, levy an administrative penalty in an amount not less than [$100.00] $250 nor more than[$1,000.00] $10,000 for each day that the health maintenance organization is in violation of P.L.1973, c.337 (C.26:2J-1 et seq.), if reasonable notice in writing is given of the intent to levy the penalty [and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation, and fails to do so within said time]and, at the discretion of the commissioner, the health maintenance organization has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the conditions which gave rise to the violation, and fails to do so within the time allowed. Any such penalty may be recovered in a summary proceeding pursuant to [the Penalty Enforcement Law (N.J.S.2A:58-1 et seq.)] "the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. Any person who violates this act is a disorderly person and shall be prosecuted and punished pursuant to the "disorderly persons law" subtitle 12 of Title 2A of the New Jersey Statutes.

c. (1) If the commissioner or the Commissioner of Banking and Insurance shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner or Commissioner of Banking and Insurance may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection c. shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner or the Commissioner of Banking and Insurance may deem appropriate under the circumstances.

d. (1) The commissioner or the Commissioner of Banking and Insurance may issue an order directing a health maintenance

organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.

(2) Within 20 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. Such hearings shall be conducted pursuant to the Administrative Procedure Act, P.L.1968, c.410 (C.52:14B-1 et seq.) and judicial review shall be available as provided therein.

e. In the case of any violation of the provisions of this act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection d. of this section, the commissioner may institute a proceeding to obtain injunctive relief, in accordance with the applicable Court Rules.

(cf: P.L.1973, c.337, s.24)

30. Section 12 of P.L.1992, c.160 (C.26:2H-18.62) is amended to read as follows:

12. a. The monies in the hospital and other health care initiatives account are appropriated for the establishment of a program which will assist hospitals and other health care facilities in the underwriting of innovative and necessary health care services and provide funding for public or private health care programs, which may include any program funded pursuant to section 25 of P.L.1991, c.187 (C.26:2H-18.47), <u>managed care regulation and oversight pursuant to P.L. , c. (C.)(pending before the Legislature as this bill),</u> and for such other programs that the commissioner deems necessary or appropriate to carry out the provisions of section 5 of P.L.1992, c.160 (C.26:2H-18.55).

The commissioner shall develop equitable regulations regarding eligibility for and access to the financial assistance, within six months of the effective date of this act.

b. Such funds as may be necessary shall be transferred by the department from the fund to the Division of Medical Assistance and Health Services in the Department of Human Services for payment to disproportionate share hospitals.

c. Notwithstanding any law to the contrary, each hospital whose revenue cap was established by the Hospital Rate Setting Commission in 1993 pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) shall pay .53% of its total operating revenue to the department for deposit in the Health Care Subsidy Fund, except that the amount to be paid by a hospital in a given year shall be prorated by the department so as not to exceed the $40 million limit set forth in this subsection. The hospital shall make monthly payments to the department beginning July 1, 1993, except that the total amount paid into the Health Care

Subsidy Fund plus interest shall not exceed $40 million per year. The commissioner shall determine the manner in which the payments shall be made.

For the purposes of this subsection, "total operating revenue" shall be defined by the department in accordance with financial reporting requirements established pursuant to N.J.A.C.8:31B-3.3.

d. The monies paid by the hospitals shall be credited to the hospital and other health care initiatives account.

(cf: P.L.1995,c.133, s.8)

31. This act shall take effect on the 180th day after enactment.

Designated the "Health Care Quality Act."

SENATE, No. 269

STATE OF NEW JERSEY

Introduced Pending Technical Review by Legislative Counsel

PRE-FILED FOR INTRODUCTION IN THE 1996 SESSION

By Senators SINAGRA and MATHEUSSEN

AN ACT concerning patient protections under health benefits plans, supplementing Titles 26 and 17 of the Revised Statutes and Title 17B of the New Jersey Statutes and amending P.L.1973, c.337.

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

1. This act shall be known and may be cited as the "Health Care Quality Act."

2. (New section) As used in sections 2 through 11 of this act:

"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.

"Covered person" means a person on whose behalf a carrier or other entity offering the plan is obligated to pay benefits 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 or other entity offering the plan is obligated to pay benefits.

"Department" means the Department of Health.

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits for covered services and is delivered or issued for delivery in this State by or through a carrier or any other entity. 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, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage

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 <u>thus</u> is new matter.

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.

"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. A managed care plan may be issued by or through a carrier which assumes financial risk for the plan or any other entity that provides and finances health benefits for a covered person.

"Network contractor" means an entity that enters into a contractual arrangement with a health care provider to form a network of providers to deliver health care services to residents of this State and contracts with a payer for access to the network for the payer's managed care plan. A network contractor shall not assume financial risk for the health care services provided by the network for a managed care plan or enter into risk sharing arrangements with providers. A network contractor may contract with payers to provide utilization management and quality assurance programs and other related services.

"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 procedures, and retrospective review.

3. (New section) a. A managed care plan in effect on the effective date of this act which provides benefits to residents of this State shall file a registration form with the department within 90 days of the effective date of this act. A managed care plan established after the effective date of this act or for which corporate ownership changes

after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the plan will begin to provide benefits to residents of this State. The registration form shall be valid for two years, but the managed care plan shall notify the department within 10 business days of any change in information provided on the registration form.

b. A carrier which offers an individual or group health benefits plan to residents of this State on an indemnity basis on the effective date of this act shall file a registration form with the department within 90 days of the effective date of this act. A carrier authorized to issue health benefits plans in this State after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the carrier will begin to offer a health benefits plan to residents of this State. The registration form shall be valid for two years, but the carrier shall notify the department within 10 business days of any change in information provided on the registration form.

c. A network contractor in operation on the effective date of this act shall file a registration form with the department within 90 days of the effective date of this act. A network contractor established after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the entity will begin to offer its services in this State. The registration form shall be valid for two years, but the network contractor shall notify the department within 10 business days of any change in information provided on the registration form.

d. The commissioner shall establish a registration form for managed care plans, indemnity carriers and network contractors which shall request, at a minimum, the official address and telephone number of the place of business of the managed care plan, carrier or network contractor.

e. The filing of a registration form by a managed care plan, indemnity carrier or network contractor with the department pursuant to this act is for informational purposes only in order to enable the department to carry out the provisions of this act. The registration required pursuant to this act shall not be construed to authorize the department to regulate managed care plans, carriers or network contractors in any manner not otherwise provided by law.

f. A managed care plan, indemnity carrier or network contractor filing a registration form with the department pursuant to this act shall pay a biennial registration fee of $200.

g. A health maintenance organization which holds a certificate of authority pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be exempt from the registration requirements of this section but shall comply with the provisions of sections 2 and 4 through 21 of this act.

A health maintenance organization shall be required to comply with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this act conflict with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.), the provisions of this act shall supercede the provisions of P.L.1973, c.337

h. A carrier which issues health benefit plans utilizing a selective contracting arrangement pursuant to section 22 of P.L.1993, c.162 (C.17B:27A-54) shall be exempt from the registration requirements of this section with respect to the selective contracting arrangement, but shall comply with the provisions of sections 2 and 4 through 21 of this act.

A carrier shall be required to comply with the provisions of section 22 of P.L.1993, c.162 (C.17B:27A-54) and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this act conflict with the provisions of section 22 of P.L.1993, c.162 (C.17B:27A-54), the provisions of this act shall supercede the provisions of P.L.1993, c.162.

4. (New section) A managed care plan or indemnity carrier, as appropriate, shall disclose in writing to a policy or contract holder or enrollee, in the case of a health maintenance organization, the terms and conditions of its health benefits plan, and shall promptly notify a policy or contract holder or enrollee in writing of any changes in those terms and conditions. The policy or contract holder shall ensure that each covered person under the policy or contract is provided with a copy of the disclosure statement.

a. The information required to be disclosed pursuant to this section shall include, but need not be limited to, a description of:

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

(2) treatment policies and restrictions or limitations on covered services and benefits;

(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 benefits, including any addition, reduction or elimination of specific 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 managed care plan or carrier with respect to the denial, reduction or termination of a covered health care benefit or the denial of payment for a health care service;

(8) the procedure to initiate an appeal pursuant to the provisions

of P.L. , c. (C.)(pending before the Legislature as Senate Bill No. 1404 of 1994); and

(9) the percentage breakdown of premium dollars spent on benefits and on administration, respectively, by the carrier on insured health benefits plans issued in the State.

b. The carrier or managed care plan shall file the information required pursuant to this section with the department.

5. (New section) a. In addition to the disclosure requirements provided in section 4 of this act, a managed care plan shall disclose to a prospective covered person, in writing, the following information, and shall promptly notify a covered person in writing of any changes in the information:

(1) 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 their professional office addresses, the percentage of participating primary care physicians who are accepting new patients and the expected waiting time for an initial appointment and medical visit; and

(2) Information about the financial affiliations between participating physicians under contract with the managed care plan or network contractor, as applicable, and other participating health care providers and facilities to which the participating physicians refer their managed care patients.

b. The managed care plan shall file the information required pursuant to this section with the department.

6. (New section) a. A managed care plan shall designate a New Jersey licensed physician to serve as medical director of the plan. The medical director shall be responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan. The treatment policies, protocols, quality assurance program and utilization management decisions of the plan shall be based on nationally recognized standards of health care practice.

b. A network contractor shall maintain quality assurance and utilization management programs for the network. The network contractor may contract with a payer for use of the quality assurance and utilization management programs for the payer's managed care plan.

The network contractor shall designate a New Jersey licensed physician to serve as medical director of the network. The medical director shall be responsible for quality assurance activities and utilization management decisions of the network. The quality assurance activities and utilization management decisions shall be based on nationally recognized standards of health care practice.

c. The medical director of the plan or network shall ensure that:

(1) Any utilization management decision to deny, reduce or terminate a health care benefit or to deny payment for a health care service, because that service is not medically necessary, shall be made by a physician with knowledge in the area of the health care service. In the case of a health care service prescribed or provided by a dentist, the decision shall be made by a dentist with knowledge in the area of the health care service;

(2) A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the plan or network, as appropriate, for those services, unless the approval was based upon fraudulent information submitted by the covered person or the participating provider;

(3) A procedure is implemented whereby participating physicians and dentists have an opportunity to review and comment on all medical and surgical and dental protocols, respectively, of the plan; and

(4) The utilization management program is available on a 24-hour basis to respond to authorization requests for emergency services and is available, at a minimum, during normal working hours for inquiries and authorization requests for nonemergency health care services.

7. (New section) Each application for credentialing or participation, as appropriate, to a managed care plan or network contractor shall be reviewed by a committee of the plan or contractor that includes appropriate representation of health care professionals with knowledge in the applicant's scope of professional practice.

8. (New section) A managed care plan or network contractor shall establish a policy governing removal of health care professionals from the plan or network which includes the following:

a. The plan or contractor shall inform all participating health care professionals of the plan's or contractor's removal policy at the time the plan or contractor contracts with the health care professional to participate in the plan or network, and at each renewal thereof.

b. If a health care professional's credentialing will be withdrawn or participation terminated prior to the date of termination of the contract, the plan or contractor shall provide the professional with 90-days notice of the withdrawal or termination, unless the withdrawal or termination is for breach of contract or because the health care professional represents an imminent danger to an individual patient or to the public health, safety or welfare.

c. If the plan or contractor finds that a health care professional represents an imminent danger to an individual patient or to the public health, safety or welfare, the plan or contractor shall promptly notify the appropriate professional State licensing board.

9. (New section) A managed care plan's or network contractor's contract with a participating health care provider:

a. Shall state that the health care provider shall not be penalized or the contract terminated by the managed care plan or network contractor because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary covered health care services; and

b. Shall not provide financial incentives to the health care provider for withholding covered health care services.

10. (New section) a. A managed care plan shall offer a point-of-service plan option to every policy or contract holder which would allow a covered person to receive covered health care benefits from out-of-network providers without having to obtain a referral or prior authorization from the managed care plan. The point-of-service plan option shall require that a covered person pay a higher deductible or copayment and higher premium for the plan option, pursuant to limits established by the department by regulation.

b. A managed care plan shall provide each covered person in a plan whose policy or contract holder elects the point-of-service plan option, with the opportunity, at the time of enrollment and during the annual open enrollment period, to enroll in the point-of-service plan option. The managed care plan shall provide written notice of the point-of-service plan option to each covered person in a plan whose policy or contract holder elects the point-of-service option and shall include in that notice a detailed explanation of the financial costs to be incurred by a covered person who selects that plan option.

c. The requirements of this section shall not apply to a managed care plan which only provides health care services to Medicaid recipients.

11. (New section) A managed care plan, indemnity carrier or network contractor that violates any provision of this act shall be liable to a civil penalty of not less than $250 and not greater than $10,000 for each day the plan, carrier or contractor is in violation of the act. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with "the penalty enforcement law," N.J.S.2A:58-1 et seq.

12. (New section) The commissioner shall enforce the provisions of this act and adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to carry out the provisions of this act.

13. (New section) Notwithstanding the provisions of chapter 26 of Title 17B of the New Jersey Statutes to the contrary, no policy shall

be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

14. (New section) Notwithstanding the provisions of chapter 27 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

15. (New section) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

16. (New section) Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

17. (New section) Notwithstanding the provisions of P.L.1938, c.366 (C.17:48-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

18. (New section) Notwithstanding the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

19. (New section) Notwithstanding the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

20. (New section) Notwithstanding the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this

act unless the health maintenance organization meets the requirements of P.L. , c. (C.) (pending before the Legislature as this bill).

21. Section 24 of P.L.1973, c. 337 (C.26:2J-24) is amended to read as follows:

24. a. The commissioner may, in lieu of suspension or revocation of a certificate of authority under section 18 hereof, levy an administrative penalty in an amount not less than [$100.00] $250 nor more than[$1,000.00] $10,000 for each day the health maintenance organization is in violation of P.L.1973, c.337 (C.26:2J-1 et seq.), if reasonable notice in writing is given of the intent to levy the penalty [and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation, and fails to do so within said time]. Any such penalty may be recovered in a summary proceeding pursuant to [the Penalty Enforcement Law (N.J.S.2A:58-1 et seq.)]"the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. Any person who violates this act is a disorderly person and shall be prosecuted and punished pursuant to the "disorderly persons law" subtitle 12 of Title 2A of the New Jersey Statutes.

c. (1) If the commissioner or the Commissioner of Insurance shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner or Commissioner of Insurance may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection c. shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner or the Commissioner of Insurance may deem appropriate under the circumstances.

d. (1) The commissioner or the Commissioner of Insurance may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.

(2) Within 20 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. Such hearings shall be conducted pursuant to the Administrative Procedure Act, P.L.1968, c. 410 (C. 52:14B-1 et seq.) and judicial review shall be available as provided therein.

e. In the case of any violation of the provisions of this act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection d. of this section, the commissioner may institute a proceeding to obtain injunctive relief, in accordance with the applicable Court Rules.

(cf: P.L.1973, c.337, s.24)

22. This act shall take effect on the 180th day after enactment.

STATEMENT

This bill, which is designated the "Health Care Quality Act," provides various consumer safeguards with respect to health insurance and the operation of managed care plans.

Specifically, the bill:

• requires managed care plans, indemnity carriers and network contractors (entities that establish health care provider networks for managed care plans) to register with the Department of Health;

• requires managed care plans and indemnity carriers to disclose to covered persons, in writing, the terms and conditions of the health benefits plan, which information shall include a description of:

a. covered services and benefits to which the covered person is entitled;

b. treatment policies and restrictions or limitations on covered services and benefits;

c. financial responsibility of the covered person, including copayments and deductibles;

d. prior authorization and any other review requirements with respect to accessing covered services;

e. where and in what manner services or benefits may be obtained;

f. changes in covered benefits, including any addition, reduction or elimination of specific benefits;

g. 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 managed care plan or carrier with respect to the denial, reduction or termination of a covered health care benefit or the denial of payment for a health care service;

h. the procedure to initiate an appeal pursuant to the provisions of Senate Bill No. 1404 of 1994 which establishes the Statewide Independent Health Benefits Plan Appeals Program in the Department of Health; and

i. the percentage breakdown of premium dollars spent on benefits and on administration, respectively, by the carrier on insured health benefits plans issued in the State.

• requires managed care plans to also disclose to a prospective covered person, in writing, the following information:

a. 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 their professional office addresses, the percentage of participating primary care physicians who are accepting new patients and the expected waiting time for an initial appointment and medical visit; and

b. information about the financial affiliations between participating physicians under contract with the managed care plan and other participating health care providers and facilities, to which the participating physicians refer their managed care patients;

• requires managed care plans and network contractors to have a medical director who is a New Jersey licensed physician and who is responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan, in the case of managed care plans, and quality assurance activities and utilization management decisions, in the case of network contractors;

•requires network contractors to maintain quality assurance and utilization management programs and provides that the network contractor may contract with payers for use of the programs for their managed care plans;

• requires managed care plans and network contractors to establish a policy governing the removal of health care professionals which provides 90-days' notice for withdrawal of credentialing (if the withdrawal of credentialing occurs prior to the date of termination of the contract) unless there is a breach of contract or the health care professional represents an imminent danger to an individual patient or to the public health, safety or welfare;

• provides that a participating health care provider shall not be penalized or have his contract terminated because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary covered health care benefits and prohibits any provision in a provider's contract that provides financial incentives for withholding covered health care services;

• requires a managed care plan to offer a point-of-service option to all policy or contract holders which would allow a covered person to receive covered health care benefits from out-of-network providers without having to obtain a referral or prior authorization from the managed care plan. The covered person would be required to pay a higher deductible or copayment and higher premium for the plan option; and

• provides that the penalty for violations of the bill shall be between $250 and $10,000 for each day the violation continues and increases the penalties in the law governing health maintenance organizations, P.L.1973, c.337, to these same amounts.

Designated the "Health Care Quality Act."

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 269

STATE OF NEW JERSEY

DATED: MARCH 10, 1997

The Senate Health Committee reports favorably Senate Bill No. 269 (1R).

This substitute, which is designated the "Health Care Quality Act," provides comprehensive consumer safeguards with respect to health insurance and the operation of health maintenance organizations.

Specifically, the substitute:

• requires carriers (insurance companies, health, hospital and medical service corporations and health maintenance organizations) to disclose to a subscriber (typically an employee or individual who purchases a health benefits plan), in writing, in easily understandable language, at the time of enrollment and upon request thereafter, the terms and conditions of the health benefits plan, which information shall include a description of:

- covered services and benefits to which the subscriber or other covered person is entitled;
- restrictions or limitations on covered services and benefits;
- financial responsibility of the covered person, including copayments and deductibles;
- prior authorization and any other review requirements with respect to accessing covered services;
- where and in what manner covered services may be obtained;
- changes in covered services or benefits, including any addition, reduction or elimination of specific services or benefits;
- 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 benefit or the denial of payment for a health care service; and
- the procedure to initiate an appeal through the Independent Health Care Appeals Program in the Department of Health and Senior Services that is created in the substitute;

• requires carriers which offer managed care plans to also disclose to a subscriber, in writing, in easily understandable language, the following information at the time of enrollment and annually thereafter:

- 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 information shall include the primary care physicians' professional office addresses and any hospital affiliation the physician has. The directory also shall provide information about participating hospitals;

- 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 patients;

- the percentage of the carrier's network physicians who are board certified;

- the carrier's managed care plan's standard for customary waiting times for appointments for urgent and routine care; and

- the availability, through the Department of Health and Senior Services, of independent consumer satisfaction survey results and an analysis of quality outcomes of health care services of managed care plans in the State.

Also, upon request of a covered person, a carrier shall promptly inform the person whether a particular network physician is board certified and whether a particular network physician is currently accepting new patients;

• requires carriers which offer a managed care plan to have a medical director who is a licensed physician and who is responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the carrier.

• requires that each application from a provider for participation to a carrier which offers a managed care plan shall be reviewed by a committee of the carrier that includes appropriate representation of providers with knowledge in the applicant's scope of professional practice;

• requires carriers to establish a policy governing the removal of health care providers. In the case of licensed health care professionals, the policy shall provide 90-days written notice for termination (if the termination occurs prior to the date of termination of the contract), unless there is a breach of contract, the health care professional represents an imminent danger to an individual patient or to the public health, safety or welfare, or there is a determination of fraud. Upon request of the professional, the carrier is required to give the professional the reasons for the termination and an opportunity for a hearing before a three-member panel appointed by the carrier, at least one member of which is a clinical peer in the same discipline and same or similar specialty as the health care professional being reviewed;

• provides that a participating health care provider shall not be penalized or have his contract terminated because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary covered health care services, and prohibits any

provision in a provider's contract that provides financial incentives for withholding covered health care services that are medically necessary, in the opinion of the medical director. Also, the contract shall protect the ability of a health care provider to communicate openly with a patient about all appropriate diagnostic testing and treatment options;

• requires carriers which offer a managed care plan to offer a point-of-service plan rider to all contract holders (typically an employer or purchaser of a health benefits plan) which would allow a covered person to receive covered health care services from out-of-network providers without having to obtain a referral or prior authorization from the carrier. The subscriber may be required to pay a higher deductible or copayment and higher premium for the rider;

• establishes the Independent Health Care Appeals Program in the Department of Health and Senior Services to ensure that carriers which are under increasing pressure to contain costs, do not achieve their cost containment goals by providing less care than is medically appropriate. The program will provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person. Under the program, the Commissioner of Health and Senior Services will contract with one or more independent utilization review organizations in the State that meet the requirements of this substitute to conduct the appeal reviews. All carriers would be required to provide the department with a description of the carrier's internal patient appeals process available to covered persons to contest a denial, reduction or termination of benefits.

The appeals program will not require carriers to provide services not otherwise covered under the health benefits plan, and the program will not consider appeals about coverage of particular pharmaceutical products; it will focus only on covered services. The program would be funded by the carriers based on a schedule of fees established by the commissioner;

• requires a carrier which offers a managed care plan to comply with Department of Health and Senior Services reporting requirements with respect to quality outcomes measures of health care services and independent consumer satisfaction surveys. The department will make available to the public, results of the surveys and its analysis of the quality outcomes measures to enable consumers to choose the most appropriate health benefits plan. Funding for department oversight and administration of the provisions of the substitute and the independent consumer satisfaction surveys and analyses of outcome measures will come from the hospital and other health care initiatives account in the Health Care Subsidy Fund pursuant to section 12 of P.L.1992, c.160 (C.26:2H-18.62);

• provides that the penalty for violations of the substitute shall be between $250 and $10,000 for each day that the violation continues, and increases the penalties in the law governing health maintenance

organizations, P.L.1973, c.337, to these same amounts. The substitute also provides that reasonable notice in writing be given to the carrier of the intent to levy the penalty and, at the discretion of the commissioner, the carrier would have 30 days or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation;

• supplements the "Health Maintenance Organizations Act" to authorize the Commissioner of Banking and Insurance to conduct an examination of a health maintenance organization as often as he deems necessary in order to protect the interests of providers, contract holders, members, and the residents of this State;

• require employers in the State who provide a comprehensive self-funded health benefits plan to their employees to annually notify the employees that they are covered by a self-insured plan that is not subject to regulation by the State, and specify which mandated health insurance benefits, such as a minimum of 48 or 96 hours inpatient care following childbirth and benefits for treatment of diabetes, are covered by the self-insured plan; and

• directs the Commissioners of Health and Senior Services and Banking and Insurance to develop recommendations and report to the Legislature and Governor within one year on the issue of regulating health care or managed care entities that seek to contract directly with employees or other purchasers on a risk-assuming basis.

As reported by the committee, this substitute is identical to the Assembly Committee Substitute for Assembly Bill Nos. 2420, 2623 and 2668 which was reported by the Assembly Health Committee on March 10, 1997.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 269

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 14, 1996

The Senate Health Committee reports favorably Senate Bill No. 269 with committee amendments.

As amended by committee, this bill, which is designated the "Health Care Quality Act," provides various consumer safeguards with respect to health insurance and the operation of managed care plans.

Specifically, the bill:

• requires managed care plans, indemnity carriers and network contractors (entities, such as preferred provider organizations or PPOs, that establish health care provider networks for managed care plans) to register with the Department of Health;

• requires managed care plans and indemnity carriers to disclose to covered persons, in writing, in easily understandable language, at the time of enrollment and annually thereafter, the terms and conditions of the health benefits plan, which information shall include a description of:

a. covered services and benefits to which the covered person is entitled;

b. treatment policies and 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 services;

c. financial responsibility of the covered person, including copayments and deductibles;

d. prior authorization and any other review requirements with respect to accessing covered services;

e. where and in what manner services or benefits may be obtained;

f. changes in covered benefits, including any addition, reduction or elimination of specific benefits;

g. 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 managed care plan or carrier with respect to the denial, reduction or termination of a covered health care benefit or the denial of payment for a health care service;

h. the procedure to initiate an appeal pursuant to the provisions of Senate Bill No. 266 of 1996 which establishes the Statewide Independent Health Benefits Plan Appeals Program in the Department of Health; and

i. such other information as the commissioner shall require.

• requires managed care plans to also disclose to a prospective covered person, in writing, in easily understandable language, the following information at the time of enrollment and annually thereafter:

a. a 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 their professional office addresses;

b. general information about the financial incentives between participating physicians under contract with the managed care plan and other participating health care providers and facilities to which the participating physicians refer their managed care patients;

c. The percentage of the managed care plan's network physicians who are board certified; and

d. The managed care plan's standard for customary waiting times for appointments for urgent and routine care.

Also, upon request of a covered person, a managed care plan shall promptly inform the person whether a particular network physician is board certified and whether a particular network physician is currently accepting new patients.

• requires managed care plans and network contractors to have a medical director who is a licensed physician and who is responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan, in the case of a managed care plan, and quality assurance activities and utilization management decisions, in the case of a network contractor. The medical director, or his designee, shall be a New Jersey licensed physician and shall be designated to serve as the medical director for medical services provided to covered persons in the State. Also, quality assurance and utilization management programs shall be in accordance with standards adopted by the Department of Health;

• requires network contractors to maintain quality assurance and utilization management programs and provides that the network contractor may contract with payers for use of the programs for their managed care plans;

• requires managed care plans and network contractors to establish a policy governing the removal of health care providers which provides 90-days' notice for withdrawal of credentialing (if the withdrawal of credentialing occurs prior to the date of termination of the contract), unless there is a breach of contract or, in the opinion of the medical director, the health care provider represents an imminent danger to an individual patient or to the public health, safety or welfare;

• provides that a participating health care provider shall not be

penalized or have his contract terminated because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary covered health care benefits, and prohibits any provision in a provider's contract that provides financial incentives for withholding covered health care services that are medically necessary, in the opinion of the medical director. Also, the contract shall protect the ability of a health care provider to communicate openly with a patient about all appropriate diagnostic testing and treatment options;

• requires a managed care plan to offer a point-of-service option rider to all policy or contract holders which would allow a covered person to receive covered health care benefits from out-of-network providers without having to obtain a referral or prior authorization from the managed care plan. The covered person may be required to pay a higher deductible or copayment and higher premium for the plan option; and

• provides that the penalty for violations of the bill shall be between $250 and $10,000 for each day the violation continues and increases the penalties in the law governing health maintenance organizations, P.L.1973, c.337, to these same amounts. The bill also provides that reasonable notice in writing be given to the managed care plan, network contractor, indemnity carrier or health maintenance organization of the intent to levy the penalty and the managed care plan, indemnity carrier, network contractor or health maintenance organization would have 30 days or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation.

The committee amended the bill to:

- clarify the definition of "network contractor;"

- require that the managed care plan's or carrier's disclosure information for covered persons be written in easily understandable language and clarify when the information shall be provided to covered persons;

- delete the requirement that the plans disclose the percentage breakdown of premium dollars spent on benefits and on administration;

- add additional disclosure requirements concerning participating providers that must be provided to covered persons, including the percentage of the managed care plan's physicians who are board certified and the plan's standard for customary waiting times for appointments for urgent and routine care. Also, upon request, a plan will be required to inform a covered person whether a particular network physician is board certified or is currently accepting new patients;

- clarify that the medical director, or his designee, shall be a New Jersey licensed physician and shall be designated to serve as the medical director for medical services provided to residents of this State;

- require that quality assurance and utilization management programs shall be in accordance with standards adopted by the

Department of Health;

- clarify that utilization management decisions to deny, reduce or terminate a health care benefit shall be made by a physician with knowledge in the area of the health care practice, rather than the health care service, as the bill originally provided;

- provide that a managed care plan or network contractor establish a policy governing removal of health care providers, which includes hospitals and other health care facilities, as well as health care professionals. The bill originally provided that the policy cover only health care professionals;

- provide that contracts with participating providers also protect the ability of health care providers to communicate openly with patients about all appropriate testing and treatment options;

- clarify, regarding the point of service requirement, that a managed care plan shall offer the option as a rider to the basic managed care plan and exempt managed care plans that have been in operation for less than three years from the requirement to offer the point of service option; and

- provide managed care plans, network contractors, indemnity carriers and health maintenance organizations with notice of violations and 30 days to remedy the defect before a fine is levied by the Commissioner of Health.

This bill was prefiled for introduction in the 1996-97 session pending technical review. As reported, the bill includes the changes required by technical review which has been performed.

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 269

with Senate Floor Amendments
(Proposed By Senator SINAGRA)

ADOPTED: MAY 22, 1997

These amendments clarify the language of section 7 of the substitute with respect to health care professionals' applications to participate in a carrier's managed care plan.

Amendments clarify that a carrier's contract with a health care provider shall state that the health care provider shall not be penalized or the contract terminated by the carrier because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary health care services, rather than covered health care services, as the substitute originally provided. Amendments also delete the phrase "in the opinion of the medical director" with respect to the prohibition on carrier contracts that provide financial incentives to withhold medically necessary services.

Amendments clarify that "point-of-service" may only be offered as a plan, deleting the term rider, to conform the substitute with recently adopted health maintenance organization (HMO) regulations and Department of Banking and Insurance policy. The amendments also exempt federally qualified, nonprofit HMOs from the requirement to offer the point-of-service plan and delete the exemption from this requirement for managed care plans that have been in operation in this State for less than three years.

Amendments provide that a carrier which offers a managed care plan utilizing a selective contracting arrangement approved in accordance with Department of Banking and Insurance regulations, that provides benefits for out-of-network providers, shall be deemed to be in compliance with this requirement. Also, an HMO affiliated with an insurance company authorized to issue health benefits plans in this State that offers point-of-service benefits exclusively through a point-of-service plan provided by the affiliated insurance company using a selective contracting arrangement, shall be deemed to be in compliance with this requirement if it offers the point-of-service plan to every contract holder as required in the substitute.

Amendments delete the provision that pharmaceutical products are not subject to the Independent Health Care Appeals Program. This amendment conforms the appeals program with the provisions of recently adopted HMO regulations.

Amendments also provide that the independent utilization review organization in the Independent Health Care Appeals Program shall

base its medical necessity reviews on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier, rather than available practice guidelines, as the substitute originally provided. This amendment conforms the provisions of the substitute with recently adopted HMO regulations governing independent patient appeals.

STATEMENT TO

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 269

with Assembly Floor Amendments
(Proposed By Assemblywoman VANDERVALK)

ADOPTED: JUNE 19, 1997

This amendment to subsection b. of section 9 of this committee substitute concerns the prohibition in a contract between a participating health care provider and a carrier offering a managed care plan against financial incentives for the provider to withhold medically necessary covered health care services.

The amendment provides that the medical necessity of covered health care services shall be determined in accordance with section 6 of the substitute, except that nothing in this subsection shall be construed to limit the use of capitated payment arrangements between a carrier and a health care provider.

OFFICE OF THE GOVERNOR
NEWS RELEASE

CN-004
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609 777-2600

TRENTON, NJ 08625
RELEASE: THURSDAY,
August 7, 1997

Gov. Christie Whitman Signs Act
To Extend State HMO Consumer Protections to 1 Million More New Jerseyans

Gov. Christie Whitman today signed the Health Care Quality Act extending the state's HMO consumer protections to more than one million additional New Jerseyans covered by other forms of managed health care.

As well as bringing all managed care consumers under the same umbrella of protections, the new law also offers important benefits to senior citizens, physicians, members of self-funded insurance plans, and to consumers in traditional fee-for-service health care.

"I am proud to say that New Jersey is a leader in guarding consumers against the abuses of managed care," Whitman said. "The new HMO regulations, which we adopted in March and which protect about 2 million New Jerseyans, have become a national model for putting patients first."

"Today, we extend those first-class protections to another one million New Jerseyans in about three dozen different managed care plans offered by health insurance companies. Through the Health Care Quality Act, we will be able to assure more New Jersey families that they will get the medical treatment -- and the fair treatment -- they deserve."

The new legislation was sponsored by Senators Jack Sinagra (R-Middlesex) and John J. Matheussen (R-Camden/Gloucester) and Assembly Members Charlotte Vandervalk (R-Bergen); Paul DiGaetano (R-Bergen/Essex/Passaic); Neil M. Cohen (D-Union); Barbara Wright (R-Mercer/Middlesex); Paul Kramer (R-Mercer/Middlesex) and Joseph V. Doria, Jr. (D-Hudson). It covers HMOs as well as managed care plans sponsored by insurance companies. Thirty five health insurance companies that contract with preferred provider organizations (PPOs) will also be subject to the law.

"The new HMO rules have made a difference to consumers and this new law will, too," said Health and Senior Services Commissioner Len Fishman. "Although the HMO rules have been in effect for just a few months, we are getting more calls than we did previously from consumers because they are becoming more aware of their rights."

(more)

Among the protections offered by the Health Care Quality Act are:

* Consumers have the right to appeal to an independent organization when medically necessary care that is a covered by the consumer's health insurance plan has been denied or limited.

* A managed care company's medical director, who is charged with decisions regarding the denial or limitation of medical services, must be a licensed physician.

* The so-called "gag rule" has been eliminated. Doctors may discuss the full range of treatment options, even if they are not covered services.

* Doctors may appeal to a three-physician panel any decision to prematurely terminate their contract. They may also request the reason for their termination in writing.

"This bill will protect doctors from having their managed care contracts unfairly terminated because they advocated medical treatment their patients need," Whitman said. "While it's important to keep medical costs under control, we can't allow anything to compromise the special relationship between a patient and his or her doctor. And when doctors are prematurely terminated, they will have the right to appeal and request reasons for termination in writing."

The law also offers assistance to consumers in traditional fee for service health plans, as well as those who receive their health benefits through an employer's self-funded plan. Those with traditional health coverage can now file an independent appeal of decisions to limit or deny medically necessary care. They also have the right to have these decisions made only by a physician.

About one-third of insured New Jerseyans receive health benefits through an employer's self-funded plan. Although federal law prohibits states from regulating these plans, this law requires employers to notify employees that they are covered by a self-funded plan. Employers must also disclose which of the state-mandated health insurance benefits, such as the minimum hospital stay for maternity or mastectomy, are not covered by the plan.

Seniors in Medicare HMOs are already covered by the state's HMO regulations. However, this new law will protect even more seniors now that the federal Balanced Budget Act of 1997 allows Medicare to offer beneficiaries additional managed care options.

As is the case with regulation of HMOs, the departments of Insurance and Health and Senior Services will share oversight of the other types of managed care organizations as a result of this bill. The Department of Health and Senior Services will monitor access and quality of care and the Department of Insurance will monitor fiscal matters and other insurance-related issues.

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MANAGED CARE CONSUMER
BILL of RIGHTS

The right to obtain a current directory of doctors within the network

The right to have a choice of specialists following a referral

The right for consumers with chronic disabilities to be referred to specialists who are experienced in treating their disabilities

The right to have access to a primary care provider or a back-up 24 hours a day, 365 days a year for urgent care

The right to call 911 in a potentially life-threatening situation without prior approval from your HMO

The right to have an HMO pay for a medical screening exam in the emergency room to determine whether an emergency medical condition exists

The right to receive up to 120 days of continued coverage - if medically necessary - from a doctor who has been terminated by an HMO

The right to have a doctor make the decision to deny or limit your coverage

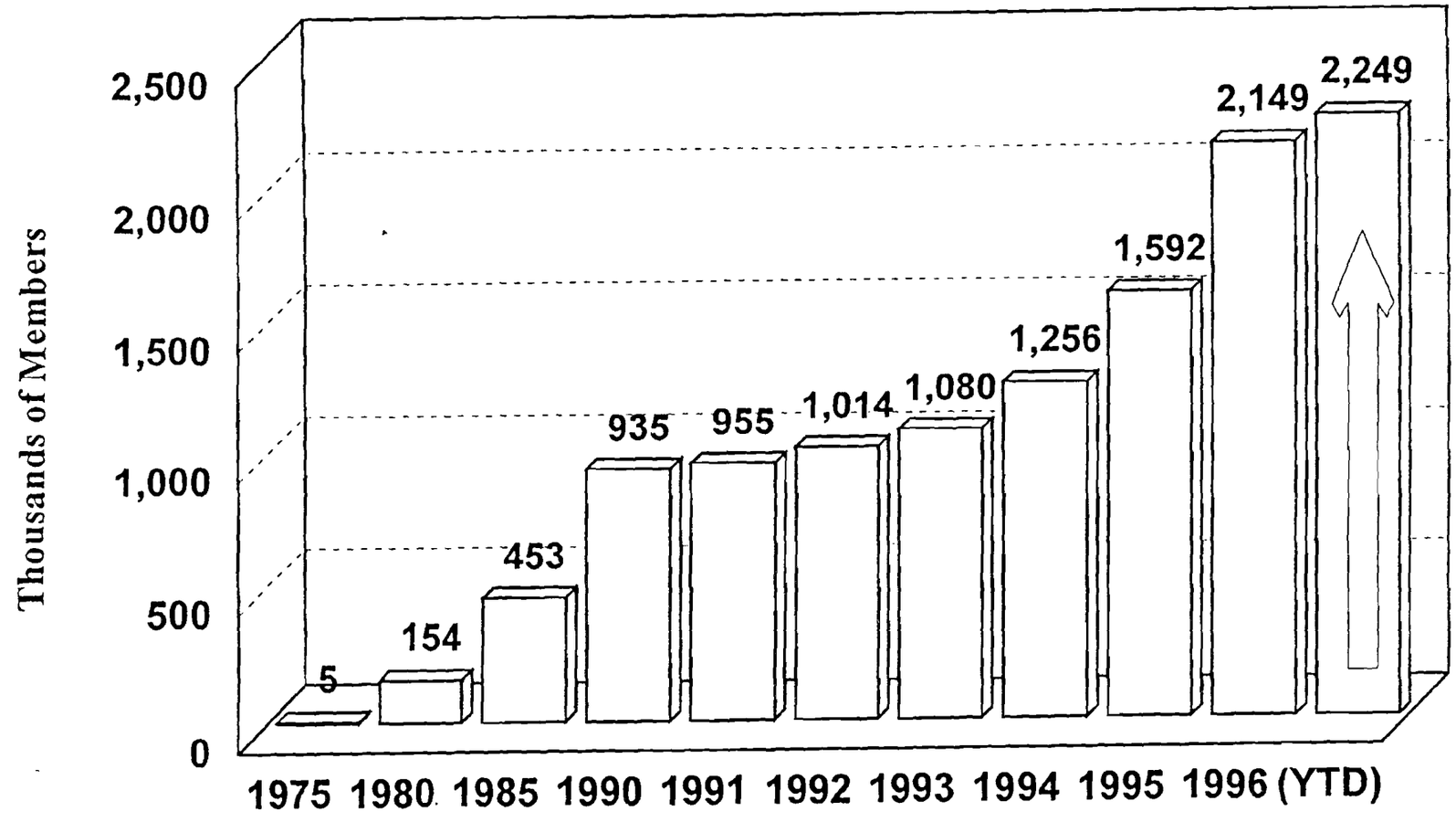
The right to have no "gag rules" in your HMO. Doctors are free to discuss all medical treatment options, even if they are not covered services

The right to know how your HMO pays their doctors, so you know if there are financial incentives or disincentives tied to medical decisions

The right to appeal a decision to deny or limit coverage, first within the HMO and then through an independent organization for a $25 filing fee

The right to know you or your doctor cannot be penalized for filing a complaint or appeal

ENROLLMENT GROWTH IN NJ HMOs
1975-1997



MEDICARE HMO GROWTH