ASSEMBLY, No. 339

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:
Assemblywoman NANCY J. PINKIN
District 18 (Middlesex)

SYNOPSIS

Transfers regulatory authority over managed care plans from DOBI to DOH.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

AN ACT concerning managed care plans and amending various parts of the statutory law.

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

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

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

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

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

"Commissioner" means the Commissioner of **[**Banking and Insurance**]** Health.

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

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

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

"Department" means the Department of **[**Banking and Insurance**]** Health.

"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

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.

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

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

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

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

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

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

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

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

review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.
(cf: P.L.2012, c.17, s.294)

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

3. 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**]** Health. 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**]** Health. 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 supersede 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 supersede the provisions of section 22 of P.L.1993, c.162.
(cf: P.L.1997, c.192, s.3)

3. Section 1 of P.L.2001, c.88 (C.26:2S-7.1) is amended to read as follows:

1. The Commissioner of ⟦Banking and Insurance⟧ Health, in consultation with the New Jersey Association of Health Plans, the Health Insurance Association of America, the Medical Society of New Jersey, the New Jersey Hospital Association, and such other representatives of managed care plans as the commissioner deems appropriate, shall adopt by regulation, a universal physician application for participation form for use by carriers which offer managed care plans for the purpose of credentialing physicians who seek to participate in a carrier's provider network and for the purpose of credentialing physicians who are employed by hospitals or other health care facilities which seek to participate in a carrier's provider network.

The commissioner, in consultation with the New Jersey Association of Health Plans, the Health Insurance Association of America, the Medical Society of New Jersey, the New Jersey Hospital Association and such other representatives of managed care plans as the commissioner deems appropriate, shall also adopt by regulation a form for renewal of credentialing, which shall be an abbreviated version of the universal application form. The renewal form shall be designed to enable a physician to indicate changes in the information provided in the application form.

The commissioner shall revise the universal application and renewal forms, as necessary, to conform with industry-wide, national standards for credentialing.

In developing the forms, the commissioner shall consult with the Commissioner of Human Services to ensure that the credentialing requirements for participation in the Medicaid program, established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), and the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) are adequately reflected on the application and renewal forms.

(cf: P.L.2012, c.17, s.295)

4. Section 3 of P.L.2001, c.88 (C.26:2S-7.3) is amended to read as follows:

3. The Commissioner of ⟦Banking and Insurance⟧ Health shall adopt regulations within 180 days of the date of enactment of this act, 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.

(cf: P.L.2012, c.17, s.296)

5. Section 2 of P.L.2005, c.286 (C.26:2S-9.3) is amended to read as follows:

2. A carrier which violates any provision of this act shall be liable to a penalty of not more than $1,000 for each violation. Each failure to timely respond to a health care provider's request for a fee schedule shall be considered a separate violation. The penalty shall

be collected by the Commissioner of [Banking and Insurance] Health in the name of the State in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).
(cf: P.L.2005, c.286, s.2)

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

10. a. A carrier which offers a managed care plan shall offer a point-of-service plan 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 may require that a subscriber pay a higher deductible or copayment and higher premium for the plan, pursuant to limits established by the department, in consultation with the Department of [Banking and Insurance] Health, by regulation.

b. A carrier shall provide each subscriber in a plan whose contract holder elects the point-of-service plan, 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 to each subscriber in a plan whose contract holder elects the point-of-service plan and shall include in that notice a detailed explanation of the financial costs to be incurred by a subscriber who selects that plan.

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 federally qualified, nonprofit health maintenance organization.

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.
(cf: P.L.1997, c.192, s.10)

7. Section 1 of P.L.2000, c.121 (C.26:2S-10.1) is amended to read as follows:

1. A carrier which offers a managed care plan that provides benefits or health care services, as applicable, for the home treatment of bleeding episodes associated with hemophilia, including the purchase of blood products and blood infusion equipment, shall comply with the provisions of this section.

a. For the purpose of providing home treatment services for bleeding episodes associated with hemophilia, the carrier shall be required to contract with, and exclusively use, providers that comply with standards adopted by regulation of the Department of **[**Banking and Insurance**]** Health in consultation with the Hemophilia Association of New Jersey. At a minimum, the standards shall require that each provider:

(1) provide services pursuant to a prescription from the covered person's attending physician and not make any substitutions of blood products without prior approval of the attending physician;

(2) provide all brands of clotting factor products in low, medium and high-assay range levels to execute treatment regimens as prescribed by a covered person's attending physician, and all needed ancillary supplies for the treatment or prevention of bleeding episodes, including, but not limited to, needles, syringes, and cold compression packs;

(3) have the ability to deliver prescribed blood products, medications, and nursing services within three hours after receipt of a prescription for an emergent situation, and maintain 24-hour on-call service to accommodate this requirement;

(4) demonstrate experience with and knowledge of bleeding disorders and the management thereof;

(5) demonstrate the ability for appropriate and necessary record keeping and documentation, including the ability to expedite product recall or notification systems and the ability to assist covered persons in obtaining third party reimbursement;

(6) provide for proper removal and disposal of hazardous waste pursuant to State and federal law;

(7) provide covered persons with a written copy of the agency's policy regarding discontinuation of services related to loss of health benefits plan coverage or inability to pay; and

(8) provide covered persons, upon request, with information about the expected costs for medications and services provided by the agency that are not otherwise covered by the covered person's health benefits plan.

b. The Department of **[**Banking and Insurance**]** Health shall compile a list of providers who meet the minimum standards established pursuant to this section and shall make the list available to carriers and covered persons, upon request.

c. As used in this section: "blood product" includes, but is not limited to, Factor VIII, Factor IX and cryoprecipitate; and "blood infusion equipment" includes, but is not limited to, syringes and

needles.
(cf: P.L.2012, c.17, s.297)

8. Section 11 of P.L.2000, c.121 (C.26:2S-10.3) is amended to read as follows:

11. The Department of [Banking and Insurance] Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt regulations to carry out the provisions of sections 1 and 2 of this act.
(cf: P.L.2012, c.17, s.298)

9. Section 3 of P.L.2011, c.190 (C.26:2S-14.2) is amended to read as follows:

3. The Commissioner of [Banking and Insurance] Health, in consultation with the Commissioner of [Health] Banking and Insurance and the State Board of Medical Examiners, shall prescribe the size, content, and format of the notice about the Independent Health Care Appeals Program to be posted in general hospitals pursuant to section 1 of P.L.2011, c.190 (C.26:2S-14.1) and in physicians' medical offices pursuant to section 2 of P.L.2011, c.190 (C.45:9-22.26), and shall make the notice available to general hospitals and physicians, and to members of the general public, by posting it on the Internet website of the Department of [Banking and Insurance] Health.
(cf: P.L.2012, c.17, s.300)

10. Section 2 of P.L.2001, c.14 (C.26:2S-20) is amended to read as follows:

2. As used in this act:

"Carrier" means a carrier as defined in section 2 of P.L.1997, c.192 (C.26:2S-2).

"Commissioner" means the Commissioner of [Banking and Insurance] Health.

"Department" means the Department of [Banking and Insurance] Health.

"Managed care plan" means a managed care plan as defined in section 2 of P.L.1997, c.192 (C.26:2S-2).

"Medicaid" means the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Medicare" means the federal Medicare program established pursuant to the federal Social Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.).

"NJ FamilyCare" means the FamilyCare Health Coverage Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

"Program" means the Managed Health Care Consumer Assistance Program established pursuant to this act.
(cf: P.L.2012, c.17, s.302)

11. Section 3 of P.L.2001, c.14 (C.26:2S-21) is amended to read as follows:

3. a. There is established the Managed Health Care Consumer Assistance Program in the Department of **[**Banking and Insurance**]** Health. The commissioner shall make agreements to operate the program as necessary, in consultation with the Commissioner of Human Services, to assure that citizens have reasonable access to services in all regions of the State.

b. The program shall:

(1) create and provide educational materials and training to consumers regarding their rights and responsibilities as enrollees in managed care plans, including materials and training specific to Medicaid, NJ FamilyCare, Medicare, and commercial managed care plans;

(2) assist and educate individual enrollees about the functions of the State and federal agencies that regulate managed care products, assist and educate enrollees about the various complaint, grievance, and appeal processes, including State fair hearings, provide assistance to individuals in determining which process is most appropriate for the individual to pursue when necessary, maintain and provide to individual enrollees the forms that may be necessary to submit a complaint, grievance or appeal with the State or federal agencies, and provide assistance to individual enrollees in completion of the forms, if necessary;

(3) maintain and provide information to individuals upon request about advocacy groups, including legal services programs Statewide and in each county that may be available to assist individuals, and maintain lists of State and Congressional representatives and the means by which to contact representatives, for distribution upon request;

(4) maintain a toll-free telephone number for consumers to call for information and assistance. The number shall be accessible to the deaf and hard of hearing, and staff or translation services shall be available to assist non-English proficient individuals who are members of language groups that meet population thresholds established by the department;

(5) ensure that individuals have timely access to the services of, and receive timely responses from, the program;

(6) provide feedback to managed care plans, beneficiary advisory groups and employers regarding enrollees' concerns and problems;

(7) provide nonpartisan information about federal and State activities relative to managed care, and provide assistance to individuals in obtaining copies of pending legislation, statutes, and regulations; and

(8) develop and maintain a data base monitoring the degree of each type of service provided by the program to individual enrollees, the types of concerns and complaints brought to the

program and the entities about which complaints and concerns are brought.

c. In order to meet its objectives, the program shall have access to:

(1) the medical and other records of an individual enrollee maintained by a managed care plan, upon the specific written authorization of the enrollee or his legal representative;

(2) the administrative records, policies, and documents of managed care plans to which individuals or the general public have access; and

(3) all licensing, certification, and data reporting records maintained by the State or reported to the federal government by the State that are not proprietary information or otherwise protected by law, with copies thereof to be supplied to the program by the State upon the request of the program.

d. The program shall take such actions as are necessary to protect the identity and confidentiality of any complainant or other individual with respect to whom the program maintains files or records. Any medical or personally identifying information received or in the possession of the program shall be considered confidential and shall be used only by the department, the program and such other agencies as the commissioner designates and shall not be subject to public access, inspection or copying under P.L.1963, c.73 (C.47:1A-1 et seq.) or the common law concerning access to public records. This subsection shall not be construed to limit the ability of the program to compile and report non-identifying data pursuant to paragraph (8) of subsection b. of this section.

e. The program shall seek to coordinate its activities with consumer advocacy organizations, legal assistance providers serving low-income and other vulnerable health care consumers, managed care and health insurance counseling assistance programs, and relevant federal and State agencies to assure that the information and assistance provided by the program are current and accurate.

f. Until such time as the program is developed, the commissioner shall make agreements with two independent, private nonprofit consumer advocacy organizations, which shall be the Community Health Law Project and New Jersey Protection and Advocacy, Inc. to operate the program on an interim basis. The interim program shall be in effect for one year from the effective date of this act. Any appropriation in this act for the program may be allocated for the interim program.

(cf: P.L.2012, c.17, s.303)

12. Section 8 of P.L.2001, c.14 (C.26:2S-25) is amended to read as follows:

8. The Commissioner of **[**Banking and Insurance**]** <u>Health</u>, pursuant to the "Administrative Procedure Act," P.L.1968, c.410

(C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.
(cf: P.L.2012, c.17, s.304)

13. This act shall take effect on the first day of the seventh month next following the date of enactment, except that the Commissioner of Health and the Commissioner of Banking and Insurance may take anticipatory administrative action in order to implement this act.

STATEMENT

This bill would transfer authority to implement the "Health Care Quality Act," which concerns managed care functions of health insurance plans, from the Department of Banking and Insurance to the Department of Health.

When it was signed into law in 1997, the "Health Care Quality Act" granted responsibility for regulating managed care to the Department of Health. That function, along with other functions related to health insurance, was shifted to the Department of Banking and Insurance in 2005 under Executive Reorganization Plan No. 005-2005. Since that time, the Department of Banking and Insurance has been responsible for regulating health insurance plans with respect to both their financial adequacy and their role in the health care system.

This bill would separate these two regulatory functions: the Department of Banking and Insurance would continue to license health insurers and would be responsible for ensuring they are able to pay claims. The Department of Health would oversee managed care functions, which include but are not limited to: requiring certain disclosures by carriers to subscribers; establishing rules for adding and removing providers from carriers' networks and other aspects of the contractual relationship between a carrier and a provider; operating the Independent Health Care Appeals Program; and operating the Managed Health Care Consumer Assistance Program.