ASSEMBLY, No. 317

STATE OF NEW JERSEY

212th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2006 SESSION

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SYNOPSIS

Requires managed care companies to pay health care claims based on assignment of benefits and disclosed fee schedules; requires coverage under certain conditions; authorizes civil actions against violators.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel

AN ACT concerning managed care plans, amending P.L.2001, c.367 and amending and supplementing P.L.1997, c.192.

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

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

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

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

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

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

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

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

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

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical community, recommendations made by or views held by physician specialty societies or physicians practicing in the relevant clinical areas, or any other relevant factor.

"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,

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.

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.

"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his prudent clinical judgement, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, condition or its symptoms and that is in accordance with generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the covered person's illness, injury or disease; and not more costly than an alternative health care service or sequence of services at least as likely to produce an equivalent therapeutic or diagnostic result as to the diagnosis or treatment of the covered person's illness, injury or condition.

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

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

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

2. Section 2 of P.L.2001, c.367 (C.26:2S-6.1) is amended to

read as follows:

2. a. With respect to a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits, in the event that:

(1) a covered person is admitted by an out-of-network health care provider to an in-network health care facility for covered, medically necessary health care services, [or]

(2) the covered person receives covered, medically necessary health care services from an out-of-network health care provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider, the carrier shall reimburse the health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan, or

(3) the covered person assigns, through an assignment of benefits, his right to receive reimbursement for medically necessary health care services to an out-of-network health care provider, the carrier shall remit payment for the reimbursement directly to the health care provider in accordance with the provisions of this section and P.L.1999, c.154 (C.17B:30-23 et seq.). Any payment made to the covered person rather than the health care provider under these circumstances shall be considered overdue and subject to an interest charge pursuant to P.L.1999, c.154 (C.17B:30-23 et seq.).

b. The provisions of this section shall apply only if the covered person complies with the preauthorization or review requirements of the health benefits plan regarding the determination of medical necessity to access in-network inpatient benefits, as set forth in writing pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

(cf: P.L.2001, c.367, s.2)

3. Section 9 of P.L.1997, c.192 (C.26:2S-9) is amended to read as follows:

9. 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 health care services;

b. Shall not provide financial incentives to the health care provider for withholding covered health care services that are medically necessary 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; [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;

d. Shall state that any change in the carrier's policy concerning the medical necessity of administering a particular treatment, including, but not limited to the administration of a particular medication, for a particular chronic medical condition, shall not affect the coverage of that treatment being given under a health care provider's supervision to a covered person who has the particular chronic medical condition, unless the covered person's health care provider has approved the administration of the alternative treatment that would be covered by the carrier; and

e. Shall state that if a person has been receiving treatment for a particular chronic medical condition prior to the time the person becomes covered under a managed care plan offered by a carrier, the carrier shall cover the treatment if it is recommended by the covered person's health care provider, regardless of the carrier's policy of the medical necessity of the treatment for that particular medical condition, unless the covered person's health care provider approves the administration of the alternative treatment that would be covered by the carrier.

(cf: P.L.1997, c.192, s.9)

4. (New section) If a covered person is under the care of a specialty physician and that physician determines that further tests are medically necessary to diagnose or treat an illness, injury or condition, no carrier that offers a managed care plan shall require the covered person's primary care physician to order or be involved with the test in order for the test to be covered under the managed care plan.

5. (New section) a. A carrier which offers a managed care plan that negotiates with a health care provider to become a participating provider shall furnish the health care provider with a written fee schedule, which may be in an electronic format if agreed upon by both parties, showing the fees for in-network health care services described by the evaluation and management codes applicable to the health care provider's specialty or subspecialty. A carrier which offers a managed care plan shall furnish a participating health care provider with a written fee schedule, which may be in an electronic format if agreed upon by both parties, showing the fees for every in-network health care service delivered to a covered person that was subject to a claim submitted in the previous calendar year by the health care provider for reimbursement under an existing contract between the carrier and health care provider.

If the carrier negotiates with the health care provider to become a

participating provider under more than one managed care plan offered by the carrier, the carrier shall provide the applicable fee schedule for each plan. If the carrier negotiates a fee schedule with a health care provider that is specific to the health care provider, the carrier shall provide only the applicable fee schedule for that health care provider. If the rate that the health care provider will be paid is a percentage of another rate, it shall be sufficient for the carrier to provide that formula to the health care provider.

b. The carrier shall reimburse the participating health care provider in accordance with the fee schedule provided to the health care provider pursuant to this section.

c. No carrier shall revise a fee schedule more than once a year and shall give the participating health care provider written notice of any change to the fee schedule 90 days prior to the effective date of the change. The participating provider may, within 30 days of receiving the written notice, terminate or provide notice of its intent to terminate its contract with the carrier effective on the date the change in the fee schedule becomes effective.

d. The fee schedule provided to the health care provider pursuant to this section is proprietary and shall be confidential. Unauthorized distribution of a fee schedule may result in the health care provider's termination from the network as provided by regulation of the commissioner.

6. (New section) a. (1) A covered person, a health care provider, a professional organization representing a health care provider, the State, any political subdivision of the State and any agency or instrumentality of the State or of any political subdivision of the State, hereinafter referred to as a person, may commence a civil action in a court of competent jurisdiction against any carrier that offers a managed care plan or the Department of Health and Senior Services alleged to be in violation of P.L.1997, c.192 (C.26:2S-1 et seq.) or any regulations promulgated pursuant thereto. The action may be for injunctive or other equitable relief to compel compliance with P.L.1997, c.192 (C.26:2S-1 et seq.) or any promulgated regulation, or to assess civil penalties for the violation as provided by section 16 of P.L.1997, c.192 (C.26:2S-16). The action may be commenced upon an allegation that a carrier or the Department of Health and Senior Services is in violation, either continuously or intermittently, of P.L.1997, c.192 (C.26:2S-1 et seq.) or a promulgated regulation, and that there is a likelihood that the violation will recur in the future.

(2) Any person may commence a civil action in any court of competent jurisdiction for declaratory and equitable relief against any carrier or the Department of Health and Senior Services in the interest of the public.

(3) The court may, on the motion of any party, or on its own motion, dismiss any action brought pursuant to this section which

on its face appears to be patently frivolous, harassing or wholly lacking in merit.

b. A court of competent jurisdiction may grant temporary and permanent equitable relief, including the imposition of such conditions as may be necessary to protect the interest of the public from violations of P.L.1997, c.192 (C.26:2S-1 et seq.) or any promulgated regulation.

c. Upon completion of the proceedings in any action brought pursuant to subsection a. of this section, the court shall adjudicate the impact of the defendant's conduct on the interest of the pubic in accordance with this section. In such adjudication the court may order that additional evidence be taken to the extent necessary to protect the rights recognized in this section.

d. If administrative or other proceedings are required or available to determine the legality of the defendant's conduct, the court shall remit the parties to such proceedings, except where immediate and irreparable damage will probably result, which proceedings shall be conducted in accordance with and subject to the applicable provision of law providing for such proceedings and the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). In so remitting the court may grant temporary equitable relief where necessary for the protection of the public interest. In so remitting the court shall retain jurisdiction of the action pending completion thereof for the purpose of determining whether the administrative findings made in the proceedings are supported by substantial evidence and the agency action is in conformance with this section.

e. In any action in which a temporary restraining order or an interlocutory injunction is sought, the court may, as a condition of granting such relief, require reasonable security, not exceeding $10,000 or cash not exceeding $500.

f. (1) In any action under this section, the court may in appropriate cases award to the prevailing party reasonable counsel and expert witness fees, but not more than $50,000 in an action brought against the Department of Health and Senior Services, where the prevailing party achieved reasonable success on the merits. The fees shall be based on the number of hours reasonably spent and a reasonable hourly rate for the counsel or expert in the action, taking into account the prevailing rate in the venue of the action and the skill and experience of the counsel or expert.

(2) The doctrines of collateral estoppel and res judicata may be applied by the court to prevent multiplicity of suits.

(3) No action commenced pursuant to the provisions of this section shall be dismissed without the express consent of the court in which the action was filed.

(4) Any payments made pursuant to a settlement or judgement entered in a case brought pursuant to this section shall be used to provide payments to hospitals in accordance with the formula used

for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et seq.) and shall be deposited into the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

g. No action shall be commenced pursuant to this section unless the person seeking to commence the suit shall, at least 30 days prior to the commencement thereof, direct a written notice of that intention by certified mail to the Attorney General, the Commissioner of Health and Senior Services and the intended defendant. The provisions of this subsection shall not apply to actions brought by the State, any political subdivision of the State and any agency or instrumentality of the State or of any political subdivision of the State.

h. This section shall be in addition to existing administrative and regulatory procedures provided in section 19 of P.L.1997, c.192 (C.26:2S-18).

7. This act shall take effect on the 90th calendar day after enactment and shall apply to any carrier that delivers, issues, executes or renews, on or after the effective date of this act, a health benefits plan in which the carrier has reserved the right to change the premium.

STATEMENT

This bill makes various revisions to the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.), which apply to health insurance carriers that offer a managed care plan.

The bill defines the terms "medical necessity" and "generally accepted standards of medical practice" as they apply to the provisions of the Health Care Quality Act.

The bill provides that a carrier which issues a managed care plan with an out-of-network benefit shall remit payment for reimbursement of a health care service directly to an out-of-network provider if that provider has been issued an assignment of benefits by the covered person. Payment shall be remitted pursuant to the provisions of the Health Care Quality Act and P.L.1999, c.154 (C.17B:30-23 et seq.), commonly referred to as the "prompt pay law," and any payment remitted to a covered person rather than the out-of-network provider under these circumstances shall be considered overdue and subject to an interest charge pursuant to the prompt pay law.

The bill provides, in cases in which a patient suffers a chronic condition and is under the care of a health care provider, the carrier shall continue to cover the treatment as determined by the health care provider rather than discontinue coverage because the carrier has made changes in its policy concerning the medical necessity of

the treatment for all persons covered under the plan during the course of the treatment. Additionally, if a patient under the care of a health care provider for such a chronic condition enrolls in a managed care plan, the carrier is required to continue covering the treatment unless the health care provider agrees to the alternative treatment covered by the carrier. It shall be the policy of this State that changes in treatment, which includes the administration of medication, may only be made or approved by the treating health care provider.

The bill provides that in a case in which a covered person is under the care of a specialty health care provider, the carrier shall not require the specialty provider to obtain a referral or otherwise involve the covered person's primary care physician before ordering tests to treat or diagnose a covered person's illness, injury or condition. These provisions are intended to streamline the administrative process behind seeking treatment from a specialty physician, thus hastening the administration of such treatment.

The bill requires carriers to provide to each health care provider fee schedules for specialty or subspecialty services and every health care service that have been the subject of a claim submitted in a calendar year. Carriers shall reimburse a provider according to the fee schedule. Carriers may not revise their fee schedules more than once a year and must give providers 90 day's notice of the changes prior to the changes' effective date. Providers may, within 30 days of receiving the change notice, terminate or provide notice of their intent to terminate their contracts, effective upon the date the proposed changes would take effect.

Finally, this bill authorizes any covered person, health care provider, professional organization representing a health care provider, the State, any political subdivision of the State and any agency or instrumentality of the State or of any political subdivision of the State, to commence a civil action in a court of competent jurisdiction against any carrier or the Department of Health and Senior Services that is alleged to be in violation of the Health Care Quality Act or any regulation promulgated thereunder. The action may be for injunctive or other equitable relief to compel compliance with the act or any promulgated regulation, or to assess civil penalties for a violation of the act. The action may be commenced upon an allegation that a carrier or the Department of Health and Senior Services is in violation, either continuously or intermittently, of the act or a promulgated regulation, that there is a likelihood that the violation will recur in the future, and that the violation impacts the public good.