ASSEMBLY, No. 851

STATE OF NEW JERSEY

212th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2006 SESSION

Sponsored by:
Assemblyman CRAIG A. STANLEY
District 28 (Essex)

SYNOPSIS

"Preferred Provider Protection Act."

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel

AN ACT concerning preferred provider organizations and supplementing Title 17B of the New Jersey Statutes.

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 "Preferred Provider Protection Act."

2. As used in this section:

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

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

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

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

"Group purchaser" means an organization or entity that enters into a selective contracting arrangement with preferred providers or preferred provider organizations. A group purchaser may include: (1) entities that contract for the benefit of their insureds, employees or members, including carriers, self-funded organizations, medical, hospital or health service corporations, trusts or employers who establish or participate in self-funded plans or programs; (2) or entities that serve as brokers for the formation of selective contracting arrangements, including health care financiers, third party administrators, health care providers or other intermediaries.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, supplies or both, and is delivered or issued for delivery in this State by or through a carrier. 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 provided pursuant to a contract with the State, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection coverage issued pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or hospital confinement indemnity coverage.

"Health care provider" means a physician or other health care professional, hospital, facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which the services are furnished.

"Preferred provider" means a health care provider or group of

health care providers who have entered into selective contracting arrangements with a carrier or preferred provider organization.

"Preferred provider organization" or "PPO" means an entity, other than a carrier, that contracts with preferred providers to establish selective contracting arrangements.

"Selective contracting arrangement" means an agreement for the payment of a selective contracting rate for covered services by the carrier to preferred providers or preferred provider organizations which includes a tangible benefit to the preferred provider in entering into the selective contracting arrangement. Selective contracting arrangements may include, but not be limited to, the following components: (1) incentives which encourage the covered person to utilize the preferred providers; (2) procedures to provide the preferred provider with a means to determine whether the patient qualifies for the selective contracting rate; (3) participation in a utilization review process to insure quality control both for patient care and cost effectiveness; and (4) procedures to encourage prompt payment for services rendered.

"Selective contracting rate" means the predetermined fee or reimbursement level for which a health care provider agrees to perform covered services. The rate shall be in effect for a fixed term and may include a discount from the health care provider's usual and customary fee.

"Tangible benefit" means, but shall not be limited to: (1) a reasonable expectation of a demonstrable increase in or maintenance of usage of the health care provider's services; (2) contractual provisions requiring quality control of patient care and participation in utilization review procedures; and (3) a reasonable expectation of prompt payment for services rendered.

3. a. Except as otherwise provided in this section, the requirements of this section shall apply to all selective contracting arrangements applicable to health care services rendered in this State and to group purchasers as provided in this section. The provisions of this section shall not apply to a group purchaser that provides health care benefits through its own network or agreements with providers.

b. A preferred provider organization's selective contracting rate shall not be enforceable or binding upon a health care provider unless it is clearly identified on the benefit card issued to a covered person by the group purchaser or other entity accessing a group purchaser's contractual agreement and presented to the preferred provider at the time that health care services are rendered. If the name of more than one preferred provider organization appears on the benefit card issued by a group purchaser or other entity, the applicable contractual agreement that shall apply, and under which payment shall be made to a health care provider, shall be determined as follows:

(1) The contractual agreement of the preferred provider organization domiciled in this State that is listed first on the front of the benefit card, reading from left to right, line by line, from top to bottom, shall be the contractual agreement applicable for payment to a health care provider on the date health care services are rendered.

(2) If there is no preferred provider organization domiciled in this State listed on the benefit card, the contractual agreement of the preferred provider organization domiciled outside this State listed first on the front of the benefit card, following the same process outlined in paragraph (1) of this subsection, shall be the contractual agreement applicable for payment to a health care provider on the date health care services are rendered.

(3) The side of the benefit card that prominently identifies the name of the carrier or plan sponsor and beneficiary shall be considered the front of the card.

(4) If no preferred provider organization is listed on the benefit card, the carrier or plan sponsor identified on the benefit card shall be considered the group purchaser for purposes of this section.

(5) If no benefit card is issued or utilized by a group purchaser or other entity, written notification shall be required of any entity accessing an existing group purchaser's contractual agreement or agreements, at least 30 days before accessing health care services through a preferred provider under the agreement.

c. A preferred provider organization's selective contracting arrangement shall not be applied or used on a retroactive basis unless all health care providers affected by the application of the selective contracting rate receive written notification from the entity that seeks the arrangement and those health care providers agree in writing to be reimbursed at the selective contracting rate.

d. A health care provider shall not be bound by the terms of a selective contracting arrangement that is in violation of this section.

e. Any claim submitted by a preferred provider for health care services provided to a covered person who is identified by the preferred provider and a group purchaser as eligible for the selective contracting rate in a selective contracting arrangement shall be subject to the standards for claims submission and timely payment established pursuant to the provisions of P.L.1999, c.154 (C.17B:30-23 et al.) and the regulations promulgated thereunder.

f. Failure to comply with the provisions of this section shall subject a group purchaser to damages payable to a health care provider of double the fair market value of the health care services provided, but in no event less than the greater of $50 per day for noncompliance or $2,000, together with attorney's fees to be determined by the court. A health care provider may institute an action for damages pursuant to this subsection in any court of competent jurisdiction.

4. Whenever a health care provider is a party to a selective contracting arrangement, there shall be a rebuttable presumption that the health care provider entered into the selective contracting arrangement with the expectation that the health care provider would receive a tangible benefit. Unless clearly indicated otherwise in a selective contracting arrangement, it shall be presumed that the health care provider negotiated the selective contracting agreement with the knowledge that the agreement would result in a tangible benefit to the health care provider.

5. a. It shall be an unfair trade practice, pursuant to the provisions of N.J.S.17B:30-1 et seq., for a carrier or group purchaser subject to this act to intentionally misrepresent to a health care provider that the carrier or group purchaser is entitled to a certain selective contracting rate or other discount from the fees charged for health care services, procedures or supplies provided by the health care provider when the carrier or group purchaser is not entitled to a selective contracting rate or discount or is entitled to a lesser discount from the health care provider on those fees.

b. It shall be an unfair trade practice for any person with knowledge that a carrier or group purchaser intends to make the type of misrepresentation prohibited by this section to provide substantial assistance to that carrier or group purchaser in accomplishing that misrepresentation.

6. The commissioner shall adopt rules and regulations in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the provisions and purposes of this act.

7. This act shall take effect immediately.

STATEMENT

The purpose of this bill is to prevent the unauthorized use of selective contracting rates by entities which have not entered into selective contracting arrangements with health care providers affected by those selective contracting rates and to ensure that health care providers receive the tangible benefits they bargained for when entering into these arrangements.

Frequently, health care providers enter into contractual agreements, commonly known as selective contracting arrangements, with preferred provider organizations. As defined in the bill, selective contracting arrangements may include, but not be limited to, the following components: (1) incentives that encourage the covered person to utilize the preferred providers; (2) procedures to provide the preferred provider with a means to determine whether

the patient qualifies for the selective contracting rate; (3) participation in a utilization review process to insure quality control both for patient care and cost effectiveness; and (4) procedures to encourage prompt payment for services rendered. In these contracts, health care providers agree to a predetermined fee or reimbursement level (the "selective contracting rate") in anticipation of receiving additional patient flow as a result of being designated a preferred provider. The potential for additional patient flow provides a tangible benefit to the health care provider and is a reason for becoming a preferred provider. However, this bill is necessary to address certain practices currently engaged in by carriers and group purchasers, which tend to undermine the selective contracting agreement. "Group purchaser" is defined in the bill as an organization or entity that enters into a selective contracting arrangement with preferred providers or preferred provider organizations, and may include: (1) entities which contract for the benefit of their insureds, employees or members, including carriers, self-funded organizations, medical, hospital or health service corporations, trusts or employers who establish or participate in self-funded plans or programs; or (2) entities which serve as brokers for the formation of such selective contracting arrangements, including health care financiers, third party administrators, health care providers or other intermediaries.

In the secondary market for selective contracting rates, a preferred provider organization makes its roster of preferred providers and selective contracting rates available to other carriers, payers, brokers or other entities for a fee. Thereafter, those entities utilize the selective contracting rate to apply a discount to the health care provider's bill, which results in a loss of revenue to the health care provider. In addition, the health care provider does not receive the benefit of increased patient flow since these rates are typically applied to patients who are covered by an entity that has not contracted with the preferred provider organization.

The bill provides that a preferred provider organization's selective contracting rate shall not be enforceable or binding upon a health care provider unless it is clearly identified on the benefit card issued to a covered person by the group purchaser or other entity accessing a group purchaser's contractual agreement and presented to the preferred provider at the time that health care services are rendered. The bill establishes procedures for determining the applicable contractual agreement that shall apply in the event that the name of more than one preferred provider organization appears on the benefits card issued to a covered person. In addition, the bill establishes certain other criteria that must be adhered to by carriers and group purchasers with respect to payments to health care providers under selective contracting arrangements, including payment of damages in a court proceeding for failure to abide by these provisions of the bill.

The bill also establishes that whenever a health care provider is a party to a selective contracting arrangement, there shall be a rebuttable presumption that the health care provider entered into the selective contracting arrangement with the expectation that the health care provider would receive a tangible benefit. In addition, unless clearly indicated otherwise in a selective contracting arrangement, it shall be presumed that the health care provider negotiated the selective contracting agreement with the knowledge that the agreement would result in a tangible benefit to the health care provider.

Finally, the bill makes it an unfair trade practice for a carrier or group purchaser subject to this act to intentionally misrepresent to a health care provider the applicability of a selective contracting rate or other discounts or for any person to provide substantial assistance to a carrier or group purchaser that engages in such a misrepresentation.

It is anticipated that the bill will stem the loss of revenue and patient flow currently experienced by affected health care providers.