SENATE, No. 2742

STATE OF NEW JERSEY

213th LEGISLATURE

INTRODUCED APRIL 27, 2009

Sponsored by:
Senator LORETTA WEINBERG
District 37 (Bergen)

SYNOPSIS

Makes various revisions to laws regulating certain health benefits plans.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning health insurance, amending P.L.1999, c.155 and supplementing various parts of statutory law.

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

1. Section 5 of P.L.1999, c.155 (C.17B:30-30) is amended to read as follows:

5. a. A payer shall maintain a record which shall be audited by a private auditing firm at the expense of the payer, to be submitted to the commissioner, Governor and the Legislature annually, in a form established by the commissioner by regulation, of the number of claims, by category:

(1) that are denied because they are for an ineligible service or the health care service was not rendered by an eligible health care provider under the health benefits or dental plan;

(2) that are rejected at their initial submission because of a lack of substantiating documentation;

(3) that are rejected at their initial submission because of incorrect coding or incorrect enrollment information;

(4) that are rejected at their initial submission because of the amount claimed;

(5) that are not paid in accordance with the time limit established by law because the payer deems the claim to require special treatment that prevents timely payments from being made;

(6) that are not paid in accordance with the time limits for payment established by law even though the claims meet the criteria established by law;

(7) upon which the 10% interest penalty established by law has been paid, and the aggregate amount of interest paid for the period covered by the report;

(8) that are denied or referred to the payer's fraud investigation unit, if applicable, or to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16) because the payer has reason to believe that the claim has been submitted fraudulently; **[**and**]**

(9) that, as a result of the payer's error in processing, are not paid in an amount at least equal to the correct amount claimed even though the claim meets the criteria established by law, and the number of days taken by the payer, from the day that the payer becomes aware of the incorrect amount, to the day that the payer issues a payment in the correct amount; and

(10) any other information the commissioner requires.

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.

b. After reviewing an audit required by subsection a. of this section, the commissioner may, if he deems it necessary: require the implementation of a plan of remedial action by the payer; require that the payer's claims processing procedures be monitored by a private auditing firm for a time period he deems appropriate; or both.

If, following an audit, the implementation of a plan of remediation or the monitoring of the payer's claims processing procedures, the commissioner determines that:

(1) an unreasonably large or disproportionate number of eligible claims continue to be rejected, denied, **[**or**]** not paid in a timely fashion , or not paid in correct amounts, for the reasons set forth in paragraph (4), (5) **[**or**]** , (6) or (9) of subsection a. of this section; or

(2) a payer has failed to pay interest as required pursuant to law, the commissioner shall impose a civil penalty of not more than $10,000 upon the payer, to be collected pursuant to **[**"the penalty enforcement law," N.J.S.2A:58-1 et seq.**]** the “Penalty Enforcement Law of 1999,” P.L.1999, c.274 (C.2A:58-10 et seq.).

c. The commissioner shall conduct an annual quality assurance audit, in accordance with a process and in a form to be designed by the commissioner, to measure the performance of each payer, with respect to the quality of the payer’s claims processing procedures. The quality assurance audit shall include, but shall not be limited to:

(1) an examination of the claims information record maintained by the payer, and the annual audit of that record, as required by subsection a. of this section;

(2) an examination of a payer’s conformance to other standards as may be determined by the commissioner to be relevant to the financial and procedural accuracy of a payer’s claims processing procedures;

(3) a consumer satisfaction survey using a select sample of a payer’s covered persons; and

(4) a provider satisfaction survey using a select sample of a payer’s eligible health care providers.

A payer shall provide the commissioner, on an annual basis, with the claims processing procedure information, lists of covered persons, and lists of eligible health care providers, necessary for the commissioner to conduct the quality assurance audit.

d. The commissioner shall make available to the public, through its official department website, and in printed format upon request, the results of the records audits and quality assurance audits conducted pursuant to subsections a. and c. of this section, respectively.

[c.**]** e. Every financial examination of a payer performed pursuant to section 11 of P.L.1938, c.366 (C.17:48-11), section 15

of P.L.1940, c.74 (C.17:48A-15), section 26 of P.L.1968, c.305 (C.17:48C-26), section 13 of P.L.1979, c.478 (C.17:48D-13), section 36 of P.L.1985, c.236 (C.17:48E-36), N.J.S.17B:21-1 et seq. or section 9 of P.L.1973, c.337 (C.26:2J-9), as applicable, shall include an examination of the payer's compliance with the provisions of this section.
(cf: P.L.1999, c.155, s.5)

2. (New section) Beginning with the calendar year starting on January 1, 2010, and in each calendar year thereafter, an insurer shall return, in the form of aggregate benefits for all group health insurance policy forms offered by the insurer pursuant to N.J.S.17B:27-26 et seq., at least 80% of the aggregate premiums collected for all of the policy forms during that calendar year. Insurers shall annually report to the Commissioner of Banking and Insurance, no later than August 1 of each year, the loss ratio calculated for all of the policy forms for the previous calendar year. In each case in which the loss ratio fails to substantially comply with the 80% loss ratio requirement, the insurer shall issue a dividend or credit against future premiums for all policyholders in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal 80% of the premiums collected in the previous calendar year. All dividends and credits shall be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report shall include an insurer’s calculation of the dividends and credits applicable to all policy forms, as well as an explanation of the insurer’s plan to issue dividends or credits.

The commissioner shall specify by regulation:

a. any informational filings required to be submitted by insurers to the commissioner in order to determine whether insurers are in compliance with their loss ratio requirements;

b. the instructions and format for calculating and reporting loss ratios and issuing dividends or credits; and

c. procedures for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder.

3. (New section) a. As used in this section:

“Carrier” means an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization, dental service corporation, dental plan organization, pharmacy benefits management company, or prepaid prescription service organization authorized to issue any health benefits plan, dental contract or plan, or prescription drug plan in this State.

“Covered person” means a person on whose behalf a carrier or organized delivery system is obligated to pay benefits pursuant to a

health benefits plan, dental contract or plan, or prescription drug plan.

"Covered service" means a service provided by a health care provider or organized delivery system to a covered person under a health benefits plan, dental contract or plan, or prescription drug plan for which the carrier or organized delivery system is obligated to pay benefits.

"Dental contract" means a dental contract issued pursuant to the provisions of the "Dental Service Corporation Act of 1968," P.L.1968, c.305 (C.17:48C-1 et seq.).

"Dental plan" means a dental plan issued pursuant to the provisions of the "Dental Plan Organization Act," P.L.1979, c.478 (C.17:48D-1 et seq.).

"Health benefits plan" means "health benefits plan" as defined by section 3 of P.L.2005, c.352 (C.17B:30-50).

"Health care provider" means an individual or entity which, acting within the scope of the individual's or entity's licensure or certification, provides a covered service defined by a health benefits plan, dental contract or plan, or prescription drug plan. Health care provider includes, but is not limited to, a physician, dentist, pharmacist, and any other health care professional licensed or certified pursuant to Title 45 of the Revised Statutes, a hospital and any other health care facility licensed pursuant to Title 26 of the Revised Statutes, a pharmacy benefits management company, and a prepaid prescription service organization and any other carrier authorized to provide a prescription service pursuant to P.L.1997, c.380 (C.17:48F-1 et seq.).

"Network" means one or more health care providers which enter into a selective contracting arrangement with a carrier or organized delivery system.

"Organized delivery system" means "organized delivery system" as defined in section 1 of P.L.1999, c.409 (C.17:48H-1).

"Pharmacy benefits management company" means a corporation, business, or other entity, however organized, or unit within a corporation, business, or entity, that administers a prescription drug plan on behalf of the sponsor of a health benefits plan.

"Pharmacy practice site" means any place in this State where prescription drugs are dispensed or pharmaceutical care is provided by a licensed pharmacist, but shall not include a medical office under the control of a licensed physician.

"Prescription drug plan" means a prepaid prescription service organization contract provided by a pharmacy benefits managment company, a certified organization or other carrier authorized to provide a prepaid prescription service pursuant to P.L.1997, c.380 (C.17:48F-1 et seq.), or any other carrier contract, policy, or plan delivered or issued in this State which provides benefits for pharmacy services, prescription drugs, or for participation in a prescription drug plan.

"Selective contracting arrangement" means an arrangement in which a carrier or organized delivery system participates in selective contracting with one or more participating health care providers, and which arrangement contains reasonable benefit differentials, including, but not limited to, predetermined fee or reimbursement rates for covered services applicable to participating and nonparticipating health care providers.

"Third party administrator" means "third party administrator" as defined by section 1 of P.L.2001, c.267 (C.17B:27B-1).

"Third party billing service" means "third party billing service" as defined by section 1 of P.L.2001, c.267 (C.17B:27B-1).

b. A carrier or organized delivery system which enters into any selective contracting arrangement with a network of health care providers, or a third party administrator or billing service for that carrier or organized delivery system, shall provide to the Commissioner of Banking and Insurance a copy of each selective contracting arrangement into which it enters, with an accompanying form summarizing all of the information required by this subsection.

(1) The selective contracting arrangement or form shall indicate the predetermined fees or reimbursement rates for covered services agreed to by any health care provider in the network, or the methodology agreed to for determining the fees or reimbursement rates, in a manner so that the commissioner, or any other party examining the arrangement or form, may determine the negotiated cost of a covered service under the arrangement through a generally recognized method of payment or mode of classification, including a fee-for-service, resource-based relative value schedule, per diem, diagnosis-related group, capitation, the Current Procedural Terminology codes developed and maintained by the American Medical Association, or the Healthcare Common Procedure Coding System utilized by the Centers for Medicare and Medicaid Services.

(2) The selective contracting arrangement or form shall also indicate whether any party to the arrangement may retain some or all of a portion of a discount, rebate, reimbursement, remuneration, revenue, or other financial incentive obtained from any source, other than from the sponsor of the health benefits plan, dental contract or plan, or prescription drug plan, or a covered person under the contract or plan, in connection with a covered service without passing this on to the sponsor or covered person.

(3) With respect to a prescription drug plan, in addition to any applicable disclosure requirements set forth in paragraphs (1) and (2) of this subsection, the selective contracting arrangement or form shall also indicate the carrier's or organized delivery system's purchase price or discount for a particular prescription drug and any individual therapeutic class of drugs, dispensing fees by drug and class of drugs paid to pharmacy practice sites, whether a retail or mail-order pharmacy, and financial incentives connected to

prescribing and other pharmacy services, including the use of prescription drug substitutions.

c. The commissioner shall create, maintain, and update on the Department of Banking and Insurance website, for availability to the public at no cost, the information disclosed on each selective contracting arrangement currently in effect and any accompanying form to the arrangement as required by this section. The commissioner shall also make this information available in a printed format upon request.

d. Any carrier, organized delivery system, third party administrator or billing service which fails to provide a selective contracting arrangement or form containing all of the information required by this section shall be liable to a civil penalty in an amount not less than $500, or more than $10,000, for each violation. A penalty shall be collected and enforced by summary proceedings pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

4. (New section) A carrier which contracts with the State Health Benefits Commission, created by section 3 of P.L.1961, c.49 (C.52:14-17.27), or with the School Employees' Health Benefits Commission, created by section 33 of P.L.2007, c.103 (C.52:14-17.46.3), to provide health benefits to covered persons under the State Health Benefits Program or School Employees' Health Benefits Program, as appropriate, and which also contracts with an insurance fund established pursuant to N.J.S.40A:10-6 et seq., or any other law, shall make available in its contract with that insurance fund the same rates, terms and conditions, administrative fees, service guarantees and penalties as those provided in its contract for the same benefits with the State Health Benefits Commission or the School Employees' Health Benefits Commission, as appropriate.

5. (New section) A carrier which contracts with the State Health Benefits Commission, created by section 3 of P.L.1961, c.49 (C.52:14-17.27), or with the School Employees' Health Benefits Commission, created by section 33 of P.L.2007, c.103 (C.52:14-17.46.3), to provide health benefits to covered persons under the State Health Benefits Program or School Employees' Health Benefits Program, as appropriate, and which also contracts with a joint insurance fund established pursuant to P.L.1983, c.372 (C.40A:10-36 et seq.), or any other law, shall make available in its contract with that insurance fund the same rates, terms and conditions, administrative fees, service guarantees and penalties as those provided in its contract for the same benefits with the State Health Benefits Commission or the School Employees' Health Benefits Commission, as appropriate.

6. (New section) A carrier which contracts with the State Health Benefits Commission, created by section 3 of P.L.1961, c.49 (C.52:14-17.27), or with the School Employees' Health Benefits Commission, created by section 33 of P.L.2007, c.103 (C.52:14-17.46.3), to provide health benefits to covered persons under the State Health Benefits Program or School Employees' Health Benefits Program, as appropriate, and which also contracts with an insurance fund pursuant to which a board of education provides health benefits pursuant to section 9 of P.L.2007, c.18 (C.18A:16-13.1), or any other law, shall make available in its contract with that insurance fund the same rates, terms and conditions, administrative fees, service guarantees and penalties as those provided in its contract for the same benefits with the State Health Benefits Commission or the School Employees' Health Benefits Commission, as appropriate.

7. This act shall take effect immediately.

STATEMENT

This bill makes various revisions to laws regulating health benefits plans in the State, including:

(1) a requirement for a quality assurance audit for insurance carriers;

(2) a minimum loss ratio requirement in the large employer market;

(3) disclosures as to selective contracting arrangements; and

(4) a requirement that employees of local units or school boards receive the benefit of certain negotiated rate structures within the State Health Benefits Program and the School Employees Health Benefits Program.

This bill requires health and dental insurance carriers that are doing business in this State and paying claims under an insured health benefits or dental plan (referred to as "payers" for purposes of the requirements section 1 of this bill), to include certain additional information in their claims processing records. The bill also requires the Commissioner of Banking and Insurance to conduct an annual quality assurance audit with respect to claims processing procedures of payers, and to make certain audit results available to the public.

The bill adds to a payer's current requirements to maintain claims processing records a requirement to maintain a record of the number of claims that, as a result of the payer's error in processing, are not paid in an amount at least equal to the correct amount claimed even though the claim meets the criteria established by law, and the number of days taken by the payer, from the day that the

payer becomes aware of the incorrect amount, to the day that the payer issues a payment in the correct amount.

The bill also requires the commissioner to conduct an annual quality assurance audit, in accordance with a process and in a form to be designed by the commissioner, to measure the performance of each payer, with respect to the quality of the payer's claims processing procedures. The quality assurance audit shall include, but shall not be limited to:

(1) an examination of the record of claims information maintained by the payer, and the annual audit of that record, as currently required;

(2) an examination of a payer's conformance to other standards as may be determined by the commissioner to be relevant to the financial and procedural accuracy of a payer's claims processing procedures; and

(3) consumer and provider satisfaction surveys.

The bill requires the commissioner to make available to the public, through its official department website, and in printed format upon request, the results of the records audits conducted pursuant to current requirements of law, as amended by this bill, and the quality assurance audits required by the provisions of this bill.

The bill also applies an 80% minimum loss ratio requirement, which now applies only to the insurers participating in the individual and small employer markets in the State, to insurers that provide large group health insurance policies, beginning with the calendar year starting January 1, 2010. Generally, this loss ratio requirement means that 80 cents of every premium dollar must be expended on the payment of claims, while the remaining 20% can be used for administrative expenses and profits.

The bill requires insurers participating in the large group market, which is composed of groups of more than 50 employees, to annually report to the Commissioner of Banking and Insurance, no later than August 1 of each year, the loss ratio calculated for all of the policy forms for the previous calendar year. In each case in which the loss ratio fails to substantially comply with the 80% loss ratio requirement, the insurer shall issue a dividend or credit against future premiums for all policyholders in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal 80% of the premiums collected in the previous calendar year.

The bill provides that the commissioner shall specify by regulation certain requirements as to informational filings by insurers, calculating and reporting loss ratios, and issuing and distributing dividends or credits.

This bill next requires disclosure of certain in-network fees, reimbursement rates, and other aspects of health benefits plans, dental contracts and plans, and prescription drug plans.

The bill provides that a carrier or organized delivery system which enters into certain selective contracting arrangements with a network of health care providers shall provide a copy of the arrangement to the Commissioner of Banking and Insurance, including an accompanying form summarizing all of the information on the arrangement required by the bill.

The selective contracting arrangement or form shall indicate the predetermined fees or reimbursement rates for covered services agreed to by any health care provider in the network, or the methodology agreed to for determining the fees or reimbursement rates, in a manner so that the commissioner, or any other party examining the arrangement or form, may determine the negotiated cost of a covered service under the arrangement through a generally recognized method of payment or mode of classification, according to certain methods as set forth in the bill.

The selective contracting arrangement or form shall also indicate whether any party to the arrangement may retain some or all of a portion of a discount, rebate, reimbursement, remuneration, revenue, or other financial incentive obtained from any source, other than from the sponsor of the health benefits plan, dental contract or plan, or prescription drug plan, or a covered person under the contract or plan, in connection with a covered service without passing this on to the sponsor or covered person.

With respect to a prescription drug plan, in addition to any other applicable disclosure requirements set forth under the bill, the selective contracting arrangement or form shall also indicate the carrier's or organized delivery system's purchase price or discount for a particular prescription drug and any individual therapeutic class of drugs, dispensing fees by drug and class of drugs paid to pharmacy practice sites, whether a retail or mail-order pharmacy, and financial incentives connected to prescribing and other pharmacy services, including the use of prescription drug substitutions.

The commissioner shall create, maintain, and update on the Department of Banking and Insurance website, for availability to the public at no cost, the information disclosed on each selective contracting arrangement currently in effect and any accompanying form to the arrangement as required by the bill. The commissioner shall also make this information available in a printed format upon request.

Any carrier, organized delivery system, third party administrator or billing service which fails to provide a selective contracting arrangement or accompanying form containing all of the information required by the bill shall be liable to a civil penalty in an amount of not less than $500, or more than $10,000, for each violation.

Finally, this bill provides that health insurance carriers providing benefits under the State Health Benefits Program or the School

Employees' Health Benefits Program shall make available to any insurance fund or joint insurance fund providing benefits to employees of local units or school boards the same negotiated rates, terms and conditions, administrative fees, service guarantees and penalties as those provided in its contracts for the same benefits with the State Health Benefits Commission or the School Employees' Health Benefits Commission, as appropriate.