[First Reprint]

SENATE, No. 2959

STATE OF NEW JERSEY

214th LEGISLATURE

INTRODUCED JUNE 20, 2011

Sponsored by:
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Assemblyman DECLAN J. O'SCANLON, JR.
District 12 (Mercer and Monmouth)
Assemblyman GARY R. CHIUSANO
District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Repeals requirement that public employers provide certain health benefit plans to public employees.

CURRENT VERSION OF TEXT

As amended by the General Assembly on June 23, 2011.

(Sponsorship Updated As Of: 6/24/2011)

AN ACT concerning the provision of health care benefits to public employees and [1]**[**amending**]** repealing section 76 of[1] P.L. , c. (pending before the Legislature as Senate, No. 2937 of 2011, and Assembly, No. 4133 of 2011).

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

[1]**[**1. Section 76 of P.L. , c. (C.)(pending before the Legislature as Senate, No. 2937 of 2011, and Assembly, No. 4133 of 2011) is amended to read as follows:

76. **[**a. As used in this section:

“emergency care” means immediate treatment provided in response to a sudden, acute and unanticipated medical crisis in order to avoid injury, impairment, or death.

“in-State health care provider” means an individual or entity, including, but not limited to, a physician or other health care professional licensed pursuant to Title 45 of the Revised Statutes, and a hospital or other health care facility licensed pursuant to Title 26 of the Revised Statutes that is not an out-of-State health care provider.

“out-of-State health care provider” means an individual or entity providing health care services at a location outside the geographic boundaries of this State.

“primary care" means the provision of preventive, diagnostic, treatment, management, and reassessment services to individuals in facilities providing family practice, general internal medicine, general pediatrics, and routine obstetrics/gynecology.

"reasonably proximate" means a geographic distance from the covered person's place of residence that does not exceed 25 miles.

“tertiary care” means specialized care performed by specialists working in an inpatient or outpatient facility for special investigation and treatment of complex diseases or conditions.

b. Notwithstanding the provisions of any other law to the contrary, a carrier which offers health benefits coverage under the State Health Benefits Program, School Employees’ Health Benefits Program, or any self-insured plan or plan offered to public employees or retirees outside the State Health Benefits Program or the School Employees’ Health Benefits Program, to an employee or retiree and any dependent eligible for such health care benefits coverage, shall only provide coverage for medically necessary health care services provided by an out-of-State health care provider as specified in subsection c. of this subsection, except for coverage authorized pursuant to subsection f. or g. of this section.

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]Assembly floor amendments adopted June 23, 2011.

c. Medically necessary tertiary health care services may be performed by an out-of-State specialty or subspecialty health care provider when there is no in-State health care provider reasonably available to treat the particular condition based on an expedited determination by the carrier and the State Health Benefits Commission, the School Employees' Health Benefits Commission or the plan administrator, as the case may be, in consultation with the Department of Health and Senior Services, that such service is not otherwise available through an in-State health care provider or where there is no in-network provider who is reasonably proximate to the covered person's place of residence.

d. (1) The out-of-State health care provider shall receive reimbursement for out-of-network charges at the lesser of the contractual rate or a rate equal to 150% of the Medicare fee schedule for those same services.

(2) The employee or retiree shall be responsible for the entire balance of the out-of-State health provider's charges that exceed the applicable out-of-network reimbursement.

e. The carrier shall establish preauthorization or review requirements of the health benefits plan regarding the determination of medical necessity for the employee, retiree, or covered dependent to access out-of-State benefits, as set forth in writing pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5), with which the covered person shall comply as a condition of receiving benefits pursuant to this section.

f. This section shall not apply to: (1) emergency care; (2) primary care; (3) an employee, retiree, or covered dependent who has his or her principal residence outside of this State or is enrolled as a full-time student at a school located outside this State and resides outside this State while attending that school, or (4) such other unusual and compelling circumstance determined by the State Health Benefits Commission, School Employees' Health Benefits Commission or the plan administrator, as the case may be, in consultation with the Department of Health and Senior Services, that warrants an individualized exception from the requirements of this section. For the purposes of this subsection, a person will be deemed to have his principal residence outside this State if all of the following conditions are met: the person spends the majority of his or her nonworking time outside the State, and resides at a location outside the State which is clearly the center of his or her domestic life, and has designated the out-of-State residence as his or her legal address and legal residence for voting.

g. This section shall not apply to cases when it is medically necessary for the employee, retiree, or covered dependent to continue current treatment with the out-of-State health care provider or under the following circumstances: (1) in cases of the pregnancy through the postpartum evaluation, up to six weeks after delivery; (2) in the case of post-operative care, up to six months following

the surgical procedure; (3) in the case of oncological treatment, up to one year following the first date of treatment; and (4) in the case of psychiatric treatment, up to one year following the first date of treatment.

h. Notwithstanding the provisions of another law to the contrary, the State Health Benefits Plan Design Committee, the School Employees' Health Benefits Plan Design Committee, and any public employer shall provide to employees the option to select a single plan that shall not limit coverage for medically necessary health care services provided by an out-of-State health care provider pursuant to this section. Each employee or retiree who selects coverage under the plan shall pay the additional portion of the premium or periodic charge associated with selecting a plan that does not limit coverage for medically necessary health care services provided by an out-of-State health care provider for health care benefits provided to the employee, retiree, and dependents covered under the plan.

i. This section shall be operative January 1, 2012.**]**

a. Notwithstanding the provisions of any other law to the contrary, beginning January 1, 2012, the State Health Benefits Plan Design Committee, the School Employees' Health Benefits Plan Design Committee, or any public employer that offers health benefit plans to public employees, retirees, and any dependent thereof, shall offer at least one health benefit plan to plan participants that shall include only in-State health care providers and that shall be subject to the requirements set forth in subsections b. through f. of this section and shall offer at least one health benefit plan to plan participants that shall include out-of-State health care providers and that shall not be subject to the requirements set forth in subsections b. through f. of this section. Each plan participant who selects coverage under a plan that includes out-of-State health care providers is not subject to the requirements of subsections b. through f. of this section and shall pay any additional premium or periodic charge associated with selecting that plan.

b. As used in this section: "emergency care" means immediate treatment provided in response to a sudden, acute and unanticipated medical crisis in order to avoid injury, impairment, or death.

"in-State health care provider" means an individual or entity, including, but not limited to, a physician or other health care professional licensed pursuant to Title 45 of the Revised Statutes, and a hospital or other health care facility licensed pursuant to Title 26 of the Revised Statutes that is not an out-of-State health care provider.

"out-of-State health care provider" means an individual or entity providing health care services at a location outside the geographic boundaries of this State.

"primary care" means the provision of preventive, diagnostic, treatment, management, and reassessment services to individuals in facilities providing family practice, general internal medicine, general pediatrics, and routine obstetrics/gynecology.

"reasonably proximate" means a geographic distance from the covered person's place of residence that does not exceed 25 miles.

"tertiary care" means specialized care performed by specialists working in an inpatient or outpatient facility for special investigation and treatment of complex diseases or conditions.

c. A carrier which offers health benefits coverage under an in-State only plan shall only provide coverage for medically necessary health care services provided by an out-of-State health care provider as specified in subsection d. of this subsection, except for coverage authorized pursuant to subsection e. or f. of this section.

d. Medically necessary tertiary health care services may be performed by an out-of-State specialty or subspecialty health care provider when there is no in-State health care provider reasonably available to treat the particular condition based on a certification from a physician licensed in New Jersey that expresses his or her professional opinion that such medical care or technology is not otherwise available through a qualified in-State health care provider, or when there is no in-State health care provider who is reasonably proximate to the covered person's place of residence. A physician who knowingly signs a false certification in accordance with this section shall be subject to disciplinary action and civil penalties pursuant to sections 8 and 9 of P.L.1978, c.73 (C.45:1-21 and 22).

e. Subsections b. through d. of this section shall not apply to: (1) emergency care; (2) primary care; or (3) such other unusual and compelling circumstance determined by the State Health Benefits Commission, School Employees' Health Benefits Commission or the plan administrator, as the case may be, in consultation with the Department of Health and Senior Services, that warrants an individualized exception from the requirements of this section.

f. Subsections b. through e. of this section shall not apply to cases when it is medically necessary for the employee, retiree, or covered dependent to continue current treatment with the out-of-State health care provider, or when the employee, retiree, or covered dependent has been receiving tertiary care from an out-of-State health care provider prior to the enactment of P.L. , c. (now pending before the Legislature as this bill) until the course of treatment is concluded.

(cf: P.L. , c. , s.76) (pending before the Legislature as Senate, No. 2937 of 2011, and Assembly, No. 4133 of 2011).**]**[1]

[1]1. Section 76 of P.L. , c. (pending before the Legislature as Senate, No. 2937 of 2011, and Assembly, No. 4133 of 2011) is repealed.[1]

2. This act shall take effect immediately.