

ASSEMBLY, No. 3996

STATE OF NEW JERSEY
217th LEGISLATURE

INTRODUCED JUNE 30, 2016

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

As introduced.



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

3

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

6

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

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

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

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

25 "Commissioner" means the Commissioner of **Banking and**
26 **Insurance** Health.

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

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

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

35 "Department" means the Department of **Banking and**
36 **Insurance** Health.

37 "Health benefits plan" means a benefits plan which pays or
38 provides hospital and medical expense benefits for covered
39 services, and is delivered or issued for delivery in this State by or
40 through a carrier. Health benefits plan includes, but is not limited
41 to, Medicare supplement coverage and risk contracts to the extent
42 not otherwise prohibited by federal law. For the purposes of this
43 act, health benefits plan shall not include the following plans,
44 policies, or contracts: accident only, credit, disability, long-term
45 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.

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

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

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

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

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

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

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

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

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1 review, discharge planning, preauthorization of ambulatory care
2 procedures, and retrospective review.

3 (cf: P.L.2012, c.17, s.294)

4

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

7 3. a. A carrier which offers a health benefits plan to residents
8 of this State on the effective date of this act, shall file a form, as
9 prescribed by the commissioner, with the department within 90 days
10 of the effective date of this act and file a copy of the form with the
11 Department of **【Banking and Insurance】** Health. A carrier
12 authorized to issue health benefits plans in this State after the
13 effective date of this act shall file a form with the department at
14 least 30 days prior to the date the carrier will begin to offer a health
15 benefits plan to residents of this State. The carrier shall file a copy
16 of the form with the Department of **【Banking and Insurance】**
17 Health. A carrier shall notify the department within 10 business
18 days of any change in information provided on the form.

19 b. The commissioner shall establish a form for carriers which
20 shall request, at a minimum:

21 (1) the official address and telephone number of the place of
22 business of the carrier; and

23 (2) a description of the carrier's internal patient appeals process
24 available to covered persons to contest a denial, reduction or
25 termination of benefits, if any.

26 c. A health maintenance organization which holds a certificate
27 of authority pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be
28 exempt from the filing requirements of this section but shall comply
29 with the provisions of this act.

30 A health maintenance organization shall be required to comply
31 with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) and any
32 rules and regulations adopted pursuant thereto, except that in the
33 event that the provisions of this act conflict with the provisions of
34 P.L.1973, c.337, the provisions of this act shall supersede the
35 provisions of P.L.1973, c.337.

36 d. A carrier which issues health benefits plans utilizing a
37 selective contracting arrangement pursuant to section 22 of
38 P.L.1993, c.162 (C.17B:27A-54) shall be required to comply with
39 the provisions of section 22 of P.L.1993, c.162 and any rules and
40 regulations adopted pursuant thereto, except that in the event that
41 the provisions of this act conflict with the provisions of section 22
42 of P.L.1993, c.162, the provisions of this act shall supersede the
43 provisions of section 22 of P.L.1993, c.162.

44 (cf: P.L.1997, c.192, s.3)

45

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

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

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

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

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

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

33

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

36 3. The Commissioner of **【Banking and Insurance】 Health** shall
37 adopt regulations within 180 days of the date of enactment of this
38 act, pursuant to the "Administrative Procedure Act," P.L.1968,
39 c.410 (C.52:14B-1 et seq.), necessary to carry out the purposes of
40 this act.

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

42

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

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

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

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

9 10. a. A carrier which offers a managed care plan shall offer a
10 point-of-service plan to every contract holder which would allow a
11 covered person to receive covered services from out-of-network
12 health care providers without having to obtain a referral or prior
13 authorization from the carrier. The point-of-service plan may
14 require that a subscriber pay a higher deductible or copayment and
15 higher premium for the plan, pursuant to limits established by the
16 department, in consultation with the Department of **【Banking and**
17 **Insurance】 Health**, by regulation.

18 b. A carrier shall provide each subscriber in a plan whose
19 contract holder elects the point-of-service plan, with the
20 opportunity, at the time of enrollment and during the annual open
21 enrollment period, to enroll in the point-of-service plan option. The
22 carrier shall provide written notice of the point-of-service plan to
23 each subscriber in a plan whose contract holder elects the point-of-
24 service plan and shall include in that notice a detailed explanation
25 of the financial costs to be incurred by a subscriber who selects that
26 plan.

27 c. The requirements of this section shall not apply to a carrier
28 contract which offers a managed care plan that provides health care
29 services to Medicaid recipients pursuant to P.L.1968, c.413
30 (C.30:4D-1 et seq.), or a federally qualified, nonprofit health
31 maintenance organization.

32 d. A carrier which offers a managed care plan utilizing a
33 selective contracting arrangement approved in accordance with
34 N.J.A.C.11:4-37.1 et seq. that provides benefits for out-of-network
35 providers shall be deemed to be in compliance with this section.

36 e. A health maintenance organization affiliated with an
37 insurance company authorized to issue health benefits plans in this
38 State that offers point-of-service benefits exclusively through a
39 point-of-service plan provided by the affiliated insurance company
40 using a selective contracting arrangement approved in accordance
41 with N.J.A.C.11:4-37.1 et seq., shall be deemed to be in compliance
42 with this section if the point-of-service plan is offered pursuant to
43 the requirements of subsections a. and b. of this section.

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

45
46 7. Section 1 of P.L.2000, c.121 (C.26:2S-10.1) is amended to
47 read as follows:

- 1 1. A carrier which offers a managed care plan that provides
2 benefits or health care services, as applicable, for the home
3 treatment of bleeding episodes associated with hemophilia,
4 including the purchase of blood products and blood infusion
5 equipment, shall comply with the provisions of this section.
- 6 a. For the purpose of providing home treatment services for
7 bleeding episodes associated with hemophilia, the carrier shall be
8 required to contract with, and exclusively use, providers that
9 comply with standards adopted by regulation of the Department of
10 **【Banking and Insurance】** Health in consultation with the
11 Hemophilia Association of New Jersey. At a minimum, the
12 standards shall require that each provider:
- 13 (1) provide services pursuant to a prescription from the covered
14 person's attending physician and not make any substitutions of
15 blood products without prior approval of the attending physician;
- 16 (2) provide all brands of clotting factor products in low, medium
17 and high-assay range levels to execute treatment regimens as
18 prescribed by a covered person's attending physician, and all needed
19 ancillary supplies for the treatment or prevention of bleeding
20 episodes, including, but not limited to, needles, syringes, and cold
21 compression packs;
- 22 (3) have the ability to deliver prescribed blood products,
23 medications, and nursing services within three hours after receipt of
24 a prescription for an emergent situation, and maintain 24-hour on-
25 call service to accommodate this requirement;
- 26 (4) demonstrate experience with and knowledge of bleeding
27 disorders and the management thereof;
- 28 (5) demonstrate the ability for appropriate and necessary record
29 keeping and documentation, including the ability to expedite
30 product recall or notification systems and the ability to assist
31 covered persons in obtaining third party reimbursement;
- 32 (6) provide for proper removal and disposal of hazardous waste
33 pursuant to State and federal law;
- 34 (7) provide covered persons with a written copy of the agency's
35 policy regarding discontinuation of services related to loss of health
36 benefits plan coverage or inability to pay; and
- 37 (8) provide covered persons, upon request, with information
38 about the expected costs for medications and services provided by
39 the agency that are not otherwise covered by the covered person's
40 health benefits plan.
- 41 b. The Department of **【Banking and Insurance】** Health shall
42 compile a list of providers who meet the minimum standards
43 established pursuant to this section and shall make the list available
44 to carriers and covered persons, upon request.
- 45 c. As used in this section: "blood product" includes, but is not
46 limited to, Factor VIII, Factor IX and cryoprecipitate; and "blood

1 infusion equipment" includes, but is not limited to, syringes and
2 needles.

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

4

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

7 11. The Department of **【Banking and Insurance】** Health,
8 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
9 (C.52:14B-1 et seq.), shall adopt regulations to carry out the
10 provisions of sections 1 and 2 of this act.

11 (cf: P.L.2012, c.17, s.298)

12

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

15 3. The Commissioner of **【Banking and Insurance】** Health, in
16 consultation with the Commissioner of **【Health】** Banking and
17 Insurance and the State Board of Medical Examiners, shall
18 prescribe the size, content, and format of the notice about the
19 Independent Health Care Appeals Program to be posted in general
20 hospitals pursuant to section 1 of P.L.2011, c.190 (C.26:2S-14.1)
21 and in physicians' medical offices pursuant to section 2 of P.L.2011,
22 c.190 (C.45:9-22.26), and shall make the notice available to general
23 hospitals and physicians, and to members of the general public, by
24 posting it on the Internet website of the Department of **【Banking**
25 **and Insurance】** Health.

26 (cf: P.L.2012, c.17, s.300)

27

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

30 2. As used in this act:

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

33 "Commissioner" means the Commissioner of **【Banking and**
34 **Insurance】** Health.

35 "Department" means the Department of **【Banking and**
36 **Insurance】** Health.

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

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

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

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

46 "Program" means the Managed Health Care Consumer
47 Assistance Program established pursuant to this act.

48 (cf: P.L.2012, c.17, s.302)

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

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

9 b. The program shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44

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

47 8. The Commissioner of **【Banking and Insurance】** Health,
48 pursuant to the "Administrative Procedure Act," P.L.1968, c.410

1 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate
2 the purposes of this act.

3 (cf: P.L.2012, c.17, s.304)

4

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

10

11

12

STATEMENT

13

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

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

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