

SENATE, No. 2154

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED MARCH 16, 2020

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

SYNOPSIS

Concerns the delivery and oversight of coverage under certain health benefits plans; establishes Health Care Patient Ombudsperson in the Division of Consumer Affairs.

CURRENT VERSION OF TEXT

As introduced.



1 **AN ACT** concerning the delivery and oversight of coverage under
2 certain health benefits plans, and supplementing and amending
3 various parts of the statutory law.

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

7
8 1. (New section) a. A carrier, multiple employer welfare
9 arrangement or other health benefits plan provider, or its agent,
10 contractor, or administrator, including but not limited to a third
11 party administrator for a self-insured health benefits plan, shall
12 issue or require the issuance of a health benefits plan identification
13 card to at least the primary covered person under the health benefits
14 plan.

15 b. The health benefits plan identification card shall, at a
16 minimum, include the following information, which shall be
17 presented in a readily identifiable manner on the card or,
18 alternatively, embedded on the card and available through
19 electronic extraction using a magnetic stripe or other means:

20 (1) the primary covered person's name and health benefits plan
21 identification number;

22 (2) the contract holder's name and health benefits plan
23 identification number, if different than the name and identification
24 number of the primary covered person;

25 (3) the health benefits plan group number, if applicable;

26 (4) the name of the issuing carrier, multiple employer welfare
27 arrangement or other health benefits plan provider, or the agent,
28 contractor or administrator that is administering the plan;

29 (5) the effective date of the health benefits plan coverage;

30 (6) the appropriate mailing address or Internet website address
31 for filing any claim pursuant to the provisions of P.L.1999,
32 c.154 (C.17B:30-23 et al.);

33 (7) a covered person's copayment obligations, for at least the
34 following:

35 (a) a primary care office visit;

36 (b) a specialty care office visit; and

37 (c) an emergency room visit; and

38 (8) the phone number or Internet website address for a covered
39 person or health care provider to obtain the following:

40 (a) confirmation of the effective date of health benefits plan
41 coverage;

42 (b) verification of a particular benefit provided under the health
43 benefits plan coverage;

44 (c) prior authorization, as provided for pursuant to section 5 of
45 P.L.2005, c.352 (C.17B:30-52) or as otherwise provided pursuant to

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 the terms of the health benefits plan; and

2 (d) contact information for health care providers participating in
3 the health benefits plan network, if applicable.

4 c. The health benefits plan identification card shall be designed
5 so that whenever the card is photocopied or electronically scanned,
6 the resulting image is clearly legible.

7

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

10 9. The Commissioner of Banking and Insurance, in
11 consultation with representatives of managed care plans and health
12 care providers as the commissioner deems appropriate, shall
13 establish by regulation a universal contract for participation form,
14 for use by any carrier which offers a managed care plan, consistent
15 with the provisions of this section, for the purposes of establishing
16 and renewing health care provider participation in that plan. The
17 commissioner shall revise the universal contract form, as necessary,
18 to conform with any available industry-wide, national standards for
19 managed care plan participation. Nothing herein shall be construed
20 to prevent a carrier from supplementing the universal contract form
21 with additional contractual provisions, so long as the additional
22 provisions do not duplicate or contradict the provisions set forth in
23 the universal contract form.

24 A carrier which offers a managed care plan shall contract with a
25 participating health care provider only after: providing that health
26 care provider an opportunity to review the proposed contract for
27 participation, presented on the universal contract form, as well as a
28 summary disclosure form for that contract which sets forth the
29 compensation terms, treatment policies, protocols, quality assurance
30 activities, and utilization management systems related to the
31 managed care plan and the health care provider's participation in
32 the managed care plan as set forth in section 3 of P.L. _____,
33 c. (C. _____) (pending before the Legislature as this bill); and, if
34 applicable, the health care provider submits, and the carrier accepts,
35 the universal physician application for participation form or renewal
36 form established pursuant to P.L.2001, c.88 (C.26:2S-7.1 et seq.).

37 The contract between a participating health care provider and a
38 carrier which offers a managed care plan:

39 a. Shall state that the health care provider shall not be
40 penalized or the contract terminated by the carrier because the
41 health care provider acts as an advocate for the patient in seeking
42 appropriate, medically necessary health care services;

43 b. Shall not provide financial incentives to the health care
44 provider for withholding covered health care services that are
45 medically necessary as determined in accordance with section 6 of
46 this act, except that nothing in this subsection shall be construed to
47 limit the use of capitated payment arrangements between a carrier
48 and a health care provider; [and]

1 c. Shall protect the ability of a health care provider to
2 communicate openly with a patient about all appropriate diagnostic
3 testing and treatment options;

4 d. Shall not require the participation of the health care provider
5 in any managed care plan other than the one or more specified
6 under the terms of the contract, and shall not include participation
7 in any future managed care plan to be offered by the carrier as a
8 condition of participating in the one or more managed care plans
9 specified under the contract;

10 e. Shall not prohibit the health care provider from entering into
11 a contract to be a participating health care provider with any other
12 carrier;

13 f. Shall not prohibit the contracting carrier from contracting
14 with any other health care provider to also be a participating health
15 care provider;

16 g. Shall not contain any provision, commonly referred to as a
17 “most favored nation” clause, that: (1) prohibits, or grants the
18 carrier the option to prohibit, the health care provider from
19 contracting with another carrier for less compensation than that
20 provided by the compensation terms specified under the contract;
21 (2) requires, or grants the carrier the option to require, the health
22 care provider to accept lower compensation in the event the health
23 care provider contracts with another carrier for less compensation
24 than that provided by the compensation terms specified under the
25 contract; (3) requires, or grants the carrier the option to require,
26 termination or renegotiation of the contract if the health care
27 provider contracts with another carrier for less compensation than
28 that provided by the compensation terms specified under the
29 contract; or (4) requires the health care provider to disclose the
30 provider’s compensation terms with any other carrier with which
31 the provider contracts. The provisions of this subsection shall not
32 apply to any contract between a carrier and a health care provider
33 that is a hospital licensed pursuant to Title 26 of the Revised
34 Statutes;

35 h. Shall not be amended by the carrier without proper notice to
36 the health care provider.

37 (1) Whenever the carrier seeks to make a material amendment to
38 the contract, which shall include any amendment that changes
39 administrative procedures under the contract in a way that may
40 reasonably be expected to significantly increase the health care
41 provider’s administrative expenses, or adds or removes a managed
42 care plan or network subject to the contract, the carrier shall send a
43 written request to the health care provider or appropriate contact
44 person as designated in the contract detailing the proposed material
45 amendment by certified mail, return receipt requested or by a secure
46 electronic mail transmission. The written request shall be delivered
47 not less than 90 calendar days prior to the proposed effective date of
48 the amendment. The health care provider may accept or reject the

1 proposed amendment in writing at any time prior to the proposed
2 effective date of the amendment, and:

3 (a) if it is accepted as evidenced by a written confirmation, the
4 amendment shall be incorporated into the contract and take effect as
5 provided by the amendment;

6 (b) if it is rejected as evidenced by a written confirmation, the
7 amendment shall not be incorporated into the contract; or

8 (c) if it is not accepted or rejected by a written confirmation, the
9 amendment shall be deemed rejected and not incorporated into the
10 contract.

11 (2) Whenever the carrier seeks to make an amendment that is
12 not a material amendment as set forth in paragraph (1) of this
13 subsection, the carrier shall send a written request to the health care
14 provider or appropriate contact person as designated in the contract
15 detailing the proposed amendment by regular mail or by a secure
16 electronic mail transmission. The written request shall be delivered
17 not less than 15 calendar days prior to the proposed effective date of
18 the amendment. The health care provider may accept or reject the
19 proposed amendment in writing at any time prior to the proposed
20 effective date of the amendment, following the same procedure for
21 accepting or rejecting a proposed material amendment set forth in
22 paragraph (1) of this subsection.

23 i. (1) Shall remain in effect for a specific duration, as
24 specified in the contract, and shall not automatically renew unless
25 the health care provider and carrier agree to the automatic renewal
26 of the contract as evidenced by a separately signed clear and
27 conspicuous automatic renewal provision in the contract, or a
28 separately signed document concerning the automatic renewal of
29 the contract; and

30 (2) Shall remain in effect for the specific duration specified in
31 the contract, notwithstanding the carrier's participation in any
32 merger, consolidation, or other acquisition of another carrier or
33 entity, or another managed care plan; and

34 j. (1) Shall provide for a binding arbitration mechanism, as
35 established by the Commissioner of Banking and Insurance
36 pursuant to this subsection, concerning contractual disputes
37 involving any contract established pursuant to this section and the
38 rights conferred therein. The commissioner shall contract with a
39 nationally recognized, independent organization that specializes in
40 arbitration to conduct the arbitration proceedings.

41 (2) Any party to the contract may initiate an arbitration
42 proceeding. The arbitrator may award reasonable attorney's fees
43 and costs to the prevailing party in the arbitration proceeding.

44 (3) Any dispute pertaining to medical necessity which is eligible
45 to be submitted to the Independent Health Care Appeals Program
46 established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)
47 shall not be the subject of arbitration pursuant to this subsection.

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

1 3. (New section) a. A carrier which offers a managed care
2 plan shall, in an offer to contract with a participating health care
3 provider, include a summary disclosure form for that contract.

4 b. The summary disclosure form shall include the following,
5 with specific cross-references to the location of the provisions
6 within the actual contract being offered from which the summary is
7 based:

8 (1) information, consistent with section 1 of P.L.2005,
9 c.286 (C.26:2S-9.2) if applicable, that is sufficient to allow the
10 participating health care provider to determine the compensation
11 terms, indicating the applicable predetermined fees or
12 reimbursement rates for covered services agreed to be performed by
13 the participating health care provider, or the methodology agreed to
14 for determining the fees or reimbursement rates through a generally
15 recognized method of payment or mode of classification, including
16 fee-for-service, resource-based relative value schedule, per diem,
17 diagnosis-related group, capitation, the Current Procedural
18 Terminology codes developed and maintained by the American
19 Medical Association, or the Healthcare Common Procedure Coding
20 System utilized by the Centers for Medicare and Medicaid Services.
21 The carrier shall indicate the effect, if any, on compensation for a
22 covered service provided if more than one procedural code or other
23 classification applies to that covered service;

24 (2) the type and number of managed care plans for which the
25 contract shall apply, and the number of networks within which the
26 health care provider shall participate;

27 (3) the term of the contract and a list of addenda, if any, to the
28 contract;

29 (4) contact information for the carrier or administrator
30 responsible for processing claims pursuant to P.L.1999,
31 c.154 (C.17B:30-23 et al.);

32 (5) the application of any internal processing edits to claims,
33 including, if applicable, the editing product software name, version,
34 and version update; and

35 (6) a summary of the internal appeals mechanism established to
36 resolve disputes raised by a health care provider under the contract
37 pursuant to subsection e. of sections 2 through 7 and section 10 of
38 P.L.1999, c.154 (C.17:48-8.4, C.17:48A-7.12, C.17:48E-10.1,
39 C.17B:26-9.1, C.17B:27-44.2, C.26:2J-8.1 and C.17:48F-13.1).

40 c. In addition to the summarization of contract provisions
41 provided pursuant to subsection b. of this section, the summary
42 disclosure form shall indicate:

43 (1) reading the summary disclosure form shall not be a
44 substitute for reading the entire contract;

45 (2) the summary disclosure form is an overview to the actual
46 contract offered to the participating health care provider, and the
47 terms and conditions stated in that contract constitute the exclusive
48 contractual rights of the parties;

1 (3) by agreeing to and signing the contract, the participating
2 health care provider shall be bound by the terms and conditions
3 stated in that contract;

4 (4) nothing within the summary disclosure form shall create any
5 additional rights or causes of action for any contracting party; and

6 (5) the terms and conditions of the contract are subject to
7 amendment pursuant to the process set forth under subsection h. of
8 section 9 of P.L.1997, c.192 (C.26:2S-9), and recommend that the
9 participating health care provider always review and deliberately
10 consider any proposed amendments.

11

12 4. Section 1 of P.L.2005, c.286 (C.26:2S-9.2) is amended to
13 read as follows:

14 1. a. A carrier which offers a managed care plan that negotiates
15 with a health care provider to become a participating provider, who
16 is reimbursed per procedure under the plan, shall, by January 1 of
17 each calendar year for a health care provider under an existing
18 contract applicable for the previous calendar year, and otherwise
19 within 15 days upon request, furnish the health care provider with a
20 written fee schedule, or in an electronic format if agreed upon by
21 both parties, showing the specifically defined compensation terms
22 or generally recognized method of payment or mode of
23 classification for determining the fees for that health care provider,
24 and the fees for [the 20 most common] all evaluation and
25 management codes and [the 20 most common office-based or
26 hospital-based] in-network services for the health care provider's
27 specialty or sub-specialty, to be provided by the health care
28 provider under the plan pursuant to the proposed or existing
29 contract between the carrier and health care provider. If the carrier
30 negotiates with the health care provider to become a participating
31 provider under more than one managed care plan offered by the
32 carrier, the carrier shall provide the applicable fee schedule for each
33 plan. If the carrier negotiates a fee schedule with the health care
34 provider that is specific to that health care provider, the carrier shall
35 provide only the applicable fee schedule for that health care
36 provider. [If the rate that the health care provider will be paid is a
37 percentage of another rate, it shall be sufficient for the carrier to
38 provide that formula to the health care provider. The carrier shall
39 furnish the fee schedule pursuant to this subsection within 15 days
40 of the request of the provider.]

41 The fee schedule provided to the health care provider by the
42 carrier is proprietary and shall be confidential. Unauthorized
43 distribution of the fee schedule may result in the health care
44 provider's termination from the network [in accordance with the
45 provisions of N.J.A.C. 8:38-1.1 et seq] as provided by regulation of
46 the Commissioner of Banking and Insurance.

47 b. The carrier shall reimburse the health care provider in
48 accordance with the annual fee schedule provided to the health care

1 provider pursuant to the contract, and the carrier shall not amend
2 this fee schedule during the calendar year for which the fee
3 schedule is applicable. [The carrier may revise the fee schedule
4 upon providing the health care provider with written notice of the
5 change and, upon request, a copy of the revised fee schedule] The
6 carrier shall deliver written notice of any amendment to the fee
7 schedule to the health care provider not less than 90 calendar days
8 prior to providing the health care provider a new annual fee
9 schedule, by January 1 as required pursuant to subsection a. of this
10 section, to apply to the calendar year next following.

11 c. Nothing in this section shall be construed to limit the ability
12 of a carrier to make payments under a managed care plan based on
13 its claims payment policies.

14 (cf: P.L.2005, c.286, s.1)

15

16 5. (New section) As used in sections 5 through 9 of this act:

17 “Benefits payer” means a carrier, organized delivery system,
18 employer, or any other person who undertakes to provide and
19 assumes financial risk for the payment of health benefits, and is
20 obligated to pay claims for health benefits on behalf of a covered
21 person to a health care provider or other claimant.

22 “Carrier” means an insurance company, health service
23 corporation, hospital service corporation, medical service
24 corporation, health maintenance organization, or prepaid
25 prescription service organization authorized to issue any health
26 benefits plan in this State.

27 “Covered person” means a person on whose behalf a benefits
28 payer is obligated to pay benefits pursuant to a health benefits plan.

29 “Covered service” means a service provided by a health care
30 provider or organized delivery system to a covered person under a
31 health benefits plan for which a benefits payer is obligated to pay
32 benefits.

33 “Health benefits plan” means any hospital or medical expense
34 insurance policy, health service corporation contract, hospital
35 service corporation contract, medical service corporation contract,
36 health maintenance organization contract, or other contract, policy,
37 or plan that pays or provides hospital or medical expense benefits
38 for covered services, and is delivered or issued for delivery in this
39 State by or through a benefits payer. Health benefits plan includes,
40 but is not limited to, the following contracts, policies, and plans:
41 accident only or disability income insurance, or any combination
42 thereof; liability insurance, including general liability insurance and
43 motor vehicle liability insurance; workers’ compensation or similar
44 insurance; and motor vehicle medical payment insurance or
45 personal injury protection coverage provided by a motor vehicle or
46 automobile insurance policy issued pursuant to Subtitle 3 of Title
47 17 of the Revised Statutes (R.S.17:17-1 et seq.) or P.L.1972,
48 c.70 (C.39:6A-1 et seq.).

1 “Health care provider” means an individual or entity, which
2 while acting within the scope of the individual’s or entity’s
3 licensure or certification, provides a covered service defined by a
4 health benefits plan. Health care provider includes, but is not
5 limited to, a physician or any other health care professional licensed
6 or certified pursuant to Title 45 of the Revised Statutes, or a
7 hospital or any other health care facility licensed pursuant to
8 P.L.1971, c.136 (C.26:2H-1 et seq.).

9 “Network” means one or more health care providers which enter
10 into a selective contracting arrangement with a benefits payer.

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

13 “Selective contracting arrangement” means an arrangement in
14 which a benefits payer participates in selective contracting with one
15 or more participating health care providers or organized delivery
16 systems, and which arrangement contains reasonable benefit
17 differentials, including, but not limited to, predetermined fee or
18 reimbursement rates for covered services applicable to participating
19 and nonparticipating health care providers and organized delivery
20 systems.

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

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

25
26 6. (New section) A person or entity, other than a benefits
27 payer, carrier, organized delivery system, health care provider, or
28 third party administrator or billing service, as set forth in section 7
29 of this act, shall not sell, lease, transfer, assign, or otherwise
30 disclose any predetermined fee or reimbursement rate for covered
31 services agreed to in any selective contracting arrangement.

32
33 7. (New section) a. Except as otherwise provided by this
34 section: (1) a benefits payer which enters into, or proposes to enter
35 into, a selective contracting arrangement; (2) a third party
36 administrator for that benefits payer; (3) a carrier or organized
37 delivery system participating or proposing to participate in the
38 selective contracting arrangement; (4) a health care provider
39 participating or proposing to participate in the selective contracting
40 arrangement; or (5) a third party billing service for that health care
41 provider, shall not sell, lease, transfer, assign, or otherwise disclose
42 any predetermined fee or reimbursement rate for covered services
43 agreed to in the selective contracting arrangement.

44 b. Notwithstanding the provisions of subsection a. of this
45 section, the benefits payer, carrier or organized delivery system
46 proposing to participate in a selective contracting arrangement with
47 a health care provider may disclose any predetermined fee or
48 reimbursement rate pursuant to the provisions of section 1 of

1 P.L.2005, c.286 (C.26:2S-9.2) for the purpose of negotiation
2 between the parties with respect to the terms of the selective
3 contracting arrangement.

4 c. Notwithstanding the provisions of subsection a. of this
5 section, the benefits payer, or a carrier or organized delivery system
6 participating in the selective contracting arrangement, may disclose
7 any predetermined fee or reimbursement rate, for the purpose of
8 administering the payment of a claim for a covered service, to: (1) a
9 third party administrator for that benefits payer; (2) a carrier or
10 organized delivery system participating in the selective contracting
11 arrangement; (3) a health care provider participating in the selective
12 contracting arrangement; (4) a third party billing service for that
13 health care provider; or (5) a covered person.

14 d. Notwithstanding the provisions of subsection a. of this
15 section, the benefits payer, or a carrier or organized delivery system
16 participating in the selective contracting arrangement, may disclose
17 any predetermined fee or reimbursement rate, for the purpose of
18 providing an incentive to utilize a network or organized delivery
19 system participating in the selective contracting arrangement, to: (1)
20 the benefits payer; (2) a carrier or organized delivery system
21 participating in the selective contracting arrangement; or (3) a
22 covered person. For the purposes of this subsection, "incentive"
23 means reduced copayments, reduced deductibles, or premium
24 discounts attributable to the use of a health care provider in a
25 network or organized delivery system for any covered service, or a
26 financial penalty attributable to the use of any health care provider
27 not participating in that network or organized delivery system.

28
29 8. (New section) A benefits payer, carrier, organized delivery
30 system, or health care provider that does not participate in a
31 selective contracting arrangement, or a third party administrator or
32 billing service acting on behalf of a benefits payer or health care
33 provider that does not participate in the selective contracting
34 arrangement, shall not calculate or pay any fee or reimbursement
35 rate for covered services by using any negotiated, predetermined fee
36 or reimbursement rate agreed to in the selective contracting
37 arrangement.

38
39 9. (New section) Any benefits payer, carrier, organized
40 delivery system, health care provider, third party administrator or
41 billing service, or other person or entity, which violates any
42 provision of sections 5 through 9 of this act shall be ordered to pay
43 restitution to any person aggrieved by the violation, and shall be
44 liable to a civil penalty in an amount not less than \$500, or more
45 than \$10,000, for each violation. A penalty shall be collected and
46 enforced by summary proceedings pursuant to the provisions of the
47 "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10
48 et seq.).

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

3 3. a. (1) There is established the Managed Health Care
4 Consumer Assistance Program in the Department of Banking and
5 Insurance. 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 (2) This program shall be transferred to the Division of
10 Consumer Affairs in the Department of Law and Public Safety and
11 continued under the Health Care Patient Ombudsperson as set forth
12 in sections 11 and 12 of P.L. , c. (C.) (pending before the
13 Legislature as this bill).

14 b. The program shall:

15 (1) create and provide educational materials and training to
16 consumers regarding their rights and responsibilities as enrollees in
17 managed care plans, including materials and training specific to
18 Medicaid, NJ FamilyCare, Medicare, and commercial managed care
19 plans;

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

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

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

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

44 (6) provide feedback to managed care plans, beneficiary
45 advisory groups and employers regarding enrollees' concerns and
46 problems;

47 (7) provide nonpartisan information about federal and State
48 activities relative to managed care, and provide assistance to

1 individuals in obtaining copies of pending legislation, statutes, and
2 regulations; and

3 (8) develop and maintain a data base monitoring the degree of
4 each type of service provided by the program to individual
5 enrollees, the types of concerns and complaints brought to the
6 program and the entities about which complaints and concerns are
7 brought.

8 c. In order to meet its objectives, the program shall have access
9 to:

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

13 (2) the administrative records, policies, and documents of
14 managed care plans to which individuals or the general public have
15 access; and

16 (3) all licensing, certification, and data reporting records
17 maintained by the State or reported to the federal government by the
18 State that are not proprietary information or otherwise protected by
19 law, with copies thereof to be supplied to the program by the State
20 upon the request of the program.

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

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

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

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

1 presented in a readily identifiable manner on the card or embedded
2 on the card and available through electronic extraction. The
3 information included on the card shall include, but not be limited to:
4 the primary covered person's name and identification number; the
5 contract holder's name and identification number, if different than
6 the primary covered person; the name of the issuing health benefits
7 plan provider, or the agent, contractor or administrator that is
8 administering the plan; contact information for filing benefits
9 claims and obtaining other information about coverage; and a
10 covered person's copayment obligations.

11 Second, the bill requires the Commissioner of Banking and
12 Insurance, in consultation with representatives of managed care
13 plans and health care providers, to establish by regulation a
14 universal contract for participation form, for use by any carrier
15 which offers a managed care plan for the purpose of establishing
16 and renewing health care provider participation in that plan.
17 Notwithstanding the adoption of a universal contract form, nothing
18 in the bill shall be construed to prevent a carrier from
19 supplementing the form with additional contractual provisions, so
20 long as the additional provisions do not duplicate or contradict the
21 provisions set forth in the universal contract form.

22 The contract between the carrier and the participating health care
23 provider shall include certain provisions, primarily intended to
24 protect the health care provider. These provisions: shall not require
25 participation in any managed care plan other than the one or more
26 specified under the terms of the contract; shall not include
27 participation in any future managed care plan to be offered by the
28 carrier as a condition of participating in the one or more managed
29 care plans specified under the contract; shall not prohibit the health
30 care provider from entering into a contract with any other carrier;
31 shall not contain any provision, commonly referred to as a "most
32 favored nation" clause, which impacts a health care provider who
33 contracts with another carrier for less compensation than that
34 provided by the compensation terms under the contract; sets forth
35 notice and written acceptance requirements for making material and
36 non-material amendments to the contract; and requires the use of an
37 independent, binding arbitration process, contracted by the
38 Commissioner of Banking and Insurance, to resolve contractual
39 disputes.

40 A carrier which offers a managed care plan shall only contract
41 with a participating health care provider after: (1) the health care
42 provider submits, and the carrier accepts, the universal physician
43 application for participation form or renewal form established
44 pursuant to P.L.2001, c.88 (C.26:2S-7.1 et seq.), if applicable; and
45 (2) the health care provider is given an opportunity to review the
46 proposed contract for participation, presented on the universal
47 contract form, as well as a summary disclosure form for that
48 contract. The summary disclosure form shall detail the

1 compensation terms, treatment policies, protocols, quality assurance
2 activities, and utilization management systems related to the
3 managed care plan and the health care provider's participation in
4 that plan. The summary disclosure form shall also indicate specific
5 cross-references to the location of the provisions within the actual
6 contract being offered by the carrier from which the summary is
7 based.

8 Additionally, a carrier shall, by January 1 of each calendar year
9 for health care providers under existing contracts, and otherwise
10 within 15 days upon request, furnish a fee schedule, showing the
11 specifically defined compensation terms, or generally recognized
12 method of payment or mode of classification for determining fees,
13 and the fees for all codes and in-network services. This annual fee
14 schedule shall not be amended during the calendar year for which it
15 is applicable, and the carrier shall provide adequate notice, not less
16 than 90 days, concerning any amendment to the fee schedule to
17 apply in a subsequent calendar year.

18 Third, the bill regulates the disclosure and use of privately
19 negotiated in-network fees and reimbursement rates agreed to
20 between health care providers and carriers and other payers, for use
21 by these parties, and their third party administrators and billing
22 services, in administering the payment of claims for services
23 provided pursuant to managed care plans and other health benefits
24 plans.

25 With respect to a selective contracting arrangement under a
26 health benefits plan, the bill provides that: (1) a benefits payer
27 which enters into, or proposes to enter into, such an arrangement;
28 (2) a third party administrator for that benefits payer; (3) a carrier or
29 organized delivery system participating or proposing to participate
30 in the selective contracting arrangement; (4) a health care provider
31 participating or proposing to participate in the selective contracting
32 arrangement; or (5) a third party billing service for that health care
33 provider, shall not sell, lease, transfer, assign, or otherwise disclose
34 any predetermined fee or reimbursement rate for covered services
35 agreed to in the selective contracting arrangement.

36 Notwithstanding this blanket prohibition, the bill establishes
37 several disclosure exceptions for the participating parties to the
38 selective contracting arrangement. First, the benefits payer, carrier
39 or organized delivery system, proposing to participate in a selective
40 contracting arrangement with a health care provider may disclose
41 any predetermined fee or reimbursements rate pursuant to the
42 provisions of section 1 of P.L.2005, c.286 (C.26:2S-9.2) for the
43 purpose of negotiation between the parties with respect to the terms
44 of the selective contracting arrangement. Second, the benefits
45 payer, or a participating carrier or organized delivery system, may
46 disclose any predetermined fee or reimbursement rate, for the
47 purpose of administering the payment of a claim, to: (1) a third
48 party administrator for that benefits payer; (2) a participating carrier

1 or organized delivery system; (3) a participating health care
2 provider; (4) a third party billing service for that health care
3 provider; or (5) a covered person. Additionally, the benefits payer,
4 carrier or organized delivery system may disclose any
5 predetermined fee or reimbursement rate, in order to provide an
6 incentive to utilize a contracted provider network or organized
7 delivery system, to: (1) the benefits payer; (2) a participating carrier
8 or organized delivery system; or (3) a covered person.

9 Any person or entity that is not a party to the selective
10 contracting arrangement as described above shall not sell, lease,
11 transfer, assign, or otherwise disclose any predetermined fee or
12 reimbursement rate for covered services agreed to in that selective
13 contracting arrangement.

14 Also, the bill provides that a benefits payer, carrier, organized
15 delivery system, or health care provider that does not participate in
16 the selective contracting arrangement, or a third party administrator
17 or billing service acting on behalf of a benefits payer or health care
18 provider that does not participate in the selective contracting
19 arrangement, shall not calculate or pay any fee or reimbursement
20 rate for covered services by using any negotiated, predetermined fee
21 or reimbursement rate agreed to in that selective contracting
22 arrangement.

23 Any benefits payer, carrier, organized delivery system, health
24 care provider, third party administrator or billing service, or other
25 person or entity which violates any applicable provisions of the bill
26 concerning in-network fee and reimbursement rate disclosures shall
27 be ordered to pay restitution to any person aggrieved by the
28 violation, and shall be liable to a civil penalty in an amount not less
29 than \$500, or more than \$10,000, for each violation. Any penalty
30 shall be collected and enforced by summary proceedings pursuant
31 to the provisions of the "Penalty Enforcement Law of 1999,"
32 P.L.1999, c.274 (C.2A:58-10 et seq.).

33 Finally, the bill establishes a Health Care Patient Ombudsperson,
34 in the Division of Consumer Affairs in the Department of Law and
35 Public Safety. The Health Care Patient Ombudsperson shall be
36 appointed by the Director of the Division of Consumer Affairs and
37 shall serve at the pleasure of the director.

38 All function, powers, and duties now vested under the Managed
39 Health Care Consumer Assistance Program in the Department of
40 Banking and Insurance, as referenced in section 3 of P.L.2001,
41 c.14 (C.26:2S-21), are transferred by the bill and assumed by the
42 Health Care Patient Ombudsperson. Additionally, the
43 ombudsperson shall coordinate functions and duties, as appropriate,
44 with the Director of the Division of Mental Health Advocacy.