SENATE, No. 1128

STATE OF NEW JERSEY

220th LEGISLATURE

INTRODUCED JANUARY 31, 2022

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.

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

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

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

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

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

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

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

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

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

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

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

(a) a primary care office visit;

(b) a specialty care office visit; and

(c) an emergency room visit; and

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

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

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

(c) prior authorization, as provided for pursuant to section 5 of P.L.2005, c.352 (C.17B:30-52) or as otherwise provided pursuant to the terms of the health benefits plan; and

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 <u>thus</u> is new matter.

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

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

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

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

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

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

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

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

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

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

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

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

g. Shall not contain any provision, commonly referred to as a "most favored nation" clause, that: (1) prohibits, or grants the carrier the option to prohibit, the health care provider from contracting with another carrier for less compensation than that provided by the compensation terms specified under the contract; (2) requires, or grants the carrier the option to require, the health care provider to accept lower compensation in the event the health care provider contracts with another carrier for less compensation than that provided by the compensation terms specified under the contract; (3) requires, or grants the carrier the option to require, termination or renegotiation of the contract if the health care provider contracts with another carrier for less compensation than that provided by the compensation terms specified under the contract; or (4) requires the health care provider to disclose the provider's compensation terms with any other carrier with which the provider contracts. The provisions of this subsection shall not apply to any contract between a carrier and a health care provider that is a hospital licensed pursuant to Title 26 of the Revised Statutes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) information, consistent with section 1 of P.L.2005, c.286 (C.26:2S-9.2) if applicable, that is sufficient to allow the participating health care provider to determine the compensation terms, indicating the applicable predetermined fees or reimbursement rates for covered services agreed to be performed by the participating health care provider, or the methodology agreed to for determining the fees or reimbursement rates through a generally recognized method of payment or mode of classification, including 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. The carrier shall indicate the effect, if any, on compensation for a covered service provided if more than one procedural code or other classification applies to that covered service;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization, or prepaid prescription service organization authorized to issue any health benefits plan in this State.

"Covered person" means a person on whose behalf a benefits payer is obligated to pay benefits pursuant to a health benefits 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 for which a benefits payer is obligated to pay benefits.

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

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

"Network" means one or more health care providers which enter into a selective contracting arrangement with a benefits payer.

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

"Selective contracting arrangement" means an arrangement in which a benefits payer participates in selective contracting with one or more participating health care providers or organized delivery systems, 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 and organized delivery systems.

"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).

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

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

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

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

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

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

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

9. (New section) Any benefits payer, carrier, organized delivery system, health care provider, third party administrator or billing service, or other person or entity, which violates any provision of sections 5 through 9 of this act shall be ordered to pay restitution to any person aggrieved by the violation, and 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.).

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

3. a. (1) There is established the Managed Health Care Consumer Assistance Program in the Department of Banking and Insurance. The commissioner shall make agreements to operate the program as necessary, in consultation with the Commissioner of Human Services, to assure that citizens have reasonable access to services in all regions of the State.

(2) This program shall be transferred to the Division of Consumer Affairs in the Department of Law and Public Safety and continued under the Health Care Patient Ombudsperson as set forth in sections 11 and 12 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. The program shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. (New section) There is hereby established in the Division of Consumer Affairs in the Department of Law and Public Safety a Health Care Patient Ombudsperson. The Health Care Patient Ombudsperson shall be appointed by the Director of the Division of Consumer Affairs and shall serve at the pleasure of the director.

12. (New section) a. All functions, powers, and duties now vested under the Managed Health Care Consumer Assistance Program in the Department of Banking and Insurance, as referenced in section 3 of P.L.2001, c.14 (C.26:2S-21), are hereby transferred to and assumed by the Health Care Patient Ombudsperson in the Division of Consumer Affairs in the Department of Law and Public Safety.

b. The Health Care Patient Ombudsperson shall coordinate functions and duties, as appropriate, with the Director of the Division of Mental Health Advocacy established pursuant to section 29 of P.L.2005, c.155 (C.52:27EE-29).

c. Whenever, in any law, rule, regulation, order, reorganization plan, contract, document, judicial or administrative proceeding, or otherwise, reference is made to the Managed Health Care Consumer Assistance Program, prior to and including its transfer to the Department of Banking and Insurance as part of the department's Office of Insurance Claims Ombudsman, the same shall mean and refer to the Health Care Patient Ombudsperson in the Division of Consumer Affairs in the Department of Law and Public Safety.

13. This act shall take effect on the first day of the seventh month next following enactment, and shall apply to all health benefits plans that are delivered, issued, executed or renewed, or approved for issuance or renewal in this State, on or after the effective date; but the Commissioner of Banking and Insurance and the Director of the Division of Consumer Affairs may take any anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

This bill concerns the delivery and oversight of coverage under various health benefits plans by mandating the issuance of identification cards, standardizing contract forms and enhancing contractual obligations between carriers and health care providers participating in plans, and establishing a Health Care Patient Ombudsperson in the Division of Consumer Affairs in the Department of Law and Public Safety.

First, the bill requires the issuance of a health benefits plan identification card to at least the primary covered person under the health benefits plan. The card shall include information, either

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

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

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

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

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

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

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

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

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

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

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

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

Any benefits payer, carrier, organized delivery system, health care provider, third party administrator or billing service, or other person or entity which violates any applicable provisions of the bill concerning in-network fee and reimbursement rate disclosures shall be ordered to pay restitution to any person aggrieved by the violation, and shall be liable to a civil penalty in an amount not less than $500, or more than $10,000, for each violation. Any 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.).

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

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