

## CHAPTER 14

**AN ACT** establishing a Managed Health Care Consumer Assistance Program, amending and supplementing P.L.1997, c.192, and making an appropriation therefor.

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

C.26:2S-19 Findings, delcarations relative to Managed Health Care Consumer Assistance Program.

1. The Legislature finds and declares that:

a. Managed health care, regardless of the form it takes, is now a major vehicle for the delivery of health care in this nation; and the rapid transition to managed health care has left consumers confused and concerned about how it affects them and how to navigate the managed health care system;

b. Despite the clear promises of reduced costs, quality service and comprehensive care made by managed care plans, many consumers are uncertain about how to obtain appropriate care and inhibited in their efforts to do so. They often lack necessary information about the benefits and referral requirements of specific plans and have no access to resources which might assist them to obtain quality care on a timely basis;

c. Consumers need help understanding their rights and responsibilities and how to access care and assert their rights in a complex managed care environment; and

d. It is, therefore, in the public interest to establish a program to provide consumers with the information and assistance they need to access the high-quality, cost-effective health care available from managed care plans and to promote the rights and interests of managed care consumers.

C.26:2S-20 Definitions relative to Managed Health Care Consumer Assistance Program.

2. As used in this act:

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

"Commissioner" means the Commissioner of Health and Senior Services.

"Department" means the Department of Health and Senior Services.

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

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

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

"NJ FamilyCare" means the FamilyCare Health Coverage Program established pursuant to P.L.2000, c.71 (C.30:4J-1 et seq.).

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

C.26:2S-21 Managed Health Care Consumer Assistance Program.

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

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.

C.26:2S-22 Report to Governor, Legislature.

4. The commissioner shall report to the Governor and the Legislature, no later than 18 months after the effective date of this act and annually thereafter, on the data collected by the program, the activities of the program and its effectiveness in meeting its objectives, including an evaluation of consumer problems, concerns and complaints, and shall accompany that report with any recommendations that the commissioner deems appropriate.

C.26:2S-23 Immunity from liability.

5. An employee, volunteer, board member or other representative of an organization selected by the commissioner pursuant to section 3 of this act shall be immune from liability for any action taken in the good faith performance of their official duties in connection with the program.

C.26:2S-24 Appropriations; fees, use.

6. a. There is appropriated \$500,000 to the department from the General Fund to provide funding for the program, except that funds may be appropriated, in lieu of part or all of the amount appropriated from the General Fund, from the monies made available to the State from tobacco companies under the nationwide settlement of the respective actions by state governments against those companies.

b. (1) The program may charge fees for the provision of materials to the public consistent with P.L.1963, c.73 (C.47:1A-1 et seq.). The commissioner may establish a separate fee schedule for training and education services that may be provided by the program to for-profit organizations, and for the distribution to nongovernmental entities of statistical information that may be developed by the program.

(2) Revenues received by the department pursuant to paragraph (1) of this subsection shall be deposited into a special nonlapsing fund which the commissioner shall create in the department for the purpose of providing funding for the program, and these revenues and the interest earned therefrom shall be utilized to fund the program in addition to the amount appropriated pursuant to subsection b. of this section.

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

C.26:2S-5 Additional disclosure requirements.

5. a. In addition to the disclosure requirements provided in section 4 of this act, a carrier which offers a managed care plan shall disclose to a subscriber, in writing, in a manner consistent with the "Life and Health Insurance Policy Language Simplification Act," P.L.1979, c.167 (C.17B:17-17 et seq.), the following information at the time of enrollment and annually thereafter:

(1) A current participating provider directory providing information on a covered person's access to primary care physicians and specialists, including the number of available participating physicians, by provider category or specialty and by county. The directory shall include the professional office address of a primary care physician and any hospital affiliation the primary care physician has. The directory shall also provide information about participating hospitals.

The carrier shall promptly notify each covered person prior to the termination or withdrawal from the carrier's provider network of the covered person's primary care physician;

(2) General information about the financial incentives between participating physicians under contract with the carrier and other participating health care providers and facilities to which the participating physicians refer their managed care patients;

(3) The percentage of the carrier's managed care plan's network physicians who are board certified;

(4) The carrier's managed care plan's standard for customary waiting times for appointments for urgent and routine care;

(5) The availability through the department, upon request of a member of the general public, of independent consumer satisfaction survey results and an analysis of quality outcomes of health care services of managed care plans in the State; and

(6) Information about the Managed Health Care Consumer Assistance Program established pursuant to P.L.2001, c.14 (C.26:2S-19 et al.) as prescribed by regulation of the commissioner, including the toll-free telephone number available to contact the program.

The carrier shall provide a prospective subscriber with information about the provider network, including hospital affiliations, and other information specified in this subsection, upon request.

b. Upon request of a covered person, a carrier shall promptly inform the person:

- (1) whether a particular network physician is board certified; and
- (2) whether a particular network physician is currently accepting new patients.

c. The carrier shall file the information required pursuant to this section with the department.

C.26:2S-25 Rules, regulations.

8. The Commissioner of Health and Senior Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

9. This act shall take effect on July 1, 2000 or immediately, whichever is later.

Approved January 29, 2001.