CHAPTER 367

AN ACT concerning health benefits plans, amending and supplementing P.L.1997, c.192,and supplementing Title 17 of the Revised Statutes, Title 17B of the New Jersey Statutes,P.L.1973, c.337 (C.26:2J-1 et seq.) and P.L.1961, c.49 (C.52:14-17.25 et seq.).

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

1. 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;

(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; and

(7) The carrier's preauthorization and review requirements of the health benefits plan regarding the determination of medical necessity that apply to a covered person who is admitted to an in-network health care facility, and the financial responsibility of the patient for the cost of services provided by an out-of-network admitting or attending health care practitioner.

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-6.1 Managed care plan to pay full contractual rate to out-of-network provider, certain circumstances.

2. a. With respect to a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits, in the event that:

(1) a covered person is admitted by an out-of-network health care provider to an in-network health care facility for covered, medically necessary health care services, or

(2) the covered person receives covered, medically necessary health care services from an out-of-network health care provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider, the carrier shall reimburse the health care facility for the services provided by the facility at the carrier's full

contracted rate without any penalty for the patient's selection of an out-of-network provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan.

b. The provisions of this section shall apply only if the covered person complies with the preauthorization or review requirements of the health benefits plan regarding the determination of medical necessity to access in-network inpatient benefits, as set forth in writing pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

C.17B:26-2.1w Policy issued under Chapter 26 of Title 17B required to cover certain out-of-network services.

3. Notwithstanding the provisions of chapter 26 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

C.17B:27-46.1aa Policy issued under Chapter 27 of Title 17B required to cover certain out-of-network services.

4. Notwithstanding the provisions of chapter 27 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

C.17B:27A-19.10 Policy, contract issued under C.17B:27A-17 et seq. required to cover certain out-of-network services.

5. Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

C.17B:27A-7.8 Policy, contract issued under C.17B:27A-2 et seq. required to cover certain out-of-network services.

6. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all policies or contracts in which the carrier has reserved the right to change the premium.

C.17:48-6aa Contracts issued under C.17:48-1 et seq. required to cover certain out-of-network services.

7. Notwithstanding the provisions of P.L.1938, c.366 (C.17:48-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

C.17:48A-7z Contract issued under C.17:48A-1 et seq. required to cover certain out-of-network services.

8. Notwithstanding the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

C.17:48E-35.25 Contract issued under C.17:48E-1 et seq. required to cover certain out-of-network services.

9. Notwithstanding the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

C.26:2J-4.26 HMO required to cover certain out-of-network services.

10. Notwithstanding the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this act unless the health maintenance organization meets the requirements of P.L.2001, c.367 (C.26:2S-6.1 et al.). The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

C.52:14-17.29h State Health Benefits Commission contracts to cover certain out-of-network services.

11. The State Health Benefits Commission shall ensure that every contract purchased or renewed by the commission on or after the effective date of P.L.2001, c.367 (C.26:2S-6.1 et al.), which provides hospital or medical expense benefits through a managed care plan as defined in section 2 of P.L.1997, c.192 (C.26:2S-2), shall meet the requirements of section 2 of P.L.2001, c.367 (C.26:2S-6.1).

12. This act shall take effect on the first day of the second month following enactment

Approved January 8, 2002.