CHAPTER 172

AN ACT concerning managed behavioral health care services and amending and supplementing P.L.1997, c.192.

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

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

C.26:2S-2 Definitions relative to health care quality.

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

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

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

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

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

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

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

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

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

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

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

"Managed behavioral health care organization" means an entity, other than a carrier, which contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to covered persons through health care providers employed by the managed behavioral health care organization or otherwise make behavioral health care services available to covered persons through contracts with health care providers. "Managed behavioral health care organization" does not include a person or entity that, for an administrative fee only, solely arranges a panel of health care providers for a carrier for the provision of behavioral health care services on a discounted fee-for-service basis.

"Managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers, who are selected to participate on the basis of explicit standards, to furnish a

comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan.

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

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

2. Section 4 of P.L.1997, c.192 (C.26:2S-4) is amended to read as follows:

C.26:2S-4 Disclosure of terms and conditions in writing to subscriber.

4. A carrier shall disclose in writing to a subscriber, 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 terms and conditions of its health benefits plan, and shall promptly provide the subscriber with written notification of any change in the terms and conditions prior to the effective date of the change. The carrier shall provide the required information at the time of enrollment and upon request thereafter.

a. The information required to be disclosed pursuant to this section shall include a description of:

(1) covered services and benefits to which the subscriber or other covered person is entitled;

(2) restrictions or limitations on covered services and benefits, including, but not limited to, physical and occupational therapy services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health care services;

(3) financial responsibility of the covered person, including copayments and deductibles;

(4) prior authorization and any other review requirements with respect to accessing covered services;

(5) where and in what manner covered services may be obtained;

(6) changes in covered services or benefits, including any addition, reduction or elimination of specific services or benefits;

(7) the covered person's right to appeal and the procedure for initiating an appeal of a utilization management decision made by or on behalf of the carrier with respect to the denial, reduction or termination of a health care benefit or the denial of payment for a health care service;

(8) the procedure to initiate an appeal through the Independent Health Care Appeals Program established pursuant to this act; and

(9) such other information as the commissioner shall require.

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

c. In the case of a carrier that owns, wholly or in part, or contracts with a managed behavioral health care organization, the information required to be disclosed pursuant to this section shall include the following:

(1) the specific behavioral health care services covered and the specific exclusions that apply to the subscriber or other covered person;

(2) the covered person's responsibilities for obtaining behavioral health care services;

(3) the reimbursement methodology that the carrier and managed behavioral health care organization use to reimburse health care providers for behavioral health care services; and

(4) if the carrier offers a managed care plan that provides for both in-network and out-of-network benefits, the procedure that a covered person must utilize when attempting to obtain behavioral health care services from a health care provider who is not included in the network

of providers used by the carrier or managed behavioral health care organization.

3. 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.

In the case of a carrier that owns, wholly or in part, or contracts with a managed behavioral health care organization, the directory shall include a list of participating providers of behavioral health care services with the address of each provider.

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-15.1 Annual report to carrier by managed behavioral health care organization.

4. a. A carrier that owns, wholly or in part, or contracts with a managed behavioral health care organization shall require the managed behavioral health care organization to provide the carrier and the commissioner with an annual report, no later than March 15th of each year and covering the preceding calendar year, which includes the following information:

(1) the payments made by the managed behavioral health care organization to health care providers for the provision of behavioral health care services to covered persons during the preceding calendar year, which shall be separately identified in the report from the other information that is required to be included pursuant to this subsection;

(2) the total expenses incurred by the managed behavioral health care organization for quality assurance and utilization management activities and treatment plan reviews, whether administrative or clinical in nature, during the preceding calendar year, which shall be separately identified in the report;

(3) the total expenses incurred by the managed behavioral health care organization for other administrative functions, including, but not limited to, accounting and financial reporting, billing and collection, data processing, debt or debt service, legal services, promotion and marketing, or provider credentialing, during the preceding calendar year, which shall each be separately identified in the report; and

(4) the amount of any premiums or other fees received by the managed behavioral health care organization during the preceding calendar year.

b. A carrier shall make available to a subscriber or other covered person, upon request, a copy of the report that is required pursuant to subsection a. of this section. The carrier may charge a fee, in an amount to be established by the commissioner, for furnishing a copy of the report or form to a subscriber or other covered person, which shall reasonably reflect the cost of preparation and the actual cost of postage and handling.

5. This act shall take effect on the 60th day after enactment.

Approved August 5, 2005.