SENATE, No. 3518

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED MARCH 9, 2021

Sponsored by:
Senator PAUL A. SARLO
District 36 (Bergen and Passaic)

SYNOPSIS

Requires health benefits plans and carriers to meet certain requirements concerning network adequacy.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning network adequacy and supplementing P.L.1997, c.192.

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

1. As used in this act:

"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, and shall include the State Health Benefits Program, the School Employees' Health Benefits Program, the Medicaid program, and a Medicaid managed care organization.

"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.

"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.

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

"Network adequacy" means the adequacy of the provider network with respect to the scope and type of health care benefits provided by a carrier, the geographic service area covered by the provider network, and access to hospital based and medical specialists pursuant to the standards in the regulations promulgated pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18) and in the existing contract between a managed care organization and the Division of Medical Assistance and Health Services in the Department of Human Services.

“Primary care provider” means a physician with a specialty designation of family medicine, general internal medicine, geriatric medicine, or general pediatric medicine.

2. a. The Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, shall, in determining the adequacy of a proposed provider network or the

ongoing adequacy of an in force provider network, approve a network for a health benefits plan only if the plan has:

(1) a sufficient number of providers, including, but not limited to, hospital based medical specialties and primary care physicians, to ensure that:

(a) 100 percent of the covered persons reside no more than a 30 minute drive from at least one physician within the geographic boundaries of the State that is eligible as a primary care physician; and

(b) 90 percent of the covered persons have access to in network medical care within 15 miles or 30 minutes driving time or public transit time within the geographic boundaries of the State;

(2) a sufficient number of hospital based medical specialties located at in network hospitals and facilities, including, but not limited to, radiologists, pathologists, neurosurgeons, anesthesiologists, and emergency room physicians, within the geographic boundaries of the State; and

(3) the following types of adult and pediatric medical specialties represented within the plan's network: family medicine; general internal medicine; adolescent medicine; allergy and immunology; cardiology; developmental and behavioral pediatrics; emergency medicine; endocrinology and diabetes; gastroenterology and nutrition; general pediatrics; general pediatrics; dermatology; hematology; human genetics and metabolism; infectious disease; neonatology; nephrology; neurology; obstetrics and gynecology, oncology; ophthalmology; orthopedics; otolaryngology; plastic surgery; podiatric medicine; pulmonary medicine, including sleep medicine; radiology; oncologists; psychiatrists; developmental and behavioral professionals; rehabilitative medicine; and rheumatology.

b. An entity providing or administering a self-funded health benefits plan which is subject to the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1001 et seq.) may elect to meet the requirements of this act.

3. a. The Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, shall investigate and determine whether a carrier has contracted with a sufficient number of health care providers to ensure that a health benefits plan's network:

(1) is adequate to meet the health needs of covered persons;

(2) provides an appropriate choice of providers sufficient to render services covered by the health benefits plan; and

(3) reasonably ensures enrollees have timely in-network access for covered benefits and in network facilities.

b. A carrier shall submit a network access plan annually to the Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, with information documenting

compliance with this act, including, for each in-network hospital, the percentage of physicians participating in network for each of the specialties of emergency medicine; anesthesiology; radiology and radiation oncology; oncology and pediatric oncology; pathology; and hospital based medicine, including critical care, to ensure that enrollees have reasonable and timely access to in network physicians services. The network access plan shall not include services provided by telemedicine. The Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, shall provide the network access plans to the Legislature annually.

4. A carrier that violates any provision of this act shall be liable for the penalties provided pursuant to section 16 of P.L.1997, c.192 (C.26:2S-16).

5. The Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act.

6. This act shall take effect on the first day of the third month next following the date of enactment, except that the Commissioner of Banking and Insurance and the Commissioner of Human Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

This bill requires carriers to take certain action to ensure that health benefits plans meet certain network adequacy requirements. Under the bill, “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, and shall include the State Health Benefits Program, the School Employees' Health Benefits Program, the Medicaid program, and a Medicaid managed care organization.

The bill requires the Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, to approve a network for a health benefits plan only if the plan meets certain requirements concerning the number of providers in the network and the medical specialties and geographic proximity of those providers.

The bill also requires the Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate,

to investigate and determine whether a carrier has contracted with a sufficient number of health care providers to ensure that a health benefits plan's network:

(1) is adequate to meet the health needs of covered persons;

(2) provides an appropriate choice of providers sufficient to render services covered by the health benefits plan; and

(3) reasonably ensures enrollees have timely in-network access for covered benefits and in network facilities.

Pursuant to the bill, a carrier is to submit a network access plan annually to the Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, with information documenting compliance with the bill, including, for each in-network hospital, the percentage of physicians participating in network for each of the specialties of emergency medicine; anesthesiology; radiology and radiation oncology; oncology and pediatric oncology; pathology; and hospital based medicine, including critical care, to ensure that enrollees have reasonable and timely access to in network physicians services. The Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, shall provide the network access plans to the Legislature annually.