17:48H-33.1

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 67

NJSA: 17:48H-33.1 (Organized delivery systems- claim enforcement laws)

BILL NO: A2458 (Substituted for S1291)

SPONSOR(S): Felice and Doria

DATE INTRODUCED: May 22, 2000

COMMITTEE: **ASSEMBLY:** Health

SENATE: ----

AMENDED DURING PASSAGE: No

DATE OF PASSAGE: **ASSEMBLY:** December 11, 2000

SENATE: February 15, 2001

DATE OF APPROVAL: April 19, 2001

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Original bill enacted)

A2458

SPONSORS STATEMENT: (Begins on page 6 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

S1291

SPONSORS STATEMENT: (Begins on page 6 of original bill) Yes

Bill and Sponsors Statement identical to A2458

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes

Identical to Assembly Statement for A2458

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: No

ASSEMBLY, No. 2458

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MAY 22, 2000

Sponsored by:
Assemblyman NICHOLAS R. FELICE
District 40 (Bergen and Passaic)
Assemblyman JOSEPH V. DORIA, JR.
District 31 (Hudson)

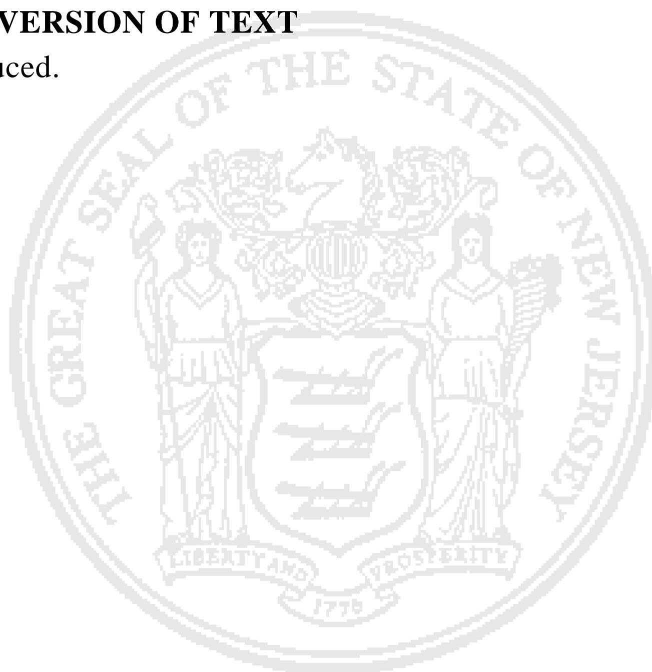
Co-Sponsored by:
Assemblymen Augustine, Bagger, Conaway and Senator Sinagra

SYNOPSIS

Provides that prompt payment and claims payment enforcement laws apply to organized delivery systems.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 2/16/2001)

1 **AN ACT** concerning organized delivery systems, supplementing
2 P.L.1999, c.409 (C.17:48H-1 et seq.) and amending P.L.1999,
3 c.155.
4
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7
8 1. (New section) a. Within 180 days of the adoption of a timetable
9 for implementation pursuant to section 1 of P.L.1999, c.154
10 (C.17B:30-23), an organized delivery system which is either certified
11 or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.), or a
12 subsidiary thereof that processes health care benefits claims as a third
13 party administrator, shall demonstrate to the satisfaction of the
14 Commissioner of Banking and Insurance that it will adopt and
15 implement all of the standards to receive and transmit health care
16 transactions electronically, according to the corresponding timetable,
17 and otherwise comply with the provisions of this section, as a
18 condition of its continued authorization to do business in this State.
19 The Commissioner of Banking and Insurance may grant extensions
20 or waivers of the implementation requirement when it has been
21 demonstrated to the commissioner's satisfaction that compliance with
22 the timetable for implementation will result in an undue hardship to an
23 organized delivery system, its subsidiary or its covered persons.
24 b. Within 12 months of the adoption of regulations establishing
25 standard health care enrollment and claim forms by the Commissioner
26 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
27 (C.17B:30-23), an organized delivery system or a subsidiary that
28 processes health care benefits claims as a third party administrator
29 shall use the standard health care enrollment and claim forms in
30 connection with all health benefits plans for which the organized
31 delivery system has contracted with a carrier to provide health care
32 services.
33 c. Twelve months after the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
36 (C.17B:30-23), an organized delivery system shall require that health
37 care providers file all claims for payment for health care services. A
38 covered person who receives health care services shall not be required
39 to submit a claim for payment but, notwithstanding the provisions of
40 this subsection to the contrary, a covered person shall be permitted to
41 submit a claim on his own behalf, at the covered person's option. All
42 claims shall be filed using the standard health care claim form
43 applicable to the health benefits plan contract or policy.

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 thus is new matter.

1 d. (1) An organized delivery system or its agent, hereinafter the
2 payer, shall remit payment for every insured claim submitted by a
3 covered person or that covered person's agent or assignee if the health
4 benefits plan contract or policy provides for assignment of benefits, no
5 later than the 30th calendar day following receipt of the claim by the
6 payer or no later than the time limit established for the payment of
7 claims in the Medicare program pursuant to
8 42 U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
9 submitted by electronic means, and no later than the 40th calendar day
10 following receipt if the claim is submitted by other than electronic
11 means, if:
12 (a) the claim is an eligible claim for a health care service provided
13 by an eligible health care provider to a covered person under the health
14 benefits plan contract or policy;
15 (b) the claim has no material defect or impropriety, including, but
16 not limited to, any lack of required substantiating documentation or
17 incorrect coding;
18 (c) there is no dispute regarding the amount claimed;
19 (d) the payer has no reason to believe that the claim has been
20 submitted fraudulently; and
21 (e) the claim requires no special treatment that prevents timely
22 payment from being made on the claim under the terms of the health
23 benefits plan contract or policy.
24 (2) If all or a portion of the claim is denied by the payer because:
25 (a) the claim is an ineligible claim;
26 (b) the claim submission is incomplete because the required
27 substantiating documentation has not been submitted to the payer;
28 (c) the diagnosis coding, procedure coding, or any other required
29 information to be submitted with the claim is incorrect;
30 (d) the payer disputes the amount claimed; or
31 (e) the claim requires special treatment that prevents timely
32 payments from being made on the claim under the terms of the health
33 benefits plan contract or policy, the payer shall notify the covered
34 person, or that covered person's agent or assignee if the health benefits
35 plan contract or policy provides for assignment of benefits, in writing
36 or by electronic means, as appropriate, within 30 days, of the
37 following: if all or a portion of the claim is denied, all the reasons for
38 the denial; if the claim lacks the required substantiating
39 documentation, including incorrect coding, a statement as to what
40 substantiating documentation or other information is required to
41 complete adjudication of the claim; if the amount of the claim is
42 disputed, a statement that it is disputed; and if the claim requires
43 special treatment that prevents timely payments from being made, a
44 statement of the special treatment to which the claim is subject.
45 (3) Any portion of a claim that meets the criteria established in
46 paragraph (1) of this subsection shall be paid by the payer in

1 accordance with the time limit established in paragraph (1) of this
2 subsection.
3 (4) A payer shall acknowledge receipt of a claim submitted by
4 electronic means from a health care provider or covered person, no
5 later than two working days following receipt of the transmission of
6 the claim.
7 (5) If a payer subject to the provisions of P.L.1983, c.320
8 (C.17:33A-1 et seq.) has reason to believe that a claim has been
9 submitted fraudulently, it shall investigate the claim in accordance with
10 its fraud prevention plan established pursuant to section 1 of P.L.1993,
11 c.362 (C.17:33A-15), or refer the claim, together with supporting
12 documentation, to the Office of the Insurance Fraud Prosecutor in the
13 Department of Law and Public Safety established pursuant to section
14 32 of P.L.1998, c.21 (C.17:33A-16).
15 (6) Payment of an eligible claim pursuant to paragraphs (1) and (3)
16 of this subsection shall be deemed to be overdue if not remitted to the
17 claimant or his agent or assignee by the payer on or before the 30th
18 calendar day or the time limit established by the Medicare program,
19 whichever is earlier, following receipt by the payer of a claim
20 submitted by electronic means and on or before the 40th calendar day
21 following receipt of a claim submitted by other than electronic means.
22 In the event payment is withheld on all or a portion of a claim by a
23 payer pursuant to subparagraph (b) of paragraph (2) of this subsection,
24 the claims payment shall be overdue if not remitted to the claimant or
25 his agent or a assignee by the payer on or before the 30th calendar day
26 or the time limit established by the Medicare program, whichever is
27 earlier, for claims submitted by electronic means and the 40th calendar
28 day for claims submitted by other than electronic means, following
29 receipt by the payer of the required documentation or modification of
30 an initial submission.
31 (7) An overdue payment shall bear simple interest at the rate of
32 10% per annum.
33 e. As used in this subsection, "insured claim" or "claim" means a
34 claim by a covered person for payment of benefits under an insured
35 health benefits plan contract or policy for which the financial
36 obligation for the payment of a claim under the health benefits plan
37 contract or policy rests upon the organized delivery system.
38
39 2. (New section) An organized delivery system which is either
40 certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.)
41 shall be subject to the provisions of P.L.1999, c.155 (C.17B:30-26 et
42 seq.) and the regulations promulgated thereunder.
43
44 3. Section 1 of P.L.1999, c.155 (C.17B:30-26) is amended to read
45 as follows:
46 1. As used in this act:

1 "Capitation payment" means a periodic payment to a health care
2 provider for his services under the terms of a contract between the
3 provider and a payer, under which the provider agrees to perform the
4 health care services set forth in the contract for a specified period of
5 time for a specified fee, but shall not include any payments made to the
6 provider on a fee-for-service basis.
7 "Carrier" means an insurance company, health service corporation,
8 hospital service corporation, medical service corporation or health
9 maintenance organization authorized to issue health benefits plans in
10 this State and a dental service corporation or dental plan organization
11 authorized to issue dental plans in this State.
12 "Commissioner" means the Commissioner of Banking and
13 Insurance.
14 "Contract holder" means an employer or organization that
15 purchases a contract for services.
16 "Covered person" means a person on whose behalf a carrier offering
17 the plan is obligated to pay benefits or provide services pursuant to the
18 health benefits or dental plan.
19 "Covered service" means a health care service provided to a
20 covered person under a health benefits or dental plan for which the
21 carrier is obligated to pay benefits or provide services.
22 "Dental plan" means a benefits plan which pays or provides dental
23 expense benefits for covered services and is delivered or issued for
24 delivery in this State by or through a dental service corporation or
25 dental plan organization authorized to issue dental plans in this State.
26 "Eligible claim" or "claim for eligible services" means a claim for a
27 covered service under a health benefits or dental plan, subject to any
28 conditions imposed by the health benefits or dental plan.
29 "Eligible health care provider" means a health care provider whose
30 services are reimbursable under a health benefits or dental plan.
31 "Health benefits plan" means a benefits plan which pays or provides
32 hospital and medical expense benefits for covered services, and is
33 delivered or issued for delivery in this State by or through a carrier.
34 Health benefits plan includes, but is not limited to, Medicare
35 supplement coverage and risk contracts to the extent not otherwise
36 prohibited by federal law. For the purposes of this act, health benefits
37 plan shall not include the following plans, policies or contracts:
38 accident only, credit, disability, long-term care, CHAMPUS
39 supplement coverage, coverage arising out of a workers' compensation
40 or similar law, automobile medical payment insurance, personal injury
41 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et
42 seq.) or hospital confinement indemnity coverage.
43 "Health care provider" means an individual or entity which, acting
44 within the scope of its licensure or certification, provides a covered
45 service defined by the health benefits or dental plan. Health care
46 provider includes, but is not limited to, a physician, dentist 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.

"Insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits or dental plan.

"Insured health benefits or dental plan" means a health benefits or dental plan providing benefits for covered services to covered persons for which the contract holder pays a premium, which may include a deductible amount payable to a health care provider, and for which the financial obligation for the payment of claims under the plan rests upon the payer.

"Organized delivery system" means an organized delivery system that is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer" means a carrier or any agent thereof or an organized delivery system or any agent thereof who is doing business in the State and is under a contractual obligation to pay insured claims.

(cf: P.L.1999, c.155, s.1)

4. This act shall take effect immediately.

STATEMENT

This bill provides that organized delivery systems, which are regulated pursuant to P.L.1999, c.409 (N.J.S.A.17B:48H-1 et seq.), shall be subject to the "prompt pay" provisions governing health and dental insurance carriers in P.L.1999, c.154, known as the "HINT" bill, and the claims payment enforcement provisions of P.L.1999, c.155 (N.J.S.A.17B:30-26 et seq.).

Organized delivery systems contract with health insurance carriers to provide either comprehensive health care services or benefits or limited health care services to the covered persons under the carrier's health benefits plan contract or policy. In many cases, organized delivery systems, under contract with an insurance carrier, are responsible for paying claims for services provided under the health benefits plan and, therefore, should be subject to the same requirements regarding claims payment with which health insurance carriers must comply.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2458

STATE OF NEW JERSEY

DATED: OCTOBER 12, 2000

The Assembly Health Committee reports favorably Assembly Bill No. 2458.

This bill provides that organized delivery systems, which are regulated pursuant to P.L.1999, c.409 (N.J.S.A.17B:48H-1 et seq.), shall be subject to the "prompt pay" provisions governing health and dental insurance carriers in P.L.1999, c.154, known as the "HINT" bill, and the claims payment enforcement provisions of P.L.1999, c.155 (N.J.S.A.17B:30-26 et seq.).

Organized delivery systems contract with health insurance carriers to provide either comprehensive health care services or benefits or limited health care services to the covered persons under the carrier's health benefits plan contract or policy. In many cases, organized delivery systems, under contract with an insurance carrier, are responsible for paying claims for services provided under the health benefits plan and, therefore, should be subject to the same requirements regarding claims payment with which health insurance carriers must comply.

This bill is identical to Senate Bill No. 1291 (Sinagra), which is currently pending in the Senate Health Committee.

SENATE, No. 1291

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MAY 18, 2000

Sponsored by:
Senator JACK SINAGRA
District 18 (Middlesex)

SYNOPSIS

Provides that prompt payment and claims payment enforcement laws apply to organized delivery systems.

CURRENT VERSION OF TEXT

As introduced.

1 **AN ACT** concerning organized delivery systems, supplementing
2 P.L.1999, c.409 (C.17:48H-1 et seq.) and amending
3 P.L.1999,c.155.
4
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7
8 1. (New section) a. Within 180 days of the adoption of a timetable
9 for implementation pursuant to section 1 of P.L.1999, c.154
10 (C.17B:30-23), an organized delivery system which is either certified
11 or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.), or a
12 subsidiary thereof that processes health care benefits claims as a third
13 party administrator, shall demonstrate to the satisfaction of the
14 Commissioner of Banking and Insurance that it will adopt and
15 implement all of the standards to receive and transmit health care
16 transactions electronically, according to the corresponding timetable,
17 and otherwise comply with the provisions of this section, as a
18 condition of its continued authorization to do business in this State.
19 The Commissioner of Banking and Insurance may grant extensions
20 or waivers of the implementation requirement when it has been
21 demonstrated to the commissioner's satisfaction that compliance with
22 the timetable for implementation will result in an undue hardship to an
23 organized delivery system, its subsidiary or its covered persons.
24 b. Within 12 months of the adoption of regulations establishing
25 standard health care enrollment and claim forms by the Commissioner
26 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
27 (C.17B:30-23), an organized delivery system or a subsidiary that
28 processes health care benefits claims as a third party administrator
29 shall use the standard health care enrollment and claim forms in
30 connection with all health benefits plans for which the organized
31 delivery system has contracted with a carrier to provide health care
32 services.
33 c. Twelve months after the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
36 (C.17B:30-23), an organized delivery system shall require that health
37 care providers file all claims for payment for health care services. A
38 covered person who receives health care services shall not be required
39 to submit a claim for payment but, notwithstanding the provisions of
40 this subsection to the contrary, a covered person shall be permitted to
41 submit a claim on his own behalf, at the covered person's option. All
42 claims shall be filed using the standard health care claim form
43 applicable to the health benefits plan contract or policy.

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 thus is new matter.

1 d. (1) An organized delivery system or its agent, hereinafter the
2 payer, shall remit payment for every insured claim submitted by a
3 covered person or that covered person's agent or assignee if the health
4 benefits plan contract or policy provides for assignment of benefits, no
5 later than the 30th calendar day following receipt of the claim by the
6 payer or no later than the time limit established for the payment of
7 claims in the Medicare program pursuant to 42
8 U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted
9 by electronic means, and no later than the 40th calendar day following
10 receipt if the claim is submitted by other than electronic means, if:
11 (a) the claim is an eligible claim for a health care service provided
12 by an eligible health care provider to a covered person under the health
13 benefits plan contract or policy;
14 (b) the claim has no material defect or impropriety, including, but
15 not limited to, any lack of required substantiating documentation or
16 incorrect coding;
17 (c) there is no dispute regarding the amount claimed;
18 (d) the payer has no reason to believe that the claim has been
19 submitted fraudulently; and
20 (e) the claim requires no special treatment that prevents timely
21 payment from being made on the claim under the terms of the health
22 benefits plan contract or policy.
23 (2) If all or a portion of the claim is denied by the payer because:
24 (a) the claim is an ineligible claim;
25 (b) the claim submission is incomplete because the required
26 substantiating documentation has not been submitted to the payer;
27 (c) the diagnosis coding, procedure coding, or any other required
28 information to be submitted with the claim is incorrect;
29 (d) the payer disputes the amount claimed; or
30 (e) the claim requires special treatment that prevents timely
31 payments from being made on the claim under the terms of the health
32 benefits plan contract or policy, the payer shall notify the covered
33 person, or that covered person's agent or assignee if the health benefits
34 plan contract or policy provides for assignment of benefits, in writing
35 or by electronic means, as appropriate, within 30 days, of the
36 following: if all or a portion of the claim is denied, all the reasons for
37 the denial; if the claim lacks the required substantiating
38 documentation, including incorrect coding, a statement as to what
39 substantiating documentation or other information is required to
40 complete adjudication of the claim; if the amount of the claim is
41 disputed, a statement that it is disputed; and if the claim requires
42 special treatment that prevents timely payments from being made, a
43 statement of the special treatment to which the claim is subject.
44 (3) Any portion of a claim that meets the criteria established in
45 paragraph (1) of this subsection shall be paid by the payer in
46 accordance with the time limit established in paragraph (1) of this

subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or covered person, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent or assignee by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent or a assignee by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits plan contract or policy for which the financial obligation for the payment of a claim under the health benefits plan contract or policy rests upon the organized delivery system.

2. (New section) An organized delivery system which is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.) shall be subject to the provisions of P.L.1999, c.155 (C.17B:30-26 et seq.) and the regulations promulgated thereunder.

3. Section 1 of P.L.1999, c.155 (C.17B:30-26) is amended to read as follows:

1. As used in this act:

"Capitation payment" means a periodic payment to a health care

provider for his services under the terms of a contract between the provider and a payer, under which the provider agrees to perform the health care services set forth in the contract for a specified period of time for a specified fee, but shall not include any payments made to the provider on a fee-for-service basis.

"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 a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"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 or dental plan.

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

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Eligible claim" or "claim for eligible services" means a claim for a covered service under a health benefits or dental plan, subject to any conditions imposed by the health benefits or dental plan.

"Eligible health care provider" means a health care provider whose services are reimbursable under a health benefits or dental 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.

"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 or dental plan. Health care provider includes, but is not limited to, a physician, dentist 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.

"Insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits or dental plan.

"Insured health benefits or dental plan" means a health benefits or dental plan providing benefits for covered services to covered persons for which the contract holder pays a premium, which may include a deductible amount payable to a health care provider, and for which the financial obligation for the payment of claims under the plan rests upon the payer.

"Organized delivery system" means an organized delivery system that is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer" means a carrier or any agent thereof or an organized delivery system or any agent thereof who is doing business in the State and is under a contractual obligation to pay insured claims.
(cf:P.L.1999, c.155, s.1)

4. This act shall take effect immediately.

STATEMENT

This bill provides that organized delivery systems, which are regulated pursuant to P.L.1999, c.409 (N.J.S.A.17B:48H-1 et seq.), shall be subject to the "prompt pay" provisions governing health and dental insurance carriers in P.L.1999, c.154, known as the "HINT" bill, and the claims payment enforcement provisions of P.L.1999, c.155 (N.J.S.A.17B:30-26 et seq.).

Organized delivery systems contract with health insurance carriers to provide either comprehensive health care services or benefits or limited health care services to the covered persons under the carrier's health benefits plan contract or policy. In many cases, organized delivery systems, under contract with an insurance carrier, are responsible for paying claims for services provided under the health benefits plan and, therefore, should be subject to the same requirements regarding claims payment with which health insurance carriers must comply.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 1291

STATE OF NEW JERSEY

DATED: NOVEMBER 1, 2000

The Senate Health Committee reports favorably Senate Bill No. 1291.

This bill provides that organized delivery systems, which are regulated pursuant to P.L.1999, c.409 (N.J.S.A.17:48H-1 et seq.), shall be subject to the "prompt pay" provisions governing health and dental insurance carriers in P.L.1999, c.154, known as the "HINT" bill, and the claims payment enforcement provisions of P.L.1999, c.155 (N.J.S.A.17B:30-26 et seq.).

Organized delivery systems contract with health insurance carriers to provide either comprehensive health care services or benefits or limited health care services to the covered persons under the carrier's health benefits plan contract or policy. In many cases, organized delivery systems, under contract with an insurance carrier, are responsible for paying claims for services provided under the health benefits plan and, therefore, should be subject to the same requirements regarding claims payment with which health insurance carriers must comply.

This bill is identical to Assembly Bill No. 2458 (Felice/Doria) which is on second reading in the General Assembly.

§§1,2 -
C.17:48H-33.1
& 17:48H-33.2

P.L. 2001, CHAPTER 67, ***approved April 19, 2001***
Assembly, No. 2458

1 **AN ACT** concerning organized delivery systems, supplementing
2 P.L.1999, c.409 (C.17:48H-1 et seq.) and amending P.L.1999,
3 c.155.
4
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7
8 1. (New section) a. Within 180 days of the adoption of a timetable
9 for implementation pursuant to section 1 of P.L.1999, c.154
10 (C.17B:30-23), an organized delivery system which is either certified
11 or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.), or a
12 subsidiary thereof that processes health care benefits claims as a third
13 party administrator, shall demonstrate to the satisfaction of the
14 Commissioner of Banking and Insurance that it will adopt and
15 implement all of the standards to receive and transmit health care
16 transactions electronically, according to the corresponding timetable,
17 and otherwise comply with the provisions of this section, as a
18 condition of its continued authorization to do business in this State.
19 The Commissioner of Banking and Insurance may grant extensions
20 or waivers of the implementation requirement when it has been
21 demonstrated to the commissioner's satisfaction that compliance with
22 the timetable for implementation will result in an undue hardship to an
23 organized delivery system, its subsidiary or its covered persons.
24 b. Within 12 months of the adoption of regulations establishing
25 standard health care enrollment and claim forms by the Commissioner
26 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
27 (C.17B:30-23), an organized delivery system or a subsidiary that
28 processes health care benefits claims as a third party administrator
29 shall use the standard health care enrollment and claim forms in
30 connection with all health benefits plans for which the organized
31 delivery system has contracted with a carrier to provide health care
32 services.
33 c. Twelve months after the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
36 (C.17B:30-23), an organized delivery system shall require that health
37 care providers file all claims for payment for health care services. A
38 covered person who receives health care services shall not be required
39 to submit a claim for payment but, notwithstanding the provisions of
40 this subsection to the contrary, a covered person shall be permitted to

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 thus is new matter.

1 submit a claim on his own behalf, at the covered person's option. All
2 claims shall be filed using the standard health care claim form
3 applicable to the health benefits plan contract or policy.
4 d. (1) An organized delivery system or its agent, hereinafter the
5 payer, shall remit payment for every insured claim submitted by a
6 covered person or that covered person's agent or assignee if the health
7 benefits plan contract or policy provides for assignment of benefits, no
8 later than the 30th calendar day following receipt of the claim by the
9 payer or no later than the time limit established for the payment of
10 claims in the Medicare program pursuant to
11 42 U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
12 submitted by electronic means, and no later than the 40th calendar day
13 following receipt if the claim is submitted by other than electronic
14 means, if:
15 (a) the claim is an eligible claim for a health care service provided
16 by an eligible health care provider to a covered person under the health
17 benefits plan contract or policy;
18 (b) the claim has no material defect or impropriety, including, but
19 not limited to, any lack of required substantiating documentation or
20 incorrect coding;
21 (c) there is no dispute regarding the amount claimed;
22 (d) the payer has no reason to believe that the claim has been
23 submitted fraudulently; and
24 (e) the claim requires no special treatment that prevents timely
25 payment from being made on the claim under the terms of the health
26 benefits plan contract or policy.
27 (2) If all or a portion of the claim is denied by the payer because:
28 (a) the claim is an ineligible claim;
29 (b) the claim submission is incomplete because the required
30 substantiating documentation has not been submitted to the payer;
31 (c) the diagnosis coding, procedure coding, or any other required
32 information to be submitted with the claim is incorrect;
33 (d) the payer disputes the amount claimed; or
34 (e) the claim requires special treatment that prevents timely
35 payments from being made on the claim under the terms of the health
36 benefits plan contract or policy, the payer shall notify the covered
37 person, or that covered person's agent or assignee if the health benefits
38 plan contract or policy provides for assignment of benefits, in writing
39 or by electronic means, as appropriate, within 30 days, of the
40 following: if all or a portion of the claim is denied, all the reasons for
41 the denial; if the claim lacks the required substantiating
42 documentation, including incorrect coding, a statement as to what
43 substantiating documentation or other information is required to
44 complete adjudication of the claim; if the amount of the claim is
45 disputed, a statement that it is disputed; and if the claim requires
46 special treatment that prevents timely payments from being made, a

1 statement of the special treatment to which the claim is subject.
2 (3) Any portion of a claim that meets the criteria established in
3 paragraph (1) of this subsection shall be paid by the payer in
4 accordance with the time limit established in paragraph (1) of this
5 subsection.
6 (4) A payer shall acknowledge receipt of a claim submitted by
7 electronic means from a health care provider or covered person, no
8 later than two working days following receipt of the transmission of
9 the claim.
10 (5) If a payer subject to the provisions of P.L.1983, c.320
11 (C.17:33A-1 et seq.) has reason to believe that a claim has been
12 submitted fraudulently, it shall investigate the claim in accordance with
13 its fraud prevention plan established pursuant to section 1 of P.L.1993,
14 c.362 (C.17:33A-15), or refer the claim, together with supporting
15 documentation, to the Office of the Insurance Fraud Prosecutor in the
16 Department of Law and Public Safety established pursuant to section
17 32 of P.L.1998, c.21 (C.17:33A-16).
18 (6) Payment of an eligible claim pursuant to paragraphs (1) and (3)
19 of this subsection shall be deemed to be overdue if not remitted to the
20 claimant or his agent or assignee by the payer on or before the 30th
21 calendar day or the time limit established by the Medicare program,
22 whichever is earlier, following receipt by the payer of a claim
23 submitted by electronic means and on or before the 40th calendar day
24 following receipt of a claim submitted by other than electronic means.
25 In the event payment is withheld on all or a portion of a claim by a
26 payer pursuant to subparagraph (b) of paragraph (2) of this subsection,
27 the claims payment shall be overdue if not remitted to the claimant or
28 his agent or a assignee by the payer on or before the 30th calendar day
29 or the time limit established by the Medicare program, whichever is
30 earlier, for claims submitted by electronic means and the 40th calendar
31 day for claims submitted by other than electronic means, following
32 receipt by the payer of the required documentation or modification of
33 an initial submission.
34 (7) An overdue payment shall bear simple interest at the rate of
35 10% per annum.
36 e. As used in this subsection, "insured claim" or "claim" means a
37 claim by a covered person for payment of benefits under an insured
38 health benefits plan contract or policy for which the financial
39 obligation for the payment of a claim under the health benefits plan
40 contract or policy rests upon the organized delivery system.
41
42 2. (New section) An organized delivery system which is either
43 certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.)
44 shall be subject to the provisions of P.L.1999, c.155 (C.17B:30-26 et
45 seq.) and the regulations promulgated thereunder.

1 3. Section 1 of P.L.1999, c.155 (C.17B:30-26) is amended to read
2 as follows:
3 1. As used in this act:
4 "Capitation payment" means a periodic payment to a health care
5 provider for his services under the terms of a contract between the
6 provider and a payer, under which the provider agrees to perform the
7 health care services set forth in the contract for a specified period of
8 time for a specified fee, but shall not include any payments made to the
9 provider on a fee-for-service basis.
10 "Carrier" means an insurance company, health service corporation,
11 hospital service corporation, medical service corporation or health
12 maintenance organization authorized to issue health benefits plans in
13 this State and a dental service corporation or dental plan organization
14 authorized to issue dental plans in this State.
15 "Commissioner" means the Commissioner of Banking and
16 Insurance.
17 "Contract holder" means an employer or organization that
18 purchases a contract for services.
19 "Covered person" means a person on whose behalf a carrier offering
20 the plan is obligated to pay benefits or provide services pursuant to the
21 health benefits or dental plan.
22 "Covered service" means a health care service provided to a
23 covered person under a health benefits or dental plan for which the
24 carrier is obligated to pay benefits or provide services.
25 "Dental plan" means a benefits plan which pays or provides dental
26 expense benefits for covered services and is delivered or issued for
27 delivery in this State by or through a dental service corporation or
28 dental plan organization authorized to issue dental plans in this State.
29 "Eligible claim" or "claim for eligible services" means a claim for a
30 covered service under a health benefits or dental plan, subject to any
31 conditions imposed by the health benefits or dental plan.
32 "Eligible health care provider" means a health care provider whose
33 services are reimbursable under a health benefits or dental plan.
34 "Health benefits plan" means a benefits plan which pays or provides
35 hospital and medical expense benefits for covered services, and is
36 delivered or issued for delivery in this State by or through a carrier.
37 Health benefits plan includes, but is not limited to, Medicare
38 supplement coverage and risk contracts to the extent not otherwise
39 prohibited by federal law. For the purposes of this act, health benefits
40 plan shall not include the following plans, policies or contracts:
41 accident only, credit, disability, long-term care, CHAMPUS
42 supplement coverage, coverage arising out of a workers' compensation
43 or similar law, automobile medical payment insurance, personal injury
44 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et
45 seq.) or hospital confinement indemnity coverage.
46 "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 or dental plan. Health care provider includes, but is not limited to, a physician, dentist 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.

"Insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits or dental plan.

"Insured health benefits or dental plan" means a health benefits or dental plan providing benefits for covered services to covered persons for which the contract holder pays a premium, which may include a deductible amount payable to a health care provider, and for which the financial obligation for the payment of claims under the plan rests upon the payer.

"Organized delivery system" means an organized delivery system that is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer" means a carrier or any agent thereof or an organized delivery system or any agent thereof who is doing business in the State and is under a contractual obligation to pay insured claims.

(cf: P.L.1999, c.155, s.1)

4. This act shall take effect immediately.

STATEMENT

This bill provides that organized delivery systems, which are regulated pursuant to P.L.1999, c.409 (N.J.S.A.17B:48H-1 et seq.), shall be subject to the "prompt pay" provisions governing health and dental insurance carriers in P.L.1999, c.154, known as the "HINT" bill, and the claims payment enforcement provisions of P.L.1999, c.155 (N.J.S.A.17B:30-26 et seq.).

Organized delivery systems contract with health insurance carriers to provide either comprehensive health care services or benefits or limited health care services to the covered persons under the carrier's health benefits plan contract or policy. In many cases, organized delivery systems, under contract with an insurance carrier, are responsible for paying claims for services provided under the health benefits plan and, therefore, should be subject to the same requirements regarding claims payment with which health insurance carriers must comply.

Provides that prompt payment and claims payment enforcement laws

1 apply to organized delivery systems.

CHAPTER 67

AN ACT concerning organized delivery systems, supplementing P.L.1999, c.409 (C.17:48H-1 et seq.) and amending P.L.1999, c.155.

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

C.17:48H-33.1 Adoption, implementation of standards by organized delivery system for electronic transactions.

1. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), an organized delivery system which is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.), or a subsidiary thereof that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to an organized delivery system, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), an organized delivery system or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all health benefits plans for which the organized delivery system has contracted with a carrier to provide health care services.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), an organized delivery system shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment but, notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the health benefits plan contract or policy.

d. (1) An organized delivery system or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a covered person or that covered person's agent or assignee if the health benefits plan contract or policy provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the health benefits plan contract or policy;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;

(d) the payer has no reason to believe that the claim has been submitted fraudulently; and

(e) the claim requires no special treatment that prevents timely payment from being made on the claim under the terms of the health benefits plan contract or policy.

(2) If all or a portion of the claim is denied by the payer because:

(a) the claim is an ineligible claim;

(b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;

(c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely payments from being made on

the claim under the terms of the health benefits plan contract or policy, the payer shall notify the covered person, or that covered person's agent or assignee if the health benefits plan contract or policy provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or covered person, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent or assignee by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent or a assignee by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits plan contract or policy for which the financial obligation for the payment of a claim under the health benefits plan contract or policy rests upon the organized delivery system.

C.17:48H-33.2 Organized delivery system subject to regulations under C.17B:30-26 et seq.

2. An organized delivery system which is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.) shall be subject to the provisions of P.L.1999, c.155 (C.17B:30-26 et seq.) and the regulations promulgated thereunder.

3. Section 1 of P.L.1999, c.155 (C.17B:30-26) is amended to read as follows:

C.17B:30-26 Definitions relative to payment of health and dental insurance plans.

1. As used in this act:

"Capitation payment" means a periodic payment to a health care provider for his services under the terms of a contract between the provider and a payer, under which the provider agrees to perform the health care services set forth in the contract for a specified period of time for a specified fee, but shall not include any payments made to the provider on a fee-for-service basis.

"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 a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"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 or dental plan.

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

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Eligible claim" or "claim for eligible services" means a claim for a covered service under a health benefits or dental plan, subject to any conditions imposed by the health benefits or dental plan.

"Eligible health care provider" means a health care provider whose services are reimbursable under a health benefits or dental 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.

"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 or dental plan. Health care provider includes, but is not limited to, a physician, dentist 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.

"Insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits or dental plan.

"Insured health benefits or dental plan" means a health benefits or dental plan providing benefits for covered services to covered persons for which the contract holder pays a premium, which may include a deductible amount payable to a health care provider, and for which the financial obligation for the payment of claims under the plan rests upon the payer.

"Organized delivery system" means an organized delivery system that is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer" means a carrier or any agent thereof or an organized delivery system or any agent thereof who is doing business in the State and is under a contractual obligation to pay insured claims.

4. This act shall take effect immediately.

Approved April 19, 2001.

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TRENTON, NJ 08625

Office of the Governor
NEWS RELEASE

CONTACT: Jayne O'Connor
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RELEASE: April 19 , 2001

DiFrancesco Signs Law Creating Hunger Prevention Program
******Signs 7 other bills******

Acting Gov. Donald T. DiFrancesco today signed legislation that creates a New Jersey Hunger Prevention and Assistance Program and allocates $5 million for grants to food banks and other similar agencies.

S-1591, sponsored by Senators Kyrillos (R-Middlesex/Monmouth) and Palaia (R-Monmouth) and Assemblymembers Azzolina (R-Middlesex/Monmouth) and Thompson (R-Middlesex/Monmouth), allocates up to $5 million in unexpended Temporary Assistance to Needy Family funds for grants to food banks and similar agencies.

The bill also establishes a New Jersey Hunger Prevention and Assistance Program in the Department of Human Services to improve the health and nutritional status of state residents in need of food assistance, supplement the efforts of emergency food programs in the state to reduce hunger, and enable families and individuals to become food secure and self-sufficient.

The Commissioner of Human Services is required by the bill to contract with Rutgers, the State University to conduct a six-pronged statewide needs assessment. The bill also establishes a 13 -member Hunger Prevention Advisory Committee within DHS to assist the commissioner in the implementation of the program.

The acting Governor also signed the following bills:

S-84, sponsored by Senator Zane (R-Salem/Cumberland/Gloucester) and Assembly members Felice (R-Bergen/Passaic) and Impreveduto (D-Bergen/Hudson), clarifies the sexual assault statute in certain circumstances.

S-1372, sponsored by Senators Bennett (R-Monmouth) and Allen (R-Burlington/Camden) and Assemblymembers DiGaetano (R-Bergen/Essex/Passaic) and Moran (R-Atlantic/Burlington/Ocean), revises the procedure for self-administration by school pupils of medication for asthma.

S-2097, sponsored by Senators Kyrillos (R-Middlesex/Monmouth) and McNamara (R-Bergen/Passaic) and Assemblymembers Azzolina (R-Middlesex/Monmouth) and Thompson (R-Middlesex/Monmouth), Expands the role of the county superintendent in pupil transportation matters and permits school districts to offer subscription busing to additional students.

A-2549, sponsored by Assemblymembers Kelly (R-Bergen/Essex/Passaic) and Cohen (D-Union) and Senator Ciesla (R-Monmouth/Ocean), permits real estate brokers, broker-salespersons and salespersons to engage in certain promotions offering free or discounted products and services.

A-2318, sponsored by Assemblymembers Charles (D-Hudson) and Lance (R-Warren/Hunterdon/ Mercer) and Senators Kenny (D-Hudson) and Kyrillos (R-Middlesex/Monmouth), appropriates $350,000 to the Division of Youth and Family Services for a grant to Hudson Cradle, a nationally recognized multi-purpose family resource and transitional residence in Jersey City that serves approximately 50 "boarder babies" annually.

A-2458, sponsored by Assemblymembers Felice (R-Bergen/Passaic) and Doria (D-Hudson) and Assemblymember Conaway (D-Burlington/Camden), provides that prompt payment and claims payment enforcement laws apply to organized delivery systems. Organized delivery systems are entities that contract with health insurance carriers to provide either comprehensive health care services or benefits or limited health care services to covered persons under the carrier's health benefits plan or policy.