26:2S-6.1

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2009 **CHAPTER:** 209

NJSA: 26:2S-6.1 (Requires managed care plans to pay health care claims based on assignment of benefits)

BILL NO: S114 (Substituted for A132)

SPONSOR(S) Weinberg and Others

DATE INTRODUCED: January 8, 2008

COMMITTEE: **ASSEMBLY:** Financial Institutions and Insurance

SENATE: Commerce

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** January 7, 2010

SENATE: January 11, 2010

DATE OF APPROVAL: January 16, 2010

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (First reprint enacted)

S114

SPONSOR'S STATEMENT: (Begins on page 3 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: Yes

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

A132

SPONSOR'S STATEMENT: (Begins on page 3 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

(continued)

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: No

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: No

LAW/RWH

[First Reprint]

SENATE, No. 114

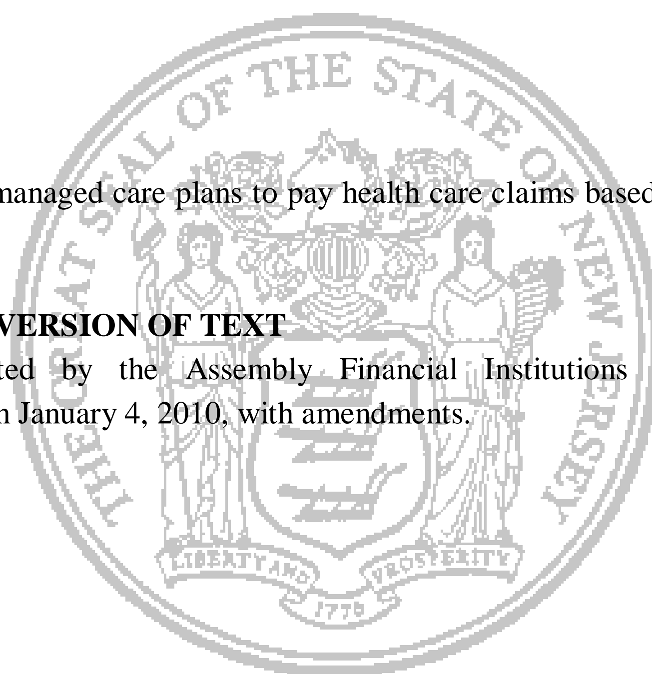
STATE OF NEW JERSEY

213th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2008 SESSION

Sponsored by:
Senator LORETTA WEINBERG
District 37 (Bergen)
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)
Assemblywoman AMY H. HANDLIN
District 13 (Middlesex and Monmouth)
Assemblywoman NANCY F. MUNOZ
District 21 (Essex, Morris, Somerset and Union)
Assemblywoman ERIC MUNOZ
District 21 (Essex, Morris, Somerset and Union)

Co-Sponsored by:
Assemblyman Conners, Assemblywoman Watson Coleman and Senator Baroni



SYNOPSIS
Requires managed care plans to pay health care claims based on assignment of benefits.

CURRENT VERSION OF TEXT
As reported by the Assembly Financial Institutions and Insurance Committee on January 4, 2010, with amendments.

(Sponsorship Updated As Of: 1/12/2010)

AN ACT concerning assignment of health benefits under managed care plans and amending P.L.2001, c.367.

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

1. Section 2 of P.L.2001, c.367 (C.26:2S-6.1) is amended to read as follows:

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 subsection a. 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. 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 the covered person assigns, through an assignment of benefits, his right to receive reimbursement for medically necessary health care services to an out-of-network health care provider, the carrier shall remit payment for the reimbursement directly to the health care provider [1]in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the covered person as joint payees, with a signature line for each of the payees. Payment shall be made[1] in accordance with the provisions of this section and P.L.1999, c.154 (C.17B:30-23 et al.). Any payment made [1]only[1] to the covered person rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Assembly AFI committee amendments adopted January 4, 2010.

1 time frames established by P.L.1999, c.154 (C.17B:30-23 et al.),
2 shall be considered overdue and subject to an interest charge as
3 provided in that act.
4 (cf: P.L.2001, c.367, s.2)
5
6 2. This act shall take effect on the [1][90th] 365th[1] day next
7 following enactment and shall apply to any health benefits plan in
8 which the carrier has reserved the right to change the premium
9 [1]and[1] which is [1][delivered, issued, executed or renewed] in effect[1]
10 on or after the effective date.

SENATE, No. 114

STATE OF NEW JERSEY

213th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2008 SESSION

Sponsored by:
Senator LORETTA WEINBERG
District 37 (Bergen)

SYNOPSIS

Requires managed care plans to pay health care claims based on assignment of benefits.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel

AN ACT concerning assignment of health benefits under managed care plans and amending P.L.2001, c.367.

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

1. Section 2 of P.L.2001, c.367 (C.26:2S-6.1) is amended to read as follows:

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 subsection a. 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. 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 the covered person assigns, through an assignment of benefits, his right to receive reimbursement for medically necessary health care services to an out-of-network health care provider, the carrier shall remit payment for the reimbursement directly to the health care provider in accordance with the provisions of this section and P.L.1999, c.154 (C.17B:30-23 et al.). Any payment made to the covered person rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the time frames established by P.L.1999, c.154 (C.17B:30-23 et al.), shall be considered overdue and subject to an interest charge as provided in that act.

(cf: P.L.2001, c.367, s.2)

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.

2. This act shall take effect on the 90th day next following enactment and shall apply to any health benefits plan in which the carrier has reserved the right to change the premium which is delivered, issued, executed or renewed on or after the effective date.

STATEMENT

This bill provides that a carrier which issues a managed care plan with an out-of-network benefit shall remit payment for reimbursement of a health care service directly to an out-of-network provider if that provider has been issued an assignment of benefits by the covered person. Payment shall be remitted pursuant to the provisions of the "Health Care Quality Act," P.L.1997, c.192 (C.26:25-1 et seq.) and P.L.1999, c.154 (C.17B:30-23 et al.), commonly referred to as the "prompt pay law." Any payment remitted to a covered person rather than the out-of-network provider under these circumstances shall be considered unpaid under the prompt pay law and, unless remitted to the health care provider within the time frames established under the prompt pay law, shall be considered overdue and subject to an interest charge as provided in that law.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 114

STATE OF NEW JERSEY

DATED: MAY 8, 2008

The Senate Commerce Committee reports favorably Senate Bill No. 114.

This bill provides that a carrier which issues a managed care plan with an out-of-network benefit shall remit payment for reimbursement of a health care service directly to an out-of-network provider if that provider has been issued an assignment of benefits by the covered person. Payment shall be remitted pursuant to the provisions of the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.) and P.L.1999, c.154 (C.17B:30-23 et al.), commonly referred to as the "prompt pay law." Any payment remitted to a covered person rather than the out-of-network provider under these circumstances shall be considered unpaid under the prompt pay law and, unless remitted to the health care provider within the time frames established under the prompt pay law, shall be considered overdue and subject to an interest charge as provided in that law.

This bill was pre-filed for introduction in the 2008-2009 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

SENATE, No. 114

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 4, 2010

The Assembly Financial Institutions and Insurance Committee reports favorably and with committee amendments Senate Bill No. 114.

This bill, as amended, provides that, with respect to a carrier that issues a managed care plan with an out-of-network benefit, in the event that the covered person assigns, through an assignment of benefits, his right to receive reimbursement for medically necessary health care services to an out-of-network health care provider, the carrier shall remit payment for the reimbursement directly to the health care provider in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the covered person, as joint payees, with a signature line for each of the payees.

Payment shall be remitted pursuant to the provisions of the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.) and P.L.1999, c.154 (C.17B:30-23 et al.), commonly referred to as the "prompt pay law." Any payment made only to a covered person rather than the out-of-network provider under these circumstances shall be considered unpaid under the prompt pay law and, unless remitted to the health care provider within the time frames established under the prompt pay law, shall be considered overdue and subject to an interest charge as provided in that law.

The bill's provisions shall take effect on the 365th day next following enactment and shall apply to any health benefits plan in which the carrier has reserved the right to change the premium and which is in effect on or after the effective date.

COMMITTEE AMENDMENTS:

The committee amended the bill to specify that, as to a carrier's payment to an out-of-network provider who has an assignment of benefits, the carrier shall remit payment directly to the provider, in the form of a check payable to the provider, or in the alternative, to the health care provider and covered person as joint payees.

The amendment also revised the effective date provision so that the bill's provisions take effect on the 365th day next following enactment and shall apply to any health benefits plan in effect on or after the effective date.

The bill, as amended, is identical to its Assembly counterpart, Assembly Bill No. 132(1R), also considered by the committee today.

ASSEMBLY, No. 132

STATE OF NEW JERSEY

213th LEGISLATURE

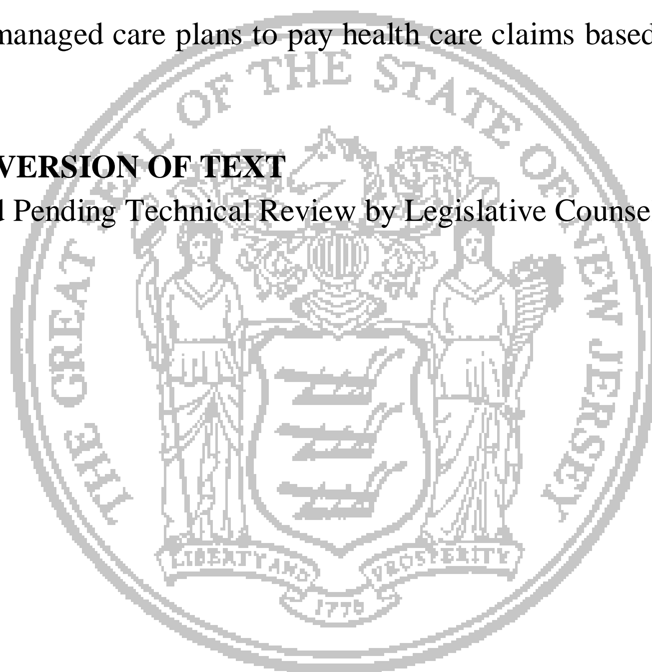
PRE-FILED FOR INTRODUCTION IN THE 2008 SESSION

Sponsored by:
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)
Assemblywoman AMY H. HANDLIN
District 13 (Middlesex and Monmouth)
Assemblywoman NANCY F. MUNOZ
District 21 (Essex, Morris, Somerset and Union)
Assemblyman ERIC MUNOZ
District 21 (Essex, Morris, Somerset and Union)

Co-Sponsored by:
Assemblyman Conners and Assemblywoman Watson Coleman

SYNOPSIS
Requires managed care plans to pay health care claims based on assignment of benefits.

CURRENT VERSION OF TEXT
Introduced Pending Technical Review by Legislative Counsel



(Sponsorship Updated As Of: 12/8/2009)

AN ACT concerning assignment of health benefits under managed care plans and amending P.L.2001, c.367.

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

1. Section 2 of P.L.2001, c.367 (C.26:2S-6.1) is amended to read as follows:

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 subsection a. 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. 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 the covered person assigns, through an assignment of benefits, his right to receive reimbursement for medically necessary health care services to an out-of-network health care provider, the carrier shall remit payment for the reimbursement directly to the health care provider in accordance with the provisions of this section and P.L.1999, c.154 (C.17B:30-23 et al.). Any payment made to the covered person rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the time frames established by P.L.1999, c.154 (C.17B:30-23 et al.), shall be considered overdue and subject to an interest charge as provided in that act.

(cf: P.L.2001, c.367, s.2)

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 2. This act shall take effect on the 90th day next following
2 enactment and shall apply to any health benefits plan in which the
3 carrier has reserved the right to change the premium which is
4 delivered, issued, executed or renewed on or after the effective date.
5
6
7 STATEMENT
8
9 This bill provides that a carrier which issues a managed care plan
10 with an out-of-network benefit shall remit payment for
11 reimbursement of a health care service directly to an out-of-
12 network provider if that provider has been issued an assignment of
13 benefits by the covered person. Payment shall be remitted pursuant
14 to the provisions of the "Health Care Quality Act," P.L.1997, c.192
15 (C.26:25-1 et seq.) and P.L.1999, c.154 (C.17B:30-23 et al.),
16 commonly referred to as the "prompt pay law." Any payment
17 remitted to a covered person rather than the out-of-network provider
18 under these circumstances shall be considered unpaid under the
19 prompt pay law and, unless remitted to the health care provider
20 within the time frames established under the prompt pay law, shall
21 be considered overdue and subject to an interest charge as provided
22 in that law.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 132

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 4, 2010

The Assembly Financial Institutions and Insurance Committee reports favorably and with committee amendments Assembly Bill No. 132.

This bill, as amended, provides that, with respect to a carrier that issues a managed care plan with an out-of-network benefit, in the event that the covered person assigns, through an assignment of benefits, his right to receive reimbursement for medically necessary health care services to an out-of-network health care provider, the carrier shall remit payment for the reimbursement directly to the health care provider in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the covered person, as joint payees, with a signature line for each of the payees.

Payment shall be remitted pursuant to the provisions of the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.) and P.L.1999, c.154 (C.17B:30-23 et al.), commonly referred to as the "prompt pay law." Any payment made only to a covered person rather than the out-of-network provider under these circumstances shall be considered unpaid under the prompt pay law and, unless remitted to the health care provider within the time frames established under the prompt pay law, shall be considered overdue and subject to an interest charge as provided in that law.

The bill's provisions shall take effect on the 365th day next following enactment and shall apply to any health benefits plan in which the carrier has reserved the right to change the premium and which is in effect on or after the effective date.

This bill was pre-filed for introduction in the 2008-2009 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

COMMITTEE AMENDMENTS:

The committee amended the bill to specify that, as to a carrier's payment to an out-of-network provider who has an assignment of

benefits, the carrier shall remit payment directly to the provider, in the form of a check payable to the provider, or in the alternative, to the health care provider and covered person as joint payees.

The amendment also revised the effective date provision so that the bill's provisions take effect on the 365th day next following enactment and shall apply to any health benefits plan in effect on or after the effective date.

The bill, as amended, is identical to its Senate counterpart, Senate Bill No. 114(1R), also considered by the committee today.