30:4D-3

LEGISLATIVE HISTORY CHECKLIST
Compiled by the NJ State Law Library

(Third party Medicaid)

NJSA: 30:4D-3

LAWS OF: 1995 **CHAPTER:** 292

BILL NO: S2350

SPONSOR(S): Bassano

DATE INTRODUCED: November 9, 1995

COMMITTEE: **ASSEMBLY** ---

SENATE: Human Services

AMENDED DURING PASSAGE: No

DATE OF PASSAGE: **ASSEMBLY:** December 21, 1995

SENATE: December 11, 1995

DATE OF APPROVAL: December 22, 1995

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT: Yes

COMMITTEE STATEMENT: **ASSEMBLY:** No

SENATE: Yes

FISCAL NOTE: No

VETO MESSAGE: No

MESSAGE ON SIGNING: No

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

KBP:pp

§4-Note to
§§1-3

P.L.1995, CHAPTER 292, *approved December 22, 1995*
1995 Senate No. 2350

1 *AN ACT* concerning coverage by third party payers for
2 Medicaid-eligible persons and amending P.L.1968, c.413.
3
4 BE IT ENACTED *by the Senate and General Assembly of the*
5 *State of New Jersey:*
6 1. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read
7 as follows:
8 3. Definitions. As used in this act, and unless the context
9 otherwise requires:
10 a. "Applicant" means any person who has made application for
11 purposes of becoming a "qualified applicant."
12 b. "Commissioner" means the Commissioner of Human
13 Services.
14 c. "Department" means the Department of Human Services,
15 which is herein designated as the single State agency to
16 administer the provisions of this act.
17 d. "Director" means the Director of the Division of Medical
18 Assistance and Health Services.
19 e. "Division" means the Division of Medical Assistance and
20 Health Services.
21 f. "Medicaid" means the New Jersey Medical Assistance and
22 Health Services Program.
23 g. "Medical assistance" means payments on behalf of
24 recipients to providers for medical care and services authorized
25 under this act.
26 h. "Provider" means any person, public or private institution,
27 agency or business concern approved by the division lawfully
28 providing medical care, services, goods and supplies authorized
29 under this act, holding, where applicable, a current valid license
30 to provide such services or to dispense such goods or supplies.
31 i. "Qualified applicant" means a person who is a resident of
32 this State and is determined to need medical care and services as
33 provided under this act, and who:
34 (1) Is a recipient of Aid to Families with Dependent Children;
35 (2) Is a recipient of Supplemental Security Income for the
36 Aged, Blind and Disabled under Title XVI of the Social Security
37 Act;
38 (3) Is an "ineligible spouse" of a recipient of Supplemental
39 Security Income for the Aged, Blind and Disabled under Title XVI
40 of the Social Security Act, as defined by the federal Social
41 Security Administration;
42 (4) Would be eligible to receive public assistance under a

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 categorical assistance program except for failure to meet an
2 eligibility condition or requirement imposed under such State
3 program which is prohibited under Title XIX of the federal Social
4 Security Act such as a durational residency requirement, relative
5 responsibility, consent to imposition of a lien;
6 (5) Is a child between 18 and 21 years of age who would be
7 eligible for Aid to Families with Dependent Children, living in the
8 family group except for lack of school attendance or pursuit of
9 formalized vocational or technical training;
10 (6) Is an individual under 21 years of age who qualifies for
11 categorical assistance on the basis of financial eligibility, but
12 does not qualify as a dependent child under the State's program
13 of Aid to Families with Dependent Children (AFDC), or groups of
14 such individuals, including but not limited to, children in foster
15 placement under supervision of the Division of Youth and Family
16 Services whose maintenance is being paid in whole or in part from
17 public funds, children placed in a foster home or institution by a
18 private adoption agency in New Jersey or children in
19 intermediate care facilities, including institutions for the
20 mentally retarded, or in psychiatric hospitals;
21 (7) Meets the standard of need applicable to his circumstances
22 under a categorical assistance program or Supplemental Security
23 Income program, but is not receiving such assistance and applies
24 for medical assistance only;
25 (8) Is determined to be medically needy and meets all the
26 eligibility requirements described below:
27 (a) The following individuals are eligible for services, if they
28 are determined to be medically needy:
29 (i) Pregnant women;
30 (ii) Dependent children under the age of 21;
31 (iii) Individuals who are 65 years of age and older; and
32 (iv) Individuals who are blind or disabled pursuant to either 42
33 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
34 (b) The following income standard shall be used to determine
35 medically needy eligibility:
36 (i) For one person and two person households, the income
37 standard shall be the maximum allowable under federal law, but
38 shall not exceed 133 1/3% of the State's payment level to two
39 person households eligible to receive assistance pursuant to
40 P.L.1959, c.86 (C.44:10-1 et seq.); and
41 (ii) For households of three or more persons, the income
42 standard shall be set at 133 1/3% of the State's payment level to
43 similar size households eligible to receive assistance pursuant to
44 P.L.1959, c.86 (C.44:10-1 et seq.).
45 (c) The following resource standard shall be used to determine
46 medically needy eligibility:
47 (i) For one person households, the resource standard shall be
48 200% of the resource standard for recipients of Supplemental
49 Security Income pursuant to 42 U.S.C.§1382(1)(B);
50 (ii) For two person households, the resource standard shall be
51 200% of the resource standard for recipients of Supplemental
52 Security Income pursuant to 42 U.S.C.§1382(2)(B);
53 (iii) For households of three or more persons, the resource
54 standard in subparagraph (c)(ii) above shall be increased by

1 $100.00 for each additional person; and
2 (iv) The resource standards established in (i), (ii), and (iii) are
3 subject to federal approval and the resource standard may be
4 lower if required by the federal Department of Health and Human
5 Services.
6 (d) Individuals whose income exceeds those established in
7 subparagraph (b) of paragraph (8) of this subsection may become
8 medically needy by incurring medical expenses as defined in 42
9 C.F.R.435.831(c) which will reduce their income to the applicable
10 medically needy income established in subparagraph (b) of
11 paragraph (8) of this subsection.
12 (e) A six-month period shall be used to determine whether an
13 individual is medically needy.
14 (f) Eligibility determinations for the medically needy program
15 shall be administered as follows:
16 (i) County welfare agencies are responsible for determining
17 and certifying the eligibility of pregnant women and dependent
18 children. The division shall reimburse county welfare agencies for
19 100% of the reasonable costs of administration which are not
20 reimbursed by the federal government for the first 12 months of
21 this program's operation. Thereafter, 75% of the administrative
22 costs incurred by county welfare agencies which are not
23 reimbursed by the federal government shall be reimbursed by the
24 division;
25 (ii) The division is responsible for certifying the eligibility of
26 individuals who are 65 years of age and older and individuals who
27 are blind or disabled. The division may enter into contracts with
28 county welfare agencies to determine certain aspects of
29 eligibility. In such instances the division shall provide county
30 welfare agencies with all information the division may have
31 available on the individual.
32 The division shall notify all eligible recipients of the
33 Pharmaceutical Assistance to the Aged and Disabled program,
34 P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the
35 medically needy program and the program's general
36 requirements. The division shall take all reasonable
37 administrative actions to ensure that Pharmaceutical Assistance
38 to the Aged and Disabled recipients, who notify the division that
39 they may be eligible for the program, have their applications
40 processed expeditiously, at times and locations convenient to the
41 recipients; and
42 (iii) The division is responsible for certifying incurred medical
43 expenses for all eligible persons who attempt to qualify for the
44 program pursuant to subparagraph (d) of paragraph (8) of this
45 subsection;
46 (9) (a) Is a child who is at least one year of age and under six
47 years of age; and
48 (b) Is a member of a family whose income does not exceed
49 133% of the poverty level and who meets the federal Medicaid
50 eligibility requirements set forth in section 9401 of Pub.L.99-509
51 (42 U.S.C.§1396a);
52 (10) Is a pregnant woman who is determined by a provider to
53 be presumptively eligible for medical assistance based on criteria
54 established by the commissioner, pursuant to section 9407 of
55 Pub.L.99-509 (42 U.S.C.§1396a(a));

1 (11) Is an individual 65 years of age and older, or an individual
2 who is blind or disabled pursuant to section 301 of Pub.L.92-603
3 (42 U.S.C.§1382c), whose income does not exceed 100% of the
4 poverty level, adjusted for family size, and whose resources do
5 not exceed 100% of the resource standard used to determine
6 medically needy eligibility pursuant to paragraph (8) of this
7 subsection;
8 (12) Is a qualified disabled and working individual pursuant to
9 section 6408 of Pub.L.101-239 (42 U.S.C.§1396d) whose income
10 does not exceed 200% of the poverty level and whose resources
11 do not exceed 200% of the resource standard used to determine
12 eligibility under the Supplemental Security Income Program,
13 P.L.1973, c.256 (C.44:7-85 et seq.);
14 (13) Is a pregnant woman or is a child who is under one year of
15 age and is a member of a family whose income does not exceed
16 185% of the poverty level and who meets the federal Medicaid
17 eligibility requirements set forth in section 9401 of Pub.L.99-509
18 (42 U.S.C.§1396a), except that a pregnant woman who is
19 determined to be a qualified applicant shall, notwithstanding any
20 change in the income of the family of which she is a member,
21 continue to be deemed a qualified applicant until the end of the
22 60-day period beginning on the last day of her pregnancy;
23 (14) Is a child born after September 30, 1983 who has attained
24 six years of age but has not attained 19 years of age and is a
25 member of a family whose income does not exceed 100% of the
26 poverty level; or
27 (15) (a) Is a specified low-income medicare beneficiary
28 pursuant to 42 U.S.C.§1396a(a)10(E)iii whose resources beginning
29 January 1, 1993 do not exceed 200% of the resource standard
30 used to determine eligibility under the Supplemental Security
31 Income program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose
32 income beginning January 1, 1993 does not exceed 110% of the
33 poverty level, and beginning January 1, 1995 does not exceed
34 120% of the poverty level.
35 (b) An individual who has, within 36 months, or within 60
36 months in the case of funds transferred into a trust, of applying
37 to be a qualified applicant for Medicaid services in a nursing
38 facility or a medical institution, or for home or community-based
39 services under section 1915(c) of the federal Social Security Act
40 (42 U.S.C.§1396n(c)), disposed of resources or income for less
41 than fair market value shall be ineligible for assistance for
42 nursing facility services, an equivalent level of services in a
43 medical institution, or home or community-based services under
44 section 1915(c) of the federal Social Security Act (42
45 U.S.C.§1396n(c)). The period of the ineligibility shall be the
46 number of months resulting from dividing the uncompensated
47 value of the transferred resources or income by the average
48 monthly private payment rate for nursing facility services in the
49 State as determined annually by the commissioner. In the case of
50 multiple resource or income transfers, the resulting penalty
51 periods shall be imposed sequentially. Application of this
52 requirement shall be governed by 42 U.S.C. §1396p(c). In
53 accordance with federal law, this provision is effective for all
54 transfers of resources or income made on or after August 11,

1993. Notwithstanding the provisions of this subsection to the contrary, the State eligibility requirements concerning resource or income transfers shall not be more restrictive than those enacted pursuant to 42 U.S.C. §1396p(c).

(c) An individual seeking nursing facility services or home or community-based services and who has a community spouse shall be required to expend those resources which are not protected for the needs of the community spouse in accordance with section 1924(c) of the federal Social Security Act (42 U.S.C. §1396r-5(c)) on the costs of long-term care, burial arrangements, and any other expense deemed appropriate and authorized by the commissioner. An individual shall be ineligible for Medicaid services in a nursing facility or for home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. §1396n(c)) if the individual expends funds in violation of this subparagraph. The period of ineligibility shall be the number of months resulting from dividing the uncompensated value of transferred resources and income by the average monthly private payment rate for nursing facility services in the State as determined by the commissioner. The period of ineligibility shall begin with the month that the individual would otherwise be eligible for Medicaid coverage for nursing facility services or home or community-based services.

This subparagraph shall be operative only if all necessary approvals are received from the federal government including, but not limited to, approval of necessary State plan amendments and approval of any waivers.

j. "Recipient" means any qualified applicant receiving benefits under this act.

k. "Resident" means a person who is living in the State voluntarily with the intention of making his home here and not for a temporary purpose. Temporary absences from the State, with subsequent returns to the State or intent to return when the purposes of the absences have been accomplished, do not interrupt continuity of residence.

l. "State Medicaid Commission" means the Governor, the Commissioner of Human Services, the President of the Senate and the Speaker of the General Assembly, hereby constituted a commission to approve and direct the means and method for the payment of claims pursuant to this act.

m. "Third party" means any person, institution, corporation, insurance company, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C.§1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

n. "Governmental peer grouping system" means a separate class of skilled nursing and intermediate care facilities administered by the State or county governments, established for the purpose of screening their reported costs and setting reimbursement rates under the Medicaid program that are

1 reasonable and adequate to meet the costs that must be incurred
2 by efficiently and economically operated State or county skilled
3 nursing and intermediate care facilities.
4 o. "Comprehensive maternity or pediatric care provider"
5 means any person or public or private health care facility that is
6 a provider and that is approved by the commissioner to provide
7 comprehensive maternity care or comprehensive pediatric care as
8 defined in subsection b. (18) and (19) of section 6 of P.L.1968,
9 c.413 (C.30:4D-6).
10 p. "Poverty level" means the official poverty level based on
11 family size established and adjusted under Section 673(2) of
12 Subtitle B, the "Community Services Block Grant Act," of
13 Pub.L.97-35 (42 U.S.C.§9902(2)).
14 (cf: P.L1995, c.153, s.1)
15 2. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
16 as follows:
17 6. a. Subject to the requirements of Title XIX of the federal
18 Social Security Act, the limitations imposed by this act and by
19 the rules and regulations promulgated pursuant thereto, the
20 department shall provide medical assistance to qualified
21 applicants, including authorized services within each of the
22 following classifications:
23 (1) Inpatient hospital services;
24 (2) Outpatient hospital services;
25 (3) Other laboratory and X-ray services;
26 (4) (a) Skilled nursing or intermediate care facility services;
27 (b) Such early and periodic screening and diagnosis of
28 individuals who are eligible under the program and are under age
29 21, to ascertain their physical or mental defects and such health
30 care, treatment, and other measures to correct or ameliorate
31 defects and chronic conditions discovered thereby, as may be
32 provided in regulations of the Secretary of the federal
33 Department of Health and Human Services and approved by the
34 commissioner;
35 (5) Physician's services furnished in the office, the patient's
36 home, a hospital, a skilled nursing or intermediate care facility or
37 elsewhere.
38 b. Subject to the limitations imposed by federal law, by this
39 act, and by the rules and regulations promulgated pursuant
40 thereto, the medical assistance program may be expanded to
41 include authorized services within each of the following
42 classifications:
43 (1) Medical care not included in subsection a.(5) above, or any
44 other type of remedial care recognized under State law, furnished
45 by licensed practitioners within the scope of their practice, as
46 defined by State law;
47 (2) Home health care services;
48 (3) Clinic services;
49 (4) Dental services;
50 (5) Physical therapy and related services;
51 (6) Prescribed drugs, dentures, and prosthetic devices; and
52 eyeglasses prescribed by a physician skilled in diseases of the eye
53 or by an optometrist, whichever the individual may select;
54 (7) Optometric services;

1 (8) Podiatric services;
2 (9) Chiropractic services;
3 (10) Psychological services;
4 (11) Inpatient psychiatric hospital services for individuals
5 under 21 years of age, or under age 22 if they are receiving such
6 services immediately before attaining age 21;
7 (12) Other diagnostic, screening, preventive, and rehabilitative
8 services, and other remedial care;
9 (13) Inpatient hospital services, nursing facility services and
10 intermediate care facility services for individuals 65 years of age
11 or over in an institution for mental diseases;
12 (14) Intermediate care facility services;
13 (15) Transportation services;
14 (16) Services in connection with the inpatient or outpatient
15 treatment or care of drug abuse, when the treatment is
16 prescribed by a physician and provided in a licensed hospital or in
17 a narcotic and drug abuse treatment center approved by the
18 Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21 et
19 seq.) and whose staff includes a medical director, and limited to
20 those services eligible for federal financial participation under
21 Title XIX of the federal Social Security Act;
22 (17) Any other medical care and any other type of remedial
23 care recognized under State law, specified by the Secretary of
24 the federal Department of Health and Human Services, and
25 approved by the commissioner;
26 (18) Comprehensive maternity care, which may include: the
27 basic number of prenatal and postpartum visits recommended by
28 the American College of Obstetrics and Gynecology; additional
29 prenatal and postpartum visits that are medically necessary;
30 necessary laboratory, nutritional assessment and counseling,
31 health education, personal counseling, managed care, outreach
32 and follow-up services; treatment of conditions which may
33 complicate pregnancy; and physician or certified nurse-midwife
34 delivery services;
35 (19) Comprehensive pediatric care, which may include:
36 ambulatory, preventive and primary care health services. The
37 preventive services shall include, at a minimum, the basic number
38 of preventive visits recommended by the American Academy of
39 Pediatrics;
40 (20) Services provided by a hospice which is participating in
41 the Medicare program established pursuant to Title XVIII of the
42 Social Security Act, Pub.L.89-97 (42 U.S.C.§1395 et seq.).
43 Hospice services shall be provided subject to approval of the
44 Secretary of the federal Department of Health and Human
45 Services for federal reimbursement;
46 (21) Mammograms, subject to approval of the Secretary of the
47 federal Department of Health and Human Services for federal
48 reimbursement, including one baseline mammogram for women
49 who are at least 35 but less than 40 years of age; one
50 mammogram examination every two years or more frequently, if
51 recommended by a physician, for women who are at least 40 but
52 less than 50 years of age; and one mammogram examination
53 every year for women age 50 and over.
54 c. Payments for the foregoing services, goods and supplies

furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. Said payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, his family, his representative or others on his behalf for the services, goods and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods or supplies not authorized by this act, if the recipient elected to receive the services, goods or supplies with the knowledge that they were not authorized.

d. Any individual eligible for medical assistance (including drugs) may obtain such assistance from any person qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability on a prepayment basis), who undertakes to provide him such services.

No copayment or other form of cost-sharing shall be imposed on any individual eligible for medical assistance, except as mandated by federal law as a condition of federal financial participation.

e. Anything in this act to the contrary notwithstanding, no payments for medical assistance shall be made under this act with respect to care or services for any individual who:

(1) Is an inmate of a public institution (except as a patient in a medical institution); provided, however, that an individual who is otherwise eligible may continue to receive services for the month in which he becomes an inmate, should the commissioner determine to expand the scope of Medicaid eligibility to include such an individual, subject to the limitations imposed by federal law and regulations, or

(2) Has not attained 65 years of age and who is a patient in an institution for mental diseases, or

(3) Is over 21 years of age and who is receiving inpatient psychiatric hospital services in a psychiatric facility; provided, however, that an individual who was receiving such services immediately prior to attaining age 21 may continue to receive such services until he reaches age 22. Nothing in this subsection shall prohibit the commissioner from extending medical assistance to all eligible persons receiving inpatient psychiatric services; provided that there is federal financial participation available.

f. [Any] A third party as defined in section 3 of P.L.1968, c.413 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in this or another state when determining the person's eligibility for enrollment or the provision of benefits by that third

1 party. In addition, any provision in a contract of insurance,
2 health benefits plan or other health care coverage document,
3 will, trust agreement, court order or other instrument which
4 reduces or excludes coverage or payment for health care-related
5 goods and services to or for an individual because of that
6 individual's actual or potential eligibility for or receipt of
7 Medicaid benefits shall be null and void, and no payments shall be
8 made under this act as a result of any such provision.
9 g. The following services shall be provided to eligible
10 medically needy individuals as follows:
11 (1) Pregnant women shall be provided prenatal care and
12 delivery services and postpartum care, including the services
13 cited in subsection a.(1), (3) and (5) of this section and subsection
14 b.(1)-(10), (12), (15) and (17) of this section, and nursing facility
15 services cited in subsection b.(13) of this section.
16 (2) Dependent children shall be provided with services cited in
17 subsection a.(3) and (5) of this section and subsection b.(1), (2),
18 (3), (4), (5), (6), (7), (10), (12), (15) and (17) of this section, and
19 nursing facility services cited in subsection b.(13) of this section.
20 (3) Individuals who are 65 years of age or older shall be
21 provided with services cited in subsection a.(3) and (5) of this
22 section and subsection b.(1)-(5), (6) excluding prescribed drugs,
23 (7), (8), (10), (12), (15) and (17) of this section, and nursing facility
24 services cited in subsection b (13) of this section.
25 (4) Individuals who are blind or disabled shall be provided with
26 services cited in subsection a.(3) and (5) of this section and
27 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
28 (12), (15) and (17) of this section, and nursing facility services
29 cited in subsection b.(13) of this section.
30 (5) (a) Inpatient hospital services, subsection a.(1) of this
31 section, shall only be provided to eligible medically needy
32 individuals, other than pregnant women, if the federal
33 Department of Health and Human Services discontinues the
34 State's waiver to establish inpatient hospital reimbursement
35 rates for the Medicare and Medicaid programs under the
36 authority of section 601(c)(3) of the Social Security Act
37 Amendments of 1983, Pub.L.98-21 (42 U.S.C.§1395ww(c)(5)).
38 Inpatient hospital services may be extended to other eligible
39 medically needy individuals if the federal Department of Health
40 and Human Services directs that these services be included.
41 (b) Outpatient hospital services, subsection a.(2) of this
42 section, shall only be provided to eligible medically needy
43 individuals if the federal Department of Health and Human
44 Services discontinues the State's waiver to establish outpatient
45 hospital reimbursement rates for the Medicare and Medicaid
46 programs under the authority of section 601(c)(3) of the Social
47 Security Amendments of 1983, Pub.L.98-21 (42
48 U.S.C.§1395ww(c)(5)). Outpatient hospital services may be
49 extended to all or to certain medically needy individuals if the
50 federal Department of Health and Human Services directs that
51 these services be included. However, the use of outpatient
52 hospital services shall be limited to clinic services and to
53 emergency room services for injuries and significant acute
54 medical conditions.

(c) The division shall monitor the use of inpatient and outpatient hospital services by medically needy persons.

h. In the case of a qualified disabled and working individual pursuant to section 6408 of Pub.L.101-239 (42 U.S.C.§1396d), the only medical assistance provided under this act shall be the payment of premiums for Medicare part A under 42 U.S.C.§1395i-2 and §1395r.

i. In the case of a specified low-income medicare beneficiary pursuant to 42 U.S.C. §1396a(a)10(E)iii, the only medical assistance provided under this act shall be the payment of premiums for Medicare part B under 42 U.S.C.§1395r as provided for in 42 U.S.C.§1396d(p)(3)(A)(ii).

(cf: P.L.1995, c.153, s.2)

3. Section 3 of P.L.1987, c.283 (C.30:4D-6d) is amended to read as follows:

3. If a person who is eligible for continued Medicaid benefits pursuant to section 2 of this act obtains employment which provides health insurance coverage through a third party as defined in section 3 of P.L.1968, c.413 (C.30:4D-3), [the employee's or employer's health insurance carrier, as the case may be,] the third party shall be the primary payer and the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) shall be the secondary payer.

(cf: P.L.1987, c.283, s.3)

4. This act shall take effect immediately and shall be retroactive to April 1, 1995.

STATEMENT

This bill broadens the definition of third party payer which is required to be the primary payer for a Medicaid-eligible person under the "New Jersey Medical Assistance and Health Services Act," P.L.1968, c.413 (C.30:4D-1 et seq.), in accordance with the provisions of the federal "Omnibus Budget Reconciliation Act of 1993," Pub.L.103-66.

The bill also prohibits a third party payer from considering a person's eligibility for Medicaid benefits in this or another state when determining the person's eligibility for enrollment or health care coverage.

This bill is designed to meet a requirement for legislative enactment by all states under Pub.L.103-66.

Broadens definition of third party payer required to be the primary payer for Medicaid-eligible persons.

(c) The division shall monitor the use of inpatient and outpatient hospital services by medically needy persons.

h. In the case of a qualified disabled and working individual pursuant to section 6408 of Pub.L.101-239 (42 U.S.C.§1396d), the only medical assistance provided under this act shall be the payment of premiums for Medicare part A under 42 U.S.C.§1395i-2 and §1395r.

i. In the case of a specified low-income medicare beneficiary pursuant to 42 U.S.C. §1396a(a)10(E)iii, the only medical assistance provided under this act shall be the payment of premiums for Medicare part B under 42 U.S.C.§1395r as provided for in 42 U.S.C.§1396d(p)(3)(A)(ii).

(cf: P.L.1995, c.153, s.2)

3. Section 3 of P.L.1987, c.283 (C.30:4D-6d) is amended to read as follows:

3. If a person who is eligible for continued Medicaid benefits pursuant to section 2 of this act obtains employment which provides health insurance coverage through a third party as defined in section 3 of P.L.1968, c.413 (C.30:4D-3), [the employee's or employer's health insurance carrier, as the case may be,] the third party shall be the primary payer and the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) shall be the secondary payer.

(cf: P.L.1987, c.283, s.3)

4. This act shall take effect immediately and shall be retroactive to April 1, 1995.

SPONSOR'S STATEMENT

This bill broadens the definition of third party payer which is required to be the primary payer for a Medicaid-eligible person under the "New Jersey Medical Assistance and Health Services Act," P.L.1968, c.413 (C.30:4D-1 et seq.), in accordance with the provisions of the federal "Omnibus Budget Reconciliation Act of 1993," Pub.L.103-66.

The bill also prohibits a third party payer from considering a person's eligibility for Medicaid benefits in this or another state when determining the person's eligibility for enrollment or health care coverage.

This bill is designed to meet a requirement for legislative enactment by all states under Pub.L.103-66.

Broadens definition of third party payer required to be the primary payer for Medicaid-eligible persons.

SENATE HUMAN SERVICES COMMITTEE

STATEMENT TO

SENATE, No. 2350

STATE OF NEW JERSEY

DATED: NOVEMBER 27, 1995

The Senate Human Services Committee favorably reports Senate Bill No. 2350.

This bill broadens the definition of third party payer which is required to be the primary payer for a Medicaid-eligible person under the "New Jersey Medical Assistance and Health Services Act," P.L.1968, c.413 (C.30:4D-1 et seq.), in accordance with the provisions of the federal "Omnibus Budget Reconciliation Act of 1993," Pub.L.103-66.

The bill also prohibits a third party payer from considering a person's eligibility for Medicaid benefits in this or another state when determining the person's eligibility for enrollment or health care coverage.

This bill is designed to meet a requirement for legislative enactment by all states under Pub.L.103-66.

This bill is identical to Assembly Bill No. 3249 (Bagger) which was released by the Assembly Insurance Committee on November 20, 1995 and is on second reading in the General Assembly.