CHAPTER 209

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:

C.26:2S-6.1 Managed care plan to pay full contractual rate to out-of-network provider, direct payments, certain circumstances.

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 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 in accordance with the provisions of this section and P.L.1999, c.154 (C.17B:30-23 et al.). Any payment made only 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.

2. This act 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.

Approved January 16, 2010.