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BULLETIN NO. 10-36

TO: **ALL INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED TO ISSUE HEALTH BENEFITS PLANS IN NEW JERSEY**

FROM: **THOMAS B. CONSIDINE, COMMISSIONER**

RE: **P.L. 2009, C. 209 – ASSIGNMENT OF HEALTH BENEFITS UNDER MANAGED CARE PLANS**

P.L. 2009, c. 209 (the Act), approved on January 16, 2010, amends the Health Care Quality Act (HCQA) (N.J.S.A. 26:2S-1 et seq.) and is codified at N.J.S.A. 26:2S-6.1(c). The Act requires a health carrier offering a managed care plan that provides for both in-network and out-of-network benefits to remit payment for the reimbursement of medically necessary health care services directly to the health care provider if the covered person has assigned his right to receive reimbursement to an out-of-network provider. The Act becomes effective January 16, 2011, and applies 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.

The Act requires the carrier to remit payment directly to the provider in the form of a check payable to the provider, or, alternatively, to the provider and the covered person as joint payees with a signature line for each payee. The Act further requires that payment be made in accordance with the timeframes established at N.J.S.A. 17B:30-23 et seq. The Act further provides that if payment is remitted to the covered person solely, when a covered person has assigned his or her benefits to an out-of-network provider, the payment will be considered unpaid and overdue and subject to an interest charge as set forth at N.J.S.A. 17:B-30-23 et seq.

The Department has received some questions, set forth below, regarding interpretation and implementation of the Act. Accordingly, the Department is issuing this Bulletin to provide guidance to carriers in complying with the Act.

1. Does the Act apply to dental-only plans? No. The Act amends The HCQA at N.J.S.A. 26:2S-1 et seq., which defines "carrier" as "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." Because The Act does not amend the statutes applicable to Dental Service Corporations or Dental Plan Organizations, the Department does not believe that the statute was intended to apply to dental only coverage, regardless of the carrier involved.

2. To what does the Act's January 16, 2011 effective date apply? As stated above, the Act applies 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. The Department has determined that the Act's January 16, 2011 effective date applies to all claims received by a carrier as defined in the HCQA at N.J.S.A. 26:2S-1 et seq., which is in receipt of a valid assignment of benefits on or after that date.

3. What constitutes a valid assignment of benefits? The Department has determined that it will not require that a carrier be in receipt of a written assignment of benefits before a carrier may remit payment directly to a provider under an assignment of benefits from a covered person. Rather, a carrier may choose to accept an out-of-network provider's statement on a paper or electronic claim form submitted to a carrier that he or she has a written assignment of benefits from a covered person on file. This option will be less administratively burdensome on both the carrier and the provider. Alternatively, it is within a carrier's discretion to require that it be in possession of a written assignment of benefits before remitting payment directly to a provider. If an assignment has been submitted to a carrier covering multiple claims, the carrier may not require multiple submissions of the same assignment for claims within the scope of that assignment. Carriers intending to require submission of a written assignment as a condition for payment of claims are reminded that N.J.S.A. 17B:30-51 requires that a payer provide such information in a clear and conspicuous manner through an internet website no later than 30 calendar days before the date on which the requirement will take effect.

4. Can a carrier determine a threshold amount at which the signatures of both the provider and the covered person are required on a remittance check? The Act states that in an assignment of benefits situation, 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." The Department believes that it would be less administratively burdensome on both the carrier and the provider if smaller claims payments could be made directly to the provider without the necessity of obtaining the signature of the covered person. Accordingly, it is the Department's position that a carrier may, in its discretion, determine a threshold amount at which the signatures of both the provider and the covered person will be required. Where the covered person is a minor or is incapable

of signing their name carriers may remit payment to the provider and the subscriber as joint payees.

The Department may issue additional Bulletins should other issues or questions arise concerning implementation of the Act. Any questions regarding this Bulletin may be addressed to Assistant Commissioner Neil Sullivan by phone at 609-292-5427 x50341 or email at neil.sullivan@dobi.state.nj.us.

December 13, 2010
Date

Thomas B. Considine
Commissioner

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