

ASSEMBLY, No. 2128

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:

Assemblyman P. CHRISTOPHER TULLY

District 38 (Bergen and Passaic)

Assemblywoman LISA SWAIN

District 38 (Bergen and Passaic)

Assemblywoman VALERIE VAINIERI HUTTLE

District 37 (Bergen)

SYNOPSIS

Prohibits health insurance carriers from denying payment for preauthorized covered services except under certain circumstances.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 **AN ACT** concerning preauthorized covered services under certain
2 health benefits plans and supplementing P.L.1997, c.192
3 (C.26:2S-1 et al.).
4

5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7

8 1. Notwithstanding any law or regulation to the contrary, a
9 carrier shall not use utilization management review for medical
10 necessity to deny payment of a claim to a covered person for a
11 covered service under a health benefits plan if the carrier provided
12 prior authorization for that service, except in situations in which:

- 13 a. the covered service was never provided;
14 b. the claim for the covered service was not timely submitted in
15 accordance with the terms of the plan; or
16 c. the covered person or health care provider engaged in fraud
17 or material misrepresentation regarding the claim for the covered
18 service.
19

20 2. This act shall take effect immediately.
21
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23 STATEMENT
24

25 This bill supplements the “Health Care Quality Act” by
26 providing that, notwithstanding any law or regulation to the
27 contrary, a health insurance carrier shall not use utilization
28 management review for medical necessity to deny payment of a
29 claim to a covered person for a covered service under a health
30 benefits plan if the carrier provided prior authorization for that
31 service, except in situations in which:

- 32 (1) the covered service was never provided;
33 (2) the claim for the covered service was not timely submitted in
34 accordance with the terms of the plan; or
35 (3) the covered person or health care provider engaged in fraud
36 or material misrepresentation regarding the claim for the covered
37 service.