



Vascular Society of New Jersey
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Monthly Report

November 2010

A Special Thanks to Our Sponsors at the VSNJ Annual Meeting:

**Bard Peripheral Vascular
Endologix
Medtronic Endovascular
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W.L. Gore & Associates**

From the Statehouse

Beverly J. Lynch

Good news for the New Jersey physician community! "Assignment of Benefits" Law Takes Effect January 16, 2011

How does it work?

After years of lobbying to advance an assignment of benefits law, Gov. Jon Corzine signed the law on January 16, 2010, in his final days in office. The law permits out of network physicians to have patients sign an "assignment of benefits" form, which will direct reimbursement to the physician, not the patient.

The law takes effect January 16, 2011, meaning that all care delivered on January 16, 2011, and forward, would qualify for the assignment of benefits provisions.

Most physicians already have an assignment of benefits form in use in their offices, but we have attached a sample form, should you need a form.

A copy of the entire law is below. The law permits an insurance company to require two signatures on the check (the physician and the patient), but we have learned that insurance companies think this requirement is too onerous to enforce and will not be requiring the dual signatures.

Questions? Call your attorney, Mark Manigan from Brach Eichler (973-228-5700) or VSNJ, at 609-392-7553.

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.

SAMPLE Assignment of Benefits form for your use in the office:

ASSIGNMENT OF BENEFITS

I AUTHORIZE AND DIRECT MY INSURER OR PAYOR TO PAY DIRECTLY TO THE ABOVE [CENTER/PRACTICE], AND THE PHYSICIANS, ANY OR ALL BENEFITS, THAT WOULD OTHERWISE BE PAYABLE TO ME (OR THE PATIENT, IF SIGNED BY A RESPONSIBLE PARTY), UP TO THE AMOUNT OF MY BILL, ACCRUING TO ME IN CONNECTION WITH MY TREATMENT AT THE [CENTER/PRACTICE].

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE, MEDIGAP OR OTHER HEALTH INSURANCE POLICY BENEFITS FOR SERVICES FURNISHED TO ME BY THE [CENTER/PRACTICE] BE MADE ON MY BEHALF TO THE [CENTER/PRACTICE]. IN THE EVENT THAT PAYMENTS ARE MADE TO THE [CENTER/PRACTICE] AND ME AS JOINT PAYEES, I AGREE TO COOPERATE WITH THE [CENTER/PRACTICE] TO ENSURE THAT THE CENTER/PRACTICE RECEIVES ALL AMOUNTS DUE TO THE [CENTER/PRACTICE].

I HEREBY AUTHORIZE THE [CENTER/PRACTICE] TO PURSUE ANY MEANS NECESSARY TO COLLECT ALL CHARGES ON MY ACCOUNT INCLUDING FOLLOW UP CALLS, APPEALS, ARBITRATION, AND CIVIL SUIT, IF ALLOWABLE UNDER LAW. IN THE EVENT THAT THE [CENTER/PRACTICE] OR PHYSICIAN ELECTS TO BRING AN APPEAL, LAWSUIT OR PETITION FOR ARBITRATION AGAINST THE INSURANCE CARRIER, I HEREBY ASSIGN TO THEM MY RIGHTS, TITLE, AND INTEREST UNDER ANY INSURANCE POLICY UNDER WHICH I AM ENTITLED TO PROCEED FOR BENEFITS, IF ALLOWABLE UNDER LAW. THIS ASSIGNMENT SHALL ALLOW AN ATTORNEY OF THEIR CHOOSING TO BRING SUIT OR SUBMIT TO ARBITRATION THEIR CLAIM OF ANY UNPAID OR UNDERPAID BILLS FOR TREATMENT RENDERED AT THE [CENTER/PRACTICE].

New Jersey Physicians: Grassroots Call to Action

Speak with Your State Legislators on New Legislation that Impacts all NJ Physicians!

THE ISSUE

Assemblyman Gary Schaer (D-Passaic), Chairman of the Assembly Financial Institutions and Insurance Committee, has introduced

new legislation (A-3378) that would place new and onerous requirements for both in- and out-of-network physicians.

If you would like to read the original legislation, which is certainly going to be amended as the weeks go by, you can go to this link:
http://www.njleg.state.nj.us/2010/Bills/A3500/3378_11.PDF

"Key provisions" of the legislation are outlined below. It is very early in the process for debate and discussion on this bill; significant amendments are expected to be made.

On October 18, the Committee held a "for discussion only" hearing. You can listen to the testimony from the physicians, facilities, and insurance industry by going to:

http://www.njleg.state.nj.us/media/archive_audio2.asp?KEY=AFI&SESSION=2010

and clicking on the October 18 Committee hearing.

It's expected that the bill will be heard again in November.

The insurance industry and the NJ Department of Banking and Insurance are pushing hard to make this law more restrictive. The New Jersey Coalition for Health Care Choice, representing over 20 physician, provider and facility organizations, are working on your behalf to defend physician rights every step of the way.

BACKGROUND

This bill was borne from the debate and discussion last year in the Legislature as the "assignment of benefits" law was passed. The carriers consistently argued that the out-of-network physicians, providers and facilities were driving up the cost of health care and insurance. The physicians, providers, and facilities organized the NJ Coalition for Health Care Choice, and have been immersed in many meetings, strategy sessions, political messaging campaign, and testimony.

ACTION NEEDED

It's time for the New Jersey physician community to meet personally with their STATE legislators. You can find the names and contact information of your Assembly members (two) and NJ State Senator by going to

<http://www.njleg.state.nj.us/members/legsearch.asp>.

Call their district offices, and ask for a constituent meeting with him to discuss A-3378.

Messages to convey:

- ✓ You have relationships with your patients to provide medical services.....but this bill requires you and your staff to become insurance counselors, which is impossible. The information that is required to be communicated to the patient is simply unworkable, and unavailable to the physician. Patients should be directed to speak with their insurance carrier and/or their employee benefits professional.
- ✓ Further, physicians should concur that providing incentives for patients by waiving copays should be prohibited.
- ✓ The legislation should not apply to any uncovered services, such as cosmetic procedures.
- ✓ Ask your state legislators to communicate your concerns to the sponsors of the bill, and to the legislative leadership. It's important the message is conveyed that this bill, in its current form, is simply unworkable, and will do nothing to improve patient care, lower costs, or provide transparency in the insurance market for patients to understand their policies.

For more information, contact Beverly Lynch, at BLYNCH@BLYNCHASSOCIATES.COM or call 609-392-7553. Personal discussion with your state legislators is the best way to lobby against this legislation.

Key provisions of A-3378, as introduced, include:

1) OON providers would be required to make a "**good faith and timely effort**" to collect each patient's co-insurance, co-payment or deductible. If a provider makes three (3) good faith and timely attempts to collect from a patient, such provider

will be deemed to have made a "**good faith and timely effort**." The bill also contains a requirement that the provider retain all records relating to any "**good faith and timely effort**" to collect a patient's payment for seven (7) years and make them available to DOBI for inspection upon request.

2) Providers may waive a patient's payment if the provider determines that the patient has a "medical or financial" hardship so long as (i) waivers are not granted "routinely or excessively" and (ii) providers must notify the carriers in the event that they grant such hardship waivers.

3) At the time of scheduling OON doctors and facilities would be required to inform patients whether the health care services they seek are in-network or OON and the provider must: (i) explain to the patient his or her financial responsibility, including deductibles, co-payments and co-insurance; and (ii) provide the patient with a description of any non-emergency services or elective procedures; and (iii) provide an estimation of the costs in the patient's primary language. Physicians in violation of this provision may be subject to licensure sanctions by the BME.

4) The recently enacted assignment of benefits legislation ("AOB Law") would be modified by the proposed bill. The existing requirement under the AOB Law that forces a carrier to pay a provider directly (or pay the provider and patient jointly) was expanded to include self-funded health benefit plans. However, under the bill, OON providers may be excluded from the direct pay benefit of the AOB Law for a one (1) year in the event a **carrier or insurance entity** determines that a provider engaged in a "pattern of violations" of the obligation to collect co-insurance, co-payments and/or deductibles, as set forth above, for a period of at least six (6) months. Providers would have the right to appeal such determination to the Office of the Insurance Claims Ombudsman in DOBI in accordance with procedures outlined in the bill.

5) Carriers would be prohibited from terminating a provider from a managed care panel solely on the basis that the provider referred to an OON provider. Additionally, the bill would restrict carriers from making unilateral changes to participating provider agreements more than once a calendar year and requires them to provide thirty (30) days advance written notice of any such changes to practitioners.

6) The bill also requires carriers and entities offering managed care plans or self-funded health benefits plans to maintain a website making available so called "quality rankings" of health care providers and other information deemed necessary by DOBI.

DI Marketplace for Physicians

It has taken awhile but we have finally entered into another doctor friendly disability insurance market. Carriers have been improving their contracts and increasing their limits for the last couple of years now.

You can actually purchase "True Own Occupation" coverage again. This definition of disability will allow you to collect on your benefits as long as you suffer a loss of income and are unable to perform the duties of your AMA approved specialty or sub-specialty. So if you are disabled and cannot earn a living as a Vascular Surgeon, even though you could do IMEs, teach medicine, or do something else in the medical field, you will be paid your full monthly benefit. As a matter of fact, they will pay you even if you do earn an income in another career.

As recently as five years ago the most individual coverage that a Vascular Surgeon could purchase, regardless of income, was \$10,000 per month. Over the last few years that limit has increased to \$12,500, then to \$15,000 per month. You can now purchase up to \$20,000 per month.

Currently there are also a couple of Group Disability providers that specialize in writing policies for doctors. Although not as strong as some of the individual disability providers their contracts are still pretty good. They have also increased their coverage limits to \$20,000 per month. So currently, you can actually purchase up to \$40,000 of combined total monthly coverage.

Want some more good news? Both Union Central and Standard offer exclusive discounts to society members. These discounts not only apply to individual disability policies but also business overhead and disability buy-out policies.

When is the last time you reviewed your disability policies? Given the expanded benefit limits and the

discounts offered through your society, now might be a good time for a 2nd look.

If you have any questions or would like an insurance review please call me at (877)972-7900 or dvargo@varbeco.com.

David J. Vargo, CFP®, CMFC
President, Varbeco Wealth Management, LLC

The New Jersey Lawsuit Reform Alliance

Medical professionals often wear multiple hats. In addition to practicing medicine and standing up to a hostile malpractice climate, many doctors are also small business owners who must navigate New Jersey's challenging business laws.

NJLRA recently launched a small business task force to learn more about this set of needs, and commissioned a survey with the [Monmouth University Polling Institute](#) to better examine the impact of New Jersey's civil justice climate on a variety of small business types. The results of this survey, released on October 7th, were alarming. Approximately one-in-five small businesses have been sued in the last five years, and another one-in-three expect to be hit with a lawsuit in the near future. Add this to the trials and tribulations New Jersey's doctors already face, and we have an even bigger problem.

Please contact [AnnMarie McDonald](#) at amcdonald@njlra.org to learn more about the small business task force, and how the medical community is often dually impacted by New Jersey's civil justice climate.

Mark Your Calendar

December 4, 2010 - ACS-NJ 59th Annual Scientific Meeting

March 9, 2011- VSNJ 33rd Annual Meeting- Nanina's In The Park, Belleville, NJ

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