Federal Standards Statement

The Department of Human Services has reviewed the applicable Federal laws and regulations and that review indicates that the adopted amendments do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Full text of the adoption follows:

SUBCHAPTER 15. ENFORCING SUPPORT OBLIGATIONS

10:110-15.2 Child support enforcement remedies

(a) Available enforcement remedies shall include, but are not limited to:

1.-3. (No change.)

4. Financial institution data match (FIDM) provisions are as follows:

i. The OCSS, in accordance with N.J.S.A. 2A:17-56.53 and 2A:17-56.57 et seq., shall conduct both in State and multistate financial institution data matches (FIDM) to identify assets of non-custodial parents held in financial institution accounts or in accordance with this subsection and Federal law at 42 U.S.C. § 666(a)17. The OCSS has authority to enter into cooperative alliances with other states for purposes of obtaining FIDM information.

(1) (No change.)

(2) Each financial institution shall provide information on all non-custodial parents who maintain an account at the financial institution and who owe past due child support that equals or exceeds the amount of support payable for three months and for which no regular payments are being made.

(A) As used in this sub-subparagraph, "regular payments" is defined as a payment of the full monthly support order, including any required arrears repayment amount due for the month. Past-due spousal support is only eligible when the obligee is living with the child and the spousal support and child support obligations are included in the same order.

(3)-(6) (No change.)

ii.-v. (No change.)

5.-11. (No change.)

12. Denial, revocation, or limitation of passport provisions are as follows:

i. Cases shall be certified by the OCSS to the Secretary of the U.S. Department of Health and Human Services for the possible denial, revocation, or limitation of delinquent obligors' passports pursuant to 42 U.S.C. § 652(K).

(1) (No change.)

(2) Past-due spousal support is only eligible for denial, revocation, or limitation of an obligor's passport when the obligee is living with the child and the spousal support and child support obligations are included in the same order.

13.-14. (No change.)

INSURANCE

(a)

DEPARTMENT OF BANKING AND INSURANCE OFFICE OF LIFE AND HEALTH

Insurance Group; Health Maintenance Organizations: Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations

Adopted Amendments: N.J.A.C. 11:2-17.9, 11:24-8.7, and 11:24A-3.7

Proposed: September 5, 2017, at 49 N.J.R. 2876(a).
Adopted: December 20, 2017, by Richard J. Badolato, Commissioner, Department of Banking and Insurance.
Filed: December 20, 2017, as R.2018 d.066, **without change**.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17B:17-1, and 26:2S-1 et seq.; and P.L. 2005, c. 352.

Effective Date: January 16, 2018.
Expiration Dates: July 5, 2018, N.J.A.C. 11:2;
January 14, 2022, N.J.A.C. 11:24;
March 1, 2018, N.J.A.C. 11:24A.

Summary of Public Comment and Agency Response:

The Department of Banking and Insurance (Department) received timely written comments from the New Jersey Hospital Association, Home Care & Hospice Association of NJ, the Medical Society of New Jersey, and the New Jersey Association of Health Plans.

1. COMMENT: Several commenters expressed their support for the Department's proposed amendments and applauds its work to clarify impermissible practices related to health benefit plan claims processing and utilization management.

RESPONSE: The Department appreciates the support for this notice of proposal.

2. COMMENT: One commenter recommended that the Department remove its proposed amendments to N.J.A.C. 11:2-17.9(l)1. The commenter noted that the proposed amendments to N.J.A.C. 11:2-17.9(l)1 provide an example for when a claim is denied for multiple reasons. The commenter believes that the example may be confusing because it would not be permitted under the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set standards. The commenter stated that the HIPAA code standards create a uniform way to perform electronic data interchange transactions for submitting, processing, and paying claims. The commenter suggested amending this section to just provide that carrier explanations "shall be consistent with HIPAA standard transaction standards as may be amended."

RESPONSE: N.J.A.C. 11:2-17.9(l)1 addresses the carrier-drafted text used to explain one or more codes on the Explanation of Benefits. The text is akin to footnotes. The Department notes that in its investigation of consumer complaints and in the performance of market conduct examinations, the Department has seen denial codes on Explanation of Benefits that contain reasons that do not apply such as those connected with an "or." The HIPAA standard transaction code sets are applicable to remittance advice forms sent to providers, not to an Explanation of Benefits sent to covered persons. For these reasons, no change is being made in response to this comment.

3. COMMENT: Two commenters expressed concern with the 10-business day requirement found in N.J.A.C 11:24-8.7. One commenter requested that the timeline be amended to require 15 days compliance with the determination by the independent utilization review organization (IURO) determination instead of the proposed 10 days. The commenter contends that the Department's proposed timeline may not be administratively feasible.

A second commenter requested that the Department consider changing the language to make the requirement read calendar days as opposed to business days. The commenter contends that the additional time can often lead to further exacerbation of the patient's illness or condition.

RESPONSE: The Department believes 10 business days provides a reasonable maximum timeframe during which the carrier must make payment or authorize a service or supply as required by the IURO determination. A reduction to 10 calendar days could create administrative burdens for the carriers and potentially lead to errors with the payment or authorization. Extending the period to 15 business days would unnecessarily delay payment or provision of a service or supply that has been determined to be medically necessary by the IURO. The Department notes that the requirement in the rule is to comply without delay, but no later than 10 business days from receipt of the determination. For these reasons, no change is being made in response to these comments.

4. COMMENT: One commenter requested that the Department amend N.J.A.C. 11:24-8.7(k) to require that the IURO provide notification of its decision to the provider as well as to the Health Maintenance Organization (HMO).

RESPONSE: The Department notes that external appeals are generally submitted by the patient or by the provider, with the patient's

consent. The party filing the appeal, generally the patient or the provider with the patient's consent, is notified of the IURO decision. Additionally, the change requested is outside of the scope of the current rule amendments. Accordingly, no change is being made in response to this comment.

5. COMMENT: One commenter requested that the Department provide clarification with respect to proposed N.J.A.C. 11:24A-3.7(a)1 and 11:24-8.7(k)1. The commenter questioned which entity would decide the existence of "medical exigencies" that would require a more rapid response than otherwise provided for in the rule.

RESPONSE: The HMO or carrier would determine medical exigencies initially, subject to review by the Department.

Federal Standards Statement

The Federal Patient Protection and Affordable Care Act, Pub.L. 111-148, as amended by the Health Care and Education Reconciliation Act, Pub.L. 111-152, and rules promulgated and guidance issued thereunder (collectively, "Federal law"), among a myriad of other things, addresses adverse benefit determinations and the right to appeal such determinations through both an internal and external appeals process. This rulemaking addresses the objective timeframe within which carriers and HMOs must take action to comply with the IURO determination resulting from the external appeal. The Department believes the consumer-oriented requirement is consistent with the appeal provisions of Federal law and does not exceed the requirements of Federal law.

Full text of the adoption follows:

CHAPTER 2
INSURANCE GROUP

SUBCHAPTER 17. UNFAIR CLAIMS SETTLEMENT PRACTICES

11:2-17.9 Rules for fair and equitable settlements applicable to life and health insurance

(a)-(k) (No change.)

(l) No insurer or carrier offering health benefits plans shall issue an explanation of benefits, explanation of payment, and remittance advice forms with denial reasons that are not applicable to the specific claim.

1. Use of denial reasons with multiple grounds shall only be used if all denial grounds apply to the specific claim, including when the reasons are separated by an "and," similar text, symbol, or punctuation. For example, if a denial reason stated that the claim was denied as follows: "lacked a referral, prior authorization, and the service was not rendered by a primary care physician," then all of those reasons must apply to the specific claim being responded to by the insurer or carrier.

CHAPTER 24
HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER 8. UTILIZATION MANAGEMENT

11:24-8.7 External appeals process

(a)-(j) (No change.)

(k) The IURO's determination shall be binding on the HMO and the member, except to the extent that other remedies are available to either party under State or Federal law. The HMO shall provide benefits (including authorization of a service or supply and payment on the claim) pursuant to the IURO's determination and comply with the IURO's determination without delay, but no later than 10 business days from receipt of the IURO's determination, regardless of whether the HMO intends to seek judicial review of the external review decision, unless there is a judicial decision stating otherwise.

1. The HMO shall provide benefits to comply with the IURO's decision sooner if the medical exigencies of the case warrant a more rapid response.

(l) (No change.)

CHAPTER 24A
HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS AND MEDICAL SERVICE CORPORATIONS

SUBCHAPTER 3. UTILIZATION MANAGEMENT

11:24A-3.7 Carrier action on the IURO decisions

(a) A carrier shall provide benefits (including authorization of a service or supply and payment of the claim) pursuant to the IURO's determination and comply with the IURO's determination without delay, but no later than 10 business days from receipt of the IURO's determination, regardless of whether the carrier intends to seek judicial review of the external review decision, unless there is a judicial decision stating otherwise.

1. The carrier shall provide benefits to comply with the IURO decision sooner if the medical exigencies of the case warrant a more rapid response.

(a)

DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF PROPERTY AND CASUALTY
Automobile Insurance
New Jersey Automobile Insurance Plans
Adopted Repeals: N.J.A.C. 11:3-1 and 2
Adopted New Rules: N.J.A.C. 11:3-1

Proposed: October 2, 2017, at 49 N.J.R. 3317(a).
Adopted: December 20, 2017, by Richard J. Badolato, Commissioner, Department of Banking and Insurance.
Filed: December 20, 2017, as R.2018 d.064, **with a non-substantial change** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).
Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, and 17:29D-1.
Effective Date: January 16, 2018.
Operative Date: July 1, 2018.
Expiration Date: December 3, 2020.

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received two timely written comments from New Jersey Manufacturers Insurance Group and the Insurance Council of New Jersey.

1. COMMENT: Two commenters expressed their support for the Department's proposed rules.

RESPONSE: The Department appreciates the support of its proposal.

Federal Standards Statement

A Federal standards analysis is not required because the adopted repeals and new rules are not subject to any Federal requirements or standards.

Full text of the adoption follows (addition to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 1. NEW JERSEY AUTOMOBILE INSURANCE PLAN

11:3-1.1 Purpose and scope

(a) This subchapter establishes a plan pursuant to N.J.S.A. 17:29D-1:

1. To provide personal private passenger automobile insurance coverage for automobiles owned or operated by qualified applicants subject to the conditions stated; and

2. To provide insurance coverage for all motor vehicles other than private passenger vehicles owned or operated by qualified applicants, subject to the conditions stated.

(b) The purposes of this subchapter are:

1. To preserve to the public the benefits of price competition by encouraging maximum use of the voluntary insurance system;