INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans
Electronic Receipt and Transmission of Health Insurance Claims

Adopted Amendments: N.J.A.C. 11:22-3.2 and 3.3

Adopted New Rules: N.J.A.C. 11:22-3, Appendix Exhibits 1A and 1B

Adopted Repeal: N.J.A.C. 11:22-3, Appendix Exhibit 1

Proposed: March 15, 2004 at 36 N.J.R. 1282(a)

Adopted: November 17, 2004 by Holly C. Bakke, Commissioner, Department of Banking and Insurance

Filed: November 17, 2004, as R. 2004 d.460, with substantive and technical changes not requiring additional public written comments (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15e and 17B:30-23

Effective Date: December 20, 2004

Expiration Date: November 6, 2005

Summary Of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received timely written comments from:

Association of Health Plans

Delta Dental

New Jersey Psychological Association

Horizon Blue Cross and Blue Shield of New Jersey

COMMENT: Several commenters expressed support for the improvements in the forms, with one commenter specifically appreciating the bifurcation of the former Appendix Exhibit 1 into

group and individual forms and noting their belief that this change will assist carriers in making the enrollment/application process more efficient.

RESPONSE: The Department thanks the commenters for their support.

At the time it adopted Appendix Exhibit 1 in October, 2001 (see 33 NJR 3461(a)) the Department's attention was focused on the group health insurance market (see Response to Comment 6 at 33 N.J.R. 3462.) Consequently, the text of the form reflected in that Appendix did not directly address information unique to applicants for coverage in the individual market. New Appendix Exhibit 1B now being adopted requires the submission of information specific to persons seeking coverage in the individual market which differs, in some important respects, from the information required to be supplied on an enrollment application for group coverage. This tailoring of the enrollment and application forms will better serve the interests of consumers in the individual market, as it will alleviate the confusion that has occurred as a result of applications for coverage in that market being made on a form that was primarily designed to address the needs of persons enrolling in, and insurers serving the group market.

COMMENT: One commenter requested that Section 4A be expanded to allow identification of the qualifying event and to include an "other" duration indicator in the "length of continuation" line.

RESPONSE: The Department interprets this comment as referring to Appendix Exhibit 1A, Section A.4. The Department does not believe that identifying the qualifying event would enhance accuracy. "Termination of employment" is a qualifying event. Continuation may be, for example, for 12 months, 18 months (COBRA), or it could be for 29 months if the person was terminated and found to be disabled within 60 days of the qualifying event. A carrier may have

to contact the person who completed the enrollment form to obtain clarification. The continuation section addresses only continuations required by State or Federal law. Adding a line for "other" would be misleading since no other durations are available.

COMMENT: One commenter suggested that Section 4.A. be amended to include a unique group identification number line.

RESPONSE: The Department interprets this comment as referring to Section A.4. The person completing the form will not know the group identification number. The continuee will be covered under the employer's plan and will use the same group identification number as the rest of the group.

COMMENT: One commenter recommended that Appendix Exhibit 1A, Section 4.A. be amended to include a space for an optional e-mail address in the continuation section.

RESPONSE: The Department agrees that an optional e-mail address would be beneficial as a variable in Part B, Employee Information, rather than in the continuation section. The Department will also add the e-mail variable to the Individual Form and makes these changes upon adoption.

COMMENT: Several commenters urged additions to Section 4.D. to provide spaces or an "other" category to accommodate domestic partners, spouses, former spouses, and others who qualify.

RESPONSE: The Department interprets this comment as referring to Appendix Exhibit 1A, Item D. The Department agrees with the comments insofar as they recommend the inclusion of

the variable category “domestic partners” in brackets and makes this change upon adoption to both Exhibits. The Department disagrees with the commenters’ suggestion that an “other” category should be included. The Department notes that a spouse is a dependent, and therefore covered by the proposed form. Former spouses are not eligible other than under a COBRA continuation.

COMMENT: One commenter sought a change in Section 4.F. that would make each term plural rather than singular.

RESPONSE: The Department interprets this comment as referring to Appendix Exhibit 1A, Item F, and agrees that “name” and “policy number” should be plural to clarify that the enrollee shall identify all sources.

COMMENT: One commenter requested variable language regarding temporary insurance cards.

RESPONSE: The Department notes that the text regarding temporary insurance cards is in brackets which means that it is already variable language.

COMMENT: One commenter recommended adding variable language to Section 4.D. to enable the enrollee to express priority preferences for dental office assignment or to expressly permit capitation coverage providers to include a supplement to gather enrollee preference information.

RESPONSE: The provider directory identifies whether a provider is accepting new patients. The rule proposal only affects enrollment forms. Therefore, the Department disagrees with the commenter’s suggestion, which treats the enrollment form as an all-purpose administrative form.

COMMENT: One commenter suggested that N.J.A.C. 11:22-3.3(c) be revised by adding the phrase “for health insurance coverage” to its text.

RESPONSE: The Department agrees that adding the suggested phrase will clarify the text of the rule and is amending it upon adoption to so provide. Given that Subchapter 3 in its entirety deals with health care claims, this clarification is not a substantive change.

COMMENT: One commenter urged the Department to amend N.J.A.C. 11:22-3.3(c) to comply with the requirements of the Federal Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Specifically, the commenter recommended: 1) the text of the language in the fifth question under Section H of the Individual Application (Appendix Exhibit 1B) be modified by adding the words “without a break in coverage of 63 or more days”; and 2) inclusion within Section H of Appendix Exhibit 1B of the question, “Was the individual’s most recent prior creditable coverage under a group health plan, governmental plan, church plan or health insurance offered in connection with any such plan?”.

RESPONSE: The Department agrees with the commenter and is amending Section H upon adoption in the manner recommended in the comment. These revisions being made to section H of Appendix Exhibit 1B will add to the text of that Appendix Exhibit requests for data that insurers need to acquire in order to comply with current requirements imposed by Section 2744(b)(1)(C) of Title XXVII of the Public Health Service Act, 42 USC sec. 300gg-44(b)(1)(C) concerning preexisting conditions. Those authorities require carriers to ascertain:

1. Whether any of the individuals to be covered under an individual plan, as of the date of the application, were continuously covered under a previous plan or plans for a period of 18 or more months without a break in coverage of 63 or more days; and

2. Were any of the individuals' most recent prior creditable coverage under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan?

The Department notes that the Summary in the notice of the proposal of these amendments, new rules and repeal indicated that one of the functions of the forms reflected in Appendix Exhibits 1A and 1B is to elicit information regarding pre-existing conditions. Furthermore, the determination of whether a preexisting condition limitation can be imposed is governed by the applicable Federal authorities, regardless of whether the information necessary to make that determination is acquired on the Application/Change Request form or in some other manner. Accordingly, the text of section H in Exhibit 1B is being amended upon adoption so as to have the questions therein inquire about the information set forth in numbers 1 and 2 above. Specifically, the phrase "without a break in coverage of 63 or more days" has been added to the fifth question in section H as originally proposed, and a sixth question has been added to inquire about the most recent prior creditable coverage of the individuals to be covered under the individual health insurance plan to which the application is being submitted.

COMMENT: One commenter recommended that the Enrollment/Change form (Appendix Exhibit 1A) be revised to require that a HIPAA (Health Insurance Portability and Accountability Act of 1996, P.L. 104-191) certificate of creditable coverage (COCC) form be submitted with the enrollment/change form.

RESPONSE: These rules address enrollment and application forms. Generally, a COCC is of interest to the claims operation of carriers, not the enrollment operation. However, to enable carriers to be proactive in their acquisition of the information regarding prior coverage that is contained in a COCC, Appendix Exhibits 1A and 1B are being revised upon adoption to afford carriers the option of requesting the submission of the COCC with the filing of the Enrollment/Change or Application/Change Request Forms.

Because some applicants may not be in possession of a COCC at the time of completing the application, the additions to Exhibits 1A and 1B indicate that, if requested, the COCC is to be supplied "if available". Pursuant to N.J.S.A. 17B:27A-4 a failure to supply a COCC, even if requested, is not a basis upon which a carrier may deny an application for individual health benefits.

Where it is available, the submission of a COCC at the time of application will, however, ease the carriers' administration of the initial claim on the policy by avoiding the need to request its submission form the insured before processing the claim. Expediting the processing of initial claims in this way will inure to the benefit of insureds. Since the changes upon adoption make the requesting and submission of the COCC optional on the parts of insurers and insureds, respectively, they do not affect the rights and obligations of carriers and insureds nor expand the scope of the rules as proposed.

COMMENT: One commenter requested that the proof of student status referenced in the Instructions for Appendix Exhibit 1B be variable and allow for either a post-secondary institution "or its authorized representative" to provide the information.

RESPONSE: The Department agrees with the commenter and has made this substantive change upon adoption.

COMMENT: One commenter expressed concern that an employee is required to divulge health information on a form (Appendix Exhibit 1A) that requires the employer's signature. The commenter fears that the employer will, consequently, become aware of protected health information without receiving appropriate consent or authorization.

RESPONSE: The employer's signature is crucial to the issue of whether the person is in fact working and eligible. The individual completing the enrollment form voluntarily discloses the information, with knowledge that the employer, acting in a fiduciary capacity for the health plan, will sign the enrollment form. Such voluntary disclosure of information for enrollment purposes is not protected health information.

Summary of Agency-Initiated Changes:

The same revisions pertaining to e-mail addresses and domestic partner information being made to Appendix Exhibit 1A in response to two comments as set forth above are also being made to Appendix Exhibit 1B.

Federal Standards Statement

The Federal Standards Statement included in the notice of the proposal of these amendments, new rules and repeal indicated that a Federal standards analysis was not required because the proposed repeal, amendments and new rules are not subject to any Federal standards or requirements. In fact, certain Federal requirements are applicable because the forms reflected

in Appendix Exhibits 1A and 1B are required to be used by carriers to elicit, respectively, employee and individual applicant information on prior creditable coverage and pre-existing conditions.

Section 2744(b)(1)(C) of Title XXVII of the Public Health Service (PHS) Act, 42 U.S.C. §§ 300gg-44(b)(1)(C), requires states to periodically provide to the Federal government information necessary to review that state's "alternate mechanism" designed to serve the health insurance needs of Federally defined eligible individuals. As part of its most recent review of New Jersey's alternate mechanism, the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services noted that N.J.A.C. 11:22-3 Appendix Exhibit 1 (now repealed as part of this adoption) currently does not request an applicant for coverage in the individual market to provide all of the information necessary to enable carriers to determine whether the person is a Federally defined eligible individual. However, a carrier is under an affirmative obligation to make such an inquiry and determination if it intends to impose a pre-existing condition limitation on the applicant.

In order to bring New Jersey's alternate mechanism into compliance with the applicable Federal standards and to enable carriers to, in all cases, gather the necessary information and make the required determination as to whether an applicant for coverage on an individual plan is a Federally defined eligible person, in addition to requesting the information solicited by the questions included in Appendix Exhibit 1B, section H as proposed, carriers need to also inquire:

1. Whether any of the individuals to be covered under an individual plan, as of the date of this application, were continuously covered under a previous plan or plans for a period of 18 or more months without a break in coverage of 63 or more days; and

2. Were any of the individuals' most recent prior creditable coverage under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan?

As is explained above, the Department is amending Appendix Exhibit 1B, section H upon adoption to include these questions. By doing so, this form, which carriers are mandated by the adopted rules to use, will be rendered consistent with, but will not exceed the Federal standards applicable to, the acquisition by carriers of information from applicants seeking coverage in the individual market.

As adopted, Appendix Exhibit 1A is also consistent with, but does not exceed, the Federal standards applicable to the acquisition by carriers of information from applicants for coverage in the group market.

Full text of the adoption follows (addition to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks ***{thus}***:

11:22-3.3 Standard enrollment/change request forms and application/change request forms

(a) – (b) (No change.)

(c) The paper standard formats for a universal enrollment/change request form and application/change request form ***for health insurance coverage*** are located at subchapter Appendix Exhibits 1A and 1B and are incorporated herein by reference.

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