

**INSURANCE**

**DEPARTMENT OF BANKING AND INSURANCE**

**DIVISION OF INSURANCE**

**Health Benefit Plans**

**Prompt Payment of Claims**

**Adopted Amendment: N.J.A.C. 11:22-1.6**

Proposed: July 20, 2009 at 41 N.J.R. 2762(a).

Adopted: June 11, 2010 by Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Filed: June 11, 2010 as R. 2010 d. 144, **with substantive and technical changes** 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; 17:1-15c; 17:1-15e; P.L. 1999, c. 154; and P.L. 2005, c. 352.

Effective Date: July 6, 2010

Expiration Date: April 26, 2011

**Summary** of Public Comments and Agency Responses:

The Department received comments from the following: UnitedHealth Group; New Jersey Association of Health Plans; Delta Dental; Medical Society of New Jersey; AmeriHealth Insurance Company of New Jersey and AmeriHealth HMO; New Jersey

Hospital Association; Lampf, Lipkind, Prupis & Petigrow; Fox Rothschild LLP; Quest Diagnostics; and New Jersey Society of Pathologists.

1. COMMENT: Some of the commenters expressed their support for the Department's proposed amendments. A few of the commenters stated that they agreed with the Department's Social and Economic Impact statements. Specifically, one commenter stated that the Department's clarification that "the rule was intended to promote the prompt, accurate payment of carriers' obligations and not to permit a party submitting the claim to assert that the carrier has waived a legitimate reason for non-payment long after (in some cases years after) the service was provided[.]" sheds needed light on the regulatory intent behind the rule. The commenter added that carriers do maintain a fundamental responsibility to pay claims consistent with applicable law, and that the Department retains the right to sanction a carrier for failure to pay claims on a prompt and accurate basis, consistent with the prompt payment laws and the Department's other statutory powers. Another commenter stated that it agrees with the Department's Economic Impact statement that "the proposed amendments will have no direct economic impact on carriers or providers because the amendments merely clarify requirements established pursuant to the Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, for denied or disputed claims."

RESPONSE: The Department thanks the commenters for their support.

2. COMMENT: Some of the commenters stated that the removal of the “good faith” and “waiver” language contained in N.J.A.C. 11:22-1.6(a)2 and (b) make clear that the regulations are consistent both with the language the Legislature purposely chose to use and the legislative intent behind the HCAPPA and the Health Care Information Networks and Technologies Act (HINT), P.L. 1999, c. 154, namely the timely and accurate payment of *eligible* claims. The commenters stated that neither the HCAPPA nor HINT include a “waiver” or “good faith” requirement. Although the Legislature had before it the “good faith” and “waiver” language when it enacted the HCAPPA, the Legislature expressly reiterated (1) the manner by which and the timeframes within which a carrier shall request information for an unclear claim and provide notice of its reasons for denying or disputing a claim, and (2) that claims in which the carrier does not provide such notice would be deemed “overdue.” (P.L. 2005, c. 352, § 10). The commenters reiterated that the Department’s proposal is entirely consistent with the Legislature’s express language and intent in the HCAPPA and HINT. One commenter added that while HINT imposed the responsibility on providers to include all information required for carriers to process claims and to submit claims promptly, some providers have continued to submit untimely and/or incomplete claims with a resultant adverse impact on the carrier. The commenter commended the Department for eliminating the requirement at N.J.A.C. 11:22-1.6(a)2 that carriers make additional efforts to obtain missing information prior to its timely adjudication of a claim. This revision will allow carriers to more promptly adjudicate claims that have been promptly and properly

submitted while, of course, requesting missing information/documentation prior to claim adjudication where appropriate.

One commenter stated that it supports the Department's rejection of the petitioner's proposed language that would require a claimant to assert waiver of a right to contest a claim within strict timeframes for the reason that legitimate unpaid claims should not expire, but should be paid. The commenter added that while it is not unsympathetic to the petitioner's frustration with the application of the rule to force payment of uncovered services by asserting waivers years after the fact, it believes that providers have a reasonable expectation to be informed that a service is not covered in a timely manner that allows the provider to seek payment from the responsible party. The commenter requested that the Department consider clarifying that a payer is required to inform a provider of its denial of a claim within 120 days so that the provider can seek payment elsewhere, and failure to do so will result in the delinquent insurer assuming responsibility for the payment.

RESPONSE: With respect to the comments that the changes are consistent with the intent of HINT, the Department does not agree that HINT mandates the changes that are being made in this adoption. Rather, the Department believes the language in the HCAPPA requires these changes. With respect to the second comment, the Department notes that the commenter's proposal/suggestion would require a carrier to pay the claim if it does not inform a provider of its denial of a claim within 120 days. HCAPPA does not support requiring a carrier to pay a claim if it is not denied within 120 days. The HCAPPA states that an eligible claim is overdue if not paid within 30 or 40 days and

that if a provider is not notified that the claim is denied within the 30 or 40 day period, “the claim shall be deemed overdue.” The statute does not mandate payment of claims where notice of denial is not provided; rather, such claims are only required to be paid with interest when they are ultimately paid.

3. COMMENT: One commenter stated that the Department’s proposed amendments do not go far enough in achieving consistency with the HCAPPA and the existing prompt payment of claims rules. According to the commenter, because managed care organizations commonly cite the regulations in their contracts rather than statute, it is essential that the regulations reflect New Jersey’s current standards with respect to payment processing and deadlines. Specifically, the HCAPPA included a provision designed to address situations in which a claim cannot be electronically adjudicated because data is missing. The Department’s proposed rules implementing the HCAPPA (39 N.J.R. 2455(a)) included language to implement this provision at N.J.A.C. 11:22-1.6(a)5 stating, “If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the carrier or its agent shall electronically notify the healthcare provider or its agent, within seven days of receipt of the claim, of that determination and request any information required to complete the adjudication of the claim.” The commenter stated that because payers have historically waited the full 30 days allowed under the prompt pay rules to deny a claim, despite knowing within hours or days that it cannot be adjudicated, it is critical that this provision be reflected

in the regulations. The commenter requested that the Department further amend the rules upon adoption to include this provision from the statute.

RESPONSE: The Department notes that it never adopted its proposed rules implementing the HCAPPA (39 N.J.R. 2455(a)), and acknowledges that there are other provisions of N.J.A.C. 11:22 that need to be amended to comply with the HCAPPA. However, the Department cannot make such changes upon the adoption of this amendment because they would be substantive changes requiring reproposal. The Department intends to issue a separate proposal on those issues.

4. COMMENT: Some of the commenters objected to the Department's proposed amendments. One commenter stated that rather than provide patients and medical providers with safeguards against often arbitrary and abusive practices by insurance carriers, practices which add to the administrative burdens of medical providers and increase the bottom line of insurance companies, the Department's proposal seeks to further decrease carrier responsibility and increase provider administrative burdens by not requiring carriers to engage in a good faith effort to expeditiously resolve claims. Further, the commenters stated that the proposal misconstrues the intent of the HCAPPA and removes the safeguards currently in place to protect insureds.

The commenters stated that the Department's proposal overlooks the clear obligation of carriers under HCAPPA to make timely claims payments, as well as to promptly (in some cases, within days) communicate with the provider regarding claims submissions. They also stated that the Department's commentary inaccurately interprets the existence of

the HCAPPA-mandated appeals and arbitration processes as giving carriers the ability and right to avoid these HCAPPA-mandated communication deadlines simply by paying interest on overdue amounts. The commenters further stated that the proposal suggests that because HCAPPA establishes an appeal process by which providers can dispute overdue claims, a carrier can ignore HCAPPA's communication timeframe mandates. The commenters stated that this is totally unsupported by HCAPPA and runs counter to the purpose and public policy rationale for HCAPPA: to protect the consumer. One commenter stated that affected parties are entitled to notice of the Department's amendments and the opportunity to comment by way of the rulemaking process before the changes take effect. Thus, these amendments, if adopted, cannot have retroactive effect on providers and carriers, and must only be applied prospectively.

One commenter stated that the proposed revision of N.J.A.C. 11:22-1.6(b) would allow carriers to delay claim payments without any safeguards in place to prevent abusive and arbitrary delays. It would allow carriers to routinely disregard the notice requirements currently in N.J.A.C. 11:22-1.6(a) without much consequence. The commenter noted that the claim will be deemed overdue and be subject to a minor interest surcharge. While a carrier may prefer to withhold reimbursement from a provider for some period of time, such delays are detrimental to providers, who often give up their pursuit of reimbursement because the administrative burden of doing so is too difficult or expensive to undertake. The explanation offered by the Department that providers often invoke the waiver language in N.J.A.C. 11:22-1.6(b) years after the date

of service, overlooks the fact that significant delays in claims processing are most commonly the result of the carrier's activity or inactivity, not the provider's. The commenter added that the proposal does not provide for any oversight standards for the Department to ensure that carriers do not abuse their right to delay the processing of claims. According to the commenter, it is quite reasonable to envision a scenario where carriers would have the financial leverage to force claimants into accepting lower claims reimbursement by simply delaying claims processing. While delaying payment may mean an additional surcharge expense to the carrier, it means more to providers who are already struggling to survive in this economy. New Jersey carriers, on the other hand, are more profitable than ever.

RESPONSE: With respect to the objection that the changes misconstrue the intent of the HCAPPA, the Department is making the proposed amendments to comply with the express language of the HCAPPA and notes that the current regulation was clearly inconsistent with the HCAPPA's statement that an eligible claim that is not timely processed is to be considered overdue. With respect to the comments on the internal payment appeal and payment arbitration processes, the Department is not relying on the internal appeal and arbitration provisions in the HCAPPA as support for these changes. It is relying on the language that states that claims for which notification of denial is not provided within 30 or 40 days shall be deemed overdue. The Department notes that the Legislature could have deemed such claims to be eligible in the HCAPPA, but declined to do so. With respect to the comment that 12 percent interest is an inadequate penalty, the Department notes that the 12 percent interest rate is not the



sole remedy for late payment of claims. A carrier that displays a pattern and practice of untimely claims payments would be guilty of an unfair claim settlement practice and subject to the penalties set forth at N.J.S.A. 17B:30-20. With respect to the comment regarding the prospective application of the amendments, when discussing the current rule text that was the subject of the amendments being proposed, the Department stated in the Summary of the notice of proposal, "... the rule was intended to promote the prompt, accurate payment of carriers' obligations and not to permit a party submitting the claim to assert that the carrier has waived a legitimate reason for non-payment long after (in some cases years after) the service was provided ... the Department's rule contemplated a process by which a claimant must act promptly to assert the demand for payment on the basis of waiver..." In addition, the Economic Impact in the notice of proposal noted that "... the amendments merely clarify requirements established pursuant to the HCAPPA for denied and disputed claims." Those requirements imposed by the HCAPPA had been in effect for some time prior to the publication of the proposed amendments.

5. COMMENT: One commenter stated that nonparticipating providers may be adversely impacted, both financially and operationally, by an incorrect interpretation and/or application of proposed N.J.A.C. 11:22-1.6 by carriers. It is unclear whether carriers are incorrectly applying N.J.A.C. 11:22-1.6 solely to health care providers participating in their networks. The commenter stated that nonparticipating health care providers are increasingly experiencing both (1) claim submissions that are unanswered in their entirety, and (2) insufficient coverage policy information from carriers in order

to determine whether the prompt pay regulations apply to the respective claims, irrespective of whether the submission includes an assignment of benefit from the covered person to such nonparticipating health care provider. Rather, carriers appear to be systemically defaulting their compliance with N.J.A.C. 11:22-1.6 solely to notifications to the covered person as an administrative mechanism to discourage the use of out-of-network services regardless of the underlying coverage policy as filed with and/or by the Department and upon which premiums were charged and collected. According to the commenter, carriers' use of two different timeframes when seeking additional information or documentation to process a claim is intended to be purely discriminatory against non-participating health care providers and to effectively discourage covered persons from utilizing their out-of-network benefits.

RESPONSE: Neither the HCAPPA nor the requirements of N.J.A.C. 11:22-1.6 are limited to network providers. N.J.A.C. 11:22-1.6(a) requires notice to providers of all claim denials as well as notice to the covered person where he or she will have increased responsibility to pay as a result of the denial (for example, where the claim is for services from an out-of-network provider).

**Summary of Agency-Initiated Change:**

The Department is making the following change upon adoption: Because not all carriers (that is, dental service corporations and dental plan organizations) that are subject to the Department's rules at N.J.A.C. 11:22-1 are subject to the HCAPPA, the

Department is rephrasing the language at amended N.J.A.C. 11:22-1.6(b) to clarify this and remove any ambiguity that might exist.

### Federal Standards Statement

A Federal standards analysis is not required because the Department's adopted amendments are not subject to any Federal standards or requirements.

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

11:22-1.6 Denied and disputed claims

(a) (No change from proposal.)

(b) If a carrier or its agent denies or disputes a claim in whole or in part and fails to provide the notice required by (a) above **\*[in accordance with]\*** **\*within the timeframes and in the manner required of carriers that are subject to\*** P.L. 2005, c. 352\*,\* the claim shall be deemed to be overdue.

(c) – (f) (No change.)