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.

Jobs Impact

The Department does not anticipate that the proposed amendments will result in the generation or loss of jobs.

The Department invites commenters to submit any data or studies concerning the jobs impact of the proposed amendments together with their comments on other aspects of the proposed amendments.

Agriculture Industry Impact

The proposed amendments will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The proposed amendments, as described in the Summary above, will impose compliance requirements on carriers and HMOs, some of whom may be "small businesses," as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Accordingly, the Department is providing a regulatory flexibility analysis.

The potential costs required to comply are set forth in the Economic Impact above. While some of the proposed amendments may cause some small businesses to incur some additional costs, these costs will likely be minimal. While the additional costs a small business might incur cannot be quantified, it is unlikely that it will be necessary for the small business to engage additional professional services in order to comply with the amendments. The proposed amendments do not provide any differentiation in compliance requirements based on business size.

Housing Affordability Impact Analysis

The proposed amendments will not have an impact on housing affordability in this State, and it is unlikely the amendments will evoke a change in the average costs associated with housing because the proposed amendments relate to the external review processes of HMOs and carriers.

Smart Growth Development Impact Analysis

The Department does not expect this notice of proposal to evoke a change in the housing production in Planning Areas 1 or 2, or within the designated centers, under the State Development and Redevelopment Plan in New Jersey because this rulemaking deals with the rules addressing carriers, HMOs, and entities regulated by the HCQA.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

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. [Within 10 business days of the receipt of the determination of the IURO as set forth in (j) above, the HMO shall submit a written report to the IURO, member and provider if the provider made the appeal on behalf of the member with the member's consent and the Department indicating how the HMO will implement the IURO's determination.]

1. The HMO shall [specify its intentions] **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 [submit a written report to the covered person and his or her provider (if the provider assisted in filing the appeal), the Department and the IURO describing how the carrier will implement the IURO's decisions within 10 business days of the date that the carrier first receives the decision of the IURO] **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 [specify its intentions] **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 INSURANCE
Health Benefit Plans
Prompt Payment of Claims
Proposed Amendments: N.J.A.C. 11:22-1.2, 1.6, 1.9, and 1.10
Proposed New Rule: N.J.A.C. 11:22-1.5

Authorized By: Richard J. Badolato, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17B:30-26 through 34; and P.L. 2005, c. 352.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.
Proposal Number: PRN 2017-229.

Submit written comments by November 4, 2017, to:

Denise M. Illes, Chief
Office of Regulatory Affairs
Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
E-mail: Legsregs@dobi.nj.gov

The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) proposes to amend the rules governing the prompt payment of health benefit claims to increase transparency and accountability related to health benefits plans. A summary of the proposed amendments and new rule follows.

N.J.A.C. 11:22-1.2 is proposed to be amended to add a definition of "explanation of benefits" (EOB). Specifically, EOB is proposed to be defined as a document a carrier issues to a covered person in response to the submission of a claim for services or supplies. The EOB identifies both the billed and allowed charges and explains whether services and supplies are covered, the application of cost sharing, the amount paid by the plan, and the reason(s) for any denials or reductions in the benefits paid.

New N.J.A.C. 11:22-1.5 is proposed, which sets forth the minimum requirements for an EOB. Specifically, every carrier shall be required to provide an EOB, electronically or in writing, to a covered person in response to the filing of a claim by a provider or a person covered under a health benefits plan. As used in this Summary, "covered person" means persons who receive benefits or health care services under a health benefits plan. It includes "covered persons" as defined in N.J.A.C. 11:24A-1.2 and "members" as defined in N.J.A.C. 11:24-1.2. A carrier or its agent must provide an EOB within 30 days if the claim is filed electronically or 40 days if a claim is submitted in writing. The EOB will be required to include at least the following information:

1. Name of the covered person;
2. Name of the provider;
3. Date of service;
4. Clear description of the service;
5. Billed charge;
6. Allowed charge;
7. Non-covered amount;
8. A specific explanation of why a charge is not covered by the health benefits plan, for example, person not covered on date of service, provider not in network, other coverage is primary, the service is not medically necessary, no prior authorization, no referral, experimental or investigational service or service excluded by contract. Use of denial reasons with multiple grounds shall only be used if each denial ground applies to the specific claim, including when the reasons are separated by an "and," similar text, symbol, or punctuation;
9. The amount that is the covered person's responsibility due to deductible, coinsurance, and copayment;
10. The accumulation toward the covered person's deductible or family deductible, if applicable;
11. The accumulation toward the covered person's maximum out-of-pocket or family maximum out-of-pocket, if applicable;
12. Amount paid by plan, interest should be shown separately, if interest is paid;
13. An explanation of the process to appeal the determination on the claim; and
14. A telephone number that the covered person can call to get additional information on the processing of the claim; or
15. If review of the claim is still pending upon issuance of the EOB, the EOB shall so state and items 6 through 10 above can be omitted.

Existing N.J.A.C. 11:22-1.6, governing denied and disputed claims, is being amended to clarify that the information required to be provided in this section is to be provided by the carrier or its agent to the provider only and is not required to be in an EOB to the covered person.

A 60-day comment period is provided for this notice of proposal, and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the notice of proposal is excepted from the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The Department believes that the proposed amendments and new rule will have a positive impact on covered persons, carriers, and providers. The proposed amendments and new rule governing the prompt payment of claims increase transparency and accountability related to health benefits plans.

Economic Impact

The Department believes that the proposed amendments and new rule will add only a modest economic cost to carriers since they already provide covered persons with information regarding claim processing. Carriers may have to provide additional information if they do not already address all of the provisions in the new rule. The Department notes that carriers are provided the flexibility to provide an explanation of benefits electronically or in writing.

Federal Standards Statement

A Federal standards analysis is not required because the proposed amendments and new rule are not subject to any Federal requirements or standards.

Jobs Impact

The Department does not anticipate that any jobs will be generated or lost as a result of the proposed amendments and new rule. The Department invites commenters to submit any data or studies on the potential jobs impact of the proposed amendments and new rule together with their comments on other aspects of the notice of proposal.

Agriculture Industry Impact

The proposed amendments and new rule will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The proposed amendments and new rule may apply to some "small businesses," as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments and new rule require carriers to provide an explanation of benefits, electronically or in writing, to covered persons in response to the filing of a claim by a provider or a person covered under a health benefits plan. While these requirements impose certain administrative, reporting, and/or recordkeeping responsibilities on carriers, it is unlikely that the requirements would necessitate any additional professional services. The cost of compliance with the proposed amendments and new rule are discussed in the Economic Impact statement above. The proposed amendments and new rule do not establish differing compliance or reporting requirements or timetables applicable to small business carriers, or exempt them from any of the requirements. The Department believes that these proposed amendments and new rule should be applied uniformly and no different compliance requirements were applied based on business size.

Housing Affordability Impact Analysis

The proposed amendments and new rule will not have an impact on housing affordability nor will they evoke a change in the average costs associated with housing. The proposed amendments and new rule affect the prompt payment of health insurance claims and increase transparency and accountability related to health benefits plans.

Smart Growth Development Impact Analysis

The Department believes that there is an extreme unlikelihood that these proposed amendments and new rule would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey, in that the proposed amendments and new rule affect the prompt payment of health insurance claims and increase transparency and accountability related to health benefits plans.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

11:22-1.2 Definitions

(a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

…

"Explanation of benefits" or "EOB" means a document a carrier issues to a covered person in response to the submission of a claim for services or supplies under a health benefits plan. The EOB identifies both the billed and allowed charges and explains whether services and supplies are covered, the application of cost sharing, the amount paid by the plan, and the reason(s) for any denials or reductions in the benefits paid.

…

11:22-1.5 Explanation of benefits

(a) Every carrier shall provide an explanation of benefits, within 30 days if the claim is filed electronically or 40 days if a claim is submitted in writing, to covered persons in response to the filing of a claim by a provider or a covered person under a health benefits plan.

(b) The explanation of benefits shall include at least the following information:

1. Name of the covered person;

2. Name of the provider;

3. Date of service;

4. Clear description of the service;

5. Billed charge;

6. Allowed charge;

7. Non-covered amount;

8. A specific explanation of why a charge is not covered by the health benefits plan, for example, person not covered on date of service, provider not in network, other coverage is primary, the service is not medically necessary, no prior authorization, no referral, experimental or investigational service, or service is excluded by contract. Use of denial reasons with multiple grounds shall only be used if each denial ground applies to the specific claim, including when the reasons are separated by an "and," similar text, symbol, or punctuation;

9. The amount that is the covered person's responsibility due to deductible, coinsurance, and copayment;

10. The accumulation toward the covered person's deductible, or family deductible, if applicable;

11. The accumulation toward the covered person's maximum out-of-pocket, or family maximum out-of-pocket, if applicable;

12. Amount paid by plan, interest should be shown separately if interest is paid;

13. An explanation of the process to appeal the determination on the claim; and

14. A telephone number that the covered person can call to get additional information on the processing of the claim.

(c) If review of the claim is still pending upon issuance of the EOB, the EOB shall so state and (b)6 through 10 above can be omitted.

11:22-[1.5]**1.6** (No change in text.)

11:22-[1.6]**1.7** Denied and disputed claims

(a) A carrier or its agent shall either deny or dispute a claim, in full or in part, that has not been processed according to N.J.A.C. 11:22-[1.5]**1.6**. If only a portion of a claim is disputed or denied, the carrier or its agent shall remit payment for the uncontested portion in accordance with N.J.A.C. 11:22-[1.5]**1.6**. The pending of a claim does not constitute a dispute or denial. The carrier or its agent shall, within 30 or 40 calendar days of receipt of the claim, whichever is applicable, notify [both the covered person, when he or she will have increased responsibility for payment, and] the provider of the basis for its decision to deny or dispute, including:

1.-3. (No change.)

4. The [toll free] **toll-free** telephone number for the carrier or its agent who can be contacted by the provider [or covered person] to discuss the claim.

(b) (No change.)

(c) If the carrier or its agent fails to pay a clean claim within the time limits set forth in N.J.A.C. 11:22-[1.5]**1.6**, the carrier shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by the carrier. The carrier may aggregate interest amounts up to $25.00, with the consent of the provider.

(d) (No change.)

(e) Unless otherwise provided by law, every carrier or its agent shall pay the amount finally agreed upon in settlement of all or part of any claim not later than ten working days from either the receipt of such agreement by the carrier or the date the performance by [the covered person or] the provider of any conditions to payment set forth in the agreement, whichever is later.

(f) (No change.)

Recodify existing N.J.A.C. 11:22-1.7 and 1.8 as **1.8 and 1.9** (No change in text.)

11:22-[1.9]**1.10** Reporting requirements

(a)–(e) (No change.)

(f) After the Commissioner has reviewed the annual report and the request for exemption, the Commissioner shall either grant or disapprove the request. Any request meeting the conditions of (e) above shall be deemed granted 30 days after its receipt by the Commissioner unless disapproved. The Commissioner may disapprove a request for one or more of the following reasons:

1.-2. (No change.)

3. The Commissioner finds that an audit is necessary to verify the accuracy of the report or to otherwise meet the purposes of [N.J.A.C. 11:22-1.9] **this section** and N.J.S.A. 17B:30-12 et seq.

(g) (No change.)

11:22-[1.10]**1.11** Remediation/penalty

(a) Upon review of the reports required by N.J.A.C. 11:22-[1.9]**1.10**, the Commissioner may require that the carrier or ODS, at its own expense:

1.-2. (No change.)

(b) The Commissioner may impose a civil penalty of not more than $10,000 upon the carrier, to be collected pursuant to "the penalty enforcement law," N.J.S.A. 2A:58-1 et seq., if, following the remediation measures in (a) above, the Commissioner determines that:

1. An unreasonably large or disproportionate number of eligible claims continue to be disputed, denied or not paid in accordance with the time frames in N.J.A.C. 11:22-[1.5]**1.6**; or

2. A carrier, ODS or the agent of a carrier or ODS has failed to pay interest as required pursuant to N.J.A.C. 11:22-[1.7]**1.8**.