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

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

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:17-1, and 26:2S-1 et seq.; and P.L. 2005, c. 352.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2017-231.

Submit comments by November 4, 2017, to:

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The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) proposes to amend certain rules to clarify impermissible practices related to health benefits plan claim processing, and the timing of authorization of services and payment of claims after an independent utilization review organization (IURO) determination adverse to the carrier or health maintenance organization (HMO). It is important to note that although "carrier" is commonly understood to refer to insurers, health service corporations, and HMOs, this rulemaking amends rules that were initially adopted to comply with the Health Care Quality Act (HCQA), P.L. 1997, c. 192 (substantially codified at N.J.S.A. 26:2S-1 et seq.), which rules defined carrier and HMO separately. Therefore, carriers are addressed separately from HMOs. These proposed amendments will increase transparency and accountability related to health benefits plans.

Specifically, this rulemaking includes the following:

N.J.A.C. 11:2-17.9, the rule governing the fair and equitable settlements applicable to life and health insurance, is proposed to be amended to add new subsection (l) to provide that no insurer or carrier issuing health benefits plans shall issue an explanation of benefits (EOB), explanation of payment, and remittance advice forms with denial reasons that are not applicable to the specific claim.

N.J.A.C. 11:24-8.7, the HMO rule concerning the external appeals process involving an IURO, is proposed to be amended to specify an HMO's obligations upon an IURO's determination. N.J.A.C. 11:24-8.7(k) currently provides that the HMO shall provide benefits in accordance with the IURO's determination without delay, regardless of whether the HMO intends to seek judicial review of the external review decision, unless there is a judicial decision stating otherwise; and that the HMO shall provide a written report to the IURO, covered person, and provider of how the HMO will implement the IURO's determination within 10 business days of the receipt of the IURO's determination. As used herein, "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. N.J.A.C. 11:24-8.7 is proposed for amendment to require that the HMO shall provide benefits 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. The Department proposes to delete the requirement to submit a written report indicating how the HMO will implement the IURO's determination. N.J.A.C. 11:24-8.7(k)1, which provides that the HMO shall specify its intentions sooner than 10 business days if the medical exigencies of the case warrant a more rapid response, is proposed for amendment to state that the HMO shall provide benefits to comply with the IURO decision within 10 business days or sooner if the medical exigencies of the case warrant a more rapid response.

N.J.A.C. 11:24A-3.7, the rule concerning carrier action after an IURO decision, is proposed for amendment to specify a carrier's obligations upon an IURO's determination. It currently provides that a carrier shall submit a written report to the covered person and provider, the Department, and the IURO describing how the carrier will implement the IURO's decisions within 10 business days of the date of receipt of the decision. It is proposed for amendment to provide that a carrier shall provide benefits 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. N.J.A.C. 11:24A-3.7(a)1, which provides that the carrier shall specify its intentions sooner than the 10 business days if the medical exigencies of the case warrant a more rapid response, will be amended to state that the carrier shall provide benefits to comply with the IURO decision within 10 business days or sooner if the medical exigencies of the case warrant a more rapid response.

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

Social Impact

The proposed amendments favorably impact covered persons and members in that they clarify impermissible practices related to health benefits plan claim processing, and the timing of authorization of services and payment of claims after an IURO determination adverse to the carrier or HMO. The proposed amendments provide additional protections for consumers regarding their health benefits plans' external review processes in that they will expedite the implementation of IURO decisions favorable to consumers and enhance consumers' confidence in, and satisfaction with, their health plan and claims review processes.

Carriers and HMOs may be somewhat unfavorably impacted by the proposed amendments, as the proposed amendments impose objective timeframes under which carriers and HMOs will be required to comply with an IURO's determination. However, these proposed amendments will lessen written reporting requirements for carriers and HMOs by eliminating currently required reporting on how the carrier or HMO will implement the IURO's determination; and improve the effectiveness and efficiency with which carriers and HMOs provide benefits and comply with IURO decisions for consumers enrolled in their health benefits plans.

Economic Impact

Carriers and HMOs may experience an immediate minimal unfavorable impact in complying with the proposed amendments in that they may need to revise processes, modify systems, or train personnel to comply with the amendments that impose objective timeframes for complying with an IURO's determination and providing services pursuant to those determinations. However, these additional costs will likely be modest in scope. Notwithstanding these costs, the implementation of these changes will reduce the incidence of delays, averting avoidable lapses in receipt of health care services and resultant deterioration in health and financial losses to consumers. For covered persons and members, such changes will also enhance the level of confidence in, and satisfaction with, their health benefits plans. Thus, the benefits to be achieved by the notice of proposal outweigh any costs that may be imposed.

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.