PUBLIC NOTICE

INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
LIFE AND HEALTH DIVISION

Notice of Action on Petition for Rulemaking

Prompt Payment of Claims – Denied and Disputed Claims
N.J.A.C. 11:22-1.6

Petitioner: New Jersey Association of Health Plans (NJAHP)

Take notice that on December 23, 2008, the above petitioner filed a petition with the Department of Banking and Insurance (Department) requesting that the Department amend its rules governing the prompt payment of health claims to clarify that if a carrier fails to provide the notice required by N.J.A.C. 11:22-1.6(a) of its decision to deny or dispute a claim, the claimant can timely assert that the carrier has waived its right to require the claimant to provide additional information and/or documentation concerning the claim, and to explicitly provide that the carrier has no obligation to pay a claim, or any part of a claim, that is not covered by the underlying policy. A notice acknowledging receipt of the petition and summarizing its content was published in the February 17, 2009 New Jersey Register at 41 N.J.R. 899(a).

Take further notice that this petition was duly considered by the Department pursuant to law. Upon due deliberation, the Department has determined that the petition should be denied in part and granted in part for the following reasons:

Petitioner requested that the Department amend N.J.A.C. 11:22-1.6(a)2 as follows (additions in boldface; deletions in brackets):

(a)2 Where missing information or documentation is a reason for denying or disputing a claim, **[**the notice shall identify with specificity the additional information or documentation that is required and the carrier shall engage in a good faith effort to expeditiously obtain such additional information or document by, among other things, telephoning the provider**]** **the carrier or its agent shall provide notice to the provider within the timeframes and in the manner required by P.L. 2005, c. 352.**

The Department has determined it should grant petitioner's request to amend N.J.A.C. 11:22-1.6(a)2 as suggested by Petitioner because the Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, clearly states that the payer must provide notice to the provider and covered person within 30 days of receipt of electronic claims, and within 40 days of receipt of other than electronic claims, and sets forth the specific information that must be contained in such notice. Accordingly, petitioner's suggested language adequately addresses carriers' notice requirements to claimants pursuant to the HCAPPA.

The Department has determined it should deny petitioner's request to amend N.J.A.C. 11:22-1.6(b) as requested by petitioner. Petitioner's suggested rule language provides that for failure to provide the notice as set forth in N.J.A.C. 11:22-1.6(a)2, a carrier or its agent waives its ability to require a

provider or covered person to submit additional information or documentation in order for the carrier to determine the covered person's right to payment for a covered service or supply. Petitioner's suggested language further requires the provider or covered person who submitted the claim to assert such a waiver no later than 60 days after the carrier's alleged failure to issue the required notice for claims for services or supplies provided by non-network providers, or 180 days for claims for services or supplies provided by network providers.

Petitioner's requested amendment of N.J.A.C. 11:22-1.6(b) would be inconsistent with the Legislature's intent in the enactment of the HCAPPA to protect claimants in their pursuit of appropriate benefits from their health carriers. The HCAPPA clearly states that if notice of a denied or disputed claim is not provided within the timeframes established by the HCAPPA, "the claim shall be deemed to be overdue." The HCAPPA further establishes a procedure for resolving overdue claims, including a carrier's internal appeal mechanism and an independent arbitration mechanism. Petitioner's suggestion to amend N.J.A.C. 11:22-1.6(b) to require claimants to assert that the carrier has waived its ability to require the submission of additional supporting information or documentation within strict timeframes would abrogate the legislative intent underlying the HCAPPA by barring claimants who failed to comply with these requirements from seeking payment of legitimate overdue claims through these mechanisms. Moreover, the prerequisites to claimants obtaining the relief afforded to them by the HCAPPAA that would be established by the petitioner's proposed

amendments are not imposed by the provisions of that law. Accordingly, the Department has determined that it would be more appropriate to amend N.J.A.C. 11:22-1.6(b) by tracking the HCAPPA language and allowing claimants to pursue the claims payment mechanisms made available to them by the HCAPPA and pursuant to the procedures and timeframes set forth therein. The Department's amendment of N.J.A.C. 11:22-1.6(b) follows (additions in boldface; deletions in brackets):

(b) **[**A**]** **If a** carrier or its agent **[**that does not**]** **denies or disputes a claim in whole or in part and fails to** provide the notice required by (a) above, **in accordance with P.L. 2005, c.352 the claim shall be deemed to be overdue** **[**shall waive its right to contest the claim for any reason other than the referral of the claim to the Office of Insurance Fraud Prosecutor in accordance with the carrier's Fraud Prevention and Detection Plan**]**.

In accordance with N.J.A.C. 1:30-4.2(a), the Department will initiate a rulemaking proceeding for amending N.J.A.C. 11:22-1.6(a)2 and (b) as described above within 90 days of the granting of petitioner's petition.

A copy of this public notice has been mailed to the petitioner.

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