**INSURANCE**
**DEPARTMENT OF BANKING AND INSURANCE**
**DIVISION OF INSURANCE**

**Health Benefit Plans**
**Prompt Payment of Claims**

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

Authorized By: Steven M. Goldman, Commissioner, Department of Banking and Insurance.

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.

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

Proposal Number: PRN 2009-228

Submit comments by September 18, 2009 to:

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The agency proposal follows:

## Summary

On December 23, 2008, the Department of Banking and Insurance (Department) received a petition for rulemaking (petition) from the New Jersey Association of Health Plans (NJAHP) requesting that the Department amend its rules regarding the prompt payment of health insurance claims. Specifically, NJAHP stated that its members are adversely impacted (financially, operationally and otherwise) by an incorrect and/or inconsistent interpretation and/or application of N.J.A.C. 11:22-1.6, and NJAHP was

seeking clarification of this provision by way of amendment. N.J.A.C. 11:22-1.6(a) requires that health carriers either deny or dispute a claim, in full or in part, that has not been paid within the timeframes and pursuant to the procedures set forth at N.J.A.C. 11:22-1.5. N.J.A.C. 11:22-1.6(a) requires the carrier to notify the provider, and the covered person if he or she will have increased responsibility for payment, of the basis for its decision to deny or dispute. N.J.A.C. 11:22-1.6(b) states that "A carrier or its agent that does not provide the notice required by (a) above 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."

NJAHP's petition sought to amend N.J.A.C. 11:22-1.6 to clarify that if a carrier fails to provide the notice required by N.J.A.C. 11:22-1.6(a), 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.

NJAHP stated that N.J.A.C. 11:22-1.6(b) refers to contesting a "claim," and "claim" as defined at N.J.A.C. 11:22-1.2 includes only covered services and persons; that there are clear public policy reasons for limiting payment to covered services; and that the Department's Economic Impact statement when originally proposing these rules did not indicate that carriers would be required to pay for services not covered under a policy. NJAHP further stated that providers have nevertheless claimed that these rules give them the right to be paid for all charges on any submitted claim with respect to

which the required notice was not provided, regardless of whether the service(s) or the person(s) to whom the services were provided were covered; whether coinsurance, annual benefit maximums, exclusions and/or time or frequency limitations apply; or whether the provider's charges exceeded the level covered under the policy. NJAHP stated that to allow recovery under these circumstances would be inconsistent with the terms of the policies as filed with and/or approved by the Department and upon which premiums were charged and collected, and would unjustly enrich the recipients.

NJAHP's petition further stated that the requirement in N.J.A.C. 11:22-1.6(a) that a carrier "shall engage in a good faith effort to expeditiously obtain additional information or documents by, among other things, telephoning the provider" is inconsistent with and contrary to P.L. 2005, c. 352, the Health Claims Authorization, Processing and Payment Act (HCAPPA) (specifically, for example, N.J.S.A. 26:2J-8.1d(1)(d) and 17B:30-51), which requires carriers to distribute to providers by posting on their websites a list of all documentation and information that must be submitted with claims, and specifies the time frames and means for carriers to inform providers that a claim has been denied or that information or documentation is inaccurate or incomplete.

NJAHP also stated that, despite the implicit requirement that a claimant act "promptly" to assert the waiver of a payer's right to contest a claim for any reason other than referral to the Office of Insurance Fraud Prosecutor and seek payment of and/or adjustment of a claim for the covered service, some claimants have asserted the "waiver" years after a claim was adjudicated and the coverage year expired. NJAHP asserted that this is not only contrary to the spirit of P.L. 1999, c. 154, the Healthcare Information Networks and Technologies Act (HINT Act) and regulations promulgated

thereunder, which intended to promote the timely payment of claims, but also unduly prejudices carriers by interfering with the administration of the coverage policies as filed with and/or approved by the Department (for example, the proper application of annual benefit maximums and limitations, and proper coordination of benefits with other carriers).

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

"(a) 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**."

NJAHP's petition further requested that the Department amend N.J.A.C. 11:22-1.6(b) as follows (additions in boldface):

"(b) A carrier or its agent that does not provide the notice required by (a) above 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.

**(i) Other than referral to the Office of the Insurance Fraud Prosecutor in accordance with the carrier's Fraud Prevention and Detection Plan, a carrier or its agent that does not provide the notice required by (a) above shall waive 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.**

**(ii) Any covered person and/or provider who submitted the claim for the service must assert any such waiver promptly and in no event later than:**

**(a) sixty (60) days after the carrier's alleged failure to issue the required notice in the event of claim submitted for services or supplies provided by a non-network provider;**

**(b) one hundred eighty (180) days after the carrier's alleged failure to issue the required notice in the event of a claim submitted for services or supplies provided by a network provider."**

The Department's notice acknowledging receipt of NJAHP's petition was published in the February 17, 2009 New Jersey Register at 41 N.J.R. 899(a). In accordance with N.J.A.C. 1:30-4.2 and 11:1-15, the Department subsequently mailed to NJAHP, and filed with the Office of Administrative Law (OAL) for publication in the New Jersey Register, a notice of action on the petition, which was published in the April 6, 2009 New Jersey Register at 41 N.J.R. 1528(b). The Department's notice of action on the petition stated that NJAHP's petition would be denied in part and granted in part, and set forth the reasons for making that determination.

The Department determined it would grant NJAHP's request to amend N.J.A.C. 11:22-1.6(a)2 as suggested by NJAHP because the HCAPPA, enacted in 2006, 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, NJAHP's suggested language adequately addresses carriers' notice requirements to claimants pursuant to the HCAPPA.

The Department agrees 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. As the NJAHP noted, 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. Nevertheless, the Department determined to deny NJAHP's request to amend N.J.A.C. 11:22-1.6(b) as NJAHP suggested because the requested amendment would be inconsistent with the Legislature's intent in enacting the HCAPPA to protect claimants in their timely pursuit of appropriate benefits from their health carriers. The HCAPPA clearly states that "If payment is withheld on all or a portion of a claim by a payer [because the claim submission is incomplete because the required substantiating documentation has not been submitted; the diagnosis coding, procedure coding or any other required information is incorrect; the payer disputes the amount of the claim; or there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud] and the provider is not notified within [30 days for claims received electronically or 40 days for claims received by other than electronic means], the claim shall be deemed to be overdue." (P.L. 2005, c. 352, section 10). Section 10 of the HCAPPA further establishes a procedure for resolving overdue claims, including a carrier's internal appeal mechanism and an independent arbitration mechanism. NJAHP's request 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 HCAPPA that would be established by NJAHP's proposed amendments are not imposed by the provisions of that law. Accordingly, the Department 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.

These proposed amendments to N.J.A.C. 11:22-1.6 are being made in accordance with the Department's notice of action on petition for rulemaking appearing in the April 6, 2009 New Jersey Register at 41 N.J.R. 1528(b).

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

## Social Impact

Carriers and providers will be favorably impacted by the proposed amendments. The amendments clarify the HCAPPA requirements regarding follow-up action that carriers and providers may/may not take after a carrier has denied or disputed a claim submitted to it by a provider, and help to ensure that neither party engages in any

conduct or takes any measures that were not intended by, or are inconsistent with, the HCAPPA. The proposed amendments will have no effect on the efficacy of the regulatory scheme's realization of the legislative intent underlying the HINT Act and the HCAPPA that all claims be paid promptly.

## Economic Impact

The proposed amendments will have no direct economic impact on carriers or providers because the amendments merely clarify requirements established pursuant to the HCAPPA for denied or disputed claims. However, both carriers and providers may be unfavorably impacted to the extent they have not been complying with these requirements previously. If a carrier does not properly deny or dispute a covered claim pursuant to the HCAPPA procedures and timeframes, the claim is deemed overdue, thereby compelling the carrier to pay the claim at an increased interest rate established by the HCAPPA. Providers may not allege a right to payment of an ineligible claim merely because a carrier failed to provide notice of its denial or dispute of the claim. Under the proposed amendments, such claims will be deemed overdue and subject to the HCAPPA procedures for determining whether payment is appropriate.

The Department is aware that several civil actions are currently pending between providers and carriers regarding the application of N.J.A.C. 11:22-1.6(b). The Department's proposal and adoption of these amendments may affect the respective positions of the parties to those actions, particularly claimants who failed to promptly pursue payment from a carrier on the basis of waiver.

## Federal Standards Statement

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

## Jobs Impact

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

## Agriculture Industry Impact

Pursuant to N.J.S.A. 4:1C-10.3, the Right to Farm Act, and N.J.S.A. 52:14B-4(a)(2) of the Administrative Procedure Act, the Department does not expect any agriculture industry impact from the proposed amendments.

## Regulatory Flexibility Analysis

These proposed amendments may apply to some "small business" carriers as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments will require carriers to provide certain notices to providers regarding denied or disputed claims, but those requirements were established by the HCAPPA and carriers have been required to comply with them for some time. 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 costs of compliance with the proposed

amendments are discussed in the Economic Impact statement above. The proposed amendments do not establish differing compliance or reporting requirements or timetables applicable to small business carriers, or exempt them from any of the requirements. The HCAPPA was enacted specifically to put in place uniform procedures and guidelines for the administration of utilization management and claim payment processes in an effort to address existing confusion among carriers and providers concerning those issues. For that reason, the Department believes that these proposed amendments should be applied uniformly because the legislative intent would be undermined if different compliance requirements were applied based on business size.

## Smart Growth Impact

The proposed amendments have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

## Housing Affordability Impact

The proposed amendments have no impact on housing affordability. The proposed amendments affect the prompt payment of health insurance claims.

## Smart Growth Development Impact

The proposed amendments have no impact on housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and

Redevelopment Plan. The proposed amendments affect the prompt payment of health insurance claims.

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

11:22-1.6 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. 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. 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. (No change.)

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**;

3. (No change.)

(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, **[**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 P.L. 2005, c. 352 the claim shall be deemed to be overdue** .

(c) – (f) (No change.)

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