PUBLIC NOTICE

BANKING AND INSURANCE
DIVISION OF INSURANCE
LIFE AND HEALTH DIVISION

Notice of Receipt of 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 Department of Banking and Insurance (Department) received a petition for rulemaking from the above petitioner requesting that the Department amend its rules regarding the prompt payment of claims. Specifically, the petitioner 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 is 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."

Petitioner is seeking 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.

Petitioner 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 proposing these rules did not indicate that carriers would be required to pay for services not covered under a policy. Petitioner further stated that providers have nevertheless claimed that these rules give them the right to be paid for all charges for 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. Petitioner 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.

Petitioner 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 inaccurance or incomplete.

Petitioner also stated that, despite the implicit requirement that a claimant act "promptly" to assert the waiver 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. Petitioner asserted that this is not only contrary to the spirit of P.L. 1999, c. 154 (the 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).

Petitioner requests 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**.

Petitioner further requests 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.

In accordance with N.J.A.C. 1:30-4.2 and 11:1-15, the Department shall subsequently mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition.