if another company has agreed, in a manner satisfactory to the Governing Committee, to assume such obligations.

(f) Participation shall be suspended upon order of the Commissioner of Banking and Insurance if he or she finds that such action is required by the financial condition of that participant.

(g) All participants in CAIP shall participate in the business written by the CAIP pursuant to an approved AIP plan of operation.

11:3-1.13 Rates and policy forms

(a) The Governing Committee shall file for prior approval by the Commissioner, all rates, rules surcharges, minimum premiums, classifications, and policy forms which shall be used by insurers writing risks through the AIP. Proceedings to review rate filings shall be conducted pursuant to N.J.S.A. 17:29A-1 et seq. All rates shall reflect the experience of the risks insured by the AIP and shall not be excessive, inadequate, or unfairly discriminatory. Every rate filing shall include an analysis of the adequacy of the rating plans. Premiums for risks shall be subject to the rating plan established in the plan of operation.

(b) Any risk with five or more vehicles not including trailers and semi-trailers shall be considered as a fleet. The AIP shall file base rates for fleets with the Commissioner for his or her prior approval which are different than the rates for non-fleet risks if the AIP determines that the loss expectancy of fleet risks insured by the AIP is different than the loss expectancy of non-fleet risks insured by the AIP.

11:3-1.14 Installment payment option

(a) The PAIP shall provide for an installment premium payment option in accordance with procedures established by the Governing Committee in the AIP plan of operation. With respect to the installment premium payment option, the AIP plan of operation shall specify:

1. The minimum initial deposit required, which shall be no more than 30 percent of the estimated total premium;

2. The schedule for the payment of premiums on an installment basis which shall provide for installment payments over a period of not less than nine months;

3. Installment charges;

4. The minimum "per installment" amounts; and

5. Any other procedures deemed necessary by the Governing Committee.

(b) Additional premium in excess of an amount set by the Governing Committee in the AIP plan of operation resulting from changes to the policy shall be spread over the remaining installments, if any, or may be billed immediately as a separate transaction.

(c) Return premium resulting from changes to the policy shall be used to reduce the outstanding balance. If the outstanding balance is eliminated, any amount remaining in excess of an amount set by the Governing Committee in the plan of operation shall be returned within 30 days. If an outstanding balance remains, the number and amounts of the remaining installments shall be adjusted accordingly, except when the return amount is less than $20.00, in which event it may be treated as a separate transaction.

(d) The CAIP shall provide for an installment premium payment option in accordance with procedures established by the Governing Committee in the AIP plan of operation.

11:3-1.15 Right to petition for appeal to the Commissioner

(a) An applicant, insured, producer, LAD carrier, CAIP servicing carrier, person applying to act as a LAD carrier or CAIP servicing carrier, or insurer may petition for appeal to the Commissioner from an adverse decision of the Governing Committee by filing a request in writing within 20 days of the date of receipt of the written decision of the Governing Committee.

1. The written request to appeal shall set forth the facts upon which it is based and include a copy of the written decision of the Governing Committee.

2. The Commissioner shall notify the petitioner and the Governing Committee within 30 days whether the request to appeal shall be granted.

3. Notice from the Commissioner that an appeal has been granted shall also provide a statement about whether the action of the Governing Committee has been stayed pending the disposition of the appeal.

(b) An appeal to the Commissioner granted pursuant to this section shall be conducted in accordance with applicable provisions of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:3-1.16 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

SUBCHAPTER 2. (RESERVED)

(a)

DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
Health Benefit Plans
Prompt Payment of Claims
Adopted Amendments: N.J.A.C. 11:22-1.2, 1.6, 1.9, and 1.10
Adopted New Rule: N.J.A.C. 11:22-1.5

Proposed: September 5, 2017, at 49 N.J.R. 2877(a).
Adopted: December 20, 2017, by Richard J. Badolato, Commissioner, Department of Banking and Insurance.
Filed: December 20, 2017, as R.2018 d.062, **with a non-substantial change** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

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

Effective Date: January 16, 2018.
Expiration Date: September 21, 2018.

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received timely written comments from the New Jersey Obstetrical & Gynecological Society; the New Jersey Society of Anesthesiologists; the New Jersey Association of Osteopathic Physicians and Surgeons; Home Care and Hospice Association of New Jersey; the New Jersey Association of Ambulatory Surgery Centers; the Medical Society of New Jersey; Delta Dental of New Jersey, Inc.; New Jersey Dental Association; Infectious Diseases Society of New Jersey, the New Jersey Society of Thoracic Surgeons; New Jersey Academy of Otolaryngology; New Jersey Society for Bariatric Surgeons, Inc.; New Jersey Chapter American College of Surgeons; and the New Jersey Association of Health Plans.

COMMENT: One commenter contends that the inclusion of provisions related to standards for an explanation of benefits (EOBs) form, which by definition is a document that a carrier issues to a covered person, seems to be misplaced in N.J.A.C. 11:22-1.1 et seq., as this subchapter is otherwise about the prompt payment of claims. The commenter noted that the Purpose and Scope for this subchapter provide that the rule "sets standards for the payment of claims relating to health benefits plans and dental plans." Minimum standards for EOBs does not relate to setting a standard for the payment of claims. Rather, an EOB is a carrier-to-consumer communication.

RESPONSE: The Department notes that while the rule deals with claim processing, the outcome of the claim processing is summarized on the EOB. The Department reasoned that it was fitting to place the rules governing the EOB in a subchapter that already addressed claims. The Department believes the rule is appropriately codified in this subchapter. However, on August 21, 2017, the Department proposed new rules and amendments to implement the Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, in N.J.A.C. 11:22-1 (49 N.J.R. 2729(a)), which are being simultaneously adopted with this EOB proposal (HCAPPA rule amendments). These HCAPPA rule amendments are more expansive than this proposal, have added new subsections to Subchapter 1, and have eliminated certain paragraphs and/or provisions that are proposed herein for technical cross-reference

amendments due to the insertion of the new EOB rule at N.J.A.C. 11:22-1.16. Accordingly, the Department is making technical adjustments to this proposal on adoption to align its provisions with the HCAPPA rule amendments.

COMMENT: One commenter stated that based on the proposal's Economic and Regulatory Flexibility Analysis statements the Department is giving carriers the flexibility to provide an EOB electronically. The commenter recommended that the following amendment to the rules (additions to proposal in **bold**):

N.J.A.C. 11:22-1.2 "Explanation of benefits" or "EOB" means a document a carrier issues **or makes available** to a covered person….

N.J.A.C. 11:22-1.5 (a) Every carrier shall provide **or make available** an explanation of benefits …

A second commenter noted that the above suggested amendment to N.J.A.C. 11:22-1.5(a) is needed to align with the commenter's current practice whereby an explanation of benefits is available to the covered member on its benefits portal, but is not mailed to the covered member if the covered member has no financial responsibility.

RESPONSE: The Department appreciates the distinction the commenters made, but the Department reminds the commenter that the requirement to provide an explanation of benefits is not as limiting as the commenter seems to have understood. The EOB can be "provided" via hard copy mailing or electronically (given all other requirements as to electronic communications have been observed), and thus comply with the rule, and therefore no change is needed.

COMMENT: One commenter stated that pursuant to N.J.A.C. 11:22-1.5(b)4, a carrier is required to include in an EOB a "clear description of the service." The commenter requested that the Department delete the word "clear," absent greater guidance as to what that means. The commenter contends that while clarity is important in most cases, it recognizes that where treatment relates to sensitive services (for example, sexual and reproductive health care for minors, mental health services, substance use disorder treatment, treatment related to domestic or intimate-partner violence), there may be a consumer request or a need to not provide a "clear" description of the service provided. Additionally, the commented requested that carriers be given flexibility to genericize information in such cases.

RESPONSE: The Department disagrees with the suggestion to delete the adjective "clear." The Department notes that the term "clear" requires an unambiguous characterization of the service or supply, such as an office visit, as opposed to a vague reference, such as medical services. The level of detail or condition-specific information provided as examples by the commenter are not required by the rule.

COMMENT: One commenter suggested that proposed N.J.A.C. 11:22-1.5(b)8 include wording that if a claim is denied for multiple reasons that all the reasons for the denial should be listed in the explanation of benefits.

Several commenters believe that only the controlling reason for non-coverage must be stated in the EOB. The commenters stated that if there is more than one reason the EOB may state that but alternatively possible reasons should not be permitted. The commenters believe that secondary reasons that a service is not covered may be listed, but each reason should be independent and not speculative.

RESPONSE: The Department refers the commenters to N.J.A.C. 11:22-1.5(b)8 which requires a specific explanation. Additionally, the rule permits multiple denial reasons, and although all applicable reasons known to the carrier at the time of denial should be listed, the rule does not mandate listing of all bases or preclude the discovery of additional bases for denial. The rule also requires that the carrier only list reasons that are applicable, and specifically provides that the listing of speculative reasons would be considered an unfair trade practice in violation of N.J.S.A. 17B:30-13.1.

COMMENT: One commenter stated that proposed N.J.A.C. 11:22-1.5(b)12 requires EOBs to include the amount of interest paid in the event the payment is overdue and the claim is paid and is adjudicated beyond the 30-day electronic/40-day written prompt-pay requirement. The commenter does not believe that consumers/covered persons will benefit from the reporting of information regarding interest paid to a provider. The commenter contends that information regarding interest payments on the EOB could be confusing, since it does not impact the covered member's financial responsibility. The commenter stated that including information regarding interest in the EOB would result in significant operational hardship and expense without significant benefit to covered members or to dental providers. The commenter noted that N.J.A.C. 11:22-1.6(c) allows carriers to issue an interest payment within 14 days of the claim payment. The commenter requested that proposed N.J.A.C. 11:22-1.5(b)12 be amended to eliminate the requirement that "interest should be shown separately if interest is paid."

RESPONSE: The Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, requires that interest be paid at the time the overdue payment of the claim is made; thus, HCAPPA effectively repealed N.J.A.C. 11:22-1.6(c) as applied to health benefits plans. Additionally, on August 21, 2017, the Department proposed new rules and amendments to implement HCAPPA including this change as to the timing of interest payments (49 N.J.R. 2729(a)), which are being simultaneously adopted with this EOB proposal. Since the payment of interest must be made at the same time as the claim is paid under HCAPPA and the updated rules at Chapter 22, Subchapter 1, carriers know the amount and can display the interest on the EOB. Moreover, the amount of interest paid on a claim is useful to the covered person where the provider is out-of-network and may be balance billing the covered person.

COMMENT: One commenter stated that N.J.S.A. 17B:30-29 specifically authorizes the pending of claims. The commenter contends that the ability to pend claims serves a useful purpose and, to the extent a clean claim is not paid within the limits required by law, carriers are required to pay interest to the provider. The commenter stated that the requirement that a carrier issue an EOB to the covered person while a claim is pended adds unnecessary administrative costs and results in the issuance of multiple explanations of benefits that may be confusing to covered members. The commenter requested that N.J.A.C. 11:22-1.5(c) be amended to read as follows (additions to proposal in **bold**):

"if review of the claim is still pending **upon expiration of 30 days if the claim is filed electronically or 40 days if the claim is submitted in writing, the carrier shall provide or make the EOB available to the covered person once the reason for pending the claim no longer exists**."

RESPONSE: The Department disagrees with the suggested amendment, and notes that such an amendment would require reproposal because it is a substantial change to the notice of proposal. The commenter correctly noted that N.J.S.A. 17B:30-29, authorizes the pending of claims. It also requires a toll-free number for covered persons to obtain information on paid and pending claims. Pending in this context refers to claims that have not been paid. The ability to "pend" a claim does not authorize carriers to ignore the requirement in HCAPPA to pay or deny claims in 30 or 40 days. This rule requires that when claims are pended and not paid within 30 or 40 days, the carrier must notify the covered person through an EOB. The EOB will serve as a status update to the covered person.

COMMENT: One commenter stated that the "10 percent" figure found in the first sentence of N.J.A.C. 11:22-1.7(c) as proposed for recodification with non-substantive amendments should be "12 percent" to be consistent with other interest-bearing clauses affecting claim processors. The commenter further stated that in proposed N.J.A.C. 11:22-1.7(c) the payment itself must include details (indicators) with the aggregate on both the explanation of benefits and the payment.

RESPONSE: The commenter is correct that HCAPPA, P.L. 2005, c. 352, requires that interest be paid on non-capitated claims at the rate of 12 percent. As noted in response to another comment, the Department has proposed new rules and amendments to implement HCAPPA (see 49 N.J.R. 2729(a)), which are being simultaneously adopted with this EOB proposal, and that update the interest amount to 12 percent. See 49 N.J.R. 2729(a), at 2734. As amended N.J.A.C. 11:22-1.5(e) now provides this correct interest amount. Therefore, the changes requested by the commenter are not necessary.

COMMENT: One commenter requested that with respect to mandatory claims testing that the Department include in its rules a requirement to conduct a complete and accurate claims testing for a duration of time that is adequate to test multiple cycles of billing appropriate to provider types that would be affected by changes in State

policy (for example, changes in insurance coverage) and related changes to HMO/ISO operations (for example, claims system edits). The commenter contends that the claims testing provision would protect against preventable claims payment delays, backlogs, and claim payment errors and inappropriate claims payment denials.

RESPONSE: The Department's rules address issuance of EOBs to members, not claim audit procedures. As such, the comment exceeds the scope of the proposal.

COMMENT: One commenter stated that the Department should expand the use of readiness review requirements to new market entrants and of any new, enhanced, supplemented, replaced, or revised program/policy/function requirements that alters the operation of a plan, and therefore, their ability to demonstrate compliance with the change.

RESPONSE: The comment exceeds the scope of the proposal; the Department's rules address issuance of an EOBs to a covered person.

COMMENT: Three commenters stated that the proposed rules could further protect the interests of covered persons by adding a requirement that EOBs be written in clear understandable plain English. The commenters contend that it is typical for EOBs to utilize codes, which are difficult to understand, when addressing why a charge is not covered. The commenters contend that these codes should either be replaced or supplemented with a clear, easy-to-understand plain English explanation, written in full sentences, for the claim denial. Additionally, the commenters, suggested that the Department consider adding a penalty provision for routinely inaccurate EOBs. The commenters stated that they have been numerous instances where there is a balance due from a covered person to a provider, but the EOB provides that there is no balance due. This situation is particularly prevalent with out-of-network providers, where the carrier may pay the provider at some unilaterally determined rate but the covered person is responsible for the balance.

RESPONSE: The Department reminds the commenters that carriers are subject to the requirements of the Unfair Trade and Claims Practices laws. It is not necessary to repeat the obligations for accuracy and consequences of inaccuracy in every rule. Additionally, another Department rule amendment proposed at 49 N.J.R. 2876(a), which is published elsewhere in this issue of the New Jersey Register, now explicitly provides that the issuance of inaccurate EOBs will constitute an unfair claim settlement procedure as defined at N.J.S.A. 17B:30-13.1 and subject the violator to the penalty provisions of N.J.S.A. 17B:30-17 to 20. Further, since N.J.A.C. 11:22-1.5(b)8 as proposed requires carriers to provide specific explanations, the explanations of the denial codes must explain the reasons for a denial of a claim. The Department believes such explanations are sufficient for an average covered person to be able to understand the reason for a denial. In light of the above, the Department believes that no changes are necessary to the rule as proposed.

COMMENT: Several commenters recommended that the Department require that the CPT code be listed. The commenters contend that without CPT codes consumers are deprived of the ability to look up fees on publicly available data bases. The commenters believe that listing the CPT codes would allow consumers to compare publicly available fee schedules to their plan's stated allowable amounts. For example, consumers cannot use the free consumer tool provided by Fair Health.

RESPONSE: The Department believes the EOB must provide information that the majority of covered persons would find useful. Although there may be some covered persons for whom a CPT code would provide useful information, the Department believes most covered persons find the description of the service to be sufficient. If a covered person wishes to learn the CPT codes the covered person could request the information from the carrier or the provider.

COMMENT: Several commenters contend that carriers should be forbidden from stating that the provider's fees are excessive or that the patient responsibility is "0" when this is not an accurate statement under the plan document or when the service is covered by hold harmless regulations.

A second commenter stated that this statement is misleading because insurers control the amount that will be paid on any claim and the complexity and uncertainty of the billing process makes it nearly impossible for the physician's practice to quantify in advance how much will be paid on a claim.

Additionally, several commenters stated that carriers should be prevented from stating that the provider may not balance bill unless this is provided for under the plan document and the rules governing inadvertent out-of-network and emergency services.

RESPONSE: These rules list only required information on an EOB and do not contain a specific list of prohibited information. To the extent that the information provided by a carrier in an EOB is inaccurate, such actions would be considered an unfair claims settlement practice. Additionally, these comments implicate other Department rules and reference to these rules is not necessary under the scope of this rule proposal which is limited to provided necessary minimum information for EOBs.

COMMENT: Several commenters stated that the carrier should indicate how the out-of-network benefit was calculated, including reference to the plan document. The commenters contend that the plan rule should be stated as well as any benchmark used. The commenters believe that if the benefit is based on a percentage of a government plan or nationally recognized data base then the EOB should state the percentage amount and the mathematical calculations that should be included. Finally, the commenters stated that if the amount is based on a proprietary data base, information should be given about the method of data collection and the calculated fee must not be based on the in-network fee schedule or other discounted fees.

Additionally, several commenters stated that the EOB should explain what the allowed charge is based on. The commenters believe that there should be a reference to the plan document's description of allowed charges. Reference should be made to how the plan derives the allowed charge. If it is a percentage of a government charge or a data-base, then this should be stated. The commenters believe that the mathematical calculation should be included.

RESPONSE: The policy or certificate, and the provider contract (where the provider is in-network), will describe the methodology used to calculate the allowed amount. Including such information on an EOB would be redundant and would unnecessarily add dense text to a document that is intended to provide a concise explanation of how claims have been paid.

COMMENT: Several commenters stated that the EOB should include a statement of the amount that the patient may be billed, including whether it may be up to the charged amount.

RESPONSE: The Department believes an average covered person can review the billed charge, allowed charge, and non-covered amount information and easily determine how the remaining patient liability is calculated. The Department disagrees that it is necessary or appropriate to include an additional item.

COMMENT: One commenter stated that the EOB should clearly state amounts that are counted towards the deductible and the maximum out-of-pocket (MOOP). The commenter further stated that if out-of-network charges are not counted toward the deductible and MOOP, the EOB should clearly state that with a reference to the Plan document. The commenter believes that payers have this information and sharing it will help consumers to become better informed users of healthcare services and facilitate the collection of deductibles.

RESPONSE: The proposed rule already provides that accumulation toward deductible and MOOP be shown. MOOP is limited to deductible, coinsurance, and copayment. If a covered person is covered under a plan with no out-of-network benefits and voluntarily uses an out-of-network provider, those charges will be shown as non-covered. If the plan has out-of-network benefits, charges for an out-of-network provider will accumulate toward a listed out-of-network deductible and a listed out-of-network MOOP.

COMMENT: Several commenters stated that the proposed amendments should require carriers to identify the appropriate venue of appeal, whether the appeal is: for medical necessity/utilization management or payment amount, through the State's external review process; or whether the appeal is through the US Department of Labor for ERISA governed plans. The commenters stated that they are aware that at least one carrier's letters to patients and providers indicates appeals processes for both State-governed plans and ERISA-governed

plans in the same letter. The commenters contend that this suggests that either may be appropriate. The commenters stated that carriers know if the plan being adjudicated is governed by the State or the Federal government. The commenters believe that carriers should be required to indicate the correct path of appeal. The commenters stated that listing both venues appears to be misleading and may deprive insureds of appeal rights. The commenters noted that if the patient picks the wrong venue time may elapse to make a timely appeal. The commenters stated that not only should the EOB indicate the correct appeal path, but all correspondence to the patient about the claim or payment denial/reduction.

RESPONSE: Notice of appeal rights to covered members appear on adverse benefit determinations and appeals therefrom. If a claim denial is an adverse benefit determination, carriers typically include text describing the appeal rights by plan type. The Department can only require carriers to include information as to such appeal rights in plans that are insured, namely not self-funded, and thus are subject to the Department's jurisdiction, and that is required in N.J.A.C. 11:22-1.5(b)13 as proposed.

COMMENT: One commenter stated that in addition to defining the content of an EOB, they recommend that the Department consider defining and regulating "remittance advice." The commenter contends that while the EOB is the explanation of payment to patients, the "remittance advice" or "RA" is the explanation to providers. Therefore, the commenter believes that these documents should be consistent with respect to the information that they convey. The documents should be "cross-walkable" so that both providers and patients understand how the claim has been processed. The commenter stated that this will facilitate patient and provider working together to appeal a claim that has been wrongfully denied or underpaid.

Additionally, several commenters stated that N.J.A.C. 11:22-5.8 should contain a statement that the patient's liability is limited to the copayment, deductible, and/or coinsurance applicable to network services and that the carrier is responsible for negotiating payment terms agreeable to the out-of-network provider. The patient should direct all inquiries about billing to the carrier who is responsible for resolving the payment issues.

RESPONSE: These rules address EOBs provided to covered persons and not remittance advice forms issued to providers. As such, this comment is beyond the scope of the rulemaking.

COMMENT: One commenter requested that the Department provide an exception to the obligation to issue or make available an EOB in cases where no balance is due after the member has paid any copayments. The commenter contends that the value of an EOB to a consumer where they have no further financial obligation is minimal. The commenter stated that by allowing a carrier to suppress issuance of an EOB in these cases allows a carrier to be more efficient by avoiding unnecessary administrative costs.

RESPONSE: Issuance of an EOB is necessary even where there is no patient liability so that the covered person knows if the claim has been processed and paid, or whether it was denied for a reason which protects the member from financial liability, such as where a network provider rendered a service without a required referral. Also, provision of the EOB where payment is made and there is no dispute gives covered members additional appropriate information as to the cost of their needed medical care.

COMMENT: One commenter stated that some carriers are authorized to issue health benefit plans and/or dental plans in this State and some provide services as third-party administrators. The commenter stated that it is essential to know in what capacity the carrier is acting, regarding the payment of claims in order to determine whether State or Federal law is applicable to the transaction.

RESPONSE: Information as to whether a health benefits plan is insured or self-funded is required to be included on the insurance identification card. See N.J.A.C. 11:22-8.3(b)2. This information need not be repeated on every EOB form.

COMMENT: One commenter believes that health care providers should receive copies of EOBs. The commenter contends that providers who receive payments directly from carriers should be privy to the EOBs furnished by their patients' carriers so that they can properly reconcile their patient's accounts.

RESPONSE: This rule addresses only EOBs issued to members. Notice to providers of claims processing is addressed in other rules. A provider who wishes to see the EOB the covered person received may ask the patient for a copy.

Summary of Agency-Initiated Changes:

The Department is making a technical change on adoption to align the provisions of this rulemaking with the HCAPPA rule amendments found at 49 N.J.R. 2729(a). As a result, proposed new N.J.A.C. 11:22-1.5 is recodified on adoption as N.J.A.C. 11:22-1.16, and the proposed recodification of existing N.J.A.C. 11:22-1.5 through 1.10 as 1.6 through 1.11 will not be adopted and all proposed cross-references will be updated accordingly.

Federal Standards Statement

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

Full text of the adoption follows (addition to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks *[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-*[1.6]* ***1.5*** (No change in text.)

11:22-*[1.7]* ***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-*[1.6]* ***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-*[1.6]* ***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 the provider of the basis for its decision to deny or dispute, including:

1.-3. (No change.)

4. The toll-free telephone number for the carrier or its agent who can be contacted by the provider 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-*[1.6]* ***1.5***, 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]* ***10*** working days from either the receipt of such agreement by the carrier or the date the performance by the provider of any conditions to payment set forth in the agreement, whichever is later.

(f) (No change.)

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

11:22-*[1.10]* ***1.9*** 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 this section and N.J.S.A. 17B:30-12 et seq.

(g) (No change.)

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

(a) Upon review of the reports required by N.J.A.C. 11:22-*[1.10]* ***1.9***, 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-*[1.6]* ***1.5***; 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-*[1.8]* ***1.7***.

11:22-1.11 — 1.15 (Reserved)

11:22-*[1.5]*** 1.16*** 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.

(a)

DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH
Health Maintenance Organizations
Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations
Adopted Amendments: N.J.A.C. 11:24-1.2 and 11:24A-1.2 and 2.3

Proposed: September 5, 2017, at 49 N.J.R. 2880(a).
Adopted: December 20, 2017, by Richard J. Badolato, Commissioner, Department of Banking and Insurance.
Filed: December 20, 2017, as R. 2018 d.065, **without change**.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, and 26:2S-1 et seq.

Effective Date: January 16, 2018.
Expiration Dates: January 14, 2022, N.J.A.C. 11:24;
March 1, 2018, N.J.A.C. 11:24A.

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received timely written comments from the Home Care and Hospice Association of New Jersey; the Medical Society of New Jersey; the New Jersey Association of Ambulatory Surgery Centers; the New Jersey Doctor-Patient Alliance; the New Jersey Hospital Association; the New Jersey Obstetrical and Gynecological Society; the New Jersey Orthopaedic Society; the New Jersey State Society of Anesthesiologists; and the New Jersey Association of Health Plans.

COMMENT: Several commenters expressed support for the Department's proposed amendments.

RESPONSE: The Department appreciates the commenters' support of its proposal.

COMMENT: Several commenters expressed concern with the phrase "qualified, accessible, and available provider" found in N.J.A.C. 11:24A-1.2 (definition of in-plan exceptions), 11:24A-2.3(a)1v and (a)3ii. One commenter questioned if these characteristics are defined solely by the carrier or can a provider's other contracts further restrict the definitions. The commenter cited an example, where a Medicaid Managed Care beneficiary residing in a nursing home (and thus has his/her room and board paid by an HMO) is denied access to the hospice program of his/her choice because the beneficiary seeks services from a hospice that is in-network for the beneficiary, but the nursing home has an exclusive contract with only one hospice, which is an out-of-network provider for that beneficiary. The commenter questioned if the hospice of the beneficiary's choice can be considered inaccessible or unavailable merely because the nursing home has a contract with a different hospice (which is an out-of-network provider for that beneficiary).

A second commenter believes that the definition sets forth a vague threshold for determining whether a consumer has access to a network provider. The commenter stated that a denial of an in-plan exception is subject to appeal. Thus, a vague standard could increase the number of appeals and complaints carriers see related to the provider network. The commenter contends that guidance on what standards the IURO would use if an appeal were made would be helpful. The commenter stated that it does not believe that the terms used in the proposed rule ("who are qualified, accessible, and available") provide any clarity and suggest the deletion of these terms. Additionally, the commenter believes that "qualified" is addressed simply by the carrier's credentialing process and the licensure requirements of the state. The commenter also stated that it would like guidance from the Department as to whether the applicable Department geo-access standards may also serve as a standard for determining access if the request for a waiver is based on a time and/or distance concern raised by the member. The commenter requested that the Department consider the following amendment or alternatively provide greater clarity around the standards to which carriers will be held: