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DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Health Benefit Plans

Proposed Readoption with Amendments: N.J.A.C. 11:22

Proposed Repeals: N.J.A.C. 11:22-3.4 and 3.5 and 11:22-3 Appendix Exhibits 1A, 1B and 2

Authorized By: Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17:48H-32, 17B:27B-25, 17B:30-13.1, 17B:30-23 et seq., 17B:30-55, 17B:30-56, 26:1A-36.14 and 52:17B-209.

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

Proposal Number: PRN 2011-122.

Submit comments by July 15, 2011 to:

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The agency proposal follows:

Summary

Pursuant to N.J.S.A. 52:14B-5.1 and Executive Order No. 66 (1978), the Department of Banking and Insurance (Department) proposes to readopt N.J.A.C. 11:22, Health Benefit Plans. This chapter is scheduled to expire on October 23, 2013, pursuant to N.J.S.A. 52:14B-5.1.c.

The Department has reviewed the chapter and a determination has been made that all subchapters should be continued because the rules are necessary, reasonable, adequate, efficient and responsive for the purposes for which they were promulgated. These rules continue to provide guidance to the insurance industry and protect consumers by requiring the provision of vital information and establishing useful standards concerning health insurance.

N.J.A.C. 11:22-1, the rules regarding the prompt payment of claims, sets standards for the timely payment of "clean" claims relating to health benefit plans and dental plans.

N.J.A.C. 11:22-2, the rules on health wellness promotion plans, establishes that health benefits plans delivered, issued, executed or renewed in this State are required to offer to covered persons certain screening tests and counseling as a result of the

Health Wellness Promotion Act, P.L. 1993, c. 327 as amended by P.L. 1999, c. 339, and codified at N.J.S.A. 26:1A-36.11 et seq.

N.J.A.C. 11:22-3, the rules on electronic receipt and transmission of health care claims, establishes timetables for the introduction and implementation of systems for the electronic receipt and transmission of health care claim information. This subchapter also establishes one set of standard health care enrollment and claim forms in paper and electronic formats that are to be used by all health care benefit payers. This subchapter implements the statutory requirement imposed by N.J.S.A. 26:2H-12.12, which requires health care professionals, institutions and facilities to file claims on behalf of their patients when seeking payment or reimbursement of health care claims.

N.J.A.C. 11:22-4 addresses organized delivery systems (ODS) and sets forth the filing requirements for an entity to be licensed as an ODS pursuant to N.J.S.A. 17:48H-1 et seq.

N.J.A.C. 11:22-5 establishes minimum standards for health benefit plans, prescription drug plans and dental plans.

N.J.A.C. 11:22-6, the rules on exclusions and preauthorization requirements, specifies standards for war and other exclusions and preauthorization requirements in health benefit plans.

N.J.A.C. 11:22-7 implements N.J.S.A. 52:17B-196 et seq., which provides for joint negotiations regarding non-fee-related matters, fees and fee-related matters by physicians and dentists with carriers. This subchapter establishes standards and

procedures for carriers to report to the Department certain information concerning the number of a carrier's covered lives and the impact of provider negotiations conducted pursuant to N.J.S.A. 52:17B-196 et seq.

N.J.A.C. 11:22-8, the rules on health insurance identification cards, establishes standards and criteria regarding information contained on health insurance identification cards issued by carriers.

The Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, enacted on January 12, 2006 and effective July 11, 2006, and codified at N.J.S.A. 17B:30-48, established uniform procedures and guidelines for health insurance carriers and medical providers to administer utilization management and claim payment processes. HCAPPA applies to all health insurance carriers except dental service corporations and dental plan organizations. The Department proposed certain amendments, new rules and repeals to N.J.A.C. 11:22-1 on July 2, 2007 (see 39 N.J.R. 2455(a)) to implement HCAPPA. The Department received numerous comments on the proposal, and final rules were not adopted. The Department realizes that several rules in N.J.A.C. 11:22-1 require updating. Additionally, the Federal Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111-148, was enacted on March 23, 2010. Some of the rules contained in N.J.A.C. 11:22-5, Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans, relating to network copayments for preventive care, and restrictions on out-of-network annual and lifetime limits, will need to be amended in the near future in order to comply with the requirements of the Affordable Care Act. The Department has also determined that

including proposed revisions to the rules at N.J.A.C. 11:22-1 and 11:22-5 as part of the readoption process of this chapter would not be appropriate because of the extensive nature of the changes needed to be made to the rules and the potential for delaying readoption of this chapter. The Department intends to propose changes to these rules in the near future.

The Department is proposing some "housekeeping" changes that eliminate certain outdated provisions and update others.

At N.J.A.C. 11:22-1.8(a), references to certain Health Maintenance Organization (HMO) and Health Care Quality Act (HCQA) rule citations are being changed to reference the Department's rule citations. This change is being made because Reorganization Plan 005-2005 filed by Acting Governor Codey on June 30, 2005, reorganized the Department of Health and Senior Services (DHSS) Office of Managed Care, and transferred from the Commissioner of DHSS to the Commissioner of the Department the authority to interpret, implement, administer and enforce numerous laws, including the HCQA, and laws subsequently enacted that directly amend or supplement the HCQA. Consequently, authority to adopt rules promulgated pursuant to the HCQA no longer resides with DHSS, but rests with the Department, and the rules were recodified from DHSS to the Deparment.

The Department is also proposing to make revisions to update references at N.J.A.C. 11:22-3, Electronic Receipt and Transmission of Health Care Claims. At N.J.A.C. 11:22-3.3(b), the Department is proposing to revise certain standard claim form numbers for forms that the Federal government requires to be used by health care

institutions, facilities and providers in submitting claims to health carriers. An outdated Federal agency reference is also being changed to reflect the new name of the agency. Also, some minor language changes are being made for clarification purposes. The Department is proposing to amend N.J.A.C. 11:22-3.3(c) by eliminating references to the subchapter Appendix Exhibits 1A and 1B, the universal enrollment/change request form and application/change request form for health insurance coverage, and replacing them with language indicating that those forms can be accessed at the Department's website. The information contained in the existing exhibits is outdated and the forms have previously been updated via Department bulletins (see Bulletins Nos. 07-07, 07-17 and 09-02). The subsection is further being amended to include a summary of the information that is contained in those forms. N.J.A.C. 11:22-3.4 (and accompanying subchapter Appendix Exhibit 2) and 3.5 are being repealed and N.J.A.C. 11:22-3.7(a) and (b) and 3.8(e) are being deleted because all these rules contain outdated timetables for health benefit payers' adoption of electronic claim and enrollment form requirements. Subchapter 3 Appendix Exhibit 2 contains an outdated HINT Operational Status Report. N.J.A.C. 11:22-3.6 is being recodified as 3.4. N.J.A.C. 11:22-3.7(c) is being amended for clarification purposes necessitated by the deletion of subsection (a). Finally, N.J.A.C. 11:22-3.7 through 11 are being recodified as N.J.A.C. 11:22-3.5 through 9.

A 60-day comment period is provided for this notice of proposal, and therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the notice is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

As noted above, these rules address several areas of concern to consumers and also provide significant consumer protections. The prompt payment of claims rules continue to have a positive impact on the public and the healthcare community by requiring claims to be paid quickly and fostering the efficient and fair resolution of disputes. The health wellness promotion plan rules continue to have a positive social impact because they require carriers to make health wellness promotion benefits available to their insureds. These services and tests can detect serious illness at an early stage and also serve to encourage covered persons to make choices that promote better health. Additionally, the health benefit plan minimum standards rules for network-based health benefit plans benefit consumers because they increase the availability and affordability of health plans affected by these rules. The health insurance identification card rules enable providers to more readily obtain information concerning their patients' health benefit plan coverage that facilitates the claim submission and payment process.

The industry also relies on the presence and effectiveness of these rules in their operations. For example, the health benefit plan carrier/provider joint negotiation agreement rules require carriers to report to the Department quarterly the number of covered lives enrolled in certain health benefits plans, and to report annually the impact of provider negotiations conducted pursuant to N.J.S.A. 52:17B-196 et seq., Collective Bargaining for Physicians and Dentists.

The minimum standards for health benefit plans, prescription drug plans and dental plans rules also have a favorable impact on carriers, providers and consumers. These rules assist in the marketability of the plans affected by the rules; continue to permit providers to expand their practices due to the increased availability of the plans; and increase consumer access to, and the affordability of, these plans.

Economic Impact

The failure to readopt this chapter would require the insurance industry to perform many significant statutory functions without guidance from the Department. This would impose significant costs on the industry because current compliance requirements would not be readily available to the industry. The industry has invested a great amount of time and resources to operate in compliance with the Department's current procedures, which benefits both insurers and the general public. Insurers and other regulated entities will be required to incur minimum costs associated with continued compliance with the requirements set forth in this chapter. These costs are associated with services and tests to detect serious illness at an early stage, maintaining the electronic receipt and transmission of health care claims, issuing health insurance identification cards that contain information that is uniform throughout the industry and ensuring that the Department is provided with quarterly reports and informational filings.

The Department's prompt payment of claims rules continue to have a positive economic impact on insureds and covered persons under health benefit plans by

requiring their claims to be paid within the statutory time frames and by clearly defining what constitutes a clean claim.

The Department believes that its minimum standards for health benefits plans, prescription drug plans and dental plans rules continue to provide economic benefits to carriers because the rules permit greater cost sharing by covered persons under the plans affected by these rules. Moreover, covered persons who actually receive medical care under these plans have their out-of-pocket costs for network care capped.

While insurers are required to continue to incur the costs described above associated with compliance with this chapter, the Department reiterates that these costs are minimal and are outweighed by the continued protections afforded to consumers, the benefits obtained by health care providers, and the guidance provided to the insurance industry.

Federal Standards Analysis

As mentioned in the Summary above, the Federal Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111-148, was enacted on March 23, 2010. Pursuant to the Federal interim final rules that became effective on September 23, 2010 (See 26 CFR Parts 54 and 602, 29 CFR Part 2590 and 45 CFR Parts 144, 146 and 147, Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient protections; final Rule and Proposed Rule, June 28, 2010), health insurance plans may not establish lifetime limits on the dollar value of essential benefits, and may only establish restricted limits

prior to January 1, 2014 on essential benefits as determined by the Secretary of Health and Human Services. The Federal rules also require health benefits plans to provide coverage without cost sharing for certain preventive health services. Federal regulations do not preempt State rules, except when compliance with the State rules would make it impossible for the regulated entity to comply with the Federal regulations as well. Paragraph 1e of New Jersey's Executive Order No. 2 signed by Governor Chris Christie on January 20, 2010, permits New Jersey State agency rules to exceed the requirements of Federal law when required by State statute or in circumstances where exceeding the requirements of Federal law or regulation is necessary in order to achieve a New Jersey specific public policy goal. Some of the rules contained in N.J.A.C. 11:22-5, Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans, relating to network copayments for preventive care, and restrictions on out-of-network annual and lifetime limits, are more stringent than the new Federal regulations, and will need to be amended in the near future in order to comply with the Federal requirements.

Jobs Impact

The Department does not anticipate that the rules proposed for readoption with amendments and repeals will result in the generation or loss of jobs.

Agriculture Industry Impact

The Department does not expect any impact on the agriculture industry from the rules proposed for readoption with amendments and repeals.

Regulatory Flexibility Analysis

Few, if any, insurers regulated by the rules in this chapter are "small businesses" as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Recordkeeping, reporting and compliance requirements will continue to be imposed by this chapter, which include the filing of enrollment/change request forms, and application/change request forms at Subchapter 3, ODS form and application requirements at Subchapter 4 and reporting requirements related to carrier/provider joint negotiation agreements at Subchapter 7. The Department has determined that all such compliance, recordkeeping and reporting requirements continue to be reasonable and necessary for the purpose for which they were originally proposed. These rules continue to apply to all insurers without regard to size, since they implement statutory provisions and/or regulatory policies that provide significant consumer protections and effective regulatory oversight of carriers. Consequently, the rules do not allow for exceptions based upon business size. The Department is unaware of any provisions of these rules that are excessively onerous to "small businesses" or unnecessary. The Department notes, however, that the proposed readoption of these rules imposes no new recordkeeping, reporting or other compliance requirements, and has eliminated the outdated requirements at Subchapter 3 for health benefits payers to report to the Department on the sequential implementation of their usage of standard transactions, code sets and forms.

Future annual costs of compliance with these rules are not expected to differ from current annual costs. The Department does not anticipate that professional services will be necessary for continued compliance with these rules. To the extent the

use of professional services are necessary, these costs will vary with individual professional services and the need of the insurer.

Smart Growth Impact

The rules proposed for readoption with amendments and repeals will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact

The Department does not expect the rules proposed for readoption with amendments and repeals to have any impact on housing affordability because the rules proposed for readoption with amendments and repeals provide consumer protections and guidance to the insurance industry relating to health insurance.

Smart Growth Development Impact

The Department does not expect the rules proposed for readoption with amendments and repeals to evoke a change in the housing production in Planning Areas 1 and 2 or, within the designated centers, under the State Development and Redevelopment Plan in New Jersey because the rules proposed for readoption with amendments and repeals provide consumer protections and guidance to the insurance industry relating to health insurance.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:22.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:22-3.4, 3.5 and 11:22-3 Appendix Exhibits 1A, 1B and 2.

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

SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

11:22-1.8 Internal and external appeals

(a) Every carrier shall establish an internal appeals mechanism to resolve disputes between carriers or their agents and participating health care providers relating to payment of claims but not including appeals made pursuant to N.J.A.C. [8:38-8.5 through 8.7 and 8:38A-3.6 and 3.7] **11:24-8.5 through 8.7 and 11:24A-3.5 through 3.7**. The internal appeals mechanism shall be described in the participating provider contract.

1. – 2. (No change.)

(b) – (d) (No change.)

SUBCHAPTER 3. ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH CARE CLAIMS

11:22-3.3 Standard enrollment/change request forms and application/change request forms

(a) (No change.)

(b) The [UB-92, HCFA 1450] **UB-04, CMS 1450** (the uniform claim **form** for use by health care institutions and facilities) and the [HCFA 1500] **CMS-1500** (the uniform claim **form** for **use by** health care providers) are recognized and adopted by the Department, in consultation with the New Jersey Department of Health and Senior Services, as the paper standard format for claims by medical institutions, facilities and providers. [These] **Information concerning these** forms [are] **is** located at the website maintained by the [Federal Health Care Financing Administration (www.hcfa.gov/forms/)] **Centers for Medicare and Medicaid Services (CMS), www.cms.gov** and incorporated herein by reference.

(c) The paper standard formats for a universal enrollment/change request form and application/change request form for health insurance coverage [are located at subchapter Appendix Exhibits 1A and 1B and are incorporated herein by reference] **can be accessed via the Department's website at http://www.state.nj.us/dobi/formlist.htm#insuranceformsandapps.**

1. The enrollment/change request form requests or contains the following information:

i. The type of activity (for example, new enrollee/subscriber, a change in covered person(s), removal or termination of a covered person(s) or request for continuation of coverage);

ii. Employee information;

iii. Plan option;

iv. Individuals covered;

v. Pre-existing conditions statement;

vi. Other/previous insurance;

vii. Dependent information;

viii. Race/ethnicity (optional);

ix. Employee signature;

x. Employer verification;

xi. Instructions for completion of the form;

xii. A conditions of enrollment statement; and

xiii. A misrepresentation statement.

2. The application/change request form requests or contains the following information:

i. The type of activity (for example, new enrollee/subscriber, a change in covered person(s) or removal or termination of a covered person(s));

ii. Applicant information;

iii. Plan option;

iv. Individuals covered;

v. Pre-existing conditions statement;

vi. Previous insurance;

vii. Dependent information;

viii. Availability of other coverage;

ix. Race/ethnicity (optional);

x. Payment information;

xi. Applicant signature;

xii. Broker/general agent information;

xiii. Eligibility requirements;

xiv. Instructions for completion of the form;

xv. A conditions of enrollment statement; and

xvi. A misrepresentation statement.

(d) – (e) (No change.)

11:22-[3.6]**3.4** (No change in text.)

11:22-[3.7]**3.5** Additional timetables

[(a) On or before October 1, 2002, all payers shall file with the Department a plan for the sequential implementation of usage of the following standard transactions, code sets and forms described below:

1. 45 CFR 162.1201, Subpart L – Eligibility for a Health Plan;
2. 45 CFR 162.1301, Subpart M – Referral Certification and Authorization;
3. 45 CFR 162.1401, Subpart N – Health Care Claim Status;
4. 45 CFR 162.1601, Subpart P – Health Care Payment and Remittance Advice;
5. 45 CFR 162.1701, Subpart Q – Health Plan Premium Payments;
6. 45 CFR 162.1801, Subpart R – Coordination of Benefits; and

7. 277 Transactions, ANSI ASC X12.317, Version 003070, Release 7, Sub-release O, October 1996, Electronic Health Care Claim Status Notification.

(b) The plan referred to in (a) shall provide for full implementation of a system for the use of those electronic transaction and code sets referred to therein no later than October 16, 2002.]

[(c)] **(a)** In accordance with N.J.A.C. 11:22-1.3, payers receiving an electronically filed claim shall individually acknowledge receipt of each claim by responding with a 277 **Transactions, ANSI ASC X12.317, Version 003070, Release 7, Sub-release O, October 1996, Electronic Health Care Claim Status Notification** acknowledgement [described in (a)7 above]. Nothing in this section shall prevent payers from also using any other responses including, but not limited to, the 997 Functional Acknowledgement of batch transfers in addition to providing a 277 acknowledgement.

[(d)] **(b)** (No change in text.)

11:22-[3.8]**3.6** Use of clearinghouses in electronic transactions

(a) – (d) (No change.)

[(e) Payers shall not be required to comply with the provisions of (b) above until December 2, 2006.]

Recodify existing 11:22-3.9 through 3.11 as **3.7 through 3.9** (No change in text.)