43 NJR 10(2)
October 17, 2011
Filed September 27, 2011

INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Health Benefit Plans

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

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

Proposed: May 16, 2011 at 43 N.J.R. 1236(a).

Adopted: September 20, 2011 by Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Filed: September 21, 2011 as R. 2011 d. 256, **without change.**

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.

Effective Date: September 21, 2011, Readoption;
October 17, 2011, Amendments and Repeals.

Expiration Date: September 21, 2018.

Summary of Public Comments and Agency Responses:

The Department received comments from the Medical Society of New Jersey (MSNJ).

COMMENT: The commenter agreed with the Department that the rules proposed for readoption are essential to the continued delivery of healthcare and claims processing for payment and should not be allowed to lapse. However, the commenter

stated that it believes that rulemaking implementing the Health Claims Authorization, Processing and Payment Act (HCAPPA) enacted in May of 2006 is still necessary to fully implement the law. The commenter stated its appreciation for the Department's issuance of bulletins and answers to frequently asked questions (FAQs) that provided guidance on major new elements of the law, but indicated that the guidance did not address all elements of the law. The commenter provided examples of elements that it believes still need to be addressed by rulemaking.

The commenter stated that the definition of "substantiating" documentation necessary to support claims has not been clarified and that, in the absence of guidelines on the definition, carriers may overreach with documentation requirements. The commenter also stated that a HCAPPA provision, N.J.S.A. 17B:26-9.1d.(10), limits the time period during which carriers may seek overpayments unless there is a pattern of inappropriate billing. Because rulemaking has not clarified what might be an "inappropriate pattern of billing," insurance carriers have freely gone beyond the 18-month time limitation with a mere allegation of an inappropriate billing pattern and, in many cases, the allegations have later been found to have been based on differences in coding interpretations. The commenter further stated that HCAPPA provides that extrapolation may only be used in specified, limited circumstances, one of which is where there is "clear evidence of fraud." The commenter stated that without rulemaking to better define "clear evidence of fraud," and a trigger to use extrapolation, carriers have been free to dangle the allegation of fraud, seek recoupment beyond the 18 month timeframe and exponentially multiply the alleged overpayment amount.

The commenter further stated that the Department's newly-enacted regulation on health insurance identification card standards at N.J.A.C. 11:22-8 has been helpful to physicians and their practices in determining plan requirements. However, the requirement that cards indicate whether a plan is fully insured or self-funded requires additional rulemaking. The commenter stated that physicians and their administrative staff are still unable to make this determination from the face of some of the newly issued identification cards. Since this determines the appropriate appeal process, it is imperative that medical practices be able to quickly make this determination and follow the appropriate appeal path or they are time barred from pursuing legitimate appeals.

The commenter also stated that it supported certain elements of the Federal Affordable Care Act, including the removal of lifetime and annual limits, exclusions for pre-existing conditions and the rescission of healthcare insurance policies. The commenter stated that it will support rulemaking on these issues and urged the Department and carriers to work toward compliance with those requirements in the interim.

RESPONSE: The Department agrees with the commenter that rulemaking is necessary to fully implement the HCAPPA, but the Department determined not to include proposing amendments of such a substantive nature in this proposed chapter readoption. The Department intends to propose rules implementing the HCAPPA at a future date. In the interim, the Department invites the commenter to provide the Department with evidence of any perceived instances of HCAPPA violations on behalf of carriers. Regarding the comment related to the health insurance identification card

rules at N.J.A.C. 11:22-8, the commenter does not indicate what additional rulemaking is needed. The rules at N.J.A.C. 11:22-8.3(b)2 require that ID cards include an indication of whether the plan is insured or self funded. There may be confusion, however, regarding the effective date of the rules. The rules apply to plans that are issued and renewed after the effective date of the rules; ID cards issued after the effective date of the rules are not required to be compliant until the plan renewal date. Accordingly, some ID cards may not currently exhibit all the information required by the rules. The Department invites the commenter to provide the Department with evidence of any perceived violation of the ID card rules. Regarding the Federal Affordable Care Act (ACA), the Department has proposed, and will continue to propose, certain new rules, amendments and repeals as necessary to comply with the provisions of the ACA and the Federal rules promulgated thereunder.

Federal Standards Analysis

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 readopted 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 to restrictions on out-of-network annual and lifetime limits, are more stringent than the new Federal regulations for reasons other than implementing a statutory requirement or a New Jersey specific public policy goal. These rules will be proposed to be amended in the near future in order to comply with the Federal requirements.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 11:22.

Full text of the adopted amendments follows:

TEXT