

LEGISLATIVE HISTORY CHECKLIST

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LAWS of 1999

CHAPTER: 154

NJSA: 17B:30-26 et al

(Health information -- electronic interchange technology incentives and prompt payments of health care claims)

BILL NO: S323 (Substituted for A2119 -- 1st Reprint)

SPONSOR(S): Littell

DATE INTRODUCED: Pre-filed

COMMITTEE:

ASSEMBLY: Appropriations; Health

SENATE: Health

AMENDED DURING PASSAGE: Yes

DATES OF PASSAGE:

ASSEMBLY: January 28, 1999 June 24, 1999

SENATE: January 28, 1999 May 10, 1999

DATE OF APPROVAL: July 1, 1999

THE FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL: Yes Senate Committee Substitute S323, S324, S325, S326, S327, S328, S329, S330, S331 (4R)

(Amendments during passage denoted by superscript numbers)

SCS for S323

SPONSORS STATEMENT: No

COMMITTEE STATEMENT:

ASSEMBLY: Yes

November 9, 1998 (Appropriations)

October 5, 1998 (Health)

SENATE: Yes

March 26, 1998 (Health)

May 21, 1998 (Budget and Appropriations)

FLOOR AMENDMENT STATEMENTS: *Yes*

LEGISLATIVE FISCAL ESTIMATE: *Yes*

3rd REPRINT SCS for S323 etc. (vetoed by Governor) *Yes*

S323

SPONSORS STATEMENT: *Yes* (Begins on page 13 of original bill)

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

A2119

SPONSORS STATEMENT: *Yes* (Begins on page 21 of original bill)

COMMITTEE STATEMENT:

ASSEMBLY:*Yes*

October 5, 1998 (Health)

Identical to Assembly statement of 10-5-98 for S323, S324, S325, S326, S327, S328, S329, S330, S331

November 9, 1998 (Appropriations)

Identical to Assembly statement of 11-9-98 for S323, S324, S325, S326, S327, S328, S329, S330, S331

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S324

SPONSORS STATEMENT: *Yes* (Begins on page 3 of original bill)

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S325

SPONSORS STATEMENT: *Yes (Begins on page 5 of original bill)*

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S326

SPONSORS STATEMENT: *Yes (Begins on page 4 of original bill)*

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S327

SPONSORS STATEMENT: *Yes (Begins on page 7 of original bill)*

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S328

SPONSORS STATEMENT: *Yes (Begins on page 7 of original bill)*

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S329

SPONSORS STATEMENT: *Yes (Begins on page 6 of original bill)*

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S330

SPONSORS STATEMENT: *Yes (Begins on page 4 of original bill)*

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S331

SPONSORS STATEMENT: *Yes (Begins on page 8 of original bill)*

COMMITTEE STATEMENT:

ASSEMBLY:*No*

SENATE:*No*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

GOVERNOR'S ACTIONS

VETO MESSAGE: *Yes*

[Press release with veto message](#)

GOVERNOR'S PRESS RELEASE ON SIGNING: *Yes*

THE FOLLOWING WERE PRINTED:

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REPORTS: *No*

HEARINGS: *No*

NEWSPAPER ARTICLES: *No*

§1 - C.17B:30-23
§2 - C.17:48-8.4
§3 - C.17:48A-7.12
§4 - C.17:48E-10.1
§5 - C.17B:26-9.1
§6 - C.17B:27-44.2
§7 - C.26:2J-8.1
§8 - C.17:48C-8.1
§9 - C.17:48D-9.4
§10 - C.17:48F-13.1
§11 - C.26:1A-15.1
§12 - C.26:1A-15.2
§13 - C.45:1-10.1
§14 - C.26:2H-12.12
§§15-16
C.17B:30-24 &
17B:30-25
§17 - Repealer

P.L. 1999, CHAPTER 154, *approved July 1, 1999*
Senate Committee Substitute (*Fourth Reprint*) for
Senate, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331

1 AN ACT concerning health information electronic data interchange
2 technology ¹[and],¹ supplementing Titles 17, 26 and 54 of the
3 Revised Statutes and Titles 17B and 54A of the New Jersey
4 Statutes ²[¹and making an appropriation]².

5
6 **BE IT ENACTED** by the Senate and General Assembly of the State
7 of New Jersey:

8
9 1. a. (1) The Commissioner of Banking and Insurance, in
10 consultation with the Commissioner of Health and Senior Services,
11 shall establish, by regulation, a timetable for implementation of the
12 electronic receipt and transmission of health care claim information by
13 each hospital, medical or health service corporation, individual and
14 group health insurer, health maintenance organization, dental service
15 corporation, dental plan organization and prepaid prescription service
16 organization, respectively, and a subsidiary of such corporation,
17 insurer or organization that processes health care benefits claims as a
18 third party administrator, authorized to do business in this State.

19 The Commissioner of Banking and Insurance shall establish the
20 timetable within 90 days of the date the federal Department of Health
21 and Human Services adopts rules establishing standards for health care
22 transactions, including: health claims or equivalent encounter

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SBA committee amendments adopted May 21, 1998.

² Assembly AAP committee amendments adopted November 9, 1998.

³ Assembly floor amendments adopted December 17, 1998.

⁴ Senate amendments adopted in accordance with Governor's recommendations March 22, 1999.

1 information, including institutional, professional, pharmacy and dental
2 health claims; enrollment and disenrollment in a health plan; eligibility
3 for a health plan; health care payment and remittance advice; health
4 care premium payments; first report of injury; health claim status; and
5 referral certification and authorization, respectively, pursuant to
6 section 262 of Pub.L.104-191 (42 U.S.C.s.1320d et seq.). The
7 commissioner may adopt more than one timetable, if necessary, to
8 conform the requirements of this section with the dates of adoption of
9 the federal rules.

10 (2) The timetable for implementation adopted by the commissioner
11 shall provide for extensions and waivers of the implementation
12 requirement pursuant to paragraph (1) of this subsection in cases
13 when it has been demonstrated to the commissioner's satisfaction that
14 compliance with the timetable for implementation will result in an
15 undue hardship to a hospital, medical or health service corporation,
16 individual or group health insurer, health maintenance organization,
17 dental service corporation, dental plan organization or prepaid
18 prescription service organization, respectively, or a subsidiary of such
19 corporation, insurer or organization that processes health care benefits
20 claims as a third party administrator, authorized to do business in this
21 State.

22 ¹(3) The Commissioner of Banking and Insurance shall report to
23 the Governor and the Legislature within one year of establishing the
24 timetable pursuant to this subsection, on the number of extensions and
25 wavers of the implementation requirement that he has granted
26 pursuant to paragraph (2) of this subsection, and the reasons therefor.¹

27 b. The Commissioner of Banking and Insurance, in consultation
28 with the Commissioner of Health and Senior Services, shall adopt, by
29 regulation ³for each type of contract, as he deems appropriate³, one
30 set of standard health care enrollment and claim forms in paper and
31 electronic formats to be used by each hospital, medical or health
32 service corporation, individual and group health insurer, health
33 maintenance organization, dental service corporation, dental plan
34 organization and prepaid prescription service organization, and a
35 subsidiary of such corporation, insurer or organization that processes
36 health care benefits claims as a third party administrator, authorized to
37 do business in this State.

38 The Commissioner of Banking and Insurance shall establish the
39 standard health care enrollment and claim forms within 90 days of the
40 date the federal Department of Health and Human Services adopts
41 rules establishing standards for the forms.

42

43 2. a. Within 180 days of the adoption of a timetable for
44 implementation pursuant to section 1 of P.L. , c. (C.)(pending
45 before the Legislature as this bill), a hospital service corporation, or
46 a subsidiary that processes health care benefits claims as a third party

1 administrator, shall demonstrate to the satisfaction of the
2 Commissioner of Banking and Insurance that it will adopt and
3 implement all of the standards to receive and transmit health care
4 transactions electronically, according to the corresponding timetable,
5 and otherwise comply with the provisions of this section,¹ as a
6 condition of its continued authorization to do business in this State.

7 The Commissioner of Banking and Insurance may grant extensions
8 or waivers of the implementation requirement when it has been
9 demonstrated to the commissioner's satisfaction that compliance with
10 the timetable for implementation will result in an undue hardship to a
11 hospital service corporation, its subsidiary or its covered persons.

12 b. Within 12 months of the adoption of regulations establishing
13 standard health care enrollment and claim forms by the Commissioner
14 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
15 (pending before the Legislature as this bill), a hospital service
16 corporation or a subsidiary that processes health care benefits claims
17 as a third party administrator shall use the standard health care
18 enrollment and claim forms in connection with all group and individual
19 contracts issued, delivered, executed or renewed in this State.

20 c. ¹[Effective two years after the effective date of P.L. , c.
21 (C.) (pending before the Legislature as this bill):

22 (1) Twelve months after the adoption of regulations establishing
23 standard health care enrollment and claim forms by the Commissioner
24 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
25 (pending before the Legislature as this bill),¹ a hospital service
26 corporation shall require that health care providers file all claims for
27 payment for health care services. A covered person who receives
28 health care services shall not be required to submit a claim for
29 payment, but notwithstanding the provisions of this subsection to the
30 contrary, a covered person shall be permitted to submit a claim on his
31 own behalf, at the covered person's option

32 ¹[(2) a hospital service corporation shall not restrict the
33 subscriber's right to assign any payment owed to the health care
34 provider; and

35 (3) all]. All¹ claims shall be filed using the standard health care¹
36 claim form applicable to the contract³.

37 d. ³[(1) ¹[For the two-year period beginning on the effective date
38 of P.L. , c. (C.) (pending before the Legislature as this bill)]
39 Twelve months after the adoption of regulations establishing standard
40 health care enrollment and claim forms by the Commissioner of
41 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
42 (pending before the Legislature as this bill)¹, a hospital service
43 corporation shall reimburse all clean claims that are filed electronically
44 by a provider or a subscriber for payment under a group or individual
45 hospital service corporation contract, within ¹[30 days after receipt of
46 the claim by the hospital service corporation] the applicable number

1 of calendar days established for payment of claims in the Medicare
2 program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

3 If a claim or portion of a claim that is submitted electronically is
4 contested or denied by the hospital service corporation, the person or
5 entity who filed the claim shall be notified in writing or electronically,
6 as appropriate, within 30 days after receipt of the claim by the hospital
7 service corporation, that the claim is contested or denied, but the
8 uncontested portion of the claim, if any, shall be paid within 30 days
9 after receipt of the claim by the hospital service corporation. The
10 notice that a claim is contested or denied shall identify the contested
11 portion of the claim and the reasons for contesting or denying the
12 claim.

13 ¹[(2) Effective two years after the effective date of P.L. , c.
14 (C.) (pending before the Legislature as this bill), a hospital service
15 corporation shall reimburse all clean claims that are filed electronically
16 by a provider or a subscriber for payment under a group or individual
17 hospital service corporation contract, within 17 days after receipt of
18 the claim by the hospital service corporation.

19 If a claim or portion of a claim that is submitted electronically is
20 contested or denied by the hospital service corporation, the person or
21 entity who filed the claim shall be notified in writing or electronically,
22 as appropriate, within 17 days after receipt of the claim by the hospital
23 service corporation, that the claim is contested or denied, but the
24 uncontested portion of the claim, if any, shall be paid within 30 days
25 after receipt of the claim by the hospital service corporation. The
26 notice that a claim is contested or denied shall identify the contested
27 portion of the claim and the reasons for contesting or denying the
28 claim.

29 (3)] (2)¹ Payment shall be treated as being made on the date a
30 draft or other valid instrument which is equivalent to payment was
31 placed in the United States mail in a properly addressed, postpaid
32 envelope or, if not so posted, on the date of delivery, or the date of
33 electronic fund transfer. An overdue payment shall bear simple
34 interest at the rate of 10% per year.

35 ¹[(4)] (3)¹ For the purposes of this section, "clean claim" has the
36 same meaning given the term in the federal Medicare program
37 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

38 (1) Effective 180 days after the effective date of P.L. , c.
39 (pending before the Legislature as this bill), a hospital service
40 corporation or its agent, hereinafter the payer, shall remit payment for
41 every insured claim submitted by a subscriber or that subscriber's
42 agent or assignee if the contract provides for assignment of benefits,
43 no later than the 30th calendar day following receipt of the claim by
44 the payer or no later than the time limit established for the payment of
45 claims in the Medicare program pursuant to
46 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is

- 1 submitted by electronic means, and no later than the 40th calendar day
2 following receipt if the claim is submitted by other than electronic
3 means, if:
- 4 (a) the claim is an eligible claim for a health care service provided
5 by an eligible health care provider to a covered person under the
6 contract;
- 7 (b) the claim has no material defect or impropriety, including, but
8 not limited to, any lack of required substantiating documentation or
9 incorrect coding;
- 10 (c) there is no dispute regarding the amount claimed;
- 11 (d) the payer has no reason to believe that the claim has been
12 submitted fraudulently; and
- 13 (e) the claim requires no special treatment that prevents timely
14 payments from being made on the claim under the terms of the
15 contract.
- 16 (2) If all or a portion of the claim is denied by the payer because:
- 17 (a) the claim is an ineligible claim;
- 18 (b) the claim submission is incomplete because the required
19 substantiating documentation has not been submitted to the payer;
- 20 (c) the diagnosis coding, procedure coding, or any other required
21 information to be submitted with the claim is incorrect;
- 22 (d) the payer disputes the amount claimed; or
- 23 (e) the claim requires special treatment that prevents timely
24 payments from being made on the claim under the terms of the
25 contract,
- 26 the payer shall notify the subscriber, or that subscriber's agent or
27 assignee if the contract provides for assignment of benefits, in writing
28 or by electronic means, as appropriate, within 30 days, of the
29 following: if all or a portion of the claim is denied, all the reasons for
30 the denial; if the claim lacks the required substantiating
31 documentation, including incorrect coding, a statement as to what
32 substantiating documentation or other information is required to
33 complete adjudication of the claim; if the amount of the claim is
34 disputed, a statement that it is disputed; and if the claim requires
35 special treatment that prevents timely payments from being made, a
36 statement of the special treatment to which the claim is subject.
- 37 (3) Any portion of a claim that meets the criteria established in
38 paragraph (1) of this subsection shall be paid by the payer in
39 accordance with the time limit established in paragraph (1) of this
40 subsection.
- 41 (4) A payer shall acknowledge receipt of a claim submitted by
42 electronic means from a health care provider or subscriber, no later
43 than two working days following receipt of the transmission of the
44 claim.
- 45 (5) If a payer subject to the provisions of P.L.1983, c.320
46 (C.17:33A-1 et seq.) has reason to believe that a claim has been

1 submitted fraudulently, it shall investigate the claim in accordance with
2 its fraud prevention plan established pursuant to section 1 of P.L.1993,
3 c.362 (C.17:33A-15), or refer the claim, together with supporting
4 documentation, to the Office of the Insurance Fraud Prosecutor in the
5 Department of Law and Public Safety established pursuant to section
6 32 of P.L.1998, c.21 (C.17:33A-16).

7 (6) Payment of an eligible claim pursuant to paragraphs (1) and
8 (3) of this subsection shall be deemed to be overdue if not remitted to
9 the claimant or his agent by the payer on or before the 30th calendar
10 day or the time limit established by the Medicare program, whichever
11 is earlier, following receipt by the payer of a claim submitted by
12 electronic means and on or before the 40th calendar day following
13 receipt of a claim submitted by other than electronic means.

14 In the event payment is withheld on all or a portion of a claim by
15 a payer pursuant to subparagraph (b) of paragraph (2) of this
16 subsection, the claims payment shall be overdue if not remitted to the
17 claimant or his agent by the payer on or before the 30th calendar day
18 or the time limit established by the Medicare program, whichever is
19 earlier, for claims submitted by electronic means and the 40th calendar
20 day for claims submitted by other than electronic means, following
21 receipt by the payer of the required documentation or modification of
22 an initial submission.

23 (7) An overdue payment shall bear simple interest at the rate of
24 10% per annum.

25 e. As used in this subsection, "insured claim" or "claim" means a
26 claim by a subscriber for payment of benefits under an insured
27 hospital service corporation contract for which the financial obligation
28 for the payment of a claim under the contract rests upon the hospital
29 service corporation.³

30
31 3. a. Within 180 days of the adoption of a timetable for
32 implementation pursuant to section 1 of P.L. , c. (C.)(pending
33 before the Legislature as this bill), a medical service corporation, or a
34 subsidiary that processes health care benefits claims as a third party
35 administrator, shall demonstrate to the satisfaction of the
36 Commissioner of Banking and Insurance that it will adopt and
37 implement all of the standards to receive and transmit health care
38 transactions electronically, according to the corresponding timetable,
39 ¹and otherwise comply with the provisions of this section, ¹as a
40 condition of its continued authorization to do business in this State.

41 The Commissioner of Banking and Insurance may grant extensions
42 or waivers of the implementation requirement when it has been
43 demonstrated to the commissioner's satisfaction that compliance with
44 the timetable for implementation will result in an undue hardship to a
45 medical service corporation, its subsidiary or its covered persons.

46 b. Within 12 months of the adoption of regulations establishing

1 standard health care enrollment and claim forms by the Commissioner
2 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
3 (pending before the Legislature as this bill), a medical service
4 corporation or a subsidiary that processes health care benefits claims
5 as a third party administrator shall use the standard health care
6 enrollment and claim forms in connection with all group and individual
7 contracts issued, delivered, executed or renewed in this State.

8 c. ¹[Effective two years after the effective date of P.L. , c.
9 (C.) (pending before the Legislature as this bill):

10 (1) Twelve months after the adoption of regulations establishing
11 standard health care enrollment and claim forms by the Commissioner
12 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
13 (pending before the Legislature as this bill),¹ a medical service
14 corporation shall require that health care providers file all claims for
15 payment for health care services. A covered person who receives
16 health care services shall not be required to submit a claim for
17 payment, but notwithstanding the provisions of this subsection to the
18 contrary, a covered person shall be permitted to submit a claim on his
19 own behalf, at the covered person's option

20 ¹[(2) a medical service corporation shall not restrict the
21 subscriber's right to assign any payment owed to the health care
22 provider; and

23 (3) all] . All¹ claims shall be filed using the standard ¹health care¹
24 claim form ³applicable to the contract³.

25 d. ³[(1) ¹[For the two-year period beginning on the effective date
26 of P.L. , c. (C.)(pending before the Legislature as this bill)]
27 Twelve months after the adoption of regulations establishing standard
28 health care enrollment and claim forms by the Commissioner of
29 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
30 (pending before the Legislature as this bill)¹, a medical service
31 corporation shall reimburse all clean claims that are filed electronically
32 by a provider or a subscriber for payment under a group or individual
33 medical service corporation contract, within ¹[30 days after receipt of
34 the claim by the medical service corporation] the applicable number
35 of calendar days established for payment of claims in the Medicare
36 program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

37 If a claim or portion of a claim that is submitted electronically is
38 contested or denied by the medical service corporation, the person or
39 entity who filed the claim shall be notified in writing or electronically,
40 as appropriate, within 30 days after receipt of the claim by the medical
41 service corporation, that the claim is contested or denied, but the
42 uncontested portion of the claim, if any, shall be paid within 30 days
43 after receipt of the claim by the medical service corporation. The
44 notice that a claim is contested or denied shall identify the contested
45 portion of the claim and the reasons for contesting or denying the
46 claim.

1 ¹[(2) Effective two years after the effective date of P.L. , c.
2 (C.) (pending before the Legislature as this bill), a medical service
3 corporation shall reimburse all clean claims that are filed electronically
4 by a provider or a subscriber for payment under a group or individual
5 medical service corporation contract, within 17 days after receipt of
6 the claim by the medical service corporation.

7 If a claim or portion of a claim that is submitted electronically is
8 contested or denied by the medical service corporation, the person or
9 entity who filed the claim shall be notified in writing or electronically,
10 as appropriate, within 17 days after receipt of the claim by the medical
11 service corporation, that the claim is contested or denied, but the
12 uncontested portion of the claim, if any, shall be paid within 30 days
13 after receipt of the claim by the medical service corporation. The
14 notice that a claim is contested or denied shall identify the contested
15 portion of the claim and the reasons for contesting or denying the
16 claim.

17 (3)] (2)¹ Payment shall be treated as being made on the date a
18 draft or other valid instrument which is equivalent to payment was
19 placed in the United States mail in a properly addressed, postpaid
20 envelope or, if not so posted, on the date of delivery, or the date of
21 electronic fund transfer. An overdue payment shall bear simple
22 interest at the rate of 10% per year.

23 ¹[(4)] (3)¹ For the purposes of this section, "clean claim" has the
24 same meaning given the term in the federal Medicare program
25 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

26 (1) Effective 180 days after the effective date of P.L. , c.
27 (pending before the Legislature as this bill), a medical service
28 corporation or its agent, hereinafter the payer, shall remit payment for
29 every insured claim submitted by a subscriber or that subscriber's
30 agent or assignee if the contract provides for assignment of benefits,
31 no later than the 30th calendar day following receipt of the claim by
32 the payer or no later than the time limit established for the payment of
33 claims in the Medicare program pursuant to
34 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
35 submitted by electronic means, and no later than the 40th calendar day
36 following receipt if the claim is submitted by other than electronic
37 means, if:

38 (a) the claim is an eligible claim for a health care service provided
39 by an eligible health care provider to a covered person under the
40 contract;

41 (b) the claim has no material defect or impropriety, including, but
42 not limited to, any lack of required substantiating documentation or
43 incorrect coding;

44 (c) there is no dispute regarding the amount claimed;

45 (d) the payer has no reason to believe that the claim has been
46 submitted fraudulently; and

- 1 (e) the claim requires no special treatment that prevents timely
2 payments from being made on the claim under the terms of the
3 contract.
- 4 (2) If all or a portion of the claim is denied by the payer because:
5 (a) the claim is an ineligible claim;
6 (b) the claim submission is incomplete because the required
7 substantiating documentation has not been submitted to the payer;
8 (c) the diagnosis coding, procedure coding, or any other required
9 information to be submitted with the claim is incorrect;
10 (d) the payer disputes the amount claimed; or
11 (e) the claim requires special treatment that prevents timely
12 payments from being made on the claim under the terms of the
13 contract, the payer shall notify the subscriber, or that subscriber's
14 agent or assignee if the contract provides for assignment of benefits,
15 in writing or by electronic means, as appropriate, within 30 days, of
16 the following: if all or a portion of the claim is denied, all the reasons
17 for the denial; if the claim lacks the required substantiating
18 documentation, including incorrect coding, a statement as to what
19 substantiating documentation or other information is required to
20 complete adjudication of the claim; if the amount of the claim is
21 disputed, a statement that it is disputed; and if the claim requires
22 special treatment that prevents timely payments from being made, a
23 statement of the special treatment to which the claim is subject.
- 24 (3) Any portion of a claim that meets the criteria established in
25 paragraph (1) of this subsection shall be paid by the payer in
26 accordance with the time limit established in paragraph (1) of this
27 subsection.
- 28 (4) A payer shall acknowledge receipt of a claim submitted by
29 electronic means from a health care provider or subscriber, no later
30 than two working days following receipt of the transmission of the
31 claim.
- 32 (5) If a payer subject to the provisions of P.L.1983, c.320
33 (C.17:33A-1 et seq.) has reason to believe that a claim has been
34 submitted fraudulently, it shall investigate the claim in accordance with
35 its fraud prevention plan established pursuant to section 1 of P.L.1993,
36 c.362 (C.17:33A-15), or refer the claim, together with supporting
37 documentation, to the Office of the Insurance Fraud Prosecutor in the
38 Department of Law and Public Safety established pursuant to section
39 32 of P.L.1998, c.21 (C.17:33A-16).
- 40 (6) Payment of an eligible claim pursuant to paragraphs (1) and
41 (3) of this subsection shall be deemed to be overdue if not remitted to
42 the claimant or his agent by the payer on or before the 30th calendar
43 day or the time limit established by the Medicare program, whichever
44 is earlier, following receipt by the payer of a claim submitted by
45 electronic means and on or before the 40th calendar day following
46 receipt of a claim submitted by other than electronic means.

1 In the event payment is withheld on all or a portion of a claim by
2 a payer pursuant to subparagraph (b) of paragraph (2) of this
3 subsection, the claims payment shall be overdue if not remitted to the
4 claimant or his agent by the payer on or before the 30th calendar day
5 or the time limit established by the Medicare program, whichever is
6 earlier, for claims submitted by electronic means and the 40th calendar
7 day for claims submitted by other than electronic means, following
8 receipt by the payer of the required documentation or modification of
9 an initial submission.

10 (7) An overdue payment shall bear simple interest at the rate of
11 10% per annum.

12 e. As used in this subsection, "insured claim" or "claim" means a
13 claim by a subscriber for payment of benefits under an insured medical
14 service corporation contract for which the financial obligation for the
15 payment of a claim under the contract rests upon the medical service
16 corporation.³

17
18 4. a. Within 180 days of the adoption of a timetable for
19 implementation pursuant to section 1 of P.L. , c. (C.)(pending
20 before the Legislature as this bill), a health service corporation, or a
21 subsidiary that processes health care benefits claims as a third party
22 administrator, shall demonstrate to the satisfaction of the
23 Commissioner of Banking and Insurance that it will adopt and
24 implement all of the standards to receive and transmit health care
25 transactions electronically, according to the corresponding timetable,
26 ¹and otherwise comply with the provisions of this section,¹ as a
27 condition of its continued authorization to do business in this State.

28 The Commissioner of Banking and Insurance may grant extensions
29 or waivers of the implementation requirement when it has been
30 demonstrated to the commissioner's satisfaction that compliance with
31 the timetable for implementation will result in an undue hardship to a
32 health service corporation, its subsidiary or its covered persons.

33 b. Within 12 months of the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
36 (pending before the Legislature as this bill), a health service
37 corporation or a subsidiary that processes health care benefits claims
38 as a third party administrator shall use the standard health care
39 enrollment and claim forms in connection with all group and individual
40 contracts issued, delivered, executed or renewed in this State.

41 c. ¹[Effective two years after the effective date of P.L. , c.
42 (C.) (pending before the Legislature as this bill):

43 (1) Twelve months after the adoption of regulations establishing
44 standard health care enrollment and claim forms by the Commissioner
45 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
46 (pending before the Legislature as this bill),¹ a health service

1 corporation shall require that health care providers file all claims for
2 payment for health care services. A covered person who receives
3 health care services shall not be required to submit a claim for
4 payment, but notwithstanding the provisions of this subsection to the
5 contrary, a covered person shall be permitted to submit a claim on his
6 own behalf, at the covered person's option

7 ¹[(2) a health service corporation shall not restrict the subscriber's
8 right to assign any payment owed to the health care provider; and

9 (3) all] . All¹ claims shall be filed using the standard ¹health care¹
10 claim form ³applicable to the contract³.

11 d.³[(1) ¹[For the two-year period beginning on the effective date
12 of P.L. , c. (C.)(pending before the Legislature as this
13 bill)]Twelve months after the adoption of regulations establishing
14 standard health care enrollment and claim forms by the Commissioner
15 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
16 (pending before the Legislature as this bill)¹, a health service
17 corporation shall reimburse all clean claims that are filed electronically
18 by a provider or a subscriber¹[,]¹ for payment under a group or
19 individual health service corporation contract, within ¹[30 days after
20 receipt of the claim by the health service corporation] the applicable
21 number of calendar days established for payment of claims in the
22 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

23 If a claim or portion of a claim that is submitted electronically is
24 contested or denied by the health service corporation, the person or
25 entity who filed the claim shall be notified in writing or electronically,
26 as appropriate, within 30 days after receipt of the claim by the health
27 service corporation, that the claim is contested or denied, but the
28 uncontested portion of the claim, if any, shall be paid within 30 days
29 after receipt of the claim by the health service corporation. The notice
30 that a claim is contested or denied shall identify the contested portion
31 of the claim and the reasons for contesting or denying the claim.

32 ¹[(2) Effective two years after the effective date of P.L. , c.
33 (C.) (pending before the Legislature as this bill), a health service
34 corporation shall reimburse all clean claims that are filed electronically
35 by a provider or a subscriber, for payment under a group or individual
36 health service corporation contract, within 17 days after receipt of the
37 claim by the health service corporation.

38 If a claim or portion of a claim that is submitted electronically is
39 contested or denied by the health service corporation, the person or
40 entity who filed the claim shall be notified in writing or electronically,
41 as appropriate, within 17 days after receipt of the claim by the health
42 service corporation, that the claim is contested or denied, but the
43 uncontested portion of the claim, if any, shall be paid within 30 days
44 after receipt of the claim by the health service corporation. The notice
45 that a claim is contested or denied shall identify the contested portion
46 of the claim and the reasons for contesting or denying the claim.

1 (3)] (2)¹ Payment shall be treated as being made on the date a
2 draft or other valid instrument which is equivalent to payment was
3 placed in the United States mail in a properly addressed, postpaid
4 envelope or, if not so posted, on the date of delivery, or the date of
5 electronic fund transfer. An overdue payment shall bear simple
6 interest at the rate of 10% per year.

7 ¹[(4)] (3)¹ For the purposes of this section, "clean claim" has the
8 same meaning given the term in the federal Medicare program
9 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

10 (1) Effective 180 days after the effective date of P.L. , c.
11 (pending before the Legislature as this bill), a health service
12 corporation or its agent, hereinafter the payer, shall remit payment for
13 every insured claim submitted by a subscriber or that subscriber's
14 agent or assignee if the contract provides for assignment of benefits,
15 no later than the 30th calendar day following receipt of the claim by
16 the payer or no later than the time limit established for the payment
17 of claims in the Medicare program pursuant to
18 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
19 submitted by electronic means, and no later than the 40th calendar day
20 following receipt if the claim is submitted by other than electronic
21 means, if:

22 (a) the claim is an eligible claim for a health care service provided
23 by an eligible health care provider to a covered person under the
24 contract;

25 (b) the claim has no material defect or impropriety, including, but
26 not limited to, any lack of required substantiating documentation or
27 incorrect coding;

28 (c) there is no dispute regarding the amount claimed;

29 (d) the payer has no reason to believe that the claim has been
30 submitted fraudulently; and

31 (e) the claim requires no special treatment that prevents timely
32 payments from being made on the claim under the terms of the
33 contract.

34 (2) If all or a portion of the claim is denied by the payer because:

35 (a) the claim is an ineligible claim;

36 (b) the claim submission is incomplete because the required
37 substantiating documentation has not been submitted to the payer;

38 (c) the diagnosis coding, procedure coding, or any other required
39 information to be submitted with the claim is incorrect;

40 (d) the payer disputes the amount claimed; or

41 (e) the claim requires special treatment that prevents timely
42 payments from being made on the claim under the terms of the
43 contract, the payer shall notify the subscriber, or that subscriber's
44 agent or assignee if the contract provides for assignment of benefits,
45 in writing or by electronic means, as appropriate, within 30 days, of
46 the following: if all or a portion of the claim is denied, all the reasons

1 for the denial; if the claim lacks the required substantiating
2 documentation, including incorrect coding, a statement as to what
3 substantiating documentation or other information is required to
4 complete adjudication of the claim; if the amount of the claim is
5 disputed, a statement that it is disputed; and if the claim requires
6 special treatment that prevents timely payments from being made, a
7 statement of the special treatment to which the claim is subject.

8 (3) Any portion of a claim that meets the criteria established in
9 paragraph (1) of this subsection shall be paid by the payer in
10 accordance with the time limit established in paragraph (1) of this
11 subsection.

12 (4) A payer shall acknowledge receipt of a claim submitted by
13 electronic means from a health care provider or subscriber, no later
14 than two working days following receipt of the transmission of the
15 claim.

16 (5) If a payer subject to the provisions of P.L.1983, c.320
17 (C.17:33A-1 et seq.) has reason to believe that a claim has been
18 submitted fraudulently, it shall investigate the claim in accordance with
19 its fraud prevention plan established pursuant to section 1 of P.L.1993,
20 c.362 (C.17:33A-15), or refer the claim, together with supporting
21 documentation, to the Office of the Insurance Fraud Prosecutor in the
22 Department of Law and Public Safety established pursuant to section
23 32 of P.L.1998, c.21 (C.17:33A-16).

24 (6) Payment of an eligible claim pursuant to paragraphs (1) and
25 (3) of this subsection shall be deemed to be overdue if not remitted to
26 the claimant or his agent by the payer on or before the 30th calendar
27 day or the time limit established by the Medicare program, whichever
28 is earlier, following receipt by the payer of a claim submitted by
29 electronic means and on or before the 40th calendar day following
30 receipt of a claim submitted by other than electronic means.

31 In the event payment is withheld on all or a portion of a claim by
32 a payer pursuant to subparagraph (b) of paragraph (2) of this
33 subsection, the claims payment shall be overdue if not remitted to the
34 claimant or his agent by the payer on or before the 30th calendar day
35 or the time limit established by the Medicare program, whichever is
36 earlier, for claims submitted by electronic means and the 40th calendar
37 day for claims submitted by other than electronic means, following
38 receipt by the payer of the required documentation or modification of
39 an initial submission.

40 (7) An overdue payment shall bear simple interest at the rate of
41 10% per annum.

42 e. As used in this subsection, "insured claim" or "claim" means a
43 claim by a subscriber for payment of benefits under an insured health
44 service corporation contract for which the financial obligation for the
45 payment of a claim under the contract rests upon the health service
46 corporation.³

1 5. a. Within 180 days of the adoption of a timetable for
2 implementation pursuant to section 1 of P.L. , c. (C.)(pending
3 before the Legislature as this bill), a health insurer, or a subsidiary that
4 processes health care benefits claims as a third party administrator,
5 shall demonstrate to the satisfaction of the Commissioner of Banking
6 and Insurance that it will adopt and implement all of the standards to
7 receive and transmit health care transactions electronically, according
8 to the corresponding timetable, ¹and otherwise comply with the
9 provisions of this section.¹ as a condition of its continued
10 authorization to do business in this State.

11 The Commissioner of Banking and Insurance may grant extensions
12 or waivers of the implementation requirement when it has been
13 demonstrated to the commissioner's satisfaction that compliance with
14 the timetable for implementation will result in an undue hardship to a
15 health insurer, its subsidiary or its covered persons.

16 b. Within 12 months of the adoption of regulations establishing
17 standard health care enrollment and claim forms by the Commissioner
18 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
19 (pending before the Legislature as this bill), a health insurer or a
20 subsidiary that processes health care benefits claims as a third party
21 administrator shall use the standard health care enrollment and claim
22 forms in connection with all individual policies issued, delivered,
23 executed or renewed in this State.

24 c. ¹[Effective two years after the effective date of P.L. ,
25 c. (C.) (pending before the Legislature as this bill):

26 (1)] Twelve months after the adoption of regulations establishing
27 standard health care enrollment and claim forms by the Commissioner
28 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
29 (pending before the Legislature as this bill),¹ a health insurer shall
30 require that health care providers file all claims for payment for health
31 care services. A covered person who receives health care services
32 shall not be required to submit a claim for payment, but
33 notwithstanding the provisions of this subsection to the contrary, a
34 covered person shall be permitted to submit a claim on his own behalf,
35 at the covered person's option

36 ¹[(2) a health insurer shall not restrict the insured's right to assign
37 any payment owed to the health care provider; and

38 (3) all]. All¹ claims shall be filed using the standard ¹health care¹
39 claim form ³applicable to the policy³.

40 d. ³[Notwithstanding the provisions of section 78 of P.L.1991,
41 c.187 (C.17B:26-12.1) to the contrary,

42 (1) ¹[For the two-year period beginning on the effective date of
43 P.L. , c. (C.)(pending before the Legislature as this bill)] Twelve
44 months after the adoption of regulations establishing standard health
45 care enrollment and claim forms by the Commissioner of Banking and
46 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before

1 the Legislature as this bill)¹, a health insurer shall reimburse all clean
 2 claims that are filed electronically by a provider or an insured for
 3 payment under an individual policy, within ¹[30 days after receipt of
 4 the claim by the insurer] the applicable number of calendar days
 5 established for payment of claims in the Medicare program pursuant
 6 to 42 U.S.C.s.1395u(c)(2)(B)¹.

7 If a claim or portion of a claim that is submitted electronically is
 8 contested or denied by the insurer, the person or entity who filed the
 9 claim shall be notified in writing or electronically, as appropriate,
 10 within 30 days after receipt of the claim by the insurer, that the claim
 11 is contested or denied, but the uncontested portion of the claim, if any,
 12 shall be paid within 30 days after receipt of the claim by the insurer.
 13 The notice that a claim is contested or denied shall identify the
 14 contested portion of the claim and the reasons for contesting or
 15 denying the claim.

16 ¹[(2) Effective two years after the effective date of P.L. , c.
 17 (C.) (pending before the Legislature as this bill), a health insurer
 18 shall reimburse all clean claims that are filed electronically by a
 19 provider or an insured for payment under an individual policy, within
 20 17 days after receipt of the claim by the insurer.

21 If a claim or portion of a claim that is submitted electronically is
 22 contested or denied by the insurer, the person or entity who filed the
 23 claim shall be notified in writing or electronically, as appropriate,
 24 within 17 days after receipt of the claim by the insurer, that the claim
 25 is contested or denied, but the uncontested portion of the claim, if any,
 26 shall be paid within 30 days after receipt of the claim by the insurer.
 27 The notice that a claim is contested or denied shall identify the
 28 contested portion of the claim and the reasons for contesting or
 29 denying the claim.

30 (3)] (2)¹ Payment shall be treated as being made on the date a
 31 draft or other valid instrument which is equivalent to payment was
 32 placed in the United States mail in a properly addressed, postpaid
 33 envelope or, if not so posted, on the date of delivery, or the date of
 34 electronic fund transfer. An overdue payment shall bear simple
 35 interest at the rate of 10% per year.

36 ¹[(4)] (3)¹ For the purposes of this section, "clean claim" has the
 37 same meaning given the term in the federal Medicare program
 38 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

39 (1) Effective 180 days after the effective date of P.L. , c.
 40 (pending before the Legislature as this bill), a health insurer or its
 41 agent, hereinafter the payer, shall remit payment for every insured
 42 claim submitted by an insured or that insured's agent or assignee if the
 43 policy provides for assignment of benefits, no later than the 30th
 44 calendar day following receipt of the claim by the payer or no later
 45 than the time limit established for the payment of claims in the
 46 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever

1 is earlier, if the claim is submitted by electronic means, and no later
2 than the 40th calendar day following receipt if the claim is submitted
3 by other than electronic means, if:
4 (a) the claim is an eligible claim for a health care service provided
5 by an eligible health care provider to a covered person under the
6 policy;
7 (b) the claim has no material defect or impropriety, including, but
8 not limited to, any lack of required substantiating documentation or
9 incorrect coding;
10 (c) there is no dispute regarding the amount claimed;
11 (d) the payer has no reason to believe that the claim has been
12 submitted fraudulently; and
13 (e) the claim requires no special treatment that prevents timely
14 payments from being made on the claim under the terms of the policy.
15 (2) If all or a portion of the claim is denied by the payer because:
16 (a) the claim is an ineligible claim;
17 (b) the claim submission is incomplete because the required
18 substantiating documentation has not been submitted to the payer;
19 (c) the diagnosis coding, procedure coding, or any other required
20 information to be submitted with the claim is incorrect;
21 (d) the payer disputes the amount claimed; or
22 (e) the claim requires special treatment that prevents timely
23 payments from being made on the claim under the terms of the policy,
24 the payer shall notify the insured, or that insured's agent or assignee
25 if the policy provides for assignment of benefits, in writing or by
26 electronic means, as appropriate, within 30 days, of the following: if
27 all or a portion of the claim is denied, all the reasons for the denial; if
28 the claim lacks the required substantiating documentation, including
29 incorrect coding, a statement as to what substantiating documentation
30 or other information is required to complete adjudication of the claim;
31 if the amount of the claim is disputed, a statement that it is disputed;
32 and if the claim requires special treatment that prevents timely
33 payments from being made, a statement of the special treatment to
34 which the claim is subject.
35 (3) Any portion of a claim that meets the criteria established in
36 paragraph (1) of this subsection shall be paid by the payer in
37 accordance with the time limit established in paragraph (1) of this
38 subsection.
39 (4) A payer shall acknowledge receipt of a claim submitted by
40 electronic means from a health care provider or insured, no later than
41 two working days following receipt of the transmission of the claim.
42 (5) If a payer subject to the provisions of P.L.1983, c.320
43 (C.17:33A-1 et seq.) has reason to believe that a claim has been
44 submitted fraudulently, it shall investigate the claim in accordance with
45 its fraud prevention plan established pursuant to section 1 of P.L.1993,
46 c.362 (C.17:33A-15), or refer the claim, together with supporting

1 documentation, to the Office of the Insurance Fraud Prosecutor in the
2 Department of Law and Public Safety established pursuant to section
3 32 of P.L.1998, c.21 (C.17:33A-16).

4 (6) Payment of an eligible claim pursuant to paragraphs (1) and
5 (3) of this subsection shall be deemed to be overdue if not remitted to
6 the claimant or his agent by the payer on or before the 30th calendar
7 day or the time limit established by the Medicare program, whichever
8 is earlier, following receipt by the payer of a claim submitted by
9 electronic means and on or before the 40th calendar day following
10 receipt of a claim submitted by other than electronic means.

11 In the event payment is withheld on all or a portion of a claim by
12 a payer pursuant to subparagraph (b) of paragraph (2) of this
13 subsection, the claims payment shall be overdue if not remitted to the
14 claimant or his agent by the payer on or before the 30th calendar day
15 or the time limit established by the Medicare program, whichever is
16 earlier, for claims submitted by electronic means and the 40th calendar
17 day for claims submitted by other than electronic means, following
18 receipt by the payer of the required documentation or modification of
19 an initial submission.

20 (7) An overdue payment shall bear simple interest at the rate of
21 10% per annum.

22 e. As used in this subsection, "insured claim" or "claim" means a
23 claim by an insured for payment of benefits under an insured policy
24 for which the financial obligation for the payment of a claim under the
25 policy rests upon the health insurer.³

26
27 6. a. Within 180 days of the adoption of a timetable for
28 implementation pursuant to section 1 of P.L. , c. (C.)(pending
29 before the Legislature as this bill), a health insurer, or a subsidiary that
30 processes health care benefits claims as a third party administrator,
31 shall demonstrate to the satisfaction of the Commissioner of Banking
32 and Insurance that it will adopt and implement all of the standards to
33 receive and transmit health care transactions electronically, according
34 to the corresponding timetable, and otherwise comply with the
35 provisions of this section,¹ as a condition of its continued
36 authorization to do business in this State.

37 The Commissioner of Banking and Insurance may grant extensions
38 or waivers of the implementation requirement when it has been
39 demonstrated to the commissioner's satisfaction that compliance with
40 the timetable for implementation will result in an undue hardship to a
41 health insurer, its subsidiary or its covered persons.

42 b. Within 12 months of the adoption of regulations establishing
43 standard health care enrollment and claim forms by the Commissioner
44 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
45 (pending before the Legislature as this bill), a health insurer or a
46 subsidiary that processes health care benefits claims as a third party

1 administrator shall use the standard health care enrollment and claim
2 forms in connection with all group ³[contracts] policies³ issued,
3 delivered, executed or renewed in this State.

4 c. ¹[Effective two years after the effective date of P.L. , c.
5 (C.) (pending before the Legislature as this bill):

6 (1)] Twelve months after the adoption of regulations establishing
7 standard health care enrollment and claim forms by the Commissioner
8 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
9 (pending before the Legislature as this bill),¹ a health insurer shall
10 require that health care providers file all claims for payment for health
11 care services. A covered person who receives health care services
12 shall not be required to submit a claim for payment, but
13 notwithstanding the provisions of this subsection to the contrary, a
14 covered person shall be permitted to submit a claim on his own behalf,
15 at the covered person's option.

16 ¹[(2) a health insurer shall not restrict the insured's right to assign
17 any payment owed to the health care provider; and

18 (3) all]. All¹ claims shall be filed using the standard ¹health care¹
19 claim form ³applicable to the policy³.

20 d. ³[Notwithstanding the provisions of section 79 of P.L.1991,
21 c.187 (C.17B:27-44.1) to the contrary,

22 (1) ¹[For the two-year period beginning on the effective date of
23 P.L. , c. (C.)(pending before the Legislature as this bill)] Twelve
24 months after the adoption of regulations establishing standard health
25 care enrollment and claim forms by the Commissioner of Banking and
26 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before
27 the Legislature as this bill),¹ a health insurer shall reimburse all clean
28 claims that are filed electronically by a provider or an insured for
29 payment under a group policy, within ¹[30 days after receipt of the
30 claim by the insurer] the applicable number of calendar days
31 established for payment of claims in the Medicare program pursuant
32 to 42 U.S.C.s.1395u(c)(2)(B)¹.

33 If a claim or portion of a claim that is submitted electronically is
34 contested or denied by the insurer, the person or entity who filed the
35 claim shall be notified in writing or electronically, as appropriate,
36 within 30 days after receipt of the claim by the insurer, that the claim
37 is contested or denied, but the uncontested portion of the claim, if any,
38 shall be paid within 30 days after receipt of the claim by the insurer.
39 The notice that a claim is contested or denied shall identify the
40 contested portion of the claim and the reasons for contesting or
41 denying the claim.

42 ¹[(2) Effective two years after the effective date of P.L. , c.
43 (C.) (pending before the Legislature as this bill), a health insurer
44 shall reimburse all clean claims that are filed electronically by a
45 provider or an insured for payment under a group policy, within 17

1 days after receipt of the claim by the insurer.

2 If a claim or portion of a claim that is submitted electronically is
3 contested or denied by the insurer, the person or entity who filed the
4 claim shall be notified in writing or electronically, as appropriate,
5 within 17 days after receipt of the claim by the insurer, that the claim
6 is contested or denied, but the uncontested portion of the claim, if any,
7 shall be paid within 30 days after receipt of the claim by the insurer.
8 The notice that a claim is contested or denied shall identify the
9 contested portion of the claim and the reasons for contesting or
10 denying the claim.

11 (3) (2)¹ Payment shall be treated as being made on the date a
12 draft or other valid instrument which is equivalent to payment was
13 placed in the United States mail in a properly addressed, postpaid
14 envelope or, if not so posted, on the date of delivery, or the date of
15 electronic fund transfer. An overdue payment shall bear simple
16 interest at the rate of 10% per year.

17 ¹[(4)] (3)¹ For the purposes of this section, "clean claim" has the
18 same meaning given the term in the federal Medicare program
19 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

20 (1) Effective 180 days after the effective date of P.L. , c.
21 (pending before the Legislature as this bill), a health insurer or its
22 agent, hereinafter the payer, shall remit payment for every insured
23 claim submitted by an insured or that insured's agent or assignee if the
24 policy provides for assignment of benefits, no later than the 30th
25 calendar day following receipt of the claim by the payer or no later
26 than the time limit established for the payment of claims in the
27 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever
28 is earlier, if the claim is submitted by electronic means, and no later
29 than the 40th calendar day following receipt if the claim is submitted
30 by other than electronic means, if:

31 (a) the claim is an eligible claim for a health care service provided
32 by an eligible health care provider to a covered person under the
33 policy;

34 (b) the claim has no material defect or impropriety, including, but
35 not limited to, any lack of required substantiating documentation or
36 incorrect coding;

37 (c) there is no dispute regarding the amount claimed;

38 (d) the payer has no reason to believe that the claim has been
39 submitted fraudulently; and

40 (e) the claim requires no special treatment that prevents timely
41 payments from being made on the claim under the terms of the policy.

42 (2) If all or a portion of the claim is denied by the payer because:

43 (a) the claim is an ineligible claim;

44 (b) the claim submission is incomplete because the required
45 substantiating documentation has not been submitted to the payer;

46 (c) the diagnosis coding, procedure coding, or any other required

1 information to be submitted with the claim is incorrect;
2 (d) the payer disputes the amount claimed; or
3 (e) the claim requires special treatment that prevents timely
4 payments from being made on the claim under the terms of the policy,
5 the payer shall notify the insured, or that insured's agent or assignee
6 if the policy provides for assignment of benefits, in writing or by
7 electronic means, as appropriate, within 30 days, of the following: if
8 all or a portion of the claim is denied, all the reasons for the denial; if
9 the claim lacks the required substantiating documentation, including
10 incorrect coding, a statement as to what substantiating documentation
11 or other information is required to complete adjudication of the claim;
12 if the amount of the claim is disputed, a statement that it is disputed;
13 and if the claim requires special treatment that prevents timely
14 payments from being made, a statement of the special treatment to
15 which the claim is subject.
16 (3) Any portion of a claim that meets the criteria established in
17 paragraph (1) of this subsection shall be paid by the payer in
18 accordance with the time limit established in paragraph (1) of this
19 subsection.
20 (4) A payer shall acknowledge receipt of a claim submitted by
21 electronic means from a health care provider or insured, no later than
22 two working days following receipt of the transmission of the claim.
23 (5) If a payer subject to the provisions of P.L.1983, c.320
24 (C.17:33A-1 et seq.) has reason to believe that a claim has been
25 submitted fraudulently, it shall investigate the claim in accordance with
26 its fraud prevention plan established pursuant to section 1 of P.L.1993,
27 c.362 (C.17:33A-15), or refer the claim, together with supporting
28 documentation, to the Office of the Insurance Fraud Prosecutor in the
29 Department of Law and Public Safety established pursuant to section
30 32 of P.L.1998, c.21 (C.17:33A-16).
31 (6) Payment of an eligible claim pursuant to paragraphs (1) and
32 (3) of this subsection shall be deemed to be overdue if not remitted to
33 the claimant or his agent by the payer on or before the 30th calendar
34 day or the time limit established by the Medicare program, whichever
35 is earlier, following receipt by the payer of a claim submitted by
36 electronic means and on or before the 40th calendar day following
37 receipt of a claim submitted by other than electronic means.
38 In the event payment is withheld on all or a portion of a claim by
39 a payer pursuant to subparagraph (b) of paragraph (2) of this
40 subsection, the claims payment shall be overdue if not remitted to the
41 claimant or his agent by the payer on or before the 30th calendar day
42 or the time limit established by the Medicare program, whichever is
43 earlier, for claims submitted by electronic means and the 40th calendar
44 day for claims submitted by other than electronic means, following
45 receipt by the payer of the required documentation or modification of
46 an initial submission.

1 (7) An overdue payment shall bear simple interest at the rate of
2 10% per annum.

3 e. As used in this subsection, "insured claim" or "claim" means a
4 claim by an insured for payment of benefits under an insured policy
5 for which the financial obligation for the payment of a claim under the
6 policy rests upon the health insurer.³

7
8 7. a. Within 180 days of the adoption of a timetable for
9 implementation pursuant to section 1 of P.L. , c. (C.)(pending
10 before the Legislature as this bill), a health maintenance organization,
11 or a subsidiary that processes health care benefits claims as a third
12 party administrator, shall demonstrate to the satisfaction of the
13 Commissioner of Banking and Insurance that it will adopt and
14 implement all of the standards to receive and transmit health care
15 transactions electronically, according to the corresponding timetable,
16 and otherwise comply with the provisions of this section,¹ as a
17 condition of its continued authorization to do business in this State.

18 The Commissioner of Banking and Insurance may grant extensions
19 or waivers of the implementation requirement when it has been
20 demonstrated to the commissioner's satisfaction that compliance with
21 the timetable for implementation will result in an undue hardship to a
22 health maintenance organization, its subsidiary or its covered
23 enrollees.

24 b. Within 12 months of the adoption of regulations establishing
25 standard health care enrollment and claim forms by the Commissioner
26 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
27 (pending before the Legislature as this bill), a health maintenance
28 organization or a subsidiary that processes health care benefits claims
29 as a third party administrator shall use the standard health care
30 enrollment and claim forms in connection with all group and individual
31 health maintenance organization coverage for health care services
32 issued, delivered, executed or renewed in this State.

33 c. ¹[Effective two years after the effective date of P.L. , c.
34 (C.) (pending before the Legislature as this bill):

35 (1)] Twelve months after the adoption of regulations establishing
36 standard health care enrollment and claim forms by the Commissioner
37 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
38 (pending before the Legislature as this bill),¹ a health maintenance
39 organization shall require that health care providers file all claims for
40 payment for health care services. A covered person who receives
41 health care services shall not be required to submit a claim for
42 payment, but notwithstanding the provisions of this subsection to the
43 contrary, a covered person shall be permitted to submit a claim on his
44 own behalf, at the covered person's option

45 ¹[(2) a health maintenance organization shall not restrict the
46 enrollee's right to assign any payment owed to the health care

1 provider; and

2 (3) all]. All¹ claims shall be filed using the standard health care¹
3 claim form applicable to the contract³.

4 d. ³[Notwithstanding the provisions of section 80 of P.L.1991,
5 c.187 (C.26:2J-5.1) to the contrary,

6 (1) ¹[For the two-year period beginning on the effective date of
7 P.L. , c. (C.) (pending before the Legislature as this bill)] Twelve
8 months after the adoption of regulations establishing standard health
9 care enrollment and claim forms by the Commissioner of Banking and
10 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before
11 the Legislature as this bill)¹, a health maintenance organization shall
12 reimburse all clean claims that are filed electronically by a provider or
13 an enrollee for payment under group or individual health maintenance
14 organization coverage for health care services, within ¹[30 days after
15 receipt of the claim by the health maintenance organization] the
16 applicable number of calendar days established for payment of claims
17 in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

18 If a claim or portion of a claim that is submitted electronically is
19 contested or denied by the health maintenance organization, the person
20 or entity who filed the claim shall be notified in writing or
21 electronically, as appropriate, within 30 days after receipt of the claim
22 by the health maintenance organization, that the claim is contested or
23 denied, but the uncontested portion of the claim, if any, shall be paid
24 within 30 days after receipt of the claim by the health maintenance
25 organization. The notice that a claim is contested or denied shall
26 identify the contested portion of the claim and the reasons for
27 contesting or denying the claim.

28 ¹[(2) Effective two years after the effective date of P.L. , c.
29 (C.) (pending before the Legislature as this bill), a health
30 maintenance organization shall reimburse all clean claims that are filed
31 electronically by a provider or an enrollee, for payment under group
32 or individual health maintenance organization coverage for health care
33 services, within 17 days after receipt of the claim by the health
34 maintenance organization.

35 If a claim or portion of a claim that is submitted electronically is
36 contested or denied by the health maintenance organization, the person
37 or entity who filed the claim shall be notified in writing or
38 electronically, as appropriate, within 17 days after receipt of the claim
39 by the health maintenance organization, that the claim is contested or
40 denied, but the uncontested portion of the claim, if any, shall be paid
41 within 30 days after receipt of the claim by the health maintenance
42 organization. The notice that a claim is contested or denied shall
43 identify the contested portion of the claim and the reasons for
44 contesting or denying the claim.

45 (3)] (2)¹ Payment shall be treated as being made on the date a
46 draft or other valid instrument which is equivalent to payment was

1 placed in the United States mail in a properly addressed, postpaid
2 envelope or, if not so posted, on the date of delivery, or the date of
3 electronic fund transfer. An overdue payment shall bear simple
4 interest at the rate of 10% per year.

5 ¹~~[(4)]~~ (3)¹ For the purposes of this section, "clean claim" has the
6 same meaning given the term in the federal Medicare program
7 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

8 (1) Effective 180 days after the effective date of P.L. , c.
9 (pending before the Legislature as this bill), a health maintenance
10 organization or its agent, hereinafter the payer, shall remit payment for
11 every insured claim submitted by an enrollee or that enrollee's agent
12 or assignee if the health maintenance organization coverage for health
13 care services provides for assignment of benefits, no later than the
14 30th calendar day following receipt of the claim by the payer or no
15 later than the time limit established for the payment of claims in the
16 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever
17 is earlier, if the claim is submitted by electronic means, and no later
18 than the 40th calendar day following receipt if the claim is submitted
19 by other than electronic means, if:

20 (a) the claim is an eligible claim for a health care service provided
21 by an eligible health care provider to a covered person under the health
22 maintenance organization coverage for health care services;

23 (b) the claim has no material defect or impropriety, including, but
24 not limited to, any lack of required substantiating documentation or
25 incorrect coding;

26 (c) there is no dispute regarding the amount claimed;

27 (d) the payer has no reason to believe that the claim has been
28 submitted fraudulently; and

29 (e) the claim requires no special treatment that prevents timely
30 payments from being made on the claim under the terms of the health
31 maintenance organization coverage for health care services.

32 (2) If all or a portion of the claim is denied by the payer because:

33 (a) the claim is an ineligible claim;

34 (b) the claim submission is incomplete because the required
35 substantiating documentation has not been submitted to the payer;

36 (c) the diagnosis coding, procedure coding, or any other required
37 information to be submitted with the claim is incorrect;

38 (d) the payer disputes the amount claimed; or

39 (e) the claim requires special treatment that prevents timely
40 payments from being made on the claim under the terms of the health
41 maintenance organization coverage for health care services, the payer
42 shall notify the enrollee, or that enrollee's agent or assignee if the
43 health maintenance organization coverage for health care services
44 provides for assignment of benefits, in writing or by electronic means,
45 as appropriate, within 30 days, of the following: if all or a portion of
46 the claim is denied, all the reasons for the denial; if the claim lacks the

1 required substantiating documentation, including incorrect coding, a
2 statement as to what substantiating documentation or other
3 information is required to complete adjudication of the claim; if the
4 amount of the claim is disputed, a statement that it is disputed; and if
5 the claim requires special treatment that prevents timely payments
6 from being made, a statement of the special treatment to which the
7 claim is subject.

8 (3) Any portion of a claim that meets the criteria established in
9 paragraph (1) of this subsection shall be paid by the payer in
10 accordance with the time limit established in paragraph (1) of this
11 subsection.

12 (4) A payer shall acknowledge receipt of a claim submitted by
13 electronic means from a health care provider or enrollee, no later than
14 two working days following receipt of the transmission of the claim.

15 (5) If a payer subject to the provisions of P.L.1983, c.320
16 (C.17:33A-1 et seq.) has reason to believe that a claim has been
17 submitted fraudulently, it shall investigate the claim in accordance with
18 its fraud prevention plan established pursuant to section 1 of P.L.1993,
19 c.362 (C.17:33A-15), or refer the claim, together with supporting
20 documentation, to the Office of the Insurance Fraud Prosecutor in the
21 Department of Law and Public Safety established pursuant to section
22 32 of P.L.1998, c.21 (C.17:33A-16).

23 (6) Payment of an eligible claim pursuant to paragraphs (1) and
24 (3) of this subsection shall be deemed to be overdue if not remitted to
25 the claimant or his agent by the payer on or before the 30th calendar
26 day or the time limit established by the Medicare program, whichever
27 is earlier, following receipt by the payer of a claim submitted by
28 electronic means and on or before the 40th calendar day following
29 receipt of a claim submitted by other than electronic means.

30 In the event payment is withheld on all or a portion of a claim by
31 a payer pursuant to subparagraph (b) of paragraph (2) of this
32 subsection, the claims payment shall be overdue if not remitted to the
33 claimant or his agent by the payer on or before the 30th calendar day
34 or the time limit established by the Medicare program, whichever is
35 earlier, for claims submitted by electronic means and the 40th calendar
36 day for claims submitted by other than electronic means, following
37 receipt by the payer of the required documentation or modification of
38 an initial submission.

39 (7) An overdue payment shall bear simple interest at the rate of
40 10% per annum.

41 e. As used in this subsection, "insured claim" or "claim" means a
42 claim by an enrollee for payment of benefits under an insured health
43 maintenance organization contract for which the financial obligation
44 for the payment of a claim under the health maintenance organization
45 coverage for health care services rests upon the health maintenance
46 organization.³

1 8. a. Within 180 days of the adoption of a timetable for
2 implementation pursuant to section 1 of P.L. , c. (C.)(pending
3 before the Legislature as this bill), a dental service corporation, or a
4 subsidiary that processes health care benefits claims as a third party
5 administrator, shall demonstrate to the satisfaction of the
6 Commissioner of Banking and Insurance that it will adopt and
7 implement all of the standards to receive and transmit health care
8 transactions electronically, according to the corresponding timetable,
9 ¹and otherwise comply with the provisions of this section,¹ as a
10 condition of its continued authorization to do business in this State.

11 The Commissioner of Banking and Insurance may grant extensions
12 or waivers of the implementation requirement when it has been
13 demonstrated to the commissioner's satisfaction that compliance with
14 the timetable for implementation will result in an undue hardship to a
15 dental service corporation, its subsidiary or its covered persons.

16 b. Within 12 months of the adoption of regulations establishing
17 standard health care enrollment and claim forms by the Commissioner
18 of Banking and Insurance pursuant to section 1 of P.L. , c.
19 (C.)(pending before the Legislature as this bill), a dental service
20 corporation or a subsidiary that processes health care benefits claims
21 as a third party administrator shall use the standard health care
22 enrollment and claim forms in connection with all group and individual
23 contracts issued, delivered, executed or renewed in this State.

24 c. ¹[Effective two years after the effective date of P.L. , c.
25 (C.)(pending before the Legislature as this bill):

26 (1) Twelve months after the adoption of regulations establishing
27 standard health care enrollment and claim forms by the Commissioner
28 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
29 (pending before the Legislature as this bill),¹ a dental service
30 corporation shall require that health care providers file all claims for
31 payment for dental services. A covered person who receives dental
32 services shall not be required to submit a claim for payment, but
33 notwithstanding the provisions of this subsection to the contrary, a
34 covered person shall be permitted to submit a claim on his own behalf,
35 at the covered person's option.

36 ¹[(2) a dental service corporation shall not restrict the subscriber's
37 right to assign any payment owed to the health care provider; and

38 (3) all]. All¹ claims shall be filed using the standard ¹health care¹
39 claim form ³applicable to the contract³.

40 d. ³[(1) ¹[For the two-year period beginning on the effective date
41 of P.L. , c. (C.)(pending before the Legislature as this bill)]
42 Twelve months after the adoption of regulations establishing standard
43 health care enrollment and claim forms by the Commissioner of
44 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
45 (pending before the Legislature as this bill)¹, a dental service
46 corporation shall reimburse all clean claims that are filed electronically

1 by a provider or a subscriber for payment under a group or individual
2 dental service corporation contract, within ¹[30 days after receipt of
3 the claim by the dental service corporation] the applicable number of
4 calendar days established for payment of claims in the Medicare
5 program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

6 If a claim or portion of a claim that is submitted electronically is
7 contested or denied by the dental service corporation, the person or
8 entity who filed the claim shall be notified in writing or electronically,
9 as appropriate, within 30 days after receipt of the claim by the dental
10 service corporation, that the claim is contested or denied, but the
11 uncontested portion of the claim, if any, shall be paid within 30 days
12 after receipt of the claim by the dental service corporation. The notice
13 that a claim is contested or denied shall identify the contested portion
14 of the claim and the reasons for contesting or denying the claim.

15 ¹[(2) Effective two years after the effective date of P.L. , c.
16 (C.) (pending before the Legislature as this bill), a dental service
17 corporation shall reimburse all clean claims that are filed electronically
18 by a provider or a subscriber for payment under a group or individual
19 dental service corporation contract, within 17 days after receipt of the
20 claim by the dental service corporation.

21 If a claim or portion of a claim that is submitted electronically is
22 contested or denied by the dental service corporation, the person or
23 entity who filed the claim shall be notified in writing or electronically,
24 as appropriate, within 17 days after receipt of the claim by the dental
25 service corporation, that the claim is contested or denied, but the
26 uncontested portion of the claim, if any, shall be paid within 30 days
27 after receipt of the claim by the dental service corporation. The notice
28 that a claim is contested or denied shall identify the contested portion
29 of the claim and the reasons for contesting or denying the claim.

30 (3) ¹(2) Payment shall be treated as being made on the date a
31 draft or other valid instrument which is equivalent to payment was
32 placed in the United States mail in a properly addressed, postpaid
33 envelope or, if not so posted, on the date of delivery, or the date of
34 electronic fund transfer. An overdue payment shall bear simple
35 interest at the rate of 10% per year.

36 ¹[(4) (3)]¹ For the purposes of this section, "clean claim" has the
37 same meaning given the term in the federal Medicare program
38 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

39 (1) Effective 180 days after the effective date of P.L. , c.
40 (pending before the Legislature as this bill), a dental service
41 corporation or its agent, hereinafter the payer, shall remit payment for
42 every insured claim submitted by a subscriber or that subscriber's
43 agent or assignee if the contract provides for assignment of benefits,
44 no later than the 30th calendar day following receipt of the claim by
45 the payer or no later than the time limit established for the payment of
46 claims in the Medicare program pursuant to

1 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
2 submitted by electronic means, and no later than the 40th calendar day
3 following receipt if the claim is submitted by other than electronic
4 means, if:

5 (a) the claim is an eligible claim for a health care service provided
6 by an eligible health care provider to a covered person under the
7 contract;

8 (b) the claim has no material defect or impropriety, including, but
9 not limited to, any lack of required substantiating documentation or
10 incorrect coding;

11 (c) there is no dispute regarding the amount claimed;

12 (d) the payer has no reason to believe that the claim has been
13 submitted fraudulently; and

14 (e) the claim requires no special treatment that prevents timely
15 payments from being made on the claim under the terms of the
16 contract.

17 (2) If all or a portion of the claim is denied by the payer because:

18 (a) the claim is an ineligible claim;

19 (b) the claim submission is incomplete because the required
20 substantiating documentation has not been submitted to the payer;

21 (c) the diagnosis coding, procedure coding, or any other required
22 information to be submitted with the claim is incorrect;

23 (d) the payer disputes the amount claimed; or

24 (e) the claim requires special treatment that prevents timely
25 payments from being made on the claim under the terms of the
26 contract, the payer shall notify the subscriber, or that subscriber's
27 agent or assignee if the contract provides for assignment of benefits,
28 in writing or by electronic means, as appropriate, within 30 days, of
29 the following: if all or a portion of the claim is denied, all the reasons
30 for the denial; if the claim lacks the required substantiating
31 documentation, including incorrect coding, a statement as to what
32 substantiating documentation or other information is required to
33 complete adjudication of the claim; if the amount of the claim is
34 disputed, a statement that it is disputed; and if the claim requires
35 special treatment that prevents timely payments from being made, a
36 statement of the special treatment to which the claim is subject.

37 (3) Any portion of a claim that meets the criteria established in
38 paragraph (1) of this subsection shall be paid by the payer in
39 accordance with the time limit established in paragraph (1) of this
40 subsection.

41 (4) A payer shall acknowledge receipt of a claim submitted by
42 electronic means from a health care provider or subscriber, no later
43 than two working days following receipt of the transmission of the
44 claim.

45 (5) If a payer subject to the provisions of P.L.1983, c.320
46 (C.17:33A-1 et seq.) has reason to believe that a claim has been

1 submitted fraudulently, it shall investigate the claim in accordance with
2 its fraud prevention plan established pursuant to section 1 of P.L.1993,
3 c.362 (C.17:33A-15), or refer the claim, together with supporting
4 documentation, to the Office of the Insurance Fraud Prosecutor in the
5 Department of Law and Public Safety established pursuant to section
6 32 of P.L.1998, c.21 (C.17:33A-16).

7 (6) Payment of an eligible claim pursuant to paragraphs (1) and
8 (3) of this subsection shall be deemed to be overdue if not remitted to
9 the claimant or his agent by the payer on or before the 30th calendar
10 day or the time limit established by the Medicare program, whichever
11 is earlier, following receipt by the payer of a claim submitted by
12 electronic means and on or before the 40th calendar day following
13 receipt of a claim submitted by other than electronic means.

14 In the event payment is withheld on all or a portion of a claim by
15 a payer pursuant to subparagraph (b) of paragraph (2) of this
16 subsection, the claims payment shall be overdue if not remitted to the
17 claimant or his agent by the payer on or before the 30th calendar day
18 or the time limit established by the Medicare program, whichever is
19 earlier, for claims submitted by electronic means and the 40th calendar
20 day for claims submitted by other than electronic means, following
21 receipt by the payer of the required documentation or modification of
22 an initial submission.

23 (7) An overdue payment shall bear simple interest at the rate of
24 10% per annum.

25 e. As used in this subsection, "insured claim" or "claim" means a
26 claim by a subscriber for payment of benefits under an insured dental
27 service corporation contract for which the financial obligation for the
28 payment of a claim under the contract rests upon the dental service
29 corporation.³

30

31 9. a. Within 180 days of the adoption of a timetable for
32 implementation pursuant to section 1 of P.L. , c. (C.)(pending
33 before the Legislature as this bill), a dental plan organization, or a
34 subsidiary that processes health care benefits claims as a third party
35 administrator, shall demonstrate to the satisfaction of the
36 Commissioner of Banking and Insurance that it will adopt and
37 implement all of the standards to receive and transmit health care
38 transactions electronically, according to the corresponding timetable,
39 and otherwise comply with the provisions of this section,¹ as a
40 condition of its continued authorization to do business in this State.

41 The Commissioner of Banking and Insurance may grant extensions
42 or waivers of the implementation requirement when it has been
43 demonstrated to the commissioner's satisfaction that compliance with
44 the timetable for implementation will result in an undue hardship to a
45 dental plan organization, its subsidiary or its covered enrollees.

46 b. Within 12 months of the adoption of regulations establishing

1 standard health care enrollment and claim forms by the Commissioner
2 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
3 (pending before the Legislature as this bill), a dental plan organization
4 or a subsidiary that processes health care benefits claims as a third
5 party administrator shall use the standard health care enrollment and
6 claim forms in connection with all group and individual contracts
7 issued, delivered, executed or renewed in this State.

8 c. ¹[Effective two years after the effective date of P.L. , c. (C.)
9 (pending before the Legislature as this bill):

10 (1)] Twelve months after the adoption of regulations establishing
11 standard health care enrollment and claim forms by the Commissioner
12 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
13 (pending before the Legislature as this bill),¹ a dental plan organization
14 shall require that health care providers file all claims for payment for
15 dental services. A covered person who receives dental services shall
16 not be required to submit a claim for payment, but notwithstanding the
17 provisions of this subsection to the contrary, a covered person shall be
18 permitted to submit a claim on his own behalf, at the covered person's
19 option

20 ¹[(2) a dental plan organization shall not restrict the enrollee's
21 right to assign any payment owed to the health care provider; and

22 (3) all]. All¹ claims shall be filed using the standard health care¹
23 claim form ³applicable to the contract³.

24 d. ³[(1) ¹[For the two-year period beginning on the effective date
25 of P.L. , c. (C.)(pending before the Legislature as this bill)]
26 Twelve months after the adoption of regulations establishing standard
27 health care enrollment and claim forms by the Commissioner of
28 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
29 (pending before the Legislature as this bill)¹, a dental plan organization
30 shall reimburse all clean claims that are filed electronically by a
31 provider or an enrollee for payment under group or individual dental
32 plan organization coverage for dental services, within ¹[30 days after
33 receipt of the claim by the dental plan organization] the applicable
34 number of calendar days established for payment of claims in the
35 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

36 If a claim or portion of a claim that is submitted electronically is
37 contested or denied by the dental plan organization, the person or
38 entity who filed the claim shall be notified in writing or electronically,
39 as appropriate, within 30 days after receipt of the claim by the dental
40 plan organization, that the claim is contested or denied, but the
41 uncontested portion of the claim, if any, shall be paid within 30 days
42 after receipt of the claim by the dental plan organization. The notice
43 that a claim is contested or denied shall identify the contested portion
44 of the claim and the reasons for contesting or denying the claim.

45 ¹[(2) Effective two years after the effective date of P.L. , c.

1 (C.) (pending before the Legislature as this bill), a dental plan
2 organization shall reimburse all clean claims that are filed
3 electronically by a provider or an enrollee for payment under group or
4 individual dental plan organization coverage for dental services, within
5 17 days after receipt of the claim by the dental plan organization.

6 If a claim or portion of a claim that is submitted electronically is
7 contested or denied by the dental plan organization, the person or
8 entity who filed the claim shall be notified in writing or electronically,
9 as appropriate, within 17 days after receipt of the claim by the dental
10 plan organization, that the claim is contested or denied, but the
11 uncontested portion of the claim, if any, shall be paid within 30 days
12 after receipt of the claim by the dental plan organization. The notice
13 that a claim is contested or denied shall identify the contested portion
14 of the claim and the reasons for contesting or denying the claim.

15 (3)](2)¹ Payment shall be treated as being made on the date a
16 draft or other valid instrument which is equivalent to payment was
17 placed in the United States mail in a properly addressed, postpaid
18 envelope or, if not so posted, on the date of delivery, or the date of
19 electronic fund transfer. An overdue payment shall bear simple
20 interest at the rate of 10% per year.

21 [(4)] (3)¹ For the purposes of this section, "clean claim" has the
22 same meaning given the term in the federal Medicare program
23 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

24 (1) Effective 180 days after the effective date of P.L. , c.
25 (pending before the Legislature as this bill), a dental plan organization
26 or its agent, hereinafter the payer, shall remit payment for every
27 insured claim submitted by an enrollee or that enrollee's agent or
28 assignee if the contract provides for assignment of benefits, no later
29 than the 30th calendar day following receipt of the claim by the payer
30 or no later than the time limit established for the payment of claims in
31 the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B),
32 whichever is earlier, if the claim is submitted by electronic means, and
33 no later than the 40th calendar day following receipt if the claim is
34 submitted by other than electronic means, if:

35 (a) the claim is an eligible claim for a health care service provided
36 by an eligible health care provider to a covered person under the
37 contract;

38 (b) the claim has no material defect or impropriety, including, but
39 not limited to, any lack of required substantiating documentation or
40 incorrect coding;

41 (c) there is no dispute regarding the amount claimed;

42 (d) the payer has no reason to believe that the claim has been
43 submitted fraudulently; and

44 (e) the claim requires no special treatment that prevents timely
45 payments from being made on the claim under the terms of the
46 contract.

- 1 (2) If all or a portion of the claim is denied by the payer because:
2 (a) the claim is an ineligible claim;
3 (b) the claim submission is incomplete because the required
4 substantiating documentation has not been submitted to the payer;
5 (c) the diagnosis coding, procedure coding, or any other required
6 information to be submitted with the claim is incorrect;
7 (d) the payer disputes the amount claimed; or
8 (e) the claim requires special treatment that prevents timely
9 payments from being made on the claim under the terms of the
10 contract, the payer shall notify the enrollee, or that enrollee's agent or
11 assignee if the contract provides for assignment of benefits, in writing
12 or by electronic means, as appropriate, within 30 days, of the
13 following: if all or a portion of the claim is denied, all the reasons for
14 the denial; if the claim lacks the required substantiating
15 documentation, including incorrect coding, a statement as to what
16 substantiating documentation or other information is required to
17 complete adjudication of the claim; if the amount of the claim is
18 disputed, a statement that it is disputed; and if the claim requires
19 special treatment that prevents timely payments from being made, a
20 statement of the special treatment to which the claim is subject.
21 (3) Any portion of a claim that meets the criteria established in
22 paragraph (1) of this subsection shall be paid by the payer in
23 accordance with the time limit established in paragraph (1) of this
24 subsection.
25 (4) A payer shall acknowledge receipt of a claim submitted by
26 electronic means from a health care provider or enrollee, no later than
27 two working days following receipt of the transmission of the claim.
28 (5) If a payer subject to the provisions of P.L.1983, c.320
29 (C.17:33A-1 et seq.) has reason to believe that a claim has been
30 submitted fraudulently, it shall investigate the claim in accordance with
31 its fraud prevention plan established pursuant to section 1 of P.L.1993,
32 c.362 (C.17:33A-15), or refer the claim, together with supporting
33 documentation, to the Office of the Insurance Fraud Prosecutor in the
34 Department of Law and Public Safety established pursuant to section
35 32 of P.L.1998, c.21 (C.17:33A-16).
36 (6) Payment of an eligible claim pursuant to paragraphs (1) and
37 (3) of this subsection shall be deemed to be overdue if not remitted to
38 the claimant or his agent by the payer on or before the 30th calendar
39 day or the time limit established by the Medicare program, whichever
40 is earlier, following receipt by the payer of a claim submitted by
41 electronic means and on or before the 40th calendar day following
42 receipt of a claim submitted by other than electronic means.
43 In the event payment is withheld on all or a portion of a claim by
44 a payer pursuant to subparagraph (b) of paragraph (2) of this
45 subsection, the claims payment shall be overdue if not remitted to the
46 claimant or his agent by the payer on or before the 30th calendar day

1 or the time limit established by the Medicare program, whichever is
2 earlier, for claims submitted by electronic means and the 40th calendar
3 day for claims submitted by other than electronic means, following
4 receipt by the payer of the required documentation or modification of
5 an initial submission.

6 (7) An overdue payment shall bear simple interest at the rate of
7 10% per annum.

8 e. As used in this subsection, "insured claim" or "claim" means a
9 claim by an enrollee for payment of benefits under an insured dental
10 plan organization contract for which the financial obligation for the
11 payment of a claim under the contract rests upon the dental plan
12 organization.³

13
14 10. a. Within 180 days of the adoption of a timetable for
15 implementation pursuant to section 1 of P.L. , c. (C.)(pending
16 before the Legislature as this bill), a prepaid prescription service
17 organization, or a subsidiary that processes health care benefits claims
18 as a third party administrator, shall demonstrate to the satisfaction of
19 the Commissioner of Banking and Insurance that it will adopt and
20 implement all of the standards to receive and transmit health care
21 transactions electronically, according to the corresponding timetable,
22 and otherwise comply with the provisions of this section,¹ as a
23 condition of its continued authorization to do business in this State.

24 The Commissioner of Banking and Insurance may grant extensions
25 or waivers of the implementation requirement when it has been
26 demonstrated to the commissioner's satisfaction that compliance with
27 the timetable for implementation will result in an undue hardship to a
28 prepaid prescription service organization, its subsidiary or its covered
29 enrollees.

30 b. Within 12 months of the adoption of regulations establishing
31 standard health care enrollment and claim forms by the Commissioner
32 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
33 (pending before the Legislature as this bill), a prepaid prescription
34 service organization or a subsidiary that processes health care benefits
35 claims as a third party administrator shall use the standard health care
36 enrollment and claim forms in connection with all contracts issued,
37 delivered, executed or renewed in this State.

38 c. ¹[Effective two years after the effective date of P.L. , c. (C.)
39 (pending before the Legislature as this bill):

40 (1)] Twelve months after the adoption of regulations establishing
41 standard health care enrollment and claim forms by the Commissioner
42 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
43 (pending before the Legislature as this bill),¹ a prepaid prescription
44 service organization shall require that health care providers file all
45 claims for payment for health care services. A covered person who
46 receives health care services shall not be required to submit a claim for

1 payment, but notwithstanding the provisions of this subsection to the
2 contrary, a covered person shall be permitted to submit a claim on his
3 own behalf, at the covered person's option

4 ¹[(2) a prepaid prescription service organization shall not restrict
5 the enrollee's right to assign any payment owed to the health care
6 provider; and

7 (3) all]. All¹ claims shall be filed using the standard ¹health care¹
8 claim form ³applicable to the contract³.

9 d. ³[(1) ¹[For the two-year period beginning on the effective date
10 of P.L. , c. (C.)(pending before the Legislature as this bill)]
11 Twelve months after the adoption of regulations establishing standard
12 health care enrollment and claim forms by the Commissioner of
13 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
14 (pending before the Legislature as this bill)¹, a prepaid prescription
15 service organization shall reimburse all clean claims that are filed
16 electronically by a provider or an enrollee for payment under a
17 prepaid prescription service organization contract, within ¹[30 days
18 after receipt of the claim by the prepaid prescription service
19 organization] the applicable number of calendar days established for
20 payment of claims in the Medicare program pursuant to
21 42 U.S.C.s.1395u(c)(2)(B)¹.

22 If a claim or portion of a claim that is submitted electronically is
23 contested or denied by the prepaid prescription service organization,
24 the person or entity who filed the claim shall be notified in writing or
25 electronically, as appropriate, within 30 days after receipt of the claim
26 by the prepaid prescription service organization, that the claim is
27 contested or denied, but the uncontested portion of the claim, if any,
28 shall be paid within 30 days after receipt of the claim by the prepaid
29 prescription service organization. The notice that a claim is contested
30 or denied shall identify the contested portion of the claim and the
31 reasons for contesting or denying the claim.

32 ¹[(2) Effective two years after the effective date of P.L. , c.
33 (C.) (pending before the Legislature as this bill), a prepaid
34 prescription service organization shall reimburse all clean claims that
35 are filed electronically by a provider or an enrollee for payment under
36 a prepaid prescription service organization contract, within 17 days
37 after receipt of the claim by the prepaid prescription service
38 organization.

39 If a claim or portion of a claim that is submitted electronically is
40 contested or denied by the prepaid prescription service organization,
41 the person or entity who filed the claim shall be notified in writing or
42 electronically, as appropriate, within 17 days after receipt of the claim
43 by the prepaid prescription service organization, that the claim is
44 contested or denied, but the uncontested portion of the claim, if any,
45 shall be paid within 30 days after receipt of the claim by the prepaid
46 prescription service organization. The notice that a claim is contested

1 or denied shall identify the contested portion of the claim and the
2 reasons for contesting or denying the claim.

3 (3)] (2)¹ Payment shall be treated as being made on the date a
4 draft or other valid instrument which is equivalent to payment was
5 placed in the United States mail in a properly addressed, postpaid
6 envelope or, if not so posted, on the date of delivery, or the date of
7 electronic fund transfer. An overdue payment shall bear simple
8 interest at the rate of 10% per year.

9 ¹[(4)] (3)¹ For the purposes of this section, "clean claim" has the
10 same meaning given the term in the federal Medicare program
11 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

12 (1) Effective 180 days after the effective date of P.L. , c.
13 (pending before the Legislature as this bill), a prepaid prescription
14 service organization or its agent, hereinafter the payer, shall remit
15 payment for every insured claim submitted by an enrollee or that
16 enrollee's agent or assignee if the contract provides for assignment of
17 benefits, no later than the 30th calendar day following receipt of the
18 claim by the payer or no later than the time limit established for the
19 payment of claims in the Medicare program pursuant to
20 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
21 submitted by electronic means, and no later than the 40th calendar day
22 following receipt if the claim is submitted by other than electronic
23 means, if:

24 (a) the claim is an eligible claim for a health care service provided
25 by an eligible health care provider to a covered person under the
26 contract;

27 (b) the claim has no material defect or impropriety, including, but
28 not limited to, any lack of required substantiating documentation or
29 incorrect coding;

30 (c) there is no dispute regarding the amount claimed;

31 (d) the payer has no reason to believe that the claim has been
32 submitted fraudulently; and

33 (e) the claim requires no special treatment that prevents timely
34 payments from being made on the claim under the terms of the
35 contract.

36 (2) If all or a portion of the claim is denied by the payer because:

37 (a) the claim is an ineligible claim;

38 (b) the claim submission is incomplete because the required
39 substantiating documentation has not been submitted to the payer;

40 (c) the diagnosis coding, procedure coding, or any other required
41 information to be submitted with the claim is incorrect;

42 (d) the payer disputes the amount claimed; or

43 (e) the claim requires special treatment that prevents timely
44 payments from being made on the claim under the terms of the
45 contract, the payer shall notify the enrollee, or that enrollee's agent or
46 assignee if the contract provides for assignment of benefits, in writing

1 or by electronic means, as appropriate, within 30 days, of the
2 following: if all or a portion of the claim is denied, all the reasons for
3 the denial; if the claim lacks the required substantiating
4 documentation, including incorrect coding, a statement as to what
5 substantiating documentation or other information is required to
6 complete adjudication of the claim; if the amount of the claim is
7 disputed, a statement that it is disputed; and if the claim requires
8 special treatment that prevents timely payments from being made, a
9 statement of the special treatment to which the claim is subject.

10 (3) Any portion of a claim that meets the criteria established in
11 paragraph (1) of this subsection shall be paid by the payer in
12 accordance with the time limit established in paragraph (1) of this
13 subsection.

14 (4) A payer shall acknowledge receipt of a claim submitted by
15 electronic means from a health care provider or enrollee, no later than
16 two working days following receipt of the transmission of the claim.

17 (5) If a payer subject to the provisions of P.L.1983, c.320
18 (C.17:33A-1 et seq.) has reason to believe that a claim has been
19 submitted fraudulently, it shall investigate the claim in accordance with
20 its fraud prevention plan established pursuant to section 1 of P.L.1993,
21 c.362 (C.17:33A-15), or refer the claim, together with supporting
22 documentation, to the Office of the Insurance Fraud Prosecutor in the
23 Department of Law and Public Safety established pursuant to section
24 32 of P.L.1998, c.21 (C.17:33A-16).

25 (6) Payment of an eligible claim pursuant to paragraphs (1) and
26 (3) of this subsection shall be deemed to be overdue if not remitted to
27 the claimant or his agent by the payer on or before the 30th calendar
28 day or the time limit established by the Medicare program, whichever
29 is earlier, following receipt by the payer of a claim submitted by
30 electronic means and on or before the 40th calendar day following
31 receipt of a claim submitted by other than electronic means.

32 In the event payment is withheld on all or a portion of a claim by
33 a payer pursuant to subparagraph (b) of paragraph (2) of this
34 subsection, the claims payment shall be overdue if not remitted to the
35 claimant or his agent by the payer on or before the 30th calendar day
36 or the time limit established by the Medicare program, whichever is
37 earlier, for claims submitted by electronic means and the 40th calendar
38 day for claims submitted by other than electronic means, following
39 receipt by the payer of the required documentation or modification of
40 an initial submission.

41 (7) An overdue payment shall bear simple interest at the rate of
42 10% per annum.

43 e. As used in this subsection, "insured claim" or "claim" means a
44 claim by an enrollee for payment of benefits under an insured prepaid
45 prescription service organization contract for which the financial
46 obligation for the payment of a claim under the contract rests upon

1 the prepaid prescription service organization.³

2

3 ⁴[11. a. A taxpayer, except for a New Jersey S corporation
4 whose shareholders shall instead be allowed the credit provided by
5 section 13 of P.L. , c. (C.)(pending before the Legislature as this
6 bill), shall be allowed a credit against the tax liability imposed by
7 section 5 of P.L.1945, c.162 (C.54:10A-5) in an amount equal to 10%
8 of the costs of the taxpayer during a fiscal or calendar accounting year,
9 referred to hereinafter in this section as a "tax year," ¹[beginning on
10 or] ending¹ after ¹[January, 1,] June 30,¹ ²[1998]1999² but before
11 ¹[January] July¹ 1, ²[2000] 2001², for the purchase, lease or rental
12 by the taxpayer of electronic data interchange technology to be used
13 to receive and transmit health care information, or such proportion of
14 these costs as is determined by the director to be the proportion of the
15 use of the technology in this State, provided that:

16 (1) The taxpayer is a health care provider licensed pursuant to
17 Title 45 of the Revised Statutes or any other health care provider who
18 is eligible for reimbursement by health care benefits payers, and the
19 technology purchased, leased or rented is used or intended for use in
20 the health care provider's professional office;

21 (2) The taxpayer is a health care facility licensed pursuant to
22 P.L.1971, c.136 (C.26:2H-1 et seq.);

23 (3) The taxpayer is a dental plan organization authorized to issue
24 health benefits plans in this State;

25 (4) The taxpayer is an entity which processes claims for health
26 care benefits or enrollments for health care benefits plans;

27 (5) The taxpayer is an employer which provides a comprehensive
28 self-funded health benefits plan to its employees or their dependents;
29 or

30 (6) The taxpayer is an information systems vendor that provides
31 software to support the transmission and receipt of health benefits
32 claims, inquiries about health benefits claims or claims payments,
33 health benefits plan enrollment transactions or health benefits-related
34 eligibility inquiries; and

35 (7) The technology purchased, leased or rented is primarily used
36 or intended for use, at a minimum, for one or more of the following
37 applications in accordance with standards adopted by the
38 Commissioner of Banking and Insurance pursuant to section 1 of
39 P.L. , c. (C.)(pending before the Legislature as this bill):
40 submission of health benefits claims, inquiries about health benefits
41 claims and claims payments, health benefits plan enrollment
42 transactions or health benefits-related eligibility inquiries.

43 As used in this section, "electronic data interchange technology"
44 means computer equipment or software which permits the electronic
45 transmission of a business document in a standard format.

46 b. No credit shall be allowed under the "Manufacturing Equipment

1 and Employment Investment Tax Credit Act," P.L.1993, c.171
2 (C.54:10A-5.16 et seq.), or under P.L.1993, c.170 (C.54:10A-5.4 et
3 seq.) for property or expenditures for which a credit is allowed, or
4 which are includable in the calculation of a credit allowed, under this
5 section.

6 c. The tax imposed for a fiscal or calendar accounting year
7 pursuant to section 5 of P.L.1945, c.162 shall first be reduced by the
8 amount of any credit allowed pursuant to this section and then by any
9 other statutory credits allowed against the tax. The credit allowed
10 under this section shall be applied in the order of the credits' tax years.
11 The amount of the credit applied under this section against the tax
12 imposed pursuant to section 5 of P.L.1945, c.162 for an accounting
13 year shall not exceed 50% of the tax liability otherwise due and shall
14 not reduce the tax liability to an amount less than the statutory
15 minimum provided in subsection (e) of section 5 of P.L.1945, c.162.
16 The amount of tax year credit otherwise allowable under this section
17 which cannot be applied for the tax year due to the limitations of this
18 subsection may be carried over, if necessary, to the seven accounting
19 years following a credit's tax year.]⁴

20

21 ⁴[12. a. A taxpayer shall be allowed a credit against the tax
22 liability imposed by P.L.1945, c.132 (C.54:18A-1 et seq.) in an
23 amount equal to 10% of the costs of the taxpayer during a year,
24 referred to hereinafter in this section as the "tax year," beginning on
25 or after January 1, ²[1998] 1999 ² but before January 1, ²[2000]
26 2001 ², for the purchase, lease or rental by the taxpayer of electronic
27 data interchange technology to be used to receive and transmit health
28 care information, or such proportion of these costs as is determined by
29 the director to be the proportion of the use of the technology in this
30 State, provided that the technology purchased, leased or rented is
31 primarily used or intended for use, at a minimum, for one or more of
32 the following applications in accordance with standards adopted by the
33 Commissioner of Banking and Insurance pursuant to section 1 of
34 P.L. , c. (C.)(pending before the Legislature as this bill):
35 submission of health benefits claims, inquiries about health benefits
36 claims, information about health benefits claims payments, health
37 benefits plan enrollment transactions, or health benefits-related
38 eligibility inquiries.

39 As used in this section, "electronic data interchange technology"
40 means computer equipment or software which permits the electronic
41 transmission of a business document in a standard format.

42 b. The tax imposed for a year pursuant to P.L.1945, c.132 shall
43 first be reduced by the amount of any credit allowed pursuant to this
44 section and then by any other statutory credits allowed against the tax.
45 The credit allowed under this section shall be applied in the order of
46 the credits' tax years. The amount of the credit applied under this

1 section against the tax imposed pursuant to P.L.1945, c.132, for
2 premiums collected in a calendar year shall not exceed 50% of the tax
3 liability otherwise due. The amount of tax year credit otherwise
4 allowable under this section which cannot be applied for the tax year
5 due to the limitations of this subsection may be carried over, if
6 necessary, to the seven accounting years following a credit's tax
7 year.]⁴

8

9 ⁴[13. a. A taxpayer shall be allowed a credit against the tax
10 otherwise due pursuant to N.J.S.54A:1-1 et seq. in an amount equal
11 to 10% of the costs of the taxpayer during a taxable year beginning on
12 or after January 1, ²[1998] 1999² but before January 1, ²[2000]
13 2001², for the purchase, lease or rental by the taxpayer of electronic
14 data interchange technology to be used to receive and transmit health
15 care information, or such proportion of these costs as is determined by
16 the director to be the proportion of the use of the technology in this
17 State, provided that:

18 (1) The taxpayer is a health care provider licensed pursuant to
19 Title 45 of the Revised Statutes or any other health care provider
20 reimbursable by health care benefits payers, and the technology
21 purchased, leased or rented is used or intended for use in the health
22 care provider's professional office;

23 (2) The taxpayer processes claims for health care benefits or
24 enrollments for health care benefits plans;

25 (3) The taxpayer provides a comprehensive self-funded health
26 benefits plan to the taxpayer's employees or their dependents; or

27 (4) The taxpayer is an information systems vendor that provides
28 software to support the transmission and receipt of health benefits
29 claims, inquiries about health benefits claims or claims payments,
30 health benefits plan enrollment transactions or health benefits-related
31 eligibility inquiries; and

32 (5) The technology purchased, leased or rented is primarily used
33 or intended for use, at a minimum, for one or more of the following
34 applications in accordance with standards adopted by the
35 Commissioner of Banking and Insurance pursuant to section 1 of
36 P.L. , c. (C.)(pending before the Legislature as this bill):
37 submission of health benefits claims, inquiries about health benefits
38 claims or claims payments, health benefits plan enrollment transactions
39 or health benefits-related eligibility inquiries.

40 As used in this section, "electronic data interchange technology"
41 means computer equipment or software which permits the electronic
42 transmission of a business document in a standard format.

43 b. If the taxpayer is a partner in a partnership, a member of an
44 association or a shareholder in a New Jersey S corporation, the credit
45 shall be allocated to each partner of the partnership, member of the
46 association or shareholder in the New Jersey S corporation in

1 proportion to the partner's, member's or shareholder's share of the
2 income or gain received by the partnership, association or New Jersey
3 S corporation for its taxable year ending within or with the partner's,
4 member's or shareholder's taxable year.

5 c. The amount of the credit claimed for the taxable year shall not
6 exceed 50% of the tax liability that would be otherwise due for that
7 year.

8 d. The amount of the credit shall be applied during the taxable
9 year in which the cost is incurred against any tax liability otherwise
10 due before other credits permitted pursuant to law are applied. ²[If the
11 credit reduces the taxpayer's tax liability to zero, the remaining
12 amount of the credit shall not be considered an overpayment of the
13 tax.]²⁴

14
15 ⁴[14.] 11.⁴ The Commissioner of Health and Senior Services, in
16 consultation with the Commissioner of Banking and Insurance, shall
17 establish an advisory board to make recommendations to the
18 commissioners on health information electronic data interchange
19 technology policy and measures to protect the confidentiality of
20 medical information. The members of the board shall include, at a
21 minimum, representation from health insurance carriers, health care
22 professionals and facilities, higher education, business and organized
23 labor, and health care consumers. The members of the board shall
24 serve without compensation but shall be entitled to reimbursement for
25 reasonable expenses incurred in the performance of their duties.

26
27 ⁴[15.] 12.⁴ The Commissioner of Health and Senior Services, in
28 conjunction with the Commissioner of Banking and Insurance, shall
29 present an annual report to the Governor and the Legislature on the
30 development and use of health information electronic data interchange
31 technology in New Jersey. The report shall be prepared ¹[with the
32 cooperation and assistance of the New Jersey Institute of Technology
33 and Thomas Edison State College and]¹ in consultation with the
34 advisory board established pursuant to section 14 of P.L. , c. (C.)
35 (pending before the Legislature as this bill). The report shall include
36 any recommendations, including proposals for regulatory and
37 legislative changes, to promote the development and use of health
38 information electronic data interchange technology in this State.

39
40 ⁴[16.] 13.⁴ Effective ¹[two years after the date of enactment of
41 P.L. , c. (C.)(pending before the Legislature as this bill),]
42 12 months after the adoption of regulations establishing standard
43 health care enrollment and claim forms by the Commissioner of
44 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
45 (pending before the Legislature as this bill)¹, a health care professional
46 licensed pursuant to Title 45 of the Revised Statutes is responsible for

1 filing all claims for third party payment, including claims filed on
2 behalf of the licensed professional's patient for any health care service
3 provided by the licensed professional that is eligible for third party
4 payment, except that at the patient's option, the patient may file the
5 claim for third party payment. ³[The]

6 a. In the case of a claim filed on behalf of the professional's
7 patient, the³ professional shall file ³[a] the³ claim within 60 days of
8 the last date of service for a course of treatment, on the standard claim
9 form adopted by the Commissioner of Banking and Insurance pursuant
10 to section 1 of P.L. , c. (C.) (pending before the Legislature as this
11 bill).

12 ³b. In the case of a claim in which the patient has assigned his
13 benefits to the professional, the professional shall file the claim within
14 180 days of the last date of service for a course of treatment, on the
15 standard claim form adopted by the Commissioner of Banking and
16 Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the
17 Legislature as this bill). If the professional does not file the claim
18 within 180 days of the last date of service for a course of treatment,
19 the third party payer shall reserve the right to deny payment of the
20 claim, in accordance with regulations established by the Commissioner
21 of Banking and Insurance, and the professional shall be prohibited
22 from seeking any payment directly from the patient.

23 (1) In establishing the standards for denial of payment, the
24 Commissioner of Banking and Insurance shall consider the good faith
25 use of information provided by the patient to the professional with
26 respect to the identity of the patient's third party payer, delays in filing
27 a claim related to coordination of benefits between third party payers
28 and any other factors the commissioner deems appropriate, and,
29 accordingly, shall define specific instances where the sanctions
30 permitted pursuant to this subsection shall not apply.

31 (2) A professional who fails to file a claim within 180 days and
32 whose claim for payment has been denied by the third party payer in
33 accordance with this subsection may, in the discretion of a judge of the
34 Superior Court, be permitted to refile the claim if the third party payer
35 has not been substantially prejudiced thereby. Application to the court
36 for permission to refile a claim shall be made within 14 days of
37 notification of denial of payment and shall be made upon motion based
38 upon affidavits showing sufficient reasons for the failure to file the
39 claim with the third party payer within 180 days.

40 c. ³ ¹The provisions of this section shall not apply to any claims
41 filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).¹

42 ³d. ³A health care professional who violates the provisions of
43 ³subsection a. of³ this section ¹[shall] may¹ be subject to
44 ¹[disciplinary action by the professional's respective licensing board]
45 a civil penalty of \$250 for each violation plus \$50 for each day after
46 the 60th day that the provider fails to submit a claim. The penalty

1 shall be sued for and collected by the Division of Consumer Affairs in
2 the Department of Law and Public Safety pursuant to "the penalty
3 enforcement law," N.J.S.2A:58-1 et seq¹.

4
5 ⁴[17.] 14.⁴ Effective ¹[two years after the date of enactment of
6 P.L. , c. (C.) (pending before the Legislature as this bill)] 12
7 months after the adoption of regulations establishing standard health
8 care enrollment and claim forms by the Commissioner of Banking and
9 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before
10 the Legislature as this bill)¹, a health care facility licensed pursuant to
11 P.L.1971, c.136 (C.26:2H-1 et seq.) is responsible for filing all claims
12 for third party payment, including claims filed on behalf of the health
13 care facility's patient for any health care service provided by the health
14 care facility that is eligible for third party payment, except that at the
15 patient's option, the patient may file the claim for third party payment.

16 ³[The]

17 a. In the case of a claim filed on behalf of the health care facility's
18 patient, the³ health care facility shall file ³[a] the³ claim within 60
19 days of the last date of service for a course of treatment, on the
20 standard claim form adopted by the Commissioner of Banking and
21 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before
22 the Legislature as this bill).

23 ³b. In the case of a claim in which the patient has assigned his
24 benefits to the health care facility, the health care facility shall file the
25 claim within 180 days of the last date of service for a course of
26 treatment, on the standard claim form adopted by the Commissioner
27 of Banking and Insurance pursuant to section 1 of P.L. , c.
28 (C.)(pending before the Legislature as this bill). If the health care
29 facility does not file the claim within 180 days of the last date of
30 service for a course of treatment, the third party payer shall reserve the
31 right to deny payment of the claim, in accordance with regulations
32 established by the Commissioner of Banking and Insurance, and the
33 health care facility shall be prohibited from seeking any payment
34 directly from the patient.

35 (1) In establishing the standards for denial of payment, the
36 Commissioner of Banking and Insurance shall consider the length of
37 delay in filing the claim, the good faith use of information provided by
38 the patient to the health care facility with respect to the identity of the
39 patient's third party payer, delays in filing a claim related to
40 coordination of benefits between third party payers and any other
41 factors the commissioner deems appropriate, and, accordingly, shall
42 define specific instances where the sanctions permitted pursuant to this
43 subsection shall not apply.

44 (2) A health care facility which fails to file a claim within 180 days
45 and whose claim for payment has been denied by the third party payer
46 in accordance with this subsection may, in the discretion of a judge of

1 the Superior Court, be permitted to refile the claim if the third party
2 payer has not been substantially prejudiced thereby. Application to the
3 court for permission to refile a claim shall be made within 14 days of
4 notification of denial of payment and shall be made upon motion based
5 upon affidavits showing sufficient reasons for the failure to file the
6 claim with the third party payer within 180 days.³

7 ³c.³ ¹The provisions of this section shall not apply to any claims
8 filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).¹

9 ³d.³ ³A health care facility ³[that] which³ violates the provisions
10 of ³subsection a. of³ this section ¹[shall] may¹ be subject to ¹[such
11 penalties as the Department of Health and Senior Services shall
12 determine pursuant to sections 13 and 14 of P.L.1971, c.136
13 (C.26:2H-13 and 26:2H-14)] a civil penalty of \$250 for each violation
14 plus \$50 for each day after the 60th day that the health care facility
15 fails to submit a claim. The penalty shall be sued for and collected by
16 the Department of Health and Senior Services pursuant to "the penalty
17 enforcement law," N.J.S.2A:58-1 et seq¹.

18
19 ⁴[18.] 15.⁴ The Commissioner of Banking and Insurance Comm
20 issioner, in consultation with the Commissioner of Health and Senior
21 Services, shall adopt regulations to effectuate the purposes of sections
22 1 through 10 of this act, pursuant to the "Administrative Procedure
23 Act," P.L.1968, c.410 (C.52:14B-1 et seq.). ³To the extent
24 practicable, the regulations shall include any provisions the
25 commissioner deems appropriate that seek to reduce the amount of, or
26 to consolidate, the paper forms sent by hospital, medical, health and
27 dental service corporations, commercial insurers, health maintenance
28 organizations, dental plan organizations and prepaid prescription
29 service organizations to health care providers and covered persons.³

30
31 ⁴[19.] 16.⁴ Thomas A. Edison State College shall study and
32 monitor the effectiveness of electronic data interchange technology in
33 reducing administrative costs, identify means by which new electronic
34 data interchange technology can be implemented to effect health care
35 system cost savings, and determine the extent of electronic data
36 interchange technology use in the State's health care system.

37 The Departments of Health and Senior Services and Banking and
38 Insurance shall cooperate with and provide assistance to the college in
39 carrying out its study pursuant to this section.

40 The college shall report to the Legislature and the Governor from
41 time to time on its findings and recommendations.¹

42
43 ⁴[20.] 17.⁴ Sections 78, 79, and 80 of P.L.1991, c.187
44 (C.17B:26-12.1, 17B:27-44.1 and 26:2J-5.1) are repealed.³

45
46 ²[20. There is appropriated \$250,000 from the General Fund to

1 the Department of State for a grant to Thomas A. Edison State
2 College to carry out the purposes of section 19 of this act.¹²

3

4 ¹[19.] ²[21.1] ³[20.2] ⁴[21.3] 18⁴. This act shall take effect
5 immediately¹; and section 11 shall apply to the fiscal or calendar
6 accounting years beginning on or after July 1, 1998, section 12 shall
7 apply to calendar years beginning after July 1, 1998, and section 13
8 shall apply to taxable years beginning on or after January 1, 1998]¹.

9

10

11

12

13 _____
14 Provides incentives to stimulate development and use of health
15 information electronic data interchange technology and provides for
prompt payment of health care claims.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: NOVEMBER 9, 1998

The Assembly Appropriations Committee reports favorably Senate Bill Nos. 323/324/325/326/327/328/329/330/331 SCS (1R) with committee amendments.

Senate Bill Nos. 323/324/325/326/327/328/329/330/331 SCS (1R), as amended, is intended to promote the development and use in New Jersey of health care information electronic data interchange (EDI) technology in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to the federal "Health Insurance Portability and Accountability Act of 1996" ("HIPAA"), Pub.L.104-191. The bill implements recommendations of the Healthcare Information Networks and Technologies (HINT) report to the Legislature under the joint auspices of Thomas A. Edison State College and the New Jersey Institute of Technology.

Standardization of health care forms and data communication. Section 1 of the bill directs the Commissioner of Banking and Insurance ("B & I") to (a) adopt by regulation a single set of health plan enrollment and claim forms, in both paper and electronic formats, for use by health care providers and health, dental and prescription plan insurers in New Jersey, and (b) establish standards for electronic conduct of insurance-related transactions (e.g., filing benefit claims, transmitting payment or remittance advice, authorizing or certifying a referral, etc.). The bill directs the commissioner to adopt the same forms and standards that are adopted by the federal government under HIPAA, thereby ensuring their consistency with the national regimen. The commissioner is also directed to establish timetables for health, dental and prescription plan insurers' implementation of the standards, but is authorized to allow extensions and waivers in cases of potential undue hardship. The commissioner is to report to the Governor and the Legislature, within one year of establishing the timetable, on the number of extensions and waivers of the implementation requirement

granted, and the reasons therefor.

Sections 2 through 10 of the bill require the several types of health, dental, and prescription service insurers to (a) implement use of the standardized enrollment and claim forms within 12 months of the regulatory adoption of those forms, and (b) demonstrate to the commissioner, within 180 days of the regulatory adoption of the timetable for the electronic transaction and communication standards referred to above, that they will implement those standards in accordance with the appropriate timetable as a condition of continued authorization to do business in New Jersey.

Provider submission of benefit claims. Sections 2 through 10, 16 and 17 of the bill require that, effective 12 months after adoption of the regulations establishing the standardized claim forms, health care providers submit all health care claims to health, dental and prescription service insurance carriers for payment. A person covered by a health, dental or prescription service benefits plan who receives health care services would be allowed, but could not be required, to submit claims to a carrier.

Prompt payment of claims. Sections 2 through 10 of the bill require insurance carriers to pay promptly any uncontested ("clean") health, dental or prescription service benefits claims that are electronically submitted, so that beginning 12 months after the adoption of regulations establishing the standardized claim forms, the carriers would be required to pay those claims within the applicable number of calendar days, following submission, as provided for payment of claims under the federal Medicare program. An overdue payment would bear simple interest at the rate of 10% per year. In the case of contested claims that are submitted electronically, a carrier would be required to notify the claimant within 30 days that the claim was contested or denied and pay the uncontested portion of the claim within 30 days.

The purpose of these special "prompt payment" rules is the encouragement of the electronic filing of claims.

Tax incentives for investment in EDI technology. Sections 11 through 13 of the bill allow a temporary 10% tax credit against the corporation business tax, the franchise tax on insurance companies generally, and the gross income tax, for the purchase, lease or rental of EDI technology to receive and transmit health care information. The gross income tax credit would be available only to licensed health care providers (e.g., doctors and dentists), entities that process enrollments or claims under health care benefits plans, employers that self-insure for employee health benefits, and vendors of computer software that supports health care EDI. The corporation business tax credit would be generally available to these taxpayers and also to licensed health care facilities.

Advisory board on EDI technology policy. Section 14 of the bill directs the Commissioner of Health and Senior Services ("HSS"), in consultation with the Commissioner of Banking and Insurance, to

establish an advisory board to make recommendations to the commissioners on health information EDI technology policy, including measures to protect the confidentiality of medical information. The advisory board will include representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, and health care consumers.

Annual report. Section 15 of the bill directs the Commissioner of HSS, in conjunction with the Commissioner of Banking and Insurance, to present an annual report to the Governor and the Legislature on the development and use of health information EDI technology in New Jersey. The report shall include any recommendations for regulatory or legislative changes to promote the development and use of health information EDI technology.

Continuing study of EDI technology. Section 19 directs Thomas A. Edison State College to study and monitor the use of EDI technology and its effectiveness in reducing administrative costs.

As amended by this committee, this bill is identical to Assembly Bill No. 2119 as amended and reported by this committee.

FISCAL IMPACT:

The only provisions of the bill with major potential fiscal impact on the State are those allowing temporary tax credits for the purchase of EDI technology. No data are available regarding the variables implicated by these provisions, e.g., the potential Statewide cost of EDI technology, the proportion of EDI technology consumers who are New Jersey corporation business taxpayers, insurance premiums taxpayers, or gross income tax payers, the annual tax liability of these taxpayers, and the proportion of EDI technology usage that is directly attributable to New Jersey health and medical transactions. Because of the lack of data it is not possible to provide a reliable cost estimate for the bill.

An estimate prepared by the Division of Taxation for Senate Bill No. 325 of 1998 (the source of the temporary tax credit provisions in the current bill) projects a loss in revenue to the State of at least \$20 million during each of FY 1999 and FY 2000. However, because that estimate is based on assumed values for the missing data points already mentioned, it is at best an order-of-magnitude estimate and should not be read as a precise dollar value estimate.

The Office of Legislative Services (OLS) notes that the primary consumers of EDI technology in New Jersey are expected to be insurance companies, hospitals, physicians and dentists. Of these groups, the OLS believes that the primary beneficiaries of the tax credit will be certain insurance premiums tax payers. In general, hospitals will not qualify for this credit because all New Jersey hospitals, with one exception, are currently non-profit institutions and, as such, do not pay corporation business taxes. (However, it is possible that a for-profit subsidiary of a hospital would be eligible to take the credit.) The costs for physicians to acquire EDI technology

access will probably not be significant, as in most cases all that will be required is the addition of a modem and software to an existing computer system. Thus, the primary beneficiaries of this credit will likely be those insurance companies not currently using EDI technology. These insurance companies will incur relatively larger infrastructure costs for the purchase of EDI technology and will have sufficient tax liability under the insurance premiums tax to take advantage of this credit.

With respect to the bill's administrative costs, OLS notes that Department of Banking and Insurance additional data processing expenditures would be borne by the insurance industry pursuant to the special purpose apportionment imposed by section 2 of P.L.1995, c.156 (C.17:1C-20), a special funding mechanism of the Department of Banking and Insurance.

COMMITTEE AMENDMENTS:

The amendments revise the tax years in which the tax incentives will be available so that three full years will be prospectively available or each taxpayer type.

The amendments delete a \$250,000 appropriation for a study which duplicates an appropriation in the current State annual appropriations act.

The amendments make a technical correction to a self-contradictory reference in section 13.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR SENATE, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331

STATE OF NEW JERSEY

DATED: OCTOBER 5, 1998

The Assembly Health Committee reports favorably the Senate Committee Substitute for Senate Bill Nos. 323, 324, 325, 326, 327, 327, 328, 329, 330 and 331 (1R).

This committee substitute is intended to promote the development and use in New Jersey of health care information electronic data interchange (EDI) technology in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to the federal "Health Insurance Portability and Accountability Act of 1996" (HIPAA), Pub.L.104-191. The substitute would implement recommendations of the Healthcare Information Networks and Technologies (HINT) report to the Legislature under the joint auspices of Thomas A. Edison State College and the New Jersey Institute of Technology.

Standardization of health care forms and data communication. Section 1 of the substitute directs the Commissioner of Banking and Insurance to: (a) adopt by regulation a single set of health plan enrollment and claim forms, in both paper and electronic formats, for use by health care providers and health, dental and prescription plan insurers in New Jersey, and (b) establish standards for electronic conduct of insurance-related transactions (e.g., filing benefit claims, transmitting payment or remittance advice, authorizing or certifying a referral, etc.). The commissioner is directed to adopt the same forms and standards that are adopted by the federal government under HIPAA, thereby ensuring their consistency with the national regimen. The commissioner is also directed to establish timetables for implementation of the standards by health, dental and prescription plan insurers, but is authorized to allow extensions and waivers in cases of potential undue hardship. The commissioner is to report to the Governor and the Legislature, within one year of establishing the timetable, on the number of extensions and waivers of the implementation requirement granted, and the reasons therefor.

Sections 2 through 10 of the substitute require the several types of

health, dental, and prescription service insurers to: (a) implement use of the standardized enrollment and claim forms within 12 months of the regulatory adoption of those forms, and (b) demonstrate to the Commissioner of Banking and Insurance, within 180 days of the regulatory adoption of the timetable for the electronic transaction and communication standards referred to above, that they will implement those standards in accordance with the appropriate timetable as a condition of continued authorization to do business in New Jersey.

Provider submission of benefit claims. Sections 2 through 10, 16 and 17 of the substitute require that, effective 12 months after adoption of the regulations establishing the standardized claim forms, health care providers must submit all health care claims to health, dental and prescription service insurance carriers for payment. A person covered by a health, dental or prescription service benefits plan who receives health care services would be allowed, but could not be required, to submit claims to a carrier.

Prompt payment of claims. Sections 2 through 10 of the substitute require insurance carriers to pay promptly any uncontested ("clean") health, dental or prescription service benefits claims that are electronically submitted, so that beginning 12 months after the adoption of regulations establishing the standardized claim forms, the carriers would be required to pay those claims within the applicable number of calendar days, following submission, as provided for payment of claims under the federal Medicare program. An overdue payment would bear simple interest at the rate of 10% per year. In the case of contested claims that are submitted electronically, a carrier would be required to notify the claimant within 30 days that the claim was contested or denied and pay the uncontested portion of the claim within 30 days.

The intent of these special "prompt payment" rules is to encourage electronic filing of claims.

Tax incentives for investment in EDI technology. Sections 11 through 13 of the substitute allow a temporary 10% tax credit, against the corporation business tax, the franchise tax on insurance companies generally, and the gross income tax, for the purchase, lease or rental of EDI technology to receive and transmit health care information. The gross income tax credit would be available only to licensed health care providers (e.g., doctors and dentists), entities that process enrollments or claims under health care benefits plans, employers that self-insure for employee health benefits, and vendors of computer software that supports health care EDI. The corporate business tax credit would be generally available to these taxpayers and also to licensed health care facilities.

Advisory board on EDI technology policy. Section 14 of the substitute directs the Commissioner of Health and Senior Services, in consultation with the Commissioner of Banking and Insurance, to establish an advisory board to make recommendations to the commissioners on health information EDI technology policy, including

measures to protect the confidentiality of medical information. The advisory board would include representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, and health care consumers.

Annual report. Section 15 of the substitute directs the Commissioner of Health and Senior Services, in conjunction with the Commissioner of Banking and Insurance, to present an annual report to the Governor and the Legislature on the development and use of health information EDI technology in New Jersey. The report is to include any recommendations for regulatory or legislative changes to promote the development and use of health information EDI technology.

Continuing study of EDI technology. Sections 19 and 20 direct Thomas A. Edison State College to study and monitor the use of EDI technology and its effectiveness in reducing administrative costs, and appropriate \$250,000 to the Department of State to fund a grant to the college to support this study.

This substitute is identical to Assembly Bill No. 2119 (Felice/Doria), which the committee also reported favorably on this date.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR **SENATE, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331**

STATE OF NEW JERSEY

DATED: MARCH 26, 1998

The Senate Health Committee reports favorably a Senate Committee Substitute for Senate Bill Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331.

The provisions of this committee substitute are intended to promote the development and use of health information electronic data interchange (EDI) technology in New Jersey, in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to the federal "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (HIPAA).

It is anticipated that this substitute will:

-- benefit health care consumers, third party payers and health care facilities and providers by simplifying and expediting the filing and payment of health care benefits claims;

-- motivate health care professionals and facilities to implement electronic claims processing systems, which will result in administrative cost savings for third party payers by reducing their claims processing costs and improve cash flow for health care professionals and facilities; and

-- provide a financial incentive for third party payers and health care facilities and providers to purchase, lease or rent computer equipment and software that will permit electronic claims processing and other health care electronic data interchanges with the potential to significantly reduce health care administrative costs in this State.

Specifically, the substitute provides as follows:

- Hospital, medical and health service corporations, individual and group commercial health insurers, health maintenance organizations, dental service corporations, dental plan organizations, prepaid prescription service organizations and their subsidiaries that process health care benefits claims as third party administrators, are required to use standard enrollment and claim forms for paper and electronic transactions in connection with all policies and contracts for health care benefits, and to demonstrate that they will adopt and implement standards established by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, to receive and

transmit health care transactions electronically, pursuant to regulations to be adopted by the commissioners within 90 days after adoption of final federal rules governing electronic claims transaction sets pursuant to HIPAA.

- All uncontested, "clean claims" for health care benefits, as defined in this substitute in accordance with federal regulations governing the Medicare program, which are submitted electronically are required to be paid by insurance carriers within 30 days after receipt of the claim by the carrier, for the first two years after the date of enactment of the substitute, and within 17 days after receipt of the claim by the carrier, thereafter. An overdue payment shall bear simple interest at the rate of 10% per year. In the case of contested claims that are submitted electronically, a carrier would be required to notify the person who submitted the claim (within 30 days for the first two years after enactment and 17 days thereafter) that the claim was contested or denied and pay the uncontested portion of the claim within 30 days.
- Beginning two years after the effective date of the substitute, health care providers (physicians and other health care professionals and hospitals and other licensed health care facilities) will be required to submit all health care claims to health insurance carriers for payment; a person covered by a health benefits plan who receives health care services will not be required to submit any such claim to his carrier, but will not be prohibited from doing so, at the person's option.
- Effective two years after the effective date of the substitute, a carrier shall not restrict the covered person's right to assign any payment owed to the health care provider.
- A 10% tax credit against the New Jersey Corporation Business Tax imposed pursuant to P.L.1945, c.162 (C.54:10A-1 et seq.), the tax imposed on insurance companies generally pursuant to P.L.1945, c.132 (C.54:18A-1 et seq.), and the gross income tax imposed pursuant to N.J.S.54A:1-1 et seq., as appropriate, is established as an incentive for the purchase, lease or rental of electronic data interchange (EDI) technology to receive and transmit health care information. The tax credits will be available for tax years beginning on or after January 1, 1998 but before January 1, 2000. The substitute also specifically provides for a gross income tax credit for sole proprietors, partners in a partnership, members of an association and shareholders in a New Jersey S corporation who purchase EDI technology. It makes the corporate business tax credit and the gross income tax credit available to: entities that process enrollments for health care benefits plans, employers providing a comprehensive self-funded health benefits plan to their employees or their dependents, and to health care providers who are eligible for reimbursement by health care benefits payers. The substitute requires the equipment purchased, leased or rented to be used for the transmission,

storage and retrieval of health care information according to standards developed by the Commissioner of Banking and Insurance.

- The Commissioner of Health and Senior Services, in consultation with the Commissioner of Banking and Insurance, shall establish an advisory board to make recommendations to the commissioners on health information EDI technology policy, including measures to protect the confidentiality of medical information. The advisory board would include, at a minimum, representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, and health care consumers.
- The Commissioner of Health and Senior Services, in conjunction with the Commissioner of Banking and Insurance, shall present an annual report to the Governor and the Legislature on the development and use of health information EDI technology in New Jersey, to include any recommendations for regulatory or legislative changes to make in order to promote the development and use of health information EDI technology. The commissioners shall prepare the report with the cooperation and assistance of the New Jersey Institute of Technology and Thomas Edison State College and in consultation with the advisory board.

This substitute is designed to effectuate recommendations of the Healthcare Information Networks and Technologies (HINT) report to the Legislature under the joint auspices of Thomas Edison State College and the New Jersey Institute of Technology, and to comply with the requirements of HIPAA.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR SENATE, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 21, 1998

The Senate Budget and Appropriations Committee reports favorably and with committee amendments the Senate Committee Substitute for Senate Bill Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331.

The purpose of this legislation is to promote the development and use in New Jersey of health care information electronic data interchange (EDI) technology in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to the federal "Health Insurance Portability and Accountability Act of 1996" ("HIPAA"), Pub.L.104-191. The bill would implement recommendations of the Healthcare Information Networks and Technologies (HINT) report to the Legislature under the joint auspices of Thomas A. Edison State College and the New Jersey Institute of Technology.

Standardization of health care forms and data communication. Section 1 of the bill directs the Commissioner of Banking and Insurance ("B & I") to (a) adopt by regulation a single set of health plan enrollment and claim forms, in both paper and electronic formats, for use by health care providers and health, dental and prescription plan insurers in New Jersey, and (b) establish standards for electronic conduct of insurance-related transactions (e.g., filing benefit claims, transmitting payment or remittance advice, authorizing or certifying a referral, etc.). The Commissioner is directed to adopt the same forms and standards that are adopted by the federal government under HIPAA, thereby ensuring their consistency with the national regimen. The Commissioner is also directed to establish timetables for health, dental and prescription plan insurers' implementation of the standards, but is authorized to allow extensions and waivers in cases of potential undue hardship. The Commissioner is to report to the Governor and the Legislature, within one year of establishing the timetable, on the number of extensions and waivers of the implementation requirement granted, and the reasons therefor.

Sections 2 through 10 of the bill require the several types of health, dental, and prescription service insurers to (a) implement use of the standardized enrollment and claim forms within 12 months of the regulatory adoption of those forms, and (b) demonstrate to the Commissioner of B & I, within 180 days of the regulatory adoption of the timetable for the electronic transaction and communication standards referred to above, that they will implement those standards in accordance with the appropriate timetable as a condition of continued authorization to do business in New Jersey.

Provider submission of benefit claims. Sections 2 through 10, 16 and 17 of the bill require that, effective 12 months after adoption of the regulations establishing the standardized claim forms, health care providers must submit all health care claims to health, dental and prescription service insurance carriers for payment. A person covered by a health, dental or prescription service benefits plan who receives health care services would be allowed, but could not be required, to submit claims to a carrier.

Prompt payment of claims. Sections 2 through 10 of the bill require insurance carriers to pay promptly any uncontested ("clean") health, dental or prescription service benefits claims that are electronically submitted, so that beginning 12 months after the adoption of regulations establishing the standardized claim forms, the carriers would be required to pay those claims within the applicable number of calendar days, following submission, as provided for payment of claims under the federal Medicare program. An overdue payment would bear simple interest at the rate of 10% per year. In the case of contested claims that are submitted electronically, a carrier would be required to notify the claimant within 30 days that the claim was contested or denied and pay the uncontested portion of the claim within 30 days.

The intent of these special "prompt payment" rules is to encourage electronic filing of claims.

Tax incentives for investment in EDI technology. Sections 11 through 13 of the bill allow a temporary 10% tax credit, against the corporation business tax, the franchise tax on insurance companies generally, and the gross income tax, for the purchase, lease or rental of EDI technology to receive and transmit health care information. The gross income tax credit would be available only to licensed health care providers (e.g., doctors and dentists), entities that process enrollments or claims under health care benefits plans, employers that self-insure for employee health benefits, and vendors of computer software that supports health care EDI. The corporate business tax credit would be generally available to these taxpayers and also to licensed health care facilities.

Advisory board on EDI technology policy. Section 14 of the bill directs the Commissioner of Health and Senior Services ("HSS"), in consultation with the Commissioner of B & I, to establish an advisory

board to make recommendations to the commissioners on health information EDI technology policy, including measures to protect the confidentiality of medical information. The advisory board would include representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, and health care consumers.

Annual report. Section 15 of the bill directs the Commissioner of HSS, in conjunction with the Commissioner of B & I, to present an annual report to the Governor and the Legislature on the development and use of health information EDI technology in New Jersey. The report is to include any recommendations for regulatory or legislative changes to promote the development and use of health information EDI technology.

Continuing study of EDI technology. Sections 19 and 20 direct Thomas A. Edison State College to study and monitor the use of EDI technology and its effectiveness in reducing administrative costs, and appropriate \$250,000 to the Department of State to fund a grant to the College to support this study.

COMMITTEE AMENDMENTS:

The committee adopted amendments to the bill to:

(1) Incorporate the requirement that the Commissioner of Banking and Insurance shall report to the Legislature on the number of extensions and waivers granted to health, dental and prescription plan insurers with respect to the requirement to implement the electronic receipt and transmission of health care claim information;

(2) Revise the deadline for implementation of the requirement that providers file payment claims for their services from two years following the date of the bill's enactment to 12 months following the adoption of the regulations prescribing the standardized forms;

(3) Delete a provision prohibiting these insurers from restricting a subscriber's right to assign payment owed to the subscriber's care provider;

(4) Adopt, as the insurer prompt payment deadline for "clean" claims electronically filed, the Medicare program's standard (currently, 30 days) in place of provisions for a 17-day deadline following a two-year phase-in period and provide that the deadline shall be implemented twelve months after adoption of the regulations standardizing the claim forms;

(5) Substitute civil penalty for disciplinary action as the sanction to which a health care professional may be liable upon violation of the bill's provision that the professional is to be responsible for filing third party payment claims on behalf of their insured patients and provide the same civil penalties for such violations by health care facilities;

(6) Incorporate the provision directing Thomas A. Edison State College to study and monitor the use of EDI technology and its

effectiveness in reducing administrative costs, and appropriating \$250,000 to support that study; and

(7) Make technical corrections.

FISCAL IMPACT

The only portions of this legislation having potential fiscal impact on the State are the provisions allowing temporary tax credits for the purchase of EDI technology. Because no data is available regarding the variables implicated by these provisions -- e.g., the potential Statewide cost of EDI technology, the proportion of EDI technology consumers who are New Jersey corporation business taxpayers or insurance premiums taxpayers, the annual tax liability of these taxpayers, and the proportion of EDI technology usage that is directly attributable to New Jersey health and medical transactions -- it is impossible to provide a reliable estimate of the cost of the bill.

STATEMENT TO

[Second Reprint]

SENATE COMMITTEE SUBSTITUTE FOR **SENATE, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331**

with Assembly Floor Amendments
(Proposed By Assemblyman FELICE)

ADOPTED: DECEMBER 17, 1998

These amendments expand the "prompt pay" provisions of the bill to:

- provide that carriers shall pay claims within 30 days or within the Medicare standard, whichever time period is less (currently, the Medicare standard also is 30 days);

- include claims submitted other than by electronic means (paper claims) and provide that carriers must pay these claims within 40 days of receipt;

- explicitly state the conditions under which a claim must be paid within the 30/40 day requirements and the reasons a claim may be denied;

- require carriers to notify claimants within 30 days if a claim is denied and provide all the reasons therefor;

- require carriers to acknowledge receipt of a claim submitted electronically no later than two working days after receipt;

- state that payment of a claim shall be deemed overdue if not remitted to the claimant or his agent on or before the 30th or 40th day for electronic and paper claims, respectively;

- provide that the "prompt pay" provisions shall take effect 180 days after enactment of the bill; and

- clarify that the prompt pay provisions only apply to "insured claims" under a covered person's health benefits plan for which the financial obligation for the payment of the claim rests with the carrier.

Amendments also provide that in the case of a claim in which the patient has assigned his benefits to a health care professional or health care facility, the professional or facility shall file the claim within 180 days of the last date of service for a course of treatment. If the claim is not filed within 180 days, the third party payer shall reserve the right to deny payment of the claim, in accordance with regulations established by the Commissioner of Banking and Insurance, and the health care professional or facility shall be prohibited from seeking any payment directly from the patient. A health care professional or facility which fails to file a claim within 180 days and whose claim for

payment has been denied by the third party payer may, in the discretion of a judge of the Superior Court, be permitted to refile the claim if the third party payer has not been substantially prejudiced thereby. The substitute still provides that claims filed on behalf of a patient (in cases of no assignment of benefits) would have to be filed by the health care professional or facility within 60 days of the last date of service for a course of treatment.

The amendments direct the Commissioner of Banking and Insurance, to the extent practicable, to adopt regulations which include any provisions the commissioner deems appropriate that seek to reduce the amount of, or to consolidate, the paper forms sent by insurers to health care providers and covered persons.

Finally, amendments repeal sections 78, 79, and 80 of P.L.1991, c.187 (C.17B:26-12.1, 17B:27-44.1 and 26:2J-5.1) which established a 60-day prompt payment of claims requirement for individual and group commercial insurers and health maintenance organizations, since these amendments establish shorter time frames for payment of claims.

FISCAL NOTE

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR SENATE, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331

STATE OF NEW JERSEY 208th LEGISLATURE

DATED: JULY 20, 1998

Bill Summary:

Senate Committee Substitute for Senate Bill Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331 (1R) of 1998 are intended to promote the development and use of health information electronic data interchange (EDI) technology in New Jersey, in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to the federal "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (HIPAA).

Specifically, the substitute:

- provides for the standardization of health care forms and data communication used by health care providers and health and dental insurers in New Jersey;
- requires health care providers to submit all health care claims to health insurance carriers for payment;
- requires insurance carriers to pay promptly any uncontested ("clean") health care benefits claims that are electronically submitted;
- allows a temporary 10 percent tax credit, against the corporation business tax, the franchise tax on insurance companies generally, and the gross income tax, for the purchase, lease or rental of electronic data interchange (EDI) technology to receive and transmit health care information;
- directs the Commissioner of Health and Senior Services, in consultation with the Commissioner of Banking and Insurance, to establish an advisory board to make recommendations on health information EDI technology policy, and provide an annual report to the Governor and the Legislature on the development and use of such technology in New Jersey; and
- appropriates \$250,000 from the General Fund to the Department

of State for a grant to Thomas A. Edison State College to study and monitor the effectiveness of EDI technology.

Fiscal Summary:

Most of the bill's provisions will have no fiscal impact on the State. However, sections 11 through 13 of the substitute provide that taxpayers who purchase EDI technology during a taxable year ending after June 30, 1998, but before July 1, 2000, are eligible to receive a 10 percent tax credit in accordance with limitations set forth by the bill. The bill requires that EDI technology must be used primarily for the submission of health benefits claims, inquiries about health benefits claims, information about health benefits claims payments, health benefits plan enrollment transactions, or health benefits-related eligibility inquiries.

The gross income tax credit would be available only to licensed health care providers (e.g., doctors and dentists), entities that process enrollments or claims under health care benefits plans, employers that self-insure for employee health benefits, and vendors that provide computer software to support health care EDI. The corporate business tax credit would be generally available to these taxpayers and also to licensed health care facilities. The value of the credit in any given year cannot exceed 50 percent of the taxpayer's liability that would otherwise be due; however, the taxpayer may carry forward the unused portion of the credit for up to seven successive tax years.

In addition to the credit, section 20 appropriates \$250,000 from the General Fund to the Department of State for a grant to Thomas A. Edison State College.

Executive Estimate:

An estimate prepared by the Division of Taxation for Senate Bill No. 325 of 1998 (which provides for the temporary tax credit referenced in sections 11 through 13 of the current bill) projects a loss in revenue to the State of at least \$20 million during each of the next two fiscal years, FY 1999 and FY 2000.

The division's estimate is derived from annual receipts from the sale of computer technology in this State, which according to the division, exceed \$10 billion annually (based on 1997 data). Of this amount, the division assumes that ten percent, or \$1 billion, of these sales are related to health care benefits processing. It is further assumed that of health care related sales, 20 percent, or \$200 million, can be applied against a positive tax liability. A ten percent credit taken against this amount yields the division's annual loss estimates.

Office of Legislative Services Analysis:

In the absence of necessary data, the Office of Legislative Services

(OLS) is unable to provide a reliable estimate of the cost of the bill, and can neither confirm nor refute the division's estimate. To calculate the loss of tax revenue it is necessary to know the potential statewide cost of EDI technology, the proportion of EDI technology consumers who are New Jersey corporation business taxpayers or insurance premiums taxpayers, the annual tax liability of these taxpayers, and the proportion of EDI technology usage that is directly attributable to New Jersey health and medical transactions. Without such information there are currently too many uncertainties regarding the size of the potential credit and which taxpayers will be eligible to take the credit for the OLS to estimate its impact.

Nevertheless, the OLS notes that the primary consumers of EDI technology in New Jersey are expected to be insurance companies, hospitals, physicians and dentists. Of these groups, the OLS believes that the primary beneficiaries of the tax credit will be certain insurance premiums tax payers. In general, hospitals will not qualify for this credit because all New Jersey hospitals, with one exception, are currently non-profit institutions and, as such, do not pay corporation business taxes. (However, it is possible that a for-profit subsidiary of a hospital would be eligible to take the credit.) In addition, although many physicians pay corporation business taxes, most profits from their medical practices are taken as salaries or partnership income and are taxed under the gross income tax. Furthermore, the costs for physicians to acquire EDI technology access will probably not be significant, in most cases requiring the addition of a modem and software to an existing computer system. Thus, the primary beneficiaries of this credit will likely be those insurance companies not currently using EDI technology. These insurance companies will incur relatively larger infrastructure costs for the purchase of EDI technology and will have sufficient tax liability under the insurance premiums tax to take advantage of this credit.

Finally, with respect to the bill's administrative costs, the Department of Banking and Insurance has informally indicated that it anticipates some additional data processing expenditures as a result of this bill; however, the OLS notes that these expenditures would be borne by the insurance industry pursuant to the special purpose apportionment imposed by section 2 of P.L. 1995, c. 156 (C.17:1C-20), a special funding mechanism of the Department of Banking and Insurance. No additional administrative expenditures are anticipated for the Department of Health and Senior Services as a result of the bill.

This fiscal note has been prepared pursuant to P.L.1980, c.67.

[Third Reprint]

SENATE COMMITTEE SUBSTITUTE FOR
**SENATE, Nos. 323, 324, 325, 326, 327,
328, 329, 330 and 331**

STATE OF NEW JERSEY
208th LEGISLATURE

ADOPTED MARCH 26, 1998

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

Co-Sponsored by:

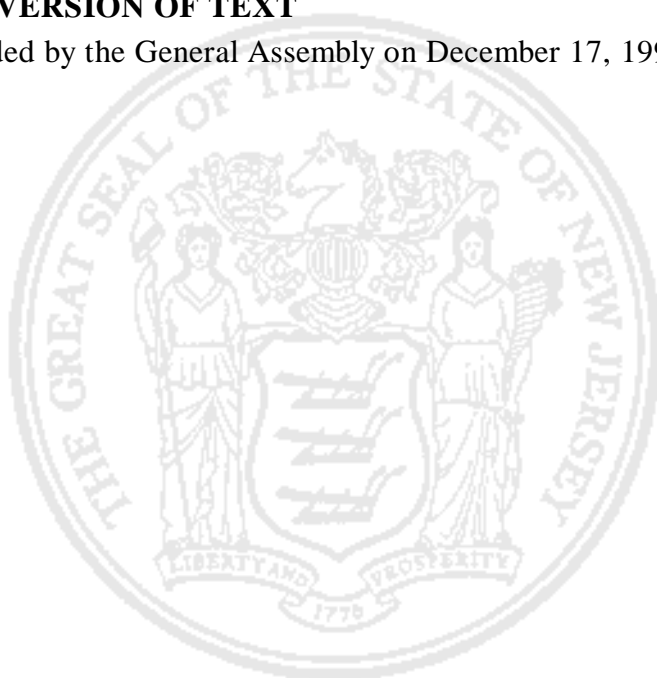
Senator Baer, Assemblymen Felice and Doria

SYNOPSIS

Provides incentives to stimulate development and use of health information electronic data interchange technology and provides for prompt payment of health care claims.

CURRENT VERSION OF TEXT

As amended by the General Assembly on December 17, 1998.



(Sponsorship Updated As Of: 12/17/1998)

1 AN ACT concerning health information electronic data interchange
2 technology ¹**[and]**,¹ supplementing Titles 17, 26 and 54 of the
3 Revised Statutes and Titles 17B and 54A of the New Jersey
4 Statutes ²**[¹and making an appropriation¹]**².

5
6 **BE IT ENACTED** by the Senate and General Assembly of the State
7 of New Jersey:

8
9 1. a. (1) The Commissioner of Banking and Insurance, in
10 consultation with the Commissioner of Health and Senior Services,
11 shall establish, by regulation, a timetable for implementation of the
12 electronic receipt and transmission of health care claim information by
13 each hospital, medical or health service corporation, individual and
14 group health insurer, health maintenance organization, dental service
15 corporation, dental plan organization and prepaid prescription service
16 organization, respectively, and a subsidiary of such corporation,
17 insurer or organization that processes health care benefits claims as a
18 third party administrator, authorized to do business in this State.

19 The Commissioner of Banking and Insurance shall establish the
20 timetable within 90 days of the date the federal Department of Health
21 and Human Services adopts rules establishing standards for health care
22 transactions, including: health claims or equivalent encounter
23 information, including institutional, professional, pharmacy and dental
24 health claims; enrollment and disenrollment in a health plan; eligibility
25 for a health plan; health care payment and remittance advice; health
26 care premium payments; first report of injury; health claim status; and
27 referral certification and authorization, respectively, pursuant to
28 section 262 of Pub.L.104-191 (42 U.S.C.s.1320d et seq.). The
29 commissioner may adopt more than one timetable, if necessary, to
30 conform the requirements of this section with the dates of adoption of
31 the federal rules.

32 (2) The timetable for implementation adopted by the commissioner
33 shall provide for extensions and waivers of the implementation
34 requirement pursuant to paragraph (1) of this subsection in cases
35 when it has been demonstrated to the commissioner's satisfaction that
36 compliance with the timetable for implementation will result in an
37 undue hardship to a hospital, medical or health service corporation,
38 individual or group health insurer, health maintenance organization,
39 dental service corporation, dental plan organization or prepaid
40 prescription service organization, respectively, or a subsidiary of such

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SBA committee amendments adopted May 21, 1998.

² Assembly AAP committee amendments adopted November 9, 1998.

³ Assembly floor amendments adopted December 17, 1998.

1 corporation, insurer or organization that processes health care benefits
2 claims as a third party administrator, authorized to do business in this
3 State.

4 ¹(3) The Commissioner of Banking and Insurance shall report to
5 the Governor and the Legislature within one year of establishing the
6 timetable pursuant to this subsection, on the number of extensions and
7 waivers of the implementation requirement that he has granted
8 pursuant to paragraph (2) of this subsection, and the reasons therefor.¹

9 b. The Commissioner of Banking and Insurance, in consultation
10 with the Commissioner of Health and Senior Services, shall adopt, by
11 regulation ³for each type of contract, as he deems appropriate³, one
12 set of standard health care enrollment and claim forms in paper and
13 electronic formats to be used by each hospital, medical or health
14 service corporation, individual and group health insurer, health
15 maintenance organization, dental service corporation, dental plan
16 organization and prepaid prescription service organization, and a
17 subsidiary of such corporation, insurer or organization that processes
18 health care benefits claims as a third party administrator, authorized to
19 do business in this State.

20 The Commissioner of Banking and Insurance shall establish the
21 standard health care enrollment and claim forms within 90 days of the
22 date the federal Department of Health and Human Services adopts
23 rules establishing standards for the forms.

24

25 2. a. Within 180 days of the adoption of a timetable for
26 implementation pursuant to section 1 of P.L. , c. (C.)(pending
27 before the Legislature as this bill), a hospital service corporation, or
28 a subsidiary that processes health care benefits claims as a third party
29 administrator, shall demonstrate to the satisfaction of the
30 Commissioner of Banking and Insurance that it will adopt and
31 implement all of the standards to receive and transmit health care
32 transactions electronically, according to the corresponding timetable,
33 ¹and otherwise comply with the provisions of this section.¹ as a
34 condition of its continued authorization to do business in this State.

35 The Commissioner of Banking and Insurance may grant extensions
36 or waivers of the implementation requirement when it has been
37 demonstrated to the commissioner's satisfaction that compliance with
38 the timetable for implementation will result in an undue hardship to a
39 hospital service corporation, its subsidiary or its covered persons.

40 b. Within 12 months of the adoption of regulations establishing
41 standard health care enrollment and claim forms by the Commissioner
42 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
43 (pending before the Legislature as this bill), a hospital service
44 corporation or a subsidiary that processes health care benefits claims
45 as a third party administrator shall use the standard health care
46 enrollment and claim forms in connection with all group and individual

1 contracts issued, delivered, executed or renewed in this State.

2 c. ¹ **Effective two years after the effective date of P.L. , c.**
3 **(C.) (pending before the Legislature as this bill):**

4 **(1) Twelve months after the adoption of regulations establishing**
5 **standard health care enrollment and claim forms by the Commissioner**
6 **of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)**
7 **(pending before the Legislature as this bill),¹ a hospital service**
8 **corporation shall require that health care providers file all claims for**
9 **payment for health care services. A covered person who receives**
10 **health care services shall not be required to submit a claim for**
11 **payment, but notwithstanding the provisions of this subsection to the**
12 **contrary, a covered person shall be permitted to submit a claim on his**
13 **own behalf, at the covered person's option**

14 ¹ **(2) a hospital service corporation shall not restrict the**
15 **subscriber's right to assign any payment owed to the health care**
16 **provider; and**

17 **(3) all]. All¹ claims shall be filed using the standard ¹health care¹**
18 **claim form ³applicable to the contract³.**

19 d. ³ **(1) ¹For the two-year period beginning on the effective date**
20 **of P.L. , c. (C.)(pending before the Legislature as this bill)]**
21 **Twelve months after the adoption of regulations establishing standard**
22 **health care enrollment and claim forms by the Commissioner of**
23 **Banking and Insurance pursuant to section 1 of P.L. , c. (C.)**
24 **(pending before the Legislature as this bill)¹, a hospital service**
25 **corporation shall reimburse all clean claims that are filed electronically**
26 **by a provider or a subscriber for payment under a group or individual**
27 **hospital service corporation contract, within ¹[30 days after receipt of**
28 **the claim by the hospital service corporation] the applicable number**
29 **of calendar days established for payment of claims in the Medicare**
30 **program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.**

31 If a claim or portion of a claim that is submitted electronically is
32 contested or denied by the hospital service corporation, the person or
33 entity who filed the claim shall be notified in writing or electronically,
34 as appropriate, within 30 days after receipt of the claim by the hospital
35 service corporation, that the claim is contested or denied, but the
36 uncontested portion of the claim, if any, shall be paid within 30 days
37 after receipt of the claim by the hospital service corporation. The
38 notice that a claim is contested or denied shall identify the contested
39 portion of the claim and the reasons for contesting or denying the
40 claim.

41 ¹ **(2) Effective two years after the effective date of P.L. , c.**
42 **(C.) (pending before the Legislature as this bill), a hospital service**
43 **corporation shall reimburse all clean claims that are filed electronically**
44 **by a provider or a subscriber for payment under a group or individual**
45 **hospital service corporation contract, within 17 days after receipt of**

1 the claim by the hospital service corporation.

2 If a claim or portion of a claim that is submitted electronically is
3 contested or denied by the hospital service corporation, the person or
4 entity who filed the claim shall be notified in writing or electronically,
5 as appropriate, within 17 days after receipt of the claim by the hospital
6 service corporation, that the claim is contested or denied, but the
7 uncontested portion of the claim, if any, shall be paid within 30 days
8 after receipt of the claim by the hospital service corporation. The
9 notice that a claim is contested or denied shall identify the contested
10 portion of the claim and the reasons for contesting or denying the
11 claim.

12 (3) (2)¹ Payment shall be treated as being made on the date a
13 draft or other valid instrument which is equivalent to payment was
14 placed in the United States mail in a properly addressed, postpaid
15 envelope or, if not so posted, on the date of delivery, or the date of
16 electronic fund transfer. An overdue payment shall bear simple
17 interest at the rate of 10% per year.

18 ¹[(4)] (3)¹ For the purposes of this section, "clean claim" has the
19 same meaning given the term in the federal Medicare program
20 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

21 (1) Effective 180 days after the effective date of P.L. , c.
22 (pending before the Legislature as this bill), a hospital service
23 corporation or its agent, hereinafter the payer, shall remit payment for
24 every insured claim submitted by a subscriber or that subscriber's
25 agent or assignee if the contract provides for assignment of benefits,
26 no later than the 30th calendar day following receipt of the claim by
27 the payer or no later than the time limit established for the payment of
28 claims in the Medicare program pursuant to
29 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
30 submitted by electronic means, and no later than the 40th calendar day
31 following receipt if the claim is submitted by other than electronic
32 means, if:

33 (a) the claim is an eligible claim for a health care service provided
34 by an eligible health care provider to a covered person under the
35 contract;

36 (b) the claim has no material defect or impropriety, including, but
37 not limited to, any lack of required substantiating documentation or
38 incorrect coding;

39 (c) there is no dispute regarding the amount claimed;

40 (d) the payer has no reason to believe that the claim has been
41 submitted fraudulently; and

42 (e) the claim requires no special treatment that prevents timely
43 payments from being made on the claim under the terms of the
44 contract.

45 (2) If all or a portion of the claim is denied by the payer because:

46 (a) the claim is an ineligible claim;

1 (b) the claim submission is incomplete because the required
2 substantiating documentation has not been submitted to the payer;

3 (c) the diagnosis coding, procedure coding, or any other required
4 information to be submitted with the claim is incorrect;

5 (d) the payer disputes the amount claimed; or

6 (e) the claim requires special treatment that prevents timely
7 payments from being made on the claim under the terms of the
8 contract.

9 the payer shall notify the subscriber, or that subscriber's agent or
10 assignee if the contract provides for assignment of benefits, in writing
11 or by electronic means, as appropriate, within 30 days, of the
12 following: if all or a portion of the claim is denied, all the reasons for
13 the denial; if the claim lacks the required substantiating
14 documentation, including incorrect coding, a statement as to what
15 substantiating documentation or other information is required to
16 complete adjudication of the claim; if the amount of the claim is
17 disputed, a statement that it is disputed; and if the claim requires
18 special treatment that prevents timely payments from being made, a
19 statement of the special treatment to which the claim is subject.

20 (3) Any portion of a claim that meets the criteria established in
21 paragraph (1) of this subsection shall be paid by the payer in
22 accordance with the time limit established in paragraph (1) of this
23 subsection.

24 (4) A payer shall acknowledge receipt of a claim submitted by
25 electronic means from a health care provider or subscriber, no later
26 than two working days following receipt of the transmission of the
27 claim.

28 (5) If a payer subject to the provisions of P.L.1983, c.320
29 (C.17:33A-1 et seq.) has reason to believe that a claim has been
30 submitted fraudulently, it shall investigate the claim in accordance with
31 its fraud prevention plan established pursuant to section 1 of P.L.1993,
32 c.362 (C.17:33A-15), or refer the claim, together with supporting
33 documentation, to the Office of the Insurance Fraud Prosecutor in the
34 Department of Law and Public Safety established pursuant to section
35 32 of P.L.1998, c.21 (C.17:33A-16).

36 (6) Payment of an eligible claim pursuant to paragraphs (1) and
37 (3) of this subsection shall be deemed to be overdue if not remitted to
38 the claimant or his agent by the payer on or before the 30th calendar
39 day or the time limit established by the Medicare program, whichever
40 is earlier, following receipt by the payer of a claim submitted by
41 electronic means and on or before the 40th calendar day following
42 receipt of a claim submitted by other than electronic means.

43 In the event payment is withheld on all or a portion of a claim by
44 a payer pursuant to subparagraph (b) of paragraph (2) of this
45 subsection, the claims payment shall be overdue if not remitted to the
46 claimant or his agent by the payer on or before the 30th calendar day

1 or the time limit established by the Medicare program, whichever is
2 earlier, for claims submitted by electronic means and the 40th calendar
3 day for claims submitted by other than electronic means, following
4 receipt by the payer of the required documentation or modification of
5 an initial submission.

6 (7) An overdue payment shall bear simple interest at the rate of
7 10% per annum.

8 e. As used in this subsection, "insured claim" or "claim" means a
9 claim by a subscriber for payment of benefits under an insured
10 hospital service corporation contract for which the financial obligation
11 for the payment of a claim under the contract rests upon the hospital
12 service corporation.³

13
14 3. a. Within 180 days of the adoption of a timetable for
15 implementation pursuant to section 1 of P.L. , c. (C.)(pending
16 before the Legislature as this bill), a medical service corporation, or a
17 subsidiary that processes health care benefits claims as a third party
18 administrator, shall demonstrate to the satisfaction of the
19 Commissioner of Banking and Insurance that it will adopt and
20 implement all of the standards to receive and transmit health care
21 transactions electronically, according to the corresponding timetable,
22 ¹and otherwise comply with the provisions of this section, ¹as a
23 condition of its continued authorization to do business in this State.

24 The Commissioner of Banking and Insurance may grant extensions
25 or waivers of the implementation requirement when it has been
26 demonstrated to the commissioner's satisfaction that compliance with
27 the timetable for implementation will result in an undue hardship to a
28 medical service corporation, its subsidiary or its covered persons.

29 b. Within 12 months of the adoption of regulations establishing
30 standard health care enrollment and claim forms by the Commissioner
31 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
32 (pending before the Legislature as this bill), a medical service
33 corporation or a subsidiary that processes health care benefits claims
34 as a third party administrator shall use the standard health care
35 enrollment and claim forms in connection with all group and individual
36 contracts issued, delivered, executed or renewed in this State.

37 c. ¹**[Effective two years after the effective date of P.L. , c.**
38 **(C.) (pending before the Legislature as this bill):**

39 **(1)]** Twelve months after the adoption of regulations establishing
40 standard health care enrollment and claim forms by the Commissioner
41 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
42 (pending before the Legislature as this bill),¹ a medical service
43 corporation shall require that health care providers file all claims for
44 payment for health care services. A covered person who receives
45 health care services shall not be required to submit a claim for
46 payment, but notwithstanding the provisions of this subsection to the

1 contrary, a covered person shall be permitted to submit a claim on his
2 own behalf, at the covered person's option

3 ¹[(2) a medical service corporation shall not restrict the
4 subscriber's right to assign any payment owed to the health care
5 provider; and

6 (3) all] All¹ claims shall be filed using the standard health care¹
7 claim form ³applicable to the contract³.

8 d. ³[(1) ¹[For the two-year period beginning on the effective date
9 of P.L. , c. (C.)(pending before the Legislature as this bill)]
10 Twelve months after the adoption of regulations establishing standard
11 health care enrollment and claim forms by the Commissioner of
12 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
13 (pending before the Legislature as this bill)¹, a medical service
14 corporation shall reimburse all clean claims that are filed electronically
15 by a provider or a subscriber for payment under a group or individual
16 medical service corporation contract, within ¹[30 days after receipt of
17 the claim by the medical service corporation] the applicable number
18 of calendar days established for payment of claims in the Medicare
19 program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

20 If a claim or portion of a claim that is submitted electronically is
21 contested or denied by the medical service corporation, the person or
22 entity who filed the claim shall be notified in writing or electronically,
23 as appropriate, within 30 days after receipt of the claim by the medical
24 service corporation, that the claim is contested or denied, but the
25 uncontested portion of the claim, if any, shall be paid within 30 days
26 after receipt of the claim by the medical service corporation. The
27 notice that a claim is contested or denied shall identify the contested
28 portion of the claim and the reasons for contesting or denying the
29 claim.

30 ¹[(2) Effective two years after the effective date of P.L. , c.
31 (C.) (pending before the Legislature as this bill), a medical service
32 corporation shall reimburse all clean claims that are filed electronically
33 by a provider or a subscriber for payment under a group or individual
34 medical service corporation contract, within 17 days after receipt of
35 the claim by the medical service corporation.

36 If a claim or portion of a claim that is submitted electronically is
37 contested or denied by the medical service corporation, the person or
38 entity who filed the claim shall be notified in writing or electronically,
39 as appropriate, within 17 days after receipt of the claim by the medical
40 service corporation, that the claim is contested or denied, but the
41 uncontested portion of the claim, if any, shall be paid within 30 days
42 after receipt of the claim by the medical service corporation. The
43 notice that a claim is contested or denied shall identify the contested
44 portion of the claim and the reasons for contesting or denying the
45 claim.

46 (3)] (2)¹ Payment shall be treated as being made on the date a

1 draft or other valid instrument which is equivalent to payment was
2 placed in the United States mail in a properly addressed, postpaid
3 envelope or, if not so posted, on the date of delivery, or the date of
4 electronic fund transfer. An overdue payment shall bear simple
5 interest at the rate of 10% per year.

6 ~~'[(4)] (3)'~~¹ For the purposes of this section, "clean claim" has the
7 same meaning given the term in the federal Medicare program
8 pursuant to 42 U.S.C.s.1395u(c)(2)(B).~~]~~

9 (1) Effective 180 days after the effective date of P.L. , c.
10 (pending before the Legislature as this bill), a medical service
11 corporation or its agent, hereinafter the payer, shall remit payment for
12 every insured claim submitted by a subscriber or that subscriber's
13 agent or assignee if the contract provides for assignment of benefits,
14 no later than the 30th calendar day following receipt of the claim by
15 the payer or no later than the time limit established for the payment of
16 claims in the Medicare program pursuant to
17 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
18 submitted by electronic means, and no later than the 40th calendar day
19 following receipt if the claim is submitted by other than electronic
20 means, if:

21 (a) the claim is an eligible claim for a health care service provided
22 by an eligible health care provider to a covered person under the
23 contract;

24 (b) the claim has no material defect or impropriety, including, but
25 not limited to, any lack of required substantiating documentation or
26 incorrect coding;

27 (c) there is no dispute regarding the amount claimed;

28 (d) the payer has no reason to believe that the claim has been
29 submitted fraudulently; and

30 (e) the claim requires no special treatment that prevents timely
31 payments from being made on the claim under the terms of the
32 contract.

33 (2) If all or a portion of the claim is denied by the payer because:

34 (a) the claim is an ineligible claim;

35 (b) the claim submission is incomplete because the required
36 substantiating documentation has not been submitted to the payer;

37 (c) the diagnosis coding, procedure coding, or any other required
38 information to be submitted with the claim is incorrect;

39 (d) the payer disputes the amount claimed; or

40 (e) the claim requires special treatment that prevents timely
41 payments from being made on the claim under the terms of the
42 contract, the payer shall notify the subscriber, or that subscriber's
43 agent or assignee if the contract provides for assignment of benefits,
44 in writing or by electronic means, as appropriate, within 30 days, of
45 the following: if all or a portion of the claim is denied, all the reasons
46 for the denial; if the claim lacks the required substantiating

1 documentation, including incorrect coding, a statement as to what
2 substantiating documentation or other information is required to
3 complete adjudication of the claim; if the amount of the claim is
4 disputed, a statement that it is disputed; and if the claim requires
5 special treatment that prevents timely payments from being made, a
6 statement of the special treatment to which the claim is subject.

7 (3) Any portion of a claim that meets the criteria established in
8 paragraph (1) of this subsection shall be paid by the payer in
9 accordance with the time limit established in paragraph (1) of this
10 subsection.

11 (4) A payer shall acknowledge receipt of a claim submitted by
12 electronic means from a health care provider or subscriber, no later
13 than two working days following receipt of the transmission of the
14 claim.

15 (5) If a payer subject to the provisions of P.L.1983, c.320
16 (C.17:33A-1 et seq.) has reason to believe that a claim has been
17 submitted fraudulently, it shall investigate the claim in accordance with
18 its fraud prevention plan established pursuant to section 1 of P.L.1993,
19 c.362 (C.17:33A-15), or refer the claim, together with supporting
20 documentation, to the Office of the Insurance Fraud Prosecutor in the
21 Department of Law and Public Safety established pursuant to section
22 32 of P.L.1998, c.21 (C.17:33A-16).

23 (6) Payment of an eligible claim pursuant to paragraphs (1) and
24 (3) of this subsection shall be deemed to be overdue if not remitted to
25 the claimant or his agent by the payer on or before the 30th calendar
26 day or the time limit established by the Medicare program, whichever
27 is earlier, following receipt by the payer of a claim submitted by
28 electronic means and on or before the 40th calendar day following
29 receipt of a claim submitted by other than electronic means.

30 In the event payment is withheld on all or a portion of a claim by
31 a payer pursuant to subparagraph (b) of paragraph (2) of this
32 subsection, the claims payment shall be overdue if not remitted to the
33 claimant or his agent by the payer on or before the 30th calendar day
34 or the time limit established by the Medicare program, whichever is
35 earlier, for claims submitted by electronic means and the 40th calendar
36 day for claims submitted by other than electronic means, following
37 receipt by the payer of the required documentation or modification of
38 an initial submission.

39 (7) An overdue payment shall bear simple interest at the rate of
40 10% per annum.

41 e. As used in this subsection, "insured claim" or "claim" means a
42 claim by a subscriber for payment of benefits under an insured medical
43 service corporation contract for which the financial obligation for the
44 payment of a claim under the contract rests upon the medical service
45 corporation.³

1 4. a. Within 180 days of the adoption of a timetable for
2 implementation pursuant to section 1 of P.L. , c. (C.)(pending
3 before the Legislature as this bill), a health service corporation, or a
4 subsidiary that processes health care benefits claims as a third party
5 administrator, shall demonstrate to the satisfaction of the
6 Commissioner of Banking and Insurance that it will adopt and
7 implement all of the standards to receive and transmit health care
8 transactions electronically, according to the corresponding timetable,
9 ¹and otherwise comply with the provisions of this section.¹ as a
10 condition of its continued authorization to do business in this State.

11 The Commissioner of Banking and Insurance may grant extensions
12 or waivers of the implementation requirement when it has been
13 demonstrated to the commissioner's satisfaction that compliance with
14 the timetable for implementation will result in an undue hardship to a
15 health service corporation, its subsidiary or its covered persons.

16 b. Within 12 months of the adoption of regulations establishing
17 standard health care enrollment and claim forms by the Commissioner
18 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
19 (pending before the Legislature as this bill), a health service
20 corporation or a subsidiary that processes health care benefits claims
21 as a third party administrator shall use the standard health care
22 enrollment and claim forms in connection with all group and individual
23 contracts issued, delivered, executed or renewed in this State.

24 c. ¹【Effective two years after the effective date of P.L. , c.
25 (C.) (pending before the Legislature as this bill):

26 (1) Twelve months after the adoption of regulations establishing
27 standard health care enrollment and claim forms by the Commissioner
28 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
29 (pending before the Legislature as this bill).¹ a health service
30 corporation shall require that health care providers file all claims for
31 payment for health care services. A covered person who receives
32 health care services shall not be required to submit a claim for
33 payment, but notwithstanding the provisions of this subsection to the
34 contrary, a covered person shall be permitted to submit a claim on his
35 own behalf, at the covered person's option

36 ¹【(2) a health service corporation shall not restrict the subscriber's
37 right to assign any payment owed to the health care provider; and

38 (3) all . All¹ claims shall be filed using the standard ¹health care¹
39 claim form³ applicable to the contract³.

40 d.³【(1) ¹【For the two-year period beginning on the effective date
41 of P.L. , c. (C.) (pending before the Legislature as this
42 bill)】Twelve months after the adoption of regulations establishing
43 standard health care enrollment and claim forms by the Commissioner
44 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
45 (pending before the Legislature as this bill)¹, a health service
46 corporation shall reimburse all clean claims that are filed electronically

1 by a provider or a subscriber¹ ~~[,]~~¹ for payment under a group or
2 individual health service corporation contract, within ¹ ~~30 days after~~
3 receipt of the claim by the health service corporation ~~the applicable~~
4 number of calendar days established for payment of claims in the
5 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

6 If a claim or portion of a claim that is submitted electronically is
7 contested or denied by the health service corporation, the person or
8 entity who filed the claim shall be notified in writing or electronically,
9 as appropriate, within 30 days after receipt of the claim by the health
10 service corporation, that the claim is contested or denied, but the
11 uncontested portion of the claim, if any, shall be paid within 30 days
12 after receipt of the claim by the health service corporation. The notice
13 that a claim is contested or denied shall identify the contested portion
14 of the claim and the reasons for contesting or denying the claim.

15 ¹ ~~[(2)~~ Effective two years after the effective date of P.L. , c.
16 (C.) (pending before the Legislature as this bill), a health service
17 corporation shall reimburse all clean claims that are filed electronically
18 by a provider or a subscriber, for payment under a group or individual
19 health service corporation contract, within 17 days after receipt of the
20 claim by the health service corporation.

21 If a claim or portion of a claim that is submitted electronically is
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23 entity who filed the claim shall be notified in writing or electronically,
24 as appropriate, within 17 days after receipt of the claim by the health
25 service corporation, that the claim is contested or denied, but the
26 uncontested portion of the claim, if any, shall be paid within 30 days
27 after receipt of the claim by the health service corporation. The notice
28 that a claim is contested or denied shall identify the contested portion
29 of the claim and the reasons for contesting or denying the claim.

30 ~~(3)~~ ¹ ~~(2)~~ Payment shall be treated as being made on the date a
31 draft or other valid instrument which is equivalent to payment was
32 placed in the United States mail in a properly addressed, postpaid
33 envelope or, if not so posted, on the date of delivery, or the date of
34 electronic fund transfer. An overdue payment shall bear simple
35 interest at the rate of 10% per year.

36 ¹ ~~[(4)] (3)~~ For the purposes of this section, "clean claim" has the
37 same meaning given the term in the federal Medicare program
38 pursuant to 42 U.S.C.s.1395u(c)(2)(B). ~~]~~

39 (1) Effective 180 days after the effective date of P.L. , c.
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41 corporation or its agent, hereinafter the payer, shall remit payment for
42 every insured claim submitted by a subscriber or that subscriber's
43 agent or assignee if the contract provides for assignment of benefits,
44 no later than the 30th calendar day following receipt of the claim by
45 the payer or no later than the time limit established for the payment of
46 claims in the Medicare program pursuant to

1 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
2 submitted by electronic means, and no later than the 40th calendar day
3 following receipt if the claim is submitted by other than electronic
4 means, if:

5 (a) the claim is an eligible claim for a health care service provided
6 by an eligible health care provider to a covered person under the
7 contract;

8 (b) the claim has no material defect or impropriety, including, but
9 not limited to, any lack of required substantiating documentation or
10 incorrect coding;

11 (c) there is no dispute regarding the amount claimed;

12 (d) the payer has no reason to believe that the claim has been
13 submitted fraudulently; and

14 (e) the claim requires no special treatment that prevents timely
15 payments from being made on the claim under the terms of the
16 contract.

17 (2) If all or a portion of the claim is denied by the payer because:

18 (a) the claim is an ineligible claim;

19 (b) the claim submission is incomplete because the required
20 substantiating documentation has not been submitted to the payer;

21 (c) the diagnosis coding, procedure coding, or any other required
22 information to be submitted with the claim is incorrect;

23 (d) the payer disputes the amount claimed; or

24 (e) the claim requires special treatment that prevents timely
25 payments from being made on the claim under the terms of the
26 contract, the payer shall notify the subscriber, or that subscriber's
27 agent or assignee if the contract provides for assignment of benefits,
28 in writing or by electronic means, as appropriate, within 30 days, of
29 the following: if all or a portion of the claim is denied, all the reasons
30 for the denial; if the claim lacks the required substantiating
31 documentation, including incorrect coding, a statement as to what
32 substantiating documentation or other information is required to
33 complete adjudication of the claim; if the amount of the claim is
34 disputed, a statement that it is disputed; and if the claim requires
35 special treatment that prevents timely payments from being made, a
36 statement of the special treatment to which the claim is subject.

37 (3) Any portion of a claim that meets the criteria established in
38 paragraph (1) of this subsection shall be paid by the payer in
39 accordance with the time limit established in paragraph (1) of this
40 subsection.

41 (4) A payer shall acknowledge receipt of a claim submitted by
42 electronic means from a health care provider or subscriber, no later
43 than two working days following receipt of the transmission of the
44 claim.

45 (5) If a payer subject to the provisions of P.L.1983, c.320
46 (C.17:33A-1 et seq.) has reason to believe that a claim has been

1 submitted fraudulently, it shall investigate the claim in accordance with
2 its fraud prevention plan established pursuant to section 1 of P.L.1993,
3 c.362 (C.17:33A-15), or refer the claim, together with supporting
4 documentation, to the Office of the Insurance Fraud Prosecutor in the
5 Department of Law and Public Safety established pursuant to section
6 32 of P.L.1998, c.21 (C.17:33A-16).

7 (6) Payment of an eligible claim pursuant to paragraphs (1) and
8 (3) of this subsection shall be deemed to be overdue if not remitted to
9 the claimant or his agent by the payer on or before the 30th calendar
10 day or the time limit established by the Medicare program, whichever
11 is earlier, following receipt by the payer of a claim submitted by
12 electronic means and on or before the 40th calendar day following
13 receipt of a claim submitted by other than electronic means.

14 In the event payment is withheld on all or a portion of a claim by
15 a payer pursuant to subparagraph (b) of paragraph (2) of this
16 subsection, the claims payment shall be overdue if not remitted to the
17 claimant or his agent by the payer on or before the 30th calendar day
18 or the time limit established by the Medicare program, whichever is
19 earlier, for claims submitted by electronic means and the 40th calendar
20 day for claims submitted by other than electronic means, following
21 receipt by the payer of the required documentation or modification of
22 an initial submission.

23 (7) An overdue payment shall bear simple interest at the rate of
24 10% per annum.

25 e. As used in this subsection, "insured claim" or "claim" means a
26 claim by a subscriber for payment of benefits under an insured health
27 service corporation contract for which the financial obligation for the
28 payment of a claim under the contract rests upon the health service
29 corporation.³

30
31 5. a. Within 180 days of the adoption of a timetable for
32 implementation pursuant to section 1 of P.L. , c. (C.)(pending
33 before the Legislature as this bill), a health insurer, or a subsidiary that
34 processes health care benefits claims as a third party administrator,
35 shall demonstrate to the satisfaction of the Commissioner of Banking
36 and Insurance that it will adopt and implement all of the standards to
37 receive and transmit health care transactions electronically, according
38 to the corresponding timetable, ¹and otherwise comply with the
39 provisions of this section.¹ as a condition of its continued
40 authorization to do business in this State.

41 The Commissioner of Banking and Insurance may grant extensions
42 or waivers of the implementation requirement when it has been
43 demonstrated to the commissioner's satisfaction that compliance with
44 the timetable for implementation will result in an undue hardship to a
45 health insurer, its subsidiary or its covered persons.

46 b. Within 12 months of the adoption of regulations establishing

1 standard health care enrollment and claim forms by the Commissioner
2 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
3 (pending before the Legislature as this bill), a health insurer or a
4 subsidiary that processes health care benefits claims as a third party
5 administrator shall use the standard health care enrollment and claim
6 forms in connection with all individual policies issued, delivered,
7 executed or renewed in this State.

8 c. ¹ [Effective two years after the effective date of P.L. ,
9 c. (C.) (pending before the Legislature as this bill):

10 (1) Twelve months after the adoption of regulations establishing
11 standard health care enrollment and claim forms by the Commissioner
12 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
13 (pending before the Legislature as this bill),¹ a health insurer shall
14 require that health care providers file all claims for payment for health
15 care services. A covered person who receives health care services
16 shall not be required to submit a claim for payment, but
17 notwithstanding the provisions of this subsection to the contrary, a
18 covered person shall be permitted to submit a claim on his own behalf,
19 at the covered person's option

20 ¹ [(2) a health insurer shall not restrict the insured's right to assign
21 any payment owed to the health care provider; and

22 (3) all]. All¹ claims shall be filed using the standard ¹ health care¹
23 claim form ³ applicable to the policy³.

24 d. ³ [Notwithstanding the provisions of section 78 of P.L.1991,
25 c.187 (C.17B:26-12.1) to the contrary,

26 (1) ¹ [For the two-year period beginning on the effective date of
27 P.L. , c. (C.)(pending before the Legislature as this bill)] Twelve
28 months after the adoption of regulations establishing standard health
29 care enrollment and claim forms by the Commissioner of Banking and
30 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before
31 the Legislature as this bill)¹, a health insurer shall reimburse all clean
32 claims that are filed electronically by a provider or an insured for
33 payment under an individual policy, within ¹ [30 days after receipt of
34 the claim by the insurer] the applicable number of calendar days
35 established for payment of claims in the Medicare program pursuant
36 to 42 U.S.C.s.1395u(c)(2)(B)¹.

37 If a claim or portion of a claim that is submitted electronically is
38 contested or denied by the insurer, the person or entity who filed the
39 claim shall be notified in writing or electronically, as appropriate,
40 within 30 days after receipt of the claim by the insurer, that the claim
41 is contested or denied, but the uncontested portion of the claim, if any,
42 shall be paid within 30 days after receipt of the claim by the insurer.
43 The notice that a claim is contested or denied shall identify the
44 contested portion of the claim and the reasons for contesting or
45 denying the claim.

1 ¹[(2) Effective two years after the effective date of P.L. , c.
2 (C.) (pending before the Legislature as this bill), a health insurer
3 shall reimburse all clean claims that are filed electronically by a
4 provider or an insured for payment under an individual policy, within
5 17 days after receipt of the claim by the insurer.

6 If a claim or portion of a claim that is submitted electronically is
7 contested or denied by the insurer, the person or entity who filed the
8 claim shall be notified in writing or electronically, as appropriate,
9 within 17 days after receipt of the claim by the insurer, that the claim
10 is contested or denied, but the uncontested portion of the claim, if any,
11 shall be paid within 30 days after receipt of the claim by the insurer.
12 The notice that a claim is contested or denied shall identify the
13 contested portion of the claim and the reasons for contesting or
14 denying the claim.

15 (3) ¹(2) Payment shall be treated as being made on the date a
16 draft or other valid instrument which is equivalent to payment was
17 placed in the United States mail in a properly addressed, postpaid
18 envelope or, if not so posted, on the date of delivery, or the date of
19 electronic fund transfer. An overdue payment shall bear simple
20 interest at the rate of 10% per year.

21 ¹[(4) (3) For the purposes of this section, "clean claim" has the
22 same meaning given the term in the federal Medicare program
23 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

24 (1) Effective 180 days after the effective date of P.L. , c.
25 (pending before the Legislature as this bill), a health insurer or its
26 agent, hereinafter the payer, shall remit payment for every insured
27 claim submitted by an insured or that insured's agent or assignee if the
28 policy provides for assignment of benefits, no later than the 30th
29 calendar day following receipt of the claim by the payer or no later
30 than the time limit established for the payment of claims in the
31 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever
32 is earlier, if the claim is submitted by electronic means, and no later
33 than the 40th calendar day following receipt if the claim is submitted
34 by other than electronic means, if:

35 (a) the claim is an eligible claim for a health care service provided
36 by an eligible health care provider to a covered person under the
37 policy;

38 (b) the claim has no material defect or impropriety, including, but
39 not limited to, any lack of required substantiating documentation or
40 incorrect coding;

41 (c) there is no dispute regarding the amount claimed;

42 (d) the payer has no reason to believe that the claim has been
43 submitted fraudulently; and

44 (e) the claim requires no special treatment that prevents timely
45 payments from being made on the claim under the terms of the policy.

46 (2) If all or a portion of the claim is denied by the payer because:

- 1 (a) the claim is an ineligible claim;
2 (b) the claim submission is incomplete because the required
3 substantiating documentation has not been submitted to the payer;
4 (c) the diagnosis coding, procedure coding, or any other required
5 information to be submitted with the claim is incorrect;
6 (d) the payer disputes the amount claimed; or
7 (e) the claim requires special treatment that prevents timely
8 payments from being made on the claim under the terms of the policy,
9 the payer shall notify the insured, or that insured's agent or assignee
10 if the policy provides for assignment of benefits, in writing or by
11 electronic means, as appropriate, within 30 days, of the following: if
12 all or a portion of the claim is denied, all the reasons for the denial; if
13 the claim lacks the required substantiating documentation, including
14 incorrect coding, a statement as to what substantiating documentation
15 or other information is required to complete adjudication of the claim;
16 if the amount of the claim is disputed, a statement that it is disputed;
17 and if the claim requires special treatment that prevents timely
18 payments from being made, a statement of the special treatment to
19 which the claim is subject.
- 20 (3) Any portion of a claim that meets the criteria established in
21 paragraph (1) of this subsection shall be paid by the payer in
22 accordance with the time limit established in paragraph (1) of this
23 subsection.
- 24 (4) A payer shall acknowledge receipt of a claim submitted by
25 electronic means from a health care provider or insured, no later than
26 two working days following receipt of the transmission of the claim.
- 27 (5) If a payer subject to the provisions of P.L.1983, c.320
28 (C.17:33A-1 et seq.) has reason to believe that a claim has been
29 submitted fraudulently, it shall investigate the claim in accordance with
30 its fraud prevention plan established pursuant to section 1 of P.L.1993,
31 c.362 (C.17:33A-15), or refer the claim, together with supporting
32 documentation, to the Office of the Insurance Fraud Prosecutor in the
33 Department of Law and Public Safety established pursuant to section
34 32 of P.L.1998, c.21 (C.17:33A-16).
- 35 (6) Payment of an eligible claim pursuant to paragraphs (1) and
36 (3) of this subsection shall be deemed to be overdue if not remitted to
37 the claimant or his agent by the payer on or before the 30th calendar
38 day or the time limit established by the Medicare program, whichever
39 is earlier, following receipt by the payer of a claim submitted by
40 electronic means and on or before the 40th calendar day following
41 receipt of a claim submitted by other than electronic means.
- 42 In the event payment is withheld on all or a portion of a claim by
43 a payer pursuant to subparagraph (b) of paragraph (2) of this
44 subsection, the claims payment shall be overdue if not remitted to the
45 claimant or his agent by the payer on or before the 30th calendar day
46 or the time limit established by the Medicare program, whichever is

1 earlier, for claims submitted by electronic means and the 40th calendar
2 day for claims submitted by other than electronic means, following
3 receipt by the payer of the required documentation or modification of
4 an initial submission.

5 (7) An overdue payment shall bear simple interest at the rate of
6 10% per annum.

7 e. As used in this subsection, "insured claim" or "claim" means a
8 claim by an insured for payment of benefits under an insured policy
9 for which the financial obligation for the payment of a claim under the
10 policy rests upon the health insurer.³

11
12 6. a. Within 180 days of the adoption of a timetable for
13 implementation pursuant to section 1 of P.L. , c. (C.)(pending
14 before the Legislature as this bill), a health insurer, or a subsidiary that
15 processes health care benefits claims as a third party administrator,
16 shall demonstrate to the satisfaction of the Commissioner of Banking
17 and Insurance that it will adopt and implement all of the standards to
18 receive and transmit health care transactions electronically, according
19 to the corresponding timetable, ¹and otherwise comply with the
20 provisions of this section.¹ as a condition of its continued
21 authorization to do business in this State.

22 The Commissioner of Banking and Insurance may grant extensions
23 or waivers of the implementation requirement when it has been
24 demonstrated to the commissioner's satisfaction that compliance with
25 the timetable for implementation will result in an undue hardship to a
26 health insurer, its subsidiary or its covered persons.

27 b. Within 12 months of the adoption of regulations establishing
28 standard health care enrollment and claim forms by the Commissioner
29 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
30 (pending before the Legislature as this bill), a health insurer or a
31 subsidiary that processes health care benefits claims as a third party
32 administrator shall use the standard health care enrollment and claim
33 forms in connection with all group ³contracts ³policies ³issued,
34 delivered, executed or renewed in this State.

35 c. ¹Effective two years after the effective date of P.L. , c.
36 (C.) (pending before the Legislature as this bill):

37 (1) Twelve months after the adoption of regulations establishing
38 standard health care enrollment and claim forms by the Commissioner
39 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
40 (pending before the Legislature as this bill),¹ a health insurer shall
41 require that health care providers file all claims for payment for health
42 care services. A covered person who receives health care services
43 shall not be required to submit a claim for payment, but
44 notwithstanding the provisions of this subsection to the contrary, a
45 covered person shall be permitted to submit a claim on his own behalf,
46 at the covered person's option.

1 ¹[(2) a health insurer shall not restrict the insured's right to assign
2 any payment owed to the health care provider; and

3 (3) all¹]. All¹ claims shall be filed using the standard ¹health care¹
4 claim form ³applicable to the policy³.

5 d. ³[Notwithstanding the provisions of section 79 of P.L.1991,
6 c.187 (C.17B:27-44.1) to the contrary,

7 (1) ¹[For the two-year period beginning on the effective date of
8 P.L. , c. (C.)(pending before the Legislature as this bill)] Twelve
9 months after the adoption of regulations establishing standard health
10 care enrollment and claim forms by the Commissioner of Banking and
11 Insurance pursuant to section 1 of P.L. , c. (C.)(pending before
12 the Legislature as this bill)¹, a health insurer shall reimburse all clean
13 claims that are filed electronically by a provider or an insured for
14 payment under a group policy, within ¹[30 days after receipt of the
15 claim by the insurer] the applicable number of calendar days
16 established for payment of claims in the Medicare program pursuant
17 to 42 U.S.C.s.1395u(c)(2)(B)¹.

18 If a claim or portion of a claim that is submitted electronically is
19 contested or denied by the insurer, the person or entity who filed the
20 claim shall be notified in writing or electronically, as appropriate,
21 within 30 days after receipt of the claim by the insurer, that the claim
22 is contested or denied, but the uncontested portion of the claim, if any,
23 shall be paid within 30 days after receipt of the claim by the insurer.
24 The notice that a claim is contested or denied shall identify the
25 contested portion of the claim and the reasons for contesting or
26 denying the claim.

27 ¹[(2) Effective two years after the effective date of P.L. , c.
28 (C.)(pending before the Legislature as this bill), a health insurer
29 shall reimburse all clean claims that are filed electronically by a
30 provider or an insured for payment under a group policy, within 17
31 days after receipt of the claim by the insurer.

32 If a claim or portion of a claim that is submitted electronically is
33 contested or denied by the insurer, the person or entity who filed the
34 claim shall be notified in writing or electronically, as appropriate,
35 within 17 days after receipt of the claim by the insurer, that the claim
36 is contested or denied, but the uncontested portion of the claim, if any,
37 shall be paid within 30 days after receipt of the claim by the insurer.
38 The notice that a claim is contested or denied shall identify the
39 contested portion of the claim and the reasons for contesting or
40 denying the claim.

41 (3) ¹(2)¹ Payment shall be treated as being made on the date a
42 draft or other valid instrument which is equivalent to payment was
43 placed in the United States mail in a properly addressed, postpaid
44 envelope or, if not so posted, on the date of delivery, or the date of
45 electronic fund transfer. An overdue payment shall bear simple

1 interest at the rate of 10% per year.

2 ¹[(4)] (3)¹ For the purposes of this section, "clean claim" has the
3 same meaning given the term in the federal Medicare program
4 pursuant to 42 U.S.C.s.1395u(c)(2)(B).¹]

5 (1) Effective 180 days after the effective date of P.L. , c.
6 (pending before the Legislature as this bill), a health insurer or its
7 agent, hereinafter the payer, shall remit payment for every insured
8 claim submitted by an insured or that insured's agent or assignee if the
9 policy provides for assignment of benefits, no later than the 30th
10 calendar day following receipt of the claim by the payer or no later
11 than the time limit established for the payment of claims in the
12 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever
13 is earlier, if the claim is submitted by electronic means, and no later
14 than the 40th calendar day following receipt if the claim is submitted
15 by other than electronic means, if:

16 (a) the claim is an eligible claim for a health care service provided
17 by an eligible health care provider to a covered person under the
18 policy;

19 (b) the claim has no material defect or impropriety, including, but
20 not limited to, any lack of required substantiating documentation or
21 incorrect coding;

22 (c) there is no dispute regarding the amount claimed;

23 (d) the payer has no reason to believe that the claim has been
24 submitted fraudulently; and

25 (e) the claim requires no special treatment that prevents timely
26 payments from being made on the claim under the terms of the policy.

27 (2) If all or a portion of the claim is denied by the payer because:

28 (a) the claim is an ineligible claim;

29 (b) the claim submission is incomplete because the required
30 substantiating documentation has not been submitted to the payer;

31 (c) the diagnosis coding, procedure coding, or any other required
32 information to be submitted with the claim is incorrect;

33 (d) the payer disputes the amount claimed; or

34 (e) the claim requires special treatment that prevents timely
35 payments from being made on the claim under the terms of the policy,

36 the payer shall notify the insured, or that insured's agent or assignee
37 if the policy provides for assignment of benefits, in writing or by

38 electronic means, as appropriate, within 30 days, of the following: if
39 all or a portion of the claim is denied, all the reasons for the denial; if

40 the claim lacks the required substantiating documentation, including
41 incorrect coding, a statement as to what substantiating documentation

42 or other information is required to complete adjudication of the claim;
43 if the amount of the claim is disputed, a statement that it is disputed;

44 and if the claim requires special treatment that prevents timely
45 payments from being made, a statement of the special treatment to

46 which the claim is subject.

1 (3) Any portion of a claim that meets the criteria established in
2 paragraph (1) of this subsection shall be paid by the payer in
3 accordance with the time limit established in paragraph (1) of this
4 subsection.

5 (4) A payer shall acknowledge receipt of a claim submitted by
6 electronic means from a health care provider or insured, no later than
7 two working days following receipt of the transmission of the claim.

8 (5) If a payer subject to the provisions of P.L.1983, c.320
9 (C.17:33A-1 et seq.) has reason to believe that a claim has been
10 submitted fraudulently, it shall investigate the claim in accordance with
11 its fraud prevention plan established pursuant to section 1 of P.L.1993,
12 c.362 (C.17:33A-15), or refer the claim, together with supporting
13 documentation, to the Office of the Insurance Fraud Prosecutor in the
14 Department of Law and Public Safety established pursuant to section
15 32 of P.L.1998, c.21 (C.17:33A-16).

16 (6) Payment of an eligible claim pursuant to paragraphs (1) and
17 (3) of this subsection shall be deemed to be overdue if not remitted to
18 the claimant or his agent by the payer on or before the 30th calendar
19 day or the time limit established by the Medicare program, whichever
20 is earlier, following receipt by the payer of a claim submitted by
21 electronic means and on or before the 40th calendar day following
22 receipt of a claim submitted by other than electronic means.

23 In the event payment is withheld on all or a portion of a claim by
24 a payer pursuant to subparagraph (b) of paragraph (2) of this
25 subsection, the claims payment shall be overdue if not remitted to the
26 claimant or his agent by the payer on or before the 30th calendar day
27 or the time limit established by the Medicare program, whichever is
28 earlier, for claims submitted by electronic means and the 40th calendar
29 day for claims submitted by other than electronic means, following
30 receipt by the payer of the required documentation or modification of
31 an initial submission.

32 (7) An overdue payment shall bear simple interest at the rate of
33 10% per annum.

34 e. As used in this subsection, "insured claim" or "claim" means a
35 claim by an insured for payment of benefits under an insured policy
36 for which the financial obligation for the payment of a claim under the
37 policy rests upon the health insurer.³

38
39 7. a. Within 180 days of the adoption of a timetable for
40 implementation pursuant to section 1 of P.L. , c. (C.)(pending
41 before the Legislature as this bill), a health maintenance organization,
42 or a subsidiary that processes health care benefits claims as a third
43 party administrator, shall demonstrate to the satisfaction of the
44 Commissioner of Banking and Insurance that it will adopt and
45 implement all of the standards to receive and transmit health care
46 transactions electronically, according to the corresponding timetable,

1 ¹and otherwise comply with the provisions of this section,¹ as a
2 condition of its continued authorization to do business in this State.

3 The Commissioner of Banking and Insurance may grant extensions
4 or waivers of the implementation requirement when it has been
5 demonstrated to the commissioner's satisfaction that compliance with
6 the timetable for implementation will result in an undue hardship to a
7 health maintenance organization, its subsidiary or its covered
8 enrollees.

9 b. Within 12 months of the adoption of regulations establishing
10 standard health care enrollment and claim forms by the Commissioner
11 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
12 (pending before the Legislature as this bill), a health maintenance
13 organization or a subsidiary that processes health care benefits claims
14 as a third party administrator shall use the standard health care
15 enrollment and claim forms in connection with all group and individual
16 health maintenance organization coverage for health care services
17 issued, delivered, executed or renewed in this State.

18 c. ¹【Effective two years after the effective date of P.L. , c.
19 (C.) (pending before the Legislature as this bill):

20 (1)】 Twelve months after the adoption of regulations establishing
21 standard health care enrollment and claim forms by the Commissioner
22 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
23 (pending before the Legislature as this bill),¹ a health maintenance
24 organization shall require that health care providers file all claims for
25 payment for health care services. A covered person who receives
26 health care services shall not be required to submit a claim for
27 payment, but notwithstanding the provisions of this subsection to the
28 contrary, a covered person shall be permitted to submit a claim on his
29 own behalf, at the covered person's option

30 ¹【(2) a health maintenance organization shall not restrict the
31 enrollee's right to assign any payment owed to the health care
32 provider; and

33 (3) all】. All¹ claims shall be filed using the standard ¹health care¹
34 claim form³ applicable to the contract³.

35 d. ³【Notwithstanding the provisions of section 80 of P.L.1991,
36 c.187 (C.26:2J-5.1) to the contrary,

37 (1) ¹【For the two-year period beginning on the effective date of
38 P.L. , c. (C.)(pending before the Legislature as this bill)】 Twelve
39 months after the adoption of regulations establishing standard health
40 care enrollment and claim forms by the Commissioner of Banking and
41 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before
42 the Legislature as this bill)¹, a health maintenance organization shall
43 reimburse all clean claims that are filed electronically by a provider or
44 an enrollee for payment under group or individual health maintenance
45 organization coverage for health care services, within ¹【30 days after

1 receipt of the claim by the health maintenance organization] the
2 applicable number of calendar days established for payment of claims
3 in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

4 If a claim or portion of a claim that is submitted electronically is
5 contested or denied by the health maintenance organization, the person
6 or entity who filed the claim shall be notified in writing or
7 electronically, as appropriate, within 30 days after receipt of the claim
8 by the health maintenance organization, that the claim is contested or
9 denied, but the uncontested portion of the claim, if any, shall be paid
10 within 30 days after receipt of the claim by the health maintenance
11 organization. The notice that a claim is contested or denied shall
12 identify the contested portion of the claim and the reasons for
13 contesting or denying the claim.

14 ¹[(2) Effective two years after the effective date of P.L. , c.
15 (C.) (pending before the Legislature as this bill), a health
16 maintenance organization shall reimburse all clean claims that are filed
17 electronically by a provider or an enrollee, for payment under group
18 or individual health maintenance organization coverage for health care
19 services, within 17 days after receipt of the claim by the health
20 maintenance organization.

21 If a claim or portion of a claim that is submitted electronically is
22 contested or denied by the health maintenance organization, the person
23 or entity who filed the claim shall be notified in writing or
24 electronically, as appropriate, within 17 days after receipt of the claim
25 by the health maintenance organization, that the claim is contested or
26 denied, but the uncontested portion of the claim, if any, shall be paid
27 within 30 days after receipt of the claim by the health maintenance
28 organization. The notice that a claim is contested or denied shall
29 identify the contested portion of the claim and the reasons for
30 contesting or denying the claim.

31 (3) (2)¹ Payment shall be treated as being made on the date a
32 draft or other valid instrument which is equivalent to payment was
33 placed in the United States mail in a properly addressed, postpaid
34 envelope or, if not so posted, on the date of delivery, or the date of
35 electronic fund transfer. An overdue payment shall bear simple
36 interest at the rate of 10% per year.

37 ¹[(4) (3)¹ For the purposes of this section, "clean claim" has the
38 same meaning given the term in the federal Medicare program
39 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

40 (1) Effective 180 days after the effective date of P.L. , c.
41 (pending before the Legislature as this bill), a health maintenance
42 organization or its agent, hereinafter the payer, shall remit payment for
43 every insured claim submitted by an enrollee or that enrollee's agent
44 or assignee if the health maintenance organization coverage for health
45 care services provides for assignment of benefits, no later than the
46 30th calendar day following receipt of the claim by the payer or no

1 later than the time limit established for the payment of claims in the
2 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever
3 is earlier, if the claim is submitted by electronic means, and no later
4 than the 40th calendar day following receipt if the claim is submitted
5 by other than electronic means, if:

6 (a) the claim is an eligible claim for a health care service provided
7 by an eligible health care provider to a covered person under the health
8 maintenance organization coverage for health care services;

9 (b) the claim has no material defect or impropriety, including, but
10 not limited to, any lack of required substantiating documentation or
11 incorrect coding;

12 (c) there is no dispute regarding the amount claimed;

13 (d) the payer has no reason to believe that the claim has been
14 submitted fraudulently; and

15 (e) the claim requires no special treatment that prevents timely
16 payments from being made on the claim under the terms of the health
17 maintenance organization coverage for health care services.

18 (2) If all or a portion of the claim is denied by the payer because:

19 (a) the claim is an ineligible claim;

20 (b) the claim submission is incomplete because the required
21 substantiating documentation has not been submitted to the payer;

22 (c) the diagnosis coding, procedure coding, or any other required
23 information to be submitted with the claim is incorrect;

24 (d) the payer disputes the amount claimed; or

25 (e) the claim requires special treatment that prevents timely
26 payments from being made on the claim under the terms of the health
27 maintenance organization coverage for health care services, the payer
28 shall notify the enrollee, or that enrollee's agent or assignee if the
29 health maintenance organization coverage for health care services
30 provides for assignment of benefits, in writing or by electronic means,
31 as appropriate, within 30 days, of the following: if all or a portion of
32 the claim is denied, all the reasons for the denial; if the claim lacks the
33 required substantiating documentation, including incorrect coding, a
34 statement as to what substantiating documentation or other
35 information is required to complete adjudication of the claim; if the
36 amount of the claim is disputed, a statement that it is disputed; and if
37 the claim requires special treatment that prevents timely payments
38 from being made, a statement of the special treatment to which the
39 claim is subject.

40 (3) Any portion of a claim that meets the criteria established in
41 paragraph (1) of this subsection shall be paid by the payer in
42 accordance with the time limit established in paragraph (1) of this
43 subsection.

44 (4) A payer shall acknowledge receipt of a claim submitted by
45 electronic means from a health care provider or enrollee, no later than
46 two working days following receipt of the transmission of the claim.

1 (5) If a payer subject to the provisions of P.L.1983, c.320
2 (C.17:33A-1 et seq.) has reason to believe that a claim has been
3 submitted fraudulently, it shall investigate the claim in accordance with
4 its fraud prevention plan established pursuant to section 1 of P.L.1993,
5 c.362 (C.17:33A-15), or refer the claim, together with supporting
6 documentation, to the Office of the Insurance Fraud Prosecutor in the
7 Department of Law and Public Safety established pursuant to section
8 32 of P.L.1998, c.21 (C.17:33A-16).

9 (6) Payment of an eligible claim pursuant to paragraphs (1) and
10 (3) of this subsection shall be deemed to be overdue if not remitted to
11 the claimant or his agent by the payer on or before the 30th calendar
12 day or the time limit established by the Medicare program, whichever
13 is earlier, following receipt by the payer of a claim submitted by
14 electronic means and on or before the 40th calendar day following
15 receipt of a claim submitted by other than electronic means.

16 In the event payment is withheld on all or a portion of a claim by
17 a payer pursuant to subparagraph (b) of paragraph (2) of this
18 subsection, the claims payment shall be overdue if not remitted to the
19 claimant or his agent by the payer on or before the 30th calendar day
20 or the time limit established by the Medicare program, whichever is
21 earlier, for claims submitted by electronic means and the 40th calendar
22 day for claims submitted by other than electronic means, following
23 receipt by the payer of the required documentation or modification of
24 an initial submission.

25 (7) An overdue payment shall bear simple interest at the rate of
26 10% per annum.

27 e. As used in this subsection, "insured claim" or "claim" means a
28 claim by an enrollee for payment of benefits under an insured health
29 maintenance organization contract for which the financial obligation
30 for the payment of a claim under the health maintenance organization
31 coverage for health care services rests upon the health maintenance
32 organization.³

33
34 8. a. Within 180 days of the adoption of a timetable for
35 implementation pursuant to section 1 of P.L. , c. (C.)(pending
36 before the Legislature as this bill), a dental service corporation, or a
37 subsidiary that processes health care benefits claims as a third party
38 administrator, shall demonstrate to the satisfaction of the
39 Commissioner of Banking and Insurance that it will adopt and
40 implement all of the standards to receive and transmit health care
41 transactions electronically, according to the corresponding timetable,
42 ¹and otherwise comply with the provisions of this section, ¹as
43 a condition of its continued authorization to do business in this State.

44 The Commissioner of Banking and Insurance may grant extensions
45 or waivers of the implementation requirement when it has been
46 demonstrated to the commissioner's satisfaction that compliance with

1 the timetable for implementation will result in an undue hardship to a
2 dental service corporation, its subsidiary or its covered persons.

3 b. Within 12 months of the adoption of regulations establishing
4 standard health care enrollment and claim forms by the Commissioner
5 of Banking and Insurance pursuant to section 1 of P.L. , c.
6 (C.)(pending before the Legislature as this bill), a dental service
7 corporation or a subsidiary that processes health care benefits claims
8 as a third party administrator shall use the standard health care
9 enrollment and claim forms in connection with all group and individual
10 contracts issued, delivered, executed or renewed in this State.

11 c. ¹ [Effective two years after the effective date of P.L. , c.
12 (C.) (pending before the Legislature as this bill):

13 (1) Twelve months after the adoption of regulations establishing
14 standard health care enrollment and claim forms by the Commissioner
15 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
16 (pending before the Legislature as this bill),¹ a dental service
17 corporation shall require that health care providers file all claims for
18 payment for dental services. A covered person who receives dental
19 services shall not be required to submit a claim for payment, but
20 notwithstanding the provisions of this subsection to the contrary, a
21 covered person shall be permitted to submit a claim on his own behalf,
22 at the covered person's option.

23 ¹ [(2) a dental service corporation shall not restrict the subscriber's
24 right to assign any payment owed to the health care provider; and

25 (3) all]. All¹ claims shall be filed using the standard ¹health care¹
26 claim form ³applicable to the contract³.

27 d. ³ [(1) ¹ [For the two-year period beginning on the effective date
28 of P.L. , c. (C.)(pending before the Legislature as this bill)]
29 Twelve months after the adoption of regulations establishing standard
30 health care enrollment and claim forms by the Commissioner of
31 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
32 (pending before the Legislature as this bill)¹, a dental service
33 corporation shall reimburse all clean claims that are filed electronically
34 by a provider or a subscriber for payment under a group or individual
35 dental service corporation contract, within ¹ [30 days after receipt of
36 the claim by the dental service corporation] the applicable number of
37 calendar days established for payment of claims in the Medicare
38 program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

39 If a claim or portion of a claim that is submitted electronically is
40 contested or denied by the dental service corporation, the person or
41 entity who filed the claim shall be notified in writing or electronically,
42 as appropriate, within 30 days after receipt of the claim by the dental
43 service corporation, that the claim is contested or denied, but the
44 uncontested portion of the claim, if any, shall be paid within 30 days
45 after receipt of the claim by the dental service corporation. The notice
46 that a claim is contested or denied shall identify the contested portion

1 of the claim and the reasons for contesting or denying the claim.

2 ¹[(2) Effective two years after the effective date of P.L. , c.
3 (C.) (pending before the Legislature as this bill), a dental service
4 corporation shall reimburse all clean claims that are filed electronically
5 by a provider or a subscriber for payment under a group or individual
6 dental service corporation contract, within 17 days after receipt of the
7 claim by the dental service corporation.

8 If a claim or portion of a claim that is submitted electronically is
9 contested or denied by the dental service corporation, the person or
10 entity who filed the claim shall be notified in writing or electronically,
11 as appropriate, within 17 days after receipt of the claim by the dental
12 service corporation, that the claim is contested or denied, but the
13 uncontested portion of the claim, if any, shall be paid within 30 days
14 after receipt of the claim by the dental service corporation. The notice
15 that a claim is contested or denied shall identify the contested portion
16 of the claim and the reasons for contesting or denying the claim.

17 (3) ¹(2) Payment shall be treated as being made on the date a
18 draft or other valid instrument which is equivalent to payment was
19 placed in the United States mail in a properly addressed, postpaid
20 envelope or, if not so posted, on the date of delivery, or the date of
21 electronic fund transfer. An overdue payment shall bear simple
22 interest at the rate of 10% per year.

23 ¹[(4) (3) For the purposes of this section, "clean claim" has the
24 same meaning given the term in the federal Medicare program
25 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

26 (1) Effective 180 days after the effective date of P.L. , c.
27 (pending before the Legislature as this bill), a dental service
28 corporation or its agent, hereinafter the payer, shall remit payment for
29 every insured claim submitted by a subscriber or that subscriber's
30 agent or assignee if the contract provides for assignment of benefits,
31 no later than the 30th calendar day following receipt of the claim by
32 the payer or no later than the time limit established for the payment of
33 claims in the Medicare program pursuant to
34 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
35 submitted by electronic means, and no later than the 40th calendar day
36 following receipt if the claim is submitted by other than electronic
37 means, if:

38 (a) the claim is an eligible claim for a health care service provided
39 by an eligible health care provider to a covered person under the
40 contract;

41 (b) the claim has no material defect or impropriety, including, but
42 not limited to, any lack of required substantiating documentation or
43 incorrect coding;

44 (c) there is no dispute regarding the amount claimed;

45 (d) the payer has no reason to believe that the claim has been
46 submitted fraudulently; and

- 1 (e) the claim requires no special treatment that prevents timely
2 payments from being made on the claim under the terms of the
3 contract.
- 4 (2) If all or a portion of the claim is denied by the payer because:
5 (a) the claim is an ineligible claim;
6 (b) the claim submission is incomplete because the required
7 substantiating documentation has not been submitted to the payer;
8 (c) the diagnosis coding, procedure coding, or any other required
9 information to be submitted with the claim is incorrect;
10 (d) the payer disputes the amount claimed; or
11 (e) the claim requires special treatment that prevents timely
12 payments from being made on the claim under the terms of the
13 contract, the payer shall notify the subscriber, or that subscriber's
14 agent or assignee if the contract provides for assignment of benefits,
15 in writing or by electronic means, as appropriate, within 30 days, of
16 the following: if all or a portion of the claim is denied, all the reasons
17 for the denial; if the claim lacks the required substantiating
18 documentation, including incorrect coding, a statement as to what
19 substantiating documentation or other information is required to
20 complete adjudication of the claim; if the amount of the claim is
21 disputed, a statement that it is disputed; and if the claim requires
22 special treatment that prevents timely payments from being made, a
23 statement of the special treatment to which the claim is subject.
- 24 (3) Any portion of a claim that meets the criteria established in
25 paragraph (1) of this subsection shall be paid by the payer in
26 accordance with the time limit established in paragraph (1) of this
27 subsection.
- 28 (4) A payer shall acknowledge receipt of a claim submitted by
29 electronic means from a health care provider or subscriber, no later
30 than two working days following receipt of the transmission of the
31 claim.
- 32 (5) If a payer subject to the provisions of P.L.1983, c.320
33 (C.17:33A-1 et seq.) has reason to believe that a claim has been
34 submitted fraudulently, it shall investigate the claim in accordance with
35 its fraud prevention plan established pursuant to section 1 of P.L.1993,
36 c.362 (C.17:33A-15), or refer the claim, together with supporting
37 documentation, to the Office of the Insurance Fraud Prosecutor in the
38 Department of Law and Public Safety established pursuant to section
39 32 of P.L.1998, c.21 (C.17:33A-16).
- 40 (6) Payment of an eligible claim pursuant to paragraphs (1) and
41 (3) of this subsection shall be deemed to be overdue if not remitted to
42 the claimant or his agent by the payer on or before the 30th calendar
43 day or the time limit established by the Medicare program, whichever
44 is earlier, following receipt by the payer of a claim submitted by
45 electronic means and on or before the 40th calendar day following
46 receipt of a claim submitted by other than electronic means.

1 In the event payment is withheld on all or a portion of a claim by
2 a payer pursuant to subparagraph (b) of paragraph (2) of this
3 subsection, the claims payment shall be overdue if not remitted to the
4 claimant or his agent by the payer on or before the 30th calendar day
5 or the time limit established by the Medicare program, whichever is
6 earlier, for claims submitted by electronic means and the 40th calendar
7 day for claims submitted by other than electronic means, following
8 receipt by the payer of the required documentation or modification of
9 an initial submission.

10 (7) An overdue payment shall bear simple interest at the rate of
11 10% per annum.

12 e. As used in this subsection, "insured claim" or "claim" means a
13 claim by a subscriber for payment of benefits under an insured dental
14 service corporation contract for which the financial obligation for the
15 payment of a claim under the contract rests upon the dental service
16 corporation.³

17
18 9. a. Within 180 days of the adoption of a timetable for
19 implementation pursuant to section 1 of P.L. , c. (C.)(pending
20 before the Legislature as this bill), a dental plan organization, or a
21 subsidiary that processes health care benefits claims as a third party
22 administrator, shall demonstrate to the satisfaction of the
23 Commissioner of Banking and Insurance that it will adopt and
24 implement all of the standards to receive and transmit health care
25 transactions electronically, according to the corresponding timetable,
26 ¹and otherwise comply with the provisions of this section,¹ as a
27 condition of its continued authorization to do business in this State.

28 The Commissioner of Banking and Insurance may grant extensions
29 or waivers of the implementation requirement when it has been
30 demonstrated to the commissioner's satisfaction that compliance with
31 the timetable for implementation will result in an undue hardship to a
32 dental plan organization, its subsidiary or its covered enrollees.

33 b. Within 12 months of the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
36 (pending before the Legislature as this bill), a dental plan organization
37 or a subsidiary that processes health care benefits claims as a third
38 party administrator shall use the standard health care enrollment and
39 claim forms in connection with all group and individual contracts
40 issued, delivered, executed or renewed in this State.

41 c. ¹Effective two years after the effective date of P.L. , c. (C.)
42 (pending before the Legislature as this bill):

43 (1) Twelve months after the adoption of regulations establishing
44 standard health care enrollment and claim forms by the Commissioner
45 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
46 (pending before the Legislature as this bill),¹ a dental plan organization

1 shall require that health care providers file all claims for payment for
2 dental services. A covered person who receives dental services shall
3 not be required to submit a claim for payment, but notwithstanding the
4 provisions of this subsection to the contrary, a covered person shall be
5 permitted to submit a claim on his own behalf, at the covered person's
6 option

7 ¹[(2) a dental plan organization shall not restrict the enrollee's
8 right to assign any payment owed to the health care provider; and

9 (3) all]. All¹ claims shall be filed using the standard ¹health care¹
10 claim form ³applicable to the contract³.

11 d. ³[(1) ¹[For the two-year period beginning on the effective date
12 of P.L. , c. (C.)(pending before the Legislature as this bill)]
13 Twelve months after the adoption of regulations establishing standard
14 health care enrollment and claim forms by the Commissioner of
15 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
16 (pending before the Legislature as this bill)¹, a dental plan organization
17 shall reimburse all clean claims that are filed electronically by a
18 provider or an enrollee for payment under group or individual dental
19 plan organization coverage for dental services, within ¹[30 days after
20 receipt of the claim by the dental plan organization] the applicable
21 number of calendar days established for payment of claims in the
22 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B)¹.

23 If a claim or portion of a claim that is submitted electronically is
24 contested or denied by the dental plan organization, the person or
25 entity who filed the claim shall be notified in writing or electronically,
26 as appropriate, within 30 days after receipt of the claim by the dental
27 plan organization, that the claim is contested or denied, but the
28 uncontested portion of the claim, if any, shall be paid within 30 days
29 after receipt of the claim by the dental plan organization. The notice
30 that a claim is contested or denied shall identify the contested portion
31 of the claim and the reasons for contesting or denying the claim.

32 ¹[(2) Effective two years after the effective date of P.L. , c.
33 (C.) (pending before the Legislature as this bill), a dental plan
34 organization shall reimburse all clean claims that are filed
35 electronically by a provider or an enrollee for payment under group or
36 individual dental plan organization coverage for dental services, within
37 17 days after receipt of the claim by the dental plan organization.

38 If a claim or portion of a claim that is submitted electronically is
39 contested or denied by the dental plan organization, the person or
40 entity who filed the claim shall be notified in writing or electronically,
41 as appropriate, within 17 days after receipt of the claim by the dental
42 plan organization, that the claim is contested or denied, but the
43 uncontested portion of the claim, if any, shall be paid within 30 days
44 after receipt of the claim by the dental plan organization. The notice
45 that a claim is contested or denied shall identify the contested portion
46 of the claim and the reasons for contesting or denying the claim.

1 (3)~~(2)~~¹ Payment shall be treated as being made on the date a
2 draft or other valid instrument which is equivalent to payment was
3 placed in the United States mail in a properly addressed, postpaid
4 envelope or, if not so posted, on the date of delivery, or the date of
5 electronic fund transfer. An overdue payment shall bear simple
6 interest at the rate of 10% per year.

7 ~~[(4)]~~ (3)¹ For the purposes of this section, "clean claim" has the
8 same meaning given the term in the federal Medicare program
9 pursuant to 42 U.S.C.s.1395u(c)(2)(B).~~]~~

10 (1) Effective 180 days after the effective date of P.L. , c.
11 (pending before the Legislature as this bill), a dental plan organization
12 or its agent, hereinafter the payer, shall remit payment for every
13 insured claim submitted by an enrollee or that enrollee's agent or
14 assignee if the contract provides for assignment of benefits, no later
15 than the 30th calendar day following receipt of the claim by the payer
16 or no later than the time limit established for the payment of claims in
17 the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B),
18 whichever is earlier, if the claim is submitted by electronic means, and
19 no later than the 40th calendar day following receipt if the claim is
20 submitted by other than electronic means, if:

21 (a) the claim is an eligible claim for a health care service provided
22 by an eligible health care provider to a covered person under the
23 contract;

24 (b) the claim has no material defect or impropriety, including, but
25 not limited to, any lack of required substantiating documentation or
26 incorrect coding;

27 (c) there is no dispute regarding the amount claimed;

28 (d) the payer has no reason to believe that the claim has been
29 submitted fraudulently; and

30 (e) the claim requires no special treatment that prevents timely
31 payments from being made on the claim under the terms of the
32 contract.

33 (2) If all or a portion of the claim is denied by the payer because:

34 (a) the claim is an ineligible claim;

35 (b) the claim submission is incomplete because the required
36 substantiating documentation has not been submitted to the payer;

37 (c) the diagnosis coding, procedure coding, or any other required
38 information to be submitted with the claim is incorrect;

39 (d) the payer disputes the amount claimed; or

40 (e) the claim requires special treatment that prevents timely
41 payments from being made on the claim under the terms of the
42 contract, the payer shall notify the enrollee, or that enrollee's agent or
43 assignee if the contract provides for assignment of benefits, in writing
44 or by electronic means, as appropriate, within 30 days, of the
45 following: if all or a portion of the claim is denied, all the reasons for
46 the denial; if the claim lacks the required substantiating

1 documentation, including incorrect coding, a statement as to what
2 substantiating documentation or other information is required to
3 complete adjudication of the claim; if the amount of the claim is
4 disputed, a statement that it is disputed; and if the claim requires
5 special treatment that prevents timely payments from being made, a
6 statement of the special treatment to which the claim is subject.

7 (3) Any portion of a claim that meets the criteria established in
8 paragraph (1) of this subsection shall be paid by the payer in
9 accordance with the time limit established in paragraph (1) of this
10 subsection.

11 (4) A payer shall acknowledge receipt of a claim submitted by
12 electronic means from a health care provider or enrollee, no later than
13 two working days following receipt of the transmission of the claim.

14 (5) If a payer subject to the provisions of P.L.1983, c.320
15 (C.17:33A-1 et seq.) has reason to believe that a claim has been
16 submitted fraudulently, it shall investigate the claim in accordance with
17 its fraud prevention plan established pursuant to section 1 of P.L.1993,
18 c.362 (C.17:33A-15), or refer the claim, together with supporting
19 documentation, to the Office of the Insurance Fraud Prosecutor in the
20 Department of Law and Public Safety established pursuant to section
21 32 of P.L.1998, c.21 (C.17:33A-16).

22 (6) Payment of an eligible claim pursuant to paragraphs (1) and
23 (3) of this subsection shall be deemed to be overdue if not remitted to
24 the claimant or his agent by the payer on or before the 30th calendar
25 day or the time limit established by the Medicare program, whichever
26 is earlier, following receipt by the payer of a claim submitted by
27 electronic means and on or before the 40th calendar day following
28 receipt of a claim submitted by other than electronic means.

29 In the event payment is withheld on all or a portion of a claim by
30 a payer pursuant to subparagraph (b) of paragraph (2) of this
31 subsection, the claims payment shall be overdue if not remitted to the
32 claimant or his agent by the payer on or before the 30th calendar day
33 or the time limit established by the Medicare program, whichever is
34 earlier, for claims submitted by electronic means and the 40th calendar
35 day for claims submitted by other than electronic means, following
36 receipt by the payer of the required documentation or modification of
37 an initial submission.

38 (7) An overdue payment shall bear simple interest at the rate of
39 10% per annum.

40 e. As used in this subsection, "insured claim" or "claim" means a
41 claim by an enrollee for payment of benefits under an insured dental
42 plan organization contract for which the financial obligation for the
43 payment of a claim under the contract rests upon the dental plan
44 organization.³

45
46 10. a. Within 180 days of the adoption of a timetable for

1 implementation pursuant to section 1 of P.L. , c. (C.)(pending
2 before the Legislature as this bill), a prepaid prescription service
3 organization, or a subsidiary that processes health care benefits claims
4 as a third party administrator, shall demonstrate to the satisfaction of
5 the Commissioner of Banking and Insurance that it will adopt and
6 implement all of the standards to receive and transmit health care
7 transactions electronically, according to the corresponding timetable,
8 ¹and otherwise comply with the provisions of this section.¹ as a
9 condition of its continued authorization to do business in this State.

10 The Commissioner of Banking and Insurance may grant extensions
11 or waivers of the implementation requirement when it has been
12 demonstrated to the commissioner's satisfaction that compliance with
13 the timetable for implementation will result in an undue hardship to a
14 prepaid prescription service organization, its subsidiary or its covered
15 enrollees.

16 b. Within 12 months of the adoption of regulations establishing
17 standard health care enrollment and claim forms by the Commissioner
18 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
19 (pending before the Legislature as this bill), a prepaid prescription
20 service organization or a subsidiary that processes health care benefits
21 claims as a third party administrator shall use the standard health care
22 enrollment and claim forms in connection with all contracts issued,
23 delivered, executed or renewed in this State.

24 c. ¹【Effective two years after the effective date of P.L. , c. (C.)
25 (pending before the Legislature as this bill):

26 (1) Twelve months after the adoption of regulations establishing
27 standard health care enrollment and claim forms by the Commissioner
28 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
29 (pending before the Legislature as this bill).¹ a prepaid prescription
30 service organization shall require that health care providers file all
31 claims for payment for health care services. A covered person who
32 receives health care services shall not be required to submit a claim for
33 payment, but notwithstanding the provisions of this subsection to the
34 contrary, a covered person shall be permitted to submit a claim on his
35 own behalf, at the covered person's option

36 ¹【(2) a prepaid prescription service organization shall not restrict
37 the enrollee's right to assign any payment owed to the health care
38 provider; and

39 (3) all¹. All¹ claims shall be filed using the standard ¹health care¹
40 claim form ³applicable to the contract³.

41 d. ³【(1) ¹【For the two-year period beginning on the effective date
42 of P.L. , c. (C.)(pending before the Legislature as this bill)】
43 Twelve months after the adoption of regulations establishing standard
44 health care enrollment and claim forms by the Commissioner of
45 Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
46 (pending before the Legislature as this bill)¹, a prepaid prescription

1 service organization shall reimburse all clean claims that are filed
2 electronically by a provider or an enrollee for payment under a
3 prepaid prescription service organization contract, within ¹ [30 days
4 after receipt of the claim by the prepaid prescription service
5 organization] the applicable number of calendar days established for
6 payment of claims in the Medicare program pursuant to
7 42 U.S.C.s.1395u(c)(2)(B)¹.

8 If a claim or portion of a claim that is submitted electronically is
9 contested or denied by the prepaid prescription service organization,
10 the person or entity who filed the claim shall be notified in writing or
11 electronically, as appropriate, within 30 days after receipt of the claim
12 by the prepaid prescription service organization, that the claim is
13 contested or denied, but the uncontested portion of the claim, if any,
14 shall be paid within 30 days after receipt of the claim by the prepaid
15 prescription service organization. The notice that a claim is contested
16 or denied shall identify the contested portion of the claim and the
17 reasons for contesting or denying the claim.

18 ¹ [(2) Effective two years after the effective date of P.L. , c.
19 (C.) (pending before the Legislature as this bill), a prepaid
20 prescription service organization shall reimburse all clean claims that
21 are filed electronically by a provider or an enrollee for payment under
22 a prepaid prescription service organization contract, within 17 days
23 after receipt of the claim by the prepaid prescription service
24 organization.

25 If a claim or portion of a claim that is submitted electronically is
26 contested or denied by the prepaid prescription service organization,
27 the person or entity who filed the claim shall be notified in writing or
28 electronically, as appropriate, within 17 days after receipt of the claim
29 by the prepaid prescription service organization, that the claim is
30 contested or denied, but the uncontested portion of the claim, if any,
31 shall be paid within 30 days after receipt of the claim by the prepaid
32 prescription service organization. The notice that a claim is contested
33 or denied shall identify the contested portion of the claim and the
34 reasons for contesting or denying the claim.

35 (3) (2)¹ Payment shall be treated as being made on the date a
36 draft or other valid instrument which is equivalent to payment was
37 placed in the United States mail in a properly addressed, postpaid
38 envelope or, if not so posted, on the date of delivery, or the date of
39 electronic fund transfer. An overdue payment shall bear simple
40 interest at the rate of 10% per year.

41 ¹ [(4) (3)¹ For the purposes of this section, "clean claim" has the
42 same meaning given the term in the federal Medicare program
43 pursuant to 42 U.S.C.s.1395u(c)(2)(B).]

44 (1) Effective 180 days after the effective date of P.L. , c.
45 (pending before the Legislature as this bill), a prepaid prescription
46 service organization or its agent, hereinafter the payer, shall remit

1 payment for every insured claim submitted by an enrollee or that
2 enrollee's agent or assignee if the contract provides for assignment of
3 benefits, no later than the 30th calendar day following receipt of the
4 claim by the payer or no later than the time limit established for the
5 payment of claims in the Medicare program pursuant to
6 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
7 submitted by electronic means, and no later than the 40th calendar day
8 following receipt if the claim is submitted by other than electronic
9 means, if:

10 (a) the claim is an eligible claim for a health care service provided
11 by an eligible health care provider to a covered person under the
12 contract;

13 (b) the claim has no material defect or impropriety, including, but
14 not limited to, any lack of required substantiating documentation or
15 incorrect coding;

16 (c) there is no dispute regarding the amount claimed;

17 (d) the payer has no reason to believe that the claim has been
18 submitted fraudulently; and

19 (e) the claim requires no special treatment that prevents timely
20 payments from being made on the claim under the terms of the
21 contract.

22 (2) If all or a portion of the claim is denied by the payer because:

23 (a) the claim is an ineligible claim;

24 (b) the claim submission is incomplete because the required
25 substantiating documentation has not been submitted to the payer;

26 (c) the diagnosis coding, procedure coding, or any other required
27 information to be submitted with the claim is incorrect;

28 (d) the payer disputes the amount claimed; or

29 (e) the claim requires special treatment that prevents timely
30 payments from being made on the claim under the terms of the
31 contract, the payer shall notify the enrollee, or that enrollee's agent or
32 assignee if the contract provides for assignment of benefits, in writing
33 or by electronic means, as appropriate, within 30 days, of the
34 following: if all or a portion of the claim is denied, all the reasons for
35 the denial; if the claim lacks the required substantiating
36 documentation, including incorrect coding, a statement as to what
37 substantiating documentation or other information is required to
38 complete adjudication of the claim; if the amount of the claim is
39 disputed, a statement that it is disputed; and if the claim requires
40 special treatment that prevents timely payments from being made, a
41 statement of the special treatment to which the claim is subject.

42 (3) Any portion of a claim that meets the criteria established in
43 paragraph (1) of this subsection shall be paid by the payer in
44 accordance with the time limit established in paragraph (1) of this
45 subsection.

46 (4) A payer shall acknowledge receipt of a claim submitted by

1 electronic means from a health care provider or enrollee, no later than
2 two working days following receipt of the transmission of the claim.

3 (5) If a payer subject to the provisions of P.L.1983, c.320
4 (C.17:33A-1 et seq.) has reason to believe that a claim has been
5 submitted fraudulently, it shall investigate the claim in accordance with
6 its fraud prevention plan established pursuant to section 1 of P.L.1993,
7 c.362 (C.17:33A-15), or refer the claim, together with supporting
8 documentation, to the Office of the Insurance Fraud Prosecutor in the
9 Department of Law and Public Safety established pursuant to section
10 32 of P.L.1998, c.21 (C.17:33A-16).

11 (6) Payment of an eligible claim pursuant to paragraphs (1) and
12 (3) of this subsection shall be deemed to be overdue if not remitted to
13 the claimant or his agent by the payer on or before the 30th calendar
14 day or the time limit established by the Medicare program, whichever
15 is earlier, following receipt by the payer of a claim submitted by
16 electronic means and on or before the 40th calendar day following
17 receipt of a claim submitted by other than electronic means.

18 In the event payment is withheld on all or a portion of a claim by
19 a payer pursuant to subparagraph (b) of paragraph (2) of this
20 subsection, the claims payment shall be overdue if not remitted to the
21 claimant or his agent by the payer on or before the 30th calendar day
22 or the time limit established by the Medicare program, whichever is
23 earlier, for claims submitted by electronic means and the 40th calendar
24 day for claims submitted by other than electronic means, following
25 receipt by the payer of the required documentation or modification of
26 an initial submission.

27 (7) An overdue payment shall bear simple interest at the rate of
28 10% per annum.

29 e. As used in this subsection, "insured claim" or "claim" means a
30 claim by an enrollee for payment of benefits under an insured prepaid
31 prescription service organization contract for which the financial
32 obligation for the payment of a claim under the contract rests upon
33 the prepaid prescription service organization.³

34
35 11. a. A taxpayer, except for a New Jersey S corporation whose
36 shareholders shall instead be allowed the credit provided by section 13
37 of P.L. , c. (C.) (pending before the Legislature as this bill), shall
38 be allowed a credit against the tax liability imposed by section 5 of
39 P.L.1945, c.162 (C.54:10A-5) in an amount equal to 10% of the costs
40 of the taxpayer during a fiscal or calendar accounting year, referred to
41 hereinafter in this section as a "tax year," ¹ [beginning on or] ending¹
42 after ¹ [January, 1,] June 30,¹ ² [1998] 1999² but before ¹ [January]
43 July¹ 1, ² [2000] 2001², for the purchase, lease or rental by the
44 taxpayer of electronic data interchange technology to be used to
45 receive and transmit health care information, or such proportion of
46 these costs as is determined by the director to be the proportion of the

1 use of the technology in this State, provided that:

2 (1) The taxpayer is a health care provider licensed pursuant to
3 Title 45 of the Revised Statutes or any other health care provider who
4 is eligible for reimbursement by health care benefits payers, and the
5 technology purchased, leased or rented is used or intended for use in
6 the health care provider's professional office;

7 (2) The taxpayer is a health care facility licensed pursuant to
8 P.L.1971, c.136 (C.26:2H-1 et seq.);

9 (3) The taxpayer is a dental plan organization authorized to issue
10 health benefits plans in this State;

11 (4) The taxpayer is an entity which processes claims for health
12 care benefits or enrollments for health care benefits plans;

13 (5) The taxpayer is an employer which provides a comprehensive
14 self-funded health benefits plan to its employees or their dependents;
15 or

16 (6) The taxpayer is an information systems vendor that provides
17 software to support the transmission and receipt of health benefits
18 claims, inquiries about health benefits claims or claims payments,
19 health benefits plan enrollment transactions or health benefits-related
20 eligibility inquiries; and

21 (7) The technology purchased, leased or rented is primarily used
22 or intended for use, at a minimum, for one or more of the following
23 applications in accordance with standards adopted by the
24 Commissioner of Banking and Insurance pursuant to section 1 of
25 P.L. , c. (C.)(pending before the Legislature as this bill):
26 submission of health benefits claims, inquiries about health benefits
27 claims and claims payments, health benefits plan enrollment
28 transactions or health benefits-related eligibility inquiries.

29 As used in this section, "electronic data interchange technology"
30 means computer equipment or software which permits the electronic
31 transmission of a business document in a standard format.

32 b. No credit shall be allowed under the "Manufacturing Equipment
33 and Employment Investment Tax Credit Act," P.L.1993, c.171
34 (C.54:10A-5.16 et seq.), or under P.L.1993, c.170 (C.54:10A-5.4 et
35 seq.) for property or expenditures for which a credit is allowed, or
36 which are includable in the calculation of a credit allowed, under this
37 section.

38 c. The tax imposed for a fiscal or calendar accounting year
39 pursuant to section 5 of P.L.1945, c.162 shall first be reduced by the
40 amount of any credit allowed pursuant to this section and then by any
41 other statutory credits allowed against the tax. The credit allowed
42 under this section shall be applied in the order of the credits' tax years.
43 The amount of the credit applied under this section against the tax
44 imposed pursuant to section 5 of P.L.1945, c.162 for an accounting
45 year shall not exceed 50% of the tax liability otherwise due and shall
46 not reduce the tax liability to an amount less than the statutory

1 minimum provided in subsection (e) of section 5 of P.L.1945, c.162.
2 The amount of tax year credit otherwise allowable under this section
3 which cannot be applied for the tax year due to the limitations of this
4 subsection may be carried over, if necessary, to the seven accounting
5 years following a credit's tax year.

6
7 12. a. A taxpayer shall be allowed a credit against the tax liability
8 imposed by P.L.1945, c.132 (C.54:18A-1 et seq.) in an amount equal
9 to 10% of the costs of the taxpayer during a year, referred to
10 hereinafter in this section as the "tax year," beginning on or after
11 January 1, ²[1998] 1999 ² but before January 1, ²[2000] 2001 ², for
12 the purchase, lease or rental by the taxpayer of electronic data
13 interchange technology to be used to receive and transmit health care
14 information, or such proportion of these costs as is determined by the
15 director to be the proportion of the use of the technology in this State,
16 provided that the technology purchased, leased or rented is primarily
17 used or intended for use, at a minimum, for one or more of the
18 following applications in accordance with standards adopted by the
19 Commissioner of Banking and Insurance pursuant to section 1 of
20 P.L. , c. (C.)(pending before the Legislature as this bill):
21 submission of health benefits claims, inquiries about health benefits
22 claims, information about health benefits claims payments, health
23 benefits plan enrollment transactions, or health benefits-related
24 eligibility inquiries.

25 As used in this section, "electronic data interchange technology"
26 means computer equipment or software which permits the electronic
27 transmission of a business document in a standard format.

28 b. The tax imposed for a year pursuant to P.L.1945, c.132 shall
29 first be reduced by the amount of any credit allowed pursuant to this
30 section and then by any other statutory credits allowed against the tax.
31 The credit allowed under this section shall be applied in the order of
32 the credits' tax years. The amount of the credit applied under this
33 section against the tax imposed pursuant to P.L.1945, c.132, for
34 premiums collected in a calendar year shall not exceed 50% of the tax
35 liability otherwise due. The amount of tax year credit otherwise
36 allowable under this section which cannot be applied for the tax year
37 due to the limitations of this subsection may be carried over, if
38 necessary, to the seven accounting years following a credit's tax year.

39
40 13. a. A taxpayer shall be allowed a credit against the tax
41 otherwise due pursuant to N.J.S.54A:1-1 et seq. in an amount equal
42 to 10% of the costs of the taxpayer during a taxable year beginning on
43 or after January 1, ²[1998] 1999 ² but before January 1, ²[2000]
44 2001 ², for the purchase, lease or rental by the taxpayer of electronic
45 data interchange technology to be used to receive and transmit health
46 care information, or such proportion of these costs as is determined by

1 the director to be the proportion of the use of the technology in this
2 State, provided that:

3 (1) The taxpayer is a health care provider licensed pursuant to
4 Title 45 of the Revised Statutes or any other health care provider
5 reimbursable by health care benefits payers, and the technology
6 purchased, leased or rented is used or intended for use in the health
7 care provider's professional office;

8 (2) The taxpayer processes claims for health care benefits or
9 enrollments for health care benefits plans;

10 (3) The taxpayer provides a comprehensive self-funded health
11 benefits plan to the taxpayer's employees or their dependents; or

12 (4) The taxpayer is an information systems vendor that provides
13 software to support the transmission and receipt of health benefits
14 claims, inquiries about health benefits claims or claims payments,
15 health benefits plan enrollment transactions or health benefits-related
16 eligibility inquiries; and

17 (5) The technology purchased, leased or rented is primarily used
18 or intended for use, at a minimum, for one or more of the following
19 applications in accordance with standards adopted by the
20 Commissioner of Banking and Insurance pursuant to section 1 of
21 P.L. , c. (C.)(pending before the Legislature as this bill):
22 submission of health benefits claims, inquiries about health benefits
23 claims or claims payments, health benefits plan enrollment transactions
24 or health benefits-related eligibility inquiries.

25 As used in this section, "electronic data interchange technology"
26 means computer equipment or software which permits the electronic
27 transmission of a business document in a standard format.

28 b. If the taxpayer is a partner in a partnership, a member of an
29 association or a shareholder in a New Jersey S corporation, the credit
30 shall be allocated to each partner of the partnership, member of the
31 association or shareholder in the New Jersey S corporation in
32 proportion to the partner's, member's or shareholder's share of the
33 income or gain received by the partnership, association or New Jersey
34 S corporation for its taxable year ending within or with the partner's,
35 member's or shareholder's taxable year.

36 c. The amount of the credit claimed for the taxable year shall not
37 exceed 50% of the tax liability that would be otherwise due for that
38 year.

39 d. The amount of the credit shall be applied during the taxable
40 year in which the cost is incurred against any tax liability otherwise
41 due before other credits permitted pursuant to law are applied. ²**[If the**
42 **credit reduces the taxpayer's tax liability to zero, the remaining**
43 **amount of the credit shall not be considered an overpayment of the**
44 **tax.]²**

1 14. The Commissioner of Health and Senior Services, in
2 consultation with the Commissioner of Banking and Insurance, shall
3 establish an advisory board to make recommendations to the
4 commissioners on health information electronic data interchange
5 technology policy and measures to protect the confidentiality of
6 medical information. The members of the board shall include, at a
7 minimum, representation from health insurance carriers, health care
8 professionals and facilities, higher education, business and organized
9 labor, and health care consumers. The members of the board shall
10 serve without compensation but shall be entitled to reimbursement for
11 reasonable expenses incurred in the performance of their duties.

12
13 15. The Commissioner of Health and Senior Services, in
14 conjunction with the Commissioner of Banking and Insurance, shall
15 present an annual report to the Governor and the Legislature on the
16 development and use of health information electronic data interchange
17 technology in New Jersey. The report shall be prepared ¹【with the
18 cooperation and assistance of the New Jersey Institute of Technology
19 and Thomas Edison State College and】¹ in consultation with the
20 advisory board established pursuant to section 14 of P.L. , c. (C.)
21 (pending before the Legislature as this bill). The report shall include
22 any recommendations, including proposals for regulatory and
23 legislative changes, to promote the development and use of health
24 information electronic data interchange technology in this State.

25
26 16. Effective ¹【two years after the date of enactment of P.L. ,
27 c. (C.)(pending before the Legislature as this bill),】 12 months after
28 the adoption of regulations establishing standard health care
29 enrollment and claim forms by the Commissioner of Banking and
30 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before
31 the Legislature as this bill)¹, a health care professional licensed
32 pursuant to Title 45 of the Revised Statutes is responsible for filing all
33 claims for third party payment, including claims filed on behalf of the
34 licensed professional's patient for any health care service provided by
35 the licensed professional that is eligible for third party payment, except
36 that at the patient's option, the patient may file the claim for third party
37 payment. ³【The】

38 a. In the case of a claim filed on behalf of the professional's
39 patient, the³ professional shall file ³【a】 the³ claim within 60 days of
40 the last date of service for a course of treatment, on the standard claim
41 form adopted by the Commissioner of Banking and Insurance pursuant
42 to section 1 of P.L. , c. (C.) (pending before the Legislature as this
43 bill).

44 ³b. In the case of a claim in which the patient has assigned his
45 benefits to the professional, the professional shall file the claim within
46 180 days of the last date of service for a course of treatment, on the

1 standard claim form adopted by the Commissioner of Banking and
2 Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the
3 Legislature as this bill). If the professional does not file the claim
4 within 180 days of the last date of service for a course of treatment,
5 the third party payer shall reserve the right to deny payment of the
6 claim, in accordance with regulations established by the Commissioner
7 of Banking and Insurance, and the professional shall be prohibited
8 from seeking any payment directly from the patient.

9 (1) In establishing the standards for denial of payment, the
10 Commissioner of Banking and Insurance shall consider the good faith
11 use of information provided by the patient to the professional with
12 respect to the identity of the patient's third party payer, delays in filing
13 a claim related to coordination of benefits between third party payers
14 and any other factors the commissioner deems appropriate, and,
15 accordingly, shall define specific instances where the sanctions
16 permitted pursuant to this subsection shall not apply.

17 (2) A professional who fails to file a claim within 180 days and
18 whose claim for payment has been denied by the third party payer in
19 accordance with this subsection may, in the discretion of a judge of the
20 Superior Court, be permitted to refile the claim if the third party payer
21 has not been substantially prejudiced thereby. Application to the court
22 for permission to refile a claim shall be made within 14 days of
23 notification of denial of payment and shall be made upon motion based
24 upon affidavits showing sufficient reasons for the failure to file the
25 claim with the third party payer within 180 days.

26 c.³ ¹The provisions of this section shall not apply to any claims
27 filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).¹

28 ³d.³ A health care professional who violates the provisions of
29 ³subsection a. of³ this section **[shall] may** be subject to
30 ¹**[disciplinary action by the professional's respective licensing board]**
31 a civil penalty of \$250 for each violation plus \$50 for each day after
32 the 60th day that the provider fails to submit a claim. The penalty
33 shall be sued for and collected by the Division of Consumer Affairs in
34 the Department of Law and Public Safety pursuant to "the penalty
35 enforcement law," N.J.S.2A:58-1 et seq¹.

36
37 17. Effective ¹[two years after the date of enactment of P.L. , c.
38 (C.) (pending before the Legislature as this bill)] 12 months after the
39 adoption of regulations establishing standard health care enrollment
40 and claim forms by the Commissioner of Banking and Insurance
41 pursuant to section 1 of P.L. , c. (C.) (pending before the
42 Legislature as this bill)¹, a health care facility licensed pursuant to
43 P.L.1971, c.136 (C.26:2H-1 et seq.) is responsible for filing all claims
44 for third party payment, including claims filed on behalf of the health
45 care facility's patient for any health care service provided by the health
46 care facility that is eligible for third party payment, except that at the

1 patient's option, the patient may file the claim for third party payment.

2 ³[The]

3 a. In the case of a claim filed on behalf of the health care facility's
4 patient, the³ health care facility shall file ³[a] the³ claim within 60
5 days of the last date of service for a course of treatment, on the
6 standard claim form adopted by the Commissioner of Banking and
7 Insurance pursuant to section 1 of P.L. , c. (C.) (pending before
8 the Legislature as this bill).

9 ³b. In the case of a claim in which the patient has assigned his
10 benefits to the health care facility, the health care facility shall file the
11 claim within 180 days of the last date of service for a course of
12 treatment, on the standard claim form adopted by the Commissioner
13 of Banking and Insurance pursuant to section 1 of P.L. , c.
14 (C.)(pending before the Legislature as this bill). If the health care
15 facility does not file the claim within 180 days of the last date of
16 service for a course of treatment, the third party payer shall reserve the
17 right to deny payment of the claim, in accordance with regulations
18 established by the Commissioner of Banking and Insurance, and the
19 health care facility shall be prohibited from seeking any payment
20 directly from the patient.

21 (1) In establishing the standards for denial of payment, the
22 Commissioner of Banking and Insurance shall consider the length of
23 delay in filing the claim, the good faith use of information provided by
24 the patient to the health care facility with respect to the identity of the
25 patient's third party payer, delays in filing a claim related to
26 coordination of benefits between third party payers and any other
27 factors the commissioner deems appropriate, and, accordingly, shall
28 define specific instances where the sanctions permitted pursuant to this
29 subsection shall not apply.

30 (2) A health care facility which fails to file a claim within 180 days
31 and whose claim for payment has been denied by the third party payer
32 in accordance with this subsection may, in the discretion of a judge of
33 the Superior Court, be permitted to refile the claim if the third party
34 payer has not been substantially prejudiced thereby. Application to the
35 court for permission to refile a claim shall be made within 14 days of
36 notification of denial of payment and shall be made upon motion based
37 upon affidavits showing sufficient reasons for the failure to file the
38 claim with the third party payer within 180 days.³

39 ³c.³ ¹The provisions of this section shall not apply to any claims
40 filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).¹

41 ³d.³ A health care facility ³[that] which³ violates the provisions of
42 ³subsection a. of³ this section ¹[shall] may¹ be subject to ¹[such
43 penalties as the Department of Health and Senior Services shall
44 determine pursuant to sections 13 and 14 of P.L.1971, c.136
45 (C.26:2H-13 and 26:2H-14)] a civil penalty of \$250 for each
46 violation plus \$50 for each day after the 60th day that the health care

1 facility fails to submit a claim. The penalty shall be sued for and
2 collected by the Department of Health and Senior Services pursuant
3 to "the penalty enforcement law," N.J.S.2A:58-1 et seq¹.
4

5 18. The Commissioner of Banking and Insurance Commissioner,
6 in consultation with the Commissioner of Health and Senior Services,
7 shall adopt regulations to effectuate the purposes of sections 1 through
8 10 of this act, pursuant to the "Administrative Procedure Act,"
9 P.L.1968, c.410 (C.52:14B-1 et seq.). ³To the extent practicable, the
10 regulations shall include any provisions the commissioner deems
11 appropriate that seek to reduce the amount of, or to consolidate, the
12 paper forms sent by hospital, medical, health and dental service
13 corporations, commercial insurers, health maintenance organizations,
14 dental plan organizations and prepaid prescription service
15 organizations to health care providers and covered persons.³
16

17 ¹19. Thomas A. Edison State College shall study and monitor the
18 effectiveness of electronic data interchange technology in reducing
19 administrative costs, identify means by which new electronic data
20 interchange technology can be implemented to effect health care
21 system cost savings, and determine the extent of electronic data
22 interchange technology use in the State's health care system.

23 The Departments of Health and Senior Services and Banking and
24 Insurance shall cooperate with and provide assistance to the college in
25 carrying out its study pursuant to this section.

26 The college shall report to the Legislature and the Governor from
27 time to time on its findings and recommendations.¹
28

29 ³20. Sections 78, 79, and 80 of P. L.1991, c.187 (C.17B:26-12.1,
30 17B:27-44.1 and 26:2J-5.1) are repealed.³
31

32 ²[¹20. There is appropriated \$250,000 from the General Fund to
33 the Department of State for a grant to Thomas A. Edison State
34 College to carry out the purposes of section 19 of this act.¹]²
35

36 ¹[^{19.}] ²[^{21.}¹] ³[^{20.}²] 21.³ This act shall take effect
37 immediately¹ [; and section 11 shall apply to the fiscal or calendar
38 accounting years beginning on or after July 1, 1998, section 12 shall
39 apply to calendar years beginning after July 1, 1998, and section 13
40 shall apply to taxable years beginning on or after January 1, 1998]¹.

SENATE, No. 323

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Establishes health care information record confidentiality and security requirements for health care facilities and providers.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 AN ACT concerning health care information records and
2 supplementing Titles 26 and 45 of the Revised Statutes.

3
4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6
7 1. The Legislature finds and declares that:

8 a. Health care information is personal and sensitive information
9 that, if improperly used or released, may do significant harm to a
10 patient's interests in privacy and in health care, and may affect a
11 patient's ability to obtain employment, education, insurance, credit and
12 other necessities;

13 b. Patients need access to their own health care information as a
14 matter of fairness to enable them to make informed decisions about
15 their health care and to correct inaccurate or incomplete information
16 about themselves;

17 c. Persons receiving, maintaining and distributing health care
18 information need clear and certain rules for the handling, maintenance,
19 dissemination and disclosure of health care information;

20 d. In order to carry out their statutory responsibilities, including
21 the investigation and prosecution of crime, the detection of fraud, the
22 protection of youth and the regulation of health care providers and
23 facilities, institutions and insurers, it is necessary that criminal and civil
24 regulatory agencies and the courts maintain their current level of
25 access to health care information; and

26 e. Health care information is obtained, used and disclosed in many
27 different contexts and for many different purposes, and a patient's
28 interest in the proper use and disclosure of his personal health care
29 information continues even when the information has been initially
30 disclosed and is held by other persons.

31
32 2. As used in sections 1 through 10 of this act:

33 "Commissioner" means the Commissioner of Health.

34 "Health care" means any preventive, diagnostic, therapeutic,
35 rehabilitative, maintenance or palliative care, counseling, service,
36 examination or procedure provided by a health care facility with
37 respect to a patient's physical or mental condition, or affecting the
38 structure or function of the human body or any part thereof, including,
39 but not limited to, the banking of blood, sperm, organs or any other
40 tissue, or a sale or dispensing of a drug, substance, device, equipment
41 or other item to a patient or for a patient's use pursuant to a
42 prescription.

43 "Health care facility" means a health care facility regulated by the
44 Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et
45 seq.).

46 "Health care information" means any data or information, whether

1 oral or recorded in any form or medium, that identifies or can readily
2 be associated with the identity of a patient and relates to a patient's
3 health care, and is obtained in the course of a patient's health care from
4 a health care facility, the patient, a member of the patient's family, a
5 person with whom the patient has a close personal relationship, or a
6 patient representative.

7 "Patient" means a person who receives or has received health care.

8 "Patient representative" means a person legally empowered to make
9 decisions about a patient's health care on the patient's behalf or the
10 administrator or executor of a deceased patient's estate.

11 "Record" means a patient's health care information record.

12

13 3. A health care facility is subject to the provisions of sections 1
14 through 10 of this act, notwithstanding the provisions of any other law
15 to the contrary, except as otherwise provided herein.

16

17 4. a. A record maintained by a health care facility is confidential
18 and shall be disclosed only for the purposes authorized by this act.

19 b. A health care facility, in accordance with regulations adopted by
20 the commissioner, shall develop and implement a written policy
21 governing the confidentiality of records maintained by the facility. The
22 policy shall include procedures designed to ensure the security of its
23 records during storage, processing or transmission, either in electronic
24 or other form, and shall stipulate that any person who is granted
25 access to a record maintained by the facility shall have previously
26 received and signed a form approved by the commissioner which
27 explains the facility's written confidentiality policy and obligates the
28 person to abide thereby.

29 c. The content of a record may be disclosed in accordance with the
30 prior written authorization of the patient or patient representative, or
31 if the patient is legally incompetent or deceased, in accordance with
32 section 7 of this act, only if the authorization is provided on a form
33 and in a manner approved by the commissioner, in consultation with
34 the Commissioner of Insurance and the Director of the Division of
35 Consumer Affairs in the Department of Law and Public Safety and the
36 purpose and period of time for which disclosure is authorized are
37 clearly stated on the authorization form.

38 d. The signing or authentication of a patient's or patient
39 representative's authorization for disclosure shall be considered
40 permission for disclosure only for the purposes explicitly contained in
41 the authorization and shall not be considered a waiver of any rights a
42 patient has under federal or State statute, court rule or common law.

43 e. If the patient's or patient representative's prior written
44 authorization is not obtained, the record shall be disclosed only under
45 the following conditions, except that nothing in this subsection shall
46 be construed to permit the disclosure of a record to a person, agency

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- 1 or other entity to whom disclosure is otherwise prohibited under State
2 or federal law:
- 3 (1) To the patient or the patient representative;
- 4 (2) To a health care provider who is providing health care to the
5 patient, except as the disclosure is limited or prohibited by the patient;
- 6 (3) To a member of the patient's immediate family, or to another
7 person with whom the patient is known to have a close personal
8 relationship, if the disclosure is made in accordance with good medical
9 or other professional practice, except as the disclosure is limited or
10 prohibited by the patient;
- 11 (4) To any person to the extent that person needs to know the
12 information in the record, if the holder of the record believes that the
13 disclosure will avoid or minimize imminent danger to the health or
14 safety of the patient or any other person, or is necessary to alleviate
15 emergency circumstances affecting the health or safety of any person;
- 16 (5) To federal, State or local government authorities, to the extent
17 that the holder of the record is required by law to report specific
18 health care information, when needed to determine compliance with
19 State or federal licensure, certification or registration requirements, or
20 when needed to protect the public health, including but not limited to
21 the reporting of child abuse or neglect, or to identify a deceased
22 patient based upon reasonable grounds that information in the record
23 is needed to assist in the identification;
- 24 (6) To qualified personnel for the purpose of conducting scientific
25 research, but a record shall be released for research only following
26 review of the research protocol by an institutional review board
27 constituted pursuant to federal regulation 45 C.F.R. § 46.101 et seq.;
28 and the patient shall not be directly or indirectly identified in any
29 report of the research and research personnel shall not disclose the
30 person's identity in any manner;
- 31 (7) To qualified personnel for the purpose of conducting
32 management audits, financial audits or program evaluation; but the
33 personnel shall not directly or indirectly identify the patient in a report
34 of an audit or evaluation, or otherwise disclose the patient's identity in
35 any manner, and identifying information shall not be released to the
36 personnel unless it is vital to the audit or evaluation;
- 37 (8) To qualified personnel involved in medical education or in the
38 patient's diagnosis and treatment, except that disclosure is limited to
39 personnel directly involved in medical education or in the patient's
40 diagnosis and treatment;
- 41 (9) To federal, State or local government entities, including grand
42 juries, conducting a criminal investigation or carrying out the entity's
43 civil or administrative duties, as authorized by law;
- 44 (10) As permitted by rules and regulations adopted by the
45 commissioner; or
- 46 (11) In all other instances authorized by State or federal law.

1 f. Except if the information is disclosed pursuant to paragraph (9)
2 of subsection e. of this section, a health care facility shall maintain as
3 part of a record the following:

4 (1) information regarding each external disclosure of health care
5 information in that record, including, but not limited to: the name,
6 address and institutional affiliation, if any, of the person to whom the
7 health care information is disclosed; the date and purpose of the
8 disclosure; and, to the extent practicable, a description of the
9 information disclosed; and

10 (2) authorization by a patient or patient representative for
11 disclosure of health care information contained in the record and any
12 revocation thereof by the patient or patient representative; or

13 (3) if authorization was not obtained by a patient or patient
14 representative for disclosure of health care information contained in
15 the record, the authorization upon which the information was
16 disclosed.

17 g. The limits on disclosure set forth in this act shall continue to
18 apply to a record after the patient is discharged from the health care
19 facility.

20 h. A record disclosed under this act shall be held confidential by
21 the recipient of the record and shall not be released by the recipient
22 unless the conditions of this act are met. A record which is received
23 by a public agency pursuant to this act may be used or released in
24 discharging the agency's law enforcement or other statutory
25 responsibilities. Any further release by a recipient agency must be
26 authorized by this act or be otherwise authorized by law.

27

28 5. A patient or patient representative has the right to:

29 a. have access to health care information concerning the patient;

30 b. receive a copy of health care information from the patient's
31 record upon payment of a reasonable charge to a health care facility as
32 determined by the commissioner;

33 c. have a notation made in the patient's record, upon the request of
34 the patient or patient representative, which reflects: any amendment
35 to, or correction of, the information in the record, or any such change
36 proposed by the patient or patient representative with which the health
37 care facility disagrees in regard to the accuracy of the record; and

38 d. revoke at any time the patient's or patient representative's
39 authorization for disclosure of health care information contained in the
40 record, unless the disclosure is required to effectuate payment for
41 health care that has been provided to the patient, or other substantial
42 action has been taken in reliance on that authorization.

43 A patient may not maintain an action against a health care facility
44 or a person employed by a health care facility for disclosure of health
45 care information made in good faith reliance on the patient's or patient
46 representative's written authorization or authorization given pursuant

1 to section 7 of this act, if the facility or employee had no notice of the
2 revocation at the time the disclosure was made.

3
4 6. a. In addition to those disclosures otherwise permitted pursuant
5 to this act, a record may be disclosed by an order of a court of
6 competent jurisdiction which is granted pursuant to an application
7 showing good cause therefor. At a good cause hearing, the court shall
8 weigh the public interest and need for disclosure against the injury to:
9 the patient, the health care provider-patient relationship, or the
10 services offered by the health care facility, and those provisions of
11 State or federal law which are intended to assure the confidentiality of
12 patient health care information. Upon the granting of the order, the
13 court, in determining the extent to which a disclosure of all or any part
14 of a record is necessary, shall impose appropriate safeguards to
15 prevent an unauthorized disclosure.

16 b. The court shall deny an application for disclosure of a record
17 unless the court makes a specific finding that the health care facility
18 and the patient or patient representative were afforded the opportunity
19 to be represented at the hearing.

20 c. Nothing in this section shall be construed to authorize disclosure
21 of any confidential communication which is otherwise protected by
22 statute, court rule or common law.

23

24 7. a. When authorization is required for disclosure of the record
25 of a deceased or legally incompetent patient, the authorization shall be
26 obtained from any one of the following:

27 (1) From an executor, administrator of the estate, or patient
28 representative;

29 (2) From the patient's spouse or primary caretaking partner or, if
30 none, by another member of the patient's family; or

31 (3) From the commissioner in the event that the commissioner
32 reasonably determines that a deceased patient has neither an
33 authorized representative or available next-of-kin.

34 b. When authorization is required for disclosure of the record of a
35 minor, it shall be obtained from the parent, guardian, or other
36 individual authorized under State law to act in the minor's behalf.

37

38 8. a. If a health care facility or a person employed by a health care
39 facility, or a person who is granted access to a record maintained by
40 the facility, fails to comply with the provisions of this act, a patient or
41 other person whose rights are violated may apply to the Superior
42 Court of this State, or any other court of competent jurisdiction, for
43 appropriate equitable relief.

44 b. A health care facility or a person employed by a health care
45 facility, or a person who is granted access to a record maintained by
46 the facility, which discloses health care information in violation of the

1 provisions of this act shall be liable for damages sustained by the
2 person about whom the information relates.

3 c. Each disclosure of a record made in violation of the provisions
4 of this act is a separate and actionable offense.

5 d. In an action brought pursuant to this section, the court may
6 award the costs of the action and reasonable attorney's fees to the
7 prevailing party.

8 e. An action under this section shall be brought within two years
9 from the date that the alleged violation is or should have been
10 discovered.

11

12 9. a. A person who, under false or fraudulent pretenses, requests
13 or obtains health care information from a health care facility or a
14 person employed by a health care facility, or requests or obtains a
15 patient's authorization for disclosure of that information, is guilty of
16 a crime of the fourth degree.

17 b. A person who, under false or fraudulent pretenses, requests or
18 obtains health care information from a health care facility or a person
19 employed by a health care facility and knowingly uses, sells or
20 transfers that information for remuneration, profit or monetary gain,
21 is guilty of a crime of the second degree if the amount involved is
22 \$75,000 or more; a crime of the third degree if the amount involved
23 exceeds \$500 but is less than \$75,000; and a crime of the fourth
24 degree if the amount involved exceeds \$200 but is less than \$500.

25 c. A person who unlawfully takes health care information from a
26 health care facility or a person employed by a health care facility and
27 knowingly uses, sells or transfers that information for remuneration,
28 profit or monetary gain, is guilty of a crime of the second degree if the
29 amount involved is \$75,000 or more; a crime of the third degree if the
30 amount involved exceeds \$500 but is less than \$75,000; and a crime
31 of the fourth degree if the amount involved exceeds \$200 but is less
32 than \$500.

33

34 10. Nothing in sections 1 through 9 of this act shall be construed
35 to limit a person's immunity from liability for civil damages in
36 accordance with the provisions of any law, including, but not limited
37 to, section 1 of P.L.1983, c.248 (C.45:9-19.1), section 21 of
38 P.L.1985, c.179 (C.17:23A-21) or P.L.1972, c.45 (C.59:1-1 et seq.).

39

40 11. The commissioner, in consultation with the Commissioner of
41 Insurance and the Director of the Division of Consumer Affairs in the
42 Department of Law and Public Safety, pursuant to the "Administrative
43 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt
44 rules and regulations to effectuate the purposes of sections 1 through
45 10 of this act.

1 12. As used in sections 12 through 21 of this act:

2 "Director" means the Director of the Division of Consumer Affairs
3 in the Department of Law and Public Safety.

4 "Health care" means any preventive, diagnostic, therapeutic,
5 rehabilitative, maintenance or palliative care, counseling, service,
6 examination or procedure provided by a health care provider with
7 respect to a patient's physical or mental condition, or affecting the
8 structure or function of the human body or any part thereof, including,
9 but not limited to, the banking of blood, sperm, organs or any other
10 tissue, or a sale or dispensing of a drug, substance, device, equipment
11 or other item to a patient or for a patient's use pursuant to a
12 prescription.

13 "Health care information" means any data or information, whether
14 oral or recorded in any form or medium, that identifies or can readily
15 be associated with the identity of a patient or other subject of record
16 and relates to a patient's health care, and is obtained in the course of
17 a patient's health care from a health care provider, the patient, a
18 member of the patient's family, a person with whom the patient has a
19 close personal relationship, or the patient's legal representative.

20 "Health care provider" means a health care provider subject to
21 regulation by a professional board pursuant to the provisions of Title
22 45 of the Revised Statutes.

23 "Patient" means a person who receives or has received health care.

24 "Patient representative" means a person legally empowered to make
25 decisions about a patient's health care on the patient's behalf or the
26 administrator or executor of a deceased patient's estate.

27 "Record" means a patient's health care information record.
28

29 13. A health care provider is subject to the provisions of sections
30 12 through 21 of this act, notwithstanding the provisions of any other
31 law to the contrary, except as otherwise provided herein.
32

33 14. a. A record maintained by a health care provider is confidential
34 and shall be disclosed only for the purposes authorized by this act.

35 b. A health care provider, in accordance with regulations adopted
36 by the director, shall develop and implement a written policy
37 governing the confidentiality of records maintained by the provider.
38 The policy shall include procedures designed to ensure the security of
39 the provider's records during storage, processing or transmission,
40 either in electronic or other form, and shall stipulate that any person
41 who is granted access to a record maintained by the provider shall
42 have previously received and signed a form approved by the director
43 which explains the provider's written confidentiality policy and
44 obligates the person to abide thereby.

45 c. The content of a record may be disclosed in accordance with the
46 prior written authorization of the patient or patient representative, or

1 if the patient is legally incompetent or deceased, in accordance with
2 section 17 of this act, only if the authorization is provided on a form
3 and in a manner approved by the director, in consultation with the
4 Commissioners of Health and Insurance, and the purpose and period
5 of time for which disclosure is authorized are clearly stated on the
6 authorization form.

7 d. The signing or authentication of a patient's or patient
8 representative's authorization for disclosure shall be considered
9 permission for disclosure only for the purposes explicitly contained in
10 the authorization and shall not be considered a waiver of any rights a
11 patient has under federal or State statute, court rule or common law.

12 e. If the patient's or patient representative's prior written
13 authorization is not obtained, the record shall be disclosed only under
14 the following conditions, except that nothing in this subsection shall
15 be construed to permit the disclosure of a record to a person, agency
16 or other entity to whom disclosure is otherwise prohibited under State
17 or federal law:

18 (1) To the patient or the patient representative;

19 (2) To another health care provider who is providing health care
20 to the patient, except as the disclosure is limited or prohibited by the
21 patient;

22 (3) To a member of the patient's immediate family, or to another
23 person with whom the patient is known to have a close personal
24 relationship, if the disclosure is made in accordance with good medical
25 or other professional practice, except as the disclosure is limited or
26 prohibited by the patient;

27 (4) To any person to the extent that person needs to know the
28 information in the record, if the holder of the record believes that the
29 disclosure will avoid or minimize imminent danger to the health or
30 safety of the patient or any other person, or is necessary to alleviate
31 emergency circumstances affecting the health or safety of any person;

32 (5) To federal, State or local government authorities, to the extent
33 that the holder of the record is required by law to report specific
34 health care information, when needed to determine compliance with
35 State or federal licensure, certification or registration requirements, or
36 when needed to protect the public health, including but not limited to
37 the reporting of child abuse or neglect, or to identify a deceased
38 patient based upon reasonable grounds that information in the record
39 is needed to assist in the identification;

40 (6) To qualified personnel for the purpose of conducting scientific
41 research, but a record shall be released for research only following
42 review of the research protocol by an institutional review board
43 constituted pursuant to federal regulation 45 C.F.R. § 46.101 et seq. ;
44 and the patient shall not be directly or indirectly identified in any
45 report of the research and research personnel shall not disclose the
46 person's identity in any manner;

1 (7) To qualified personnel for the purpose of conducting
2 management audits, financial audits or program evaluation; but the
3 personnel shall not directly or indirectly identify the patient in a report
4 of an audit or evaluation, or otherwise disclose the patient's identity in
5 any manner, and identifying information shall not be released to the
6 personnel unless it is vital to the audit or evaluation;

7 (8) To qualified personnel involved in medical education or in the
8 patient's diagnosis and treatment, except that disclosure is limited to
9 personnel directly involved in medical education or in the patient's
10 diagnosis and treatment;

11 (9) To federal, State or local government entities, including grand
12 juries, conducting a criminal investigation or carrying out the entity's
13 civil or administrative duties, as authorized by law;

14 (10) As permitted by rules and regulations adopted by the
15 Commissioner of Health; or

16 (11) In all other instances authorized by State or federal law.

17 f. Except if the information is disclosed pursuant to paragraph (9)
18 of subsection e. of this section, a health care provider shall maintain as
19 part of a record the following:

20 (1) information regarding each external disclosure of health care
21 information in that record, including, but not limited to: the name,
22 address and institutional affiliation, if any, of the person to whom the
23 health care information is disclosed; the date and purpose of the
24 disclosure; and, to the extent practicable, a description of the
25 information disclosed; and

26 (2) authorization by a patient or patient representative for
27 disclosure of health care information contained in the record and any
28 revocation thereof by the patient or patient representative; or

29 (3) if authorization was not obtained by a patient or patient
30 representative for disclosure of health care information contained in
31 the record, the authorization upon which the information was
32 disclosed.

33 g. The limits on disclosure set forth in this act shall continue to
34 apply to a record after the patient is no longer receiving health care
35 services from the health care provider.

36 h. A record disclosed under this act shall be held confidential by
37 the recipient of the record and shall not be released by the recipient
38 unless the conditions of this act are met. A record which is received
39 by a public agency pursuant to this act may be used or released in
40 discharging the agency's law enforcement or other statutory
41 responsibilities. Any further release by a recipient agency must be
42 authorized by this act or be otherwise authorized by law.

43
44 15. A patient or patient representative has the right to:

- 45 a. have access to health care information concerning the patient;
46 b. receive a copy of health care information from the patient's

1 record upon payment of a reasonable charge to a health care provider
2 as determined by the director;

3 c. have a notation made in the patient's record, upon the request of
4 the patient or patient representative, which reflects: any amendment
5 to, or correction of, the information in the record, or any such change
6 proposed by the patient or patient representative with which the health
7 care provider disagrees in regard to the accuracy of the record; and

8 d. revoke at any time the patient's or patient representative's
9 authorization for disclosure of health care information contained in the
10 record, unless the disclosure is required to effectuate payment for
11 health care that has been provided to the patient, or other substantial
12 action has been taken in reliance on that authorization.

13 A patient may not maintain an action against a health care provider
14 or a person employed by a health care provider for disclosure of health
15 care information made in good faith reliance on the patient's or patient
16 representative's written authorization or authorization given pursuant
17 to section 17 of this act, if the provider or employee had no notice of
18 the revocation at the time the disclosure was made.

19

20 16. a. In addition to those disclosures otherwise permitted
21 pursuant to this act, a record may be disclosed by an order of a court
22 of competent jurisdiction which is granted pursuant to an application
23 showing good cause therefor. At a good cause hearing, the court shall
24 weigh the public interest and need for disclosure against the injury to:
25 the patient, the health care provider-patient relationship, the services
26 offered by the health care provider, and those provisions of State or
27 federal law which are intended to assure the confidentiality of patient
28 health care information. Upon the granting of the order, the court, in
29 determining the extent to which a disclosure of all or any part of a
30 record is necessary, shall impose appropriate safeguards to prevent an
31 unauthorized disclosure.

32 b. The court shall deny an application for disclosure of a record
33 unless the court makes a specific finding that the health care provider
34 and the patient or patient representative were afforded the opportunity
35 to be represented at the hearing.

36 c. Nothing in this section shall be construed to authorize disclosure
37 of any confidential communication which is otherwise protected by
38 statute, court rule or common law.

39

40 17. a. When authorization is required for disclosure of the record
41 of a deceased or legally incompetent patient, the authorization shall be
42 obtained from any one of the following:

43 (1) From an executor, administrator of the estate, or patient
44 representative;

45 (2) From the patient's spouse or primary caretaking partner or, if
46 none, by another member of the patient's family; or

1 (3) From the director in the event that the director reasonably
2 determines that a deceased patient has neither an authorized
3 representative or available next-of-kin.

4 b. When authorization is required for disclosure of the record of a
5 minor, it shall be obtained from the parent, guardian, or other
6 individual authorized under State law to act in the minor's behalf.

7
8 18. a. If a health care provider or a person employed by a health
9 care provider, or a person who is granted access to a record
10 maintained by the provider, fails to comply with the provisions of this
11 act, a patient or other person whose rights are violated may apply to
12 the Superior Court of this State, or any other court of competent
13 jurisdiction, for appropriate equitable relief.

14 b. A health care provider or a person employed by a health care
15 provider, or a person who is granted access to a record maintained by
16 the provider, who discloses health care information in violation of the
17 provisions of this act shall be liable for damages sustained by the
18 person about whom the information relates.

19 c. Each disclosure of a record made in violation of the provisions
20 of this act is a separate and actionable offense.

21 d. In an action brought pursuant to this section, the court may
22 award the costs of the action and reasonable attorney's fees to the
23 prevailing party.

24 e. An action under this section shall be brought within two years
25 from the date that the alleged violation is or should have been
26 discovered.

27
28 19. a. A person who, under false or fraudulent pretenses, requests
29 or obtains health care information from a health care provider or a
30 person employed by a health care provider, or requests or obtains a
31 patient's authorization for disclosure of that information, is guilty of
32 a crime of the fourth degree.

33 b. A person who, under false or fraudulent pretenses, requests or
34 obtains health care information from a health care provider or a person
35 employed by a health care provider and knowingly uses, sells or
36 transfers that information for remuneration, profit or monetary gain,
37 is guilty of a crime of the second degree if the amount involved is
38 \$75,000 or more; a crime of the third degree if the amount involved
39 exceeds \$500 but is less than \$75,000; and a crime of the fourth
40 degree if the amount involved exceeds \$200 but is less than \$500.

41 c. A person who unlawfully takes health care information from a
42 health care provider or a person employed by a health care provider
43 and knowingly uses, sells or transfers that information for
44 remuneration, profit or monetary gain, is guilty of a crime of the
45 second degree if the amount involved is \$75,000 or more; a crime of
46 the third degree if the amount involved exceeds \$500 but is less than

1 \$75,000; and a crime of the fourth degree if the amount involved
2 exceeds \$200 but is less than \$500.

3
4 20. Nothing in sections 12 through 19 of this act shall be construed
5 to limit a person's immunity from liability for civil damages in
6 accordance with the provisions of any law, including, but not limited
7 to, section 1 of P.L.1983, c.248 (C.45:9-19.1) , section 21 of
8 P.L.1985, c.179 (C.17:23A-21) or P.L.1972, c.45 (C.59:1-1 et seq.).

9
10 21. The director, in consultation with the Commissioners of Health
11 and Insurance, pursuant to the "Administrative Procedure Act,"
12 P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations
13 to effectuate the purposes of sections 12 through 20 of this act.

14
15 22. This act shall take effect 180 days after enactment.

16

17

18 STATEMENT

19

20 This bill establishes uniform health care information record
21 confidentiality, security and access requirements for all health care
22 patients in New Jersey, whether they are receiving services in a
23 licensed health care facility or from a health care provider regulated
24 under Title 45 of the Revised Statutes. The bill also establishes civil
25 and criminal penalties for violations of these requirements.

26 The bill requires that health care facilities and providers implement
27 a written confidentiality policy which includes procedures to ensure
28 the security of their health care information records during storage,
29 processing or transmission, either in electronic or other form. The bill
30 provides that the content of a patient health care information record
31 may be disclosed with the prior written authorization of the patient or
32 his representative only if the authorization is provided on a form and
33 in a manner approved by the Commissioner of Health, in consultation
34 with the Commissioner of Insurance and the Director of the Division
35 of Consumer Affairs, and the purpose and period of time for which
36 disclosure is authorized is clearly stated on the form.

37 The bill also provides that if a patient's or patient representative's
38 prior written authorization for disclosure of health care information is
39 not obtained, information contained in the record shall be disclosed
40 only under the following conditions:

- 41 • To the patient or the patient representative;
- 42 • To a health care provider who is providing health care to the
43 patient, except as limited or prohibited by the patient;
- 44 • To a member of the patient's immediate family, or to another
45 person with whom the patient is known to have a close
46 personal relationship, in accordance with good medical or

- 1 other professional practice, except as limited or prohibited by
2 the patient;
- 3 • To any person in order to avoid or minimize imminent danger
4 to the health or safety of the patient or any other person, or to
5 alleviate emergency circumstances affecting the health or safety
6 of any person;
 - 7 • To federal, State or local government authorities, as required
8 by law;
 - 9 • To qualified personnel for the purpose of conducting scientific
10 research;
 - 11 • To qualified personnel for the purpose of conducting
12 management audits, financial audits or program evaluation;
 - 13 • To qualified personnel involved in medical education or in the
14 patient's diagnosis and treatment;
 - 15 • To federal, State or local government entities, including grand
16 juries, conducting a criminal investigation or carrying out their
17 civil or administrative duties as authorized by law;
 - 18 • As permitted by Department of Health rules and regulations; or
19 • In all other instances authorized by State or federal law.

20 The bill requires that, except in the case of a disclosure of patient
21 information to a federal, State or local government entity, the health
22 care facility or provider shall maintain in the patient record information
23 about any disclosure from the patient record.

24 The bill provides, however, that no provision therein shall be
25 construed to permit the disclosure of a record to a person, agency or
26 other entity to whom disclosure is otherwise prohibited under State or
27 federal law.

28 The bill also stipulates that a patient or patient representative has
29 the right to:

- 30 • have access to health care information concerning the patient;
- 31 • receive a copy of health care information from the patient's
32 record upon payment of a reasonable charge;
- 33 • have a notation made in the patient's record which reflects any
34 amendment to, or correction of, the information in the record;
35 and
- 36 • revoke at any time the patient's or patient representative's
37 authorization for disclosure of health care information in the
38 record, unless the disclosure is required to effectuate payment
39 for health care that has been provided, or other substantial
40 action has been taken in reliance on that authorization.

41 The bill permits a patient's health care information record to be
42 disclosed by a court order based upon good cause, after weighing the
43 public interest and need for disclosure against the injury to: the
44 patient, the health care provider-patient relationship, the services
45 offered by the health care facility or provider, and State or federal law
46 governing patient health care information confidentiality.

1 In addition, the bill requires that health care information disclosed
2 pursuant to its provisions be held confidential by the recipient of the
3 record and not be released by the recipient unless the conditions of this
4 bill are met.

5 The bill also specifies those persons who may provide authorization
6 for the disclosure of the record of a patient who is deceased or legally
7 incompetent, or a minor.

8 With regard to penalties for noncompliance, the bill provides as
9 follows:

- 10 • If a health care facility or provider, or an employee thereof, or
11 a recipient of a patient's record, fails to comply with the
12 provisions of the bill, a patient or other person whose rights
13 are violated may apply to a court of competent jurisdiction for
14 appropriate equitable relief, which may include actual damages
15 and reasonable attorney's fees and court costs.
- 16 • A person who, under false or fraudulent pretenses, requests or
17 obtains health care information from a health care facility or
18 provider, or an employee thereof, or requests or obtains a
19 patient's authorization for disclosure of that information, is
20 guilty of a fourth degree crime (punishable by a fine of up to
21 \$7,500, or imprisonment for up to 18 months, or both).
- 22 • A person who, under false or fraudulent pretenses, requests or
23 obtains health care information from a health care facility or
24 provider, or an employee thereof, and knowingly uses, sells or
25 transfers that information for remuneration, profit or monetary
26 gain, or a person who unlawfully takes health care information
27 from a health care facility or provider, or an employee thereof,
28 and knowingly uses, sells or transfers that information for
29 remuneration, profit or monetary gain, is guilty of a second
30 degree crime if the amount involved is \$75,000 or more, a third
31 degree crime if the amount involved exceeds \$500 but is less
32 than \$75,000, and a fourth degree crime if the amount involved
33 exceeds \$200 but is less than \$500.

34 The bill stipulates that no provision therein shall be construed to
35 limit a person's immunity from civil liability in accordance with the
36 provisions of any law, including section 1 of P.L.1983, c.248
37 (C.45:9-19.1), which protects "whistle blowers" who report physician
38 misconduct to the State Board of Medical Examiners; section 21 of
39 P.L.1985, c.179 (C.17:23A-21), the insurance information practices
40 law; and P.L.1972, c.45 (C.59:1-1 et seq.), the "New Jersey Tort
41 Claims Act."

42 This bill is part of a legislative package designed to effectuate the
43 recommendations of the Healthcare Information Networks and
44 Technologies (HINT) report to the Legislature under the joint auspices
45 of Thomas Edison State College and the New Jersey Institute of
46 Technology.

ASSEMBLY, No. 2119

STATE OF NEW JERSEY 208th LEGISLATURE

INTRODUCED JUNE 1, 1998

Sponsored by:

Assemblyman NICHOLAS R. FELICE

District 40 (Bergen and Passaic)

Assemblyman JOSEPH V. DORIA, JR.

District 31 (Hudson)

SYNOPSIS

Provides incentives to stimulate development and use of health information electronic data interchange technology; appropriates \$250,000.

CURRENT VERSION OF TEXT

As introduced.



A2119 FELICE, DORIA

2

1 AN ACT concerning health information electronic data interchange
2 technology, supplementing Titles 17, 26 and 54 of the Revised
3 Statutes and Titles 17B and 54A of the New Jersey Statutes and
4 making an appropriation.

5

6 **BE IT ENACTED** by the Senate and General Assembly of the State
7 of New Jersey:

8

9 1. a. (1) The Commissioner of Banking and Insurance, in
10 consultation with the Commissioner of Health and Senior Services,
11 shall establish, by regulation, a timetable for implementation of the
12 electronic receipt and transmission of health care claim information by
13 each hospital, medical or health service corporation, individual and
14 group health insurer, health maintenance organization, dental service
15 corporation, dental plan organization and prepaid prescription service
16 organization, respectively, and a subsidiary of such corporation,
17 insurer or organization that processes health care benefits claims as a
18 third party administrator, authorized to do business in this State.

19 The Commissioner of Banking and Insurance shall establish the
20 timetable within 90 days of the date the federal Department of Health
21 and Human Services adopts rules establishing standards for health care
22 transactions, including: health claims or equivalent encounter
23 information, including institutional, professional, pharmacy and dental
24 health claims; enrollment and disenrollment in a health plan; eligibility
25 for a health plan; health care payment and remittance advice; health
26 care premium payments; first report of injury; health claim status; and
27 referral certification and authorization, respectively, pursuant to
28 section 262 of Pub.L.104-191 (42 U.S.C.s.1320d et seq.). The
29 commissioner may adopt more than one timetable, if necessary, to
30 conform the requirements of this section with the dates of adoption of
31 the federal rules.

32 (2) The timetable for implementation adopted by the commissioner
33 shall provide for extensions and waivers of the implementation
34 requirement pursuant to paragraph (1) of this subsection in cases
35 when it has been demonstrated to the commissioner's satisfaction that
36 compliance with the timetable for implementation will result in an
37 undue hardship to a hospital, medical or health service corporation,
38 individual or group health insurer, health maintenance organization,
39 dental service corporation, dental plan organization or prepaid
40 prescription service organization, respectively, or a subsidiary of such
41 corporation, insurer or organization that processes health care benefits
42 claims as a third party administrator, authorized to do business in this
43 State.

44 (3) The Commissioner of Banking and Insurance shall report to the
45 Governor and the Legislature within one year of establishing the
46 timetable pursuant to this subsection, on the number of extensions and

1 waivers of the implementation requirement that he has granted
2 pursuant to paragraph (2) of this subsection, and the reasons therefor.

3 b. The Commissioner of Banking and Insurance, in consultation
4 with the Commissioner of Health and Senior Services, shall adopt, by
5 regulation, one set of standard health care enrollment and claim forms
6 in paper and electronic formats to be used by each hospital, medical or
7 health service corporation, individual and group health insurer, health
8 maintenance organization, dental service corporation, dental plan
9 organization and prepaid prescription service organization, and a
10 subsidiary of such corporation, insurer or organization that processes
11 health care benefits claims as a third party administrator, authorized to
12 do business in this State.

13 The Commissioner of Banking and Insurance shall establish the
14 standard health care enrollment and claim forms within 90 days of the
15 date the federal Department of Health and Human Services adopts
16 rules establishing standards for the forms.

17

18 2. a. Within 180 days of the adoption of a timetable for
19 implementation pursuant to section 1 of P.L. , c. (C.)(pending
20 before the Legislature as this bill), a hospital service corporation, or
21 a subsidiary that processes health care benefits claims as a third party
22 administrator, shall demonstrate to the satisfaction of the
23 Commissioner of Banking and Insurance that it will adopt and
24 implement all of the standards to receive and transmit health care
25 transactions electronically, according to the corresponding timetable,
26 and otherwise comply with the provisions of this section, as a
27 condition of its continued authorization to do business in this State.

28 The Commissioner of Banking and Insurance may grant extensions
29 or waivers of the implementation requirement when it has been
30 demonstrated to the commissioner's satisfaction that compliance with
31 the timetable for implementation will result in an undue hardship to a
32 hospital service corporation, its subsidiary or its covered persons.

33 b. Within 12 months of the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
36 (pending before the Legislature as this bill), a hospital service
37 corporation or a subsidiary that processes health care benefits claims
38 as a third party administrator shall use the standard health care
39 enrollment and claim forms in connection with all group and individual
40 contracts issued, delivered, executed or renewed in this State.

41 c. Twelve months after the adoption of regulations establishing
42 standard health care enrollment and claim forms by the Commissioner
43 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
44 (pending before the Legislature as this bill), a hospital service
45 corporation shall require that health care providers file all claims for
46 payment for health care services. A covered person who receives

1 health care services shall not be required to submit a claim for
2 payment, but notwithstanding the provisions of this subsection to the
3 contrary, a covered person shall be permitted to submit a claim on his
4 own behalf, at the covered person's option. All claims shall be filed
5 using the standard health care claim form.

6 d. (1) Twelve months after the adoption of regulations establishing
7 standard health care enrollment and claim forms by the Commissioner
8 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
9 (pending before the Legislature as this bill), a hospital service
10 corporation shall reimburse all clean claims that are filed electronically
11 by a provider or a subscriber for payment under a group or individual
12 hospital service corporation contract, within the applicable number of
13 calendar days established for payment of claims in the Medicare
14 program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

15 If a claim or portion of a claim that is submitted electronically is
16 contested or denied by the hospital service corporation, the person or
17 entity who filed the claim shall be notified in writing or electronically,
18 as appropriate, within 30 days after receipt of the claim by the hospital
19 service corporation, that the claim is contested or denied, but the
20 uncontested portion of the claim, if any, shall be paid within 30 days
21 after receipt of the claim by the hospital service corporation. The
22 notice that a claim is contested or denied shall identify the contested
23 portion of the claim and the reasons for contesting or denying the
24 claim.

25 (2) Payment shall be treated as being made on the date a draft or
26 other valid instrument which is equivalent to payment was placed in
27 the United States mail in a properly addressed, postpaid envelope or,
28 if not so posted, on the date of delivery, or the date of electronic fund
29 transfer. An overdue payment shall bear simple interest at the rate of
30 10% per year.

31 (3) For the purposes of this section, "clean claim" has the same
32 meaning given the term in the federal Medicare program pursuant to
33 42 U.S.C.s.1395u(c)(2)(B).

34
35 3. a. Within 180 days of the adoption of a timetable for
36 implementation pursuant to section 1 of P.L. , c. (C.)(pending
37 before the Legislature as this bill), a medical service corporation, or a
38 subsidiary that processes health care benefits claims as a third party
39 administrator, shall demonstrate to the satisfaction of the
40 Commissioner of Banking and Insurance that it will adopt and
41 implement all of the standards to receive and transmit health care
42 transactions electronically, according to the corresponding timetable,
43 and otherwise comply with the provisions of this section, as a
44 condition of its continued authorization to do business in this State.

45 The Commissioner of Banking and Insurance may grant extensions
46 or waivers of the implementation requirement when it has been

1 demonstrated to the commissioner's satisfaction that compliance with
2 the timetable for implementation will result in an undue hardship to a
3 medical service corporation, its subsidiary or its covered persons.

4 b. Within 12 months of the adoption of regulations establishing
5 standard health care enrollment and claim forms by the Commissioner
6 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
7 (pending before the Legislature as this bill), a medical service
8 corporation or a subsidiary that processes health care benefits claims
9 as a third party administrator shall use the standard health care
10 enrollment and claim forms in connection with all group and individual
11 contracts issued, delivered, executed or renewed in this State.

12 c. Twelve months after the adoption of regulations establishing
13 standard health care enrollment and claim forms by the Commissioner
14 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
15 (pending before the Legislature as this bill), a medical service
16 corporation shall require that health care providers file all claims for
17 payment for health care services. A covered person who receives
18 health care services shall not be required to submit a claim for
19 payment, but notwithstanding the provisions of this subsection to the
20 contrary, a covered person shall be permitted to submit a claim on his
21 own behalf, at the covered person's option. All claims shall be filed
22 using the standard health care claim form.

23 d. (1) Twelve months after the adoption of regulations establishing
24 standard health care enrollment and claim forms by the Commissioner
25 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
26 (pending before the Legislature as this bill), a medical service
27 corporation shall reimburse all clean claims that are filed electronically
28 by a provider or a subscriber for payment under a group or individual
29 medical service corporation contract, within the applicable number of
30 calendar days established for payment of claims in the Medicare
31 program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

32 If a claim or portion of a claim that is submitted electronically is
33 contested or denied by the medical service corporation, the person or
34 entity who filed the claim shall be notified in writing or electronically,
35 as appropriate, within 30 days after receipt of the claim by the medical
36 service corporation, that the claim is contested or denied, but the
37 uncontested portion of the claim, if any, shall be paid within 30 days
38 after receipt of the claim by the medical service corporation. The
39 notice that a claim is contested or denied shall identify the contested
40 portion of the claim and the reasons for contesting or denying the
41 claim.

42 (2) Payment shall be treated as being made on the date a draft or
43 other valid instrument which is equivalent to payment was placed in
44 the United States mail in a properly addressed, postpaid envelope or,
45 if not so posted, on the date of delivery, or the date of electronic fund
46 transfer. An overdue payment shall bear simple interest at the rate of

1 10% per year.

2 (3) For the purposes of this section, "clean claim" has the same
3 meaning given the term in the federal Medicare program pursuant to
4 42 U.S.C.s.1395u(c)(2)(B).

5
6 4. a. Within 180 days of the adoption of a timetable for
7 implementation pursuant to section 1 of P.L. , c. (C.)(pending
8 before the Legislature as this bill), a health service corporation, or a
9 subsidiary that processes health care benefits claims as a third party
10 administrator, shall demonstrate to the satisfaction of the
11 Commissioner of Banking and Insurance that it will adopt and
12 implement all of the standards to receive and transmit health care
13 transactions electronically, according to the corresponding timetable,
14 and otherwise comply with the provisions of this section, as a
15 condition of its continued authorization to do business in this State.

16 The Commissioner of Banking and Insurance may grant extensions
17 or waivers of the implementation requirement when it has been
18 demonstrated to the commissioner's satisfaction that compliance with
19 the timetable for implementation will result in an undue hardship to a
20 health service corporation, its subsidiary or its covered persons.

21 b. Within 12 months of the adoption of regulations establishing
22 standard health care enrollment and claim forms by the Commissioner
23 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
24 (pending before the Legislature as this bill), a health service
25 corporation or a subsidiary that processes health care benefits claims
26 as a third party administrator shall use the standard health care
27 enrollment and claim forms in connection with all group and individual
28 contracts issued, delivered, executed or renewed in this State.

29 c. Twelve months after the adoption of regulations establishing
30 standard health care enrollment and claim forms by the Commissioner
31 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
32 (pending before the Legislature as this bill), a health service
33 corporation shall require that health care providers file all claims for
34 payment for health care services. A covered person who receives
35 health care services shall not be required to submit a claim for
36 payment, but notwithstanding the provisions of this subsection to the
37 contrary, a covered person shall be permitted to submit a claim on his
38 own behalf, at the covered person's option. All claims shall be filed
39 using the standard health care claim form.

40 d. (1) Twelve months after the adoption of regulations establishing
41 standard health care enrollment and claim forms by the Commissioner
42 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
43 (pending before the Legislature as this bill), a health service
44 corporation shall reimburse all clean claims that are filed electronically
45 by a provider or a subscriber for payment under a group or individual
46 health service corporation contract, within the applicable number of

1 calendar days established for payment of claims in the Medicare
2 program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

3 If a claim or portion of a claim that is submitted electronically is
4 contested or denied by the health service corporation, the person or
5 entity who filed the claim shall be notified in writing or electronically,
6 as appropriate, within 30 days after receipt of the claim by the health
7 service corporation, that the claim is contested or denied, but the
8 uncontested portion of the claim, if any, shall be paid within 30 days
9 after receipt of the claim by the health service corporation. The notice
10 that a claim is contested or denied shall identify the contested portion
11 of the claim and the reasons for contesting or denying the claim.

12 (2) Payment shall be treated as being made on the date a draft or
13 other valid instrument which is equivalent to payment was placed in
14 the United States mail in a properly addressed, postpaid envelope or,
15 if not so posted, on the date of delivery, or the date of electronic fund
16 transfer. An overdue payment shall bear simple interest at the rate of
17 10% per year.

18 (3) For the purposes of this section, "clean claim" has the same
19 meaning given the term in the federal Medicare program pursuant to
20 42 U.S.C.s.1395u(c)(2)(B).

21
22 5. a. Within 180 days of the adoption of a timetable for
23 implementation pursuant to section 1 of P.L. , c. (C.)(pending
24 before the Legislature as this bill), a health insurer, or a subsidiary that
25 processes health care benefits claims as a third party administrator,
26 shall demonstrate to the satisfaction of the Commissioner of Banking
27 and Insurance that it will adopt and implement all of the standards to
28 receive and transmit health care transactions electronically, according
29 to the corresponding timetable, and otherwise comply with the
30 provisions of this section, as a condition of its continued authorization
31 to do business in this State.

32 The Commissioner of Banking and Insurance may grant extensions
33 or waivers of the implementation requirement when it has been
34 demonstrated to the commissioner's satisfaction that compliance with
35 the timetable for implementation will result in an undue hardship to a
36 health insurer, its subsidiary or its covered persons.

37 b. Within 12 months of the adoption of regulations establishing
38 standard health care enrollment and claim forms by the Commissioner
39 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
40 (pending before the Legislature as this bill), a health insurer or a
41 subsidiary that processes health care benefits claims as a third party
42 administrator shall use the standard health care enrollment and claim
43 forms in connection with all individual policies issued, delivered,
44 executed or renewed in this State.

45 c. Twelve months after the adoption of regulations establishing
46 standard health care enrollment and claim forms by the Commissioner

1 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
2 (pending before the Legislature as this bill), a health insurer shall
3 require that health care providers file all claims for payment for health
4 care services. A covered person who receives health care services
5 shall not be required to submit a claim for payment, but
6 notwithstanding the provisions of this subsection to the contrary, a
7 covered person shall be permitted to submit a claim on his own behalf,
8 at the covered person's option. All claims shall be filed using the
9 standard health care claim form.

10 d. Notwithstanding the provisions of section 78 of P.L.1991, c.187
11 (C.17B:26-12.1) to the contrary,

12 (1) Twelve months after the adoption of regulations establishing
13 standard health care enrollment and claim forms by the Commissioner
14 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
15 (pending before the Legislature as this bill), a health insurer shall
16 reimburse all clean claims that are filed electronically by a provider or
17 an insured for payment under an individual policy, within the
18 applicable number of calendar days established for payment of claims
19 in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

20 If a claim or portion of a claim that is submitted electronically is
21 contested or denied by the insurer, the person or entity who filed the
22 claim shall be notified in writing or electronically, as appropriate,
23 within 30 days after receipt of the claim by the insurer, that the claim
24 is contested or denied, but the uncontested portion of the claim, if any,
25 shall be paid within 30 days after receipt of the claim by the insurer.
26 The notice that a claim is contested or denied shall identify the
27 contested portion of the claim and the reasons for contesting or
28 denying the claim.

29 (2) Payment shall be treated as being made on the date a draft or
30 other valid instrument which is equivalent to payment was placed in
31 the United States mail in a properly addressed, postpaid envelope or,
32 if not so posted, on the date of delivery, or the date of electronic fund
33 transfer. An overdue payment shall bear simple interest at the rate of
34 10% per year.

35 (3) For the purposes of this section, "clean claim" has the same
36 meaning given the term in the federal Medicare program pursuant to
37 42 U.S.C.s.1395u(c)(2)(B).

38

39 6. a. Within 180 days of the adoption of a timetable for
40 implementation pursuant to section 1 of P.L. , c. (C.)(pending
41 before the Legislature as this bill), a health insurer, or a subsidiary that
42 processes health care benefits claims as a third party administrator,
43 shall demonstrate to the satisfaction of the Commissioner of Banking
44 and Insurance that it will adopt and implement all of the standards to
45 receive and transmit health care transactions electronically, according
46 to the corresponding timetable, and otherwise comply with the

1 provisions of this section, as a condition of its continued authorization
2 to do business in this State.

3 The Commissioner of Banking and Insurance may grant extensions
4 or waivers of the implementation requirement when it has been
5 demonstrated to the commissioner's satisfaction that compliance with
6 the timetable for implementation will result in an undue hardship to a
7 health insurer, its subsidiary or its covered persons.

8 b. Within 12 months of the adoption of regulations establishing
9 standard health care enrollment and claim forms by the Commissioner
10 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
11 (pending before the Legislature as this bill), a health insurer or a
12 subsidiary that processes health care benefits claims as a third party
13 administrator shall use the standard health care enrollment and claim
14 forms in connection with all group contracts issued, delivered,
15 executed or renewed in this State.

16 c. Twelve months after the adoption of regulations establishing
17 standard health care enrollment and claim forms by the Commissioner
18 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
19 (pending before the Legislature as this bill), a health insurer shall
20 require that health care providers file all claims for payment for health
21 care services. A covered person who receives health care services
22 shall not be required to submit a claim for payment, but
23 notwithstanding the provisions of this subsection to the contrary, a
24 covered person shall be permitted to submit a claim on his own behalf,
25 at the covered person's option. All claims shall be filed using the
26 standard health care claim form.

27 d. Notwithstanding the provisions of section 79 of P.L.1991, c.187
28 (C.17B:27-44.1) to the contrary,

29 (1) Twelve months after the adoption of regulations establishing
30 standard health care enrollment and claim forms by the Commissioner
31 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
32 (pending before the Legislature as this bill), a health insurer shall
33 reimburse all clean claims that are filed electronically by a provider or
34 an insured for payment under a group policy, within the applicable
35 number of calendar days established for payment of claims in the
36 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

37 If a claim or portion of a claim that is submitted electronically is
38 contested or denied by the insurer, the person or entity who filed the
39 claim shall be notified in writing or electronically, as appropriate,
40 within 30 days after receipt of the claim by the insurer, that the claim
41 is contested or denied, but the uncontested portion of the claim, if any,
42 shall be paid within 30 days after receipt of the claim by the insurer.
43 The notice that a claim is contested or denied shall identify the
44 contested portion of the claim and the reasons for contesting or
45 denying the claim.

46 (2) Payment shall be treated as being made on the date a draft or

1 other valid instrument which is equivalent to payment was placed in
2 the United States mail in a properly addressed, postpaid envelope or,
3 if not so posted, on the date of delivery, or the date of electronic fund
4 transfer. An overdue payment shall bear simple interest at the rate of
5 10% per year.

6 (3) For the purposes of this section, "clean claim" has the same
7 meaning given the term in the federal Medicare program pursuant to
8 42 U.S.C.s.1395u(c)(2)(B).

9

10 7. a. Within 180 days of the adoption of a timetable for
11 implementation pursuant to section 1 of P.L. , c. (C.)(pending
12 before the Legislature as this bill), a health maintenance organization,
13 or a subsidiary that processes health care benefits claims as a third
14 party administrator, shall demonstrate to the satisfaction of the
15 Commissioner of Banking and Insurance that it will adopt and
16 implement all of the standards to receive and transmit health care
17 transactions electronically, according to the corresponding timetable,
18 and otherwise comply with the provisions of this section, as a
19 condition of its continued authorization to do business in this State.

20 The Commissioner of Banking and Insurance may grant extensions
21 or waivers of the implementation requirement when it has been
22 demonstrated to the commissioner's satisfaction that compliance with
23 the timetable for implementation will result in an undue hardship to a
24 health maintenance organization, its subsidiary or its covered
25 enrollees.

26 b. Within 12 months of the adoption of regulations establishing
27 standard health care enrollment and claim forms by the Commissioner
28 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
29 (pending before the Legislature as this bill), a health maintenance
30 organization or a subsidiary that processes health care benefits claims
31 as a third party administrator shall use the standard health care
32 enrollment and claim forms in connection with all group and individual
33 health maintenance organization coverage for health care services
34 issued, delivered, executed or renewed in this State.

35 c. Twelve months after the adoption of regulations establishing
36 standard health care enrollment and claim forms by the Commissioner
37 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
38 (pending before the Legislature as this bill), a health maintenance
39 organization shall require that health care providers file all claims for
40 payment for health care services. A covered person who receives
41 health care services shall not be required to submit a claim for
42 payment, but notwithstanding the provisions of this subsection to the
43 contrary, a covered person shall be permitted to submit a claim on his
44 own behalf, at the covered person's option. All claims shall be filed
45 using the standard health care claim form.

46 d. Notwithstanding the provisions of section 80 of P.L.1991, c.187

1 (C.26:2J-5.1) to the contrary,

2 (1) Twelve months after the adoption of regulations establishing
3 standard health care enrollment and claim forms by the Commissioner
4 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
5 (pending before the Legislature as this bill), a health maintenance
6 organization shall reimburse all clean claims that are filed
7 electronically by a provider or an enrollee for payment under group or
8 individual health maintenance organization coverage for health care
9 services, within the applicable number of calendar days established for
10 payment of claims in the Medicare program pursuant to
11 42 U.S.C.s.1395u(c)(2)(B).

12 If a claim or portion of a claim that is submitted electronically is
13 contested or denied by the health maintenance organization, the person
14 or entity who filed the claim shall be notified in writing or
15 electronically, as appropriate, within 30 days after receipt of the claim
16 by the health maintenance organization, that the claim is contested or
17 denied, but the uncontested portion of the claim, if any, shall be paid
18 within 30 days after receipt of the claim by the health maintenance
19 organization. The notice that a claim is contested or denied shall
20 identify the contested portion of the claim and the reasons for
21 contesting or denying the claim.

22 (2) Payment shall be treated as being made on the date a draft or
23 other valid instrument which is equivalent to payment was placed in
24 the United States mail in a properly addressed, postpaid envelope or,
25 if not so posted, on the date of delivery, or the date of electronic fund
26 transfer. An overdue payment shall bear simple interest at the rate of
27 10% per year.

28 (3) For the purposes of this section, "clean claim" has the same
29 meaning given the term in the federal Medicare program pursuant to
30 42 U.S.C.s.1395u(c)(2)(B).

31

32 8. a. Within 180 days of the adoption of a timetable for
33 implementation pursuant to section 1 of P.L. , c. (C.)(pending
34 before the Legislature as this bill), a dental service corporation, or a
35 subsidiary that processes health care benefits claims as a third party
36 administrator, shall demonstrate to the satisfaction of the
37 Commissioner of Banking and Insurance that it will adopt and
38 implement all of the standards to receive and transmit health care
39 transactions electronically, according to the corresponding timetable,
40 and otherwise comply with the provisions of this section, as a
41 condition of its continued authorization to do business in this State.

42 The Commissioner of Banking and Insurance may grant extensions
43 or waivers of the implementation requirement when it has been
44 demonstrated to the commissioner's satisfaction that compliance with
45 the timetable for implementation will result in an undue hardship to a
46 dental service corporation, its subsidiary or its covered persons.

1 b. Within 12 months of the adoption of regulations establishing
2 standard health care enrollment and claim forms by the Commissioner
3 of Banking and Insurance pursuant to section 1 of P.L. , c.
4 (C.)(pending before the Legislature as this bill), a dental service
5 corporation or a subsidiary that processes health care benefits claims
6 as a third party administrator shall use the standard health care
7 enrollment and claim forms in connection with all group and individual
8 contracts issued, delivered, executed or renewed in this State.

9 c. Twelve months after the adoption of regulations establishing
10 standard health care enrollment and claim forms by the Commissioner
11 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
12 (pending before the Legislature as this bill), a dental service
13 corporation shall require that health care providers file all claims for
14 payment for dental services. A covered person who receives dental
15 services shall not be required to submit a claim for payment, but
16 notwithstanding the provisions of this subsection to the contrary, a
17 covered person shall be permitted to submit a claim on his own behalf,
18 at the covered person's option. All claims shall be filed using the
19 standard health care claim form.

20 d. (1) Twelve months after the adoption of regulations establishing
21 standard health care enrollment and claim forms by the Commissioner
22 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
23 (pending before the Legislature as this bill), a dental service
24 corporation shall reimburse all clean claims that are filed electronically
25 by a provider or a subscriber for payment under a group or individual
26 dental service corporation contract, within the applicable number of
27 calendar days established for payment of claims in the Medicare
28 program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

29 If a claim or portion of a claim that is submitted electronically is
30 contested or denied by the dental service corporation, the person or
31 entity who filed the claim shall be notified in writing or electronically,
32 as appropriate, within 30 days after receipt of the claim by the dental
33 service corporation, that the claim is contested or denied, but the
34 uncontested portion of the claim, if any, shall be paid within 30 days
35 after receipt of the claim by the dental service corporation. The notice
36 that a claim is contested or denied shall identify the contested portion
37 of the claim and the reasons for contesting or denying the claim.

38 (2) Payment shall be treated as being made on the date a draft or
39 other valid instrument which is equivalent to payment was placed in
40 the United States mail in a properly addressed, postpaid envelope or,
41 if not so posted, on the date of delivery, or the date of electronic fund
42 transfer. An overdue payment shall bear simple interest at the rate of
43 10% per year.

44 (3) For the purposes of this section, "clean claim" has the same
45 meaning given the term in the federal Medicare program pursuant to
46 42 U.S.C.s.1395u(c)(2)(B).

1 9. a. Within 180 days of the adoption of a timetable for
2 implementation pursuant to section 1 of P.L. , c. (C.)(pending
3 before the Legislature as this bill), a dental plan organization, or a
4 subsidiary that processes health care benefits claims as a third party
5 administrator, shall demonstrate to the satisfaction of the
6 Commissioner of Banking and Insurance that it will adopt and
7 implement all of the standards to receive and transmit health care
8 transactions electronically, according to the corresponding timetable,
9 and otherwise comply with the provisions of this section, as a
10 condition of its continued authorization to do business in this State.

11 The Commissioner of Banking and Insurance may grant extensions
12 or waivers of the implementation requirement when it has been
13 demonstrated to the commissioner's satisfaction that compliance with
14 the timetable for implementation will result in an undue hardship to a
15 dental plan organization, its subsidiary or its covered enrollees.

16 b. Within 12 months of the adoption of regulations establishing
17 standard health care enrollment and claim forms by the Commissioner
18 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
19 (pending before the Legislature as this bill), a dental plan organization
20 or a subsidiary that processes health care benefits claims as a third
21 party administrator shall use the standard health care enrollment and
22 claim forms in connection with all group and individual contracts
23 issued, delivered, executed or renewed in this State.

24 c. Twelve months after the adoption of regulations establishing
25 standard health care enrollment and claim forms by the Commissioner
26 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
27 (pending before the Legislature as this bill), a dental plan organization
28 shall require that health care providers file all claims for payment for
29 dental services. A covered person who receives dental services shall
30 not be required to submit a claim for payment, but notwithstanding the
31 provisions of this subsection to the contrary, a covered person shall be
32 permitted to submit a claim on his own behalf, at the covered person's
33 option. All claims shall be filed using the standard health care claim
34 form.

35 d. (1) Twelve months after the adoption of regulations establishing
36 standard health care enrollment and claim forms by the Commissioner
37 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
38 (pending before the Legislature as this bill), a dental plan organization
39 shall reimburse all clean claims that are filed electronically by a
40 provider or an enrollee for payment under group or individual dental
41 plan organization coverage for dental services, within the applicable
42 number of calendar days established for payment of claims in the
43 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

44 If a claim or portion of a claim that is submitted electronically is
45 contested or denied by the dental plan organization, the person or
46 entity who filed the claim shall be notified in writing or electronically,

1 as appropriate, within 30 days after receipt of the claim by the dental
2 plan organization, that the claim is contested or denied, but the
3 uncontested portion of the claim, if any, shall be paid within 30 days
4 after receipt of the claim by the dental plan organization. The notice
5 that a claim is contested or denied shall identify the contested portion
6 of the claim and the reasons for contesting or denying the claim.

7 (2) Payment shall be treated as being made on the date a draft or
8 other valid instrument which is equivalent to payment was placed in
9 the United States mail in a properly addressed, postpaid envelope or,
10 if not so posted, on the date of delivery, or the date of electronic fund
11 transfer. An overdue payment shall bear simple interest at the rate of
12 10% per year.

13 (3) For the purposes of this section, "clean claim" has the same
14 meaning given the term in the federal Medicare program pursuant to
15 42 U.S.C.s.1395u(c)(2)(B).

16

17 10. a. Within 180 days of the adoption of a timetable for
18 implementation pursuant to section 1 of P.L. , c. (C.)(pending
19 before the Legislature as this bill), a prepaid prescription service
20 organization, or a subsidiary that processes health care benefits claims
21 as a third party administrator, shall demonstrate to the satisfaction of
22 the Commissioner of Banking and Insurance that it will adopt and
23 implement all of the standards to receive and transmit health care
24 transactions electronically, according to the corresponding timetable,
25 and otherwise comply with the provisions of this section, as a
26 condition of its continued authorization to do business in this State.

27 The Commissioner of Banking and Insurance may grant extensions
28 or waivers of the implementation requirement when it has been
29 demonstrated to the commissioner's satisfaction that compliance with
30 the timetable for implementation will result in an undue hardship to a
31 prepaid prescription service organization, its subsidiary or its covered
32 enrollees.

33 b. Within 12 months of the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
36 (pending before the Legislature as this bill), a prepaid prescription
37 service organization or a subsidiary that processes health care benefits
38 claims as a third party administrator shall use the standard health care
39 enrollment and claim forms in connection with all contracts issued,
40 delivered, executed or renewed in this State.

41 c. Twelve months after the adoption of regulations establishing
42 standard health care enrollment and claim forms by the Commissioner
43 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
44 (pending before the Legislature as this bill), a prepaid prescription
45 service organization shall require that health care providers file all
46 claims for payment for health care services. A covered person who

1 receives health care services shall not be required to submit a claim for
2 payment, but notwithstanding the provisions of this subsection to the
3 contrary, a covered person shall be permitted to submit a claim on his
4 own behalf, at the covered person's option. All claims shall be filed
5 using the standard health care claim form.

6 d. (1) Twelve months after the adoption of regulations establishing
7 standard health care enrollment and claim forms by the Commissioner
8 of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)
9 (pending before the Legislature as this bill), a prepaid prescription
10 service organization shall reimburse all clean claims that are filed
11 electronically by a provider or an enrollee for payment under a prepaid
12 prescription service organization contract, within the applicable
13 number of calendar days established for payment of claims in the
14 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

15 If a claim or portion of a claim that is submitted electronically is
16 contested or denied by the prepaid prescription service organization,
17 the person or entity who filed the claim shall be notified in writing or
18 electronically, as appropriate, within 30 days after receipt of the claim
19 by the prepaid prescription service organization, that the claim is
20 contested or denied, but the uncontested portion of the claim, if any,
21 shall be paid within 30 days after receipt of the claim by the prepaid
22 prescription service organization. The notice that a claim is contested
23 or denied shall identify the contested portion of the claim and the
24 reasons for contesting or denying the claim.

25 (2) Payment shall be treated as being made on the date a draft or
26 other valid instrument which is equivalent to payment was placed in
27 the United States mail in a properly addressed, postpaid envelope or,
28 if not so posted, on the date of delivery, or the date of electronic fund
29 transfer. An overdue payment shall bear simple interest at the rate of
30 10% per year.

31 (3) For the purposes of this section, "clean claim" has the same
32 meaning given the term in the federal Medicare program pursuant to
33 42 U.S.C.s.1395u(c)(2)(B).

34
35 11. a. A taxpayer, except for a New Jersey S corporation whose
36 shareholders shall instead be allowed the credit provided by section 13
37 of P.L. , c. (C.)(pending before the Legislature as this bill),
38 shall be allowed a credit against the tax liability imposed by section 5
39 of P.L.1945, c.162 (C.54:10A-5) in an amount equal to 10% of the
40 costs of the taxpayer during a fiscal or calendar accounting year,
41 referred to hereinafter in this section as a "tax year," ending after
42 June 30, 1998 but before July 1, 2000, for the purchase, lease or rental
43 by the taxpayer of electronic data interchange technology to be used
44 to receive and transmit health care information, or such proportion of
45 these costs as is determined by the director to be the proportion of the
46 use of the technology in this State, provided that:

1 (1) The taxpayer is a health care provider licensed pursuant to Title
2 45 of the Revised Statutes or any other health care provider who is
3 eligible for reimbursement by health care benefits payers, and the
4 technology purchased, leased or rented is used or intended for use in
5 the health care provider's professional office;

6 (2) The taxpayer is a health care facility licensed pursuant to
7 P.L.1971, c.136 (C.26:2H-1 et seq.);

8 (3) The taxpayer is a dental plan organization authorized to issue
9 health benefits plans in this State;

10 (4) The taxpayer is an entity which processes claims for health care
11 benefits or enrollments for health care benefits plans;

12 (5) The taxpayer is an employer which provides a comprehensive
13 self-funded health benefits plan to its employees or their dependents;
14 or

15 (6) The taxpayer is an information systems vendor that provides
16 software to support the transmission and receipt of health benefits
17 claims, inquiries about health benefits claims or claims payments,
18 health benefits plan enrollment transactions or health benefits-related
19 eligibility inquiries; and

20 (7) The technology purchased, leased or rented is primarily used
21 or intended for use, at a minimum, for one or more of the following
22 applications in accordance with standards adopted by the
23 Commissioner of Banking and Insurance pursuant to section 1 of
24 P.L. , c. (C.)(pending before the Legislature as this bill):
25 submission of health benefits claims, inquiries about health benefits
26 claims and claims payments, health benefits plan enrollment
27 transactions or health benefits-related eligibility inquiries.

28 As used in this section, "electronic data interchange technology"
29 means computer equipment or software which permits the electronic
30 transmission of a business document in a standard format.

31 b. No credit shall be allowed under the "Manufacturing Equipment
32 and Employment Investment Tax Credit Act," P.L.1993, c.171
33 (C.54:10A-5.16 et seq.), or under P.L.1993, c.170 (C.54:10A-5.4 et
34 seq.) for property or expenditures for which a credit is allowed, or
35 which are includable in the calculation of a credit allowed, under this
36 section.

37 c. The tax imposed for a fiscal or calendar accounting year
38 pursuant to section 5 of P.L.1945, c.162 shall first be reduced by the
39 amount of any credit allowed pursuant to this section and then by any
40 other statutory credits allowed against the tax. The credit allowed
41 under this section shall be applied in the order of the credits' tax years.
42 The amount of the credit applied under this section against the tax
43 imposed pursuant to section 5 of P.L.1945, c.162 for an accounting
44 year shall not exceed 50% of the tax liability otherwise due and shall
45 not reduce the tax liability to an amount less than the statutory
46 minimum provided in subsection (e) of section 5 of P.L.1945, c.162.

1 The amount of tax year credit otherwise allowable under this section
2 which cannot be applied for the tax year due to the limitations of this
3 subsection may be carried over, if necessary, to the seven accounting
4 years following a credit's tax year.

5
6 12. a. A taxpayer shall be allowed a credit against the tax liability
7 imposed by P.L.1945, c.132 (C.54:18A-1 et seq.) in an amount equal
8 to 10% of the costs of the taxpayer during a year, referred to
9 hereinafter in this section as the "tax year," beginning on or after
10 January 1, 1998 but before January 1, 2000, for the purchase, lease or
11 rental by the taxpayer of electronic data interchange technology to be
12 used to receive and transmit health care information, or such
13 proportion of these costs as is determined by the director to be the
14 proportion of the use of the technology in this State, provided that the
15 technology purchased, leased or rented is primarily used or intended
16 for use, at a minimum, for one or more of the following applications
17 in accordance with standards adopted by the Commissioner of Banking
18 and Insurance pursuant to section 1 of P.L. , c. (C.)(pending before
19 the Legislature as this bill): submission of health benefits claims,
20 inquiries about health benefits claims, information about health benefits
21 claims payments, health benefits plan enrollment transactions, or health
22 benefits-related eligibility inquiries.

23 As used in this section, "electronic data interchange technology"
24 means computer equipment or software which permits the electronic
25 transmission of a business document in a standard format.

26 b. The tax imposed for a year pursuant to P.L.1945, c.132 shall
27 first be reduced by the amount of any credit allowed pursuant to this
28 section and then by any other statutory credits allowed against the tax.
29 The credit allowed under this section shall be applied in the order of
30 the credits' tax years. The amount of the credit applied under this
31 section against the tax imposed pursuant to P.L.1945, c.132, for
32 premiums collected in a calendar year shall not exceed 50% of the tax
33 liability otherwise due. The amount of tax year credit otherwise
34 allowable under this section which cannot be applied for the tax year
35 due to the limitations of this subsection may be carried over, if
36 necessary, to the seven accounting years following a credit's tax year.

37
38 13. a. A taxpayer shall be allowed a credit against the tax
39 otherwise due pursuant to N.J.S.54A:1-1 et seq. in an amount equal
40 to 10% of the costs of the taxpayer during a taxable year beginning on
41 or after January 1, 1998 but before January 1, 2000, for the purchase,
42 lease or rental by the taxpayer of electronic data interchange
43 technology to be used to receive and transmit health care information,
44 or such proportion of these costs as is determined by the director to
45 be the proportion of the use of the technology in this State, provided
46 that:

1 (1) The taxpayer is a health care provider licensed pursuant to
2 Title 45 of the Revised Statutes or any other health care provider
3 reimbursable by health care benefits payers, and the technology
4 purchased, leased or rented is used or intended for use in the health
5 care provider's professional office;

6 (2) The taxpayer processes claims for health care benefits or
7 enrollments for health care benefits plans;

8 (3) The taxpayer provides a comprehensive self-funded health
9 benefits plan to the taxpayer's employees or their dependents; or

10 (4) The taxpayer is an information systems vendor that provides
11 software to support the transmission and receipt of health benefits
12 claims, inquiries about health benefits claims or claims payments,
13 health benefits plan enrollment transactions or health benefits-related
14 eligibility inquiries; and

15 (5) The technology purchased, leased or rented is primarily used
16 or intended for use, at a minimum, for one or more of the following
17 applications in accordance with standards adopted by the
18 Commissioner of Banking and Insurance pursuant to section 1 of
19 P.L. , c. (C.)(pending before the Legislature as this bill):
20 submission of health benefits claims, inquiries about health benefits
21 claims or claims payments, health benefits plan enrollment transactions
22 or health benefits-related eligibility inquiries.

23 As used in this section, "electronic data interchange technology"
24 means computer equipment or software which permits the electronic
25 transmission of a business document in a standard format.

26 b. If the taxpayer is a partner in a partnership, a member of an
27 association or a shareholder in a New Jersey S corporation, the credit
28 shall be allocated to each partner of the partnership, member of the
29 association or shareholder in the New Jersey S corporation in
30 proportion to the partner's, member's or shareholder's share of the
31 income or gain received by the partnership, association or New Jersey
32 S corporation for its taxable year ending within or with the partner's,
33 member's or shareholder's taxable year.

34 c. The amount of the credit claimed for the taxable year shall not
35 exceed 50% of the tax liability that would be otherwise due for that
36 year.

37 d. The amount of the credit shall be applied during the taxable year
38 in which the cost is incurred against any tax liability otherwise due
39 before other credits permitted pursuant to law are applied. If the
40 credit reduces the taxpayer's tax liability to zero, the remaining
41 amount of the credit shall not be considered an overpayment of the
42 tax.

43
44 14. The Commissioner of Health and Senior Services, in
45 consultation with the Commissioner of Banking and Insurance, shall
46 establish an advisory board to make recommendations to the

1 commissioners on health information electronic data interchange
2 technology policy and measures to protect the confidentiality of
3 medical information. The members of the board shall include, at a
4 minimum, representation from health insurance carriers, health care
5 professionals and facilities, higher education, business and organized
6 labor, and health care consumers. The members of the board shall
7 serve without compensation but shall be entitled to reimbursement for
8 reasonable expenses incurred in the performance of their duties.

9
10 15. The Commissioner of Health and Senior Services, in
11 conjunction with the Commissioner of Banking and Insurance, shall
12 present an annual report to the Governor and the Legislature on the
13 development and use of health information electronic data interchange
14 technology in New Jersey. The report shall be prepared in consultation
15 with the advisory board established pursuant to section 14 of P.L. ,
16 c. (C.) (pending before the Legislature as this bill). The report
17 shall include any recommendations, including proposals for regulatory
18 and legislative changes, to promote the development and use of health
19 information electronic data interchange technology in this State.

20
21 16. Effective 12 months after the adoption of regulations
22 establishing standard health care enrollment and claim forms by the
23 Commissioner of Banking and Insurance pursuant to section 1 of
24 P.L. , c. (C.) (pending before the Legislature as this bill), a
25 health care professional licensed pursuant to Title 45 of the Revised
26 Statutes is responsible for filing all claims for third party payment,
27 including claims filed on behalf of the licensed professional's patient
28 for any health care service provided by the licensed professional that
29 is eligible for third party payment, except that at the patient's option,
30 the patient may file the claim for third party payment. The
31 professional shall file a claim within 60 days of the last date of service
32 for a course of treatment, on the standard claim form adopted by the
33 Commissioner of Banking and Insurance pursuant to section 1 of
34 P.L. , c. (C.) (pending before the Legislature as this bill). The
35 provisions of this section shall not apply to any claims filed pursuant
36 to P.L.1972, c.70 (C.39:6A-1 et seq.).

37 A health care professional who violates the provisions of this
38 section may be subject to a civil penalty of \$250 for each violation plus
39 \$50 for each day after the 60th day that the provider fails to submit a
40 claim. The penalty shall be sued for and collected by the Division of
41 Consumer Affairs in the Department of Law and Public Safety
42 pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

43
44 17. Effective 12 months after the adoption of regulations
45 establishing standard health care enrollment and claim forms by the
46 Commissioner of Banking and Insurance pursuant to section 1 of

1 P.L. , c. (C.) (pending before the Legislature as this bill), a
2 health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1
3 et seq.) is responsible for filing all claims for third party payment,
4 including claims filed on behalf of the health care facility's patient for
5 any health care service provided by the health care facility that is
6 eligible for third party payment, except that at the patient's option, the
7 patient may file the claim for third party payment. The health care
8 facility shall file a claim within 60 days of the last date of service for
9 a course of treatment, on the standard claim form adopted by the
10 Commissioner of Banking and Insurance pursuant to section 1 of
11 P.L. , c. (C.) (pending before the Legislature as this bill).
12 The provisions of this section shall not apply to any claims filed
13 pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

14 A health care facility that violates the provisions of this section may
15 be subject to a civil penalty of \$250 for each violation plus \$50 for
16 each day after the 60th day that the health care facility fails to submit
17 a claim. The penalty shall be sued for and collected by the Department
18 of Health and Senior Services pursuant to "the penalty enforcement
19 law," N.J.S.2A:58-1 et seq.

20

21 18. The Commissioner of Banking and Insurance Commissioner,
22 in consultation with the Commissioner of Health and Senior Services,
23 shall adopt regulations to effectuate the purposes of sections 1 through
24 10 of this act, pursuant to the "Administrative Procedure Act,"
25 P.L.1968, c.410 (C.52:14B-1 et seq.).

26

27 19. Thomas A. Edison State College shall study and monitor the
28 effectiveness of electronic data interchange technology in reducing
29 administrative costs, identify means by which new electronic data
30 interchange technology can be implemented to effect health care
31 system cost savings, and determine the extent of electronic data
32 interchange technology use in the State's health care system.

33 The Departments of Health and Senior Services and Banking and
34 Insurance shall cooperate with and provide assistance to the college in
35 carrying out its study pursuant to this section.

36 The college shall report to the Legislature and the Governor from
37 time to time on its findings and recommendations.

38

39 20. There is appropriated \$250,000 from the General Fund to the
40 Department of State for a grant to Thomas A. Edison State College to
41 carry out the purposes of section 19 of this act.

42

43 21. This act shall take effect immediately.

STATEMENT

1

2

3 The purpose of this bill is to promote the development and use in
4 New Jersey of health care information electronic data interchange
5 (EDI) technology in accordance with standards adopted by the
6 Commissioner of Banking and Insurance pursuant to the federal
7 "Health Insurance Portability and Accountability Act of 1996"
8 ("HIPAA"), Pub.L.104-191. The bill would implement
9 recommendations of the Healthcare Information Networks and
10 Technologies (HINT) report to the Legislature under the joint auspices
11 of Thomas A. Edison State College and the New Jersey Institute of
12 Technology.

13 **Standardization of health care forms and data communication.**

14 Section 1 of the bill directs the Commissioner of Banking and
15 Insurance to (a) adopt by regulation a single set of health plan
16 enrollment and claim forms, in both paper and electronic formats, for
17 use by health care providers and health, dental and prescription plan
18 insurers in New Jersey, and (b) establish standards for electronic
19 conduct of insurance-related transactions (e.g., filing benefit claims,
20 transmitting payment or remittance advice, authorizing or certifying a
21 referral, etc.). The commissioner is directed to adopt the same forms
22 and standards that are adopted by the federal government under
23 HIPAA, thereby ensuring their consistency with the national regimen.
24 The commissioner is also directed to establish timetables for health,
25 dental and prescription plan insurers' implementation of the standards,
26 but is authorized to allow extensions and waivers in cases of potential
27 undue hardship. The commissioner is to report to the Governor and
28 the Legislature, within one year of establishing the timetable, on the
29 number of extensions and waivers of the implementation requirement
30 granted, and the reasons therefor.

31 Sections 2 through 10 of the bill require the several types of health,
32 dental, and prescription service insurers to (a) implement use of the
33 standardized enrollment and claim forms within 12 months of the
34 regulatory adoption of those forms, and (b) demonstrate to the
35 Commissioner of Banking and Insurance, within 180 days of the
36 regulatory adoption of the timetable for the electronic transaction and
37 communication standards referred to above, that they will implement
38 those standards in accordance with the appropriate timetable as a
39 condition of continued authorization to do business in New Jersey.

40 **Provider submission of benefit claims.** Sections 2 through 10, 16
41 and 17 of the bill require that, effective 12 months after adoption of
42 the regulations establishing the standardized claim forms, health care
43 providers must submit all health care claims to health, dental and
44 prescription service insurance carriers for payment. A person covered
45 by a health, dental or prescription service benefits plan who receives
46 health care services would be allowed, but could not be required, to

1 submit claims to a carrier.

2 **Prompt payment of claims.** Sections 2 through 10 of the bill
3 require insurance carriers to pay promptly any uncontested ("clean")
4 health, dental or prescription service benefits claims that are
5 electronically submitted, so that beginning 12 months after the
6 adoption of regulations establishing the standardized claim forms, the
7 carriers would be required to pay those claims within the applicable
8 number of calendar days, following submission, as provided for
9 payment of claims under the federal Medicare program. An overdue
10 payment would bear simple interest at the rate of 10% per year. In the
11 case of contested claims that are submitted electronically, a carrier
12 would be required to notify the claimant within 30 days that the claim
13 was contested or denied and pay the uncontested portion of the claim
14 within 30 days.

15 The intent of these special "prompt payment" rules is to encourage
16 electronic filing of claims.

17 **Tax incentives for investment in EDI technology.** Sections 11
18 through 13 of the bill allow a temporary 10% tax credit, against the
19 corporation business tax, the franchise tax on insurance companies
20 generally, and the gross income tax, for the purchase, lease or rental
21 of EDI technology to receive and transmit health care information.
22 The gross income tax credit would be available only to licensed health
23 care providers (e.g., doctors and dentists), entities that process
24 enrollments or claims under health care benefits plans, employers that
25 self-insure for employee health benefits, and vendors of computer
26 software that supports health care EDI. The corporate business tax
27 credit would be generally available to these taxpayers and also to
28 licensed health care facilities.

29 **Advisory board on EDI technology policy.** Section 14 of the bill
30 directs the Commissioner of Health and Senior Services, in
31 consultation with the Commissioner of Banking and Insurance, to
32 establish an advisory board to make recommendations to the
33 commissioners on health information EDI technology policy, including
34 measures to protect the confidentiality of medical information. The
35 advisory board would include representation from health insurance
36 carriers, health care professionals and facilities, higher education,
37 business and organized labor, and health care consumers.

38 **Annual report.** Section 15 of the bill directs the Commissioner of
39 Health and Senior Services, in conjunction with the Commissioner of
40 Banking and Insurance, to present an annual report to the Governor
41 and the Legislature on the development and use of health information
42 EDI technology in New Jersey. The report is to include any
43 recommendations for regulatory or legislative changes to promote the
44 development and use of health information EDI technology.

45 **Continuing study of EDI technology.** Sections 19 and 20 direct
46 Thomas A. Edison State College to study and monitor the use of EDI

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- 1 technology and its effectiveness in reducing administrative costs, and
- 2 appropriate \$250,000 to the Department of State to fund a grant to the
- 3 College to support this study.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2119

STATE OF NEW JERSEY

DATED: OCTOBER 5, 1998

The Assembly Health Committee reports favorably Assembly Bill No. 2119.

This bill is intended to promote the development and use in New Jersey of health care information electronic data interchange (EDI) technology in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to the federal "Health Insurance Portability and Accountability Act of 1996" (HIPAA), Pub.L.104-191. The bill would implement recommendations of the Healthcare Information Networks and Technologies (HINT) report to the Legislature under the joint auspices of Thomas A. Edison State College and the New Jersey Institute of Technology.

Standardization of health care forms and data communication. Section 1 of the bill directs the Commissioner of Banking and Insurance to: (a) adopt by regulation a single set of health plan enrollment and claim forms, in both paper and electronic formats, for use by health care providers and health, dental and prescription plan insurers in New Jersey, and (b) establish standards for electronic conduct of insurance-related transactions (e.g., filing benefit claims, transmitting payment or remittance advice, authorizing or certifying a referral, etc.). The commissioner is directed to adopt the same forms and standards that are adopted by the federal government under HIPAA, thereby ensuring their consistency with the national regimen. The commissioner is also directed to establish timetables for implementation of the standards by health, dental and prescription plan insurers, but is authorized to allow extensions and waivers in cases of potential undue hardship. The commissioner is to report to the Governor and the Legislature, within one year of establishing the timetable, on the number of extensions and waivers of the implementation requirement granted, and the reasons therefor.

Sections 2 through 10 of the bill require the several types of health, dental, and prescription service insurers to: (a) implement use of the standardized enrollment and claim forms within 12 months of the regulatory adoption of those forms, and (b) demonstrate to the Commissioner of Banking and Insurance, within 180 days of the regulatory adoption of the timetable for the electronic transaction and communication standards referred to above, that they will implement those standards in accordance with the appropriate timetable as a

condition of continued authorization to do business in New Jersey.

Provider submission of benefit claims. Sections 2 through 10, 16 and 17 of the bill require that, effective 12 months after adoption of the regulations establishing the standardized claim forms, health care providers must submit all health care claims to health, dental and prescription service insurance carriers for payment. A person covered by a health, dental or prescription service benefits plan who receives health care services would be allowed, but could not be required, to submit claims to a carrier.

Prompt payment of claims. Sections 2 through 10 of the bill require insurance carriers to pay promptly any uncontested ("clean") health, dental or prescription service benefits claims that are electronically submitted, so that beginning 12 months after the adoption of regulations establishing the standardized claim forms, the carriers would be required to pay those claims within the applicable number of calendar days, following submission, as provided for payment of claims under the federal Medicare program. An overdue payment would bear simple interest at the rate of 10% per year. In the case of contested claims that are submitted electronically, a carrier would be required to notify the claimant within 30 days that the claim was contested or denied and pay the uncontested portion of the claim within 30 days.

The intent of these special "prompt payment" rules is to encourage electronic filing of claims.

Tax incentives for investment in EDI technology. Sections 11 through 13 of the bill allow a temporary 10% tax credit, against the corporation business tax, the franchise tax on insurance companies generally, and the gross income tax, for the purchase, lease or rental of EDI technology to receive and transmit health care information. The gross income tax credit would be available only to licensed health care providers (e.g., doctors and dentists), entities that process enrollments or claims under health care benefits plans, employers that self-insure for employee health benefits, and vendors of computer software that supports health care EDI. The corporate business tax credit would be generally available to these taxpayers and also to licensed health care facilities.

Advisory board on EDI technology policy. Section 14 of the bill directs the Commissioner of Health and Senior Services, in consultation with the Commissioner of Banking and Insurance, to establish an advisory board to make recommendations to the commissioners on health information EDI technology policy, including measures to protect the confidentiality of medical information. The advisory board would include representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, and health care consumers.

Annual report. Section 15 of the bill directs the Commissioner of Health and Senior Services, in conjunction with the Commissioner of Banking and Insurance, to present an annual report to the Governor

and the Legislature on the development and use of health information EDI technology in New Jersey. The report is to include any recommendations for regulatory or legislative changes to promote the development and use of health information EDI technology.

Continuing study of EDI technology. Sections 19 and 20 direct Thomas A. Edison State College to study and monitor the use of EDI technology and its effectiveness in reducing administrative costs, and appropriate \$250,000 to the Department of State to fund a grant to the college to support this study.

This bill is identical to the Senate Committee Substitute for Senate Bill Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331 (1R) (Littell), which the committee also reported favorably on this date.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2119

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: NOVEMBER 9, 1998

The Assembly Appropriations Committee reports favorably Assembly Bill No. 2119 with committee amendments.

Assembly Bill No.2119, as amended, is intended to promote the development and use in New Jersey of health care information electronic data interchange (EDI) technology in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to the federal "Health Insurance Portability and Accountability Act of 1996" ("HIPAA"), Pub.L.104-191. The bill implements recommendations of the Healthcare Information Networks and Technologies (HINT) report to the Legislature under the joint auspices of Thomas A. Edison State College and the New Jersey Institute of Technology.

Standardization of health care forms and data communication.

Section 1 of the bill directs the Commissioner of Banking and Insurance ("B & I") to (a) adopt by regulation a single set of health plan enrollment and claim forms, in both paper and electronic formats, for use by health care providers and health, dental and prescription plan insurers in New Jersey, and (b) establish standards for electronic conduct of insurance-related transactions (e.g., filing benefit claims, transmitting payment or remittance advice, authorizing or certifying a referral, etc.). The bill directs the commissioner to adopt the same forms and standards that are adopted by the federal government under HIPAA, thereby ensuring their consistency with the national regimen. The commissioner is also directed to establish timetables for health, dental and prescription plan insurers' implementation of the standards, but is authorized to allow extensions and waivers in cases of potential undue hardship. The commissioner is to report to the Governor and the Legislature, within one year of establishing the timetable, on the number of extensions and waivers of the implementation requirement granted, and the reasons therefor.

Sections 2 through 10 of the bill require the several types of health, dental, and prescription service insurers to (a) implement use of the standardized enrollment and claim forms within 12 months of the regulatory adoption of those forms, and (b) demonstrate to the commissioner, within 180 days of the regulatory adoption of the

timetable for the electronic transaction and communication standards referred to above, that they will implement those standards in accordance with the appropriate timetable as a condition of continued authorization to do business in New Jersey.

Provider submission of benefit claims. Sections 2 through 10, 16 and 17 of the bill require that, effective 12 months after adoption of the regulations establishing the standardized claim forms, health care providers submit all health care claims to health, dental and prescription service insurance carriers for payment. A person covered by a health, dental or prescription service benefits plan who receives health care services would be allowed, but could not be required, to submit claims to a carrier.

Prompt payment of claims. Sections 2 through 10 of the bill require insurance carriers to pay promptly any uncontested ("clean") health, dental or prescription service benefits claims that are electronically submitted, so that beginning 12 months after the adoption of regulations establishing the standardized claim forms, the carriers would be required to pay those claims within the applicable number of calendar days, following submission, as provided for payment of claims under the federal Medicare program. An overdue payment would bear simple interest at the rate of 10% per year. In the case of contested claims that are submitted electronically, a carrier would be required to notify the claimant within 30 days that the claim was contested or denied and pay the uncontested portion of the claim within 30 days.

The purpose of these special "prompt payment" rules is the encouragement of the electronic filing of claims.

Tax incentives for investment in EDI technology. Sections 11 through 13 of the bill allow a temporary 10% tax credit against the corporation business tax, the franchise tax on insurance companies generally, and the gross income tax, for the purchase, lease or rental of EDI technology to receive and transmit health care information. The gross income tax credit would be available only to licensed health care providers (e.g., doctors and dentists), entities that process enrollments or claims under health care benefits plans, employers that self-insure for employee health benefits, and vendors of computer software that supports health care EDI. The corporation business tax credit would be generally available to these taxpayers and also to licensed health care facilities.

Advisory board on EDI technology policy. Section 14 of the bill directs the Commissioner of Health and Senior Services ("HSS"), in consultation with the Commissioner of Banking and Insurance, to establish an advisory board to make recommendations to the commissioners on health information EDI technology policy, including measures to protect the confidentiality of medical information. The advisory board will include representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, and health care consumers.

Annual report. Section 15 of the bill directs the Commissioner of HSS, in conjunction with the Commissioner of Banking and Insurance, to present an annual report to the Governor and the Legislature on the development and use of health information EDI technology in New Jersey. The report shall include any recommendations for regulatory or legislative changes to promote the development and use of health information EDI technology.

Continuing study of EDI technology. Section 19 directs Thomas A. Edison State College to study and monitor the use of EDI technology and its effectiveness in reducing administrative costs.

As amended by this committee, this bill is identical to Senate Bill No. 323/324/325/326/327/328/329/330/331 SCS (1R) as amended and reported by this committee.

FISCAL IMPACT:

The only provisions of the bill with major potential fiscal impact on the State are those allowing temporary tax credits for the purchase of EDI technology. No data are available regarding the variables implicated by these provisions, e.g., the potential Statewide cost of EDI technology, the proportion of EDI technology consumers who are New Jersey corporation business taxpayers, insurance premiums taxpayers, or gross income tax payers, the annual tax liability of these taxpayers, and the proportion of EDI technology usage that is directly attributable to New Jersey health and medical transactions. Because of the lack of data it is not possible to provide a reliable cost estimate for the bill.

An estimate prepared by the Division of Taxation for Senate Bill No. 325 of 1998 (the source of the temporary tax credit provisions in the current bill) projects a loss in revenue to the State of at least \$20 million during each of FY 1999 and FY 2000. However, because that estimate is based on assumed values for the missing data points already mentioned, it is at best an order-of-magnitude estimate and should not be read as a precise dollar value estimate.

The Office of Legislative Services (OLS) notes that the primary consumers of EDI technology in New Jersey are expected to be insurance companies, hospitals, physicians and dentists. Of these groups, the OLS believes that the primary beneficiaries of the tax credit will be certain insurance premiums tax payers. In general, hospitals will not qualify for this credit because all New Jersey hospitals, with one exception, are currently non-profit institutions and, as such, do not pay corporation business taxes. (However, it is possible that a for-profit subsidiary of a hospital would be eligible to take the credit.) The costs for physicians to acquire EDI technology access will probably not be significant, as in most cases all that will be required is the addition of a modem and software to an existing computer system. Thus, the primary beneficiaries of this credit will likely be those insurance companies not currently using EDI technology. These insurance companies will incur relatively larger

infrastructure costs for the purchase of EDI technology and will have sufficient tax liability under the insurance premiums tax to take advantage of this credit.

With respect to the bill's administrative costs, OLS notes that Department of Banking and Insurance additional data processing expenditures would be borne by the insurance industry pursuant to the special purpose apportionment imposed by section 2 of P.L.1995, c.156 (C.17:1C-20), a special funding mechanism of the Department of Banking and Insurance.

COMMITTEE AMENDMENTS:

The amendments revise the tax years in which the tax incentives will be available so that three full years will be prospectively available or each taxpayer type.

The amendments delete a \$250,000 appropriation for a study which duplicates an appropriation in the current State annual appropriations act.

The amendments make a technical correction to a self-contradictory reference in section 13.

SENATE, No. 324

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Requires Commissioner of Health and Senior Services to report annually to Governor and Legislature on health care expenditures in NJ.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 AN ACT concerning the reporting of health care expenditures and
2 supplementing Title 26 of the Revised Statutes.

3
4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6
7 1. The Legislature finds and declares that the public interest
8 requires a full and complete reporting to the Governor and Legislature
9 by the Department of Health and Senior Services with regard to
10 Statewide health care expenditures, based upon required annual
11 surveys, which will ensure that State efforts to achieve health care
12 expenditure savings are informed by the most reliable current data and
13 trends with respect to costs and the various sources thereof in
14 recognition of the importance of the health care industry to this State
15 and its impact on every citizen residing in New Jersey.

16
17 2. The Commissioner of Health and Senior Services, in conjunction
18 with the Commissioners of Human Services, Banking and Insurance,
19 Commerce and Economic Development, and Labor, and the Health
20 Information Electronic Data Interchange Policy Advisory Council
21 established pursuant to P.L., c. (C.) (pending before the Legislature
22 as Senate Bill No. 50 or Assembly Bill No.1476 of 1996), shall
23 present an annual report to the Governor and the Legislature on
24 Statewide health care expenditures based upon a survey of health care
25 facilities and providers, health insurers, insurers writing automobile
26 insurance and workers' compensation insurance, business and
27 organized labor. The Commissioner of Health and Senior Services
28 may contract with an independent agency or organization to conduct
29 the survey and prepare the report.

30 The report shall include, at a minimum, the following: total health
31 care expenditures Statewide; a breakdown of public and private
32 expenditures and expenditures by type of health care service category,
33 paralleling national health care expenditure categories utilized by the
34 United States Health Care Financing Administration; a comparison of
35 expenditures by category from the previous annual report to the
36 current report; expenditure comparisons by category with the most
37 recent national health care expenditure data available; identified means
38 of achieving health care expenditure savings consistent with
39 maintaining health care quality and access to services; and any
40 recommendations for legislative or administrative action to effectuate
41 these savings.

42
43 3. The Commissioner of Health and Senior Services shall include
44 in the report prepared pursuant to section 2 of this act information
45 about administrative cost savings achieved by acute care hospitals as
46 a result of increased utilization of electronic data interchange

1 technology. The commissioner shall determine the specific
2 information to be included in the report in consultation with the Health
3 Information Electronic Data Interchange Policy Advisory Council
4 established pursuant to P.L. , c. (C.)(pending before the
5 Legislature as Senate Bill No. 50 or Assembly Bill No. 1476 of 1996).
6 The commissioner shall solicit and be entitled to receive this
7 information from each acute care hospital as part of the survey
8 conducted pursuant to section 2 of this act.

9 As used in this section, "electronic data interchange technology"
10 means computer equipment or software which permits the electronic
11 transmission of a business document in a standard format.

12

13 4. This act shall take effect immediately.

14

15

16

STATEMENT

17

18 This bill requires the Commissioner of Health and Senior Services,
19 in conjunction with the Commissioners of Human Services, Banking
20 and Insurance, Commerce and Economic Development, and Labor,
21 and the Healthcare Information Electronic Data Interchange Policy
22 Advisory Council (which would be established by Senate
23 Bill No. 50 (2R) Aca or Assembly Bill No. 1473 Aca of 1996), to
24 present an annual report to the Governor and the Legislature on
25 Statewide health care expenditures. The report would be based upon
26 a survey of health care facilities and providers, health insurers, insurers
27 writing automobile insurance and workers' compensation coverage,
28 business and organized labor.

29 The bill further requires the Commissioner of Health and Senior
30 Services to include in the annual report information about
31 administrative cost savings achieved by acute care hospitals as a result
32 of increased utilization of electronic data interchange technology. The
33 commissioner is to determine the specific information to be included
34 in the report in consultation with the Healthcare Information
35 Electronic Data Interchange Policy Advisory Council. The
36 commissioner will solicit and be entitled to receive this information
37 from each acute care hospital as part of the survey conducted for the
38 report.

39 This bill is part of a legislative package designed to effectuate the
40 recommendations of the Healthcare Information Networks and
41 Technologies (HINT) report to the Legislature under the joint auspices
42 of Thomas Edison State College and the New Jersey Institute of
43 Technology. The bill is intended to ensure a regular and formal
44 follow-up by State government to the Statewide health care
45 automation and cost survey conducted for the HINT report which will
46 enable State policy makers to be apprised of the latest developments

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4

- 1 with respect to Statewide health care expenditures and possible means
- 2 to achieve cost savings.

SENATE, No. 325

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Provides temporary tax credits for the purchase, lease or rental of electronic data interchange technology to store, retrieve and transmit health care information.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 AN ACT providing tax credits for certain costs of the purchase, lease
2 or rental of electronic data interchange technology, supplementing
3 P.L.1945, c.162 (C.54:10A-1 et seq.), P.L.1945, c.132 (C.54:18A-
4 1 et seq.) and Title 54A of the New Jersey Statutes.

5
6 **BE IT ENACTED** by the Senate and General Assembly of the State
7 of New Jersey:

8
9 1. a. A taxpayer, except for a New Jersey S corporation, whose
10 shareholders shall instead be allowed the credit provided by section 3
11 of P.L., c. (C.) (now pending before the Legislature as this bill),
12 shall be allowed a credit against the tax liability imposed by section 5
13 of P.L.1945, c.162 (C.54:10A-5) in an amount equal to 10% of the
14 costs of the taxpayer during a fiscal or calendar accounting year,
15 referred to hereinafter in this section as a "tax year," beginning on or
16 after January, 1, 1997 but before January 1, 1999, for the purchase,
17 lease or rental by the taxpayer of electronic data interchange
18 technology to be used to store, retrieve and transmit health care
19 information, or such proportion of these costs as is determined by the
20 director to be the proportion of the use of the technology in this State,
21 provided that:

22 (1) The taxpayer is a health care provider licensed pursuant to Title
23 45 of the Revised Statutes or any other health care provider
24 reimburseable by health care benefits payers, and the technology
25 purchased, leased or rented is used or intended for use in the health
26 care provider's professional office;

27 (2) The taxpayer is a health care facility licensed pursuant to
28 P.L.1971, c.136 (C.26:2H-1 et seq.);

29 (3) The taxpayer is a health maintenance organization authorized
30 to issue health benefits plans in this State; or

31 (4) The taxpayer is an entity which processes claims for health care
32 benefits or enrollments for health care benefits plans; and

33 (5) The technology purchased, leased or rented is primarily used
34 or intended for use, at a minimum, for one or more of the following
35 applications in accordance with standards adopted by the Health
36 Information Electronic Data Interchange Policy Council established
37 pursuant to P.L....., c....., (C.....)(now pending before the
38 Legislature as Senate, No. 50 or Assembly, No. 1476 of 1996), or if
39 no standards have been adopted by the council, the American National
40 Standards Institute: submission of health benefits claims, inquiries
41 about health benefits claims, information about health benefits claims
42 payments, health benefits plan enrollment transactions, or health
43 benefits-related eligibility inquiries.

44 As used in this section, "electronic data interchange technology"
45 means computer equipment or software which permits the electronic
46 transmission of a business document in a standard format.

1 b. No credit shall be allowed under the "Manufacturing Equipment
2 and Employment Investment Tax Credit Act," P.L.1993, c.171
3 (C.54:10A-5.16 et al.), or under P.L.1993, c.170 (C.54:10A-5.4 et
4 seq.) for property or expenditures for which a credit is allowed, or
5 which are includable in the calculation of a credit allowed, under this
6 section.

7 c. The tax imposed for a fiscal or calendar accounting year
8 pursuant to section 5 of P.L.1945, c.162 shall first be reduced by the
9 amount of any credit allowed pursuant to this section and then by any
10 other statutory credits allowed against the tax. The credit allowed
11 under this section shall be applied in the order of the credits' tax years.
12 The amount of the credit applied under this section against the tax
13 imposed pursuant to section 5 of P.L.1945, c.162, for an accounting
14 year shall not exceed 50% of the tax liability otherwise due and shall
15 not reduce the tax liability to an amount less than the statutory
16 minimum provided in subsection (e) of section 5 of P.L.1945, c.162.
17 The amount of tax year credit otherwise allowable under this section
18 which cannot be applied for the tax year due to the limitations of this
19 subsection may be carried over, if necessary, to the seven accounting
20 years following a credit's tax year.

21
22 2. a. A taxpayer shall be allowed a credit against the tax liability
23 imposed by P.L.1945, c.132 (C.54:18A-1 et seq.) in an amount equal
24 to 10% of the costs of the taxpayer during a year, referred to
25 hereinafter in this section as the "tax year," beginning on or after
26 January 1, 1997 but before January 1, 1999, for the purchase, lease or
27 rental by the taxpayer of electronic data interchange technology to be
28 used to store, retrieve and transmit health care information, or such
29 proportion of these costs as is determined by the director to be the
30 proportion of the use of the technology in this State, provided that the
31 technology purchased, leased or rented is primarily used or intended
32 for use, at a minimum, for one or more of the following applications
33 in accordance with standards adopted by the Health Information
34 Electronic Data Interchange Policy Council established pursuant to
35 P.L....., c....., (C.....)(now pending before the Legislature
36 as Senate, No. 50 or Assembly, No. 1476 of 1996), or if no standards
37 have been adopted by the council, the American National Standards
38 Institute: submission of health benefits claims, inquiries about health
39 benefits claims, information about health benefits claims payments,
40 health benefits plan enrollment transactions, or health benefits-related
41 eligibility inquiries.

42 As used in this section, "electronic data interchange technology"
43 means computer equipment or software which permits the electronic
44 transmission of a business document in a standard format.

45 b. The tax imposed for a year pursuant to P.L.1945, c.132 shall
46 first be reduced by the amount of any credit allowed pursuant to this

1 section and then by any other statutory credits allowed against the tax.
2 The credit allowed under this section shall be applied in the order of
3 the credits' tax years. The amount of the credit applied under this
4 section against the tax imposed pursuant to P.L.1945, c.132, for
5 premiums collected in a calendar year shall not exceed 50% of the tax
6 liability otherwise due. The amount of tax year credit otherwise
7 allowable under this section which cannot be applied for the tax year
8 due to the limitations of this subsection may be carried over, if
9 necessary, to the seven accounting years following a credit's tax year.

10

11 3. a. A taxpayer shall be allowed a credit against the tax otherwise
12 due pursuant to N.J.S.54A:1-1 et seq. in an amount equal to 10% of
13 the costs of the taxpayer during a taxable year beginning on or after
14 January 1, 1997 but before January 1, 1999, for the purchase, lease or
15 rental by the taxpayer of electronic data interchange technology to be
16 used to store, retrieve and transmit health care information, or such
17 proportion of these costs as is determined by the director to be the
18 proportion of the use of the technology in this State, provided that:

19 (1) The taxpayer is a health care provider licensed pursuant to Title
20 45 of the Revised Statutes or any other health care provider
21 reimburseable by health care benefits payers, and the technology
22 purchased, leased or rented is used or intended for use in the health
23 care provider's professional office; or

24 (2) The taxpayer processes claims for health care benefits or
25 enrollments for health care benefits plans; and

26 (3) The technology purchased, leased or rented is primarily used
27 or intended for use, at a minimum, for one or more of the following
28 applications in accordance with standards adopted by the Health
29 Information Electronic Data Interchange Policy Council established
30 pursuant to P.L....., c....., (C.....)(now pending before the
31 Legislature as Senate, No. 50 or Assembly, No. 1476 of 1996), or if
32 no standards have been adopted by the council, the American National
33 Standards Institute: submission of health benefits claims, inquiries
34 about health benefits claims, information about health benefits claims
35 payments, health benefits plan enrollment transactions, or health
36 benefits-related eligibility inquiries.

37 As used in this section, "electronic data interchange technology"
38 means computer equipment or software which permits the electronic
39 transmission of a business document in a standard format.

40 b. If the taxpayer is a partner in a partnership, a member of an
41 association or a shareholder in a New Jersey S corporation, the credit
42 shall be allocated to each partner of the partnership, member of the
43 association or shareholder in the New Jersey S corporation in
44 proportion to the partner's, member's or shareholder's share of the
45 income or gain received by the partnership, association or New Jersey
46 S corporation for its taxable year ending within or with the partner's,

1 member's or shareholder's taxable year.

2 c. The amount of the credit claimed for the taxable year shall not
3 exceed 50% of the tax liability that would be otherwise due for that
4 year.

5 d. The amount of the credit shall be applied during the taxable year
6 in which the cost is incurred against any tax liability otherwise due
7 before other credits permitted pursuant to law are applied. If the
8 credit reduces the taxpayer's tax liability to zero, the remaining
9 amount of the credit shall not be considered an overpayment of the
10 tax.

11

12 4. This act shall take effect immediately; and section 1 shall apply
13 to the fiscal or calendar accounting years beginning on or after July 1,
14 1997, section 2 shall apply to calendar years beginning after July 1,
15 1997, and section 3 shall apply to taxable years beginning on or after
16 January 1, 1997.

17

18

19

STATEMENT

20

21 This bill provides a 10% tax credit against the New Jersey
22 Corporation Business Tax imposed pursuant to P.L.1945, c.162
23 (C.54:10A-1 et seq.), the tax imposed on insurance companies
24 generally pursuant to P.L.1945, c.132 (C.54:18A-1 et seq.), and the
25 gross income tax imposed pursuant to N.J.S.54A:1-1 et seq., as
26 appropriate, for the purchase, lease or rental of electronic data
27 interchange (EDI) technology for use to store, retrieve and transmit
28 health care information. The tax credits will be available for tax years
29 beginning on or after January 1, 1997 but before January 1, 1999,

30 The bill also specifically provides for a gross income tax credit for
31 sole proprietors, partners in a partnership, members of an association
32 and shareholders in a New Jersey S corporation that purchase EDI
33 technology. It makes the corporate business tax credit and the gross
34 income tax credit available to entities that process enrollments for
35 health care benefits plans and to health care providers who are
36 reimbursable by health care benefits payers. Finally, the bill requires
37 the equipment purchased, leased or rented to be used for the
38 transmission, storage and retrieval of health care information
39 according to standards developed by the Health Information Electronic
40 Data Interchange Council, established by Senate, No. 50 or Assembly,
41 No. 1476 of 1996.

42 These tax credits are intended to provide a financial incentive for
43 health care facilities and providers, third party payers and those who
44 process claims for health care benefits or enrollments for health care
45 benefits plans to purchase, lease or rent computer equipment and
46 software that will permit electronic claims processing and other

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6

1 electronic data exchanges. This will have the potential of significantly
2 reducing health care administrative costs in this State, according to the
3 Healthcare Information Networks and Technologies (HINT) report to
4 the Legislature under the joint auspices of Thomas Edison State
5 College and the New Jersey Institute of Technology. This bill is part
6 of a legislative package designed to effectuate the recommendations
7 included in the HINT report.

SENATE, No. 326

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Imposes fee on payment transactions by health care facilities and providers and establishes “Electronic Data Interchange Technology Development Fund.”

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 AN ACT concerning payment transactions by health care facilities and
2 providers and supplementing Title 26 of the Revised Statutes.

3
4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6
7 1. As used in this act:

8 "Commissioner" means the Commissioner of Health.

9 "Electronic data interchange technology" means computer
10 equipment or software which permits the electronic transmission of a
11 business document in a standard format.

12 "Fund" means the Electronic Data Interchange Technology
13 Development Fund established pursuant to this act.

14 "Health care facility" means a health care facility licensed by the
15 Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et
16 seq.).

17 "Health care provider" means a health care provider subject to
18 regulation by a professional board pursuant to the provisions of Title
19 45 of the Revised Statutes, but excluding pharmacists.

20
21 2. There is established the Electronic Data Interchange Technology
22 Development Fund in the Department of Health.

23 a. The fund shall be comprised of revenues from the automated
24 transition incentive fee established pursuant to section 4 of this act and
25 from such other sources as the Legislature may determine. Interest
26 earned on the monies in the fund shall be credited to the fund.

27 Except as provided in subsection b. of this section, the fund shall be
28 a nonlapsing fund dedicated for use by the State to provide
29 low-interest loans to, and to support the issuance of bonds by, health
30 care facilities and health care providers for the purpose of acquiring
31 electronic data interchange technology to store, retrieve and transmit
32 health care information.

33 b. Of the monies in the fund, 2.5% shall annually be allocated to
34 the Health Information Electronic Data Interchange Policy Council
35 established pursuant to P.L. , c. (C.)(pending before the
36 Legislature as Senate Bill No. or Assembly Bill No. of 1996)
37 to fund its administrative costs, out of which amount \$250,000 shall
38 be allocated to the New Jersey Institute of Technology and \$250,000
39 shall be allocated to Thomas Edison State College for consulting
40 services provided to the council; and 2.5% shall annually be used by
41 the Department of Health for costs related to its survey and annual
42 report on Statewide health care expenditures pursuant to P.L. , c.
43 (C.)(pending before the Legislature as Senate Bill No. or
44 Assembly Bill No. of 1996).

45 c. The fund shall be administered by a person appointed by the
46 commissioner or an agency designated by the commissioner. The

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1 administrator of the fund is responsible for overseeing and
2 coordinating the collection and disbursement of fund monies. The
3 administrator is responsible for promptly informing the commissioner
4 if monies are not or are not reasonably expected to be collected or
5 disbursed.

6

7 3. Bonds issued pursuant to this act shall not be deemed to
8 constitute a debt or liability of the State or of any political subdivision
9 thereof, nor a pledge of the faith and credit of the State or of any such
10 political subdivision, but shall be payable solely from the funds
11 provided pursuant to this act. The bonds shall contain on the face
12 thereof a statement to the effect that neither the State of New Jersey
13 nor any political subdivision thereof shall be obligated to pay the same
14 or the interest thereon and that neither the faith and credit nor the
15 taxing power of the State of New Jersey or of any political subdivision
16 thereof is pledged to the payment of the principal of or the interest on
17 the bonds. The issuance of bonds pursuant to this act shall not directly
18 or indirectly or contingently obligate the State or any political
19 subdivision thereof to levy or to pledge any form of taxation whatever
20 therefor.

21

22 4. a. Effective July 1, 1996, the commissioner shall assess each
23 health care facility and health care provider an automated transition
24 incentive fee of \$0.50 on every paper-based payment transaction and
25 \$0.10 on every electronically automated payment transaction, the
26 proceeds from which shall be deposited in the fund.

27 b. The provisions of subsection a. of this section are subject to
28 federal approval with respect to payment transactions in connection
29 with patients covered by the federal Medicare program established
30 pursuant to the federal Social Security Act, Pub.L.89-97 (42
31 U.S.C.§1395 et seq.) and the Medicaid program established pursuant
32 to P.L.1968, c.413 (C.30:4D-1 et seq.).

33

34 5. The commissioner shall establish the criteria for determining
35 eligibility for financial assistance provided to a health care facility or
36 a health care provider from the fund and the terms and conditions of
37 that assistance, for which purpose the commissioner shall consult, at
38 a minimum, with the following organizations: the New Jersey Hospital
39 Association, the Medical Society of New Jersey, the Hospital Alliance
40 of New Jersey, the New Jersey Association of Health Care Facilities,
41 the New Jersey Association of Non-Profit Homes for the Aging, and
42 the Home Health Agency Assembly of New Jersey, Inc.

43

44 6. The commissioner shall report annually to the Governor and the
45 Legislature on the activities of the fund and the results of the fund in
46 meeting its objectives.

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1 7. The commissioner, pursuant to the "Administrative Procedure
2 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and
3 regulations to effectuate the purposes of this act.

4
5 8. This act shall take effect immediately.
6

7
8 STATEMENT
9

10 This bill establishes the Electronic Data Interchange Technology
11 Development Fund in the Department of Health to provide
12 low-interest loans to, and to support the issuance of bonds by, health
13 care facilities and providers for the purpose of acquiring electronic
14 data interchange technology to store, retrieve and transmit health care
15 information. The fund shall be comprised of revenues from an
16 automated transition incentive fee to be assessed against health care
17 facilities and providers of \$0.50 on every paper-based payment
18 transaction and \$0.10 on every electronically automated payment
19 transaction, which takes effect July 1, 1996 (subject to federal
20 approval for Medicare and Medicaid patient-related payment
21 transactions), and from such other sources as the Legislature may
22 determine, plus interest earned on the monies in the fund.

23 The bill exempts pharmacists from the automated transition
24 incentive fee because they have largely made the transition to
25 automated transactions already. According to the Healthcare
26 Information Networks and Technologies (HINT) report to the
27 Legislature under the joint auspices of Thomas Edison State College
28 and the New Jersey Institute of Technology, 89% of pharmacies
29 surveyed by the HINT project are computerized (the highest
30 percentage among all components of the health care industry),
31 compared with only 38% of physicians and 37% of payers.

32 This bill is part of a legislative package designed to effectuate the
33 recommendations of the HINT report. The bill is intended to provide
34 a financial incentive for health care facilities and providers to purchase
35 computer equipment and software that will permit electronic claims
36 processing and other electronic data exchanges, which have the
37 potential to significantly reduce health care administrative costs in this
38 State.

SENATE, No. 327

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Requires payment of health insurance claims in 30 days.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



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2

1 AN ACT requiring prompt payment of health insurance claims,
2 supplementing P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74
3 (C.17:48A-1 et seq.) and P.L.1985, c.236 (C.17:48E-1 et seq.), and
4 amending P.L.1991, c.187.

5

6 **BE IT ENACTED** by the Senate and General Assembly of the State
7 of New Jersey:

8

9 1. (New section) a. A hospital service corporation shall reimburse
10 all claims or any portion of any claim from a subscriber or a
11 subscriber's assignee, for payment under a group or individual hospital
12 service corporation contract, within 30 days after receipt of the claim
13 by the hospital service corporation. If a claim or a portion of a claim
14 is contested by the hospital service corporation, the subscriber or the
15 subscriber's assignee shall be notified in writing within 25 days after
16 receipt of the claim by the hospital service corporation, that the claim
17 is contested or denied; except that, the uncontested portion of the
18 claim shall be paid within 30 days after receipt of the claim by the
19 hospital service corporation. The notice that a claim is contested shall
20 identify the contested portion of the claim and the reasons for
21 contesting the claim.

22 A hospital service corporation, upon receipt of the additional
23 information requested from the subscriber or the subscriber's assignee,
24 shall pay or deny the contested claim or portion of the contested claim,
25 within 45 days.

26 Payment shall be treated as being made on the date a draft or other
27 valid instrument which is equivalent to payment was placed in the
28 United States mail in a properly addressed, postpaid envelope or, if
29 not so posted, on the date of delivery, or the date of electronic fund
30 transfer.

31 A subscriber or a subscriber's assignee shall provide written notice
32 of a claim to a hospital service corporation no later than 21 days
33 following the commencement of health care services, and every bill or
34 invoice shall be submitted to the hospital service corporation: (1) if
35 submitted by the subscriber's assignee, within 30 days of the date on
36 which any health care services included in the bill or invoice were
37 provided; or (2) if submitted by a subscriber, within 10 days of the
38 receipt of the bill or invoice from the provider of services.

39 b. An overdue payment shall bear simple interest, commencing on
40 the 31st day after the claim is submitted, at the periodic rate for any
41 calendar quarter which shall not exceed the prime rate as published in
42 the Wall Street Journal on the first business day of the immediately
43 preceding calendar quarter plus an additional 5%, rounded to the

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 nearest one quarter of 1%, per annum.

2 c. The Department of Insurance shall adopt rules and regulations
3 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
4 (C.52:14B-1 et seq.) to carry out the provisions of this section.

5

6 2. (New section) a. A medical service corporation shall reimburse
7 all claims or any portion of any claim from a subscriber or a
8 subscriber's assignee, for payment under a group or individual medical
9 service corporation contract, within 30 days after receipt of the claim
10 by the medical service corporation. If a claim or a portion of a claim
11 is contested by the medical service corporation, the subscriber or the
12 subscriber's assignee shall be notified in writing within 25 days after
13 receipt of the claim by the medical service corporation, that the claim
14 is contested or denied; except that, the uncontested portion of the
15 claim shall be paid within 30 days after receipt of the claim by the
16 medical service corporation. The notice that a claim is contested shall
17 identify the contested portion of the claim and the reasons for
18 contesting the claim.

19 A medical service corporation, upon receipt of the additional
20 information requested from the subscriber or the subscriber's assignee,
21 shall pay or deny the contested claim or portion of the contested claim,
22 within 45 days.

23 Payment shall be treated as being made on the date a draft or other
24 valid instrument which is equivalent to payment was placed in the
25 United States mail in a properly addressed, postpaid envelope or, if
26 not so posted, on the date of delivery, or the date of electronic fund
27 transfer.

28 A subscriber or a subscriber's assignee shall provide written notice
29 of a claim to a medical service corporation no later than 21 days
30 following the commencement of health care services, and every bill or
31 invoice shall be submitted to the medical service corporation: (1) if
32 submitted by the subscriber's assignee, within 30 days of the date on
33 which any health care services included in the bill or invoice were
34 provided; or (2) if submitted by a subscriber, within 10 days of the
35 receipt of the bill or invoice from the provider of services.

36 b. An overdue payment shall bear simple interest, commencing on
37 the 31st day after the claim is submitted, at the periodic rate for any
38 calendar quarter which shall not exceed the prime rate as published in
39 the Wall Street Journal on the first business day of the immediately
40 preceding calendar quarter plus an additional 5%, rounded to the
41 nearest one quarter of 1%, per annum.

42 c. The Department of Insurance shall adopt rules and regulations
43 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
44 (C.52:14B-1 et seq.) to carry out the provisions of this section.

45

46 3. (New section) a. A health service corporation shall reimburse

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1 all claims or any portion of any claim from a subscriber or a
2 subscriber's assignee, for payment under a group or individual health
3 service corporation contract, within 30 days after receipt of the claim
4 by the health service corporation. If a claim or a portion of a claim is
5 contested by the health service corporation, the subscriber or the
6 subscriber's assignee shall be notified in writing within 25 days after
7 receipt of the claim by the health service corporation, that the claim is
8 contested or denied; except that, the uncontested portion of the claim
9 shall be paid within 30 days after receipt of the claim by the health
10 service corporation. The notice that a claim is contested shall identify
11 the contested portion of the claim and the reasons for contesting the
12 claim.

13 A health service corporation, upon receipt of the additional
14 information requested from the subscriber or the subscriber's assignee,
15 shall pay or deny the contested claim or portion of the contested claim,
16 within 45 days.

17 Payment shall be treated as being made on the date a draft or other
18 valid instrument which is equivalent to payment was placed in the
19 United States mail in a properly addressed, postpaid envelope or, if
20 not so posted, on the date of delivery, or the date of electronic fund
21 transfer.

22 A subscriber or a subscriber's assignee shall provide written notice
23 of a claim to a health service corporation no later than 21 days
24 following the commencement of health care services, and every bill or
25 invoice shall be submitted to the health service corporation: (1) if
26 submitted by the subscriber's assignee, within 30 days of the date on
27 which any health care services included in the bill or invoice were
28 provided; or (2) if submitted by a subscriber, within 10 days of the
29 receipt of the bill or invoice from the provider of services.

30 b. An overdue payment shall bear simple interest, commencing on
31 the 31st day after the claim is submitted, at the periodic rate for any
32 calendar quarter which shall not exceed the prime rate as published in
33 the Wall Street Journal on the first business day of the immediately
34 preceding calendar quarter plus an additional 5%, rounded to the
35 nearest one quarter of 1%, per annum.

36 c. The Department of Insurance shall adopt rules and regulations
37 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
38 (C.52:14B-1 et seq.) to carry out the provisions of this section.

39

40 4. Section 78 of P.L.1991, c.187 (C.17B:26-12.1) is amended to
41 read as follows:

42 78. a. A health insurer shall reimburse all claims or any portion of
43 any claim from an insured or an insured's assignee, for payment under
44 a health insurance policy, within **[60]** 30 days after receipt of the
45 claim by the health insurer. If a claim or a portion of a claim is
46 contested by the health insurer, the insured or the insured's assignee

1 shall be notified in writing within ~~45~~ 25 days after receipt of the
2 claim by the health insurer, that the claim is contested or denied;
3 except that, the uncontested portion of the claim shall be paid within
4 ~~60~~ 30 days after receipt of the claim by the health insurer. The
5 notice that a claim is contested shall identify the contested portion of
6 the claim and the reasons for contesting the claim.

7 A health insurer, upon receipt of the additional information
8 requested from the insured or the insured's assignee, shall pay or deny
9 the contested claim or portion of the contested claim, within ~~90~~ 45
10 days.

11 Payment shall be treated as being made on the date a draft or other
12 valid instrument which is equivalent to payment was placed in the
13 United States mail in a properly addressed, postpaid envelope or, if
14 not so posted, on the date of delivery, or the date of electronic fund
15 transfer.

16 An insured or an insured's assignee shall provide written notice of
17 a claim to a health insurer no later than 21 days following the
18 commencement of health care services, and every bill or invoice shall
19 be submitted to the health insurer: (1) if submitted by the insured's
20 assignee, within 30 days of the date on which any health care services
21 included in the bill or invoice were provided; or (2) if submitted by an
22 insured, within 10 days of the receipt of the bill or invoice from the
23 provider of services.

24 b. An overdue payment shall bear simple interest ~~at the rate of~~
25 ~~10% per year~~, commencing on the 31st day after the claim is
26 submitted, at the periodic rate for any calendar quarter which shall not
27 exceed the prime rate as published in the Wall Street Journal on the
28 first business day of the immediately preceding calendar quarter plus
29 an additional 5%, rounded to the nearest one quarter of 1%, per
30 annum.

31 c. For the purposes of this section, "health insurer" means an
32 insurer authorized to provide health insurance on an individual basis
33 pursuant to chapter 26 of Title 17B of the New Jersey Statutes.

34 d. The Department of Insurance shall adopt rules and regulations
35 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
36 (C.52:14B-1 et seq.) to carry out the provisions of this section.
37 (cf: P.L.1991, c.187, s.78)

38

39 5. Section 79 of P.L.1991, c.187 (C.17B:27-44.1) is amended to
40 read as follows:

41 79. a. A health insurer shall reimburse all claims or any portion of
42 any claim from an insured or an insured's assignee, for payment under
43 a health insurance policy, within ~~60~~ 30 days after receipt of the
44 claim by the health insurer. If a claim or a portion of a claim is
45 contested by the health insurer, the insured or the insured's assignee
46 shall be notified in writing within ~~45~~ 25 days after receipt of the

1 claim by the health insurer, that the claim is contested or denied;
2 except that, the uncontested portion of the claim shall be paid within
3 **[60]** 30 days after receipt of the claim by the health insurer. The
4 notice that a claim is contested shall identify the contested portion of
5 the claim and the reasons for contesting the claim.

6 A health insurer, upon receipt of the additional information
7 requested from the insured or the insured's assignee, shall pay or deny
8 the contested claim or portion of the contested claim, within **[90]** 45
9 days.

10 Payment shall be treated as being made on the date a draft or other
11 valid instrument which is equivalent to payment was placed in the
12 United States mail in a properly addressed, postpaid envelope or, if
13 not so posted, on the date of delivery, or the date of electronic fund
14 transfer.

15 An insured or an insured's assignee shall provide written notice of
16 a claim to a health insurer no later than 21 days following the
17 commencement of health care services, and every bill or invoice shall
18 be submitted to the health insurer: (1) if submitted by the insured's
19 assignee, within 30 days of the date on which any health care services
20 included in the bill or invoice were provided; or (2) if submitted by an
21 insured, within 10 days of the receipt of the bill or invoice from the
22 provider of services.

23 b. An overdue payment shall bear simple interest **[at the rate of**
24 **10% per year]**, commencing on the 31st day after the claim is
25 submitted, at the periodic rate for any calendar quarter which shall not
26 exceed the prime rate as published in the Wall Street Journal on the
27 first business day of the immediately preceding calendar quarter plus
28 an additional 5%, rounded to the nearest one quarter of 1%, per
29 annum.

30 c. For the purposes of this section, "health insurer" means an
31 insurer authorized to provide health insurance on a group basis
32 pursuant to chapter 27 of Title 17B of the New Jersey Statutes.

33 d. The Department of Insurance shall adopt rules and regulations
34 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
35 (C.52:14B-1 et seq.) to carry out the provisions of this section.
36 (cf: P.L.1991, c.187, s.79)

37
38 6. Section 80 of P.L.1991, c.187 (C.26:2J-5.1) is amended to read
39 as follows:

40 80. a. A health maintenance organization shall reimburse all claims
41 or any portion of any claim from an enrollee or an enrollee's assignee,
42 for payment under health maintenance organization coverage, within
43 **[60]** 30 days after receipt of the claim by the health maintenance
44 organization. If a claim or a portion of a claim is contested by the
45 health maintenance organization, the enrollee or the enrollee's assignee
46 shall be notified in writing within **[45]** 25 days after receipt of the

1 claim by the health maintenance organization, that the claim is
2 contested or denied; except that, the uncontested portion of the claim
3 shall be paid within ~~60~~ 30 days after receipt of the claim by the
4 health maintenance organization. The notice that a claim is contested
5 shall identify the contested portion of the claim and the reasons for
6 contesting the claim.

7 A health maintenance organization, upon receipt of the additional
8 information requested from the enrollee or the enrollee's assignee, shall
9 pay or deny the contested claim or portion of the contested claim,
10 within ~~90~~ 45 days.

11 Payment shall be treated as being made on the date a draft or other
12 valid instrument which is equivalent to payment was placed in the
13 United States mail in a properly addressed, postpaid envelope or, if
14 not so posted, on the date of delivery, or the date of electronic fund
15 transfer.

16 An enrollee or an enrollee's assignee shall provide written notice of
17 a claim to a health maintenance organization no later than 21 days
18 following the commencement of health care services, and every bill or
19 invoice shall be submitted to the health maintenance organization: (1)
20 if submitted by the enrollee's assignee, within 30 days of the date on
21 which any health care services included in the bill or invoice were
22 provided; or (2) if submitted by an enrollee, within 10 days of the
23 receipt of the bill or invoice from the provider of services.

24 b. An overdue payment shall bear simple interest ~~at the rate of~~
25 ~~10% per year~~, commencing on the 31st day after the claim is
26 submitted, at the periodic rate for any calendar quarter which shall not
27 exceed the prime rate as published in the Wall Street Journal on the
28 first business day of the immediately preceding calendar quarter plus
29 an additional 5%, rounded to the nearest one quarter of 1%, per
30 annum.

31 c. For the purposes of this section, "health maintenance
32 organization" means a health maintenance organization authorized
33 pursuant to the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.).

34 d. The Department of Health shall adopt rules and regulations
35 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
36 (C.52:14B-1 et seq.) to carry out the provisions of this section.
37 (cf: P.L.1991, c.187, s.80)

38

39 7. This act shall take effect immediately.

40

41

42

STATEMENT

43

44 This bill amends the "prompt payment" requirements of the "Health
45 Care Cost Reduction Act," P.L.1991, c.187 (C.26:2H-18.24 et al.) to
46 require that all uncontested health insurance claims be paid by

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1 commercial health insurers and health maintenance organizations
2 (HMO's) within 30 days (rather than 60 days as the law currently
3 provides). The bill would also implement these prompt payment
4 requirements for other carriers. In addition, the bill requires that
5 written notice of a claim be provided to a carrier no later than 21 days
6 following the commencement of health care services, and further
7 requires timely submission of bills and invoices to the carrier.

8 This bill is intended to motivate health insurers and HMO's to
9 implement electronic claims processing systems, which will result in
10 administrative savings for health insurers and HMO's by reducing their
11 claim processing costs and for health care providers by improving their
12 cash flow. The bill is part of a legislative package designed to
13 effectuate the recommendations of the Healthcare Information
14 Networks and Technologies (HINT) report to the Legislature under
15 the joint auspices of Thomas Edison State College and the New Jersey
16 Institute of Technology.

SENATE, No. 328

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Provides for resolution of certain billing disputes between insurer and health care provider without involving insured.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 AN ACT concerning the resolution of certain health care claim
2 payment disputes and supplementing various parts of the statutory
3 law.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. a. A hospital service corporation shall adopt and, after approval
9 by the Commissioner of Insurance pursuant to subsection b. of this
10 section, implement a procedure which shall be used to resolve billing
11 and payment disputes between health care providers or covered
12 individuals and the corporation . If a dispute is between a health care
13 provider and the corporation, the procedure shall provide for direct
14 communication between the provider and the hospital service
15 corporation and shall not require any action by the covered individual
16 after initial verification that the covered individual received the
17 services or treatment which are the subject of the dispute. When the
18 corporation notifies a provider or individual of a billing or payment
19 dispute, the corporation shall notify the provider or covered individual
20 of the internal appeal process implemented pursuant to this section.

21 The procedure shall include an internal appeal process by which the
22 hospital service corporation, the provider or the covered individual
23 may request an independent review of the initial resolution of the
24 dispute by an arbitrator or independent review organization agreed
25 upon by the parties to the appeal. The decision of the arbitrator or
26 review organization, as appropriate, shall be binding on the provider
27 and hospital service corporation. The internal appeal process shall
28 apply only for health benefits contracts issued, delivered, executed or
29 renewed after the approval of the the procedure by the Commissioner
30 of Insurance pursuant to subsection b. of this section.

31 b. A hospital service corporation shall, within 120 days of the
32 adoption of regulations by the commissioner pursuant to this act, file
33 its internal dispute resolution procedure with the commissioner. The
34 procedure shall be deemed approved 120 days after filing if not
35 affirmatively approved or disapproved within that 120 days. During
36 the 120-day review period, the commissioner may request such
37 amendments to the procedure as the commissioner deems necessary.
38 Any subsequent amendments to a filed and approved procedure shall
39 be deemed approved 120 days after filing if not affirmatively approved
40 or disapproved within 120 days from the filing date.

41
42 2. a. A medical service corporation shall adopt and, after approval
43 by the Commissioner of Insurance pursuant to subsection b. of this
44 section, implement a procedure which shall be used to resolve billing
45 and payment disputes between health care providers or covered
46 individuals and the corporation. If a dispute is between a health care

1 provider and the corporation, the procedure shall provide for direct
2 communication between the provider and the medical service
3 corporation and shall not require any action by the covered individual
4 after initial verification that the covered individual received the
5 services or treatment which are the subject of the dispute. When the
6 corporation notifies a provider or individual of a billing or payment
7 dispute, the corporation shall notify the provider or covered individual
8 of the internal appeal process implemented pursuant to this section.

9 The procedure shall include an internal appeal process by which the
10 medical service corporation, the provider or the covered individual
11 may request an independent review of the initial resolution of the
12 dispute by an arbitrator or independent review organization agreed
13 upon by the parties to the appeal.

14 The decision of the arbitrator or review organization, as
15 appropriate, shall be binding on the provider and medical service
16 corporation. The internal appeal process shall apply only for health
17 benefits contracts issued, delivered, executed or renewed after the
18 approval of the the procedure by the Commissioner of Insurance
19 pursuant to subsection b. of this section.

20 b. A medical service corporation shall, within 120 days of the
21 adoption of regulations by the commissioner pursuant to this act, file
22 its internal dispute resolution procedure with the commissioner. The
23 procedure shall be deemed approved 120 days after filing if not
24 affirmatively approved or disapproved within that 120 days. During
25 the 120-day review period, the commissioner may request such
26 amendments to the procedure as the commissioner deems necessary.
27 Any subsequent amendments to a filed and approved procedure shall
28 be deemed approved 120 days after filing if not affirmatively approved
29 or disapproved within 120 days from the filing date.

30
31 3. a. A health service corporation shall adopt and, after approval
32 by the Commissioner of Insurance pursuant to subsection b. of this
33 section, implement a procedure which shall be used to resolve billing
34 and payment disputes between health care providers or covered
35 individuals and the corporation. If a dispute is between a health care
36 provider and the corporation, the procedure shall provide for direct
37 communication between the provider and the health service
38 corporation and shall not require any action by the covered individual
39 after initial verification that the covered individual received the
40 services or treatment which are the subject of the dispute. When the
41 corporation notifies a provider or individual of a billing or payment
42 dispute, the corporation shall notify the provider or covered individual
43 of the internal appeal process implemented pursuant to this section.

44 The procedure shall include an internal appeal process by which the
45 health service corporation, the provider or the covered individual may
46 request an independent review of the initial resolution of the dispute

1 by an arbitrator or independent review organization agreed upon by
2 the parties to the appeal.

3 The decision of the arbitrator or review organization, as
4 appropriate, shall be binding on the provider and health service
5 corporation. The internal appeal process shall apply only for health
6 benefits contracts issued, delivered, executed or renewed after the
7 approval of the the procedure by the Commissioner of Insurance
8 pursuant to subsection b. of this section.

9 b. A health service corporation shall, within 120 days of the
10 adoption of regulations by the commissioner pursuant to this act, file
11 its internal dispute resolution procedure with the commissioner. The
12 procedure shall be deemed approved 120 days after filing if not
13 affirmatively approved or disapproved within that 120 days. During
14 the 120-day review period, the commissioner may request such
15 amendments to the procedure as the commissioner deems necessary.
16 Any subsequent amendments to a filed and approved procedure shall
17 be deemed approved 120 days after filing if not affirmatively approved
18 or disapproved within 120 days from the filing date.

19

20 4. a. An insurer issuing individual health insurance policies shall
21 adopt and, after approval by the Commissioner of Insurance pursuant
22 to subsection b. of this section, implement a procedure which shall be
23 used to resolve billing and payment disputes between health care
24 providers or covered individuals and the insurer. If a dispute is
25 between a health care provider and the corporation, the procedure
26 shall require direct communication between the provider and the health
27 insurer and shall not require any action by the covered individual after
28 initial verification that the covered individual received the services or
29 treatment which are the subject of the dispute. When the insurer
30 notifies a provider or individual of a billing or payment dispute, the
31 insurer shall notify the provider or covered individual of the internal
32 appeal process implemented pursuant to this section.

33 The procedure shall include an internal appeal process by which the
34 insurer, the provider or the covered individual may request an
35 independent review of the initial resolution of the dispute by an
36 arbitrator or independent review organization agreed upon by the
37 parties to the appeal.

38 The decision of the arbitrator or review organization, as
39 appropriate, shall be binding on the provider and insurer. The internal
40 appeal process shall apply only for health benefits contracts issued,
41 delivered, executed or renewed after the approval of the the procedure
42 by the Commissioner of Insurance pursuant to subsection b. of this
43 section.

44 b. A health insurer shall, within 120 days of the adoption of
45 regulations by the commissioner pursuant to this act, file its internal
46 dispute resolution procedure with the commissioner. The procedure

1 shall be deemed approved 120 days after filing if not affirmatively
2 approved or disapproved within that 120 days. During the 120-day
3 review period, the commissioner may request such amendments to the
4 procedure as the commissioner deems necessary. Any subsequent
5 amendments to a filed and approved procedure shall be deemed
6 approved 120 days after filing if not affirmatively approved or
7 disapproved within 120 days from the filing date.

8
9 5. a. An insurer issuing group health insurance policies shall adopt
10 and, after approval by the Commissioner of Insurance pursuant to
11 subsection b. of this section, implement a procedure which shall be
12 used to resolve billing and payment disputes between health care
13 providers or covered individuals and the insurer. If a dispute is
14 between a health care provider and the corporation, the procedure
15 shall require direct communication between the provider and the health
16 insurer and shall not require any action by the covered individual after
17 initial verification that the covered individual received the services or
18 treatment which are the subject of the dispute. When the insurer
19 notifies a provider or individual of a billing or payment dispute, the
20 insurer shall notify the provider or covered individual of the internal
21 appeal process implemented pursuant to this section.

22 The procedure shall include an internal appeal process by which the
23 insurer, the provider or the covered individual may request an
24 independent review of the initial resolution of the dispute by an
25 arbitrator or independent review organization agreed upon by the
26 parties to the appeal.

27 The decision of the arbitrator or review organization, as
28 appropriate, shall be binding on the provider and insurer. The internal
29 appeal process shall apply only for health benefits contracts issued,
30 delivered, executed or renewed after the approval of the the procedure
31 by the Commissioner of Insurance pursuant to subsection b. of this
32 section.

33 b. A health insurer shall, within 120 days of the adoption of
34 regulations by the commissioner pursuant to this act, file its internal
35 dispute resolution procedure with the commissioner. The procedure
36 shall be deemed approved 120 days after filing if not affirmatively
37 approved or disapproved within that 120 days. During the 120-day
38 review period, the commissioner may request such amendments to the
39 procedure as the commissioner deems necessary. Any subsequent
40 amendments to a filed and approved procedure shall be deemed
41 approved 120 days after filing if not affirmatively approved or
42 disapproved within 120 days from the filing date.

43
44 6. a. A dental service corporation shall adopt and, after approval
45 by the Commissioner of Insurance pursuant to subsection b. of this
46 section, implement a procedure which shall be used to resolve billing

1 and payment disputes between health care providers or covered
2 individuals and the corporation. If a dispute is between a health care
3 provider and the corporation, the procedure shall provide for direct
4 communication between the provider and the dental service
5 corporation and shall not require any action by the covered individual
6 after initial verification that the covered individual received the
7 services or treatment which are the subject of the dispute. When the
8 corporation notifies a provider or individual of a billing or payment
9 dispute, the corporation shall notify the provider or covered individual
10 of the internal appeal process implemented pursuant to this section.

11 The procedure shall include an internal appeal process by which the
12 dental service corporation, the provider or the covered individual may
13 request an independent review of the initial resolution of the dispute
14 by an arbitrator or independent review organization agreed upon by
15 the parties to the appeal.

16 The decision of the arbitrator or review organization, as
17 appropriate, shall be binding on the provider and health maintenance
18 organization. The internal appeal process shall apply only for health
19 benefits contracts issued, delivered, executed or renewed after the
20 approval of the the procedure by the Commissioner of Insurance
21 pursuant to subsection b. of this section.

22 b. A dental service corporation shall, within 120 days of the
23 adoption of regulations by the commissioner pursuant to this act, file
24 its internal dispute resolution procedure with the commissioner. The
25 procedure shall be deemed approved 120 days after filing if not
26 affirmatively approved or disapproved within that 120 days. During
27 the 120-day review period, the commissioner may request such
28 amendments to the procedure as the commissioner deems necessary.
29 Any subsequent amendments to a filed and approved procedure shall
30 be deemed approved 120 days after filing if not affirmatively approved
31 or disapproved within 120 days from the filing date.

32
33 7. a. A dental plan organization shall adopt and, after approval by
34 the Commissioner of Insurance pursuant to subsection b. of this
35 section, implement a procedure which shall be used to resolve billing
36 and payment disputes between health care providers or covered
37 individuals and the organization. If a dispute is between a health care
38 provider and the corporation, the procedure shall provide for direct
39 communication between the provider and the dental plan organization
40 and shall not require any action by the covered individual after initial
41 verification that the covered individual received the services or
42 treatment which are the subject of the dispute. When the organization
43 notifies a provider or individual of a billing or payment dispute, the
44 organization shall notify the provider or covered individual of the
45 internal appeal process implemented pursuant to this section.

46 The procedure shall include an internal appeal process by which the

1 dental plan organization, the provider or the covered individual may
2 request an independent review of the initial resolution of the dispute
3 by an arbitrator or independent review organization agreed upon by
4 the parties to the appeal.

5 The decision of the arbitrator or review organization, as
6 appropriate, shall be binding on the provider and dental plan
7 organization. The internal appeal process shall apply only for health
8 benefits contracts issued, delivered, executed or renewed after the
9 approval of the the procedure by the Commissioner of Insurance
10 pursuant to subsection b. of this section.

11 b. A dental plan organization shall, within 120 days of the adoption
12 of regulations by the commissioner pursuant to this act, file its internal
13 dispute resolution procedure with the commissioner. The procedure
14 shall be deemed approved 120 days after filing if not affirmatively
15 approved or disapproved within that 120 days. During the 120-day
16 review period, the commissioner may request such amendments to the
17 procedure as the commissioner deems necessary. Any subsequent
18 amendments to a filed and approved procedure shall be deemed
19 approved 120 days after filing if not affirmatively approved or
20 disapproved within 120 days from the filing date.

21
22 8. The Commissioner of Insurance shall promulgate rules pursuant
23 to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1
24 et seq.), to effectuate the purposes of this act.

25
26 9. This act shall take effect immediately.

27
28

29 STATEMENT

30

31 This bill provides for the resolution of billing and payment disputes
32 between insurers and health care providers or covered individuals. It
33 requires hospital, medical and health service corporations, commercial
34 health insurers, dental plan organizations and dental service
35 corporations to adopt and implement, after approval by the
36 Commissioner of Insurance, a procedure that will be used to resolve
37 billing and payment disputes between the provider or covered
38 individuals and the payer. The Commissioner of Insurance has
39 120 days to review dispute resolution procedures; require the dispute
40 resolution procedures to include disputes with covered individuals;
41 require the decision of an arbitrator or independent review
42 organization to be binding only for contracts issued, delivered,
43 executed, or renewed after the approval of dispute resolution
44 procedures by the commissioner; and require a health care insurer to
45 notify a provider or covered individual of the appeal process
46 established in compliance with the bill in the event of a dispute. The

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1 bill requires direct communication between the provider and the
2 insurer if the dispute is between these two parties and provides that
3 the covered individual will not be required to take any action to rectify
4 the problem, other than verify that the services or treatment were
5 received.

6 The bill also requires that the procedure include an appeal process
7 whereby the insurer, the provider or the covered individual may
8 request an independent review of the initial resolution of the dispute
9 by an arbitrator or independent review organization, agreed upon by
10 the parties to the appeal. The decision of the arbitrator or review
11 organization, as appropriate, will be binding on the provider and
12 carrier. This appeal process will only apply to health benefits
13 contracts issued, delivered, executed or renewed after the approval of
14 the dispute resolution.

15 This bill is part of a legislative package designed to effectuate the
16 recommendations of the Healthcare Information Networks and
17 Technologies (HINT) report to the Legislature under the joint auspices
18 of Thomas Edison State College and the New Jersey Institute of
19 Technology.

SENATE, No. 329

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Requires health insurers to process medical and claims information electronically.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 AN ACT requiring health insurers and certain health care benefits
2 claims processors to receive and transmit health care claim
3 information electronically and supplementing various parts of
4 statutory law.

5

6 **BE IT ENACTED** by the Senate and General Assembly of the State
7 of New Jersey:

8

9 1. Within 90 days of the promulgation of demonstration standards
10 and a timetable for implementation by the Commissioner of Banking
11 and Insurance pursuant to section 7 of this act, a hospital service
12 corporation, or a subsidiary that processes health care benefits claims
13 as a third party administrator, shall demonstrate to the satisfaction of
14 the commissioner that it will adopt and implement the demonstration
15 standards, according to the corresponding timetable, to receive,
16 transmit and store health care claim information electronically, as a
17 condition of its continued authorization to transact business in this
18 State.

19 The commissioner may, in the commissioner's discretion, grant
20 extensions or waivers of the implementation requirement when it has
21 been demonstrated to the commissioner's satisfaction that compliance
22 with the timetable for implementation will result in an undue hardship
23 to a hospital service corporation, its subsidiary or its covered
24 individuals.

25

26 2. Within 90 days of the promulgation of demonstration standards
27 and a timetable for implementation by the Commissioner of Banking
28 and Insurance pursuant to section 7 of this act, a medical service
29 corporation, or a subsidiary that processes health care benefits claims
30 as a third party administrator, shall demonstrate to the satisfaction of
31 the commissioner that it will adopt and implement the demonstration
32 standards, according to the corresponding timetable, to receive,
33 transmit and store health care claim information electronically, as a
34 condition of its continued authorization to transact business in this
35 State.

36 The commissioner may, in the commissioner's discretion, grant
37 extensions or waivers of the implementation requirement when it has
38 been demonstrated to the commissioner's satisfaction that compliance
39 with the timetable for implementation will result in an undue hardship
40 to a medical service corporation, its subsidiary or its covered
41 individuals.

42

43 3. Within 90 days of the promulgation of demonstration standards
44 and a timetable for implementation by the Commissioner of Banking
45 and Insurance pursuant to section 7 of this act, a health service
46 corporation , or a subsidiary that processes health care benefits claims

1 as a third party administrator, shall demonstrate to the satisfaction of
2 the commissioner that it will adopt and implement the demonstration
3 standards, according to the corresponding timetable, to receive,
4 transmit and store health care claim information electronically, as a
5 condition of its continued authorization to transact business in this
6 State.

7 The commissioner may, in the commissioner's discretion, grant
8 extensions or waivers of the implementation requirement when it has
9 been demonstrated to the commissioner's satisfaction that compliance
10 with the timetable for implementation will result in an undue hardship
11 to a health service corporation, its subsidiary or its covered
12 individuals.

13

14 4. Within 90 days of the promulgation of demonstration standards
15 and a timetable for implementation by the Commissioner of Banking
16 and Insurance pursuant to section 7 of this act, a health insurer issuing
17 individual health insurance policies, or a subsidiary that processes
18 health care benefits claims as a third party administrator, shall
19 demonstrate to the satisfaction of the commissioner that it will adopt
20 and implement the demonstration standards, according to the
21 corresponding timetable, to receive, transmit and store health care
22 claim information electronically, as a condition of its continued
23 authorization to transact business in this State.

24 The commissioner may, in the commissioner's discretion, grant
25 extensions or waivers of the implementation requirement when it has
26 been demonstrated to the commissioner's satisfaction that compliance
27 with the timetable for implementation will result in an undue hardship
28 to a health insurer, its subsidiary or its covered individuals.

29

30 5. Within 90 days of the promulgation of demonstration standards
31 and a timetable for implementation by the Commissioner of Banking
32 and Insurance pursuant to section 7 of this act, a health insurer issuing
33 group health insurance policies, or a subsidiary that processes health
34 care benefits claims as a third party administrator, shall demonstrate
35 to the satisfaction of the commissioner that it will adopt and implement
36 the demonstration standards, according to the corresponding
37 timetable, to receive, transmit and store health care claim information
38 electronically, as a condition of its continued authorization to transact
39 business in this State.

40 The commissioner may, in the commissioner's discretion, grant
41 extensions or waivers of the implementation requirement when it has
42 been demonstrated to the commissioner's satisfaction that compliance
43 with the timetable for implementation will result in an undue hardship
44 to a health insurer, its subsidiary or its covered individuals.

45

46 6. Within 90 days of the promulgation of demonstration standards

1 and a timetable for implementation by the Commissioner of Banking
2 and Insurance pursuant to section 7 of this act, a health maintenance
3 organization, or a subsidiary that processes health care benefits claims
4 as a third party administrator, shall demonstrate to the satisfaction of
5 the commissioner that it will adopt and implement the demonstration
6 standards, according to the corresponding timetable, to receive,
7 transmit and store health care claim information electronically as a
8 condition of its continued authorization to operate in this State.

9 The commissioner may, in the commissioner's discretion, grant
10 extensions or waivers of the implementation requirement when it has
11 been demonstrated to the commissioner's satisfaction that compliance
12 with the timetable for implementation will result in an undue hardship
13 to a health maintenance organization, its subsidiary or its enrollees.

14

15 7. a. The Commissioner of Banking and Insurance, in consultation
16 with the Healthcare Information Electronic Data Interchange Policy
17 Advisory Council established pursuant to P.L., c. (C.) (now before the
18 Legislature as Senate, No. 50 of 1996), shall establish demonstration
19 standards, along with a timetable for implementation, for the electronic
20 receipt, transmission and storage of health care claim information by
21 hospital service, medical service and health service corporations,
22 health insurers, health maintenance organizations, dental service
23 corporations and dental plan organizations, respectively , or
24 subsidiaries of such corporations, insurers or organizations that
25 process health care benefits claims as third party administrators. The
26 commissioner may, in the commissioner's discretion, grant extensions
27 or waivers of the implementation requirement when it has been
28 demonstrated to the commissioner's satisfaction that compliance with
29 the timetable for implementation will result in an undue hardship to a
30 hospital service, medical service, or health service corporation, health
31 insurer, dental service corporation, dental plan organization, or health
32 maintenance organization, its subsidiary or its covered individuals or
33 enrollees.

34 b. In establishing these standards, the commissioner shall:

35 (1) Encourage the use of an electronic data interchange (EDI)
36 network developed in consultation with the council pursuant to P.L. ,
37 c. (C.) (now before the Legislature as Senate, No. 50 of 1996);

38 (2) Encourage hospital service, medical service and health service
39 corporations, health insurers, health maintenance organizations, dental
40 service corporations and dental plan organizations, or subsidiaries of
41 such corporations, insurers or organizations that process health care
42 benefits claims as third party administrators to issue patient
43 identification cards or systems , such as magnetic stripe, "smart cards,"
44 or other patient identification technology, to covered individuals; and

45 (3) Encourage and facilitate the development of privately owned
46 and operated secure networks which are interconnected and available

1 to all participants in the health care services delivery process.

2 c. The timetable for implementation promulgated by the
3 commissioner shall provide for extensions and waivers of the
4 implementation requirement pursuant to subsection a. of this section.

5 d. The commissioner shall report annually to the policy council, the
6 Legislature and the Governor on progress made in the implementation
7 of these demonstration standards in this State.

8

9 8. Within 90 days of the promulgation of demonstration standards
10 and a timetable for implementation by the Commissioner of Banking
11 and Insurance pursuant to section 7 of this act, a dental plan
12 organization, or a subsidiary that processes health care benefits claims
13 as a third party administrator, shall demonstrate to the satisfaction of
14 the commissioner that it will adopt and implement the demonstration
15 standards, according to the corresponding timetable, to receive,
16 transmit and store health care claim information electronically as a
17 condition of its continued authorization to operate in this State.

18 The commissioner may, in the commissioner's discretion, grant
19 extensions or waivers of the implementation requirement when it has
20 been demonstrated to the commissioner's satisfaction that compliance
21 with the timetable for implementation will result in an undue hardship
22 to a dental plan organization, its subsidiary or its enrollees.

23

24 9. Within 90 days of the promulgation of demonstration standards
25 and a timetable for implementation by the Commissioner of Banking
26 and Insurance pursuant to section 7 of this act, a dental service
27 corporation, or a subsidiary that processes health care benefits claims
28 as a third party administrator, shall demonstrate to the satisfaction of
29 the commissioner that it will adopt and implement the demonstration
30 standards, according to the corresponding timetable, to receive,
31 transmit and store health care claim information electronically as a
32 condition of its continued authorization to operate in this State.

33 The commissioner may, in the commissioner's discretion, grant
34 extensions or waivers of the implementation requirement when it has
35 been demonstrated to the commissioner's satisfaction that compliance
36 with the timetable for implementation will result in an undue hardship
37 to a dental service corporation, its subsidiary or its subscribers.

38

39 10. The commissioner shall promulgate regulations pursuant to the
40 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.)
41 to effectuate the provisions of this act.

42

43 11. This act shall take effect immediately.

1 STATEMENT

2

3 This bill requires hospital, medical or health service corporations,
4 commercial health insurers, health maintenance organizations
5 (HMO's), dental plan organizations and dental service corporations,
6 or their subsidiaries that process health benefits claims as third party
7 administrators, to demonstrate that they will adopt and implement
8 standards established by the Commissioner of Banking and Insurance
9 to receive, transmit and store health care claim information
10 electronically.

11 The Commissioner of Banking and Insurance, in consultation with
12 the Healthcare Information Electronic Data Interchange Policy
13 Advisory Council (which would be established by Senate Bill No. 50
14 (2R) Aca or Assembly Bill No. 1473 Aca of 1996, which were
15 reported by the committee on this date), will establish these
16 demonstration standards, along with a timetable for adoption and
17 implementation. The bill authorizes the commissioner to grant
18 extensions or waivers of the implementation requirement if it is
19 demonstrated that compliance with the timetable for implementation
20 will result in an undue hardship to a carrier, subsidiary or its covered
21 individuals or enrollees.

22 The bill directs the commissioner, in establishing the standards, to:

23 (1) Encourage the use of the electronic data interchange (EDI)
24 network;

25 (2) Encourage carriers to issue patient identification cards or
26 systems to covered individuals; and

27 (3) Encourage and facilitate the development of privately owned
28 and operated secure networks which are interconnected and available
29 to all participants in the health care services delivery process.

30 This bill is part of a legislative package designed to effectuate the
31 recommendations of the Healthcare Information Networks and
32 Technologies (HINT) report to the Legislature under the joint auspices
33 of Thomas Edison State College and the New Jersey Institute of
34 Technology.

SENATE, No. 330

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Requires health insurers to use standardized enrollment and claim forms.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



S330 LITTELL

1 AN ACT requiring health insurers and certain subsidiaries of insurers
2 to use standard enrollment and claim forms and supplementing
3 various parts of the statutory law.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. Within 12 months of the promulgation of regulations by the
9 Commissioner of Banking and Insurance pursuant to this act, a
10 hospital service corporation or a subsidiary that processes health care
11 benefits claims as a third party administrator shall use the standard
12 health care enrollment and claim forms promulgated pursuant to
13 section 7 of this act in connection with all group and individual
14 contracts issued, delivered, executed or renewed in this State.

15
16 2. Within 12 months of the promulgation of regulations by the
17 Commissioner of Banking and Insurance pursuant to² this act, a
18 medical service corporation or a subsidiary that processes health care
19 benefits claims as a third party administrator shall use the standard
20 health care enrollment and claim forms promulgated pursuant to
21 section 7 of this act in connection with all group and individual
22 contracts issued, delivered, executed or renewed in this State.

23
24 3. Within 12 months of the promulgation of regulations by the
25 Commissioner of Banking and Insurance pursuant to this act, a health
26 service corporation or a subsidiary that processes health care benefits
27 claims as a third party administrator shall use the standard health care
28 enrollment and claim forms promulgated pursuant to section 7 of this
29 act in connection with all group and individual contracts issued,
30 delivered, executed or renewed in this State.

31
32 4. Within 12 months of the promulgation of regulations by the
33 Commissioner of Banking and Insurance pursuant to this act, a health
34 insurer or a subsidiary that processes health care benefits claims as a
35 third party administrator shall use the standard health care enrollment
36 and claim forms promulgated pursuant to section 7 of this act in
37 connection with all individual policies issued, delivered, executed or
38 renewed in this State.

39
40 5. Within 12 months of the promulgation of regulations by the
41 Commissioner of Banking and Insurance pursuant to this act, a health
42 insurer or a subsidiary that processes health care benefits claims as a
43 third party administrator shall use the standard health care enrollment
44 and claim forms promulgated pursuant to section 7 of this act in
45 connection with all group policies issued, delivered, executed or
46 renewed in this State.

1 6. Within 12 months of the promulgation of regulations by the
2 Commissioner of Banking and Insurance pursuant to this act, a health
3 maintenance organization or a subsidiary that processes health care
4 benefits claims as a third party administrator shall use the standard
5 health care enrollment and claim forms promulgated pursuant to
6 section 7 of this act in connection with all contracts for health care
7 services issued, delivered, executed or renewed in this State.

8
9 7. a. The Commissioner of Banking and Insurance shall
10 promulgate regulations to establish one set of standard health care
11 enrollment and claim forms in paper or electronic format to be used by
12 all hospital service, medical service and health service corporations, all
13 health insurers all health maintenance organizations , all dental service
14 corporations, all dental plan organizations , or subsidiaries that process
15 health care benefits claims as third party administrators, and all
16 insurers writing automobile insurance and workers' compensation
17 coverage, or a subsidiary of an insurer writing worker's compensation
18 coverage that processes health care benefits claims as a third party
19 administrator, authorized to do business in this State.

20 b. In developing and promulgating the forms, the commissioner
21 shall:

22 (1) Consult with the Healthcare Information Electronic Data
23 Interchange Policy Advisory Council established pursuant to P . L . ,
24 c . (C .) (now pending before the Legislature as
25 Senate, No. 50 of 1996);

26 (2) Consult with the boards of the New Jersey Individual Health
27 Coverage Program and the New Jersey Small Employer Health
28 Benefits Program and with respect to claim forms, take into
29 consideration the claim forms adopted by those programs pursuant to
30 section 11 of P.L.1993, c.164 (C.17B:27A-16.4) and section 29 of
31 P.L.1992, c.162 (C.17B:27A-45), respectively; and

32 (3) Use national standards for electronic data interchange (EDI) as
33 recommended by the advisory council and the boards of the two
34 programs.

35
36 8. Within 12 months of the promulgation of regulations by the
37 Commissioner of Banking and Insurance pursuant to this act, a dental
38 plan organization or a subsidiary that processes health care benefits
39 claims as a third party administrator shall use the standard health care
40 enrollment and claim forms promulgated pursuant to section 7 of this
41 act in connection with all contracts for health care services issued,
42 delivered, executed or renewed in this State.

43
44 9. Within 12 months of the promulgation of regulations by the
45 Commissioner of Banking and Insurance pursuant to this act, a dental
46 service corporation or a subsidiary that processes health care benefits

1 claims as a third party administrator shall use the standard health care
2 enrollment and claim forms promulgated pursuant to section 7 of this
3 act in connection with all contracts for dental services issued,
4 delivered, executed or renewed in this State.

5
6 10. Within 12 months of the promulgation of regulations by the
7 Commissioner of Banking and Insurance pursuant to this act, an
8 insurer authorized to write automobile insurance pursuant to
9 P.L.1972, c.70 (C.39:6A-1 et seq.) shall use the standard health care
10 claim forms promulgated pursuant to section 7 of this act in
11 connection with all its claims for health care services in this State.

12
13 11. Within 12 months of the promulgation of regulations by the
14 Commissioner of Banking and Insurance pursuant to this act, an
15 insurer authorized to transact the business of workers' compensation
16 insurance pursuant to Chapter 15 of Title 34 of the Revised Statutes,
17 or a subsidiary that processes health care benefits claims as a third
18 party administrator shall use the standard claim forms promulgated
19 pursuant to section 7 of this act in connection with all claims for health
20 care services in this State.

21
22 12. The commissioner shall promulgate regulations to effectuate
23 the purposes of this act pursuant to the "Administrative Procedure
24 Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

25
26 13. This act shall take effect immediately.

27
28
29 STATEMENT

30
31 This bill requires hospital, medical or health service corporations,
32 commercial health insurers, dental plan organizations, dental service
33 corporations, insurers who write automobile or workers' compensation
34 insurance and health maintenance organizations (HMO's), and their
35 subsidiaries that process health care benefits claims as third party
36 administrators, to use standard enrollment and claim forms for paper
37 and electronic transactions in connection with all policies and
38 contracts for health care benefits within 12 months after the
39 promulgation of regulations for such forms by the commissioner.

40 In promulgating the regulations, the commissioner is required to
41 consult with the Healthcare Information Electronic Data Interchange
42 Policy Council (to be established by Senate, No. 50 or Assembly, No.
43 1473 of 1996, now pending before the Legislature) which includes
44 representatives from among the various types of health care benefit
45 providers who would be required to use the forms. The commissioner
46 is also required to consult with the boards of the New Jersey

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5

1 Individual Health Coverage Program and the New Jersey Small
2 Employer Health Benefits Program and take into consideration the
3 claim forms adopted by those programs. The commissioner will use
4 national standards for electronic data interchange (EDI) as
5 recommended by the policy council and the program boards.

6 This bill is part of a legislative package designed to effectuate the
7 recommendations of the Healthcare Information Networks and
8 Technologies (HINT) report to the Legislature under the joint auspices
9 of Thomas Edison State College and the New Jersey Institute of
10 Technology.

SENATE, No. 331

STATE OF NEW JERSEY
208th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 1998 SESSION

Sponsored by:

Senator ROBERT E. LITTELL

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Establishes Health Information Electronic Data Interchange Policy Advisory Council.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



S331 LITTELL

1 AN ACT creating the Health Information Electronic Data Interchange
2 Policy Advisory Council in the Department of Health and Senior
3 Services, and supplementing Title 26 of the Revised Statutes.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. The Legislature finds and declares that:

9 a. The delivery of health care services and payment for those
10 services is often a fragmented process, sometimes inaccurately
11 described as a "system," that is comprised of health care providers,
12 insurance carriers or other benefit payers, employers who provide the
13 insurance or other benefit plans under which their employees are
14 covered, and patients, who are, ultimately, the consumers.

15 b. These various sectors perform separate, but interdependent
16 functions in the health care service delivery process, and while they
17 may perceive themselves and operate as economically independent
18 units, they are nevertheless functionally dependent in providing or
19 consuming health care services for which they then expect prompt
20 payment.

21 c. While the technology exists to advance communication in every
22 sector of this process, each sector operates as a computerized
23 information island, fully functional in itself but without the ability or
24 motivation for computer-to-computer communication with other such
25 islands.

26 d. As a result, despite the available technology, a plethora of bills
27 can emanate from even relatively simple diagnostic or treatment
28 services and the resulting massive flow of information, on paper,
29 creates much of the increasing administrative burden placed on the
30 system.

31 e. It has been estimated that the health care industry in New Jersey
32 currently processes 150 million health care claims annually, 85% of
33 which are on paper, and that significant administrative cost savings
34 could be realized with the use of standardized enrollment and claim
35 forms, standardized health care communication protocols and the use
36 of electronic data interchange, or EDI, to receive, transmit and store
37 medical and claims information.

38 f. Thus, while state-of-the-art technology is the expected norm in
39 the diagnosis and treatment of illness and injury, in terms of recording,
40 routing and paying for those services, the several parties to the process
41 are using the venerable "paper trail" for billing purposes, which allows
42 them to avoid communicating in a more efficient manner.

43 g. Given the multiple parties and divergent interests which are
44 involved in and affected by the health care services delivery process,
45 a council representing those various interests and concerns, to assist
46 in the development of standards for an effective electronic data

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1 interchange network for use by the various parties; and to assist and
2 enable them to achieve some commonality of purpose in the exchange
3 of such information, is necessary and appropriate if the citizens of New
4 Jersey are to benefit from the efficiencies and economies such an
5 interchange can effect.

6

7 2. The Health Information Electronic Data Interchange Policy
8 Advisory Council, hereinafter referred to as the council, is created in
9 the Executive Branch of State Government. For the purposes of
10 complying with the provisions of Article V, Section IV, paragraph 1
11 of the New Jersey Constitution, the council is allocated within the
12 Department of Health and Senior Services, but notwithstanding this
13 allocation, the council shall be independent of any supervision or
14 control by the department or by any board or officer thereof, and shall
15 request appropriations for its expenses independently therefrom.

16

17 3. The council shall consist of 31 members, as follows:

18 a. The Commissioner of Health and Senior Services or the
19 commissioner's designee, ex officio, who shall serve as chairman of the
20 council;

21 b. The Commissioner of Banking and Insurance or the
22 commissioner's designee, ex officio;

23 c. The Commissioner of Human Services or the commissioner's
24 designee, ex officio;

25 d. The State Treasurer or the State Treasurer's designee, ex officio;

26 e. The Attorney General or the Attorney General's designee, ex
27 officio;

28 f. The Director of the Division of Pensions and Benefits, in the
29 director's capacity as the secretary to the State Health Benefits
30 Commission or the secretary's designee, ex officio;

31 g. The President of the New Jersey Hospital Association, or the
32 President's designee, ex officio;

33 h. The President of the University of Medicine and Dentistry of
34 New Jersey, or the President's designee, ex officio;

35 i. The President of Thomas Edison State College or the President's
36 designee, ex officio;

37 j. Six members to be appointed by the President of the Senate, no
38 more than three of whom shall be of the same political party, as
39 follows:

40 (1) One representative of the medical profession, upon the
41 recommendation of the Medical Society of New Jersey;

42 (2) One representative of business, upon the recommendation of
43 the New Jersey Business and Industry Association;

44 (3) One representative of a health maintenance organization, upon
45 the recommendation of the New Jersey Health Maintenance
46 Organization Association; (4) One representative of a health insurer

- 1 domiciled in this State; (5) One representative of the home health care
2 industry, upon the recommendation of the Home Health Assembly of
3 New Jersey; and
- 4 (6) One representative of physical therapists in the State, upon
5 recommendation of the American Physical Therapy Association of
6 New Jersey;
- 7 k. Six members to be appointed by the Speaker of the General
8 Assembly, no more than three of whom shall be of the same political
9 party, as follows:
- 10 (1) One representative of the pharmacy profession, upon the
11 recommendation of the Pharmacist Institute of New Jersey;
- 12 (2) One representative of organized labor, upon the
13 recommendation of the New Jersey State AFL-CIO;
- 14 (3) One representative of hospitals, upon the recommendation of
15 the New Jersey Hospital Association; (4) One representative of a
16 health service corporation, or if none exists, a hospital or medical
17 service corporation, domiciled in this State; (5) One representative of
18 the dental profession, upon the recommendation of the New Jersey
19 Dental Association; and
- 20 (6) One representative of the occupational therapists in this State,
21 upon the recommendation of the New Jersey Occupational Therapy
22 Association;
- 23 l. 10 members to be appointed by the Governor, no more than five
24 of whom shall be of the same political party, as follows:
- 25 (1) One representative of the chiropractic profession, upon the
26 recommendation of the New Jersey Chiropractic Society;
- 27 (2) One representative of small business, upon the recommendation
28 of the New Jersey State Chamber of Commerce;
- 29 (3) One representative of long-term health care facilities, upon the
30 recommendation of the New Jersey Association of Health Care
31 Facilities;
- 32 (4) One representative of a health insurer authorized to transact
33 business in this State, but not domiciled in this State, upon the
34 recommendation of the Health Insurance Association of America;
- 35 (5) One representative of the nursing profession, upon the
36 recommendation of the New Jersey State Nurses Association;
- 37 (6) One representative of the osteopathic profession, upon the
38 recommendation of the New Jersey Association of Osteopathic
39 Physicians and Surgeons;
- 40 (7) One representative of the mental health professions, upon the
41 recommendation of the Statewide Mental Health Coalition; and
- 42 (8) Three members of the public, none of whom shall represent the
43 sectors of business, labor, health care providers or the professions or
44 insurers listed above, but who shall be consumers of health care
45 services.

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1 4. a. The council shall organize upon the appointment of a
2 majority of its authorized membership.

3 b. Appointed members of the council shall serve for three year
4 terms, except that, of the members first appointed, two each of the
5 members appointed by the President of the Senate and the Speaker of
6 the General Assembly and two of the members appointed by the
7 Governor shall be appointed for terms of one year, and two each of the
8 members appointed by the President of the Senate and the Speaker of
9 the General Assembly and two of the members appointed by the
10 Governor shall be appointed for terms of two years.

11 c. Each member shall hold office for the term of appointment and
12 until a successor is appointed and qualified. All vacancies shall be
13 filled in the same manner as the original appointment. Members
14 appointed to fill a vacancy occurring for any reason other than the
15 expiration of the term shall serve for the unexpired term only. An
16 appointed member of the council shall be eligible for reappointment.
17 An appointed member may be removed for cause.

18 d. Appointed members shall serve without compensation, but shall
19 be reimbursed for necessary expenses incurred in the performance of
20 their duties.

21 e. Action may be taken and motions and resolutions may be
22 adopted by the council by an affirmative vote of not less than a
23 majority of the quorum required to conduct business.

24

25 5. The council shall appoint an executive director, who shall serve
26 as secretary to the council. The executive director shall serve at the
27 pleasure of the council and shall be in the unclassified service of the
28 Civil Service. Upon the appointment of a majority of the members of
29 the council, the Commissioner of Health and Senior Services shall
30 appoint an acting executive director from among his staff, who shall
31 serve until the appointment of an executive director by the council and
32 who shall not be eligible for appointment by the council.

33 The Commissioner of Health and Senior Services shall provide staff
34 support to assist the council in carrying out its responsibilities. The
35 council is entitled to the assistance and services of the employees of
36 any State, county or municipal department, board, bureau, commission
37 or agency, as it may require and as may be available to it for its
38 purposes.

39 The council is authorized to contract with outside providers for
40 services in support of council responsibilities and documented as
41 otherwise unavailable to the council.

42

43 6. a. The council shall develop standards for an effective electronic
44 data interchange (EDI) network for use by the various sectors in the
45 health care services delivery process. In particular, the council's
46 responsibilities shall include, but not be limited to:

- 1 (1) Developing standards for interorganizational communication
2 among the participants in the health care services delivery process.
- 3 (2) Developing standards for the transmission of forms and
4 information among the various sectors of the health care services
5 delivery process.
- 6 (3) Encouraging health insurers and other benefit providers to issue
7 patient identification cards or equipment, such as magnetic stripe,
8 "smart cards" or other patient identification technology, that provide
9 rapid, efficient electronic access to health care services, to covered
10 individuals.
- 11 (4) Encouraging and facilitating the development of secure
12 networks which would be interconnected and available to all
13 participants of the health care services delivery process.
- 14 b. In developing the standards for the EDI network pursuant to
15 subsection a. of this section, the council shall consider the following
16 guidelines:
 - 17 (1) National standards, such as those developed by the American
18 National Standards Institute (ANSI) and the Health Care Financing
19 Administration (HCFA) shall be evaluated and adopted wherever
20 possible.
 - 21 (2) To the greatest extent possible, all participants shall be
22 provided with equal functionality in their access to the network.
23 Interconnection speeds and types of connections may vary, but the
24 services offered shall be available to all participants.
 - 25 (3) The State's EDI network shall encourage direct connections to
26 the Internet or similar networks for communication and research
27 purposes.
 - 28 (4) The network's design shall be flexible and allow for new
29 services to be offered without impacting existing services.
 - 30 (5) Wherever possible, the State's EDI network shall utilize
31 existing networks that are available for other applications and shall
32 take into consideration existing proprietary networks which can
33 connect to and transmit specified health care enrollment, claim and
34 medical information to the open networks in the State.
 - 35 (6) Whenever possible, all participants in the network shall
36 establish a single connection to the network and this single connection
37 should support all functions of the network.
 - 38 (7) All providers of network services shall agree to work in an
39 ethical manner so as not to achieve a competitive advantage when
40 collecting or accumulating content information from the transmissions
41 carried on their network.
- 42 c. To the maximum extent possible and practicable, the council
43 shall coordinate its responsibilities and activities with other health
44 information initiatives undertaken by the Department of Health and
45 Senior Services and other State agencies.

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1 7. The council shall support the State's responsibilities to monitor
2 the quantity and quality of health care services in the following
3 manner:

4 a. The council shall examine carefully the Community Health
5 Management Information System (CHMIS) model and similar
6 information network models of a health care monitoring data base and
7 consider recommending appropriate design features.

8 b. The council shall recommend that the State's EDI network
9 provides appropriate structure for capture of data for monitoring
10 health care quantity and quality by the State.

11 c. The council shall recommend that a data base system is
12 developed to capture data and store it in appropriate form for routine
13 monitoring reports and policy research.

14 d. The council, in coordination with other State agencies, shall
15 develop recommendations with respect to the establishment of, and
16 compliance with, health care information confidentiality and security
17 requirements by health care providers and payers including the
18 maintenance of the confidentiality of proprietary information of health
19 care providers and payers.

20 e. The council shall recommend a procedure for routinely
21 producing and distributing monitoring reports on the performance of
22 payers and providers.

23

24 8. In addition to its responsibilities pursuant to sections 6 and 7 of
25 this act, the council shall:

26 a. Advise the Commissioner of Banking and Insurance, in the
27 development of recommended standards, using national standards
28 wherever possible, for the electronic receipt, transmission and storage
29 of health care claim information by hospital service, medical service
30 and health service corporations, health insurers and health maintenance
31 organizations pursuant to section 7 of P.L., c. (C.)(now pending
32 before the Legislature as Senate, No.48 of 1996).

33 b. Advise the Commissioner of Banking and Insurance in the
34 development of standard health care enrollment and claim forms
35 pursuant to section 7 of P.L. , c. (C.)(now pending before the
36 Legislature as Senate, No.49 of 1996).

37 c. Consult with the Commissioner of Health and Senior Services
38 in his preparation of the annual report on health care expenditures in
39 New Jersey required by P.L. , c.(C.)(now before the Legislature as
40 Senate, No.43of 1996.).

41

42 9. a. The council shall submit an annual report to the Governor
43 and the Legislature which assesses current efforts, and makes such
44 recommendations, including legislative or administrative action for
45 proposed efforts, to reduce health care administrative costs through
46 electronic data interchange and other automated information

1 technology, and which specifies the costs of implementation and
2 discusses any anticipated difficulties with respect to the use of the
3 technology.

4 b. In addition, every fifth annual report shall also include an
5 analysis of the council's accomplishment of its stated objectives, a
6 forecast of emerging technologies and the EDI needs of the health care
7 services industry for the ensuing five years, and how the council
8 anticipates responding to those needs and incorporating those
9 technologies in its operations over the next five years, including any
10 recommendations for change in its membership or charge, or other
11 legislative or administrative action.

12 c. If funds are available, the reports required by this section shall
13 be prepared with the cooperation and assistance of the New Jersey
14 Institute of Technology and Thomas Edison State College and the
15 council shall use the funds appropriated to it or otherwise made
16 available to it to fund the costs of Thomas Edison State College and
17 the New Jersey Institute of Technology for their services provided to
18 the council in this regard.

19

20 10. The council shall make recommendations to the Commissioner
21 of Health and Senior Services through resolutions adopted by a
22 recorded majority vote of the council regarding the development of
23 standards for the State's EDI network. If the commissioner disagrees
24 with the recommendations of the council, the commissioner shall
25 present the reasons therefor to the council.

26

27 11. This act shall take effect immediately.

28

29

30

STATEMENT

31

32 This bill establishes the Health Information Electronic Data
33 Interchange Policy Advisory Council in the Department of Health and
34 Senior Services.

35 The council will be comprised of 31 members, representing the
36 various participants in the health care services delivery process,
37 including health care providers, insurers, employers and consumers of
38 health care services. The council will be primarily responsible for
39 developing standards for an effective electronic data interchange
40 (EDI) network for use in the health care services delivery process.

41 Specifically, the council's responsibilities will include:

42 (1) Developing standards for interorganizational communication
43 among the participants in the health care services delivery process.

44 (2) Developing standards for the transmission of forms and
45 information among the various sectors of the health care services
46 delivery process.

1 (3) Encouraging health insurers and other benefit providers to issue
2 patient identification cards or equipment that provide rapid, efficient
3 electronic access to health care services, to covered individuals.

4 (4) Encouraging and facilitating the development of secure
5 networks that would be interconnected and available to all participants
6 of the health care services delivery process.

7 In developing the standards for the EDI network, the council is to
8 consider the following guidelines:

9 (1) National standards, such as those developed by the American
10 National Standards Institute (ANSI) and the Health Care Financing
11 Administration (HCFA) will be evaluated and adopted wherever
12 possible.

13 (2) To the greatest extent possible, all participants will be provided
14 with equal functionality in their access to the network.
15 Interconnection speeds and types of connections may vary, but the
16 services offered will be available to all participants.

17 (3) The State's EDI network will encourage direct connections to
18 the Internet or similar networks for communication and research
19 purposes.

20 (4) The network's design will be flexible and allow for new services
21 to be offered without impacting existing services.

22 (5) Wherever possible, the network will utilize existing networks
23 that are available for other applications and will take into
24 consideration existing proprietary networks which can connect to and
25 transmit specified health care enrollment, claim and medical
26 information to the open networks in the State.

27 (6) Whenever possible, all participants in the network will establish
28 a single connection to the network and this single connection should
29 support all functions of the network.

30 (7) All providers of network services will agree to work in an
31 ethical manner so as not to achieve a competitive advantage when
32 collecting or accumulating content information from the transmissions
33 carried on their network.

34 To the maximum extent possible and practicable the council shall
35 coordinate its responsibilities and functions with other health
36 information initiatives undertaken by the Department of Health and
37 Senior Services and other State agencies.

38 In addition, the council will advise the Commissioner of Banking
39 and Insurance in the development of recommended standards for the
40 electronic processing of health care coverage claim information by
41 health insurers pursuant to Senate Bill No. 48 or Assembly Bill No.
42 1481 of 1996; and will advise the commissioner in the development of
43 standard health care enrollment and claim forms pursuant to Senate
44 Bill No.49 or Assembly Bill No.1473 of 1996, as well as with the
45 Commissioner of Health and Senior Services in his preparation of the

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10

1 annual report on health care expenditures required by Senate Bill No.
2 43 or Assembly Bill No.1479 of 1996.

3 This bill is part of a legislative package designed to effectuate the
4 recommendations of the Healthcare Information Networks and
5 Technologies (HINT) report to the Legislature under the joint auspices
6 of Thomas Edison State College and the New Jersey Institute of
7 Technology.

**SENATE COMMITTEE SUBSTITUTE
FOR SENATE, NOS. 323, 324, 325, 326, 327, 328, 329, 330 and 331
(THIRD REPRINT)**

To the Senate:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Senate Committee Substitute for Senate, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331 (Third Reprint) with my recommendations for reconsideration.

SUMMARY OF BILL

This bill provides for the prompt payment of claims by health insurance carriers; health maintenance organizations; health, hospital, medical and dental service organizations and any intermediary contracted or affiliated with the carrier to perform administrative claims functions. The bill reduces the amount of time in which an uncontested claim must be paid by a carrier from the current 60 days to 30 days or the time limit established by the Medicare program, whichever is earlier, for electronic claims. It reduces the amount of time for payment of an uncontested manual claim to 40 days following receipt of the claim. The bill also requires that a carrier shall deny a contested claim, stating all reasons for denial, within 30 days, instead of 90 days as is currently required. The bill directs a carrier to acknowledge receipt of a claim submitted by electronic means, no later than two working days following receipt of the claim.

The bill directs the Commissioner of the Department of Banking and Insurance (DBI) to adopt by regulation, for each type of contract the Commissioner deems appropriate, one set of standard health care enrollment and claim forms to be used by hospitals, HMOs, insurers and others who process such forms.

The bill also requires health care providers to promptly submit their claims to insurance carriers and HMO's. In the case of a claim filed on behalf of the provider's patient, submission must be made within 60 days of service. If the provider fails to comply, fines may be imposed. In the case of a claim where the patient has assigned his benefits to the provider, the claim must be submitted within six (6) months of service or the claim may be justifiably denied.

The bill requires the Commissioner of Health and Senior Services (DHSS), in

consultation with DBI's Commissioner, to establish an advisory board to make recommendations to the commissioners regarding health information electronic data interchange technology policy and measures to protect the confidentiality of medical information. The commissioners shall present an annual report to the Governor and the Legislature on the development and use of such technology in the State.

The bill provides that Thomas A. Edison State College shall study and monitor the effectiveness of such technology in reducing costs of health care and that DBI and DHSS shall cooperate with and provide assistance to the college in carrying out its study.

The bill also affords health care providers, facilities and benefits plans processors a temporary, two-year tax credit of 10% against the gross income tax, corporation business tax, and the franchise tax on insurance companies for the purchase, lease or rental of electronic data interchange technology used to receive and/or transmit health care claims. The gross income tax credit would be available to licensed health care providers such as doctors and dentists, entities that process enrollments or claims under health care benefit plans, employers that self-insure for employee health benefits, and vendors of computer software that supplies health care electronic data interchange technology. The corporation business tax credit would be generally available to those taxpayers and also to licensed health care facilities.

B. RECOMMENDED ACTION

I support the Legislature's efforts and primarily those of Senator Robert Littell to promote the use in New Jersey of health care information electronic data interchange technology. The quick and efficient transmission of data will go far in improving the management of the health care system in our State.

While promotion of the use of such technology is important, I believe the bill in its current form provides an unnecessary tax credit to health care providers, health care facilities, vendors of certain computer software and entities that process enrollments and claims under health care benefit plans. Under current federal and State tax laws, these groups are already entitled to a business deduction with respect to expenses incurred in the purchase, lease or rental of such technology. Therefore, a tax credit would provide a

double tax benefit for the same expense. The Department of Treasury advises that the additional tax credit would result in an estimated loss of revenue of \$20 million annually for each of the two years the tax credits are in existence. Furthermore, the bill provides that the time period within which electronically transmitted claims must be paid is shorter than that provided for manually transmitted claims. Thus, I believe that adequate incentive for the use of health care information electronic data interchange technology already exists without the grant of a tax credit.

Therefore, I herewith return Senate Committee Substitute for Senate, Nos. 323, 324, 325, 326, 327, 328, 329, 330 and 331 (Third Reprint) with the following recommendations:

<u>Page 36, Section 11, Line 35-</u> <u>Page 39, Section 13, Line 44:</u>	Delete sections 11-13 in their entirety
<u>Page 40, Section 14, Line 1:</u>	Delete "14" and insert "11"
<u>Page 40, Section 15, Line 13:</u>	Delete "15" and insert "12"
<u>Page 40, Section 16, Line 26:</u>	Delete "16" and insert "13"
<u>Page 41, Section 17, Line 37:</u>	Delete "17" and insert "14"
<u>Page 43, Section 18, Line 5:</u>	Delete "18" and insert "15"
<u>Page 43, Section 19, Line 17:</u>	Delete "19" and insert "16"
<u>Page 43, Section 20, Line 29:</u>	Delete "20" and insert "17"
<u>Page 43, Section 21, Line 36:</u>	Delete "21" and insert "18"

Respectfully,

Christine Todd Whitman
Governor

Attest:

John J. Farmer, Jr.
Chief Counsel to the Governor

PO BOX 004
TRENTON, NJ 08625

Office of the Governor
NEWS RELEASE

CONTACT: Gene Herman

609-777-2600

RELEASE: March 15, 1999

Gov. Christie Whitman has conditionally vetoed the following pieces of legislation:

A-2367, sponsored by Assembly Members Richard H. Bagger (R-Middlesex/Morris/Somerset/Union) and David W. Wolfe (R-Monmouth/Ocean) and Senators Joseph M. Kyrillos (R-Middlesex/Monmouth) and Peter A. Inverso (R-Mercer/Middlesex), which would have excluded from the New Jersey Gross Income Tax earnings on investments in all educational individual retirement accounts (EIRAs) and qualified state tuition savings accounts. The only plan that enjoys that exclusion today is the New Jersey Better Educational Savings Trust (NJ BEST), the state's qualified state tuition savings account, which the Governor proposed and which the legislature supported.

In her conditional veto, the Governor said she agreed with the Legislature that extending state tax benefits currently enjoyed by the NJBEST to all qualified state tuition savings accounts is perfectly acceptable. But she said EIRAs, authorized by Congress and administered by private institutions, are quite different. They offer generous federal tax benefits not offered through NJ BEST or similar qualified state tuition savings accounts offered in other states. In particular, EIRAs offer an exclusion from the federal income tax while NJ BEST and similar state tuition savings accounts in other states offer only a deferral from the federal income tax until the time that monies are withdrawn, the Governor said. She said the major federal tax benefit available to EIRAs already offsets the various advantages of NJ BEST and other state plans. Gov. Whitman said she is mindful of the need to continue making saving for higher education more attractive. She said she believed a deferral of taxation, rather than a total exclusion from the New Jersey Gross Income Tax, will accomplish the purpose of making savings for higher education more attractive. Finally, the Governor recommended allowing earnings obtained as of 1998 to receive the new and improved benefits as opposed to only earnings as of 1999 in the proposed legislation.

SCS for S-323, 324, 325, 326, 327, 328, 329, 330 and 331, sponsored by Senator Robert E. Littell (R-Sussex/Hunterdon/Morris) and Assembly Members Nicholas R. Felice (R-Bergen/Passaic) and Joseph V. Doria, Jr. (D-Hudson), which provides for the prompt payment of claims by health carriers, health maintenance organizations, health, hospital, medical and dental service organizations and any intermediary contracted or affiliated with the carrier to perform administrative claims functions. The bill requires the Commissioner of Health and Senior Services (DHSS), in consultation with the Commissioner of the Department of Banking and Insurance (DBI), establish an advisory board to make recommendations to the commissioners regarding health information electronic data interchange technology policy and measures to protect the

confidentiality of medical information. The bill also would have afforded health care providers, facilities and benefits plans processors a temporary, two-year tax credit of 10% against the gross income tax, corporation business tax, and the franchise tax on insurance companies for the purchase, lease or rental of electronic data interchange technology used to receive and/or transmit health care claims. In her conditional veto, the Governor said she supports the Legislature's efforts to promote the use of health care information electronic data interchange technology, but the bill in its current form provides an unnecessary tax credit to health care providers, health care facilities, vendors of certain computer software and entities that process enrollments under health care benefit plans.

The Governor said under federal and state laws these groups are already entitled to a business deduction with respect to expenses incurred in the purchase, lease or rental of such technology. Therefore, she said, a tax credit would provide a double tax benefit for the same expense. Gov. Whitman said the Department of Treasury estimates that the additional tax credit would result in an estimated loss of revenue of \$20 million annually for each of the two years the tax credits would be in existence. Furthermore, the Governor said the bill provides that the time period within which electronically transmitted claims must be paid is shorter than that provided for manually transmitted claims. Thus, she said, adequate incentive for the use of health care information electronic data interchange technology already exists without the grant of a tax credit.

A-415, sponsored by Assembly Members Jeffrey W. Moran (R-Atlantic/Burlington/Ocean) and Anthony Impreveduto (D- Bergen/Hudson) and Senators Robert W. Singer (R- Burlington/Momouth/Ocean) and Edward T. O'Connor, Jr. (D-Hudson), would have revised licensing provisions for orthotists and prosthetists. The bill revised current statutes to provide an alternative pathway for licensure for those with associate's degrees in science instead of limiting licensure to those with a bachelor's degree. Candidates for licensure would also be required to complete a clinical practice or internship and pass an examination developed by the Orthotics and Prosthetics Board of Examiners.

Additionally, the bill would have established two grandfather provisions. The first applied to people who have practiced full- time in an established prosthetic-orthotic facility as an orthotist, prosthetist or prosthetist-orthotist for three years immediately prior to the effective date of the bill. Such a person would have been able to file an application with the Orthotics and Prosthetics Board of Examiners within 180 days after the date procedures were established by the board for applying for licensure to continue to practice. The applicant would have been able to obtain a license without taking an examination after paying the license fee established by the bill and after the board had completed an investigation of the applicant's work history. The second grandfather provision would have applied to persons who had practiced in the same manner for three years or more, but not necessarily the three years immediately prior to the effective date of the bill, and have also passed a certifying examination in orthotics and prosthetics approved by a program accredited by the National Commission for Certifying Agencies. The bill would have provided that such a person may obtain a license without satisfying either of the other methods for licensure.

The Governor commended the bill's sponsors for their efforts to address a perceived shortage of orthotists and prosthetists by providing an alternative pathway for licensure.

The Governor said while she appreciated the need to open the profession to provide consumer choice and increased patient coverage, she also appreciated the importance of setting high standards for professional licensure to protect consumers. Therefore, she recommend that the alternative pathway for licensure for those with associate's degrees be limited to a five- year period. Upon expiration of that period, the Governor recommended that a bachelor's degree be required for licensure, which is consistent with the current licensure statute. Gov. Whitman also recommended that the 360 day grandfather provision be eliminated and that a simplified 180 day grandfather provision be created. Additionally, she recommended a technical change to the grandfather provision to reflect that the board must finally determine whether to approve an applicant for licensure after it has completed its investigation of the work history of the applicant.

PO BOX 004
TRENTON, NJ 08625

Office of the Governor
NEWS RELEASE

CONTACT: Gene Herman

609-777-2600

RELEASE: July 1, 1999

Gov. Christie Whitman today signed the following bills:

SCS Substitute for S-323, 324, 325, 326, 327, 328, 329, 330, 331, sponsored by Senator Robert E. Littell (R-Sussex/Hunterdon/Morris) and Assembly Members Nicholas R. Felice (R-Bergen/Passaic) and Joseph V. Doria, Jr. (D-Hudson), provides for the prompt payment of health care claims by health insurance carriers, health maintenance organizations, health, hospital, medical and dental service organizations or any intermediary contracted or affiliated with the carrier to perform administrative functions. The bill reduces the amount of time in which an uncontested claim must be paid by a carrier from the current 60 days to 30 days or the time limit established by the Medicare program, whichever is earlier, for electronic claims. It reduces the amount of time for payment of an uncontested manual claim to 40 days following receipt of the claim. The bill also requires that a carrier shall deny a contested claim, stating all reasons for denial, within 30 days, instead of 90 days as is currently required. The bill directs a carrier to acknowledge receipt of a claim submitted by electronic means no later than two working days following receipt of the claim.

The bill incorporates the recommendations made by the Governor in her conditional veto of the bill on March 12. The bill was conditionally vetoed with the recommendation that a provision that would have provided a tax cut to carriers with the intention of stimulating development and use of health information electronic data interchange technology be deleted. In her conditional veto, the Governor said that while promotion of the use of such technology is important, under current state and federal law, these groups are already entitled to a business deduction with respect to expenses incurred in the purchase, lease or rental of such technology.

S-168, sponsored by Senators John O. Bennett (R-Monmouth) and Diane B. Allen (R-Burlington/Camden) and Assembly Members John V. Kelly (R-Bergen/Essex/Passaic) and Barbara Wright (R-Mercer/Middlesex), requires public school health services to employ persons holding an educational services certificate with an endorsement as a school nurse issued by the State Board of Examiners. The bill grandfathers currently employed non-certified nursing staff. Additionally, the bill makes an exception for those non-nursing personnel who are otherwise authorized by statute or regulation to perform specific health-related services.

A-2121, sponsored by Assembly Members Guy F. Talarico (R-Bergen) and Nicholas Asselta (R-Cape May/Atlantic/Cumberland) and Senators Jack Sinagra (R-Middlesex) and Richard J. Codey (D-Essex), provides for insurance carrier reporting of claims

payment practices to the Department of Banking and Insurance and for enforcement of violations of claims payment requirements. At a provider or covered person's request, a payer shall provide information as to all material required to be submitted to the payer with a claim for reimbursement. The bill also requires carriers to provide covered persons and providers with a toll-free telephone number for making inquiries regarding paid or pending claims. A carrier must respond to any covered person's or provider's claim inquiry within three days of the inquiry.

The bill incorporates the recommendations made by the Governor in her conditional veto of the original bill on May 3. The bill was conditionally vetoed to give the Commissioner of Banking and Insurance more discretion in imposing penalties and to change the effective date to better coincide with previous legislation requiring prompt payment of claims. The bill also eliminates the requirement that a payee (insurance carrier or HMO) provide a provider with a monthly statement of claims if the provider chooses to file claims manually rather than electronically, as the Governor recommended in her conditional veto.