LEGISLATIVE HISTORY CHECKLIST

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LAWS of 1999

CHAPTER: 154

NJSA:17B:30-26 et al
(Health information -- electronic interchange technology incentivesand 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, 1999June 24, 1999
SENATE:January 28, 1999May 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*

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§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

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

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

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

The Commissioner of Banking and Insurance shall establish the timetable within 90 days of the date the federal Department of Health and Human Services adopts rules establishing standards for health care 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.

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

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

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

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

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

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

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

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

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

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

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

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

(3) all**]**. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

b. Within 12 months of the adoption of regulations establishing

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

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

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

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

(3) all] . All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all] . All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all**]**. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the policy[3].

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

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

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

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

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

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

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

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

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

is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting

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

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

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

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

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

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

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

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

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

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

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

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

(3) all]. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the policy[3].

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

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

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

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

days after receipt of the claim by the insurer.

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

provider; and

(3) all]. All[1] claims shall be filed using the standard[1] health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all**]**. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

b. Within 12 months of the adoption of regulations establishing

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

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

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

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

(3) all**]**. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all]. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

the prepaid prescription service organization.[3]

[4][11. a. A taxpayer, except for a New Jersey S corporation whose shareholders shall instead be allowed the credit provided by section 13 of P.L. , c. (C.)(pending before the Legislature as this bill), shall be allowed a credit against the tax liability imposed by section 5 of P.L.1945, c.162 (C.54:10A-5) in an amount equal to 10% of the costs of the taxpayer during a fiscal or calendar accounting year, referred to hereinafter in this section as a "tax year," [1][beginning on or] ending[1] after [1][January, 1,] June 30,[1] [2][1998]1999 [2] but before [1][January] July[1] 1, [2][2000] 2001[2], for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to receive and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the use of the technology in this State, provided that:

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

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

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

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

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

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

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

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

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

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

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

[4]**[**12. a. A taxpayer shall be allowed a credit against the tax liability imposed by P.L.1945, c.132 (C.54:18A-1 et seq.) in an amount equal to 10% of the costs of the taxpayer during a year, referred to hereinafter in this section as the "tax year," beginning on or after January 1, [2]**[**1998**]** 1999 [2] but before January 1,[2]**[**2000**]** 2001 [2], for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to receive and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the use of the technology in this State, provided that the technology purchased, leased or rented is primarily used or intended for use, at a minimum, for one or more of the following applications in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the Legislature as this bill): 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.

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

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

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

4[13. a. A taxpayer shall be allowed a credit against the tax otherwise due pursuant to N.J.S.54A:1-1 et seq. in an amount equal to 10% of the costs of the taxpayer during a taxable year beginning on or after January 1, 2[1998] 1999[2] but before January 1, 2[2000] 2001[2], for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to receive and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the use of the technology in this State, provided that:

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

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

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

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

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

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

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

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

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

d. The amount of the credit shall be applied during the taxable year in which the cost is incurred against any tax liability otherwise due before other credits permitted pursuant to law are applied. [2][If the credit reduces the taxpayer's tax liability to zero, the remaining amount of the credit shall not be considered an overpayment of the tax.][2]][4]

[4][14.] 11.[4] 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 electronic data interchange technology policy and measures to protect the confidentiality of medical information. The members of the board shall 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 members of the board shall serve without compensation but shall be entitled to reimbursement for reasonable expenses incurred in the performance of their duties.

[4][15.] 12.[4] 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 electronic data interchange technology in New Jersey. The report shall be prepared [1][with the cooperation and assistance of the New Jersey Institute of Technology and Thomas Edison State College and][1] in consultation with the advisory board established pursuant to section 14 of P.L. , c. (C.) (pending before the Legislature as this bill). The report shall include any recommendations, including proposals for regulatory and legislative changes, to promote the development and use of health information electronic data interchange technology in this State.

[4][16.] 13.[4] Effective [1][two years after the date of enactment of P.L. , c. (C.)(pending before the Legislature as this bill),] 12 months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill)[1], a health care professional licensed pursuant to Title 45 of the Revised Statutes is responsible for

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

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

[3]b. In the case of a claim in which the patient has assigned his benefits to the professional, the professional shall file the claim within 180 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the Legislature as this bill). If the professional does not file the claim within 180 days of the last date of service for a course of treatment, 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 professional shall be prohibited from seeking any payment directly from the patient.

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

(2) A professional who fails to file a claim within 180 days and whose claim for payment has been denied by the third party payer in accordance with this subsection 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. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to file the claim with the third party payer within 180 days.

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

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

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

[4][17.] 14.[4] Effective [1][two years after the date of enactment of P.L. , c. (C.) (pending before the Legislature as this bill)] 12 months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill)[1], a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) is responsible for filing all claims for third party payment, including claims filed on behalf of the health care facility's patient for any health care service provided by the health care facility that is eligible for third party payment, except that at the patient's option, the patient may file the claim for third party payment. [3][The]

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

[3]b. In the case of a claim in which the patient has assigned his benefits to the health care facility, the health care facility shall file the claim within 180 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the Legislature as this bill). If the health care facility does not file the claim within 180 days of the last date of service for a course of treatment, 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 facility shall be prohibited from seeking any payment directly from the patient.

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

(2) A health care facility which fails to file a claim within 180 days and whose claim for payment has been denied by the third party payer in accordance with this subsection 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. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to file the claim with the third party payer within 180 days.[3]

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

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

[4][18.] 15.[4] The Commissioner of Banking and Insurance Comm 1issioner, in consultation with the Commissioner of Health and Senior Services, shall adopt regulations to effectuate the purposes of sections 1 through 10 of this act, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). [3]To the extent practicable, the regulations shall include any provisions the commissioner deems appropriate that seek to reduce the amount of, or to consolidate, the paper forms sent by hospital, medical, health and dental service corporations, commercial insurers, health maintenance organizations, dental plan organizations and prepaid prescription service organizations to health care providers and covered persons.[3]

[4][[1]19.] 16.[4] Thomas A. Edison State College shall study and monitor the effectiveness of electronic data interchange technology in reducing administrative costs, identify means by which new electronic data interchange technology can be implemented to effect health care system cost savings, and determine the extent of electronic data interchange technology use in the State's health care system.

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

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

[4][[3]20.] 17.[4] 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) are repealed.[3]

[2][[1]20. There is appropriated $250,000 from the General Fund to

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

[1][19.][2][21.[1]][3][20.[2]][4][21.[3]] 18[4]. This act shall take effect immediately[1][; and section 11 shall apply to the fiscal or calendar accounting years beginning on or after July 1, 1998, section 12 shall apply to calendar years beginning after July 1, 1998, and section 13 shall apply to taxable years beginning on or after January 1, 1998][1].

Provides incentives to stimulate development and use of health 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)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all]. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

the claim by the hospital service corporation.

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all] . All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all**]** . All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

b. Within 12 months of the adoption of regulations establishing

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

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

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

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

(3) all]. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the policy[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all]. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the policy[3].

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

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

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

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

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

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

interest at the rate of 10% per year.

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all]. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all]. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all]. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) all**]**. All[1] claims shall be filed using the standard [1]health care[1] claim form [3]applicable to the contract[3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

11. a. A taxpayer, except for a New Jersey S corporation whose shareholders shall instead be allowed the credit provided by section 13 of P.L. , c. (C.)(pending before the Legislature as this bill), shall be allowed a credit against the tax liability imposed by section 5 of P.L.1945, c.162 (C.54:10A-5) in an amount equal to 10% of the costs of the taxpayer during a fiscal or calendar accounting year, referred to hereinafter in this section as a "tax year," [1][beginning on or] ending[1] after [1][January, 1,] June 30,[1] [2][1998]1999 [2] but before [1][January] July[1] 1, [2][2000] 2001 [2], for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to receive and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the

use of the technology in this State, provided that:

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

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

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

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

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

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

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

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

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

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

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

12. a. A taxpayer shall be allowed a credit against the tax liability imposed by P.L.1945, c.132 (C.54:18A-1 et seq.) in an amount equal to 10% of the costs of the taxpayer during a year, referred to hereinafter in this section as the "tax year," beginning on or after January 1, [2]**[**1998**]** 1999 [2] but before January 1,[2]**[**2000**]** 2001 [2], for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to receive and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the use of the technology in this State, provided that the technology purchased, leased or rented is primarily used or intended for use, at a minimum, for one or more of the following applications in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the Legislature as this bill): 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

14. 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 electronic data interchange technology policy and measures to protect the confidentiality of medical information. The members of the board shall 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 members of the board shall serve without compensation but shall be entitled to reimbursement for reasonable expenses incurred in the performance of their duties.

15. 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 electronic data interchange technology in New Jersey. The report shall be prepared [1]**[**with the cooperation and assistance of the New Jersey Institute of Technology and Thomas Edison State College and**]**[1] in consultation with the advisory board established pursuant to section 14 of P.L. , c. (C.) (pending before the Legislature as this bill). The report shall include any recommendations, including proposals for regulatory and legislative changes, to promote the development and use of health information electronic data interchange technology in this State.

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

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

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

standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the Legislature as this bill). If the professional does not file the claim within 180 days of the last date of service for a course of treatment, 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 professional shall be prohibited from seeking any payment directly from the patient.

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

(2) A professional who fails to file a claim within 180 days and whose claim for payment has been denied by the third party payer in accordance with this subsection 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. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to file the claim with the third party payer within 180 days.

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

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

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

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

[3]b. In the case of a claim in which the patient has assigned his benefits to the health care facility, the health care facility shall file the claim within 180 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the Legislature as this bill). If the health care facility does not file the claim within 180 days of the last date of service for a course of treatment, 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 facility shall be prohibited from seeking any payment directly from the patient.

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

(2) A health care facility which fails to file a claim within 180 days and whose claim for payment has been denied by the third party payer in accordance with this subsection 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. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to file the claim with the third party payer within 180 days.[3]

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

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

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

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

[1]19. Thomas A. Edison State College shall study and monitor the effectiveness of electronic data interchange technology in reducing administrative costs, identify means by which new electronic data interchange technology can be implemented to effect health care system cost savings, and determine the extent of electronic data interchange technology use in the State's health care system.

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

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

[3]20. 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) are repealed.[3]

[2][[1]20. There is appropriated $250,000 from the General Fund to the Department of State for a grant to Thomas A. Edison State College to carry out the purposes of section 19 of this act.[1]][2]

[1][19.] [2][21.[1]] [3][20.[2]] 21.[3] This act shall take effect immediately[1][; and section 11 shall apply to the fiscal or calendar accounting years beginning on or after July 1, 1998, section 12 shall apply to calendar years beginning after July 1, 1998, and section 13 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.

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

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

1. The Legislature finds and declares that:

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

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

c. Persons receiving, maintaining and distributing health care information need clear and certain rules for the handling, maintenance, dissemination and disclosure of health care information;

d. In order to carry out their statutory responsibilities, including the investigation and prosecution of crime, the detection of fraud, the protection of youth and the regulation of health care providers and facilities, institutions and insurers, it is necessary that criminal and civil regulatory agencies and the courts maintain their current level of access to health care information; and

e. Health care information is obtained, used and disclosed in many different contexts and for many different purposes, and a patient's interest in the proper use and disclosure of his personal health care information continues even when the information has been initially disclosed and is held by other persons.

2. As used in sections 1 through 10 of this act:

"Commissioner" means the Commissioner of Health.

"Health care" means any preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, counseling, service, examination or procedure provided by a health care facility with respect to a patient's physical or mental condition, or affecting the structure or function of the human body or any part thereof, including, but not limited to, the banking of blood, sperm, organs or any other tissue, or a sale or dispensing of a drug, substance, device, equipment or other item to a patient or for a patient's use pursuant to a prescription.

"Health care facility" means a health care facility regulated by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Health care information" means any data or information, whether

oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and relates to a patient's health care, and is obtained in the course of a patient's health care from a health care facility, the patient, a member of the patient's family, a person with whom the patient has a close personal relationship, or a patient representative.

"Patient" means a person who receives or has received health care.

"Patient representative" means a person legally empowered to make decisions about a patient's health care on the patient's behalf or the administrator or executor of a deceased patient's estate.

"Record" means a patient's health care information record.

3. A health care facility is subject to the provisions of sections 1 through 10 of this act, notwithstanding the provisions of any other law to the contrary, except as otherwise provided herein.

4. a. A record maintained by a health care facility is confidential and shall be disclosed only for the purposes authorized by this act.

b. A health care facility, in accordance with regulations adopted by the commissioner, shall develop and implement a written policy governing the confidentiality of records maintained by the facility. The policy shall include procedures designed to ensure the security of its records during storage, processing or transmission, either in electronic or other form, and shall stipulate that any person who is granted access to a record maintained by the facility shall have previously received and signed a form approved by the commissioner which explains the facility's written confidentiality policy and obligates the person to abide thereby.

c. The content of a record may be disclosed in accordance with the prior written authorization of the patient or patient representative, or if the patient is legally incompetent or deceased, in accordance with section 7 of this act, only if the authorization is provided on a form and in a manner approved by the commissioner, in consultation with the Commissioner of Insurance and the Director of the Division of Consumer Affairs in the Department of Law and Public Safety and the purpose and period of time for which disclosure is authorized are clearly stated on the authorization form.

d. The signing or authentication of a patient's or patient representative's authorization for disclosure shall be considered permission for disclosure only for the purposes explicitly contained in the authorization and shall not be considered a waiver of any rights a patient has under federal or State statute, court rule or common law.

e. If the patient's or patient representative's prior written authorization is not obtained, the record shall be disclosed only under the following conditions, except that nothing in this subsection shall be construed to permit the disclosure of a record to a person, agency

or other entity to whom disclosure is otherwise prohibited under State or federal law:

(1) To the patient or the patient representative;

(2) To a health care provider who is providing health care to the patient, except as the disclosure is limited or prohibited by the patient;

(3) To a member of the patient's immediate family, or to another person with whom the patient is known to have a close personal relationship, if the disclosure is made in accordance with good medical or other professional practice, except as the disclosure is limited or prohibited by the patient;

(4) To any person to the extent that person needs to know the information in the record, if the holder of the record believes that the disclosure will avoid or minimize imminent danger to the health or safety of the patient or any other person, or is necessary to alleviate emergency circumstances affecting the health or safety of any person;

(5) To federal, State or local government authorities, to the extent that the holder of the record is required by law to report specific health care information, when needed to determine compliance with State or federal licensure, certification or registration requirements, or when needed to protect the public health, including but not limited to the reporting of child abuse or neglect, or to identify a deceased patient based upon reasonable grounds that information in the record is needed to assist in the identification;

(6) To qualified personnel for the purpose of conducting scientific research, but a record shall be released for research only following review of the research protocol by an institutional review board constituted pursuant to federal regulation 45 C.F.R.§ 46.101 et seq.; and the patient shall not be directly or indirectly identified in any report of the research and research personnel shall not disclose the person's identity in any manner;

(7) To qualified personnel for the purpose of conducting management audits, financial audits or program evaluation; but the personnel shall not directly or indirectly identify the patient in a report of an audit or evaluation, or otherwise disclose the patient's identity in any manner, and identifying information shall not be released to the personnel unless it is vital to the audit or evaluation;

(8) To qualified personnel involved in medical education or in the patient's diagnosis and treatment, except that disclosure is limited to personnel directly involved in medical education or in the patient's diagnosis and treatment;

(9) To federal, State or local government entities, including grand juries, conducting a criminal investigation or carrying out the entity's civil or administrative duties, as authorized by law;

(10) As permitted by rules and regulations adopted by the commissioner; or

(11) In all other instances authorized by State or federal law.

f. Except if the information is disclosed pursuant to paragraph (9) of subsection e. of this section, a health care facility shall maintain as part of a record the following:

(1) information regarding each external disclosure of health care information in that record, including, but not limited to: the name, address and institutional affiliation, if any, of the person to whom the health care information is disclosed; the date and purpose of the disclosure; and, to the extent practicable, a description of the information disclosed; and

(2) authorization by a patient or patient representative for disclosure of health care information contained in the record and any revocation thereof by the patient or patient representative; or

(3) if authorization was not obtained by a patient or patient representative for disclosure of health care information contained in the record, the authorization upon which the information was disclosed.

g. The limits on disclosure set forth in this act shall continue to apply to a record after the patient is discharged from the health care facility.

h. A record disclosed under this act shall be held confidential by the recipient of the record and shall not be released by the recipient unless the conditions of this act are met. A record which is received by a public agency pursuant to this act may be used or released in discharging the agency's law enforcement or other statutory responsibilities. Any further release by a recipient agency must be authorized by this act or be otherwise authorized by law.

5. A patient or patient representative has the right to:

a. have access to health care information concerning the patient;

b. receive a copy of health care information from the patient's record upon payment of a reasonable charge to a health care facility as determined by the commissioner;

c. have a notation made in the patient's record, upon the request of the patient or patient representative, which reflects: any amendment to, or correction of, the information in the record, or any such change proposed by the patient or patient representative with which the health care facility disagrees in regard to the accuracy of the record; and

d. revoke at any time the patient's or patient representative's authorization for disclosure of health care information contained in the record, unless the disclosure is required to effectuate payment for health care that has been provided to the patient, or other substantial action has been taken in reliance on that authorization.

A patient may not maintain an action against a health care facility or a person employed by a health care facility for disclosure of health care information made in good faith reliance on the patient's or patient representative's written authorization or authorization given pursuant

to section 7 of this act, if the facility or employee had no notice of the revocation at the time the disclosure was made.

6. a. In addition to those disclosures otherwise permitted pursuant to this act, a record may be disclosed by an order of a court of competent jurisdiction which is granted pursuant to an application showing good cause therefor. At a good cause hearing, the court shall weigh the public interest and need for disclosure against the injury to: the patient, the health care provider-patient relationship, or the services offered by the health care facility, and those provisions of State or federal law which are intended to assure the confidentiality of patient health care information. Upon the granting of the order, the court, in determining the extent to which a disclosure of all or any part of a record is necessary, shall impose appropriate safeguards to prevent an unauthorized disclosure.

b. The court shall deny an application for disclosure of a record unless the court makes a specific finding that the health care facility and the patient or patient representative were afforded the opportunity to be represented at the hearing.

c. Nothing in this section shall be construed to authorize disclosure of any confidential communication which is otherwise protected by statute, court rule or common law.

7. a. When authorization is required for disclosure of the record of a deceased or legally incompetent patient, the authorization shall be obtained from any one of the following:

(1) From an executor, administrator of the estate, or patient representative;

(2) From the patient's spouse or primary caretaking partner or, if none, by another member of the patient's family; or

(3) From the commissioner in the event that the commissioner reasonably determines that a deceased patient has neither an authorized representative or available next-of-kin.

b. When authorization is required for disclosure of the record of a minor, it shall be obtained from the parent, guardian, or other individual authorized under State law to act in the minor's behalf.

8. a. If a health care facility or a person employed by a health care facility, or a person who is granted access to a record maintained by the facility, fails to comply with the provisions of this act, a patient or other person whose rights are violated may apply to the Superior Court of this State, or any other court of competent jurisdiction, for appropriate equitable relief.

b. A health care facility or a person employed by a health care facility, or a person who is granted access to a record maintained by the facility, which discloses health care information in violation of the

provisions of this act shall be liable for damages sustained by the person about whom the information relates.

c. Each disclosure of a record made in violation of the provisions of this act is a separate and actionable offense.

d. In an action brought pursuant to this section, the court may award the costs of the action and reasonable attorney's fees to the prevailing party.

e. An action under this section shall be brought within two years from the date that the alleged violation is or should have been discovered.

9. a. A person who, under false or fraudulent pretenses, requests or obtains health care information from a health care facility or a person employed by a health care facility, or requests or obtains a patient's authorization for disclosure of that information, is guilty of a crime of the fourth degree.

b. A person who, under false or fraudulent pretenses, requests or obtains health care information from a health care facility or a person employed by a health care facility and knowingly uses, sells or transfers that information for remuneration, profit or monetary gain, is guilty of a crime of the second degree if the amount involved is $75,000 or more; a crime of the third degree if the amount involved exceeds $500 but is less than $75,000; and a crime of the fourth degree if the amount involved exceeds $200 but is less than $500.

c. A person who unlawfully takes health care information from a health care facility or a person employed by a health care facility and knowingly uses, sells or transfers that information for remuneration, profit or monetary gain, is guilty of a crime of the second degree if the amount involved is $75,000 or more; a crime of the third degree if the amount involved exceeds $500 but is less than $75,000; and a crime of the fourth degree if the amount involved exceeds $200 but is less than $500.

10. Nothing in sections 1 through 9 of this act shall be construed to limit a person's immunity from liability for civil damages in accordance with the provisions of any law, including, but not limited to, section 1 of P.L.1983, c.248 (C.45:9-19.1), section 21 of P.L.1985, c.179 (C.17:23A-21) or P.L.1972, c.45 (C.59:1-1 et seq.).

11. The commissioner, in consultation with the Commissioner of Insurance and the Director of the Division of Consumer Affairs in the Department of Law and Public Safety, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of sections 1 through 10 of this act.

12. As used in sections 12 through 21 of this act:

"Director" means the Director of the Division of Consumer Affairs in the Department of Law and Public Safety.

"Health care" means any preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, counseling, service, examination or procedure provided by a health care provider with respect to a patient's physical or mental condition, or affecting the structure or function of the human body or any part thereof, including, but not limited to, the banking of blood, sperm, organs or any other tissue, or a sale or dispensing of a drug, substance, device, equipment or other item to a patient or for a patient's use pursuant to a prescription.

"Health care information" means any data or information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient or other subject of record and relates to a patient's health care, and is obtained in the course of a patient's health care from a health care provider, the patient, a member of the patient's family, a person with whom the patient has a close personal relationship, or the patient's legal representative.

"Health care provider" means a health care provider subject to regulation by a professional board pursuant to the provisions of Title 45 of the Revised Statutes.

"Patient" means a person who receives or has received health care.

"Patient representative" means a person legally empowered to make decisions about a patient's health care on the patient's behalf or the administrator or executor of a deceased patient's estate.

"Record" means a patient's health care information record.

13. A health care provider is subject to the provisions of sections 12 through 21 of this act, notwithstanding the provisions of any other law to the contrary, except as otherwise provided herein.

14. a. A record maintained by a health care provider is confidential and shall be disclosed only for the purposes authorized by this act.

b. A health care provider, in accordance with regulations adopted by the director, shall develop and implement a written policy governing the confidentiality of records maintained by the provider. The policy shall include procedures designed to ensure the security of the provider's records during storage, processing or transmission, either in electronic or other form, and shall stipulate that any person who is granted access to a record maintained by the provider shall have previously received and signed a form approved by the director which explains the provider's written confidentiality policy and obligates the person to abide thereby.

c. The content of a record may be disclosed in accordance with the prior written authorization of the patient or patient representative, or

if the patient is legally incompetent or deceased, in accordance with section 17 of this act, only if the authorization is provided on a form and in a manner approved by the director, in consultation with the Commissioners of Health and Insurance, and the purpose and period of time for which disclosure is authorized are clearly stated on the authorization form.

d. The signing or authentication of a patient's or patient representative's authorization for disclosure shall be considered permission for disclosure only for the purposes explicitly contained in the authorization and shall not be considered a waiver of any rights a patient has under federal or State statute, court rule or common law.

e. If the patient's or patient representative's prior written authorization is not obtained, the record shall be disclosed only under the following conditions, except that nothing in this subsection shall be construed to permit the disclosure of a record to a person, agency or other entity to whom disclosure is otherwise prohibited under State or federal law:

(1) To the patient or the patient representative;

(2) To another health care provider who is providing health care to the patient, except as the disclosure is limited or prohibited by the patient;

(3) To a member of the patient's immediate family, or to another person with whom the patient is known to have a close personal relationship, if the disclosure is made in accordance with good medical or other professional practice, except as the disclosure is limited or prohibited by the patient;

(4) To any person to the extent that person needs to know the information in the record, if the holder of the record believes that the disclosure will avoid or minimize imminent danger to the health or safety of the patient or any other person, or is necessary to alleviate emergency circumstances affecting the health or safety of any person;

(5) To federal, State or local government authorities, to the extent that the holder of the record is required by law to report specific health care information, when needed to determine compliance with State or federal licensure, certification or registration requirements, or when needed to protect the public health, including but not limited to the reporting of child abuse or neglect, or to identify a deceased patient based upon reasonable grounds that information in the record is needed to assist in the identification;

(6) To qualified personnel for the purpose of conducting scientific research, but a record shall be released for research only following review of the research protocol by an institutional review board constituted pursuant to federal regulation 45 C.F.R.§ 46.101 et seq.; and the patient shall not be directly or indirectly identified in any report of the research and research personnel shall not disclose the person's identity in any manner;

(7) To qualified personnel for the purpose of conducting management audits, financial audits or program evaluation; but the personnel shall not directly or indirectly identify the patient in a report of an audit or evaluation, or otherwise disclose the patient's identity in any manner, and identifying information shall not be released to the personnel unless it is vital to the audit or evaluation;

(8) To qualified personnel involved in medical education or in the patient's diagnosis and treatment, except that disclosure is limited to personnel directly involved in medical education or in the patient's diagnosis and treatment;

(9) To federal, State or local government entities, including grand juries, conducting a criminal investigation or carrying out the entity's civil or administrative duties, as authorized by law;

(10) As permitted by rules and regulations adopted by the Commissioner of Health; or

(11) In all other instances authorized by State or federal law.

f. Except if the information is disclosed pursuant to paragraph (9) of subsection e. of this section, a health care provider shall maintain as part of a record the following:

(1) information regarding each external disclosure of health care information in that record, including, but not limited to: the name, address and institutional affiliation, if any, of the person to whom the health care information is disclosed; the date and purpose of the disclosure; and, to the extent practicable, a description of the information disclosed; and

(2) authorization by a patient or patient representative for disclosure of health care information contained in the record and any revocation thereof by the patient or patient representative; or

(3) if authorization was not obtained by a patient or patient representative for disclosure of health care information contained in the record, the authorization upon which the information was disclosed.

g. The limits on disclosure set forth in this act shall continue to apply to a record after the patient is no longer receiving health care services from the health care provider.

h. A record disclosed under this act shall be held confidential by the recipient of the record and shall not be released by the recipient unless the conditions of this act are met. A record which is received by a public agency pursuant to this act may be used or released in discharging the agency's law enforcement or other statutory responsibilities. Any further release by a recipient agency must be authorized by this act or be otherwise authorized by law.

15. A patient or patient representative has the right to:

a. have access to health care information concerning the patient;

b. receive a copy of health care information from the patient's

record upon payment of a reasonable charge to a health care provider as determined by the director;

c. have a notation made in the patient's record, upon the request of the patient or patient representative, which reflects: any amendment to, or correction of, the information in the record, or any such change proposed by the patient or patient representative with which the health care provider disagrees in regard to the accuracy of the record; and

d. revoke at any time the patient's or patient representative's authorization for disclosure of health care information contained in the record, unless the disclosure is required to effectuate payment for health care that has been provided to the patient, or other substantial action has been taken in reliance on that authorization.

A patient may not maintain an action against a health care provider or a person employed by a health care provider for disclosure of health care information made in good faith reliance on the patient's or patient representative's written authorization or authorization given pursuant to section 17 of this act, if the provider or employee had no notice of the revocation at the time the disclosure was made.

16. a. In addition to those disclosures otherwise permitted pursuant to this act, a record may be disclosed by an order of a court of competent jurisdiction which is granted pursuant to an application showing good cause therefor. At a good cause hearing, the court shall weigh the public interest and need for disclosure against the injury to: the patient, the health care provider-patient relationship, the services offered by the health care provider, and those provisions of State or federal law which are intended to assure the confidentiality of patient health care information. Upon the granting of the order, the court, in determining the extent to which a disclosure of all or any part of a record is necessary, shall impose appropriate safeguards to prevent an unauthorized disclosure.

b. The court shall deny an application for disclosure of a record unless the court makes a specific finding that the health care provider and the patient or patient representative were afforded the opportunity to be represented at the hearing.

c. Nothing in this section shall be construed to authorize disclosure of any confidential communication which is otherwise protected by statute, court rule or common law.

17. a. When authorization is required for disclosure of the record of a deceased or legally incompetent patient, the authorization shall be obtained from any one of the following:

(1) From an executor, administrator of the estate, or patient representative;

(2) From the patient's spouse or primary caretaking partner or, if none, by another member of the patient's family; or

(3) From the director in the event that the director reasonably determines that a deceased patient has neither an authorized representative or available next-of-kin.

b. When authorization is required for disclosure of the record of a minor, it shall be obtained from the parent, guardian, or other individual authorized under State law to act in the minor's behalf.

18. a. If a health care provider or a person employed by a health care provider, or a person who is granted access to a record maintained by the provider, fails to comply with the provisions of this act, a patient or other person whose rights are violated may apply to the Superior Court of this State, or any other court of competent jurisdiction, for appropriate equitable relief.

b. A health care provider or a person employed by a health care provider, or a person who is granted access to a record maintained by the provider, who discloses health care information in violation of the provisions of this act shall be liable for damages sustained by the person about whom the information relates.

c. Each disclosure of a record made in violation of the provisions of this act is a separate and actionable offense.

d. In an action brought pursuant to this section, the court may award the costs of the action and reasonable attorney's fees to the prevailing party.

e. An action under this section shall be brought within two years from the date that the alleged violation is or should have been discovered.

19. a. A person who, under false or fraudulent pretenses, requests or obtains health care information from a health care provider or a person employed by a health care provider, or requests or obtains a patient's authorization for disclosure of that information, is guilty of a crime of the fourth degree.

b. A person who, under false or fraudulent pretenses, requests or obtains health care information from a health care provider or a person employed by a health care provider and knowingly uses, sells or transfers that information for remuneration, profit or monetary gain, is guilty of a crime of the second degree if the amount involved is $75,000 or more; a crime of the third degree if the amount involved exceeds $500 but is less than $75,000; and a crime of the fourth degree if the amount involved exceeds $200 but is less than $500.

c. A person who unlawfully takes health care information from a health care provider or a person employed by a health care provider and knowingly uses, sells or transfers that information for remuneration, profit or monetary gain, is guilty of a crime of the second degree if the amount involved is $75,000 or more; a crime of the third degree if the amount involved exceeds $500 but is less than

$75,000; and a crime of the fourth degree if the amount involved exceeds $200 but is less than $500.

20. Nothing in sections 12 through 19 of this act shall be construed to limit a person's immunity from liability for civil damages in accordance with the provisions of any law, including, but not limited to, section 1 of P.L.1983, c.248 (C.45:9-19.1) , section 21 of P.L.1985, c.179 (C.17:23A-21) or P.L.1972, c.45 (C.59:1-1 et seq.).

21. The director, in consultation with the Commissioners of Health and Insurance,pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of sections 12 through 20 of this act.

22. This act shall take effect 180 days after enactment.

STATEMENT

This bill establishes uniform health care information record confidentiality, security and access requirements for all health care patients in New Jersey, whether they are receiving services in a licensed health care facility or from a health care provider regulated under Title 45 of the Revised Statutes. The bill also establishes civil and criminal penalties for violations of these requirements.

The bill requires that health care facilities and providers implement a written confidentiality policy which includes procedures to ensure the security of their health care information records during storage, processing or transmission, either in electronic or other form. The bill provides that the content of a patient health care information record may be disclosed with the prior written authorization of the patient or his representative only if the authorization is provided on a form and in a manner approved by the Commissioner of Health, in consultation with the Commissioner of Insurance and the Director of the Division of Consumer Affairs, and the purpose and period of time for which disclosure is authorized is clearly stated on the form.

The bill also provides that if a patient's or patient representative's prior written authorization for disclosure of health care information is not obtained, information contained in the record shall be disclosed only under the following conditions:

- To the patient or the patient representative;
- To a health care provider who is providing health care to the patient, except as limited or prohibited by the patient;
- To a member of the patient's immediate family, or to another person with whom the patient is known to have a close personal relationship, in accordance with good medical or

other professional practice, except as limited or prohibited by the patient;

- To any person in order to avoid or minimize imminent danger to the health or safety of the patient or any other person, or to alleviate emergency circumstances affecting the health or safety of any person;
- To federal, State or local government authorities, as required by law;
- To qualified personnel for the purpose of conducting scientific research;
- To qualified personnel for the purpose of conducting management audits, financial audits or program evaluation;
- To qualified personnel involved in medical education or in the patient's diagnosis and treatment;
- To federal, State or local government entities, including grand juries, conducting a criminal investigation or carrying out their civil or administrative duties as authorized by law;
- As permitted by Department of Health rules and regulations; or
- In all other instances authorized by State or federal law.

The bill requires that, except in the case of a disclosure of patient information to a federal, State or local government entity, the health care facility or provider shall maintain in the patient record information about any disclosure from the patient record.

The bill provides, however, that no provision therein shall be construed to permit the disclosure of a record to a person, agency or other entity to whom disclosure is otherwise prohibited under State or federal law.

The bill also stipulates that a patient or patient representative has the right to:

- have access to health care information concerning the patient;
- receive a copy of health care information from the patient’s record upon payment of a reasonable charge;
- have a notation made in the patient's record which reflects any amendment to, or correction of, the information in the record; and
- revoke at any time the patient's or patient representative's authorization for disclosure of health care information in the record, unless the disclosure is required to effectuate payment for health care that has been provided, or other substantial action has been taken in reliance on that authorization.

The bill permits a patient's health care information record to be disclosed by a court order based upon good cause, after weighing the public interest and need for disclosure against the injury to: the patient, the health care provider-patient relationship, the services offered by the health care facility or provider, and State or federal law governing patient health care information confidentiality.

In addition, the bill requires that health care information disclosed pursuant to its provisions be held confidential by the recipient of the record and not be released by the recipient unless the conditions of this bill are met.

The bill also specifies those persons who may provide authorization for the disclosure of the record of a patient who is deceased or legally incompetent, or a minor.

With regard to penalties for noncompliance, the bill provides as follows:

- If a health care facility or provider, or an employee thereof, or a recipient of a patient's record, fails to comply with the provisions of the bill, a patient or other person whose rights are violated may apply to a court of competent jurisdiction for appropriate equitable relief, which may include actual damages and reasonable attorney's fees and court costs.
- A person who, under false or fraudulent pretenses, requests or obtains health care information from a health care facility or provider, or an employee thereof, or requests or obtains a patient's authorization for disclosure of that information, is guilty of a fourth degree crime (punishable by a fine of up to $7,500, or imprisonment for up to 18 months, or both).
- A person who, under false or fraudulent pretenses, requests or obtains health care information from a health care facility or provider, or an employee thereof, and knowingly uses, sells or transfers that information for remuneration, profit or monetary gain, or a person who unlawfully takes health care information from a health care facility or provider, or an employee thereof, and knowingly uses, sells or transfers that information for remuneration, profit or monetary gain, is guilty of a second degree crime if the amount involved is $75,000 or more, a third degree crime if the amount involved exceeds $500 but is less than $75,000, and a fourth degree crime if the amount involved exceeds $200 but is less than $500.

The bill stipulates that no provision therein shall be construed to limit a person's immunity from civil liability in accordance with the provisions of any law, including section 1 of P.L.1983, c.248 (C.45:9-19.1), which protects "whistle blowers" who report physician misconduct to the State Board of Medical Examiners; section 21 of P.L.1985, c.179 (C.17:23A-21), the insurance information practices law; and P.L.1972, c.45 (C.59:1-1 et seq.), the "New Jersey Tort Claims Act."

This bill is part of a legislative package designed to effectuate the 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.

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.

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

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

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

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

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

(3) The Commissioner of Banking and Insurance shall report to the Governor and the Legislature within one year of establishing the timetable pursuant to this subsection, on the number of extensions and

waivers of the implementation requirement that he has granted pursuant to paragraph (2) of this subsection, and the reasons therefor.

b. The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, shall adopt, by regulation, one set of standard health care enrollment and claim forms in paper and electronic formats to be used by each hospital, medical or health service corporation, individual and group health insurer, health maintenance organization, dental service corporation, dental plan organization and prepaid prescription service organization, and a subsidiary of such corporation, insurer or organization that processes health care benefits claims as a third party administrator, authorized to do business in this State.

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

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

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

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

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a hospital service corporation shall require that health care providers file all claims for payment for health care services. A covered person who receives

health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form.

d. (1)Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a hospital service corporation shall reimburse all clean claims that are filed electronically by a provider or a subscriber for payment under a group or individual hospital service corporation contract, within the applicable number of calendar days established for payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

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

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

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

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

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been

demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a medical service corporation, its subsidiary or its covered persons.

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

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

d. (1) Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a medical service corporation shall reimburse all clean claims that are filed electronically by a provider or a subscriber for payment under a group or individual medical service corporation contract, within the applicable number of calendar days established for payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

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

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

10% per year.

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

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

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

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

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

d. (1) Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a health service corporation shall reimburse all clean claims that are filed electronically by a provider or a subscriber for payment under a group or individual health service corporation contract, within the applicable number of

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

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

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

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

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

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

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

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner

of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a health insurer shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form.

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

(1) Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a health insurer shall reimburse all clean claims that are filed electronically by a provider or an insured for payment under an individual policy, within the applicable number of calendar days established for payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

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

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

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

6. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L. , c. (C.)(pending before the Legislature as this bill), a health insurer, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the

provisions of this section, as a condition of its continued authorization to do business in this State.

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

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

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

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

(1) Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a health insurer shall reimburse all clean claims that are filed electronically by a provider or an insured for payment under a group policy, within the applicable number of calendar days established for payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

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

(2) Payment shall be treated as being made on the date a draft or

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

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

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

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

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

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

d. Notwithstanding the provisions of section 80 of P.L.1991, c.187

(C.26:2J-5.1) to the contrary,

(1) Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a health maintenance organization shall reimburse all clean claims that are filed electronically by a provider or an enrollee for payment under group or individual health maintenance organization coverage for health care services, within the applicable number of calendar days established for payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

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

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

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

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

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

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

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

d. (1) Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a dental service corporation shall reimburse all clean claims that are filed electronically by a provider or a subscriber for payment under a group or individual dental service corporation contract, within the applicable number of calendar days established for payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

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

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

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

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

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

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

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

d. (1) Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a dental plan organization shall reimburse all clean claims that are filed electronically by a provider or an enrollee for payment under group or individual dental plan organization coverage for dental services, within the applicable number of calendar days established for payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

If a claim or portion of a claim that is submitted electronically is contested or denied by the dental plan organization, the person or entity who filed the claim shall be notified in writing or electronically,

as appropriate, within 30 days after receipt of the claim by the dental plan organization, that the claim is contested or denied, but the uncontested portion of the claim, if any, shall be paid within 30 days after receipt of the claim by the dental plan organization. The notice that a claim is contested or denied shall identify the contested portion of the claim and the reasons for contesting or denying the claim.

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

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

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

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

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

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a prepaid prescription service organization shall require that health care providers file all claims for payment for health care services. A covered person who

receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form.

d. (1)Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a prepaid prescription service organization shall reimburse all clean claims that are filed electronically by a provider or an enrollee for payment under a prepaid prescription service organization contract, within the applicable number of calendar days established for payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B).

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

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

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

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

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

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

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

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

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

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

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

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

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

c. The tax imposed for a fiscal or calendar accounting year pursuant to section 5 of P.L.1945, c.162 shall first be reduced by the amount of any credit allowed pursuant to this section and then by any other statutory credits allowed against the tax. The credit allowed under this section shall be applied in the order of the credits' tax years. The amount of the credit applied under this section against the tax imposed pursuant to section 5 of P.L.1945, c.162 for an accounting year shall not exceed 50% of the tax liability otherwise due and shall not reduce the tax liability to an amount less than the statutory minimum provided in subsection (e) of section 5 of P.L.1945, c.162.

The amount of tax year credit otherwise allowable under this section which cannot be applied for the tax year due to the limitations of this subsection may be carried over, if necessary, to the seven accounting years following a credit's tax year.

12. a. A taxpayer shall be allowed a credit against the tax liability imposed by P.L.1945, c.132 (C.54:18A-1 et seq.) in an amount equal to 10% of the costs of the taxpayer during a year, referred to hereinafter in this section as the "tax year," beginning on or after January 1, 1998 but before January 1, 2000, for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to receive and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the use of the technology in this State, provided that the technology purchased, leased or rented is primarily used or intended for use, at a minimum, for one or more of the following applications in accordance with standards adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.)(pending before the Legislature as this bill): 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.

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

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

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

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

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

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

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

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

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

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

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

d. The amount of the credit shall be applied during the taxable year in which the cost is incurred against any tax liability otherwise due before other credits permitted pursuant to law are applied. If the credit reduces the taxpayer’s tax liability to zero, the remaining amount of the credit shall not be considered an overpayment of the tax.

14. 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 electronic data interchange technology policy and measures to protect the confidentiality of medical information. The members of the board shall 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 members of the board shall serve without compensation but shall be entitled to reimbursement for reasonable expenses incurred in the performance of their duties.

15. 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 electronic data interchange technology in New Jersey. The report shall be prepared in consultation with the advisory board established pursuant to section 14 of P.L. , c. (C.) (pending before the Legislature as this bill). The report shall include any recommendations, including proposals for regulatory and legislative changes, to promote the development and use of health information electronic data interchange technology in this State.

16. Effective 12 months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill), a health care professional licensed pursuant to Title 45 of the Revised Statutes is responsible for filing all claims for third party payment, including claims filed on behalf of the licensed professional's patient for any health care service provided by the licensed professional that is eligible for third party payment, except that at the patient's option, the patient may file the claim for third party payment. The professional shall file a claim within 60 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill). The provisions of this section shall not apply to any claims filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

A health care professional who violates the provisions of this section may be subject to a civil penalty of $250 for each violation plus $50 for each day after the 60th day that the provider fails to submit a claim. The penalty shall be sued for and collected by the Division of Consumer Affairs in the Department of Law and Public Safety pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

17. Effective 12 months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of

P.L. , c. (C.) (pending before the Legislature as this bill), a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) is responsible for filing all claims for third party payment, including claims filed on behalf of the health care facility's patient for any health care service provided by the health care facility that is eligible for third party payment, except that at the patient's option, the patient may file the claim for third party payment. The health care facility shall file a claim within 60 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L. , c. (C.) (pending before the Legislature as this bill). The provisions of this section shall not apply to any claims filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

A health care facility that violates the provisions of this section may be subject to a civil penalty of $250 for each violation plus $50 for each day after the 60th day that the health care facility fails to submit a claim. The penalty shall be sued for and collected by the Department of Health and Senior Services pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

18. The Commissioner of Banking and Insurance Commissioner, in consultation with the Commissioner of Health and Senior Services, shall adopt regulations to effectuate the purposes of sections 1 through 10 of this act, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

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

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

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

20. There is appropriated $250,000 from the General Fund to the Department of State for a grant to Thomas A. Edison State College to carry out the purposes of section 19 of this act.

21. This act shall take effect immediately.

STATEMENT

The purpose of this bill 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 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 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.

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.

AN ACT concerning the reporting of health care expenditures and supplementing Title 26 of the Revised Statutes.

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

1. The Legislature finds and declares that the public interest requires a full and complete reporting to the Governor and Legislature by the Department of Health and Senior Services with regard to Statewide health care expenditures, based upon required annual surveys, which will ensure that State efforts to achieve health care expenditure savings are informed by the most reliable current data and trends with respect to costs and the various sources thereof in recognition of the importance of the health care industry to this State and its impact on every citizen residing in New Jersey.

2. The Commissioner of Health and Senior Services, in conjunction with the Commissioners of Human Services, Banking and Insurance, Commerce and Economic Development, and Labor, and the Health Information Electronic Data Interchange Policy Advisory Council established pursuant to P.L., c. (C.) (pending before the Legislature as Senate Bill No. 50 or Assembly Bill No.1476 of 1996), shall present an annual report to the Governor and the Legislature on Statewide health care expenditures based upon a survey of health care facilities and providers, health insurers, insurers writing automobile insurance and workers' compensation insurance, business and organized labor. The Commissioner of Health and Senior Services may contract with an independent agency or organization to conduct the survey and prepare the report.

The report shall include, at a minimum, the following: total health care expenditures Statewide; a breakdown of public and private expenditures and expenditures by type of health care service category, paralleling national health care expenditure categories utilized by the United States Health Care Financing Administration; a comparison of expenditures by category from the previous annual report to the current report; expenditure comparisons by category with the most recent national health care expenditure data available; identified means of achieving health care expenditure savings consistent with maintaining health care quality and access to services; and any recommendations for legislative or administrative action to effectuate these savings.

3. The Commissioner of Health and Senior Services shall include in the report prepared pursuant to section 2 of this act information about administrative cost savings achieved by acute care hospitals as a result of increased utilization of electronic data interchange

technology. The commissioner shall determine the specific information to be included in the report in consultation with the Health Information Electronic Data Interchange Policy Advisory Council established pursuant to P.L. , c. (C.)(pending before the Legislature as Senate Bill No. 50 or Assembly Bill No. 1476 of 1996). The commissioner shall solicit and be entitled to receive this information from each acute care hospital as part of the survey conducted pursuant to section 2 of this act.

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

4. This act shall take effect immediately.

STATEMENT

This bill requires the Commissioner of Health and Senior Services, in conjunction with the Commissioners of Human Services, Banking and Insurance, Commerce and Economic Development, and Labor, and the Healthcare Information Electronic Data Interchange Policy Advisory Council (which would be established by Senate Bill No. 50 (2R) Aca or Assembly Bill No. 1473 Aca of 1996), to present an annual report to the Governor and the Legislature on Statewide health care expenditures. The report would be based upon a survey of health care facilities and providers, health insurers, insurers writing automobile insurance and workers' compensation coverage, business and organized labor.

The bill further requires the Commissioner of Health and Senior Services to include in the annual report information about administrative cost savings achieved by acute care hospitals as a result of increased utilization of electronic data interchange technology. The commissioner is to determine the specific information to be included in the report in consultation with the Healthcare Information Electronic Data Interchange Policy Advisory Council. The commissioner will solicit and be entitled to receive this information from each acute care hospital as part of the survey conducted for the report.

This bill is part of a legislative package designed to effectuate the 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. The bill is intended to ensure a regular and formal follow-up by State government to the Statewide health care automation and cost survey conducted for the HINT report which will enable State policy makers to be apprised of the latest developments

with respect to Statewide health care expenditures and possible means 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.

AN ACT providing tax credits for certain costs of the purchase, lease or rental of electronic data interchange technology, supplementing P.L.1945, c.162 (C.54:10A-1 et seq.), P.L.1945, c.132 (C.54:18A-1 et seq.) and Title 54A of the New Jersey Statutes.

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

1. a. A taxpayer, except for a New Jersey S corporation, whose shareholders shall instead be allowed the credit provided by section 3 of P.L., c. (C.)(now pending before the Legislature as this bill), shall be allowed a credit against the tax liability imposed by section 5 of P.L.1945, c.162 (C.54:10A-5) in an amount equal to 10% of the costs of the taxpayer during a fiscal or calendar accounting year, referred to hereinafter in this section as a "tax year," beginning on or after January, 1, 1997 but before January 1, 1999, for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to store, retrieve and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the use of the technology in this State, provided that:

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

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

(3) The taxpayer is a health maintenance organization authorized to issue health benefits plans in this State; or

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

(5) The technology purchased, leased or rented is primarily used or intended for use, at a minimum, for one or more of the following applications in accordance with standards adopted by the Health Information Electronic Data Interchange Policy Council established pursuant to P.L....., c....., (C.....)(now pending before the Legislature as Senate, No. 50 or Assembly, No. 1476 of 1996), or if no standards have been adopted by the council, the American National Standards Institute: 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.

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

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

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

2. a. A taxpayer shall be allowed a credit against the tax liability imposed by P.L.1945, c.132 (C.54:18A-1 et seq.) in an amount equal to 10% of the costs of the taxpayer during a year, referred to hereinafter in this section as the "tax year," beginning on or after January 1, 1997 but before January 1, 1999, for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to store, retrieve and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the use of the technology in this State, provided that the technology purchased, leased or rented is primarily used or intended for use, at a minimum, for one or more of the following applications in accordance with standards adopted by the Health Information Electronic Data Interchange Policy Council established pursuant to P.L....., c....., (C.....)(now pending before the Legislature as Senate, No. 50 or Assembly, No. 1476 of 1996), or if no standards have been adopted by the council, the American National Standards Institute: 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.

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

b. The tax imposed for a year pursuant to P.L.1945, c.132 shall first be reduced by the amount of any credit allowed pursuant to this

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

3. a. A taxpayer shall be allowed a credit against the tax otherwise due pursuant to N.J.S.54A:1-1 et seq. in an amount equal to 10% of the costs of the taxpayer during a taxable year beginning on or after January 1, 1997 but before January 1, 1999, for the purchase, lease or rental by the taxpayer of electronic data interchange technology to be used to store, retrieve and transmit health care information, or such proportion of these costs as is determined by the director to be the proportion of the use of the technology in this State, provided that:

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

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

(3) The technology purchased, leased or rented is primarily used or intended for use, at a minimum, for one or more of the following applications in accordance with standards adopted by the Health Information Electronic Data Interchange Policy Council established pursuant to P.L....., c....., (C.....)(now pending before the Legislature as Senate, No. 50 or Assembly, No. 1476 of 1996), or if no standards have been adopted by the council, the American National Standards Institute: 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.

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

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

member’s or shareholder's taxable year.

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

d. The amount of the credit shall be applied during the taxable year in which the cost is incurred against any tax liability otherwise due before other credits permitted pursuant to law are applied. If the credit reduces the taxpayer’s tax liability to zero, the remaining amount of the credit shall not be considered an overpayment of the tax.

4. This act shall take effect immediately; and section 1 shall apply to the fiscal or calendar accounting years beginning on or after July 1, 1997, section 2 shall apply to calendar years beginning after July 1, 1997 , and section 3 shall apply to taxable years beginning on or after January 1, 1997.

STATEMENT

This bill provides 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, for the purchase, lease or rental of electronic data interchange (EDI) technology for use to store, retrieve and transmit health care information. The tax credits will be available for tax years beginning on or after January 1, 1997 but before January 1, 1999,

The bill 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 that 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 and to health care providers who are reimbursable by health care benefits payers. Finally, the bill 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 Health Information Electronic Data Interchange Council, established by Senate, No. 50 or Assembly, No. 1476 of 1996.

These tax credits are intended to provide a financial incentive for health care facilities and providers, third party payers and those who process claims for health care benefits or enrollments for health care benefits plans to purchase, lease or rent computer equipment and software that will permit electronic claims processing and other

electronic data exchanges. This will have the potential of significantly reducing health care administrative costs in this State, according to 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. This bill is part of a legislative package designed to effectuate the recommendations 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.

AN ACT concerning payment transactions by health care facilities and providers and supplementing Title 26 of the Revised Statutes.

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

1. As used in this act:

"Commissioner" means the Commissioner of Health.

"Electronic data interchange technology" means computer equipment or software which permits the electronic transmission of a business document in a standard format.

"Fund" means the Electronic Data Interchange Technology Development Fund established pursuant to this act.

"Health care facility" means a health care facility licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

“Health care provider” means a health care provider subject to regulation by a professional board pursuant to the provisions of Title 45 of the Revised Statutes, but excluding pharmacists.

2. There is established the Electronic Data Interchange Technology Development Fund in the Department of Health.

a. The fund shall be comprised of revenues from the automated transition incentive fee established pursuant to section 4 of this act and from such other sources as the Legislature may determine. Interest earned on the monies in the fund shall be credited to the fund.

Except as provided in subsection b. of this section, the fund shall be a nonlapsing fund dedicated for use by the State to provide low-interest loans to, and to support the issuance of bonds by, health care facilities and health care providers for the purpose of acquiring electronic data interchange technology to store, retrieve and transmit health care information.

b. Of the monies in the fund, 2.5% shall annually be allocated to the Health Information Electronic Data Interchange Policy Council established pursuant to P.L. , c. (C.)(pending before the Legislature as Senate Bill No. or Assembly Bill No. of 1996) to fund its administrative costs, out of which amount $250,000 shall be allocated to the New Jersey Institute of Technology and $250,000 shall be allocated to Thomas Edison State College for consulting services provided to the council; and 2.5% shall annually be used by the Department of Health for costs related to its survey and annual report on Statewide health care expenditures pursuant to P.L. , c. (C.)(pending before the Legislature as Senate Bill No. or Assembly Bill No. of 1996).

c. The fund shall be administered by a person appointed by the commissioner or an agency designated by the commissioner. The

administrator of the fund is responsible for overseeing and coordinating the collection and disbursement of fund monies. The administrator is responsible for promptly informing the commissioner if monies are not or are not reasonably expected to be collected or disbursed.

3. Bonds issued pursuant to this act shall not be deemed to constitute a debt or liability of the State or of any political subdivision thereof, nor a pledge of the faith and credit of the State or of any such political subdivision, but shall be payable solely from the funds provided pursuant to this act. The bonds shall contain on the face thereof a statement to the effect that neither the State of New Jersey nor any political subdivision thereof shall be obligated to pay the same or the interest thereon and that neither the faith and credit nor the taxing power of the State of New Jersey or of any political subdivision thereof is pledged to the payment of the principal of or the interest on the bonds. The issuance of bonds pursuant to this act shall not directly or indirectly or contingently obligate the State or any political subdivision thereof to levy or to pledge any form of taxation whatever therefor.

4. a. Effective July 1, 1996, the commissioner shall assess each health care facility and health care provider an automated transition incentive fee of $0.50 on every paper-based payment transaction and $0.10 on every electronically automated payment transaction, the proceeds from which shall be deposited in the fund.

b. The provisions of subsection a. of this section are subject to federal approval with respect to payment transactions in connection with patients covered by the federal Medicare program established pursuant to the federal Social Security Act, Pub.L.89-97 (42 U.S.C.§1395 et seq.) and the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

5. The commissioner shall establish the criteria for determining eligibility for financial assistance provided to a health care facility or a health care provider from the fund and the terms and conditions of that assistance, for which purpose the commissioner shall consult, at a minimum, with the following organizations: the New Jersey Hospital Association, the Medical Society of New Jersey, the Hospital Alliance of New Jersey, the New Jersey Association of Health Care Facilities, the New Jersey Association of Non-Profit Homes for the Aging, and the Home Health Agency Assembly of New Jersey, Inc.

6. The commissioner shall report annually to the Governor and the Legislature on the activities of the fund and the results of the fund in meeting its objectives.

7. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

8. This act shall take effect immediately.

STATEMENT

This bill establishes the Electronic Data Interchange Technology Development Fund in the Department of Health to provide low-interest loans to, and to support the issuance of bonds by, health care facilities and providers for the purpose of acquiring electronic data interchange technology to store, retrieve and transmit health care information. The fund shall be comprised of revenues from an automated transition incentive fee to be assessed against health care facilities and providers of $0.50 on every paper-based payment transaction and $0.10 on every electronically automated payment transaction, which takes effect July 1, 1996 (subject to federal approval for Medicare and Medicaid patient-related payment transactions), and from such other sources as the Legislature may determine, plus interest earned on the monies in the fund.

The bill exempts pharmacists from the automated transition incentive fee because they have largely made the transition to automated transactions already. According to 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, 89% of pharmacies surveyed by the HINT project are computerized (the highest percentage among all components of the health care industry), compared with only 38% of physicians and 37% of payers.

This bill is part of a legislative package designed to effectuate the recommendations of the HINT report. The bill is intended to provide a financial incentive for health care facilities and providers to purchase computer equipment and software that will permit electronic claims processing and other electronic data exchanges, which have the potential to significantly reduce health care administrative costs in this 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.

AN ACT requiring prompt payment of health insurance claims, supplementing P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.) and P.L.1985, c.236 (C.17:48E-1 et seq.), and amending P.L.1991, c.187.

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

1. (New section) a. A hospital service corporation shall reimburse all claims or any portion of any claim from a subscriber or a subscriber's assignee, for payment under a group or individual hospital service corporation contract, within 30 days after receipt of the claim by the hospital service corporation. If a claim or a portion of a claim is contested by the hospital service corporation, the subscriber or the subscriber's assignee shall be notified in writing within 25 days after receipt of the claim by the hospital service corporation, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within 30 days after receipt of the claim by the hospital service corporation. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

A hospital service corporation, upon receipt of the additional information requested from the subscriber or the subscriber's assignee, shall pay or deny the contested claim or portion of the contested claim, within 45 days.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery, or the date of electronic fund transfer.

A subscriber or a subscriber's assignee shall provide written notice of a claim to a hospital service corporation no later than 21 days following the commencement of health care services, and every bill or invoice shall be submitted to the hospital service corporation: (1) if submitted by the subscriber's assignee, within 30 days of the date on which any health care services included in the bill or invoice were provided; or (2) if submitted by a subscriber, within 10 days of the receipt of the bill or invoice from the provider of services.

b. An overdue payment shall bear simple interest, commencing on the 31st day after the claim is submitted, at the periodic rate for any calendar quarter which shall not exceed the prime rate as published in the <u>Wall Street Journal</u> on the first business day of the immediately 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 <u>thus</u> is new matter.

nearest one quarter of 1%, per annum.

c. The Department of Insurance shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

2. (New section) a. A medical service corporation shall reimburse all claims or any portion of any claim from a subscriber or a subscriber's assignee, for payment under a group or individual medical service corporation contract, within 30 days after receipt of the claim by the medical service corporation. If a claim or a portion of a claim is contested by the medical service corporation, the subscriber or the subscriber's assignee shall be notified in writing within 25 days after receipt of the claim by the medical service corporation, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within 30 days after receipt of the claim by the medical service corporation. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

A medical service corporation, upon receipt of the additional information requested from the subscriber or the subscriber's assignee, shall pay or deny the contested claim or portion of the contested claim, within 45 days.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery, or the date of electronic fund transfer.

A subscriber or a subscriber's assignee shall provide written notice of a claim to a medical service corporation no later than 21 days following the commencement of health care services, and every bill or invoice shall be submitted to the medical service corporation: (1) if submitted by the subscriber's assignee, within 30 days of the date on which any health care services included in the bill or invoice were provided; or (2) if submitted by a subscriber, within 10 days of the receipt of the bill or invoice from the provider of services.

b. An overdue payment shall bear simple interest, commencing on the 31st day after the claim is submitted, at the periodic rate for any calendar quarter which shall not exceed the prime rate as published in the Wall Street Journal on the first business day of the immediately preceding calendar quarter plus an additional 5%, rounded to the nearest one quarter of 1%, per annum.

c. The Department of Insurance shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

3. (New section) a. A health service corporation shall reimburse

all claims or any portion of any claim from a subscriber or a subscriber's assignee, for payment under a group or individual health service corporation contract, within 30 days after receipt of the claim by the health service corporation. If a claim or a portion of a claim is contested by the health service corporation, the subscriber or the subscriber's assignee shall be notified in writing within 25 days after receipt of the claim by the health service corporation, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within 30 days after receipt of the claim by the health service corporation. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

A health service corporation, upon receipt of the additional information requested from the subscriber or the subscriber's assignee, shall pay or deny the contested claim or portion of the contested claim, within 45 days.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery, or the date of electronic fund transfer.

A subscriber or a subscriber's assignee shall provide written notice of a claim to a health service corporation no later than 21 days following the commencement of health care services, and every bill or invoice shall be submitted to the health service corporation: (1) if submitted by the subscriber's assignee, within 30 days of the date on which any health care services included in the bill or invoice were provided; or (2) if submitted by a subscriber, within 10 days of the receipt of the bill or invoice from the provider of services.

b. An overdue payment shall bear simple interest, commencing on the 31st day after the claim is submitted, at the periodic rate for any calendar quarter which shall not exceed the prime rate as published in the Wall Street Journal on the first business day of the immediately preceding calendar quarter plus an additional 5%, rounded to the nearest one quarter of 1%, per annum.

c. The Department of Insurance shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

4. Section 78 of P.L.1991, c.187 (C.17B:26-12.1) is amended to read as follows:

78. a. A health insurer shall reimburse all claims or any portion of any claim from an insured or an insured's assignee, for payment under a health insurance policy, within [60] 30 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignee

shall be notified in writing within [45] 25 days after receipt of the claim by the health insurer, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within [60] 30 days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

A health insurer, upon receipt of the additional information requested from the insured or the insured's assignee, shall pay or deny the contested claim or portion of the contested claim, within [90] 45 days.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery, or the date of electronic fund transfer.

An insured or an insured's assignee shall provide written notice of a claim to a health insurer no later than 21 days following the commencement of health care services, and every bill or invoice shall be submitted to the health insurer: (1) if submitted by the insured's assignee, within 30 days of the date on which any health care services included in the bill or invoice were provided; or (2) if submitted by an insured, within 10 days of the receipt of the bill or invoice from the provider of services.

b. An overdue payment shall bear simple interest [at the rate of 10% per year], commencing on the 31st day after the claim is submitted, at the periodic rate for any calendar quarter which shall not exceed the prime rate as published in the Wall Street Journal on the first business day of the immediately preceding calendar quarter plus an additional 5%, rounded to the nearest one quarter of 1%, per annum.

c. For the purposes of this section, "health insurer" means an insurer authorized to provide health insurance on an individual basis pursuant to chapter 26 of Title 17B of the New Jersey Statutes.

d. The Department of Insurance shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

(cf: P.L.1991, c.187, s.78)

5. Section 79 of P.L.1991, c.187 (C.17B:27-44.1) is amended to read as follows:

79. a. A health insurer shall reimburse all claims or any portion of any claim from an insured or an insured's assignee, for payment under a health insurance policy, within [60] 30 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignee shall be notified in writing within [45] 25 days after receipt of the

claim by the health insurer, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within **[**60**]** 30 days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

A health insurer, upon receipt of the additional information requested from the insured or the insured's assignee, shall pay or deny the contested claim or portion of the contested claim, within **[**90**]** 45 days.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery, or the date of electronic fund transfer.

An insured or an insured's assignee shall provide written notice of a claim to a health insurer no later than 21 days following the commencement of health care services, and every bill or invoice shall be submitted to the health insurer: (1) if submitted by the insured's assignee, within 30 days of the date on which any health care services included in the bill or invoice were provided; or (2) if submitted by an insured, within 10 days of the receipt of the bill or invoice from the provider of services.

b. An overdue payment shall bear simple interest **[**at the rate of 10% per year**]**, commencing on the 31st day after the claim is submitted, at the periodic rate for any calendar quarter which shall not exceed the prime rate as published in the Wall Street Journal on the first business day of the immediately preceding calendar quarter plus an additional 5%, rounded to the nearest one quarter of 1%, per annum.

c. For the purposes of this section, "health insurer" means an insurer authorized to provide health insurance on a group basis pursuant to chapter 27 of Title 17B of the New Jersey Statutes.

d. The Department of Insurance shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

(cf: P.L.1991, c.187, s.79)

6. Section 80 of P.L.1991, c.187 (C.26:2J-5.1) is amended to read as follows:

80. a. A health maintenance organization shall reimburse all claims or any portion of any claim from an enrollee or an enrollee's assignee, for payment under health maintenance organization coverage, within **[**60**]** 30 days after receipt of the claim by the health maintenance organization. If a claim or a portion of a claim is contested by the health maintenance organization, the enrollee or the enrollee's assignee shall be notified in writing within **[**45**]** 25 days after receipt of the

claim by the health maintenance organization, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within [60] 30 days after receipt of the claim by the health maintenance organization. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

A health maintenance organization, upon receipt of the additional information requested from the enrollee or the enrollee's assignee, shall pay or deny the contested claim or portion of the contested claim, within [90] 45 days.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery, or the date of electronic fund transfer.

An enrollee or an enrollee's assignee shall provide written notice of a claim to a health maintenance organization no later than 21 days following the commencement of health care services, and every bill or invoice shall be submitted to the health maintenance organization: (1) if submitted by the enrollee's assignee, within 30 days of the date on which any health care services included in the bill or invoice were provided; or (2) if submitted by an enrollee, within 10 days of the receipt of the bill or invoice from the provider of services.

b. An overdue payment shall bear simple interest [at the rate of 10% per year], commencing on the 31st day after the claim is submitted, at the periodic rate for any calendar quarter which shall not exceed the prime rate as published in the Wall Street Journal on the first business day of the immediately preceding calendar quarter plus an additional 5%, rounded to the nearest one quarter of 1%, per annum.

c. For the purposes of this section, "health maintenance organization" means a health maintenance organization authorized pursuant to the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.).

d. The Department of Health shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

(cf: P.L.1991, c.187, s.80)

7. This act shall take effect immediately.

STATEMENT

This bill amends the "prompt payment" requirements of the "Health Care Cost Reduction Act," P.L.1991, c.187 (C.26:2H-18.24 et al.) to require that all uncontested health insurance claims be paid by

commercial health insurers and health maintenance organizations (HMO's) within 30 days (rather than 60 days as the law currently provides). The bill would also implement these prompt payment requirements for other carriers. In addition, the bill requires that written notice of a claim be provided to a carrier no later than 21 days following the commencement of health care services, and further requires timely submission of bills and invoices to the carrier.

This bill is intended to motivate health insurers and HMO's to implement electronic claims processing systems, which will result in administrative savings for health insurers and HMO's by reducing their claim processing costs and for health care providers by improving their cash flow. The bill is part of a legislative package designed to effectuate the 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.

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.

AN ACT concerning the resolution of certain health care claim payment disputes and supplementing various parts of the statutory law.

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

1. a. A hospital service corporation shall adopt and, after approval by the Commissioner of Insurance pursuant to subsection b. of this section, implement a procedure which shall be used to resolve billing and payment disputes between health care providers or covered individuals and the corporation . If a dispute is between a health care provider and the corporation, the procedure shall provide for direct communication between the provider and the hospital service corporation and shall not require any action by the covered individual after initial verification that the covered individual received the services or treatment which are the subject of the dispute. When the corporation notifies a provider or individual of a billing or payment dispute, the corporation shall notify the provider or covered individual of the internal appeal process implemented pursuant to this section.

The procedure shall include an internal appeal process by which the hospital service corporation, the provider or the covered individual may request an independent review of the initial resolution of the dispute by an arbitrator or independent review organization agreed upon by the parties to the appeal. The decision of the arbitrator or review organization, as appropriate, shall be binding on the provider and hospital service corporation. The internal appeal process shall apply only for health benefits contracts issued, delivered, executed or renewed after the approval of the the procedure by the Commissioner of Insurance pursuant to subsection b. of this section.

b. A hospital service corporation shall, within 120 days of the adoption of regulations by the commissioner pursuant to this act, file its internal dispute resolution procedure with the commissioner. The procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within that 120 days. During the 120-day review period, the commissioner may request such amendments to the procedure as the commissioner deems necessary. Any subsequent amendments to a filed and approved procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within 120 days from the filing date.

2. a. A medical service corporation shall adopt and, after approval by the Commissioner of Insurance pursuant to subsection b. of this section, implement a procedure which shall be used to resolve billing and payment disputes between health care providers or covered individuals and the corporation. If a dispute is between a health care

provider and the corporation, the procedure shall provide for direct communication between the provider and the medical service corporation and shall not require any action by the covered individual after initial verification that the covered individual received the services or treatment which are the subject of the dispute. When the corporation notifies a provider or individual of a billing or payment dispute, the corporation shall notify the provider or covered individual of the internal appeal process implemented pursuant to this section.

The procedure shall include an internal appeal process by which the medical service corporation, the provider or the covered individual may request an independent review of the initial resolution of the dispute by an arbitrator or independent review organization agreed upon by the parties to the appeal.

The decision of the arbitrator or review organization, as appropriate, shall be binding on the provider and medical service corporation. The internal appeal process shall apply only for health benefits contracts issued, delivered, executed or renewed after the approval of the the procedure by the Commissioner of Insurance pursuant to subsection b. of this section.

b. A medical service corporation shall, within 120 days of the adoption of regulations by the commissioner pursuant to this act, file its internal dispute resolution procedure with the commissioner. The procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within that 120 days. During the 120-day review period, the commissioner may request such amendments to the procedure as the commissioner deems necessary. Any subsequent amendments to a filed and approved procedure shall be deemed approved120 days after filing if not affirmatively approved or disapproved within 120 days from the filing date.

3. a. A health service corporation shall adopt and, after approval by the Commissioner of Insurance pursuant to subsection b. of this section, implement a procedure which shall be used to resolve billing and payment disputes between health care providers or covered individuals and the corporation. If a dispute is between a health care provider and the corporation, the procedure shall provide for direct communication between the provider and the health service corporation and shall not require any action by the covered individual after initial verification that the covered individual received the services or treatment which are the subject of the dispute.When the corporation notifies a provider or individual of a billing or payment dispute, the corporation shall notify the provider or covered individual of the internal appeal process implemented pursuant to this section.

The procedure shall include an internal appeal process by which the health service corporation, the provider or the covered individual may request an independent review of the initial resolution of the dispute

by an arbitrator or independent review organization agreed upon by the parties to the appeal.

The decision of the arbitrator or review organization, as appropriate, shall be binding on the provider and health service corporation.The internal appeal process shall apply only for health benefits contracts issued, delivered, executed or renewed after the approval of the the procedure by the Commissioner of Insurance pursuant to subsection b. of this section.

b. A health service corporation shall, within 120 days of the adoption of regulations by the commissioner pursuant to this act, file its internal dispute resolution procedure with the commissioner. The procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within that 120 days. During the120-day review period, the commissioner may request such amendments to the procedure as the commissioner deems necessary. Any subsequent amendments to a filed and approved procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within 120 days from the filing date.

4. a. An insurer issuing individual health insurance policies shall adopt and, after approval by the Commissioner of Insurance pursuant to subsection b. of this section, implement a procedure which shall be used to resolve billing and payment disputes between health care providers or covered individuals and the insurer. If a dispute is between a health care provider and the corporation, the procedure shall require direct communication between the provider and the health insurer and shall not require any action by the covered individual after initial verification that the covered individual received the services or treatment which are the subject of the dispute. When the insurer notifies a provider or individual of a billing or payment dispute, the insurer shall notify the provider or covered individual of the internal appeal process implemented pursuant to this section.

The procedure shall include an internal appeal process by which the insurer, the provider or the covered individual may request an independent review of the initial resolution of the dispute by an arbitrator or independent review organization agreed upon by the parties to the appeal.

The decision of the arbitrator or review organization, as appropriate, shall be binding on the provider and insurer. The internal appeal process shall apply only for health benefits contracts issued, delivered, executed or renewed after the approval of the the procedure by the Commissioner of Insurance pursuant to subsection b. of this section.

b. A health insurer shall, within 120 days of the adoption of regulations by the commissioner pursuant to this act, file its internal dispute resolution procedure with the commissioner. The procedure

shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within that 120 days. During the 120-day review period, the commissioner may request such amendments to the procedure as the commissioner deems necessary. Any subsequent amendments to a filed and approved procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within 120 days from the filing date.

5. a. An insurer issuing group health insurance policies shall adopt and, after approval by the Commissioner of Insurance pursuant to subsection b. of this section, implement a procedure which shall be used to resolve billing and payment disputes between health care providers or covered individuals and the insurer. If a dispute is between a health care provider and the corporation, the procedure shall require direct communication between the provider and the health insurer and shall not require any action by the covered individual after initial verification that the covered individual received the services or treatment which are the subject of the dispute. When the insurer notifies a provider or individual of a billing or payment dispute, the insurer shall notify the provider or covered individual of the internal appeal process implemented pursuant to this section.

The procedure shall include an internal appeal process by which the insurer, the provider or the covered individual may request an independent review of the initial resolution of the dispute by an arbitrator or independent review organization agreed upon by the parties to the appeal.

The decision of the arbitrator or review organization, as appropriate, shall be binding on the provider and insurer. The internal appeal process shall apply only for health benefits contracts issued, delivered, executed or renewed after the approval of the the procedure by the Commissioner of Insurance pursuant to subsection b. of this section.

b. A health insurer shall, within 120 days of the adoption of regulations by the commissioner pursuant to this act, file its internal dispute resolution procedure with the commissioner. The procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within that 120 days. During the 120-day review period, the commissioner may request such amendments to the procedure as the commissioner deems necessary. Any subsequent amendments to a filed and approved procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within 120 days from the filing date.

6. a. A dental service corporation shall adopt and, after approval by the Commissioner of Insurance pursuant to subsection b. of this section, implement a procedure which shall be used to resolve billing

and payment disputes between health care providers or covered individuals and the corporation. If a dispute is between a health care provider and the corporation, the procedure shall provide for direct communication between the provider and the dental service corporation and shall not require any action by the covered individual after initial verification that the covered individual received the services or treatment which are the subject of the dispute. When the corporation notifies a provider or individual of a billing or payment dispute, the corporation shall notify the provider or covered individual of the internal appeal process implemented pursuant to this section.

The procedure shall include an internal appeal process by which the dental service corporation, the provider or the covered individual may request an independent review of the initial resolution of the dispute by an arbitrator or independent review organization agreed upon by the parties to the appeal.

The decision of the arbitrator or review organization, as appropriate, shall be binding on the provider and health maintenance organization. The internal appeal process shall apply only for health benefits contracts issued, delivered, executed or renewed after the approval of the the procedure by the Commissioner of Insurance pursuant to subsection b. of this section.

b. A dental service corporation shall, within 120 days of the adoption of regulations by the commissioner pursuant to this act, file its internal dispute resolution procedure with the commissioner. The procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within that 120 days. During the 120-day review period, the commissioner may request such amendments to the procedure as the commissioner deems necessary. Any subsequent amendments to a filed and approved procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within 120 days from the filing date.

7. a. A dental plan organization shall adopt and, after approval by the Commissioner of Insurance pursuant to subsection b. of this section, implement a procedure which shall be used to resolve billing and payment disputes between health care providers or covered individuals and the organization. If a dispute is between a health care provider and the corporation, the procedure shall provide for direct communication between the provider and the dental plan organization and shall not require any action by the covered individual after initial verification that the covered individual received the services or treatment which are the subject of the dispute. When the organization notifies a provider or individual of a billing or payment dispute, the organization shall notify the provider or covered individual of the internal appeal process implemented pursuant to this section.

The procedure shall include an internal appeal process by which the

dental plan organization, the provider or the covered individual may request an independent review of the initial resolution of the dispute by an arbitrator or independent review organization agreed upon by the parties to the appeal.

The decision of the arbitrator or review organization, as appropriate, shall be binding on the provider and dental plan organization. The internal appeal process shall apply only for health benefits contracts issued, delivered, executed or renewed after the approval of the the procedure by the Commissioner of Insurance pursuant to subsection b. of this section.

b. A dental plan organization shall, within 120 days of the adoption of regulations by the commissioner pursuant to this act, file its internal dispute resolution procedure with the commissioner. The procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within that 120 days. During the 120-day review period, the commissioner may request such amendments to the procedure as the commissioner deems necessary. Any subsequent amendments to a filed and approved procedure shall be deemed approved 120 days after filing if not affirmatively approved or disapproved within 120 days from the filing date.

8. The Commissioner of Insurance shall promulgate rules pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.

9. This act shall take effect immediately.

STATEMENT

This bill provides for the resolution of billing and payment disputes between insurers and health care providers or covered individuals. It requires hospital, medical and health service corporations, commercial health insurers, dental plan organizations and dental service corporations to adopt and implement, after approval by the Commissioner of Insurance, a procedure that will be used to resolve billing and payment disputes between the provider or covered individuals and the payer. The Commissioner of Insurance has 120 days to review dispute resolution procedures; require the dispute resolution procedures to include disputes with covered individuals; require the decision of an arbitrator or independent review organization to be binding only for contracts issued, delivered, executed, or renewed after the approval of dispute resolution procedures by the commissioner; and require a health care insurer to notify a provider or covered individual of the appeal process established in compliance with the bill in the event of a dispute. The

bill requires direct communication between the provider and the insurer if the dispute is between these two parties and provides that the covered individual will not be required to take any action to rectify the problem, other than verify that the services or treatment were received.

The bill also requires that the procedure include an appeal process whereby the insurer, the provider or the covered individual may request an independent review of the initial resolution of the dispute by an arbitrator or independent review organization, agreed upon by the parties to the appeal. The decision of the arbitrator or review organization, as appropriate, will be binding on the provider and carrier. This appeal process will only apply to health benefits contracts issued, delivered, executed or renewed after the approval of the dispute resolution.

This bill is part of a legislative package designed to effectuate the 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.

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.

AN ACT requiring health insurers and certain health care benefits claims processors to receive and transmit health care claim information electronically and supplementing various parts of statutory law.

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

1. Within 90 days of the promulgation of demonstration standards and a timetable for implementation by the Commissioner of Banking and Insurance pursuant to section 7 of this act, a hospital service corporation, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the commissioner that it will adopt and implement the demonstration standards, according to the corresponding timetable, to receive, transmit and store health care claim information electronically, as a condition of its continued authorization to transact business in this State.

The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a hospital service corporation, its subsidiary or its covered individuals.

2. Within 90 days of the promulgation of demonstration standards and a timetable for implementation by the Commissioner of Banking and Insurance pursuant to section 7 of this act, a medical service corporation, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the commissioner that it will adopt and implement the demonstration standards, according to the corresponding timetable, to receive, transmit and store health care claim information electronically, as a condition of its continued authorization to transact business in this State.

The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a medical service corporation, its subsidiary or its covered individuals.

3. Within 90 days of the promulgation of demonstration standards and a timetable for implementation by the Commissioner of Banking and Insurance pursuant to section 7 of this act, a health service corporation , or a subsidiary that processes health care benefits claims

as a third party administrator, shall demonstrate to the satisfaction of the commissioner that it will adopt and implement the demonstration standards, according to the corresponding timetable, to receive, transmit and store health care claim information electronically, as a condition of its continued authorization to transact business in this State.

The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health service corporation, its subsidiary or its covered individuals.

4. Within 90 days of the promulgation of demonstration standards and a timetable for implementation by the Commissioner of Banking and Insurance pursuant to section 7 of this act, a health insurer issuing individual health insurance policies, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the commissioner that it will adopt and implement the demonstration standards, according to the corresponding timetable, to receive, transmit and store health care claim information electronically, as a condition of its continued authorization to transact business in this State.

The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health insurer, its subsidiary or its covered individuals.

5. Within 90 days of the promulgation of demonstration standards and a timetable for implementation by the Commissioner of Banking and Insurance pursuant to section 7 of this act, a health insurer issuing group health insurance policies, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the commissioner that it will adopt and implement the demonstration standards, according to the corresponding timetable, to receive, transmit and store health care claim information electronically, as a condition of its continued authorization to transact business in this State.

The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health insurer, its subsidiary or its covered individuals.

6. Within 90 days of the promulgation of demonstration standards

and a timetable for implementation by the Commissioner of Banking and Insurance pursuant to section 7 of this act, a health maintenance organization, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the commissioner that it will adopt and implement the demonstration standards, according to the corresponding timetable, to receive, transmit and store health care claim information electronically as a condition of its continued authorization to operate in this State.

The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health maintenance organization, its subsidiary or its enrollees.

7. a. The Commissioner of Banking andInsurance, in consultation with the Healthcare Information Electronic Data Interchange Policy Advisory Council established pursuant to P.L., c. (C.)(now before the Legislature as Senate, No. 50 of 1996), shall establish demonstration standards, along with a timetable for implementation, for the electronic receipt, transmission and storage of health care claim information by hospital service, medical service and health service corporations, health insurers, health maintenance organizations, dental service corporations and dental plan organizations, respectively , or subsidiaries of such corporations, insurers or organizations that process health care benefits claims as third party administrators. The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a hospital service, medical service, or health service corporation, health insurer, dental service corporation, dental plan organization, or health maintenance organization, its subsidiary or its covered individuals or enrollees.

b. In establishing these standards, the commissioner shall:

(1) Encourage the use of an electronic data interchange (EDI) network developed in consultation with the council pursuant to P.L. , c. (C.)(now before the Legislature as Senate, No. 50 of 1996);

(2) Encourage hospital service, medical service and health service corporations, health insurers, health maintenance organizations, dental service corporations and dental plan organizations, or subsidiaries of such corporations, insurers or organizations that process health care benefits claims as third party administrators to issue patient identification cards or systems , such as magnetic stripe, "smart cards," or other patient identification technology, to covered individuals; and

(3) Encourage and facilitate the development of privately owned and operated secure networks which are interconnected and available

to all participants in the health care services delivery process.

c. The timetable for implementation promulgated by the commissioner shall provide for extensions and waivers of the implementation requirement pursuant to subsection a. of this section.

d. The commissioner shall report annually to the policy council, the Legislature and the Governor on progress made in the implementation of these demonstration standards in this State.

8. Within 90 days of the promulgation of demonstration standards and a timetable for implementation by the Commissioner of Banking and Insurance pursuant to section 7 of this act, a dental plan organization, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the commissioner that it will adopt and implement the demonstration standards, according to the corresponding timetable, to receive, transmit and store health care claim information electronically as a condition of its continued authorization to operate in this State.

The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a dental plan organization, its subsidiary or its enrollees.

9. Within 90 days of the promulgation of demonstration standards and a timetable for implementation by the Commissioner of Banking and Insurance pursuant to section 7 of this act, a dental service corporation, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the commissioner that it will adopt and implement the demonstration standards, according to the corresponding timetable, to receive, transmit and store health care claim information electronically as a condition of its continued authorization to operate in this State.

The commissioner may, in the commissioner's discretion, grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a dental service corporation, its subsidiary or its subscribers.

10. The commissioner shall promulgate regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the provisions of this act.

11. This act shall take effect immediately.

STATEMENT

This bill requires hospital, medical or health service corporations, commercial health insurers, health maintenance organizations (HMO's), dental plan organizations and dental service corporations, or their subsidiaries that process health benefits claims as third party administrators, to demonstrate that they will adopt and implement standards established by the Commissioner of Banking and Insurance to receive, transmit and store health care claim information electronically.

The Commissioner of Banking and Insurance, in consultation with the Healthcare Information Electronic Data Interchange Policy Advisory Council (which would be established by Senate Bill No. 50 (2R) Aca or Assembly Bill No. 1473 Aca of 1996, which were reported by the committee on this date), will establish these demonstration standards, along with a timetable for adoption and implementation. The bill authorizes the commissioner to grant extensions or waivers of the implementation requirement if it is demonstrated that compliance with the timetable for implementation will result in an undue hardship to a carrier, subsidiary or its covered individuals or enrollees.

The bill directs the commissioner, in establishing the standards, to:

(1) Encourage the use of the electronic data interchange (EDI) network;

(2) Encourage carriers to issue patient identification cards or systems to covered individuals; and

(3) Encourage and facilitate the development of privately owned and operated secure networks which are interconnected and available to all participants in the health care services delivery process.

This bill is part of a legislative package designed to effectuate the 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.

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.

AN ACT requiring health insurers and certain subsidiaries of insurers to use standard enrollment and claim forms and supplementing various parts of the statutory law.

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

1. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, a hospital service corporation or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms promulgated pursuant to section 7 of this act in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

2. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to2 this act, a medical service corporation or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms promulgated pursuant to section 7 of this act in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

3. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, a health service corporation or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms promulgated pursuant to section 7 of this act in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

4. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, a health insurer or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms promulgated pursuant to section 7 of this act in connection with all individual policies issued, delivered, executed or renewed in this State.

5. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, a health insurer or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms promulgated pursuant to section 7 of this act in connection with all group policies issued, delivered, executed or renewed in this State.

6. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, a health maintenance organization or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms promulgated pursuant to section 7 of this act in connection with all contracts for health care services issued, delivered, executed or renewed in this State.

7. a. The Commissioner of Banking and Insurance shall promulgate regulations to establish one set of standard health care enrollment and claim forms in paper or electronic format to be used by all hospital service, medical service and health service corporations, all health insurers all health maintenance organizations , all dental service corporations, all dental plan organizations , or subsidiaries that process health care benefits claims as third party administrators, and all insurers writing automobile insurance and workers' compensation coverage, or a subsidiary of an insurer writing worker's compensation coverage that processes health care benefits claims as a third party administrator, authorized to do business in this State.

b. In developing and promulgating the forms, the commissioner shall:

(1) Consult with the Healthcare Information Electronic Data Interchange Policy Advisory Council established pursuant to P.L., c. (C.) (now pending before the Legislature as Senate, No. 50 of 1996);

(2) Consult with the boards of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program and with respect to claim forms, take into consideration the claim forms adopted by those programs pursuant to section 11 of P.L.1993, c.164 (C.17B:27A-16.4) and section 29 of P.L.1992, c.162 (C.17B:27A-45), respectively; and

(3) Use national standards for electronic data interchange (EDI) as recommended by the advisory council and the boards of the two programs.

8. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, a dental plan organization or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms promulgated pursuant to section 7 of this act in connection with all contracts for health care services issued, delivered, executed or renewed in this State.

9. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, a dental service corporation or a subsidiary that processes health care benefits

claims as a third party administrator shall use the standard health care enrollment and claim forms promulgated pursuant to section 7 of this act in connection with all contracts for dental services issued, delivered, executed or renewed in this State.

10. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, an insurer authorized to write automobile insurance pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) shall use the standard health care claim forms promulgated pursuant to section 7 of this act in connection with all its claims for health care services in this State.

11. Within 12 months of the promulgation of regulations by the Commissioner of Banking and Insurance pursuant to this act, an insurer authorized to transact the business of workers' compensation insurance pursuant to Chapter 15 of Title 34 of the Revised Statutes, or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard claim forms promulgated pursuant to section 7 of this act in connection with all claims for health care services in this State.

12. The commissioner shall promulgate regulations to effectuate the purposes of this act pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

13. This act shall take effect immediately.

STATEMENT

This bill requires hospital, medical or health service corporations, commercial health insurers, dental plan organizations, dental service corporations, insurers who write automobile or workers' compensation insurance and health maintenance organizations (HMO's), and their subsidiaries that process health care benefits claims as third party administrators, to use standard enrollment and claim forms for paper and electronic transactions in connection with all policies and contracts for health care benefits within 12 months after the promulgation of regulations for such forms by the commissioner.

In promulgating the regulations, the commissioner is required to consult with the Healthcare Information Electronic Data Interchange Policy Council (to be established by Senate, No. 50 or Assembly, No. 1473 of 1996, now pending before the Legislature) which includes representatives from among the various types of health care benefit providers who would be required to use the forms. The commissioner is also required to consult with the boards of the New Jersey

Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program and take into consideration the claim forms adopted by those programs. The commissioner will use national standards for electronic data interchange (EDI) as recommended by the policy council and the program boards.

This bill is part of a legislative package designed to effectuate the 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.

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.

AN ACT creating the Health Information Electronic Data Interchange Policy Advisory Council in the Department of Health and Senior Services, and supplementing Title 26 of the Revised Statutes.

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

1. The Legislature finds and declares that:

a. The delivery of health care services and payment for those services is often a fragmented process, sometimes inaccurately described as a "system," that is comprised of health care providers, insurance carriers or other benefit payers, employers who provide the insurance or other benefit plans under which their employees are covered, and patients, who are, ultimately, the consumers.

b. These various sectors perform separate, but interdependent functions in the health care service delivery process, and while they may perceive themselves and operate as economically independent units, they are nevertheless functionally dependent in providing or consuming health care services for which they then expect prompt payment.

c. While the technology exists to advance communication in every sector of this process, each sector operates as a computerized information island, fully functional in itself but without the ability or motivation for computer-to-computer communication with other such islands.

d. As a result, despite the available technology, a plethora of bills can emanate from even relatively simple diagnostic or treatment services and the resulting massive flow of information, on paper, creates much of the increasing administrative burden placed on the system.

e. It has been estimated that the health care industry in New Jersey currently processes 150 million health care claims annually, 85% of which are on paper, and that significant administrative cost savings could be realized with the use of standardized enrollment and claim forms, standardized health care communication protocols and the use of electronic data interchange, or EDI, to receive, transmit and store medical and claims information.

f. Thus, while state-of-the-art technology is the expected norm in the diagnosis and treatment of illness and injury, in terms of recording, routing and paying for those services, the several parties to the process are using the venerable "paper trail" for billing purposes, which allows them to avoid communicating in a more efficient manner.

g. Given the multiple parties and divergent interests which are involved in and affected by the health care services delivery process, a council representing those various interests and concerns, to assist in the development of standards for an effective electronic data

interchange network for use by the various parties; and to assist and enable them to achieve some commonality of purpose in the exchange of such information, is necessary and appropriate if the citizens of New Jersey are to benefit from the efficiencies and economies such an interchange can effect.

2. The Health Information Electronic Data Interchange Policy Advisory Council, hereinafter referred to as the council, is created in the Executive Branch of State Government. For the purposes of complying with the provisions of Article V, Section IV, paragraph 1 of the New Jersey Constitution, the council is allocated within the Department of Health and Senior Services, but notwithstanding this allocation, the council shall be independent of any supervision or control by the department or by any board or officer thereof, and shall request appropriations for its expenses independently therefrom.

3. The council shall consist of 31 members, as follows:

a. The Commissioner of Health and Senior Services or the commissioner's designee, ex officio, who shall serve as chairman of the council;

b. The Commissioner of Banking and Insurance or the commissioner's designee, ex officio;

c. The Commissioner of Human Services or the commissioner's designee, ex officio;

d. The State Treasurer or the State Treasurer's designee, ex officio;

e. The Attorney General or the Attorney General's designee, ex officio;

f. The Director of the Division of Pensions and Benefits, in the director's capacity as the secretary to the State Health Benefits Commission or the secretary's designee, ex officio;

g. The President of the New Jersey Hospital Association, or the President's designee, ex officio;

h. The President of the University of Medicine and Dentistry of New Jersey, or the President's designee, ex officio;

i. The President of Thomas Edison State College or the President's designee, ex officio;

j. Six members to be appointed by the President of the Senate, no more than three of whom shall be of the same political party, as follows:

(1) One representative of the medical profession, upon the recommendation of the Medical Society of New Jersey;

(2) One representative of business, upon the recommendation of the New Jersey Business and Industry Association;

(3) One representative of a health maintenance organization, upon the recommendation of the New Jersey Health Maintenance Organization Association; (4) One representative of a health insurer

domiciled in this State; (5) One representative of the home health care industry, upon the recommendation of the Home Health Assembly of New Jersey; and

(6) One representative of physical therapists in the State, upon recommendation of the American Physical Therapy Association of New Jersey;

k. Six members to be appointed by the Speaker of the General Assembly, no more than three of whom shall be of the same political party, as follows:

(1) One representative of the pharmacy profession, upon the recommendation of the Pharmacist Institute of New Jersey;

(2) One representative of organized labor, upon the recommendation of the New Jersey State AFL-CIO;

(3) One representative of hospitals, upon the recommendation of the New Jersey Hospital Association; (4) One representative of a health service corporation, or if none exists, a hospital or medical service corporation, domiciled in this State; (5) One representative of the dental profession, upon the recommendation of the New Jersey Dental Association; and

(6) One representative of the occupational therapists in this State, upon the recommendation of the New Jersey Occupational Therapy Association;

l. 10 members to be appointed by the Governor, no more than five of whom shall be of the same political party, as follows:

(1) One representative of the chiropractic profession, upon the recommendation of the New Jersey Chiropractic Society;

(2) One representative of small business, upon the recommendation of the New Jersey State Chamber of Commerce;

(3) One representative of long-term health care facilities, upon the recommendation of the New Jersey Association of Health Care Facilities;

(4) One representative of a health insurer authorized to transact business in this State, but not domiciled in this State, upon the recommendation of the Health Insurance Association of America;

(5) One representative of the nursing profession, upon the recommendation of the New Jersey State Nurses Association;

(6) One representative of the osteopathic profession, upon the recommendation of the New Jersey Association of Osteopathic Physicians and Surgeons;

(7) One representative of the mental health professions, upon the recommendation of the Statewide Mental Health Coalition; and

(8) Three members of the public, none of whom shall represent the sectors of business, labor, health care providers or the professions or insurers listed above, but who shall be consumers of health care services.

4. a. The council shall organize upon the appointment of a majority of its authorized membership.

b. Appointed members of the council shall serve for three year terms, except that, of the members first appointed, two each of the members appointed by the President of the Senate and the Speaker of the General Assembly and two of the members appointed by the Governor shall be appointed for terms of one year, and two each of the members appointed by the President of the Senate and the Speaker of the General Assembly and two of the members appointed by the Governor shall be appointed for terms of two years.

c. Each member shall hold office for the term of appointment and until a successor is appointed and qualified. All vacancies shall be filled in the same manner as the original appointment. Members appointed to fill a vacancy occurring for any reason other than the expiration of the term shall serve for the unexpired term only. An appointed member of the council shall be eligible for reappointment. An appointed member may be removed for cause.

d. Appointed members shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties.

e. Action may be taken and motions and resolutions may be adopted by the council by an affirmative vote of not less than a majority of the quorum required to conduct business.

5. The council shall appoint an executive director, who shall serve as secretary to the council. The executive director shall serve at the pleasure of the council and shall be in the unclassified service of the Civil Service. Upon the appointment of a majority of the members of the council, the Commissioner of Health and Senior Services shall appoint an acting executive director from among his staff, who shall serve until the appointment of an executive director by the council and who shall not be eligible for appointment by the council.

The Commissioner of Health and Senior Services shall provide staff support to assist the council in carrying out its responsibilities. The council is entitled to the assistance and services of the employees of any State, county or municipal department, board, bureau, commission or agency, as it may require and as may be available to it for its purposes.

The council is authorized to contract with outside providers for services in support of council responsibilities and documented as otherwise unavailable to the council.

6. a. The council shall develop standards for an effective electronic data interchange (EDI) network for use by the various sectors in the health care services delivery process. In particular, the council's responsibilities shall include, but not be limited to:

(1) Developing standards for interorganizational communication among the participants in the health care services delivery process.

(2) Developing standards for the transmission of forms and information among the various sectors of the health care services delivery process.

(3) Encouraging health insurers and other benefit providers to issue patient identification cards or equipment, such as magnetic stripe, "smart cards" or other patient identification technology, that provide rapid, efficient electronic access to health care services, to covered individuals.

(4) Encouraging and facilitating the development of secure networks which would be interconnected and available to all participants of the health care services delivery process.

b. In developing the standards for the EDI network pursuant to subsection a. of this section, the council shall consider the following guidelines:

(1) National standards, such as those developed by the American National Standards Institute (ANSI) and the Health Care Financing Administration (HCFA) shall be evaluated and adopted wherever possible.

(2) To the greatest extent possible, all participants shall be provided with equal functionality in their access to the network. Interconnection speeds and types of connections may vary, but the services offered shall be available to all participants.

(3) The State's EDI network shall encourage direct connections to the Internet or similar networks for communication and research purposes.

(4) The network's design shall be flexible and allow for new services to be offered without impacting existing services.

(5) Wherever possible, the State's EDI network shall utilize existing networks that are available for other applications and shall take into consideration existing proprietary networks which can connect to and transmit specified health care enrollment, claim and medical information to the open networks in the State.

(6) Whenever possible, all participants in the network shall establish a single connection to the network and this single connection should support all functions of the network.

(7) All providers of network services shall agree to work in an ethical manner so as not to achieve a competitive advantage when collecting or accumulating content information from the transmissions carried on their network.

c. To the maximum extent possible and practicable, the council shall coordinate its responsibilities and activities with other health information initiatives undertaken by the Department of Health and Senior Services and other State agencies.

7. The council shall support the State's responsibilities to monitor the quantity and quality of health care services in the following manner:

a. The council shall examine carefully the Community Health Management Information System (CHMIS) model and similar information network models of a health care monitoring data base and consider recommending appropriate design features.

b. The council shall recommend that the State's EDI network provides appropriate structure for capture of data for monitoring health care quantity and quality by the State.

c. The council shall recommend that a data base system is developed to capture data and store it in appropriate form for routine monitoring reports and policy research.

d. The council, in coordination with other State agencies, shall develop recommendations with respect to the establishment of, and compliance with, health care information confidentiality and security requirements by health care providers and payers including the maintenance of the confidentiality of proprietary information of health care providers and payers.

e. The council shall recommend a procedure for routinely producing and distributing monitoring reports on the performance of payers and providers.

8. In addition to its responsibilities pursuant to sections 6 and 7 of this act, the council shall:

a. Advise the Commissioner of Banking and Insurance, in the development of recommended standards, using national standards wherever possible, for the electronic receipt, transmission and storage of health care claim information by hospital service, medical service and health service corporations, health insurers and health maintenance organizations pursuant to section 7 of P.L., c. (C.)(now pending before the Legislature as Senate, No.48 of 1996).

b. Advise the Commissioner of Banking and Insurance in the development of standard health care enrollment and claim forms pursuant to section 7 of P.L. , c. (C.)(now pending before the Legislature as Senate, No.49 of 1996).

c. Consult with the Commissioner of Health and Senior Services in his preparation of the annual report on health care expenditures in New Jersey required by P.L. , c.(C.)(now before the Legislature as Senate, No.43of 1996.).

9. a. The council shall submit an annual report to the Governor and the Legislature which assesses current efforts, and makes such recommendations, including legislative or administrative action for proposed efforts, to reduce health care administrative costs through electronic data interchange and other automated information

technology, and which specifies the costs of implementation and discusses any anticipated difficulties with respect to the use of the technology.

b. In addition, every fifth annual report shall also include an analysis of the council's accomplishment of its stated objectives, a forecast of emerging technologies and the EDI needs of the health care services industry for the ensuing five years, and how the council anticipates responding to those needs and incorporating those technologies in its operations over the next five years, including any recommendations for change in its membership or charge, or other legislative or administrative action.

c. If funds are available, the reports required by this section shall be prepared with the cooperation and assistance of the New Jersey Institute of Technology and Thomas Edison State College and the council shall use the funds appropriated to it or otherwise made available to it to fund the costs of Thomas Edison State College and the New Jersey Institute of Technology for their services provided to the council in this regard.

10. The council shall make recommendations to the Commissioner of Health and Senior Services through resolutions adopted by a recorded majority vote of the council regarding the development of standards for the State's EDI network. If the commissioner disagrees with the recommendations of the council, the commissioner shall present the reasons therefor to the council.

11. This act shall take effect immediately.

STATEMENT

This bill establishes the Health Information Electronic Data Interchange Policy Advisory Council in the Department of Health and Senior Services.

The council will be comprised of 31 members, representing the various participants in the health care services delivery process, including health care providers, insurers, employers and consumers of health care services. The council will be primarily responsible for developing standards for an effective electronic data interchange (EDI) network for use in the health care services delivery process.

Specifically, the council's responsibilities will include:

(1) Developing standards for interorganizational communication among the participants in the health care services delivery process.

(2) Developing standards for the transmission of forms and information among the various sectors of the health care services delivery process.

(3) Encouraging health insurers and other benefit providers to issue patient identification cards or equipment that provide rapid, efficient electronic access to health care services, to covered individuals.

(4) Encouraging and facilitating the development of secure networks that would be interconnected and available to all participants of the health care services delivery process.

In developing the standards for the EDI network, the council is to consider the following guidelines:

(1) National standards, such as those developed by the American National Standards Institute (ANSI) and the Health Care Financing Administration (HCFA) will be evaluated and adopted wherever possible.

(2) To the greatest extent possible, all participants will be provided with equal functionality in their access to the network. Interconnection speeds and types of connections may vary, but the services offered will be available to all participants.

(3) The State's EDI network will encourage direct connections to the Internet or similar networks for communication and research purposes.

(4) The network's design will be flexible and allow for new services to be offered without impacting existing services.

(5) Wherever possible, the network will utilize existing networks that are available for other applications and will take into consideration existing proprietary networks which can connect to and transmit specified health care enrollment, claim and medical information to the open networks in the State.

(6) Whenever possible, all participants in the network will establish a single connection to the network and this single connection should support all functions of the network.

(7) All providers of network services will agree to work in an ethical manner so as not to achieve a competitive advantage when collecting or accumulating content information from the transmissions carried on their network.

To the maximum extent possible and practicable the council shall coordinate its responsibilities and functions with other health information initiatives undertaken by the Department of Health and Senior Services and other State agencies.

In addition, the council will advise the Commissioner of Banking and Insurance in the development of recommended standards for the electronic processing of health care coverage claim information by health insurers pursuant to Senate Bill No. 48 or Assembly Bill No. 1481 of 1996; and will advise the commissioner in the development of standard health care enrollment and claim forms pursuant to Senate Bill No.49 or Assembly Bill No.1473 of 1996, as well as with the Commissioner of Health and Senior Services in his preparation of the

annual report on health care expenditures required by Senate Bill No. 43 or Assembly Bill No.1479 of 1996.

This bill is part of a legislative package designed to effectuate the 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.

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:

Page 36, Section 11, Line 35- Page 39, Section 13, Line 44:	Delete sections 11-13 in their entirety
Page 40, Section 14, Line 1:	Delete “14” and insert “11”
Page 40, Section 15, Line 13:	Delete “15” and insert “12”
Page 40, Section 16, Line 26:	Delete “16” and insert “13”
Page 41, Section 17, Line 37:	Delete “17” and insert “14”
Page 43, Section 18, Line 5:	Delete “18” and insert “15”
Page 43, Section 19, Line 17:	Delete “19” and insert “16”
Page 43, Section 20, Line 29:	Delete “20” and insert “17”
Page 43, Section 21, Line 36:	Delete “21” and insert “18”

Respectfully,

Christine Todd Whitman
Governor

Attest:

John J. Farmer, Jr.
Chief Counsel to the Governor

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RELEASE: March 15, 1999

Office of the Governor
NEWS RELEASE

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 data 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 licenser 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.

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RELEASE: July 1, 1999

Office of the Governor
NEWS RELEASE

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.