



**SENATE:** Yes

**FLOOR AMENDMENT STATEMENTS:**

Yes 12-10-98  
Yes 12-17-98

Identical to Floor Amendment Statements for 12-17-98 for ACS for A2121

**LEGISLATIVE FISCAL ESTIMATE:** No

**S1148**

**SPONSORS STATEMENT:** (Begins on page 16 of original bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY:** No

**SENATE:** No

**FLOOR AMENDMENT STATEMENTS:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

**S1228**

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

**COMMITTEE STATEMENT:** **AASSEMBLY:** No

**SENATE:** No

**FLOOR AMENDMENT STATEMENTS:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

**VETO MESSAGE:** Yes

**GOVERNOR'S PRESS RELEASE ON SIGNING:** Yes

**FOLLOWING WERE PRINTED:**

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**REPORTS:** No

**HEARINGS:** No

**NEWSPAPER ARTICLES:** No

P.L. 1999, CHAPTER 155, *approved July 1, 1999*  
Assembly Substitute (*Second Reprint*) for  
Assembly, No. 2121

1 AN ACT concerning <sup>1</sup>[prompt]<sup>1</sup> payment of health and dental insurance  
2 claims <sup>1</sup>[.] and<sup>1</sup> supplementing Title 17B of the New Jersey Statutes  
3 <sup>1</sup>[and repealing sections 78, 79 and 80 of P.L.1991, c.187]<sup>1</sup>.  
4

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

8 1. As used in this act:

9 "Capitation payment" means a periodic payment to a health care  
10 provider for his services under the terms of a contract between the  
11 provider and a payer, under which the provider agrees to perform the  
12 health care services set forth in the contract for a specified period of  
13 time for a specified fee, but shall not include any payments made to the  
14 provider on a fee-for-service basis;

15 "Carrier" means an insurance company, health service corporation,  
16 hospital service corporation, medical service corporation or health  
17 maintenance organization authorized to issue health benefits plans in  
18 this State and a dental service corporation or dental plan organization  
19 authorized to issue dental plans in this State.

20 "Commissioner" means the Commissioner of Banking and  
21 Insurance.

22 "Contract holder" means an employer or organization that  
23 purchases a contract for services.

24 "Covered person" means a person on whose behalf a carrier  
25 offering the plan is obligated to pay benefits or provide services  
26 pursuant to the health benefits or dental plan.

27 "Covered service" means a health care service provided to a  
28 covered person under a health benefits or dental plan for which the  
29 carrier is obligated to pay benefits or provide services.

30 "Dental plan" means a benefits plan which pays or provides dental  
31 expense benefits for covered services and is delivered or issued for  
32 delivery in this State by or through a dental service corporation or  
33 dental plan organization authorized to issue dental plans in this State.

34 "Eligible claim" or "claim for eligible services" means a claim for  
35 a covered service under a health benefits or dental plan, subject to any  
36 conditions imposed by the health benefits or dental plan;

37 "Eligible health care provider" means a health care provider whose  
38 services are reimbursable under a health benefits or dental plan;

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

**Matter underlined thus is new matter.**

**Matter enclosed in superscript numerals has been adopted as follows:**

<sup>1</sup>Senate floor amendments adopted December 17, 1998.

<sup>2</sup>Assembly amendments adopted in accordance with Governor's recommendations May 20, 1999.

1 "Health benefits plan" means a benefits plan which pays or  
2 provides hospital and medical expense benefits for covered services,  
3 and is delivered or issued for delivery in this State by or through a  
4 carrier. Health benefits plan includes, but is not limited to, Medicare  
5 supplement coverage and risk contracts to the extent not otherwise  
6 prohibited by federal law. For the purposes of this act, health benefits  
7 plan shall not include the following plans, policies or contracts:  
8 accident only, credit, disability, long-term care, CHAMPUS  
9 supplement coverage, coverage arising out of a workers' compensation  
10 or similar law, automobile medical payment insurance, personal injury  
11 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et  
12 seq.) or hospital confinement indemnity coverage.

13 "Health care provider" means an individual or entity which, acting  
14 within the scope of its licensure or certification, provides a covered  
15 service defined by the health benefits or dental plan. Health care  
16 provider includes, but is not limited to, a physician, dentist and other  
17 health care professionals licensed pursuant to Title 45 of the Revised  
18 Statutes, and a hospital and other health care facilities licensed  
19 pursuant to Title 26 of the Revised Statutes.

20 "Insured claim" or "claim" means a claim by a covered person for  
21 payment of benefits under an insured health benefits or dental plan;

22 "Insured health benefits or dental plan" means a health benefits or  
23 dental plan providing benefits for covered services to covered persons  
24 for which the contract holder pays a premium, which may include a  
25 deductible amount payable to a health care provider, and for which the  
26 financial obligation for the payment of claims under the plan rests upon  
27 the payer.

28 "Payer" means a carrier or any agent thereof who is doing business  
29 in the State and is under a contractual obligation to pay insured claims.

30

31 2. The provisions of this act shall apply only to insured health  
32 benefits or dental plans and insured claims submitted to payers.

33

34 <sup>2</sup>[3. <sup>1</sup>[a. A payer shall remit payment for every insured claim  
35 submitted by a covered person or that person's agent or assignee, if  
36 the health benefits or dental plan provides for assignment of benefits,  
37 no later than the 30th calendar day following receipt of the claim by  
38 the payer, or not later than the time limit established for the payment  
39 of claims in the Medicare program pursuant to  
40 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if:

41 (1) the claim is an eligible claim for a health care service provided  
42 by an eligible health care provider to a covered person under the health  
43 benefits or dental plan;

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

1 (3) there is no dispute regarding the amount claimed;

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

4 (5) the claim requires no special treatment that prevents timely  
5 payments from being made on the claim under the terms of the health  
6 benefits or dental plan.

7 b. If all or a portion of the claim is denied by the payer because:

8 (1) the claim is an ineligible claim;

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

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

13 (4) the payer disputes the amount claimed; or

14 (5) the claim requires special treatment that prevents timely  
15 payments from being made on the claim under the terms of the health  
16 benefits or dental plan,

17 the payer shall notify the covered person, or that person's agent or  
18 assignee, if the health benefits or dental plan provides for assignment  
19 of benefits, in writing or by electronic means, as appropriate, within 30  
20 days, of the following: if all or a portion of the claim is denied, all the  
21 reasons for the denial; if the claim lacks the required substantiating  
22 documentation, including incorrect coding, a statement as to what  
23 substantiating documentation or other information is required to  
24 complete adjudication of the claim; if the amount of the claim is  
25 disputed, a statement that it is disputed; and if the claim requires  
26 special treatment that prevents timely payments from being made, a  
27 statement of the special treatment to which the claim is subject.

28 c. Any portion of a claim that meets the criteria established in  
29 subsection a. of this section shall be paid by the payer in accordance  
30 with the time limit established in subsection a. of this section.

31 d. A payer shall acknowledge receipt of a claim submitted by  
32 electronic means from a health care provider or covered person, no  
33 later than two working days following receipt of the transmission of  
34 the claim.

35 e.]<sup>1</sup> Beginning no later than nine months after the date of  
36 enactment of this act, a payer shall provide a participating health care  
37 provider, upon request of the provider, with a monthly statement  
38 showing the claims, other than electronic claims, received from the  
39 provider during the previous month. The statement shall include the  
40 date the claim was received by the payer.

41 <sup>1</sup>[f. If a payer subject to the provisions of P.L.1983, c.320  
42 (C.17:33A-1 et seq.) has reason to believe that a claim has been  
43 submitted fraudulently, it shall investigate the claim in accordance with  
44 its fraud prevention plan established pursuant to section 1 of P.L.1993,  
45 c.362 (C.17:33A-15), or refer the claim, together with supporting  
46 documentation, to the Office of the Insurance Fraud Prosecutor in the

1 Department of Law and Public Safety established pursuant to section  
2 32 of P.L.1998, c.21 (C.17:33A-16).]¹]²

3

4 ¹[4. a. Payment of an eligible claim pursuant to subsections a. or  
5 c. of section 3 of this act shall be deemed to be overdue if not remitted  
6 to the claimant by the payer on or before the 30th calendar day  
7 following receipt by the payer of a claim.

8 In the event payment is withheld on all or a portion of a claim by  
9 a payer pursuant to paragraph (2) of subsection b. of section 3 of this  
10 act, the claims payment shall be overdue if not remitted to the claimant  
11 by the payer on or before the 30th calendar day following receipt by  
12 the payer of the required documentation or modification of an initial  
13 submission.

14 b. An overdue payment shall bear simple interest at the rate of  
15 10% per annum.]¹

16

17 ¹[5.] ²[4.¹] ³.² A payer shall, at the request of a covered person,  
18 that person's agent, or an eligible health care provider, provide  
19 information as to the material required to be submitted to the payer  
20 with a claim for reimbursement, including any documentation which is  
21 to be submitted with the claim and information as to the proper  
22 coding, including the standard diagnosis and procedure codes used by  
23 the payer.

24

25 ¹[6.] ²[5.¹] ⁴.² A payer shall provide covered persons and eligible  
26 health care providers with a toll-free telephone number for making  
27 inquiries regarding paid claims or pending claims. If the commissioner  
28 determines that the toll-free telephone numbers provided by the payer  
29 are not adequate, he may require separate toll-free numbers for  
30 covered persons and health care providers.

31 A payer shall respond to any covered person's or health care  
32 provider's claim inquiry no later than three business days after receipt  
33 of the inquiry.

34

35 ¹[7.] ²[6.¹] ⁵.² a. A payer shall maintain a record which shall be  
36 audited by a private auditing firm at the expense of the payer, to be  
37 submitted to the commissioner, Governor and the Legislature  
38 ²[semiannually or, at the request of the commissioner,  
39 quarterly] annually², in a form established by the commissioner by  
40 regulation, of the number of claims, by category:

41 (1) that are denied because they are for an ineligible service or the  
42 health care service was not rendered by an eligible health care provider  
43 under the health benefits or dental plan;

44 (2) that are rejected at their initial submission because of a lack of  
45 substantiating documentation;

46 (3) that are rejected at their initial submission because of incorrect

1 coding or incorrect enrollment information;

2 (4) that are rejected at their initial submission because of the  
3 amount claimed;

4 (5) that are not paid in accordance with the time limit established  
5 <sup>1</sup>[in subsection a. of section 3 of this act] by law<sup>1</sup> because the payer  
6 deems the claim to require special treatment that prevents timely  
7 payments from being made;

8 (6) that are not paid in accordance with the time limits for payment  
9 established <sup>1</sup>[in sections 3 and 4 of this act] by law<sup>1</sup> even though the  
10 claims meet the criteria established <sup>1</sup>[in paragraphs (1) through (5) of  
11 subsection a. of section 3 of this act] by law<sup>1</sup>;

12 (7) upon which the <sup>1</sup>10%<sup>1</sup> interest <sup>1</sup>[provided for in section 4 of  
13 this act] penalty established by law<sup>1</sup> has been paid, and the aggregate  
14 amount of interest paid for the period covered by the report; <sup>2</sup>[and]<sup>2</sup>

15 (8) that are denied or referred to the payer's fraud investigation  
16 unit, if applicable, or to the Office of the Insurance Fraud Prosecutor  
17 in the Department of Law and Public Safety established pursuant to  
18 section 32 of P.L.1998, c.21 (C.17:33A-16) because the payer has  
19 reason to believe that the claim has been submitted fraudulently<sup>2</sup>; and  
20 (9) any other information the commissioner requires<sup>2</sup>.

21 b. <sup>2</sup>[If the commissioner determines that a payer has an  
22 unreasonably large or disproportionate number of claims that have  
23 been rejected, denied or not paid in a timely fashion for the reasons set  
24 forth in paragraphs (4), (5) or (6) of subsection a. of this section, or  
25 that the payer has failed to pay interest on overdue claims payments as  
26 required by <sup>1</sup>[section 4 of this act] law<sup>1</sup>, he may, after notice and  
27 hearing, conduct an investigation of the payer's claims processing  
28 procedures.

29 c. As the result of his findings] After reviewing an audit<sup>2</sup>, the  
30 commissioner may, if he deems it necessary: require the  
31 implementation of a plan of remedial action by the payer; require that  
32 the payer's claims processing procedures be monitored by a private  
33 auditing firm for a time period he deems appropriate; or both.

34 If, following an audit, the implementation of a plan of remediation  
35 or the monitoring of the payer's claims processing procedures, the  
36 commissioner determines that:

37 (1) an unreasonably large or disproportionate number of eligible  
38 claims continue to be rejected, denied, or not paid in a timely fashion  
39 for the reasons set forth in paragraphs (4), (5) or (6) of subsection a.  
40 of this section; or

41 (2) a payer has failed to pay interest as required pursuant to  
42 <sup>1</sup>[section 4 of this act] law<sup>1</sup>, the commissioner shall impose a civil  
43 penalty of not <sup>2</sup>[less] more<sup>2</sup> than \$10,000 upon the payer, to be

1 collected pursuant to "the penalty enforcement law," N.J.S.2A:58-1  
2 et seq.

3 <sup>2</sup>[d.] c.<sup>2</sup> Every financial examination of a payer performed  
4 pursuant to section 11 of P.L.1938, c.366 (C.17:48-11), section 15  
5 of P.L.1940, c.74 (C.17:48A-15), section 26 of P.L.1968, c.305  
6 (C.17:48C-26), section 13 of P.L.1979, c.478 (C.17:48D-13), section  
7 36 of P.L.1985, c.236 (C.17:48E-36), N.J.S.17B:21-1 et seq. or  
8 section 9 of P.L.1973, c.337 (C.26:2J-9), as applicable, shall include  
9 an examination of the payer's compliance with the provisions of this  
10 section.

11

12 <sup>2</sup>6. a. In addition to the annual audit required by section 5 of this  
13 act, the payer shall maintain and report to the commissioner on no less  
14 than a quarterly basis, a record of claims as provided in paragraphs (1)  
15 through (9) of subsection a. of section 5 of this act.

16 b. After reviewing a report, the commissioner may require an  
17 immediate audit of the payer by a private audit firm and after  
18 reviewing the audit, if he deems it necessary, may proceed with a  
19 remediation or monitoring procedure as provided by subsection b. of  
20 section 5 of this act.<sup>2</sup>

21

22 <sup>1</sup>[8.] 7.<sup>1</sup> a. Payment of a capitation payment to a health care  
23 provider shall be deemed to be overdue if not remitted to the provider  
24 on the fifth business day following the due date of the payment in the  
25 contract, if: the health care provider is not in violation of the terms of  
26 the contract; and the health care provider has supplied such  
27 information to the insurer as may be required under the contract before  
28 payment is to be made.

29 b. An overdue payment shall bear simple interest at the rate of  
30 10% per annum.

31

32 <sup>1</sup>[9.] 8.<sup>1</sup> No later than <sup>2</sup>[90] 180<sup>2</sup> days following the date of  
33 enactment of this act, the commissioner shall adopt regulations  
34 pursuant to the "Administrative Procedure Act," P.L.1968, c.410  
35 (C.52:14B-1 et seq.) necessary to carry out the purposes of this act.

36

37 <sup>1</sup>[10.] 9.<sup>1</sup> The provisions of this act shall not apply to any payer  
38 determined by the commissioner to be impaired, to be subject to the  
39 provisions of the "Life and Health Insurers Rehabilitation and  
40 Liquidation Act," P.L.1992, c.65 (C.17B:32-31 et seq.), or to any  
41 claims payable by the "New Jersey Life and Health Insurance Guaranty  
42 Association Act" pursuant to P.L.1991, c. 208 (C.17B:32A-1 et seq.).

43

44 <sup>1</sup>[11. Sections 78, 79, and 80 of P. L.1991, c.187 (C.17B:26-  
45 12.1, 17B:27-44.1 and 26:2J-5.1) are repealed.]<sup>1</sup>



1       <sup>1</sup>[12.] 10.<sup>1</sup> This act shall take effect on the <sup>2</sup>[90th] 180th<sup>2</sup> day  
2 after enactment.

3

4

5

\_\_\_\_\_

6

7 Provides for carrier reporting of claims payment practices to Dept. of  
8 Banking and Insurance and for enforcement of violations of claims  
9 payment requirements.

STATEMENT TO  
ASSEMBLY SUBSTITUTE FOR  
**ASSEMBLY, No. 2121**

with Senate Floor Amendments  
(Proposed By Senator SINAGRA)

ADOPTED: DECEMBER 17, 1998

These amendments delete the provisions of the substitute that set forth the specific "prompt pay" requirements for health insurance carriers. As amended, the substitute includes provisions for enforcement by the Department of Banking and Insurance of the "prompt pay" requirements that are set forth in other pending legislation.

# ASSEMBLY, No. 2121

## STATE OF NEW JERSEY 208th LEGISLATURE

INTRODUCED JUNE 1, 1998

**Sponsored by:**

**Assemblyman GUY F. TALARICO**

**District 38 (Bergen)**

**Assemblyman NICHOLAS ASSELTA**

**District 1 (Cape May, Atlantic and Cumberland)**

**Co-Sponsored by:**

**Assemblymen Conaway, Conners, Impreveduto, Assemblywoman Watson Coleman, Assemblyman Cohen, Assemblywoman Gill, Assemblymen Roberts, Barnes, R. Smith, Green, Assemblywoman Previte, Assemblymen Doria, LeFevre, Assemblywoman Heck, Assemblymen Bodine, Felice, Holzapfel, Assemblywoman Weinberg, Assemblymen Romano, Wisniewski, Greenwald, Assemblywoman Friscia, Assemblymen Charles, Garica, Assemblywoman Pou, Assemblymen Caraballo, Zisa, T. Smith, Arnone, Corodemus, Kelly, Kramer, Gibson, Wolfe, Azzolina, Biondi, Chatzidakis, Cottrell, Geist, Assemblywoman Quigley, Assemblymen Malone, Thompson, Assemblywoman Wright, Assemblymen Zecker, Bagger, Assemblywomen Buono, Crecco, Assemblymen DeCroce, Gregg, Gusciora, Lance, Luongo, Moran, Assemblywoman Murphy, Assemblymen O'Toole, Payne, Rooney, Stanley, Steele, Stuhltrager, Tucker, Assemblywoman Cruz-Perez, Assemblymen Weingarten, Augustine, Jones, DiGaetano, Merkt and Connors**

**SYNOPSIS**

Requires prompt payment of health and dental insurance claims.

**CURRENT VERSION OF TEXT**

As introduced.

(Sponsorship Updated As Of: 9/15/1998)

1 AN ACT concerning prompt payment of health insurance claims,  
2 amending P.L.1991, c.187 and supplementing Title 17 of the  
3 Revised Statutes and Title 17B of the New Jersey Statutes.

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

7  
8 1. Section 78 of P.L.1991, c.187 (C.17B:26-12.1) is amended to  
9 read as follows:

10 78. a. (1) A health insurer or its agent shall, within 10 working  
11 days following receipt of a claim, acknowledge receipt of that claim  
12 unless payment is made prior to the expiration of the 10-working-day  
13 period, and shall include in the notice the address and telephone  
14 number of the health insurer or authorized claims representative who  
15 will handle the claim.

16 (2) A health insurer or its agent shall reimburse all clean claims or  
17 any portion of any clean claim from an insured or an insured's  
18 assignee, for payment under a health insurance policy, within [60] 30  
19 days after receipt of [the] a manual claim or within 17 days after  
20 receipt of an electronic claim by the health insurer or its agent. If a  
21 claim or a portion of a claim is contested by the health insurer or its  
22 agent, the insured or the insured's assignee shall be notified in writing  
23 within [45] 30 days after receipt of [the] a manual claim or 17 days  
24 after receipt of an electronic claim by the health insurer or its agent,  
25 that the claim is contested or denied; except that, the uncontested  
26 portion of the claim shall be paid within [60] 30 days after receipt of  
27 [the] a manual claim or 17 days after receipt of an electronic claim by  
28 the health insurer or its agent.

29 The notice that a claim is contested shall [identify the contested  
30 portion of the claim and the reasons for contesting the claim] be  
31 conveyed on a standard claims payment dispute form and shall include:

32 (a) the date of the service, the type of service and the name of the  
33 insured and health care provider who are the subjects of the claim;

34 (b) the contested portion of the claim and all of the reasons, using  
35 standard codes of explanation, for which the claim is contested;

36 (c) the specific information needed by the health insurer to make  
37 a determination that the claim is a clean claim; and

38 (d) the name, address, telephone number and facsimile number of  
39 the health insurer's claims representative who is knowledgeable about  
40 the claim, with whom the insured or the insured's assignee or the  
41 health care provider should correspond to resolve problems with the  
42 claim.

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

Matter underlined thus is new matter.

1 A health insurer or its agent, upon receipt of the additional  
2 information requested from the insured or the insured's assignee, shall  
3 pay or deny the contested claim or portion of the contested claim,  
4 within **[90]** 30 days.

5 Payment shall be treated as being made on the date a draft or other  
6 valid instrument which is equivalent to payment was placed in the  
7 United States mail in a properly addressed, postpaid envelope or, if  
8 not so posted, on the date of delivery or electronic fund transfer.

9 b. An overdue payment shall bear simple interest at the rate of 10%  
10 per year, commencing on the 31st day after receipt of a manual claim  
11 or any clean portion of a manual claim or on the 18th day after receipt  
12 of an electronic claim or any clean portion of an electronic claim, by  
13 the health insurer or its agent. For the purpose of determining interest  
14 charges in the event the insured or his assignee prevails in a contested  
15 claim, a payment shall be considered overdue at the expiration of the  
16 30-day period for manual claims and the 17-day period for electronic  
17 claims provided in subsection a. of this section or, if the insured or his  
18 assignee was required to provide additional information to the health  
19 insurer or its agent, within 10 business days following receipt by the  
20 health insurer or its agent of all information requested by the health  
21 insurer or its agent, whichever date is later.

22 c. For the purposes of this section, "health insurer" means an  
23 insurer authorized to provide health insurance on an individual basis  
24 pursuant to chapter 26 of Title 17B of the New Jersey Statutes, "clean  
25 claim" has the same meaning given the term in the federal Medicare  
26 program pursuant to 42 U.S.C.s.1395u(c)(2)(B) and "agent" means  
27 any intermediary contracted or affiliated with the health insurer to  
28 perform administrative functions including, but not limited to, the  
29 payment of claims or the receipt, processing or transfer of claims or  
30 claim information.

31 d. The Department of Banking and Insurance shall adopt rules and  
32 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
33 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.  
34 (cf: P.L.1991, c.187, s.78)

35  
36 2. Section 79 of P.L.1991, c.187 (C.17B:27-44.1) is amended to  
37 read as follows:

38 79. a. (1) A health insurer or its agent shall, within 10 working  
39 days following receipt of a claim, acknowledge receipt of that claim  
40 unless payment is made prior to the expiration of the 10 working day  
41 period, and shall include in the notice the address and telephone  
42 number of the health insurer or authorized claims representative who  
43 will handle the claim.

44 (2) A health insurer or its agent shall reimburse all clean claims or  
45 any portion of any clean claim from an insured or an insured's  
46 assignee, for payment under a health insurance policy, within

1 ~~60~~ 30 days after receipt of ~~the~~ a manual claim or within 17 days  
2 after receipt of an electronic claim by the health insurer or its agent.  
3 If a claim or a portion of a claim is contested by the health insurer or  
4 its agent, the insured or the insured's assignee shall be notified in  
5 writing within ~~45~~ 30 days after receipt of ~~the~~ a manual claim or  
6 17 days after receipt of an electronic claim by the health insurer or its  
7 agent, that the claim is contested or denied; except that, the  
8 uncontested portion of the claim shall be paid within ~~60~~ 30 days  
9 after receipt of ~~the~~ a manual claim or 17 days after receipt of an  
10 electronic claim by the health insurer or its agent.

11 The notice that a claim is contested shall ~~identify the contested~~  
12 ~~portion of the claim and the reasons for contesting the claim~~ be  
13 conveyed on a standard claims payment dispute form and shall include:

14 (a) the date of the service, the type of service and the name of the  
15 insured and health care provider who are the subjects of the claim;

16 (b) the contested portion of the claim and all of the reasons, using  
17 standard codes of explanation, for which the claim is contested;

18 (c) the specific information needed by the health insurer to make  
19 a determination that the claim is a clean claim; and

20 (d) the name, address, telephone number and facsimile number of  
21 the health insurer's claims representative who is knowledgeable about  
22 the claim, with whom the insured or the insured's assignee or the  
23 health care provider should correspond to resolve problems with the  
24 claim.

25 A health insurer or its agent, upon receipt of the additional  
26 information requested from the insured or the insured's assignee, shall  
27 pay or deny the contested claim or portion of the contested claim,  
28 within ~~90~~ 30 days.

29 Payment shall be treated as being made on the date a draft or other  
30 valid instrument which is equivalent to payment was placed in the  
31 United States mail in a properly addressed, postpaid envelope or, if  
32 not so posted, on the date of delivery or electronic fund transfer.

33 b. An overdue payment shall bear simple interest at the rate of 10%  
34 per year, commencing on the 31st day after receipt of a manual claim  
35 or any clean portion of a manual claim or on the 18th day after receipt  
36 of an electronic claim or any clean portion of an electronic claim, by  
37 the health insurer or its agent. For the purpose of determining interest  
38 charges in the event the insured or his assignee prevails in a contested  
39 claim, a payment shall be considered overdue at the expiration of the  
40 30-day period for manual claims and the 17-day period for electronic  
41 claims provided in subsection a. of this section or, if the insured or his  
42 assignee was required to provide additional information to the health  
43 insurer or its agent, within 10 business days following receipt by the  
44 health insurer or its agent of all information requested by the health  
45 insurer or its agent, whichever date is later.

46 c. For the purposes of this section, "health insurer" means an

1 insurer authorized to provide health insurance on a group basis  
2 pursuant to chapter 27 of Title 17B of the New Jersey Statutes, "clean  
3 claim" has the same meaning given the term in the federal Medicare  
4 program pursuant to 42 U.S.C.s.1395u(c)(2)(B) and "agent" means  
5 any intermediary contracted or affiliated with the health insurer to  
6 perform administrative functions including, but not limited to, the  
7 payment of claims or the receipt, processing or transfer of claims or  
8 claim information.

9 d. The Department of Banking and Insurance shall adopt rules and  
10 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
11 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.  
12 (cf: P.L.1991, c.187, s.79)

13  
14 3. Section 80 of P.L.1991, c.187 (C.26:2J-5.1) is amended to read  
15 as follows:

16 80. a. (1) A health maintenance organization or its agent shall,  
17 within 10 working days following receipt of a claim, acknowledge  
18 receipt of that claim unless payment is made prior to the expiration of  
19 the 10 working day period, and shall include in the notice the address  
20 and telephone number of the health maintenance organization or  
21 authorized claims representative who will handle the claim.

22 (2) A health maintenance organization or its agent shall reimburse  
23 all clean claims or any portion of any clean claim from an enrollee or  
24 an enrollee's assignee, for payment under a health maintenance  
25 organization coverage, within ~~60~~ 30 days after receipt of ~~the~~ a  
26 manual claim or within 17 days after receipt of an electronic claim by  
27 the health maintenance organization or its agent. If a claim or a  
28 portion of a claim is contested by the health maintenance organization  
29 or its agent, the enrollee or the enrollee's assignee shall be notified in  
30 writing within ~~45~~ 30 days after receipt of ~~the~~ a manual claim or  
31 17 days after receipt of an electronic claim by the health maintenance  
32 organization or its agent, that the claim is contested or denied; except  
33 that, the uncontested portion of the claim shall be paid within ~~60~~ 30  
34 days after receipt of ~~the~~ a manual claim or 17 days after receipt of an  
35 electronic claim by the health maintenance organization or its agent.

36 The notice that a claim is contested shall ~~identify the contested~~  
37 portion of the claim and the reasons for contesting the claim be  
38 conveyed on a standard claims payment dispute form and shall include:

39 (a) the date of the service, the type of service and the name of the  
40 enrollee and health care provider who are the subjects of the claim;

41 (b) the contested portion of the claim and all of the reasons, using  
42 standard codes of explanation, for which the claim is contested;

43 (c) the specific information needed by the health maintenance  
44 organization to make a determination that the claim is a clean claim;  
45 and

46 (d) the name, address, telephone number and facsimile number of

1 the health maintenance organization's claims representative who is  
2 knowledgeable about the claim, with whom the enrollee or the  
3 enrollee's assignee or the health care provider should correspond to  
4 resolve problems with the claim.

5 A health maintenance organization or its agent, upon receipt of the  
6 additional information requested from the enrollee or the enrollee's  
7 assignee, shall pay or deny the contested claim or portion of the  
8 contested claim, within ~~90~~ 30 days.

9 Payment shall be treated as being made on the date a draft or other  
10 valid instrument which is equivalent to payment was placed in the  
11 United States mail in a properly addressed, postpaid envelope or, if  
12 not so posted, on the date of delivery or electronic fund transfer.

13 b. An overdue payment shall bear simple interest at the rate of 10%  
14 per year, commencing on the 31st day after receipt of a manual claim  
15 or any clean portion of a manual claim or on the 18th day after receipt  
16 of an electronic claim or any clean portion of an electronic claim, by  
17 the health maintenance organization or its agent. For the purpose of  
18 determining interest charges in the event the enrollee or his assignee  
19 prevails in a contested claim, a payment shall be considered overdue  
20 at the expiration of the 30-day period for manual claims and the 17-  
21 day period for electronic claims provided in subsection a. of this  
22 section or, if the enrollee or his assignee was required to provide  
23 additional information to the health maintenance organization or its  
24 agent, within 10 business days following receipt by the health  
25 maintenance organization or its agent of all information requested by  
26 the health maintenance organization or its agent, whichever date is  
27 later.

28 c. For the purposes of this section, "health maintenance  
29 organization" means a health maintenance organization authorized  
30 pursuant to the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.),  
31 "clean claim" has the same meaning given the term in the federal  
32 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B) and "agent"  
33 means any intermediary contracted or affiliated with the health  
34 maintenance organization to perform administrative functions  
35 including, but not limited to, the payment of claims or the receipt,  
36 processing or transfer of claims or claim information.

37 d. The Department of Health and Senior Services shall adopt rules  
38 and regulations pursuant to the "Administrative Procedure Act,"  
39 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of  
40 this section.

41 (cf: P.L.1991, c.187, s.80)

42  
43 4. (New Section) a. (1) A health service corporation or its agent  
44 shall, within 10 working days following receipt of a claim,  
45 acknowledge receipt of that claim unless payment is made prior to the  
46 expiration of the 10 working day period, and shall include in the notice



1 the address and telephone number of the health service corporation or  
2 authorized claims representative who will handle the claim.

3 (2) A health service corporation or its agent shall reimburse all  
4 clean claims or any portion of any clean claim from a subscriber or a  
5 subscriber's assignee, for payment under a health insurance policy,  
6 within 30 days after receipt of a manual claim or within 17 days after  
7 receipt of an electronic claim by the health service corporation or its  
8 agent. If a claim or a portion of a claim is contested by the health  
9 service corporation or its agent, the subscriber or the subscriber's  
10 assignee shall be notified in writing within 30 days after receipt of a  
11 manual claim or 17 days after receipt of an electronic claim by the  
12 health service corporation or its agent, that the claim is contested or  
13 denied; except that, the uncontested portion of the claim shall be paid  
14 within 30 days after receipt of a manual claim or 17 days after receipt  
15 of an electronic claim by the health service corporation or its agent.

16 The notice that a claim is contested shall be conveyed on a standard  
17 claims payment dispute form and shall include:

18 (a) the date of the service, the type of service and the name of the  
19 subscriber and health care provider who are the subjects of the claim;

20 (b) the contested portion of the claim and all of the reasons, using  
21 standard codes of explanation, for which the claim is contested;

22 (c) the specific information needed by the health service  
23 corporation to make a determination that the claim is a clean claim;  
24 and

25 (d) the name, address, telephone number and facsimile number of  
26 the health service corporation's claims representative who is  
27 knowledgeable about the claim, with whom the subscriber or the  
28 subscriber's assignee or the health care provider should correspond to  
29 resolve problems with the claim.

30 A health service corporation or its agent, upon receipt of the  
31 additional information requested from the subscriber or the  
32 subscriber's assignee, shall pay or deny the contested claim or portion  
33 of the contested claim, within 30 days.

34 Payment shall be treated as being made on the date a draft or other  
35 valid instrument which is equivalent to payment was placed in the  
36 United States mail in a properly addressed, postpaid envelope or, if  
37 not so posted, on the date of delivery or electronic fund transfer.

38 b. An overdue payment shall bear simple interest at the rate of 10%  
39 per year, commencing on the 31st day after receipt of a manual claim  
40 or any clean portion of a manual claim or on the 18th day after receipt  
41 of an electronic claim or any clean portion of an electronic claim, by  
42 the health service corporation or its agent. For the purpose of  
43 determining interest charges in the event the subscriber or his assignee  
44 prevails in a contested claim, a payment shall be considered overdue  
45 at the expiration of the 30-day period for manual claims and the 17-  
46 day period for electronic claims provided in subsection a. of this

1 section or, if the subscriber or his assignee was required to provide  
2 additional information to the health service corporation or its agent,  
3 within 10 business days following receipt by the health service  
4 corporation or its agent of all information requested by the health  
5 service corporation or its agent, whichever date is later.

6 c. For the purposes of this section, "clean claim" has the same  
7 meaning given the term in the federal Medicare program pursuant to  
8 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
9 contracted or affiliated with the health service corporation to perform  
10 administrative functions including, but not limited to, the payment of  
11 claims or the receipt, processing or transfer of claims or claim  
12 information.

13 d. The Department of Banking and Insurance shall adopt rules and  
14 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
15 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.  
16

17 5. (New Section) a. (1) A medical service corporation or its  
18 agent shall, within 10 working days following receipt of a claim,  
19 acknowledge receipt of that claim unless payment is made prior to the  
20 expiration of the 10 working day period, and shall include in the notice  
21 the address and telephone number of the medical service corporation  
22 or authorized claims representative who will handle the claim.

23 (2) A medical service corporation or its agent shall reimburse all  
24 clean claims or any portion of any clean claim from a subscriber or a  
25 subscriber's assignee, for payment under a health insurance policy,  
26 within 30 days after receipt of a manual claim or within 17 days after  
27 receipt of an electronic claim by the medical service corporation or its  
28 agent. If a claim or a portion of a claim is contested by the medical  
29 service corporation or its agent, the subscriber or the subscriber's  
30 assignee shall be notified in writing within 30 days after receipt of a  
31 manual claim or 17 days after receipt of an electronic claim by the  
32 medical service corporation or its agent, that the claim is contested or  
33 denied; except that, the uncontested portion of the claim shall be paid  
34 within 30 days after receipt of a manual claim or 17 days after receipt  
35 of an electronic claim by the medical service corporation or its agent.

36 The notice that a claim is contested shall be conveyed on a standard  
37 claims payment dispute form and shall include:

38 (a) the date of the service, the type of service and the name of the  
39 subscriber and health care provider who are the subjects of the claim;

40 (b) the contested portion of the claim and all of the reasons, using  
41 standard codes of explanation, for which the claim is contested;

42 (c) the specific information needed by the medical service  
43 corporation to make a determination that the claim is a clean claim;  
44 and

45 (d) the name, address, telephone number and facsimile number of  
46 the medical service corporation's claims representative who is

1 knowledgeable about the claim, with whom the subscriber or the  
2 subscriber's assignee or the health care provider should correspond to  
3 resolve problems with the claim.

4 A medical service corporation or its agent, upon receipt of the  
5 additional information requested from the subscriber or the  
6 subscriber's assignee, shall pay or deny the contested claim or portion  
7 of the contested claim, within 30 days.

8 Payment shall be treated as being made on the date a draft or other  
9 valid instrument which is equivalent to payment was placed in the  
10 United States mail in a properly addressed, postpaid envelope or, if  
11 not so posted, on the date of delivery or electronic fund transfer.

12 b. An overdue payment shall bear simple interest at the rate of 10%  
13 per year, commencing on the 31st day after receipt of a manual claim  
14 or any clean portion of a manual claim or on the 18th day after receipt  
15 of an electronic claim or any clean portion of an electronic claim, by  
16 the medical service corporation or its agent. For the purpose of  
17 determining interest charges in the event the subscriber or his assignee  
18 prevails in a contested claim, a payment shall be considered overdue  
19 at the expiration of the 30-day period for manual claims and the 17-  
20 day period for electronic claims provided in subsection a. of this  
21 section or, if the subscriber or his assignee was required to provide  
22 additional information to the medical service corporation or its agent,  
23 within 10 business days following receipt by the medical service  
24 corporation or its agent of all information requested by the medical  
25 service corporation or its agent, whichever date is later.

26 c. For the purposes of this section, "clean claim" has the same  
27 meaning given the term in the federal Medicare program pursuant to  
28 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
29 contracted or affiliated with the medical service corporation to  
30 perform administrative functions including, but not limited to, the  
31 payment of claims or the receipt, processing or transfer of claims or  
32 claim information.

33 d. The Department of Banking and Insurance shall adopt rules and  
34 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
35 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

36  
37 6. (New Section) a. (1) A hospital service corporation or its  
38 agent shall, within 10 working days following receipt of a claim,  
39 acknowledge receipt of that claim unless payment is made prior to the  
40 expiration of the 10 working day period, and shall include in the notice  
41 the address and telephone number of the hospital service corporation  
42 or authorized claims representative who will handle the claim.

43 (2) A hospital service corporation or its agent shall reimburse all  
44 clean claims or any portion of any clean claim from a subscriber or a  
45 subscriber's assignee, for payment under a health insurance policy,  
46 within 30 days after receipt of a manual claim or within 17 days after

1 receipt of an electronic claim by the hospital service corporation or its  
2 agent. If a claim or a portion of a claim is contested by the hospital  
3 service corporation or its agent, the subscriber or the subscriber's  
4 assignee shall be notified in writing within 30 days after receipt of a  
5 manual claim or 17 days after receipt of an electronic claim by the  
6 hospital service corporation or its agent, that the claim is contested or  
7 denied; except that, the uncontested portion of the claim shall be paid  
8 within 30 days after receipt of a manual claim or 17 days after receipt  
9 of an electronic claim by the hospital service corporation or its agent.

10 The notice that a claim is contested shall be conveyed on a standard  
11 claims payment dispute form and shall include:

12 (a) the date of the service, the type of service and the name of the  
13 subscriber and health care provider who are the subjects of the claim;

14 (b) the contested portion of the claim and all of the reasons, using  
15 standard codes of explanation, for which the claim is contested;

16 (c) the specific information needed by the hospital service  
17 corporation to make a determination that the claim is a clean claim;  
18 and

19 (d) the name, address, telephone number and facsimile number of  
20 the hospital service corporation's claims representative who is  
21 knowledgeable about the claim, with whom the subscriber or the  
22 subscriber's assignee or the health care provider should correspond to  
23 resolve problems with the claim.

24 A hospital service corporation or its agent, upon receipt of the  
25 additional information requested from the subscriber or the  
26 subscriber's assignee, shall pay or deny the contested claim or portion  
27 of the contested claim, within 30 days.

28 Payment shall be treated as being made on the date a draft or other  
29 valid instrument which is equivalent to payment was placed in the  
30 United States mail in a properly addressed, postpaid envelope or, if  
31 not so posted, on the date of delivery or electronic fund transfer.

32 b. An overdue payment shall bear simple interest at the rate of 10%  
33 per year, commencing on the 31st day after receipt of a manual claim  
34 or any clean portion of a manual claim or on the 18th day after receipt  
35 of an electronic claim or any clean portion of an electronic claim, by  
36 the hospital service corporation or its agent. For the purpose of  
37 determining interest charges in the event the subscriber or his assignee  
38 prevails in a contested claim, a payment shall be considered overdue  
39 at the expiration of the 30-day period for manual claims and the 17-  
40 day period for electronic claims provided in subsection a. of this  
41 section or, if the subscriber or his assignee was required to provide  
42 additional information to the hospital service corporation or its agent,  
43 within 10 business days following receipt by the hospital service  
44 corporation or its agent of all information requested by the hospital  
45 service corporation or its agent, whichever date is later.

46 c. For the purposes of this section, "clean claim" has the same

1 meaning given the term in the federal Medicare program pursuant to  
2 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
3 contracted or affiliated with the hospital service corporation to  
4 perform administrative functions including, but not limited to, the  
5 payment of claims or the receipt, processing or transfer of claims or  
6 claim information.

7 d. The Department of Banking and Insurance shall adopt rules and  
8 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
9 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.  
10

11 7. (New Section) a. (1) A dental service corporation or its agent  
12 shall, within 10 working days following receipt of a claim,  
13 acknowledge receipt of that claim unless payment is made prior to the  
14 expiration of the 10 working day period, and shall include in the notice  
15 the address and telephone number of the dental service corporation or  
16 authorized claims representative who will handle the claim.

17 (2) A dental service corporation or its agent shall reimburse all  
18 clean claims or any portion of any clean claim from a subscriber or a  
19 subscriber's assignee, for payment under a health insurance policy,  
20 within 30 days after receipt of a manual claim or within 17 days after  
21 receipt of an electronic claim by the dental service corporation or its  
22 agent. If a claim or a portion of a claim is contested by the dental  
23 service corporation or its agent, the subscriber or the subscriber's  
24 assignee shall be notified in writing within 30 days after receipt of a  
25 manual claim or 17 days after receipt of an electronic claim by the  
26 dental service corporation or its agent, that the claim is contested or  
27 denied; except that, the uncontested portion of the claim shall be paid  
28 within 30 days after receipt of a manual claim or 17 days after receipt  
29 of an electronic claim by the dental service corporation or its agent.

30 The notice that a claim is contested shall be conveyed on a standard  
31 claims payment dispute form and shall include:

32 (a) the date of the service, the type of service and the name of the  
33 subscriber and health care provider who are the subjects of the claim;

34 (b) the contested portion of the claim and all of the reasons, using  
35 standard codes of explanation, for which the claim is contested;

36 (c) the specific information needed by the dental service  
37 corporation to make a determination that the claim is a clean claim;  
38 and

39 (d) the name, address, telephone number and facsimile number of  
40 the dental service corporation's claims representative who is  
41 knowledgeable about the claim, with whom the subscriber or the  
42 subscriber's assignee or the health care provider should correspond to  
43 resolve problems with the claim.

44 A dental service corporation or its agent, upon receipt of the  
45 additional information requested from the subscriber or the  
46 subscriber's assignee, shall pay or deny the contested claim or portion

1 of the contested claim, within 30 days.

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

6 b. An overdue payment shall bear simple interest at the rate of 10%  
7 per year, commencing on the 31st day after receipt of a manual claim  
8 or any clean portion of a manual claim or on the 18th day after receipt  
9 of an electronic claim or any clean portion of an electronic claim, by  
10 the dental service corporation or its agent. For the purpose of  
11 determining interest charges in the event the subscriber or his assignee  
12 prevails in a contested claim, a payment shall be considered overdue  
13 at the expiration of the 30-day period for manual claims and the 17-  
14 day period for electronic claims provided in subsection a. of this  
15 section or, if the subscriber or his assignee was required to provide  
16 additional information to the dental service corporation or its agent,  
17 within 10 business days following receipt by the dental service  
18 corporation or its agent of all information requested by the dental  
19 service corporation or its agent, whichever date is later.

20 c. For the purposes of this section, "clean claim" has the same  
21 meaning given the term in the federal Medicare program pursuant to  
22 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
23 contracted or affiliated with the dental service corporation to perform  
24 administrative functions including, but not limited to, the payment of  
25 claims or the receipt, processing or transfer of claims or claim  
26 information.

27 d. The Department of Banking and Insurance shall adopt rules and  
28 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
29 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

30

31 8. (New Section) a. (1) A dental plan organization or its agent  
32 shall, within 10 working days following receipt of a claim,  
33 acknowledge receipt of that claim unless payment is made prior to the  
34 expiration of the 10 working day period, and shall include in the notice  
35 the address and telephone number of the dental plan organization or  
36 authorized claims representative who will handle the claim.

37 (2) A dental plan organization or its agent shall reimburse all clean  
38 claims or any portion of any clean claim from an enrollee or an  
39 enrollee's assignee, for payment under a health insurance policy, within  
40 30 days after receipt of a manual claim or within 17 days after receipt  
41 of an electronic claim by the dental plan organization or its agent. If  
42 a claim or a portion of a claim is contested by the dental plan  
43 organization or its agent, the enrollee or the enrollee's assignee shall  
44 be notified in writing within 30 days after receipt of a manual claim or  
45 17 days after receipt of an electronic claim by the dental plan  
46 organization or its agent, that the claim is contested or denied; except

1 that, the uncontested portion of the claim shall be paid within 30 days  
2 after receipt of a manual claim or 17 days after receipt of an electronic  
3 claim by the dental plan organization or its agent.

4 The notice that a claim is contested shall be conveyed on a standard  
5 claims payment dispute form and shall include:

6 (a) the date of the service, the type of service and the name of the  
7 enrollee and health care provider who are the subjects of the claim;

8 (b) the contested portion of the claim and all of the reasons, using  
9 standard codes of explanation, for which the claim is contested;

10 (c) the specific information needed by the dental plan organization  
11 to make a determination that the claim is a clean claim; and

12 (d) the name, address, telephone number and facsimile number of  
13 the dental plan organization's claims representative who is  
14 knowledgeable about the claim, with whom the enrollee or the  
15 enrollee's assignee or the health care provider should correspond to  
16 resolve problems with the claim.

17 A dental plan organization or its agent, upon receipt of the  
18 additional information requested from the enrollee or the enrollee's  
19 assignee, shall pay or deny the contested claim or portion of the  
20 contested claim, within 30 days.

21 Payment shall be treated as being made on the date a draft or other  
22 valid instrument which is equivalent to payment was placed in the  
23 United States mail in a properly addressed, postpaid envelope or, if  
24 not so posted, on the date of delivery or electronic fund transfer.

25 b. An overdue payment shall bear simple interest at the rate of 10%  
26 per year, commencing on the 31st day after receipt of a manual claim  
27 or any clean portion of a manual claim or on the 18th day after receipt  
28 of an electronic claim or any clean portion of an electronic claim, by  
29 the dental plan organization or its agent. For the purpose of  
30 determining interest charges in the event the enrollee or his assignee  
31 prevails in a contested claim, a payment shall be considered overdue  
32 at the expiration of the 30-day period for manual claims and the 17-  
33 day period for electronic claims provided in subsection a. of this  
34 section or, if the enrollee or his assignee was required to provide  
35 additional information to the dental plan organization or its agent,  
36 within 10 business days following receipt by the dental plan  
37 organization or its agent of all information requested by the dental  
38 plan organization or its agent, whichever date is later.

39 c. For the purposes of this section, "clean claim" has the same  
40 meaning given the term in the federal Medicare program pursuant to  
41 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
42 contracted or affiliated with the dental plan organization to perform  
43 administrative functions including, but not limited to, the payment of  
44 claims or the receipt, processing or transfer of claims or claim  
45 information.

46 d. The Department of Banking and Insurance shall adopt rules and

1 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
2 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

3  
4 9. (New section) a. The Commissioner of Banking and Insurance  
5 shall establish an Independent Third Party Payment Appeals Program  
6 in the Division of Enforcement and Consumer Protection in the  
7 Department of Banking and Insurance to address health care payment  
8 complaints of any health care provider or insured. Under the program,  
9 any health care provider or insured shall have the right to an  
10 independent review of a health care coverage payment complaint made  
11 pursuant to this section.

12 b. The commissioner may contract with one or more independent  
13 utilization review organizations or other independent health care  
14 review organizations whose staff has experience in reviewing  
15 negotiated contract arrangements and health care payment  
16 methodologies, to implement the program. The review organization  
17 shall submit to the department and maintain a current list identifying  
18 all carriers, health care facilities and other health care providers and  
19 payers with whom the review organization maintains any health-related  
20 business arrangements. The list shall include a brief description of the  
21 nature of any such arrangement.

22 c. To initiate a complaint, a health care provider or insured shall  
23 file a written complaint with the program on forms provided by the  
24 department.

25 Upon receipt of a complaint, the program shall assess the nature of  
26 the complaint and, if determined to be carrier-payment related,  
27 immediately assign the complaint to a review organization for review  
28 and determination. In making a determination as to which review  
29 organization shall review a complaint, the program shall take into  
30 consideration the list of business arrangements submitted by the review  
31 organization. The program shall ensure that assignment of a complaint  
32 to a review organization will not result in a conflict of interest or  
33 otherwise create an appearance of impropriety.

34 d. Upon receipt of a complaint, the review organization shall:

35 (1) Acknowledge the complaint, in writing, to the health care  
36 provider or the insured who filed the complaint, within 10 business  
37 days of receipt of the complaint;

38 (2) Conduct a full review of the complaint and issue a decision  
39 regarding payment, as soon as possible, but no later than 30 business  
40 days from receipt of all documentation necessary to complete the  
41 review;

42 (3) Immediately notify the provider or insured, in writing, of its  
43 decision. A final decision of the review organization shall be binding  
44 on the carrier and provider or insured, as applicable; and

45 (4) In reaching its decision, the review organization shall take into  
46 consideration all pertinent medical records, applicable generally



1 accepted practice guidelines, contract and payment terms between the  
2 carrier and insured or provider, applicable billing records and other  
3 documents submitted by the parties.

4 e. When appropriate, the review organization shall recommend to  
5 the commissioner that the commissioner assess penalties against a  
6 carrier in accordance with the provisions of this section. The penalties  
7 shall be sued for and collected in a summary manner pursuant to "the  
8 penalty enforcement law," N.J.S.2A:58-1 et seq. The penalties shall  
9 be in addition to any interest payments owed to the health care  
10 provider or insured.

11 (1) For any violation of sections 78, 79 or 80 of P.L.1991, c.187  
12 (C.17B:26-12.1, 17B:27-44.1 or 26:2J-5.1) or sections 4 through 8 of  
13 P.L. , c. (C. )(pending before the Legislature as this bill), a carrier  
14 shall be liable to a penalty of \$500 per claim for each day an  
15 uncontested claim or uncontested portion of a claim is processed  
16 beyond the 30-day limit for manual claims, and the 17-day limit for  
17 electronic claims, up to a maximum of \$10,000 for each violation.

18 (2) A carrier who fails to respond to review organization inquiries  
19 within the time period specified by the review organization shall be  
20 liable to a penalty of \$1,000 per day for each day the carrier fails to  
21 respond.

22 f. The commissioner shall establish a reasonable, per case  
23 reimbursement schedule for the review organization. The cost of the  
24 review shall be borne by the carrier.

25 g. For the purpose of ensuring access to an independent review  
26 pursuant to this section, every health care coverage identification card  
27 issued to an insured by or on behalf of the carrier shall include the  
28 telephone number of the Division of Enforcement and Consumer  
29 Protection.

30 h. The commissioner shall contract with one or more independent  
31 auditors to perform an audit of all carriers, at the carriers' expense, to  
32 verify compliance with the provisions of P.L. , c. (pending before  
33 the Legislature as this bill). The department shall audit all carriers one  
34 year after the effective date of P.L. , c. (pending before the  
35 Legislature as this bill) and at such future intervals as the  
36 commissioner deems necessary based on the past performance of a  
37 carrier in complying with the provisions of P.L. , c. (pending before  
38 the Legislature as this bill).

39 i. The commissioner shall report to the Governor and the  
40 Legislature by October 1 of each year on the status of the Independent  
41 Third Party Payment Appeals Program, and include in the report  
42 carrier-specific and aggregate statistics on the number of complaints  
43 filed, the average length of time required to adjudicate the complaints,  
44 the disposition of the complaints, and the dollar amount of penalties  
45 assessed for violations of P.L. , c. (pending before the Legislature  
46 as this bill). The department shall make copies of the report available

1 to the public.

2 j. For the purposes of this section, "carrier" means an individual or  
3 group health insurer, health, medical, hospital or dental service  
4 organization, health maintenance organization and dental plan  
5 organization and includes any intermediary contracted or affiliated  
6 with the carrier to perform administrative functions including, but not  
7 limited to, the payment of claims or the receipt, processing or transfer  
8 of claims or claim information; and "insured" means an insured, health,  
9 medical, hospital or dental service organization subscriber and health  
10 maintenance organization or dental plan organization enrollee.

11 k. The Commissioner of Banking and Insurance shall adopt  
12 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
13 c.410 (C.52:14B-1 et seq.) to carry out the purposes of this section.

14

15 10. This act shall take effect on the 60th day after enactment.

16

17

18

#### STATEMENT

19

20 This bill expands existing law concerning prompt payment of claims  
21 by health insurance carriers and health maintenance organizations to  
22 include health, hospital, medical and dental service corporations and  
23 dental plan organizations and any intermediary contracted or affiliated  
24 with the carrier to perform administrative claims functions. The bill  
25 also reduces the amount of time in which a claim must be paid or  
26 contested by a carrier from 60 days to 30 days for manual claims and  
27 17 days for electronic claims. The bill also requires that a carrier shall  
28 pay or deny a contested claim within 30 days, rather than 90 days as  
29 the law currently provides.

30 In order to ensure enforcement of the prompt pay provisions, the  
31 bill establishes an Independent Third Party Payment Appeals Program  
32 in the Division of Enforcement and Consumer Protection in the  
33 Department of Banking and Insurance to address health care payment  
34 complaints of any health care provider or insured person. Under the  
35 program, any provider or insured person shall have the right to an  
36 independent review of a health care coverage payment complaint  
37 against a health insurance carrier. The decision of the review  
38 organization will be binding on all parties.

39 Under the program, the Department of Banking and Insurance  
40 would contract with one or more independent utilization review  
41 organizations or other independent health care review organizations  
42 whose staff has experience in reviewing negotiated contract  
43 arrangements and health care payment methodologies to implement the  
44 program. To initiate a complaint, a health care provider or insured  
45 person would file a written complaint with the program on forms  
46 provided by the department. Upon receipt of a complaint, the program

1 shall assess the nature of the complaint and, if determined to be  
2 carrier-payment related, immediately assign the complaint to a review  
3 organization for review and determination.

4 The review organization will conduct a full review of the complaint  
5 and issue a decision, as soon as possible, but no later than 30 business  
6 days from receipt of all documentation necessary to complete the  
7 review. In reaching its decision, the review organization shall take  
8 into consideration all pertinent medical records, applicable generally  
9 accepted practice guidelines, contract and payment terms between the  
10 carrier and insured or provider, applicable billing records, and other  
11 documents submitted by the parties.

12 When appropriate, the review organization shall recommend to the  
13 Commissioner of Banking and Insurance that the commissioner assess  
14 penalties against a carrier who is in violation of the prompt pay  
15 provisions of the bill. The penalties shall be in addition to any interest  
16 payments owed to the health care provider or insured person. The  
17 penalties are:

18 (1) \$500 per claim for each day an uncontested claim or  
19 uncontested portion of a claim is processed beyond the 30-day limit  
20 for manual claims and the 17-day limit for electronic claims, up to a  
21 maximum of \$10,000 for each violation; and

22 (2) \$1,000 per day for each day a carrier fails to respond to review  
23 organization inquiries within the time period specified by the review  
24 organization.

25 For the purpose of ensuring access to an independent review, all  
26 health care coverage identification cards issued by or on behalf of  
27 carriers to insured persons shall include the telephone number of the  
28 Division of Enforcement and Consumer Protection.

29 The bill also requires the commissioner to contract with one or  
30 more independent auditors to perform an audit of all carriers, at the  
31 carriers' expense, to verify compliance with the provisions of the bill.

32 Finally, the bill provides that the Commissioner of Banking and  
33 Insurance shall report to the Governor and the Legislature by October  
34 1 of each year on the status of the Independent Third Party Payment  
35 Appeals Program, and include in the report carrier-specific and  
36 aggregate statistics on the number of complaints filed, the average  
37 length of time required to adjudicate the complaints, the disposition of  
38 the complaints, and the dollar amount of penalties assessed for  
39 violations of the bill.

# ASSEMBLY BANKING AND INSURANCE COMMITTEE

## STATEMENT TO

### ASSEMBLY, No. 2121

# STATE OF NEW JERSEY

DATED: SEPTEMBER 14, 1998

The Assembly Banking and Insurance Committee reports favorably Assembly Bill No. 2121.

This bill expands existing law concerning prompt payment of claims by commercial individual and group health insurance carriers and health maintenance organizations to include health, hospital, medical and dental service corporations and dental plan organizations and any intermediary contracted or affiliated with the carrier to perform administrative claims functions. The bill also reduces the amount of time in which a claim must be paid or contested by a carrier from 60 days to 30 days for manual claims and 17 days for electronic claims. The bill also requires that a carrier shall pay or deny a contested claim within 30 days, rather than 90 days as the law currently provides.

In order to ensure enforcement of the prompt pay provisions, the bill establishes an Independent Third Party Payment Appeals Program in the Division of Enforcement and Consumer Protection in the Department of Banking and Insurance to address health care payment complaints of any health care provider or insured person. Under the program, any provider or insured person shall have the right to an independent review of a health care coverage payment complaint against a health insurance carrier. The decision of the review organization will be binding on all parties.

Under the program, the Department of Banking and Insurance may contract with one or more independent utilization review organizations or other independent health care review organizations whose staff has experience in reviewing negotiated contract arrangements and health care payment methodologies to implement the program. To initiate a complaint, a health care provider or insured person would file a written complaint with the program on forms provided by the department. Upon receipt of a complaint, the program shall assess the nature of the complaint and, if determined to be carrier-payment related, immediately assign the complaint to a review organization for review and determination.

The review organization will conduct a full review of the complaint and issue a decision, as soon as possible, but no later than 30 business days from receipt of all documentation necessary to complete the review. In reaching its decision, the review organization shall take

into consideration all pertinent medical records, applicable generally accepted practice guidelines, contract and payment terms between the carrier and insured or provider, applicable billing records, and other documents submitted by the parties. A final decision of the review organization shall be binding on the carrier and provider or insured, as applicable. However, the provisions of the bill do not restrict a carrier, provider or insured from pursuing other legal remedies available under current law.

When appropriate, the review organization shall recommend to the Commissioner of Banking and Insurance that the commissioner assess penalties against a carrier who is in violation of the prompt pay provisions of the bill. The penalties shall be in addition to any interest payments owed to the health care provider or insured person. The penalties are:

(1) \$500 per claim for each day an uncontested claim or uncontested portion of a claim is processed beyond the 30-day limit for manual claims and the 17-day limit for electronic claims, up to a maximum of \$10,000 for each violation; and

(2) \$1,000 per day for each day a carrier fails to respond to review organization inquiries within the time period specified by the review organization.

For the purpose of ensuring access to an independent review, all health care coverage identification cards issued by or on behalf of carriers to insured persons shall include the telephone number of the Division of Enforcement and Consumer Protection.

The bill also requires the commissioner to contract with one or more independent auditors to perform an audit of all carriers, at the carriers' expense, to verify compliance with the provisions of the bill.

Finally, the bill provides that the Commissioner of Banking and Insurance shall report to the Governor and the Legislature by October 1 of each year on the status of the Independent Third Party Payment Appeals Program, and include in the report carrier-specific and aggregate statistics on the number of complaints filed, the average length of time required to adjudicate the complaints, the disposition of the complaints, and the dollar amount of penalties assessed for violations of the bill.

# SENATE HEALTH COMMITTEE

## STATEMENT TO

### SENATE COMMITTEE SUBSTITUTE FOR **SENATE, Nos. 1148 and 1228**

# **STATE OF NEW JERSEY**

DATED: OCTOBER 15, 1998

The Senate Health Committee reports favorably a Senate Committee Substitute for Senate Bill Nos. 1148 and 1228.

This substitute provides for the prompt payment of health care and dental claims by commercial insurance companies, health, hospital and medical service corporations, health maintenance organizations, dental service corporations and dental plan organizations authorized to issue health benefits and dental plans in this State. The provisions of this substitute shall apply only to insured health benefits or dental plans and insured claims submitted to payers. Under the substitute, "payer" means a health benefits plan or dental carrier, or any agent thereof, who is under a contractual obligation to pay insured claims.

To provide for enforcement of the prompt payment provisions, the substitute also provides for: reporting by payers to the Commissioner of Banking and Insurance about claim denials and claims that are not paid in a timely fashion; and enforcement actions the commissioner may take in the event of an unreasonably large or disproportionate number of rejected, denied or unpaid claims by a payer.

**Prompt Payment of Claims:** The substitute provides that a payer shall remit payment for every insured claim submitted by a covered person or that person's agent or assignee, if the health benefits or dental plan provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer, or the time limit established for the payment of claims in the Medicare program, whichever is earlier, if: (1) 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 benefits or dental plan; (2) the claim has no defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding; (3) there is no dispute regarding the amount claimed; (4) the payer has no reason to believe that the claim has been submitted fraudulently; and (5) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the health benefits or dental plan.

A payer is also required to pay any portion of a claim that meets the above criteria in accordance with the time limit established in the

substitute.

If all or a portion of the claim is denied by the payer because: (1) the claim is an ineligible claim; (2) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer; (3) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect; (4) the payer disputes the amount claimed; or (5) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the health benefits or dental plan, the payer shall notify the covered person, or that person's agent or assignee, if the plan provides for the assignment of benefits, in writing or by electronic means, within 21 days, of the reason the claim or portion thereof was denied.

The substitute directs a payer to acknowledge receipt of a claim submitted by electronic means, no later than 24 hours following receipt of the claim. Also, beginning no later than nine months after the date of enactment, a payer shall provide a participating health care provider with a monthly statement showing the claims, other than electronic claims, received from the provider during the previous month. The statement shall include the date the claim was received by the payer.

Payment of an eligible claim, or portion thereof, shall be deemed to be overdue if not remitted to the claimant by the payer on or before the 30th calendar day following receipt by the payer of a claim. An overdue payment shall bear simple interest at the rate of 10% per annum.

The substitute requires a payer to provide covered persons and eligible health care providers with a toll-free telephone number for making inquiries regarding paid claims or pending claims. If the Commissioner of Banking and Insurance determines that the toll-free telephone numbers provided by the payer are not adequate, he may require separate toll-free numbers for covered persons and health care providers. A payer shall respond to any covered person's or health care provider's claim inquiry no later than three business days after receipt of the inquiry.

**Payer Reporting Requirements:** A payer is required to maintain a record, to be submitted to the Commissioner of Banking and Insurance semiannually or, at the request of the commissioner, quarterly, of the number of claims, by category: (1) that are denied because they are for an ineligible service or the health care service was not rendered by an eligible health care provider under the health benefits or dental plan; (2) that are rejected at their initial submission because of a lack of substantiating documentation; (3) that are rejected at their initial submission because of incorrect coding or incorrect enrollment information; (4) that are rejected at their initial submission because of the amount claimed; (5) that are not paid in accordance with the time limit established in the substitute because the payer deems the claim to require special treatment that prevents timely payments from being made; (6) that are not paid in accordance with

the time limits for payment established in the substitute even though the claims meet the criteria for payment; (7) upon which the required interest due has been paid, and the aggregate amount of interest paid for the period covered by the report; and (8) that are denied or referred to the payer's fraud investigation unit, if applicable, or to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety because the payer has reason to believe that the claim has been submitted fraudulently.

Also, a payer is required to maintain a record, to be submitted to the commissioner, of the inquiries that have been made in writing or by telephone and electronic mail, by a covered person or eligible health care provider, and have resulted in a finding by the payer that the claim has been lost by the payer or has not been received by the payer.

The substitute also requires that the annual financial examination that each payer is required to undergo by law, shall include an examination of the payer's compliance with these reporting and record keeping requirements.

**Enforcement actions:** If the Commissioner of Banking and Insurance determines that a payer has an unreasonably large or disproportionate number of claims that have been rejected, denied or not paid in a timely fashion, or that an unreasonably large or disproportionate number of claims have been reported to be lost or not received by the payer, or that the payer has failed to pay interest on overdue claims payments, he may, after notice and hearing: conduct an investigation of the payer's claims processing procedures; order an audit of the payer's claims processing procedures by a private auditing firm, at the expense of the payer; or both. As the result of his findings, the commissioner may, if he deems it necessary: require the implementation of a plan of remedial action by the payer; require that the payer's claims processing procedures be monitored by a private auditing firm for a time period he deems appropriate; or both.

If, following an audit, the implementation of a plan of remediation or the monitoring of the payer's claims processing procedures, the commissioner determines that: (1) an unreasonably large or disproportionate number of eligible claims continue to be rejected, denied, or not paid in a timely fashion; (2) a payer has failed to pay required interest; or (3) an unreasonably large or disproportionate number of claims continue to be reported lost or not received by the payer, the commissioner may impose a civil penalty of not less than \$10,000 upon the payer.

**Capitation Payments:** With respect to capitation payments to a health care provider, the substitute provides that payment of a capitation payment shall be deemed to be overdue if not remitted to the provider on the fifth business day following the due date of the payment in the contract, if: the health care provider is not in violation of the terms of the contract; and the health care provider has supplied such information to the insurer as may be required under the contract before payment is to be made. An overdue payment shall bear simple



interest at the rate of 10% per annum.

**Repealers:** The substitute repeals 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 are obviated by this substitute. These sections required that commercial insurers and health maintenance organizations pay health care claims within 60 days.

STATEMENT TO  
SENATE COMMITTEE SUBSTITUTE FOR  
**SENATE, Nos. 1148 and 1228**

with Senate Floor Amendments  
(Proposed By Senator SINAGRA)

ADOPTED: DECEMBER 10, 1998

These amendments:

- clarify in the definition of "payer" that payer means a carrier or any agent thereof who is doing business in the State;
- add the word "material" to modify defect or impropriety in the reasons for not denying a claim;
- require that a payer notify a claimant within 30 days, rather than 21 days, if a claim will be denied and include in the notice all the reasons for the denial;
- require a payer to acknowledge receipt of a claim submitted electronically within two working days of receipt, rather than 24 hours, and to provide a monthly summary of outstanding claims, only upon request of the provider;
- require that the record of claims payment practices a payer must maintain and submit to the Commissioner of Banking and Insurance, be audited by a private auditing firm at the expense of the payer and be submitted to the Governor and the Legislature, as well as the commissioner. The substitute originally provided the commissioner with the option to order the audit after determining that an unreasonable number of claims have been denied, rejected or not paid in a timely fashion;
- delete the requirement that a payer maintain and submit to the commissioner, a record of telephone and mail inquiries that result in a finding that a claim has been lost or not received by the payer;
- provide that the commissioner shall, rather than may, impose a civil penalty on a payer if the commissioner determines that an unreasonable number of claims have been denied, rejected or not paid in a timely fashion or the payer has failed to pay interest on the overdue claims; and
- require the commissioner to adopt regulations to carry out the purposes of the substitute, within 90 days, rather than 180 days, and provide that the substitute will take effect 90 days, rather than 60 days, after enactment.

STATEMENT TO

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR  
**SENATE, Nos 1148 and 1228**

with Senate Floor Amendments  
(Proposed By Senator SINAGRA)

ADOPTED: DECEMBER 17, 1998

These amendments delete the provisions of the substitute that set forth the specific "prompt pay" requirements for health insurance carriers. As amended, the substitute includes provisions for enforcement by the Department of Banking and Insurance of the "prompt pay" requirements that are set forth in other pending legislation.

# SENATE, No. 1148

## STATE OF NEW JERSEY 208th LEGISLATURE

INTRODUCED JUNE 4, 1998

**Sponsored by:**

**Senator JACK SINAGRA**

**District 18 (Middlesex)**

**Senator RICHARD J. CODEY**

**District 27 (Essex)**

**Co-Sponsored by:**

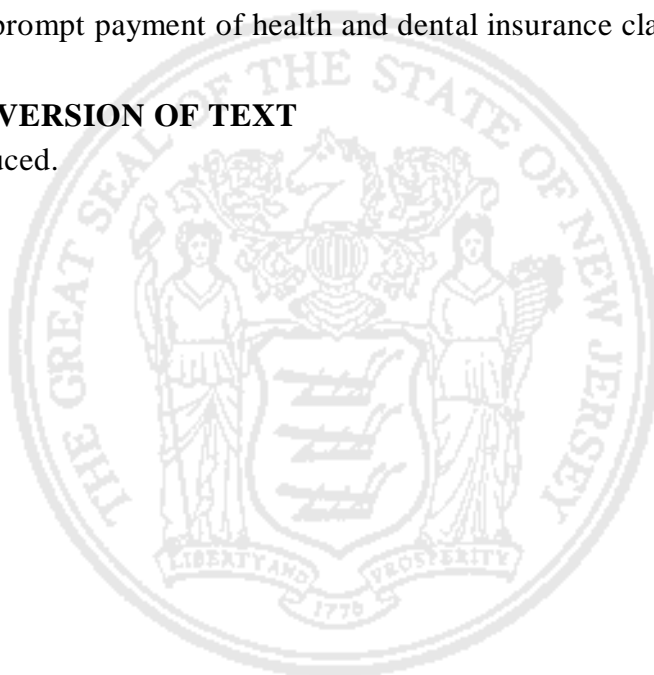
**Senators Inverso, Bark, Bassano, Cafiero, Singer, Matheussen, Adler, Kenny, Vitale, Baer, Martin, Palaia, Cardinale, Allen, Connors, O'Connor, Bucco, Zane, Girgenti, Kosco, Bryant, Lynch, Furnari, Bennett, Littell, Lesniak, Ciesla and Turner**

**SYNOPSIS**

Requires prompt payment of health and dental insurance claims.

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 9/18/1998)**

S1148 SINAGRA, CODEY

2

1 AN ACT concerning prompt payment of health insurance claims,  
2 amending P.L.1991, c.187 and supplementing Title 17 of the  
3 Revised Statutes and Title 17B of the New Jersey Statutes.

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

7  
8 1. Section 78 of P.L.1991, c.187 (C.17B:26-12.1) is amended to  
9 read as follows:

10 78. a. (1) A health insurer or its agent shall, within 10 working  
11 days following receipt of a claim, acknowledge receipt of that claim  
12 unless payment is made prior to the expiration of the 10-working-day  
13 period, and shall include in the notice the address and telephone  
14 number of the health insurer or authorized claims representative who  
15 will handle the claim.

16 (2) A health insurer or its agent shall reimburse all clean claims or  
17 any portion of any clean claim from an insured or an insured's  
18 assignee, for payment under a health insurance policy, within [60] 30  
19 days after receipt of [the] a manual claim or within 17 days after  
20 receipt of an electronic claim by the health insurer or its agent. If a  
21 claim or a portion of a claim is contested by the health insurer or its  
22 agent, the insured or the insured's assignee shall be notified in writing  
23 within [45] 30 days after receipt of [the] a manual claim or 17 days  
24 after receipt of an electronic claim by the health insurer or its agent,  
25 that the claim is contested or denied; except that, the uncontested  
26 portion of the claim shall be paid within [60] 30 days after receipt of  
27 [the] a manual claim or 17 days after receipt of an electronic claim by  
28 the health insurer or its agent.

29 The notice that a claim is contested shall [identify the contested  
30 portion of the claim and the reasons for contesting the claim] be  
31 conveyed on a standard claims payment dispute form and shall include:

32 (a) the date of the service, the type of service and the name of the  
33 insured and health care provider who are the subjects of the claim;

34 (b) the contested portion of the claim and all of the reasons, using  
35 standard codes of explanation, for which the claim is contested;

36 (c) the specific information needed by the health insurer to make a  
37 determination that the claim is a clean claim; and

38 (d) the name, address, telephone number and facsimile number of  
39 the health insurer's claims representative who is knowledgeable about  
40 the claim, with whom the insured or the insured's assignee or the  
41 health care provider should correspond to resolve problems with the  
42 claim.

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

Matter underlined thus is new matter.

1 A health insurer or its agent, upon receipt of the additional  
2 information requested from the insured or the insured's assignee, shall  
3 pay or deny the contested claim or portion of the contested claim,  
4 within **[90]** 30 days.

5 Payment shall be treated as being made on the date a draft or other  
6 valid instrument which is equivalent to payment was placed in the  
7 United States mail in a properly addressed, postpaid envelope or, if  
8 not so posted, on the date of delivery or electronic fund transfer.

9 b. An overdue payment shall bear simple interest at the rate of  
10 10% per year, commencing on the 31st day after receipt of a manual  
11 claim or any clean portion of a manual claim or on the 18th day after  
12 receipt of an electronic claim or any clean portion of an electronic  
13 claim, by the health insurer or its agent. For the purpose of  
14 determining interest charges in the event the insured or his assignee  
15 prevails in a contested claim, a payment shall be considered overdue  
16 at the expiration of the 30-day period for manual claims and the 17-  
17 day period for electronic claims provided in subsection a. of this  
18 section or, if the insured or his assignee was required to provide  
19 additional information to the health insurer or its agent, within 10  
20 business days following receipt by the health insurer or its agent of all  
21 information requested by the health insurer or its agent, whichever  
22 date is later.

23 c. For the purposes of this section, "health insurer" means an  
24 insurer authorized to provide health insurance on an individual basis  
25 pursuant to chapter 26 of Title 17B of the New Jersey Statutes, "clean  
26 claim" has the same meaning given the term in the federal Medicare  
27 program pursuant to 42 U.S.C.s.1395u(c)(2)(B) and "agent" means  
28 any intermediary contracted or affiliated with the health insurer to  
29 perform administrative functions including, but not limited to, the  
30 payment of claims or the receipt, processing or transfer of claims or  
31 claim information.

32 d. The Department of Banking and Insurance shall adopt rules and  
33 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
34 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.  
35 (cf: P.L.1991, c.187, s.78)

36  
37 2. Section 79 of P.L.1991, c.187 (C.17B:27-44.1) is amended to  
38 read as follows:

39 79. a. (1) A health insurer or its agent shall, within 10 working  
40 days following receipt of a claim, acknowledge receipt of that claim  
41 unless payment is made prior to the expiration of the 10 working day  
42 period, and shall include in the notice the address and telephone  
43 number of the health insurer or authorized claims representative who  
44 will handle the claim.

45 (2) A health insurer or its agent shall reimburse all clean claims or  
46 any portion of any clean claim from an insured or an insured's

1 assignee, for payment under a health insurance policy, within ~~60~~ 30  
2 days after receipt of ~~the~~ a manual claim or within 17 days after  
3 receipt of an electronic claim by the health insurer or its agent. If a  
4 claim or a portion of a claim is contested by the health insurer or its  
5 agent, the insured or the insured's assignee shall be notified in writing  
6 within ~~45~~ 30 days after receipt of ~~the~~ a manual claim or 17 days  
7 after receipt of an electronic claim by the health insurer or its agent,  
8 that the claim is contested or denied; except that, the uncontested  
9 portion of the claim shall be paid within ~~60~~ 30 days after receipt of  
10 ~~the~~ a manual claim or 17 days after receipt of an electronic claim by  
11 the health insurer or its agent.

12 The notice that a claim is contested shall ~~identify the contested~~  
13 ~~portion of the claim and the reasons for contesting the claim~~ be  
14 conveyed on a standard claims payment dispute form and shall include:

15 (a) the date of the service, the type of service and the name of the  
16 insured and health care provider who are the subjects of the claim;

17 (b) the contested portion of the claim and all of the reasons, using  
18 standard codes of explanation, for which the claim is contested;

19 (c) the specific information needed by the health insurer to make  
20 a determination that the claim is a clean claim; and

21 (d) the name, address, telephone number and facsimile number of  
22 the health insurer's claims representative who is knowledgeable about  
23 the claim, with whom the insured or the insured's assignee or the  
24 health care provider should correspond to resolve problems with the  
25 claim.

26 A health insurer or its agent, upon receipt of the additional  
27 information requested from the insured or the insured's assignee, shall  
28 pay or deny the contested claim or portion of the contested claim,  
29 within ~~90~~ 30 days.

30 Payment shall be treated as being made on the date a draft or other  
31 valid instrument which is equivalent to payment was placed in the  
32 United States mail in a properly addressed, postpaid envelope or, if  
33 not so posted, on the date of delivery or electronic fund transfer.

34 b. An overdue payment shall bear simple interest at the rate of 10%  
35 per year, commencing on the 31st day after receipt of a manual claim  
36 or any clean portion of a manual claim or on the 18th day after receipt  
37 of an electronic claim or any clean portion of an electronic claim, by  
38 the health insurer or its agent. For the purpose of determining interest  
39 charges in the event the insured or his assignee prevails in a contested  
40 claim, a payment shall be considered overdue at the expiration of the  
41 30-day period for manual claims and the 17-day period for electronic  
42 claims provided in subsection a. of this section or, if the insured or his  
43 assignee was required to provide additional information to the health  
44 insurer or its agent, within 10 business days following receipt by the  
45 health insurer or its agent of all information requested by the health  
46 insurer or its agent, whichever date is later.

1 c. For the purposes of this section, "health insurer" means an  
2 insurer authorized to provide health insurance on a group basis  
3 pursuant to chapter 27 of Title 17B of the New Jersey Statutes, "clean  
4 claim" has the same meaning given the term in the federal Medicare  
5 program pursuant to 42 U.S.C.s.1395u(c)(2)(B) and "agent" means  
6 any intermediary contracted or affiliated with the health insurer to  
7 perform administrative functions including, but not limited to, the  
8 payment of claims or the receipt, processing or transfer of claims or  
9 claim information.

10 d. The Department of Banking and Insurance shall adopt rules and  
11 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
12 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.  
13 (cf: P.L.1991, c.187, s.79)

14  
15 3. Section 80 of P.L.1991, c.187 (C.26:2J-5.1) is amended to read  
16 as follows:

17 80. a. (1) A health maintenance organization or its agent shall,  
18 within 10 working days following receipt of a claim, acknowledge  
19 receipt of that claim unless payment is made prior to the expiration of  
20 the 10 working day period, and shall include in the notice the address  
21 and telephone number of the health maintenance organization or  
22 authorized claims representative who will handle the claim.

23 (2) A health maintenance organization or its agent shall reimburse  
24 all clean claims or any portion of any clean claim from an enrollee or  
25 an enrollee's assignee, for payment under a health maintenance  
26 organization coverage, within ~~60~~ 30 days after receipt of ~~the~~ a  
27 manual claim or within 17 days after receipt of an electronic claim by  
28 the health maintenance organization or its agent. If a claim or a  
29 portion of a claim is contested by the health maintenance organization  
30 or its agent, the enrollee or the enrollee's assignee shall be notified in  
31 writing within ~~45~~ 30 days after receipt of ~~the~~ a manual claim or  
32 17 days after receipt of an electronic claim by the health maintenance  
33 organization or its agent, that the claim is contested or denied; except  
34 that, the uncontested portion of the claim shall be paid within ~~60~~ 30  
35 days after receipt of ~~the~~ a manual claim or 17 days after receipt of an  
36 electronic claim by the health maintenance organization or its agent.

37 The notice that a claim is contested shall ~~identify the contested~~  
38 portion of the claim and the reasons for contesting the claim ~~be~~  
39 conveyed on a standard claims payment dispute form and shall include:

40 (a) the date of the service, the type of service and the name of the  
41 enrollee and health care provider who are the subjects of the claim;

42 (b) the contested portion of the claim and all of the reasons, using  
43 standard codes of explanation, for which the claim is contested;

44 (c) the specific information needed by the health maintenance  
45 organization to make a determination that the claim is a clean claim;  
46 and



1     (d) the name, address, telephone number and facsimile number of  
2 the health maintenance organization's claims representative who is  
3 knowledgeable about the claim, with whom the enrollee or the  
4 enrollee's assignee or the health care provider should correspond to  
5 resolve problems with the claim.

6     A health maintenance organization or its agent, upon receipt of the  
7 additional information requested from the enrollee or the enrollee's  
8 assignee, shall pay or deny the contested claim or portion of the  
9 contested claim, within **[90]** 30 days.

10     Payment shall be treated as being made on the date a draft or other  
11 valid instrument which is equivalent to payment was placed in the  
12 United States mail in a properly addressed, postpaid envelope or, if  
13 not so posted, on the date of delivery or electronic fund transfer.

14     b. An overdue payment shall bear simple interest at the rate of 10%  
15 per year, commencing on the 31st day after receipt of a manual claim  
16 or any clean portion of a manual claim or on the 18th day after receipt  
17 of an electronic claim or any clean portion of an electronic claim, by  
18 the health maintenance organization or its agent. For the purpose of  
19 determining interest charges in the event the enrollee or his assignee  
20 prevails in a contested claim, a payment shall be considered overdue  
21 at the expiration of the 30-day period for manual claims and the 17-  
22 day period for electronic claims provided in subsection a. of this  
23 section or, if the enrollee or his assignee was required to provide  
24 additional information to the health maintenance organization or its  
25 agent, within 10 business days following receipt by the health  
26 maintenance organization or its agent of all information requested by  
27 the health maintenance organization or its agent, whichever date is  
28 later.

29     c. For the purposes of this section, "health maintenance  
30 organization" means a health maintenance organization authorized  
31 pursuant to the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.,  
32 "clean claim" has the same meaning given the term in the federal  
33 Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B) and "agent"  
34 means any intermediary contracted or affiliated with the health  
35 maintenance organization to perform administrative functions  
36 including, but not limited to, the payment of claims or the receipt,  
37 processing or transfer of claims or claim information.

38     d. The Department of Health and Senior Services shall adopt rules  
39 and regulations pursuant to the "Administrative Procedure Act,"  
40 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of  
41 this section.

42 (cf: P.L.1991, c.187, s.80)

43  
44     4. (New Section) a. (1) A health service corporation or its agent  
45 shall, within 10 working days following receipt of a claim,  
46 acknowledge receipt of that claim unless payment is made prior to the

1 expiration of the 10 working day period, and shall include in the notice  
2 the address and telephone number of the health service corporation or  
3 authorized claims representative who will handle the claim.

4 (2) A health service corporation or its agent shall reimburse all  
5 clean claims or any portion of any clean claim from a subscriber or a  
6 subscriber's assignee, for payment under a health insurance policy,  
7 within 30 days after receipt of a manual claim or within 17 days after  
8 receipt of an electronic claim by the health service corporation or its  
9 agent. If a claim or a portion of a claim is contested by the health  
10 service corporation or its agent, the subscriber or the subscriber's  
11 assignee shall be notified in writing within 30 days after receipt of a  
12 manual claim or 17 days after receipt of an electronic claim by the  
13 health service corporation or its agent, that the claim is contested or  
14 denied; except that, the uncontested portion of the claim shall be paid  
15 within 30 days after receipt of a manual claim or 17 days after receipt  
16 of an electronic claim by the health service corporation or its agent.

17 The notice that a claim is contested shall be conveyed on a standard  
18 claims payment dispute form and shall include:

19 (a) the date of the service, the type of service and the name of the  
20 subscriber and health care provider who are the subjects of the claim;

21 (b) the contested portion of the claim and all of the reasons, using  
22 standard codes of explanation, for which the claim is contested;

23 (c) the specific information needed by the health service corporation  
24 to make a determination that the claim is a clean claim; and

25 (d) the name, address, telephone number and facsimile number of  
26 the health service corporation's claims representative who is  
27 knowledgeable about the claim, with whom the subscriber or the  
28 subscriber's assignee or the health care provider should correspond to  
29 resolve problems with the claim.

30 A health service corporation or its agent, upon receipt of the  
31 additional information requested from the subscriber or the  
32 subscriber's assignee, shall pay or deny the contested claim or portion  
33 of the contested claim, within 30 days.

34 Payment shall be treated as being made on the date a draft or other  
35 valid instrument which is equivalent to payment was placed in the  
36 United States mail in a properly addressed, postpaid envelope or, if  
37 not so posted, on the date of delivery or electronic fund transfer.

38 b. An overdue payment shall bear simple interest at the rate of 10%  
39 per year, commencing on the 31st day after receipt of a manual claim  
40 or any clean portion of a manual claim or on the 18th day after receipt  
41 of an electronic claim or any clean portion of an electronic claim, by  
42 the health service corporation or its agent. For the purpose of  
43 determining interest charges in the event the subscriber or his assignee  
44 prevails in a contested claim, a payment shall be considered overdue  
45 at the expiration of the 30-day period for manual claims and the 17-  
46 day period for electronic claims provided in subsection a. of this

1 section or, if the subscriber or his assignee was required to provide  
2 additional information to the health service corporation or its agent,  
3 within 10 business days following receipt by the health service  
4 corporation or its agent of all information requested by the health  
5 service corporation or its agent, whichever date is later.

6 c. For the purposes of this section, "clean claim" has the same  
7 meaning given the term in the federal Medicare program pursuant to  
8 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
9 contracted or affiliated with the health service corporation to perform  
10 administrative functions including, but not limited to, the payment of  
11 claims or the receipt, processing or transfer of claims or claim  
12 information.

13 d. The Department of Banking and Insurance shall adopt rules and  
14 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
15 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.  
16

17 5. (New Section) a. (1) A medical service corporation or its  
18 agent shall, within 10 working days following receipt of a claim,  
19 acknowledge receipt of that claim unless payment is made prior to the  
20 expiration of the 10 working day period, and shall include in the notice  
21 the address and telephone number of the medical service corporation  
22 or authorized claims representative who will handle the claim.

23 (2) A medical service corporation or its agent shall reimburse all  
24 clean claims or any portion of any clean claim from a subscriber or a  
25 subscriber's assignee, for payment under a health insurance policy,  
26 within 30 days after receipt of a manual claim or within 17 days after  
27 receipt of an electronic claim by the medical service corporation or its  
28 agent. If a claim or a portion of a claim is contested by the medical  
29 service corporation or its agent, the subscriber or the subscriber's  
30 assignee shall be notified in writing within 30 days after receipt of a  
31 manual claim or 17 days after receipt of an electronic claim by the  
32 medical service corporation or its agent, that the claim is contested or  
33 denied; except that, the uncontested portion of the claim shall be paid  
34 within 30 days after receipt of a manual claim or 17 days after receipt  
35 of an electronic claim by the medical service corporation or its agent.

36 The notice that a claim is contested shall be conveyed on a standard  
37 claims payment dispute form and shall include:

38 (a) the date of the service, the type of service and the name of the  
39 subscriber and health care provider who are the subjects of the claim;

40 (b) the contested portion of the claim and all of the reasons, using  
41 standard codes of explanation, for which the claim is contested;

42 (c) the specific information needed by the medical service  
43 corporation to make a determination that the claim is a clean claim;  
44 and

45 (d) the name, address, telephone number and facsimile number of  
46 the medical service corporation's claims representative who is

1 knowledgeable about the claim, with whom the subscriber or the  
2 subscriber's assignee or the health care provider should correspond to  
3 resolve problems with the claim.

4 A medical service corporation or its agent, upon receipt of the  
5 additional information requested from the subscriber or the  
6 subscriber's assignee, shall pay or deny the contested claim or portion  
7 of the contested claim, within 30 days.

8 Payment shall be treated as being made on the date a draft or other  
9 valid instrument which is equivalent to payment was placed in the  
10 United States mail in a properly addressed, postpaid envelope or, if  
11 not so posted, on the date of delivery or electronic fund transfer.

12 b. An overdue payment shall bear simple interest at the rate of 10%  
13 per year, commencing on the 31st day after receipt of a manual claim  
14 or any clean portion of a manual claim or on the 18th day after receipt  
15 of an electronic claim or any clean portion of an electronic claim, by  
16 the medical service corporation or its agent. For the purpose of  
17 determining interest charges in the event the subscriber or his assignee  
18 prevails in a contested claim, a payment shall be considered overdue  
19 at the expiration of the 30-day period for manual claims and the 17-  
20 day period for electronic claims provided in subsection a. of this  
21 section or, if the subscriber or his assignee was required to provide  
22 additional information to the medical service corporation or its agent,  
23 within 10 business days following receipt by the medical service  
24 corporation or its agent of all information requested by the medical  
25 service corporation or its agent, whichever date is later.

26 c. For the purposes of this section, "clean claim" has the same  
27 meaning given the term in the federal Medicare program pursuant to  
28 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
29 contracted or affiliated with the medical service corporation to  
30 perform administrative functions including, but not limited to, the  
31 payment of claims or the receipt, processing or transfer of claims or  
32 claim information.

33 d. The Department of Banking and Insurance shall adopt rules and  
34 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
35 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

36  
37 6. (New Section) a. (1) A hospital service corporation or its agent  
38 shall, within 10 working days following receipt of a claim,  
39 acknowledge receipt of that claim unless payment is made prior to the  
40 expiration of the 10 working day period, and shall include in the notice  
41 the address and telephone number of the hospital service corporation  
42 or authorized claims representative who will handle the claim.

43 (2) A hospital service corporation or its agent shall reimburse all  
44 clean claims or any portion of any clean claim from a subscriber or a  
45 subscriber's assignee, for payment under a health insurance policy,  
46 within 30 days after receipt of a manual claim or within 17 days after

1 receipt of an electronic claim by the hospital service corporation or its  
2 agent. If a claim or a portion of a claim is contested by the hospital  
3 service corporation or its agent, the subscriber or the subscriber's  
4 assignee shall be notified in writing within 30 days after receipt of a  
5 manual claim or 17 days after receipt of an electronic claim by the  
6 hospital service corporation or its agent, that the claim is contested or  
7 denied; except that, the uncontested portion of the claim shall be paid  
8 within 30 days after receipt of a manual claim or 17 days after receipt  
9 of an electronic claim by the hospital service corporation or its agent.

10 The notice that a claim is contested shall be conveyed on a standard  
11 claims payment dispute form and shall include:

12 (a) the date of the service, the type of service and the name of the  
13 subscriber and health care provider who are the subjects of the claim;

14 (b) the contested portion of the claim and all of the reasons, using  
15 standard codes of explanation, for which the claim is contested;

16 (c) the specific information needed by the hospital service  
17 corporation to make a determination that the claim is a clean claim;  
18 and

19 (d) the name, address, telephone number and facsimile number of  
20 the hospital service corporation's claims representative who is  
21 knowledgeable about the claim, with whom the subscriber or the  
22 subscriber's assignee or the health care provider should correspond to  
23 resolve problems with the claim.

24 A hospital service corporation or its agent, upon receipt of the  
25 additional information requested from the subscriber or the  
26 subscriber's assignee, shall pay or deny the contested claim or portion  
27 of the contested claim, within 30 days.

28 Payment shall be treated as being made on the date a draft or other  
29 valid instrument which is equivalent to payment was placed in the  
30 United States mail in a properly addressed, postpaid envelope or, if  
31 not so posted, on the date of delivery or electronic fund transfer.

32 b. An overdue payment shall bear simple interest at the rate of 10%  
33 per year, commencing on the 31st day after receipt of a manual claim  
34 or any clean portion of a manual claim or on the 18th day after receipt  
35 of an electronic claim or any clean portion of an electronic claim, by  
36 the hospital service corporation or its agent. For the purpose of  
37 determining interest charges in the event the subscriber or his assignee  
38 prevails in a contested claim, a payment shall be considered overdue  
39 at the expiration of the 30-day period for manual claims and the 17-  
40 day period for electronic claims provided in subsection a. of this  
41 section or, if the subscriber or his assignee was required to provide  
42 additional information to the hospital service corporation or its agent,  
43 within 10 business days following receipt by the hospital service  
44 corporation or its agent of all information requested by the hospital  
45 service corporation or its agent, whichever date is later.

46 c. For the purposes of this section, "clean claim" has the same

1 meaning given the term in the federal Medicare program pursuant to  
2 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
3 contracted or affiliated with the hospital service corporation to  
4 perform administrative functions including, but not limited to, the  
5 payment of claims or the receipt, processing or transfer of claims or  
6 claim information.

7 d. The Department of Banking and Insurance shall adopt rules and  
8 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
9 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.  
10

11 7. (New Section) a. (1) A dental service corporation or its agent  
12 shall, within 10 working days following receipt of a claim,  
13 acknowledge receipt of that claim unless payment is made prior to the  
14 expiration of the 10 working day period, and shall include in the notice  
15 the address and telephone number of the dental service corporation or  
16 authorized claims representative who will handle the claim.

17 (2) A dental service corporation or its agent shall reimburse all  
18 clean claims or any portion of any clean claim from a subscriber or a  
19 subscriber's assignee, for payment under a health insurance policy,  
20 within 30 days after receipt of a manual claim or within 17 days after  
21 receipt of an electronic claim by the dental service corporation or its  
22 agent. If a claim or a portion of a claim is contested by the dental  
23 service corporation or its agent, the subscriber or the subscriber's  
24 assignee shall be notified in writing within 30 days after receipt of a  
25 manual claim or 17 days after receipt of an electronic claim by the  
26 dental service corporation or its agent, that the claim is contested or  
27 denied; except that, the uncontested portion of the claim shall be paid  
28 within 30 days after receipt of a manual claim or 17 days after receipt  
29 of an electronic claim by the dental service corporation or its agent.

30 The notice that a claim is contested shall be conveyed on a standard  
31 claims payment dispute form and shall include:

32 (a) the date of the service, the type of service and the name of the  
33 subscriber and health care provider who are the subjects of the claim;

34 (b) the contested portion of the claim and all of the reasons, using  
35 standard codes of explanation, for which the claim is contested;

36 (c) the specific information needed by the dental service corporation  
37 to make a determination that the claim is a clean claim; and

38 (d) the name, address, telephone number and facsimile number of  
39 the dental service corporation's claims representative who is  
40 knowledgeable about the claim, with whom the subscriber or the  
41 subscriber's assignee or the health care provider should correspond to  
42 resolve problems with the claim.

43 A dental service corporation or its agent, upon receipt of the  
44 additional information requested from the subscriber or the  
45 subscriber's assignee, shall pay or deny the contested claim or portion  
46 of the contested claim, within 30 days.

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

5 b. An overdue payment shall bear simple interest at the rate of 10%  
6 per year, commencing on the 31st day after receipt of a manual claim  
7 or any clean portion of a manual claim or on the 18th day after receipt  
8 of an electronic claim or any clean portion of an electronic claim, by  
9 the dental service corporation or its agent. For the purpose of  
10 determining interest charges in the event the subscriber or his assignee  
11 prevails in a contested claim, a payment shall be considered overdue  
12 at the expiration of the 30-day period for manual claims and the 17-  
13 day period for electronic claims provided in subsection a. of this  
14 section or, if the subscriber or his assignee was required to provide  
15 additional information to the dental service corporation or its agent,  
16 within 10 business days following receipt by the dental service  
17 corporation or its agent of all information requested by the dental  
18 service corporation or its agent, whichever date is later.

19 c. For the purposes of this section, "clean claim" has the same  
20 meaning given the term in the federal Medicare program pursuant to  
21 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
22 contracted or affiliated with the dental service corporation to perform  
23 administrative functions including, but not limited to, the payment of  
24 claims or the receipt, processing or transfer of claims or claim  
25 information.

26 d. The Department of Banking and Insurance shall adopt rules and  
27 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
28 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

29  
30 8. (New Section) a. (1) A dental plan organization or its agent  
31 shall, within 10 working days following receipt of a claim,  
32 acknowledge receipt of that claim unless payment is made prior to the  
33 expiration of the 10 working day period, and shall include in the notice  
34 the address and telephone number of the dental plan organization or  
35 authorized claims representative who will handle the claim.

36 (2) A dental plan organization or its agent shall reimburse all clean  
37 claims or any portion of any clean claim from an enrollee or an  
38 enrollee's assignee, for payment under a health insurance policy, within  
39 30 days after receipt of a manual claim or within 17 days after receipt  
40 of an electronic claim by the dental plan organization or its agent. If  
41 a claim or a portion of a claim is contested by the dental plan  
42 organization or its agent, the enrollee or the enrollee's assignee shall  
43 be notified in writing within 30 days after receipt of a manual claim or  
44 17 days after receipt of an electronic claim by the dental plan  
45 organization or its agent, that the claim is contested or denied; except  
46 that, the uncontested portion of the claim shall be paid within 30 days

1 after receipt of a manual claim or 17 days after receipt of an electronic  
2 claim by the dental plan organization or its agent.

3 The notice that a claim is contested shall be conveyed on a standard  
4 claims payment dispute form and shall include:

5 (a) the date of the service, the type of service and the name of the  
6 enrollee and health care provider who are the subjects of the claim;

7 (b) the contested portion of the claim and all of the reasons, using  
8 standard codes of explanation, for which the claim is contested;

9 (c) the specific information needed by the dental plan organization  
10 to make a determination that the claim is a clean claim; and

11 (d) the name, address, telephone number and facsimile number of  
12 the dental plan organization's claims representative who is  
13 knowledgeable about the claim, with whom the enrollee or the  
14 enrollee's assignee or the health care provider should correspond to  
15 resolve problems with the claim.

16 A dental plan organization or its agent, upon receipt of the  
17 additional information requested from the enrollee or the enrollee's  
18 assignee, shall pay or deny the contested claim or portion of the  
19 contested claim, within 30 days.

20 Payment shall be treated as being made on the date a draft or other  
21 valid instrument which is equivalent to payment was placed in the  
22 United States mail in a properly addressed, postpaid envelope or, if  
23 not so posted, on the date of delivery or electronic fund transfer.

24 b. An overdue payment shall bear simple interest at the rate of 10%  
25 per year, commencing on the 31st day after receipt of a manual claim  
26 or any clean portion of a manual claim or on the 18th day after receipt  
27 of an electronic claim or any clean portion of an electronic claim, by  
28 the dental plan organization or its agent. For the purpose of  
29 determining interest charges in the event the enrollee or his assignee  
30 prevails in a contested claim, a payment shall be considered overdue  
31 at the expiration of the 30-day period for manual claims and the 17-  
32 day period for electronic claims provided in subsection a. of this  
33 section or, if the enrollee or his assignee was required to provide  
34 additional information to the dental plan organization or its agent,  
35 within 10 business days following receipt by the dental plan  
36 organization or its agent of all information requested by the dental  
37 plan organization or its agent, whichever date is later.

38 c. For the purposes of this section, "clean claim" has the same  
39 meaning given the term in the federal Medicare program pursuant to  
40 42 U.S.C.s.1395u(c)(2)(B) and "agent" means any intermediary  
41 contracted or affiliated with the dental plan organization to perform  
42 administrative functions including, but not limited to, the payment of  
43 claims or the receipt, processing or transfer of claims or claim  
44 information.

45 d. The Department of Banking and Insurance shall adopt rules and  
46 regulations pursuant to the "Administrative Procedure Act," P.L.1968,



1 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

2

3 9. (New section) a. The Commissioner of Banking and Insurance  
4 shall establish an Independent Third Party Payment Appeals Program  
5 in the Division of Enforcement and Consumer Protection in the  
6 Department of Banking and Insurance to address health care payment  
7 complaints of any health care provider or insured. Under the program,  
8 any health care provider or insured shall have the right to an  
9 independent review of a health care coverage payment complaint made  
10 pursuant to this section.

11 b. The commissioner may contract with one or more independent  
12 utilization review organizations or other independent health care  
13 review organizations whose staff has experience in reviewing  
14 negotiated contract arrangements and health care payment  
15 methodologies, to implement the program. The review organization  
16 shall submit to the department and maintain a current list identifying  
17 all carriers, health care facilities and other health care providers and  
18 payers with whom the review organization maintains any health-related  
19 business arrangements. The list shall include a brief description of the  
20 nature of any such arrangement.

21 c. To initiate a complaint, a health care provider or insured shall  
22 file a written complaint with the program on forms provided by the  
23 department.

24 Upon receipt of a complaint, the program shall assess the nature of  
25 the complaint and, if determined to be carrier-payment related,  
26 immediately assign the complaint to a review organization for review  
27 and determination. In making a determination as to which review  
28 organization shall review a complaint, the program shall take into  
29 consideration the list of business arrangements submitted by the review  
30 organization. The program shall ensure that assignment of a complaint  
31 to a review organization will not result in a conflict of interest or  
32 otherwise create an appearance of impropriety.

33 d. Upon receipt of a complaint, the review organization shall:

34 (1) Acknowledge the complaint, in writing, to the health care  
35 provider or the insured who filed the complaint, within 10 business  
36 days of receipt of the complaint;

37 (2) Conduct a full review of the complaint and issue a decision  
38 regarding payment, as soon as possible, but no later than 30 business  
39 days from receipt of all documentation necessary to complete the  
40 review;

41 (3) Immediately notify the provider or insured, in writing, of its  
42 decision. A final decision of the review organization shall be binding  
43 on the carrier and provider or insured, as applicable; and

44 (4) In reaching its decision, the review organization shall take into  
45 consideration all pertinent medical records, applicable generally  
46 accepted practice guidelines, contract and payment terms between the

1 carrier and insured or provider, applicable billing records and other  
2 documents submitted by the parties.

3 e. When appropriate, the review organization shall recommend to  
4 the commissioner that the commissioner assess penalties against a  
5 carrier in accordance with the provisions of this section. The penalties  
6 shall be sued for and collected in a summary manner pursuant to "the  
7 penalty enforcement law," N.J.S.2A:58-1 et seq. The penalties shall  
8 be in addition to any interest payments owed to the health care  
9 provider or insured.

10 (1) For any violation of sections 78, 79 or 80 of P.L.1991, c.187  
11 (C.17B:26-12.1, 17B:27-44.1 or 26:2J-5.1) or sections 4 through 8 of  
12 P.L. , c. (C. )(pending before the Legislature as this bill), a carrier  
13 shall be liable to a penalty of \$500 per claim for each day an  
14 uncontested claim or uncontested portion of a claim is processed  
15 beyond the 30-day limit for manual claims, and the 17-day limit for  
16 electronic claims, up to a maximum of \$10,000 for each violation.

17 (2) A carrier who fails to respond to review organization inquiries  
18 within the time period specified by the review organization shall be  
19 liable to a penalty of \$1,000 per day for each day the carrier fails to  
20 respond.

21 f. The commissioner shall establish a reasonable, per case  
22 reimbursement schedule for the review organization. The cost of the  
23 review shall be borne by the carrier.

24 g. For the purpose of ensuring access to an independent review  
25 pursuant to this section, every health care coverage identification card  
26 issued to an insured by or on behalf of the carrier shall include the  
27 telephone number of the Division of Enforcement and Consumer  
28 Protection.

29 h. The commissioner shall contract with one or more independent  
30 auditors to perform an audit of all carriers, at the carriers' expense, to  
31 verify compliance with the provisions of P.L. , c. (pending before  
32 the Legislature as this bill). The department shall audit all carriers one  
33 year after the effective date of P.L. , c. (pending before the  
34 Legislature as this bill) and at such future intervals as the  
35 commissioner deems necessary based on the past performance of a  
36 carrier in complying with the provisions of P.L. , c. (pending before  
37 the Legislature as this bill).

38 i. The commissioner shall report to the Governor and the  
39 Legislature by October 1 of each year on the status of the Independent  
40 Third Party Payment Appeals Program, and include in the report  
41 carrier-specific and aggregate statistics on the number of complaints  
42 filed, the average length of time required to adjudicate the complaints,  
43 the disposition of the complaints, and the dollar amount of penalties  
44 assessed for violations of P.L. , c. (pending before the Legislature  
45 as this bill). The department shall make copies of the report available  
46 to the public.

1 j. For the purposes of this section, "carrier" means an individual or  
2 group health insurer, health, medical, hospital or dental service  
3 organization, health maintenance organization and dental plan  
4 organization and includes any intermediary contracted or affiliated  
5 with the carrier to perform administrative functions including, but not  
6 limited to, the payment of claims or the receipt, processing or transfer  
7 of claims or claim information; and "insured" means an insured, health,  
8 medical, hospital or dental service organization subscriber and health  
9 maintenance organization or dental plan organization enrollee.

10 k. The Commissioner of Banking and Insurance shall adopt  
11 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
12 c.410 (C.52:14B-1 et seq.) to carry out the purposes of this section.

13  
14 10. This act shall take effect on the 60th day after enactment.

15

16

17

#### STATEMENT

18

19 This bill expands existing law concerning prompt payment of claims  
20 by health insurance carriers and health maintenance organizations to  
21 include health, hospital, medical and dental service corporations and  
22 dental plan organizations and any intermediary contracted or affiliated  
23 with the carrier to perform administrative claims functions. The bill  
24 also reduces the amount of time in which a claim must be paid or  
25 contested by a carrier from 60 days to 30 days for manual claims and  
26 17 days for electronic claims. The bill also requires that a carrier shall  
27 pay or deny a contested claim within 30 days, rather than 90 days as  
28 the law currently provides.

29 In order to ensure enforcement of the prompt pay provisions, the  
30 bill establishes an Independent Third Party Payment Appeals Program  
31 in the Division of Enforcement and Consumer Protection in the  
32 Department of Banking and Insurance to address health care payment  
33 complaints of any health care provider or insured person. Under the  
34 program, any provider or insured person shall have the right to an  
35 independent review of a health care coverage payment complaint  
36 against a health insurance carrier. The decision of the review  
37 organization will be binding on all parties.

38 Under the program, the Department of Banking and Insurance  
39 would contract with one or more independent utilization review  
40 organizations or other independent health care review organizations  
41 whose staff has experience in reviewing negotiated contract  
42 arrangements and health care payment methodologies to implement the  
43 program. To initiate a complaint, a health care provider or insured  
44 person would file a written complaint with the program on forms  
45 provided by the department. Upon receipt of a complaint, the program  
46 shall assess the nature of the complaint and, if determined to be

1 carrier-payment related, immediately assign the complaint to a review  
2 organization for review and determination.

3 The review organization will conduct a full review of the complaint  
4 and issue a decision, as soon as possible, but no later than 30 business  
5 days from receipt of all documentation necessary to complete the  
6 review. In reaching its decision, the review organization shall take  
7 into consideration all pertinent medical records, applicable generally  
8 accepted practice guidelines, contract and payment terms between the  
9 carrier and insured or provider, applicable billing records, and other  
10 documents submitted by the parties.

11 When appropriate, the review organization shall recommend to the  
12 Commissioner of Banking and Insurance that the commissioner assess  
13 penalties against a carrier who is in violation of the prompt pay  
14 provisions of the bill. The penalties shall be in addition to any interest  
15 payments owed to the health care provider or insured person. The  
16 penalties are:

17 (1) \$500 per claim for each day an uncontested claim or  
18 uncontested portion of a claim is processed beyond the 30-day limit  
19 for manual claims and the 17-day limit for electronic claims, up to a  
20 maximum of \$10,000 for each violation; and

21 (2) \$1,000 per day for each day a carrier fails to respond to review  
22 organization inquiries within the time period specified by the review  
23 organization.

24 For the purpose of ensuring access to an independent review, all  
25 health care coverage identification cards issued by or on behalf of  
26 carriers to insured persons shall include the telephone number of the  
27 Division of Enforcement and Consumer Protection.

28 The bill also requires the commissioner to contract with one or  
29 more independent auditors to perform an audit of all carriers, at the  
30 carriers' expense, to verify compliance with the provisions of the bill.

31 Finally, the bill provides that the Commissioner of Banking and  
32 Insurance shall report to the Governor and the Legislature by October  
33 1 of each year on the status of the Independent Third Party Payment  
34 Appeals Program, and include in the report carrier-specific and  
35 aggregate statistics on the number of complaints filed, the average  
36 length of time required to adjudicate the complaints, the disposition of  
37 the complaints, and the dollar amount of penalties assessed for  
38 violations of the bill.

**SENATE, No. 1228**

**STATE OF NEW JERSEY**  
**208th LEGISLATURE**

INTRODUCED JUNE 22, 1998

**Sponsored by:**

**Senator PETER A. INVERSO**

**District 14 (Mercer and Middlesex)**

**SYNOPSIS**

Clarifies and extends provisions of prompt payment of health care claims law to all health insurers and health maintenance organizations.

**CURRENT VERSION OF TEXT**

As introduced.



S1228 INVERSO

2

1 AN ACT concerning prompt payment of claims and bills for health care  
2 services by carriers, amending P.L.1991, c.187 and supplementing  
3 Title 17 of the Revised Statutes.

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

7  
8 1. Section 78 of P.L.1991, c.187 (C.17B:26-12.1) is amended to  
9 read as follows:

10 78. a. **[A]** (1) Except in a case in which the obligation of a health  
11 insurer to pay a claim submitted by an insured, insured's agent or  
12 assignee or a health care provider is not reasonably clear as specified  
13 in paragraph (2) of this subsection or there is a reasonable basis  
14 supported by specific information available for review by the  
15 Department of Banking and Insurance that the claim for health care  
16 services rendered was submitted fraudulently, a health insurer shall  
17 reimburse all claims or any portion of any claim from an insured [or  
18 an] , insured's agent or assignee or health care provider, for payment  
19 [under] for health care services provided pursuant to a health  
20 insurance policy or agreement, within [60] 50 days after receipt of  
21 [the] a manual claim or within 30 days after receipt of an electronic  
22 claim by the health insurer. **[If a claim or a portion of a claim is**  
23 **contested by the health insurer, the insured or the insured's assignee**  
24 **shall be notified in writing within 50 days after receipt of the claim by**  
25 **the health insurer, that the claim is contested or denied; except that,**  
26 **the uncontested portion of the claim shall be paid within 60 days after**  
27 **receipt of the claim by the health insurer. The notice that a claim is**  
28 **contested shall identify the contested portion of the claim and the**  
29 **reasons for contesting the claim. A health insurer, upon receipt of the**  
30 **additional information requested from the insured or the insured's**  
31 **assignee shall pay or deny the contested claim or portion of the**  
32 **contested claim, within 90 days.]**

33 (2) In a case in which the obligation of a health insurer to pay a  
34 claim for health services rendered is not reasonably clear due to a good  
35 faith dispute regarding: the eligibility of a person for coverage; the  
36 liability of another health maintenance organization, insurer, health,  
37 hospital or medical service corporation or other third party payer for  
38 all or part of the claim; the amount of the claim; the health care  
39 services covered under a policy or agreement; or the manner in which  
40 services were accessed or provided, a health insurer shall pay any  
41 undisputed portion of a manual claim within 50 days and within 30  
42 days in the case of an electronic claim, after receipt of the claim. The

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

**Matter underlined thus is new matter.**

1 health insurer also shall notify the insured, insured's agent or assignee  
2 or health care provider, as appropriate, in writing or by electronic  
3 means, within 50 calendar days in the case of a manual claim and  
4 within 30 calendar days in the case of an electronic claim after the  
5 receipt of the claim: (a) that it is not obligated to pay the claim,  
6 stating the specific reasons why it is not liable; or (b) to request all  
7 additional information needed to determine liability to pay the claim ;  
8 and (c) shall provide the name, address, telephone number and  
9 facsimile number, if appropriate, of the insurer's representative  
10 handling the claim. Upon receipt of the information requested by the  
11 health insurer or of an appeal of a claim for health care services  
12 denied pursuant to this paragraph, a health insurer shall comply with  
13 paragraph (1) of this subsection.

14 (3) Payment shall be treated as being **[made]** remitted on the date  
15 a draft or other valid instrument which is equivalent to payment was  
16 placed in the United States mail in a properly addressed, postpaid  
17 envelope or, if not so posted, on the date of delivery.

18 b. An overdue payment shall bear simple interest at the rate of 10%  
19 per year beginning on the 51st calendar day following receipt of a  
20 manual claim or on the 31st day after receipt of an electronic claim by  
21 the insurer. In the event that a portion of a claim is contested or  
22 denied by the insurer, any portion of the claim which is eligible to be  
23 paid shall be deemed to be overdue if not remitted by the insurer  
24 within 50 days of receipt by the insurer in the case of a manual claim,  
25 and within 30 days of receipt in the case of an electronic claim. In the  
26 event that payment is withheld on all or a portion of a claim by an  
27 insurer pursuant to paragraph (2) of subsection a. of this section, if the  
28 insurer subsequently determines it is liable for payment of the claim,  
29 the payment shall be overdue beginning on the 51st calendar day in the  
30 case of a manual claim and the 31st calendar day in the case of an  
31 electronic claim, following receipt by the insurer of the required  
32 additional information.

33 c. For the purposes of this section **[, ]**: "health insurer" means an  
34 insurer authorized to provide health insurance on an individual basis  
35 pursuant to chapter 26 of Title 17B of the New Jersey Statutes; and  
36 "health care provider" includes, but is not limited to, a physician and  
37 other health care professional licensed pursuant to Title 45 of the  
38 Revised Statutes, or a hospital and other health care facility licensed  
39 pursuant to Title 26 of the Revised Statutes.

40 d. The Department of Banking and Insurance shall adopt rules and  
41 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
42 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

43 e. Each claim for health care services processed in violation of this  
44 section shall constitute a separate violation and in addition to interest  
45 penalties provided in this section, a health insurer may be subject to  
46 penalties provided in N.J.S.17B:30-1 et seq.

1 f. An insured, insured's agent or assignee or a health care provider  
2 may file a complaint about a violation of this section with the  
3 Commissioner of Banking and Insurance.

4 (cf: P.L.1991, c.187, s.78)

5  
6 2. Section 79 of P.L.1991, c.187 (C.17B:27-44.1) is amended to  
7 read as follows:

8 79. a. **[A]** (1) Except in a case in which the obligation of a health  
9 insurer to pay a claim submitted by an insured, insured's agent or  
10 assignee or a health care provider is not reasonably clear as specified  
11 in paragraph (2) of this subsection or there is a reasonable basis  
12 supported by specific information available for review by the  
13 Department of Banking and Insurance that the claim for health care  
14 services rendered was submitted fraudulently, a health insurer shall  
15 reimburse all claims or any portion of any claim from an insured **[or],**  
16 an insured's agent or assignee or a health care provider, for payment  
17 **[under]** for health care services provided pursuant to a health  
18 insurance policy or agreement, within **[60]** 50 days after receipt of  
19 **[the]** a manual claim or within 30 days after receipt of an electronic  
20 claim by the health insurer. **[If a claim or a portion of a claim is**  
21 contested by the health insurer, the insured or the insured's assignee  
22 shall be notified in writing within 50 days after receipt of the claim by  
23 the health insurer, that the claim is contested or denied; except that,  
24 the uncontested portion of the claim shall be paid within 60 days after  
25 receipt of the claim by the health insurer. The notice that a claim is  
26 contested shall identify the contested portion of the claim and the  
27 reasons for contesting the claim. A health insurer, upon receipt of the  
28 additional information requested from the insured or the insured's  
29 assignee shall pay or deny the contested claim or portion of the  
30 contested claim, within 90 days.]

31 (2) In a case in which the obligation of a health insurer to pay a  
32 claim for health services rendered is not reasonably clear due to a good  
33 faith dispute regarding: the eligibility of a person for coverage; the  
34 liability of another health maintenance organization, insurer, health,  
35 hospital or medical service corporation or other third party payer for  
36 all or part of the claim; the amount of the claim; the health care  
37 services covered under a policy or agreement; or the manner in which  
38 services were accessed or provided, a health insurer shall pay any  
39 undisputed portion of a manual claim within 50 days and within  
40 30 days in the case of an electronic claim, after receipt of the claim.  
41 The health insurer also shall notify the insured, insured's agent or  
42 assignee or health care provider, as appropriate, in writing or by  
43 electronic means, within 50 calendar days in the case of a manual claim  
44 and within 30 calendar days in the case of an electronic claim after the  
45 receipt of the claim: (a) that it is not obligated to pay the claim,  
46 stating the specific reasons why it is not liable; or (b) to request all



1 additional information needed to determine liability to pay the claim;  
2 and (c) shall provide the name, address, telephone number and  
3 facsimile number, if appropriate, of the insurer's representative  
4 handling the claim. Upon receipt of the information requested by the  
5 health insurer or of an appeal of a claim for health care services  
6 denied pursuant to this paragraph, a health insurer shall comply with  
7 paragraph (1) of this subsection.

8 (3) Payment shall be treated as being **[made]** remitted on the date  
9 a draft or other valid instrument which is equivalent to payment was  
10 placed in the United States mail in a properly addressed, postpaid  
11 envelope or, if not so posted, on the date of delivery.

12 b. An overdue payment shall bear simple interest at the rate of 10%  
13 per year beginning on the 51st calendar day following receipt of a  
14 manual claim or on the 31st day after receipt of an electronic claim by  
15 the insurer. In the event that a portion of a claim is contested or  
16 denied by the insurer, any portion of the claim which is eligible to be  
17 paid shall be deemed to be overdue if not remitted by the insurer  
18 within 50 days of receipt by the insurer in the case of a manual claim,  
19 and within 30 days of receipt in the case of an electronic claim. In the  
20 event that payment is withheld on all or a portion of a claim by an  
21 insurer pursuant to paragraph (2) of subsection a. of this section, if the  
22 insurer subsequently determines it is liable for payment of the claim,  
23 the payment shall be overdue beginning on the 51st calendar day in the  
24 case of a manual claim and the 31st calendar day in the case of an  
25 electronic claim, following receipt by the insurer of the required  
26 additional information.

27 c. For the purposes of this section~~[, ]~~: "health insurer" means an  
28 insurer authorized to provide health insurance on a group basis  
29 pursuant to chapter 27 of Title 17B of the New Jersey Statutes; and  
30 "health care provider" includes, but is not limited to, a physician and  
31 other health care professional licensed pursuant to Title 45 of the  
32 Revised Statutes, or a hospital and other health care facility licensed  
33 pursuant to Title 26 of the Revised Statutes.

34 d. The Department of Banking and Insurance shall adopt rules and  
35 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
36 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

37 e. Each claim for health care services processed in violation of this  
38 section shall constitute a separate violation and in addition to interest  
39 penalties provided in this section, a health insurer may be subject to  
40 penalties provided in N.J.S.17B:30-1 et seq.

41 f. An insured, insured's agent or assignee or a health care provider  
42 may file a complaint about a violation of this section with the  
43 Commissioner of Banking and Insurance.

44 (cf: P.L.1991, c.187, s.79)

1       3. Section 80 of P.L.1991, c.187 (C.26:2J-5.1) is amended to read  
2 as follows:

3       80. a. **[A]** (1) Except in a case in which the obligation of a health  
4 maintenance organization to pay a claim submitted by an enrollee,  
5 enrollee's agent or assignee or a health care provider is not reasonably  
6 clear as specified in paragraph (2) of this subsection or there is a  
7 reasonable basis supported by specific information available for review  
8 by the Department of Health and Senior Services that the claim for  
9 health care services rendered was submitted fraudulently, a health  
10 maintenance organization shall reimburse all claims or any portion of  
11 any claim from an enrollee [or], an enrollee's agent or assignee or a  
12 health care provider, for payment [under health maintenance  
13 organization coverage] for health care services provided pursuant to  
14 a health maintenance organization contract or agreement, within [60]  
15 50 days after receipt of [the] a manual claim or within 30 days after  
16 receipt of an electronic claim by the health maintenance organization.  
17 **[If a claim or a portion of a claim is contested by the health**  
18 **maintenance organization, the enrollee or the enrollee's assignee, shall**  
19 **be notified in writing within 50 days after receipt of the claim by the**  
20 **health maintenance organization, that the claim is contested or denied;**  
21 **except that, the uncontested portion of the claim shall be paid within**  
22 **60 days after receipt of the claim by the health maintenance**  
23 **organization. The notice that a claim is contested shall identify the**  
24 **contested portion of the claim and the reasons for contesting the claim.**

25       A health maintenance organization, upon receipt of the additional  
26 information requested from the enrollee or the enrollee's assignee shall  
27 pay or deny the contested claim or portion of the contested claim,  
28 within 90 days.]

29       (2) In a case in which the obligation of a health maintenance  
30 organization to pay a claim for health services rendered is not  
31 reasonably clear due to a good faith dispute regarding: the eligibility  
32 of a person for coverage; the liability of another health maintenance  
33 organization, insurer, health, hospital or medical service corporation  
34 or other third party payer for all or part of the claim; the amount of the  
35 claim; the health care services covered under a contract or agreement;  
36 or the manner in which services were accessed or provided, a health  
37 maintenance organization shall pay any undisputed portion of a manual  
38 claim within 50 days and within 30 days in the case of an electronic  
39 claim, after receipt of the claim. The health maintenance organization  
40 also shall notify the enrollee, enrollee's agent or assignee or health care  
41 provider, as appropriate, in writing or by electronic means within 50  
42 calendar days in the case of a manual claim and within 30 calendar  
43 days in the case of an electronic claim after the receipt of the claim: (a)  
44 that it is not obligated to pay the claim, stating the specific reasons  
45 why it is not liable; or (b) to request all additional information needed  
46 to determine liability to pay the claim; and (c) shall provide the name,

1 address, telephone number and facsimile number, if appropriate, of the  
2 health maintenance organization's representative handling the claim .  
3 Upon receipt of the information requested by the health maintenance  
4 organization or of an appeal of a claim for health care services denied  
5 pursuant to this paragraph, a health maintenance organization shall  
6 comply with paragraph (1) of this subsection.

7 (3) Payment shall be treated as being **made** remitted on the date  
8 a draft or other valid instrument which is equivalent to payment was  
9 placed in the United States mail in a properly addressed, postpaid  
10 envelope or, if not so posted, on the date of delivery.

11 b. An overdue payment shall bear simple interest at the rate of 10%  
12 per year beginning on the 51st calendar day following receipt of a  
13 manual claim or on the 31st day after receipt of an electronic claim by  
14 the health maintenance organization. In the event that a portion of a  
15 claim is contested or denied by the health maintenance organization,  
16 any portion of the claim which is eligible to be paid shall be deemed to  
17 be overdue if not remitted by the health maintenance organization  
18 within 50 days of receipt by the health maintenance organization in the  
19 case of a manual claim, and within 30 days of receipt in the case of an  
20 electronic claim. In the event that payment is withheld on all or a  
21 portion of a claim by a health maintenance organization pursuant to  
22 paragraph (2) of subsection a. of this section, if the health maintenance  
23 organization subsequently determines it is liable for payment of the  
24 claim , the payment shall be overdue beginning on the 51st calendar  
25 day in the case of a manual claim and the 31st calendar day in the case  
26 of an electronic claim, following receipt by the health maintenance  
27 organization of the required additional information.

28 c. For the purposes of this section **[, ]**: "health care provider"  
29 includes, but is not limited to, a physician and other health care  
30 professional licensed pursuant to Title 45 of the Revised Statutes, or  
31 a hospital and other health care facility licensed pursuant to Title 26  
32 of the Revised Statutes; and "health maintenance organization" means  
33 a health maintenance organization authorized pursuant to the  
34 provisions of P.L.1973, c.337 (C.26:2J-1 et seq.).

35 d. The Department of Health and Senior Services shall adopt rules  
36 and regulations pursuant to the "Administrative Procedure Act,"  
37 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the provisions of  
38 this section.

39 e. Each claim for health care services processed in violation of this  
40 section shall constitute a separate violation and in addition to interest  
41 penalties provided in this section, a health maintenance organization  
42 may be subject to penalties provided in section 24 of P.L.1973, c.337  
43 (C.26:2J-24).

44 f. An enrollee, enrollee's agent or assignee or a health care provider  
45 may file a complaint about a violation of this section with the

1 Commissioner of Health and Senior Services.

2 (cf: P.L.1991, c.187, s.80)

3

4 4. (New section) a. (1) Except in a case in which the obligation  
5 of a health service corporation to pay a claim submitted by a  
6 subscriber, subscriber's agent or assignee or a health care provider is  
7 not reasonably clear as specified in paragraph (2) of this subsection or  
8 there is a reasonable basis supported by specific information available  
9 for review by the Department of Banking and Insurance that the claim  
10 for health care services rendered was submitted fraudulently, a health  
11 service corporation shall reimburse all claims or any portion of any  
12 claim from a subscriber, subscriber's agent or assignee or health care  
13 provider, for payment for health care services provided pursuant to a  
14 contract or agreement, within 50 days after receipt of a manual claim  
15 or within 30 days after receipt of an electronic claim by the health  
16 service corporation.

17 (2) In a case in which the obligation of a health service corporation  
18 to pay a claim for health services rendered is not reasonably clear due  
19 to a good faith dispute regarding: the eligibility of a person for  
20 coverage; the liability of another health maintenance organization,  
21 insurer, health, hospital or medical service corporation or other third  
22 party payer for all or part of the claim; the amount of the claim; the  
23 health care services covered under a contract or agreement; or the  
24 manner in which services were accessed or provided, a health service  
25 corporation shall pay any undisputed portion of a manual claim within  
26 50 days and within 30 days in the case of an electronic claim, after  
27 receipt of the claim. The health service corporation also shall notify  
28 the subscriber, subscriber's agent or assignee or health care provider,  
29 as appropriate, in writing or by electronic means, within 50 calendar  
30 days in the case of a manual claim and within 30 calendar days in the  
31 case of an electronic claim after the receipt of the claim: (a) that it is  
32 not obligated to pay the claim, stating the specific reasons why it is not  
33 liable; or (b) to request all additional information needed to determine  
34 liability to pay the claim; and (c) shall provide the name, address,  
35 telephone number and facsimile number, if appropriate, of the health  
36 service corporation's representative handling the claim. Upon receipt  
37 of the information requested by the health service corporation or of an  
38 appeal of a claim for health care services denied pursuant to this  
39 paragraph, a health service corporation shall comply with paragraph  
40 (1) of this subsection.

41 (3) Payment shall be treated as being remitted on the date a draft  
42 or other valid instrument which is equivalent to payment was placed  
43 in the United States mail in a properly addressed, postpaid envelope  
44 or, if not so posted, on the date of delivery.

45 b. An overdue payment shall bear simple interest at the rate of 10%  
46 per year beginning on the 51st calendar day following receipt of a

1 manual claim or on the 31st day after receipt of an electronic claim by  
2 the health service corporation. In the event that a portion of a claim  
3 is contested or denied by the health service corporation, any portion  
4 of the claim which is eligible to be paid shall be deemed to be overdue  
5 if not remitted by the health service corporation within 50 days of  
6 receipt by the health service corporation in the case of a manual claim,  
7 and within 30 days of receipt in the case of an electronic claim. In the  
8 event that payment is withheld on all or a portion of a claim by a  
9 health service corporation pursuant to paragraph (2) of subsection a.  
10 of this section, if the health service corporation subsequently  
11 determines it is liable for payment of the claim, the payment shall be  
12 overdue beginning on the 51st calendar day in the case of manual claim  
13 and the 31st calendar day in the case of an electronic claim, following  
14 receipt by the health service corporation of the required additional  
15 information.

16 c. For the purposes of this section: "health care provider" includes,  
17 but is not limited to, a physician and other health care professional  
18 licensed pursuant to Title 45 of the Revised Statutes, or a hospital and  
19 other health care facility licensed pursuant to Title 26 of the Revised  
20 Statutes.

21 d. The Department of Banking and Insurance shall adopt rules and  
22 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
23 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

24 e. Each claim for health care services processed in violation of this  
25 section shall constitute a separate violation and in addition to interest  
26 penalties provided in this section, a health service corporation may be  
27 subject to penalties provided in N.J.S.17B:30-1 et seq.

28 f. A subscriber, subscriber's agent or assignee or health care  
29 provider may file a complaint about a violation of this section with the  
30 Commissioner of Banking and Insurance.

31

32 5. (New section) a. (1) Except in a case in which the obligation  
33 of a hospital service corporation to pay a claim submitted by a  
34 subscriber, subscriber's agent or assignee or a health care provider is  
35 not reasonably clear as specified in paragraph (2) of this subsection or  
36 there is a reasonable basis supported by specific information available  
37 for review by the Department of Banking and Insurance that the claim  
38 for health care services rendered was submitted fraudulently, a hospital  
39 service corporation shall reimburse all claims or any portion of any  
40 claim from a subscriber, subscriber's agent or assignee or health care  
41 provider, for payment for health care services provided pursuant to a  
42 contract or agreement, within 50 days after receipt of a manual claim  
43 or within 30 days after receipt of an electronic claim by the hospital  
44 service corporation.

45 (2) In a case in which the obligation of a hospital service  
46 corporation to pay a claim for health services rendered is not

1 reasonably clear due to a good faith dispute regarding: the eligibility  
2 of a person for coverage; the liability of another health maintenance  
3 organization, insurer, health, hospital or medical service corporation  
4 or other third party payer for all or part of the claim; the amount of the  
5 claim; the health care services covered under a contract or agreement;  
6 or the manner in which services were accessed or provided, a hospital  
7 service corporation shall pay any undisputed portion of a manual claim  
8 within 50 days and within 30 days in the case of an electronic claim,  
9 after receipt of the claim. The hospital service corporation also shall  
10 notify the subscriber, subscriber's agent or assignee or health care  
11 provider, as appropriate, in writing or by electronic means, within 50  
12 calendar days in the case of a manual claim and within 30 calendar  
13 days in the case of an electronic claim after the receipt of the claim: (a)  
14 that it is not obligated to pay the claim, stating the specific reasons  
15 why it is not liable; or (b) to request all additional information needed  
16 to determine liability to pay the claim; and (c) shall provide the name,  
17 address, telephone number and facsimile number, if appropriate, of the  
18 hospital service corporation's representative handling the claim. Upon  
19 receipt of the information requested by the hospital service  
20 corporation or of an appeal of a claim for health care services denied  
21 pursuant to this paragraph, a hospital service corporation shall comply  
22 with paragraph (1) of this subsection.

23 (3) Payment shall be treated as being remitted on the date a draft  
24 or other valid instrument which is equivalent to payment was placed  
25 in the United States mail in a properly addressed, postpaid envelope  
26 or, if not so posted, on the date of delivery.

27 b. An overdue payment shall bear simple interest at the rate of 10%  
28 per year beginning on the 51st calendar day following receipt of a  
29 manual claim or on the 31st day after receipt of an electronic claim by  
30 the hospital service corporation. In the event that a portion of a claim  
31 is contested or denied by the hospital service corporation, any portion  
32 of the claim which is eligible to be paid shall be deemed to be overdue  
33 if not remitted by the hospital service corporation within 50 days of  
34 receipt by the hospital service corporation in the case of a manual  
35 claim, and within 30 days of receipt in the case of an electronic claim.  
36 In the event that payment is withheld on all or a portion of a claim by  
37 a hospital service corporation pursuant to paragraph (2) of subsection  
38 a. of this section, if the hospital service corporation subsequently  
39 determines it is liable for payment of the claim, the payment shall be  
40 overdue beginning on the 51st calendar day in the case of a manual  
41 claim and the 31st calendar day in the case of an electronic claim,  
42 following receipt by the hospital service corporation of the required  
43 additional information.

44 c. For the purposes of this section: "health care provider" includes,  
45 but is not limited to, a physician and other health care professional  
46 licensed pursuant to Title 45 of the Revised Statutes, or a hospital and

1 other health care facility licensed pursuant to Title 26 of the Revised  
2 Statutes.

3 d. The Department of Banking and Insurance shall adopt rules and  
4 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
5 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

6 e. Each claim for health care services processed in violation of this  
7 section shall constitute a separate violation and in addition to interest  
8 penalties provided in this section, a hospital service corporation may  
9 be subject to penalties provided in N.J.S.17B:30-1 et seq.

10 f. A subscriber, subscriber's agent or assignee or health care  
11 provider may file a complaint about a violation of this section with the  
12 Commissioner of Banking and Insurance.

13

14 6. (New section) a. (1) Except in a case in which the obligation  
15 of a medical service corporation to pay a claim submitted by a  
16 subscriber, subscriber's agent or assignee or a health care provider is  
17 not reasonably clear as specified in paragraph (2) of this subsection or  
18 there is a reasonable basis supported by specific information available  
19 for review by the Department of Banking and Insurance that the claim  
20 for health care services rendered was submitted fraudulently, a medical  
21 service corporation shall reimburse all claims or any portion of any  
22 claim from a subscriber, subscriber's agent or assignee or health care  
23 provider, for payment for health care services provided pursuant to a  
24 contract or agreement, within 50 days after receipt of a manual claim  
25 or within 30 days after receipt of an electronic claim by the medical  
26 service corporation.

27 (2) In a case in which the obligation of a medical service  
28 corporation to pay a claim for health services rendered is not  
29 reasonably clear due to a good faith dispute regarding: the eligibility  
30 of a person for coverage; the liability of another health maintenance  
31 organization, insurer, health, hospital or medical service corporation  
32 or other third party payer for all or part of the claim; the amount of the  
33 claim; the health care services covered under a contract or agreement;  
34 or the manner in which services were accessed or provided, a medical  
35 service corporation shall pay any undisputed portion of a manual claim  
36 within 50 days and within 30 days in the case of an electronic claim,  
37 after receipt of the claim. The medical service corporation also shall  
38 notify the subscriber, subscriber's agent or assignee or health care  
39 provider, as appropriate, in writing or by electronic means, within 50  
40 calendar days in the case of a manual claim and within 30 calendar  
41 days in the case of an electronic claim after the receipt of the claim: (a)  
42 that it is not obligated to pay the claim, stating the specific reasons  
43 why it is not liable; or (b) to request all additional information needed  
44 to determine liability to pay the claim; and (c) shall provide the name,  
45 address, telephone number and facsimile number, if appropriate, of the  
46 medical service corporation's representative handling the claim. Upon

1 receipt of the information requested by the medical service corporation  
2 or of an appeal of a claim for health care services denied pursuant to  
3 this paragraph, a medical service corporation shall comply with  
4 paragraph (1) of this subsection.

5 (3) Payment shall be treated as being remitted on the date a draft  
6 or other valid instrument which is equivalent to payment was placed  
7 in the United States mail in a properly addressed, postpaid envelope  
8 or, if not so posted, on the date of delivery.

9 b. An overdue payment shall bear simple interest at the rate of 10%  
10 per year beginning on the 51st calendar day following receipt of a  
11 manual claim or on the 31st day after receipt of an electronic claim by  
12 the medical service corporation. In the event that a portion of a claim  
13 is contested or denied by the medical service corporation, any portion  
14 of the claim which is eligible to be paid shall be deemed to be overdue  
15 if not remitted by the medical service corporation within 50 days of  
16 receipt by the medical service corporation in the case of a manual  
17 claim, and within 30 days of receipt in the case of an electronic claim.  
18 In the event that payment is withheld on all or a portion of a claim by  
19 a medical service corporation pursuant to paragraph (2) of subsection  
20 a. of this section, if the medical service corporation subsequently  
21 determines it is liable for payment of the claim, the payment shall be  
22 overdue beginning on the 51st calendar day in the case of a manual  
23 claim and the 31st calendar day in the case of an electronic claim,  
24 following receipt by the medical service corporation of the required  
25 additional information.

26 c. For the purposes of this section: "health care provider" includes,  
27 but is not limited to, a physician and other health care professional  
28 licensed pursuant to Title 45 of the Revised Statutes, or a hospital and  
29 other health care facility licensed pursuant to Title 26 of the Revised  
30 Statutes.

31 d. The Department of Banking and Insurance shall adopt rules and  
32 regulations pursuant to the "Administrative Procedure Act," P.L.1968,  
33 c.410 (C.52:14B-1 et seq.) to carry out the provisions of this section.

34 e. Each claim for health care services processed in violation of this  
35 section shall constitute a separate violation and in addition to interest  
36 penalties provided in this section, a medical service corporation may  
37 be subject to penalties provided in N.J.S.17B:30-1 et seq.

38 f. A subscriber, subscriber's agent or assignee or health care  
39 provider may file a complaint about a violation of this section with the  
40 Commissioner of Banking and Insurance.

41

42 7. This act shall take effect immediately.



1 STATEMENT

2

3 This bill amends the health insurer and health maintenance  
4 organization "prompt payment of claims" law to clarify the provisions  
5 of those laws and to specify the conditions under which payments may  
6 be contested. The bill also extends the prompt payment provisions to  
7 health, hospital and medical service corporations.

8 Specifically, the bill provides that except in a case in which the  
9 obligation of a health insurer to pay a claim submitted by an insured,  
10 insured's agent or assignee or a health care provider is not reasonably  
11 clear or there is a reasonable basis supported by specific information  
12 available for review by the Department of Banking and Insurance (or  
13 Department of Health and Senior Services in the case of a health  
14 maintenance organization) that the claim for health care services  
15 rendered was submitted fraudulently, a health insurer shall reimburse  
16 all claims or any portion of any claim from an insured, insured's agent  
17 or assignee or health care provider, for payment for health care  
18 services provided pursuant to a health insurance policy or agreement,  
19 within 50 days in the case of a manual claim and 30 days in the case of  
20 an electronic claim, after receipt of the claim by the health insurer.

21 In a case in which the obligation of a health insurer to pay a claim  
22 for health services rendered is not reasonably clear due to a good faith  
23 dispute regarding: the eligibility of a person for coverage; the liability  
24 of another health maintenance organization, insurer, health, hospital  
25 or medical service corporation or other third party payer for all or part  
26 of the claim; the amount of the claim; the health care services covered  
27 under a policy or agreement; or the manner in which services were  
28 accessed or provided, a health insurer shall pay any undisputed portion  
29 of the claim. The insurer also shall notify the insured, insured's  
30 assignee or health care provider, as appropriate, in writing within 50  
31 calendar days in the case of a manual claim and within 30 calendar  
32 days in the case of an electronic claim, of the receipt of the claim: (a)  
33 that it is not obligated to pay the claim, stating the specific reasons  
34 why it is not liable; or (b) to request all additional information needed  
35 to determine liability to pay the claim and (c) shall provide the name,  
36 address, telephone number and facsimile number, if appropriate, of the  
37 insurer's representative handling the claim. Upon receipt of the  
38 information requested by the health insurer or an appeal of a claim for  
39 health care services denied, a health insurer shall comply with the 50-  
40 day and 30-day payment requirement, respectively.

41 For the purposes of this bill, "health care provider" includes, but is  
42 not limited to, a physician and other health care professional licensed  
43 pursuant to Title 45 of the Revised Statutes, or a hospital and other  
44 health care facility licensed pursuant to Title 26 of the Revised  
45 Statutes.

46 The bill also provides that each claim for health care services

**S1228 INVERSO**

14

1 processed in violation of the bill shall constitute a separate violation  
2 and in addition to interest penalties provided in the law, a health  
3 insurer may be subject to penalties provided in the health insurance  
4 trade practices act or the "Health Maintenance Organizations Act," as  
5 appropriate.

**ASSEMBLY SUBSTITUTE FOR  
ASSEMBLY BILL NO. 2121 (First Reprint)**

To the General Assembly:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Assembly Substitute for Assembly Bill No. 2121 (First Reprint) with my recommendations for reconsideration.

Summary of Bill

This bill provides an enforcement mechanism to assure the prompt payment of claims by health insurance payers; health maintenance organizations; health, hospital, medical and dental service organizations and any intermediary contracted or affiliated with the payer to perform administrative claims functions. The bill compliments the proposed HINT legislation (Senate Bill No. 323) which reduces the amount of time in which a claim must be paid or contested by the aforesaid entities.

Specifically, the bill provides that, within nine months after enactment of the bill, a payer shall give a provider, upon the provider's request, a monthly statement showing the claims (other than electronic claims) received from the provider during the previous month. At a provider or covered person's request, a payer shall provide information as to all material required to submitted to the payer with a claim for reimbursement.

The bill also requires payers to provide covered persons and providers with a toll-free telephone number for making inquires regarding paid or pending claims. A payer must respond to any covered person's or provider's claim inquiry within three days of the inquiry.

Additionally, payers are required to maintain claims records, audited by a private auditing firm at the expense of the payer, to be submitted to the Commissioner of the Department of Banking and Insurance, the Governor and the Legislature semiannually (or quarterly, if the Commissioner so requests) in a form to be established by regulation. Such records are to show by category claims that have been denied for ineligible service, lack of substantiating claims documentation, suspected fraud, etc.

If the Commissioner of the Department of Banking and Insurance determines that a payer has an unreasonably large number of claims that have been denied or not paid in

a timely manner, she may, after notice and hearing, conduct an investigation of the payer's payment practices and require remedial action by the payer, require that the payer's processing procedures be monitored by a private auditing firm and/or ultimately fine the payer not less than \$10,000.

#### B. Recommended Action

While I commend the Legislature for recognizing the need to ensure that valid health insurance claims are paid in a timely manner, I also agree with Senator Littell who, in sponsoring Senate Bill No. 323, sought to encourage the use of electronic submission of health insurance claims in order to alleviate the administrative costs of processing claims, which cost is ultimately passed on to consumers. The incentive for electronic filing provided by Senate Bill No. 323's assurance of faster payment of electronic claims than those filed manually should not be negated in any way by encouraging providers who currently file claims manually to continue to do so. I am concerned that this bill's requirement that a payer give to each provider who files claims manually, and who so requests, a monthly statement of all claims filed by that provider with that payer, encourages the continuation of manual filing by effectively providing some "bookkeeping" services. While I am aware of health care providers' need for certainty that their claims have been received by the appropriate payers in order to trigger the "prompt pay" provisions of Senate Bill No. 323, I believe that the opportunity to receive confirmation of receipt of an electronically filed claim within two working days of submission, as provided in Senate Bill No. 323, coupled with this bill's requirement that payers must maintain toll-free telephone numbers for providers who are inquiring as to status of claims and must respond to such inquiries within three business days, adequately affords a means to "start the clock" for purposes of assuring prompt payment of claims.

I am also concerned that certain reporting requirements of this bill will lead to increased administrative costs without providing a benefit that justifies the increased costs. Specifically, I believe payers' annual submission to the Commissioner, the Governor and the Legislature of privately audited records detailing denied or rejected claims is sufficient, provided records of denied or rejected claims are submitted to the Commissioner on a

quarterly basis.

In recognizing that some violations of the provisions of this bill may be more egregious than others and should be treated accordingly, I recommend that the Commissioner be afforded more discretion in imposing penalties than is currently allowed by this bill.

Lastly, as this bill is intended to enforce the prompt payment provisions of Senate Bill No. 323, I am recommending that its effective date be changed in order to coincide with the date it is anticipated that Senate Bill No. 323's prompt payment provisions will become effective.

Therefore, I herewith return Assembly Substitute for Assembly Bill No. 2121 (First Reprint) and recommend that it be amended as follows:

<u>Page 4, Section 3, Lines 33-38</u> :	Delete in their entirety
<u>Page 5, Section 4, Line 14</u> :	Delete "4."
<u>Page 5, Section 5, Line 22</u> :	Delete "5." and insert "4."
<u>Page 5, Section 6, Line 32</u> :	Delete "6." and insert "5."
<u>Page 5, Section 6, Lines 34-35</u> :	Delete "semiannually or, at the request of the commissioner, quarterly" and insert "annually"
<u>Page 6, Section 6, Line 10</u> :	After "report," delete "and"
<u>Page 6, Section 6, Line 15</u> :	After "fraudulently" insert "; and (9) any other information the commissioner requires"
<u>Page 6, Section 6, Lines 16-23</u> :	After "b." delete lines 16-23 in their entirety
<u>Page 6, Section 6, Line 24</u> :	Delete "c. As the result of his findings" and insert "After reviewing an audit"
<u>Page 6, Section 6, Line 38</u> :	Delete "less" and insert "more"
<u>Page 6, Section 6, Line 41</u> :	Delete "d" and insert "c"
<u>Page 7, Section 6, Line 2</u> :	Insert new section "6. a. In addition to the annual audit required by section 5 of this act, the payer shall maintain and report to the commissioner on no less than a quarterly basis, a record of claims as provided in paragraphs (1) through (9) of subsection a. of section 5 of this act. b. After reviewing a report, the commissioner may require an immediate audit of

the payer by a private audit firm and after reviewing the audit, if he deems it necessary, may proceed with a remediation or monitoring procedure as provided by subsection b. of section 5 of this act.”

Page 7, Section 8, Line 13 :

Delete “90” and insert “180”

Page 7, Section 10, Line 28 :

Delete “90” and insert “180”

Respectfully,

Christine Todd Whitman  
Governor

Attest:

John J. Farmer, Jr.  
Chief Counsel to the Governor

PO BOX 004  
TRENTON, NJ 08625

*Office of the Governor*  
**NEWS RELEASE**

CONTACT: Gene Herman

609-777-2600

RELEASE: July 1, 1999

Gov. Christie Whitman today signed the following bills:

**SCS Substitute for S-323, 324, 325, 326, 327, 328, 329, 330, 331**, sponsored by Senator Robert E. Littell (R-Sussex/Hunterdon/Morris) and Assembly Members Nicholas R. Felice (R-Bergen/Passaic) and Joseph V. Doria, Jr. (D-Hudson), provides for the prompt payment of health care claims by health insurance carriers, health maintenance organizations, health, hospital, medical and dental service organizations or any intermediary contracted or affiliated with the carrier to perform administrative functions. The bill reduces the amount of time in which an uncontested claim must be paid by a carrier from the current 60 days to 30 days or the time limit established by the Medicare program, whichever is earlier, for electronic claims. It reduces the amount of time for payment of an uncontested manual claim to 40 days following receipt of the claim. The bill also requires that a carrier shall deny a contested claim, stating all reasons for denial, within 30 days, instead of 90 days as is currently required. The bill directs a carrier to acknowledge receipt of a claim submitted by electronic means no later than two working days following receipt of the claim.

The bill incorporates the recommendations made by the Governor in her conditional veto of the bill on March 12. The bill was conditionally vetoed with the recommendation that a provision that would have provided a tax cut to carriers with the intention of stimulating development and use of health information electronic data interchange technology be deleted. In her conditional veto, the Governor said that while promotion of the use of such technology is important, under current state and federal law, these groups are already entitled to a business deduction with respect to expenses incurred in the purchase, lease or rental of such technology.

**S-168**, sponsored by Senators John O. Bennett (R-Monmouth) and Diane B. Allen (R-Burlington/Camden) and Assembly Members John V. Kelly (R-Bergen/Essex/Passaic) and Barbara Wright (R-Mercer/Middlesex), requires public school health services to employ persons holding an educational services certificate with an endorsement as a school nurse issued by the State Board of Examiners. The bill grandfathers currently employed non-certified nursing staff. Additionally, the bill makes an exception for those non-nursing personnel who are otherwise authorized by statute or regulation to perform specific health-related services.

**A-2121**, sponsored by Assembly Members Guy F. Talarico (R-Bergen) and Nicholas Asselta (R-Cape May/Atlantic/Cumberland) and Senators Jack Sinagra (R-Middlesex) and Richard J. Codey (D-Essex), provides for insurance carrier reporting of claims

payment practices to the Department of Banking and Insurance and for enforcement of violations of claims payment requirements. At a provider or covered person's request, a payer shall provide information as to all material required to be submitted to the payer with a claim for reimbursement. The bill also requires carriers to provide covered persons and providers with a toll-free telephone number for making inquiries regarding paid or pending claims. A carrier must respond to any covered person's or provider's claim inquiry within three days of the inquiry.

The bill incorporates the recommendations made by the Governor in her conditional veto of the original bill on May 3. The bill was conditionally vetoed to give the Commissioner of Banking and Insurance more discretion in imposing penalties and to change the effective date to better coincide with previous legislation requiring prompt payment of claims. The bill also eliminates the requirement that a payee (insurance carrier or HMO) provide a provider with a monthly statement of claims if the provider chooses to file claims manually rather than electronically, as the Governor recommended in her conditional veto.