17B:30-26 et seq.

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: **1999** **CHAPTER:** 155

NJSA: 17B:30-26 et seq. (Health insurance – prompt payment)

BILL NO: A2121 (Substituted for S1148/S1228 SCS – 2nd Reprint)

SPONSOR(S): Talarico and Asselta

DATE INTRODUCED: June 1, 1998

COMMITTEE: **ASSEMBLY:** Banking and Insurance

SENATE: ---

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** February 18, 1999 Re-enacted 6-14-99

SENATE: January 28, 1999 Re-enacted 6-21-99

DATE OF APPROVAL: July 1, 1999

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL: Assembly Committee Substitute (2R)
(Amendments during passage denoted by superscript numbers)

ACS for A2121

SPONSORS STATEMENT: No

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: No

FLOOR AMENDMENT STATEMENTS: Yes

LEGISLATIVE FISCAL ESTIMATE: No

A2121

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

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

SCS for S1148/S1228

SPONSORS STATEMENT: No

COMMITTEE STATEMENT: **ASSEMBLY**: No

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: **ASSEMBLY**: 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

§1-9
C.17B:30-26
to 17B:30-34
§10
Note to §§1-9

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

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

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

1. As used in this act:

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

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

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

"Eligible health care provider" means a health care provider whose 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:
[1]Senate floor amendments adopted December 17, 1998.
[2] Assembly amendments adopted in accordance with Governor's recommendations May 20, 1999.

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

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

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

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

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

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

[2]3. **[1]**a. 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 not later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if:

(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 material 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.

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

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

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

e.**]**[1] Beginning no later than nine months after the date of enactment of this act, a payer shall provide a participating health care provider, upon request of the 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.

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

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

[1]**[**4. a. Payment of an eligible claim pursuant to subsections a. or c. of section 3 of this act 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.

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

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

[1]**[**5.**]** [2]**[**4.[1]**]** 3.[2] A payer shall, at the request of a covered person, that person's agent, or an eligible health care provider, provide information as to the material required to be submitted to the payer with a claim for reimbursement, including any documentation which is to be submitted with the claim and information as to the proper coding, including the standard diagnosis and procedure codes used by the payer.

[1]**[**6.**]** [2]**[**5.[1]**]** 4.[2] A payer shall 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 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.

[1]**[**7.**]** [2]**[** 6.[1]**]** 5.[2] a. A payer shall maintain a record which shall be audited by a private auditing firm at the expense of the payer, to be submitted to the commissioner, Governor and the Legislature [2]**[**semiannually or, at the request of the commissioner, quarterly**]** annually[2], in a form established by the commissioner by regulation, 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 [1][in subsection a. of section 3 of this act] by law[1] 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 [1][in sections 3 and 4 of this act]by law[1] even though the claims meet the criteria established [1][in paragraphs (1) through (5) of subsection a. of section 3 of this act] by law[1];

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

(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 established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16) because the payer has reason to believe that the claim has been submitted fraudulently[2]; and

(9) any other information the commissioner requires[2].

b. [2][If the commissioner 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 for the reasons set forth in paragraphs (4), (5) or (6) of subsection a. of this section, or that the payer has failed to pay interest on overdue claims payments as required by [1][section 4 of this act] law[1], he may, after notice and hearing, conduct an investigation of the payer's claims processing procedures.

c. As the result of his findings] After reviewing an audit[2], 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 for the reasons set forth in paragraphs (4), (5) or (6) of subsection a. of this section; or

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

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

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

[2]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.[2]

[1]**[**8.**]** 7.[1] a. Payment of a capitation payment to a health care provider 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.

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

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

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

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

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

Provides for carrier reporting of claims payment practices to Dept. of Banking and Insurance and for enforcement of violations of claims 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)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[60**]** 30 days after receipt of **[**the**]**a manual claim or within 17 days after receipt of an electronic claim by the health insurer or its agent. If a claim or a portion of a claim is contested by the health insurer or its agent, the insured or the insured's assignee shall be notified in writing within **[**45**]** 30 days after receipt of **[**the**]** a manual claim or 17 days after receipt of an electronic claim by the health insurer or its agent, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within **[**60**]** 30 days after receipt of **[**the**]**a manual claim or 17 days after receipt of an electronic claim by the health insurer or its agent.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) A health maintenance organization or its agent shall reimburse all clean claims or any portion of any clean claim from an enrollee or an enrollee's assignee, for payment under a health maintenance organization coverage, within **[**60**]** 30 days after receipt of **[**the**]**a manual claim or within 17 days after receipt of an electronic claim by the health maintenance organization or its agent. If a claim or a portion of a claim is contested by the health maintenance organization or its agent, the enrollee or the enrollee's assignee shall be notified in writing within **[**45**]** 30 days after receipt of **[**the**]** a manual claim or 17 days after receipt of an electronic claim by the health maintenance organization or its agent, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within **[**60**]** 30 days after receipt of **[**the**]**a manual claim or 17 days after receipt of an electronic claim by the health maintenance organization or its agent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of the contested claim, within 30 days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. (New section) a. The Commissioner of Banking and Insurance shall establish 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. Under the program, any health care provider or insured shall have the right to an independent review of a health care coverage payment complaint made pursuant to this section.

b. The commissioner 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. The review organization shall submit to the department and maintain a current list identifying all carriers, health care facilities and other health care providers and payers with whom the review organization maintains any health-related business arrangements. The list shall include a brief description of the nature of any such arrangement.

c. To initiate a complaint, a health care provider or insured shall 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. In making a determination as to which review organization shall review a complaint, the program shall take into consideration the list of business arrangements submitted by the review organization. The program shall ensure that assignment of a complaint to a review organization will not result in a conflict of interest or otherwise create an appearance of impropriety.

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

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

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

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

(4) 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.

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

(1) For any violation of sections 78, 79 or 80 of P.L.1991, c.187 (C.17B:26-12.1, 17B:27-44.1 or 26:2J-5.1) or sections 4 through 8 of P.L. , c. (C.)(pending before the Legislature as this bill), a carrier shall be liable to a penalty of $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.

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

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

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

h. The commissioner shall 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 P.L. , c. (pending before the Legislature as this bill). The department shall audit all carriers one year after the effective date of P.L. , c. (pending before the Legislature as this bill) and at such future intervals as the commissioner deems necessary based on the past performance of a carrier in complying with the provisions of P.L. , c. (pending before the Legislature as this bill).

i. The commissioner 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 P.L. , c. (pending before the Legislature as this bill). The department shall make copies of the report available

to the public.

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

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

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

STATEMENT

This bill expands existing law concerning prompt payment of claims by 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 would 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.

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.

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 pursing 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)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

assignee, for payment under a health insurance policy, within [60] 30 days after receipt of [the]a manual claim or within 17 days after receipt of an electronic claim by the health insurer or its agent. If a claim or a portion of a claim is contested by the health insurer or its agent, the insured or the insured's assignee shall be notified in writing within [45] 30 days after receipt of [the] a manual claim or 17 days after receipt of an electronic claim by the health insurer or its agent, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within [60] 30 days after receipt of [the]a manual claim or 17 days after receipt of an electronic claim by the health insurer or its agent.

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

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

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

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

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

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

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

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

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

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

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

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

(2) A health maintenance organization or its agent shall reimburse all clean claims or any portion of any clean claim from an enrollee or an enrollee's assignee, for payment under a health maintenance organization coverage, within **[**60**]** 30 days after receipt of **[**the**]**a manual claim or within 17 days after receipt of an electronic claim by the health maintenance organization or its agent. If a claim or a portion of a claim is contested by the health maintenance organization or its agent, the enrollee or the enrollee's assignee shall be notified in writing within **[**45**]** 30 days after receipt of **[**the**]** a manual claim or 17 days after receipt of an electronic claim by the health maintenance organization or its agent, that the claim is contested or denied; except that, the uncontested portion of the claim shall be paid within **[**60**]** 30 days after receipt of **[**the**]**a manual claim or 17 days after receipt of an electronic claim by the health maintenance organization or its agent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. (New section) a. The Commissioner of Banking and Insurance shall establish 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. Under the program, any health care provider or insured shall have the right to an independent review of a health care coverage payment complaint made pursuant to this section.

b. The commissioner 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. The review organization shall submit to the department and maintain a current list identifying all carriers, health care facilities and other health care providers and payers with whom the review organization maintains any health-related business arrangements. The list shall include a brief description of the nature of any such arrangement.

c. To initiate a complaint, a health care provider or insured shall 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. In making a determination as to which review organization shall review a complaint, the program shall take into consideration the list of business arrangements submitted by the review organization. The program shall ensure that assignment of a complaint to a review organization will not result in a conflict of interest or otherwise create an appearance of impropriety.

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

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

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

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

(4) 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.

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

(1) For any violation of sections 78, 79 or 80 of P.L.1991, c.187 (C.17B:26-12.1, 17B:27-44.1 or 26:2J-5.1) or sections 4 through 8 of P.L. , c. (C.)(pending before the Legislature as this bill), a carrier shall be liable to a penalty of $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.

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

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

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

h. The commissioner shall 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 P.L. , c. (pending before the Legislature as this bill). The department shall audit all carriers one year after the effective date of P.L. , c. (pending before the Legislature as this bill) and at such future intervals as the commissioner deems necessary based on the past performance of a carrier in complying with the provisions of P.L. , c. (pending before the Legislature as this bill).

i. The commissioner 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 P.L. , c. (pending before the Legislature as this bill). The department shall make copies of the report available to the public.

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

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

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

STATEMENT

This bill expands existing law concerning prompt payment of claims by 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 would 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.

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, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commissioner of Health and Senior Services.
(cf: P.L.1991, c.187, s.80)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. This act shall take effect immediately.

STATEMENT

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

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

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

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

The bill also provides that each claim for health care services

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

Page 4, Section 3, Lines 33-38 :	Delete in their entirety
Page 5, Section 4, Line 14 :	Delete "4."
Page 5, Section 5, Line 22 :	Delete "5." and insert "4."
Page 5, Section 6, Line 32 :	Delete "6." and insert "5."
Page 5, Section 6, Lines 34-35 :	Delete "semiannually or, at the request of the commissioner, quarterly" and insert "annually"
Page 6, Section 6, Line 10 :	After "report;" delete "and"
Page 6, Section 6, Line 15 :	After "fraudulently" insert "; and (9) any other information the commissioner requires"
Page 6, Section 6, Lines 16-23 :	After "b." delete lines 16-23 in their entirety
Page 6, Section 6, Line 24 :	Delete "c. As the result of his findings" and insert "After reviewing an audit"
Page 6, Section 6, Line 38 :	Delete "less" and insert "more"
Page 6, Section 6, Line 41 :	Delete "d" and insert "c"
Page 7, Section 6, Line 2 :	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

CONTACT: Gene Herman

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RELEASE: July 1, 1999

Office of the Governor
NEWS RELEASE

Gov. Christie Whitman today signed the following bills:

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

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

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

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

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

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