ASSEMBLY, No. 318

STATE OF NEW JERSEY

212th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2006 SESSION

Sponsored by:
Assemblyman NEIL M. COHEN
District 20 (Union)
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SYNOPSIS

Requires certain disclosures from carriers; establishes new health care claims payment and appeals process; limits use of utilization management under certain circumstances.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel

(Sponsorship Updated As Of: 1/27/2006)

AN ACT concerning payment of health care claims and revising various parts of the statutory law.

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

1. (New section) As used in sections 1 through 10 of this act:

"Agent" means any entity that processes claims as a third party administrator for a carrier.

"Assignment of benefits" means any written instrument executed by the covered person or his authorized representative which assigns a health care provider the covered person's right to receive reimbursement for a health care service under a health benefits plan.

"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.

"Claim" means a claim by a covered person or health care provider who has received an assignment of benefits from the covered person, for payment relating to health care services covered under a health benefits plan issued by a carrier.

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

"Eligible health care provider" means a health care provider whose services are reimbursable under a health benefits plan.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical community, recommendations made by or views held by physician specialty societies or physicians practicing in the relevant clinical areas, or any other relevant factor.

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. 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

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

Matter underlined <u>thus</u> is new matter.

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 plan. Health care provider includes, but is not limited to, a physician 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.

"In-network provider" means a health care provider that is a member of a carrier's provider network.

"Medical necessity" or medically necessary means or describes a health care service that a health care provider, exercising his prudent clinical judgement, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is in accordance with generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the covered person's illness, injury or disease; and not more costly than an alternative health care service or sequence of services at least as likely to produce an equivalent therapeutic or diagnostic result as to the diagnosis or treatment of the covered person's illness, disease or injury.

"Network plan" means a health benefits plan offered by a carrier under which the financing and delivery of health care, including items and services paid for as health care, are provided, in whole or in part, through a defined set of health care providers under contract with the carrier.

"Out-of-network provider" means a health care provider that is not a member of a carrier's provider network.

"Payer" means a carrier or any agent thereof under contractual obligation to pay a claim.

"Provider network" means a defined set of health care providers under contract with a carrier to deliver health care services to a person covered by the carrier.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for or otherwise provided under the health benefits plan. The system may include, but shall not be limited to: preadmission certification, the application of practice

guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

2. (New section) A payer shall provide the following information concerning the processing and payment of claims in a clear and conspicuous manner through an Internet website not later than 90 calendar days before the information or policies or any changes in the information or policies take effect:

a. the material, documents or other information required to be submitted to the payer with a claim;

b. a description of claims for which the submission of additional clinical information or documentation is required for the adjudication of a claim fitting that description;

c. the name and version of any computer claims processing software or program used by the payer to review or audit the relationships among billing codes;

d. a detailed description of each coding and bundling edit that the payer reasonably believes that, when applied to a claim, will result in the payer seeking reimbursement for overpayment of a claim, pursuant to section 7 of this act, not less than 500 times per year;

e. the payer's policy or procedure for reducing the payment for a duplicate or subsequent procedure provided by a health care provider on the same date of service;

f. the payer's policy or guidelines used in making medical necessity determinations that affect or would affect the payment, in part or whole, of a claim and the title, author or source, and publication date of any reference used in the development of the payer's medical necessity determinations policy or guidelines;

g. the payer's clinical policies, based on generally accepted standards of medical practice, that could affect the processing or adjudication of a claim; and

h. any other information the commissioner deems necessary.

3. (New section) a. A payer shall use the standard paper or electronic health care enrollment and claim forms developed by the commissioner pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23).

b. A payer shall require that a health care provider file all claims for payment of health care benefits, unless the covered person chooses to submit a claim to the payer on his own behalf. A claim shall be filed using the standard health care claim form designated by the commissioner pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23).

4. (New section) a. A covered person may, through an assignment of benefits, assign to a health care provider his right to

receive payment for a claim for covered health care services. If a person is covered by a network plan, he may assign his benefits to an in-network or out-of-network provider. The out-of-network provider receiving the assignment of benefits shall provide separate written notice to the payer of the execution of the assignment of benefits.

b. When a covered person executes an assignment of benefits, the payer shall give written notice to the covered person when payment of the claim relating to the assignment of benefits was remitted to the health care provider.

c. If a covered person executes an assignment of benefits but the payer remits payment of the claim to the covered person rather than the health care provider, the claim shall not be considered adjudicated. The payer shall remit payment of the claim to the health care provider pursuant to section 5 of this act.

d. Accepting an assignment of benefits shall not mean that a health care provider has agreed to accept the payer's fee schedule or specific payment rate.

e. Any provision of a contract that violates the provisions of this section shall be null and void.

5. (New section) a. A payer shall remit payment for the adjudication of a claim for health care services delivered to a covered person by an eligible health care provider no later than the 30th calendar day following the receipt of a claim submitted by electronic means or no later than the 40th day following receipt of a claim submitted by other than electronic means. A claim shall not be considered adjudicated until the entire amount requested in the claim is paid to the health care provider.

b. The payer may withhold payment of the claim in whole or in part if all or a portion of the claim cannot be entered into the payer's claim processing system for any of the following reasons:

(1) the health care provider is not eligible at the time of providing the health care service to the covered person;

(2) the person who received the health care service was not a covered person at the time of service;

(3) the diagnosis coding, procedure coding or any other data which the health care provider was notified to submit with the claim pursuant to section 2 of this act is missing or incorrect; or

(4) there is strong evidence of fraud by the health care provider and the payer has initiated an investigation into the suspected fraud.

If the payer intends to withhold payment of a claim in whole or in part pursuant to this subsection, it shall notify the health care provider within seven days of receiving a claim submitted by electronic means, or within 14 days of receiving a claim submitted by other means, of the reason that payment will be withheld and, if applicable, any documentation or information that is required to complete the adjudication of the claim. The payer shall remit

payment for the adjudication of the claim on or before the 15th calendar day, for claims submitted electronically, or the 25th calendar day, for claims submitted by other means, following the payer's receipt of the modified claim or the required documentation or information.

c. If the payer does not remit payment of a claim in full under the time frame set forth in subsections a. and b. of this section, the claim or any unpaid portion thereof shall be considered overdue and the payer shall remit payment for the complete adjudication of the claim and any accrued interest in accordance with the provisions of section 6 of this act. If the payer does not notify the health care provider of its intent to withhold payment of a claim within the time frame set forth in subsection b. of this section, the entire claim or any unpaid portion thereof shall be considered overdue, and the payer shall remit payment for the complete adjudication of the claim and any accrued interest in accordance with the provisions of section 6 of this act.

6. (New section) An overdue claim shall accrue interest at the rate of 20% per annum. A payer shall pay the interest at the time payment for the adjudication of the claim is made.

7. (New section) a. A payer may recuperate monies paid to a health care provider for the adjudication of a claim no later than one year following the first payment made on the claim by the payer and under the following circumstances:

(1) the payer has determined that the claim for health care services is covered or partially covered by other insurance available to the covered person;

(2) the payer has determined that the payment was made as a result of fraud by the health care provider and the payer has reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law; or

(3) the payer has made an error in the processing or payment of the claim which resulted in an overpayment of the claim.

The payer shall provide the health care provider notice and documentation of the circumstances which have prompted the request for reimbursement of the payment.

b. No payer shall base a reimbursement request for a particular claim on extrapolation of another claim that meets the criteria set forth in subsection a. of this section, except under the following circumstances:

(1) in judicial or quasi-judicial proceedings, including arbitration;

(2) in administrative proceedings; or

(3) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise

unavailable.

c. In seeking reimbursement of a claims payment, no payer shall collect or attempt to collect:

(1) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request and any substantiating documentation to the health care provider;

(2) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request and any substantiating documentation to the health care provider and until the health care provider's rights to appeal set forth under section 9 of this act are exhausted;

(3) the funds for the reimbursement by assessing them against payment of any future claims submitted by the health care provider unless the health care provider has agreed to the conditions of repayment in writing; or

(4) a monetary penalty against the reimbursement request, including, but not limited to, an interest charge or late fee.

d. If a reimbursement request has met the provisions of this section and the amount is equal to or greater than $5,000, a payer shall provide the health care provider the opportunity to establish a payment schedule by which the health care provider may reimburse the payer through installment payments made over a time period of no less than one year. No payer shall assess interest against reimbursement payments made by the health care provider according to the agreed upon payment schedule.

8. (New section) a. A payer that employs a utilization management system, either directly or through a third party under contract to employ a utilization management system, shall review its process not later than March 31 of each calendar year and shall report to the commissioner the following:

(1) the number of determinations made by the payer using the utilization management process;

(2) the frequency with which the payer determines that a specific health care service, including, but not limited to, the delivery of a specific procedure, test or medication, should not or will not be covered, paid for or otherwise provided under the health benefits plan;

(3) the administrative costs to the payer for employing a utilization management system and an analysis of whether employment of the system resulted in savings that were reflected in the decrease in the premium of the health benefits plan; and

(4) any other information required by the commissioner.

The annual report is hereby declared to be a public record and shall be subject to all the provisions of P.L.1963, c.73 (C.47:1A-1 et seq.) concerning such public records.

b. No payer shall employ utilization management to limit or

prevent the delivery of a specific health care service unless the payer can demonstrate to the commissioner that under the system, not less than 10% of all determinations concerning that particular health care service resulted in the payer deciding not to cover, pay for or otherwise provide for the health care service under the health benefits plan.

c. No payer that employs a third party to provide utilization management services on its behalf shall base the reimbursement for the services on a contingent fee basis.

9. (New section) a. A payer shall establish an internal appeal mechanism to resolve any dispute regarding compliance with the requirements of this act. The payer shall conduct the appeal at no cost to the health care provider.

A health care provider may initiate an appeal on a form prescribed by the commissioner which shall describe the type of substantiating documentation that shall be submitted with the form. The payer shall conduct a review of the appeal and notify the health care provider of its determination on or before the 10th calendar day following the receipt of the appeal form. If the health care provider is not notified of the payer's determination of the appeal within 10 days, the health care provider may refer the dispute to arbitration as provided by subsection b. of this section.

If the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this act and pay the of money in dispute, if applicable, with accrued interest at the rate of 20% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If the payer issues a determination against the health care provider, the payer shall notify the health care provider of its findings on or before the 10th calendar day following the receipt of the appeal form and shall include in the notification written instructions for referring the dispute to arbitration as provided by subsection b. of this section.

The payer shall report annually to the commissioner the number of appeals it has received and the resolution of each appeal.

b. Any dispute regarding the determination of an internal appeal conducted pursuant to subsection a. of this section may be referred to arbitration as provided in this subsection. The commissioner shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the commissioner. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that

disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of arbitration pursuant to this subsection.

An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, subject to confidentiality requirements established by State or federal law.

An arbitrator's determination shall be:

(1) signed by the arbitrator;

(2) issued in writing, in a form prescribed by the commissioner, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and

(3) issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitration shall be nonappealable and binding on all parties to the dispute.

If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this act, the arbitrator shall order the payer to make payment of the claim, together with accrued interest at the rate of 20% per annum, on or before the 10th business day following the issuance of the determination.

The arbitrator shall file a copy of each determination with and in the form prescribed by the commissioner.

10. Section 3 of P.L.2003, c.250 (C.17:48E-10.2) is amended to read as follows:

3. a. (1) A health service corporation that makes a dental benefit payment to a covered person for services rendered by an out-of-network dentist shall issue the payment to the covered person in accordance with the time frames set forth in section [4 of P.L.1999, c.154 (C.17:48E-10.1)] 5 of P.L ,c. (C.) (pending before the Legislature as this bill), and shall, within three days of issuing the payment, provide a notification to the out-of-network dentist of the amount and date of the payment and the services for which the payment was made.

(2) In the case of a health service corporation that supplies an administrative services only contract and makes a dental benefit payment to a covered person for services rendered by an out-of-network dentist under that contract, paragraph (1) of this subsection shall not apply, but the health service corporation shall, within three days of issuing the payment, provide a notification to the out-of-network dentist of the amount and date of the payment.

b. A covered person may enter into an agreement with an out-of-network dentist to sign over the dental benefit payment received

from the health service corporation to the dentist. The agreement shall:

(1) be in writing;

(2) be signed by the person who is entitled to receive the dental benefit payment from the health service corporation;

(3) be retained by the dentist for at least six years following the date of the most recent payment from the covered person; and

(4) give the covered person at least 10 business days within which to sign over the dental benefit to the dentist.

c. A covered person who agrees to sign over a dental benefit payment in accordance with this section, shall comply with the terms of the agreement; except that, if the covered person owes the out-of-network dentist less than the amount of the dental benefit payment, the covered person shall pay the dentist the balance owed to the dentist.

d. A covered person who fails to sign over the dental benefit payment in accordance with this section, shall be liable to the out-of-network dentist for payment of attorney fees and costs reasonably incurred by the dentist in enforcing the agreement established pursuant to this section.

(cf: P.L.2003, c.250, s.3)

11. Section 1 of P.L.2001, c.67 (C.17:48H-33.1) is amended to read as follows:

1. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), an organized delivery system which is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.), or a subsidiary thereof that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

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

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), an organized delivery system or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and

claim forms in connection with all health benefits plans for which the organized delivery system has contracted with a carrier to provide health care services.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), an organized delivery system shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment but, notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the health benefits plan contract or policy.

d. [(1) An organized delivery system or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a covered person or that covered person's agent or assignee if the health benefits plan contract or policy provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

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

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

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

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

(e) the claim requires no special treatment that prevents timely payment from being made on the claim under the terms of the health benefits plan contract or policy.

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

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

(7) An overdue payment shall bear simple interest at the rate of

10% per annum.] (Deleted by amendment P.L. , c. .)

e. [As used in this subsection, "insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits plan contract or policy for which the financial obligation for the payment of a claim under the health benefits plan contract or policy rests upon the organized delivery system.] (Deleted by amendment P.L. , c. .)

(cf: P.L.2001, c.67, s.1)

12. (New section) An organized delivery system which is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.) shall be subject to the provisions of P.L. , c. (C.) (pending before the Legislature as this bill) and any regulations promulgated thereunder.

13. Section 4 of P.L.2001, c.267 (C.17B:27B-4) is amended to read as follows:

4. The commissioner may issue a license to an applicant or approve an application for registration as a third party administrator if he finds that the applicant meets the standards established by this act, including, but not limited to, the following:

a. all of the materials required by this act or by the commissioner have been filed;

b. the persons responsible for conducting the applicant's affairs are competent, trustworthy and possess good reputations, and have appropriate experience, training and education;

c. the applicant has demonstrated the ability to assure that its services will be performed in a manner which will ensure the efficient operation of its business, including appropriate financial controls;

d. the standard contract forms to be used by the applicant are acceptable;

e. the applicant has adequate financial arrangements with the benefits payers for which it will perform its services and adequate arrangements for complying with the provisions of P.L.1999, c.154 (C.17B:30-23 et al.) and P.L. , c. (C.) (pending before the Legislature as this bill); and

f. the compensation arrangements made between the applicant and benefits payers do not result in the assumption of financial risk by the applicant.

In the case of an applicant for registration, the provisions of subsections d., e., and f. of this section shall apply only to services provided by the applicant to benefits payers other than an insurer.

(cf: P.L.2001, c.267, s.4)

14. Section 18 of P.L.2001, c.267 (C.17B:27B-18) is amended to read as follows:

18. The commissioner may approve an application for certification as a third party billing service if he finds that the applicant meets the standards established by this act, including, but not limited to, the following:

a. all of the material required by this act or by the commissioner have been filed;

b. the persons responsible for conducting the applicant's affairs are competent, trustworthy and possess good reputations, and have appropriate experience, training and education;

c. the applicant has demonstrated the ability to ensure that its services will be performed in a manner which will result in the efficient operation of its business, including, if the applicant accepts payments from benefits payers on behalf of its clients, appropriate financial controls;

d. the standard contract forms to be used by the applicant are acceptable; and

e. the applicant has adequate arrangements for complying with the provisions of P.L.1999, c.154 (C.17B:30-23 et al.) and P.L. , c. (C.) (pending before the Legislature as this bill).

(cf: P.L.2001, c.267, s.18)

15. Section 22 of P.L.2001, c.267 (C.17B:27B-22) is amended to read as follows:

22. a. A third party billing service shall immediately notify the commissioner of any material change in its ownership, control, or other fact or circumstance affecting its qualification for certification.

b. A third party billing service shall file such reports, at such times as may be required by the commissioner, including reports that will verify compliance with the provisions of P.L.1999, c.154 (C.17B:30-23 et al.) and P.L. , c. (C.) (pending before the Legislature as this bill).

(cf: P.L.2001, c.267, s.22)

16. Section 7 of P.L.2003, c.112 (C.17B:30-47) is amended to read as follows:

7. a. The following procedures shall apply for those hospitals that wish to participate in the voluntary assignment program created by this act.

b. The hospital shall file with the commission a notice signifying its intent to participate voluntarily and certifying the following:

(1) the hospital has determined that the patient is not eligible for charity care under the New Jersey Hospital Care Payment Assistance Program established by the Department of Health and Senior Services pursuant to section 10 of P.L.1992, c.160 (C.26:2H-18.60);

(2) the hospital has submitted a [\"clean claim\"] claim pursuant to [P.L.1999, c.154 (C.17B:30-23 et al.)] P.L. , c. (C.) (pending before the Legislature as this bill) and P.L.1999, c.155 (C.17B:30-26 et seq.) to the patient, a responsible party, Medicaid, Medicare or a health plan, as applicable, within a reasonable time following the patient's discharge, or in the case of outpatient service, the date of service;

(3) the claims have been fully adjudicated by a health plan, Medicare or Medicaid, where applicable, and a debt remains outstanding;

(4) the hospital has not initiated collection procedures against the patient or responsible party while a claim was pending adjudication with Medicare or a health plan, for which a debt remains outstanding;

(5) the hospital has notified the patient of the hospital's intention, if the account is not paid in full, or alternatively through a payment plan with the hospital, to proceed with legal action, or to turn the bill over to the State Hospital Care Payment Commission for collection.

c. Nothing herein shall be deemed to create any new right to collection of hospital debts by hospitals beyond existing law; nor shall it be deemed to preclude any existing right to collection.

d. The commission may determine the content of the notice required by paragraph (5) of subsection b. of this section to the patient concerning the likelihood that the account will be turned over to the commission for collection.

e. The minimum amount of an unpaid bill that may be assigned to the commission by a hospital is $100, or such other minimum as the commission shall determine by regulation.

f. Upon receipt of the voluntary assignment, the Department of the Treasury shall send, on behalf of the commission, a notice to the person named as a debtor of the hospital, notifying the person as to receipt of the assignment by the commission, providing the person with 30 days to challenge the validity of the debt, and providing notice that in the absence of such challenge, a Certificate of Debt will be filed with the Superior Court of New Jersey. The notice shall also include a statement [on] of the commission's intention to take action to set off the liability against any refund of taxes pursuant to the "New Jersey Gross Income Tax Act" including an earned income tax credit, a NJ SAVER rebate or a homestead rebate, or other such funds as may be authorized by law.

g. If the person named as a debtor responds within the 30-day period, the person shall be provided with an opportunity to present, either in writing or in person, evidence as to why the person does not believe he is responsible for the debt. The commission shall provide written notice to both the person and the hospital as to its determination regarding the validity of the debt, including the

imposition of collection fees and interest, if applicable.

h. If the person fails to respond within 30 days to the commission, the commission may utilize the provisions of the Set off of Individual Liability (SOIL) program established pursuant to P.L.1981, c.239 (C.54A:9-8.1 et seq.), to collect any surcharge levied under this section that is unpaid on or after the effective date of this act.

As additional remedies, the commission may utilize the services of a collection agency to settle the debt and may also issue a certificate to the Clerk of the Superior Court stating that the person identified in the certificate is indebted under this law in such amount as shall be stated in the certificate. The certificate shall reference this act. Thereupon the clerk to whom such certificate shall have been issued shall immediately enter upon the record of docketed judgments: the name of the person as debtor; the State as creditor; the address of the person, if shown in the certificate; the amount of the debt so certified; a reference to this act under which the debt is assessed; and the date of making the entries. The docketing of the entries shall have the same force and effect as a civil judgment docketed in the Superior Court, and the commission shall have all the remedies and may take all of the proceedings for the collection thereof which may be had or taken upon the recovery of a judgment in an action, but without prejudice to any right of appeal. Upon entry by the clerk of the certificate in the record of docketed judgments in accordance with this provision, interest in the amount specified by the court rules for post-judgment interest shall accrue from the date of the docketing of the certificate; however, payment of the interest may be waived by the commission.

i. Any collection efforts undertaken pursuant to this act shall be undertaken in accordance with the "Health Insurance Portability and Accountability Act of 1996," Pub.L. 104-191 and 45 C.F.R. 160.101 to 164.534, or any other similar law. The commission and any other entity performing collection activities pursuant to this act is authorized to enter into any agreements required to comply with such laws, including, but not limited to, entering into agreements with the hospitals and collection agencies to provide for appropriate safeguarding of information.

(cf: P.L.2003, c.112, s.7)

17. (New section) The commissioner shall enforce the provisions this act. A payer or organized delivery system or its agent found in violation of any provision of this act shall be liable for a civil penalty of not less than $250 and not greater than $10,000 for each day that the payer or organized delivery system or its agent is in violation if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer or organized delivery system or its agent

has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

b. If the commissioner has reason to believe that a payer or organized delivery system or its agent is engaging in a practice or activity, for the purpose of avoiding or circumventing the legislative intent of this act, the commissioner is authorized to promulgate rules or regulations necessary to prohibit that practice or activity and levy a civil penalty of not less than $250 and not more than $10,000 for each day that person is in violation of that rule or regulation.

c. For the purpose of administering the provisions this act, 50% of the penalty monies collected pursuant to subsection a. and b. of this section shall be deposited into the General Fund. For the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et seq.), 50% of the penalty monies collected pursuant to subsection a. and b. of this section shall be deposited into the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

18. (New section) a. (1) A covered person, a health care provider, a professional organization representing a health care provider, the State, any political subdivision of the State and any agency or instrumentality of the State or of any political subdivision of the State, hereinafter referred to as a person, may commence a civil action in a court of competent jurisdiction against any payer or the Department of Banking and Insurance alleged to be in violation of this act or any regulation promulgated thereunder. The action may be for injunctive or other equitable relief to compel compliance with this act or regulation promulgated pursuant thereto, or to assess civil penalties for the violation as provided by this act. The action may be commenced upon an allegation that a payer or the Department of Banking and Insurance is in violation, either continuously or intermittently, of this act or promulgated regulation, and that there is a likelihood that the violation will recur in the future.

(2) Any person may commence a civil action in any court of competent jurisdiction for declaratory and equitable relief against any payer or the Department of Banking and Insurance in the interest of the public.

(3) The court may, on the motion of any party, or on its own motion, dismiss any action brought pursuant to this section which on its face appears to be patently frivolous, harassing or wholly

lacking in merit.

b. A court of competent jurisdiction may grant temporary and permanent equitable relief, including the imposition of such conditions as may be necessary to protect the interest of the public from violations against this act or promulgated regulation.

c. Upon completion of the proceedings in any action brought pursuant to subsection a. of this section, the court shall adjudicate the impact of the defendant's conduct on the interest of the pubic in accordance with this section. In such adjudication the court may order that additional evidence be taken to the extent necessary to protect the rights recognized in this section.

d. If administrative or other proceedings are required or available to determine the legality of the defendant's conduct, the court shall remit the parties to such proceedings, except where immediate and irreparable damage will probably result, which proceedings shall be conducted in accordance with and subject to the applicable provision of law providing for such proceedings and the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). In so remitting the court may grant temporary equitable relief where necessary for the protection of the public interest. In so remitting the court shall retain jurisdiction of the action pending completion thereof for the purpose of determining whether the administrative findings made in the proceedings are supported by substantial evidence and the agency action is in conformance with this section.

e. In any action in which a temporary restraining order or an interlocutory injunction is sought, the court may, as a condition of granting such relief, require reasonable security, not exceeding $10,000 or cash not exceeding $500.

f. (1) In any action under this section, the court may in appropriate cases award to the prevailing party reasonable counsel and expert witness fees, but not more than $50,000 in an action brought against the Department of Banking and Insurance, where the prevailing party achieved reasonable success on the merits. The fees shall be based on the number of hours reasonably spent and a reasonable hourly rate for the counsel or expert in the action taking into account the prevailing rate in the venue of the action and the skill and experience of the counsel or expert.

(2) The doctrines of collateral estoppel and res judicata may be applied by the court to prevent multiplicity of suits.

(3) No action commenced pursuant to the provisions of this section shall be dismissed without the express consent of the court in which the action was filed.

(4) Any payments made pursuant to a settlement or judgement entered in a case brought pursuant to this section shall be used to provide payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et seq.) and shall be

deposited into the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

g. No action shall be commenced pursuant to this section unless the person seeking to commence the suit shall, at least 30 days prior to the commencement thereof, direct a written notice of the intention by certified mail to the Attorney General, the Commissioner of Banking and Insurance and the intended defendant. The provisions of this subsection shall not apply to actions brought by the State, any political subdivision of the State and any agency or instrumentality of the State or of any political subdivision of the State.

h. This section shall be in addition to existing administrative and regulatory procedures provided in section 17 of this act.

19. (New section) The commissioner shall promulgate rules and 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.

20. The following are repealed:

Sections 2 through 7 of P.L.1999, c.154 (C.17:48-8.4; 17:48A-7.12; 17:48E-10.1; 17B:26-9.1; 17B:27-44.2; 26:2J-8.1)

Section 3 of P.L.1999, c.155 (C.17B:30-28)

21. This act shall take effect 180 days after enactment and shall apply to any carrier or organized delivery system that delivers, issues, executes or renews on or after the effective date of this act a health benefits plan in which the carrier or the organized delivery system has reserved the right to change the premium.

STATEMENT

This bill replaces the current law that governs the processing and payment of health care claims by health insurance carriers. It has become clear that the current system, established under P.L.1999, c.154 (C.17B:30-23 et al.), commonly referred to as the "prompt pay act," has not ensured that health care providers will be promptly and equitably paid by health insurance carriers for services they provide to covered persons.

Specifically, the bill provides that health insurance carriers or their agents, collectively referred to as "payers," which include hospital, medical, and health service corporations, commercial individual and group insurers, health maintenance organizations and organized delivery systems, shall pay a claim with the presumption that the claim has been submitted properly by the provider. The claim must be paid within 30 or 40 days, depending on the method of the claim's submission. The bill provides exceptions to this

policy if a claim cannot be entered into the claims processing system for various technical reasons and specifies a time frame in which the payer must provide notification of any problems so that the claim can be resubmitted for payment. Any claim that is not paid in-full or processed in the manner and within the time frames provided in the bill, shall be considered overdue and be assessed interest at the rate of 20% per annum.

The bill provides a system in which the payer can recuperate monies paid to a health care provider for the adjudication of a claim. Within one year of the claims payment, the payer can seek recuperation if the payer determines that the claim was covered or partially covered by other insurance available to the covered person; the payer determined that the payment was a result of fraud perpetrated by the health care provider and the payer has reported the fraud as required by law; or the payer made an error in the processing or payment of the claim. The payer must provide documentation of the circumstances that prompted the request, and the health care provider has 45 days from the date of receiving the documentation to reimburse the payer or file an appeal according to the provisions of the bill. If a reimbursement request has met the requirements set forth in the bill, and the request is for an amount equal to or greater than $5,000, the payer shall give the provider the opportunity to establish a repayment schedule of no less than one year. The payer may not charge any interest or late fee on the recuperated monies.

In order to facilitate the efficient processing and payment of claims, the bill requires the payer to disclose certain information concerning the method by which payers process and pay health care claims. This information must be posted in a clear and conspicuous manner on an Internet website not later than 90 days before the information or policies or changes in the information or policies take effect.

This bill requires that all claims be submitted using the standard paper or electronic claims form developed by the Commissioner of Banking and Insurance, and requires that health care providers submit all claims on the behalf of the covered person, unless the covered person opts to submit a claim own his own behalf. This bill gives a covered person the right to assign to a provider his right to receive payment for a claim for health care services. Upon the execution of an assignment of benefits, the payer shall remit the claims payment to the provider and give notice to the covered person when payment has been made. If the payer remits payment to the covered person rather than a provider despite the proper execution of an assignment of benefits, the claim shall not be considered paid. Payment shall be made to the health care provider within the time frames established in the bill or the claim shall be considered overdue. If a health care provider accepts an assignment of benefits, it shall not be construed that the provider agrees to the

payer's fee schedule or payment rates.

The bill requires payers that employ a utilization management system collect and report to the commissioner certain information concerning that system, including the number of utilization management decisions that have resulted in the payer denying coverage for a health care service. Unless the payer can demonstrate to the commissioner that more than 10% of all utilization management determinations for a particular health care service have resulted in a denial of coverage, the payer shall not employ a utilization management system to review that particular health care service.

The bill provides a two-step appeals process to resolve any dispute regarding the compliance of either a payer or provider with the provisions of this act. Payers must establish an internal appeals mechanism to resolve disputes within 10 days of their initiation by the provider. If a payer finds for the provider, it must pay the disputed amount in-full plus accrued interest at the rate of 20% per annum. If a payer rules against the provider, it must communicate its findings in writing, including written instructions for referring the dispute to arbitration.

Following an internal appeal, either party can refer the dispute to binding arbitration; however no disputes pertaining to medical necessity which are eligible to be submitted to the Independent Health Care Appeals Program or involving payment amounts less than $1,000 shall be accepted for arbitration. If the arbitrator finds in favor of the payer, the payer shall remit payment, including accrued interest at 20% per annum, within 10 days.

The bill provides for the imposition of civil monetary penalties for violations of the bill's provisions. Fifty percent of the penalty monies collected shall be deposited into the General Fund for the purpose of paying for the additional administrative duties this bill requires of the Department of Banking and Insurance, and the remaining 50% shall be deposited in the Heath Care Subsidy Fund for the purpose of providing charity care subsidies to hospitals.

Finally, this bill authorizes any covered person, health care provider, professional organization representing a health care provider, the State, any political subdivision of the State and any agency or instrumentality of the State or of any political subdivision of the State, to commence a civil action in a court of competent jurisdiction against any payer or the Department of Banking and Insurance that is alleged to be in violation of this act or any regulation promulgated thereunder. The action may be for injunctive or other equitable relief to compel compliance with this act or promulgated regulation, or to assess civil penalties for the violation as provided by this act. The action may be commenced upon an allegation that a payer or the Department of Banking and Insurance is in violation, either continuously or intermittently, of this act or promulgated regulation, that there is a likelihood that the

violation will recur in the future, and that the violation impacts the public good.

This bill repeals or deletes several sections of the prompt pay act and provisions in P.L.2001, c.67 which governed the processing and payment of claims. The bill makes technical amendments to other sections of statutory law which refer to the sections repealed herein and makes the provisions of this bill applicable to the new provisions supplementing Title 17B of the New Jersey Statutes.