CHAPTER 22

HEALTH BENEFIT PLANS

Authority

N.J.S.A. 17:1-8.1, 17:1-14, 17:1-15c, 17:1-15e, 17:29B-1 et seq., 17B:30-13.1, 17B:30-23 et seq. and 26:2J-15b; and P.L. 2009, c. 113.

Source and Effective Date

R.2006 d.199, effective April 26, 2006.
See: 37 N.J.R. 3779(a), 38 N.J.R. 2499(b).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 22, Health Benefit Plans, expires on October 23, 2013. See: 43 N.J.R. 1236(a).

Chapter Historical Note

Chapter 22, Health Benefit Plans, was adopted as R.2000 d.452, effective November 6, 2000. See: 32 N.J.R. 2860(a), 32 N.J.R. 4014(a).

Subchapter 1, Prompt Payment of Claims, was adopted as new rules by R.2001 d.13, effective January 2, 2001. See: 32 N.J.R. 1985(a), 33 N.J.R. 105(a).

Subchapter 3, Electronic Receipt and Transmission of Health Care Claims, was adopted as new rules by R.2001 d.364, effective October 1, 2001. See: 33 N.J.R. 750(a), 33 N.J.R. 3461(a).

Subchapter 4, Organized Delivery Systems, was adopted as new rules by R.2002 d.336, effective October 21, 2002. See: 34 N.J.R. 20(a), 34 N.J.R. 3607(a).

Subchapter 5, Minimum Standards for Network-Based Health Benefit Plans, was adopted as new rules by R.2003 d.419, effective November 3, 2003. See: 34 N.J.R. 3485(a), 35 N.J.R. 5116(a).

Subchapter 6, Exclusions and Preauthorization Requirements, was adopted as new rules by R.2004 d.80, effective February 17, 2004. See: 35 N.J.R. 2396(a), 36 N.J.R. 958(a).

Subchapter 7, Carrier/Provider Joint Negotiation Agreements, was adopted as new rules by R.2004 d.295, effective August 2, 2004. See: 35 N.J.R. 5036(a), 36 N.J.R. 3553(a).

Chapter 22, Health Benefit Plans, was readopted by R.2006 d.199, effective April 26, 2006. See: Source and Effective Date. See, also, section annotations.

Subchapter 8, Health Insurance Identification Cards, was adopted as new rules by R.2009 d.333, effective November 2, 2009 (operative July 1, 2010). See: 40 N.J.R. 6527(a), 41 N.J.R. 4117(b).

Subchapter 5, Minimum Standards for Network-Based Health Benefit Plans, was renamed Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans by R.2009 d.265, effective September 8, 2009 (operative September 8, 2010). See: 40 N.J.R. 6915(a), 41 N.J.R. 3302(b).

Subchapter 9, Maternity Installment Payments, was adopted as new rules by R.2011 d.190, effective July 5, 2011. See: 43 N.J.R. 146(a), 43 N.J.R. 1533(a).

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SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

11:22-1.1 Purpose and scope

(a) This chapter implements N.J.S.A. 17B:30-26 through 34, which sets standards for the payment of claims relating to health benefit plans and dental plans.

(b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, dental service corporation and dental plan organization that issues health benefit plans or dental plans in this State; any organized delivery system; and to any agent, employee or other representative of such entity that processes claims for such entity.

Amended by R.2003 d.446, effective November 17, 2003.
See: 35 N.J.R. 2394(a), 35 N.J.R. 5292(a).
In (b), inserted "any organized delivery system;" following "dental plans in this State;".

11:22-1.2 Definitions

(a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"ADR" means alternate dispute resolution.

"Agent" means any entity, including a subsidiary of a carrier, or an organized delivery system as defined by N.J.S.A. 17:48H-1 with which a carrier has contracted to perform claims processing or claims payment services.

"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 carrier, 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.

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

"Clean claim" means:

1. The claim is for a service or supply covered by the health benefits plan or dental plan;

2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;

3. The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;

4. The carrier does not reasonably believe that the claim has been submitted fraudulently; and

5. The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

"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 or supply" means a service or supply provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provides services or supplies.