

CHAPTER 22

HEALTH BENEFIT PLANS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, 17:48H-32, 17B:27B-25, 17B:30-13.1, 17B:30-23 et seq., 17B:30-55, 17B:30-56, 26:1A-36.14 and 52:17B-209.

Source and Effective Date

R.2011 d.256, effective September 21, 2011.
See: 43 N.J.R. 1236(a), 43 N.J.R. 2668(b).

Chapter Expiration Date

Chapter 22, Health Benefit Plans, expires on September 21, 2018.

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: 37 N.J.R. 3779(a), 38 N.J.R. 2499(b).

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).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 22, Health Benefit Plans, was scheduled to expire on April 26, 2013. See: 43 N.J.R. 1203(a).

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).

Chapter 22, Health Benefit Plans, was readopted as R.2011 d.256, effective September 21, 2011. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

- 11:22-1.1 Purpose and scope
- 11:22-1.2 Definitions
- 11:22-1.3 Acknowledgement of receipt of claims
- 11:22-1.4 Claim submission requirements

- 11:22-1.5 Prompt payment of claims
- 11:22-1.6 Denied and disputed claims
- 11:22-1.7 Prompt payment of capitation payments
- 11:22-1.8 Internal and external appeals
- 11:22-1.9 Reporting requirements
- 11:22-1.10 Remediation/penalty

APPENDIX A. NEW JERSEY CLAIMS PAYMENT EXHIBIT

APPENDIX A-1. INSTRUCTIONS

APPENDIX B. QUARTERLY (ANNUAL) CLAIMS PROMPT PAYMENT REPORT

APPENDIX B-1. INSTRUCTIONS

SUBCHAPTER 2. HEALTH WELLNESS PROMOTION PLANS

- 11:22-2.1 Scope
- 11:22-2.2 Definitions
- 11:22-2.3 Provision of a health wellness promotion program
- 11:22-2.4 Dollar amounts to be provided for services or benefits

SUBCHAPTER 3. ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH CARE CLAIMS

- 11:22-3.1 Purpose and scope
- 11:22-3.2 Definitions
- 11:22-3.3 Standard enrollment/change request forms and application/change request forms
- 11:22-3.4 Health care providers; claims
- 11:22-3.5 Additional timetables
- 11:22-3.6 Use of clearinghouses in electronic transactions
- 11:22-3.7 Information protection practices
- 11:22-3.8 Fraud prevention and detection
- 11:22-3.9 Penalties
- 11:22-3.10 through 11:22-3.11 (Reserved)

APPENDIX. EXHIBITS 1 THROUGH 3

SUBCHAPTER 4. ORGANIZED DELIVERY SYSTEMS

- 11:22-4.1 Purpose and scope
- 11:22-4.2 Definitions
- 11:22-4.3 License requirement
- 11:22-4.4 Application procedures
- 11:22-4.5 Application review procedures
- 11:22-4.6 Notice of change in documents
- 11:22-4.7 Examinations
- 11:22-4.8 Net worth, deposits and bond
- 11:22-4.9 Financial reports
- 11:22-4.10 Treatment as domestic insurer
- 11:22-4.11 Suspension or revocation
- 11:22-4.12 Plan for insolvency
- 11:22-4.13 Confidentiality
- 11:22-4.14 Penalties

APPENDIX. EXHIBITS A THROUGH C

SUBCHAPTER 5. MINIMUM STANDARDS FOR HEALTH BENEFIT PLANS, PRESCRIPTION DRUG PLANS AND DENTAL PLANS

- 11:22-5.1 Purpose and scope
- 11:22-5.2 Definitions
- 11:22-5.3 Network deductible
- 11:22-5.4 Network coinsurance
- 11:22-5.5 Network copayment
- 11:22-5.6 Out-of-pocket limits
- 11:22-5.7 Benefit maximums in health benefit plans
- 11:22-5.8 Network and out-of-network coverage
- 11:22-5.9 Prescription drug benefits
- 11:22-5.10 Dental benefits
- 11:22-5.11 Effect on previously-approved forms

**SUBCHAPTER 6. EXCLUSIONS AND
PREAUTHORIZATION REQUIREMENTS**

- 11:22-6.1 Purpose and scope
- 11:22-6.2 Definitions
- 11:22-6.3 War exclusions
- 11:22-6.4 Requirements for preauthorization provisions
- 11:22-6.5 Effect on previously filed forms

**SUBCHAPTER 7. CARRIER/PROVIDER JOINT
NEGOTIATION AGREEMENTS**

- 11:22-7.1 Purpose and scope
- 11:22-7.2 Definitions
- 11:22-7.3 Quarterly and annual reports

APPENDIX A

APPENDIX B

**SUBCHAPTER 8. HEALTH INSURANCE
IDENTIFICATION CARDS**

- 11:22-8.1 Purpose and scope
- 11:22-8.2 Definitions
- 11:22-8.3 Requirement to issue identification cards
- 11:22-8.4 Time limits
- 11:22-8.5 Informational filing
- 11:22-8.6 Operative date

**SUBCHAPTER 9. MATERNITY INSTALLMENT
PAYMENTS**

- 11:22-9.1 Purpose and scope
- 11:22-9.2 Definitions
- 11:22-9.3 General requirements
- 11:22-9.4 Global reimbursement
- 11:22-9.5 Installment reimbursement
- 11:22-9.6 Operative date

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.

SUBCHAPTER 4. ORGANIZED DELIVERY SYSTEMS

11:22-4.1 Purpose and scope

(a) This subchapter sets forth the filing and requirements for an entity to be licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.

(b) This subchapter applies to any entity seeking to become licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.; or an existing organized delivery system required to obtain a license to operate pursuant to N.J.S.A. 17:48H-11. A non-exhaustive list of examples of entities and arrangements that are subject to these rules is set forth in Exhibit B in the Appendix to this subchapter, incorporated herein by reference.

11:22-4.2 Definitions

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

“Affiliate” means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the organized delivery system.

“Capitation” means a fixed per member, per month, payment or percentage of premium payment for which the provider assumes the risk for the cost of contracted services without regard to the type, value or frequency of the services provided.

“Carrier” means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17-4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A-1 et seq., a health service corporation authorized to transact business in accordance with N.J.S.A. 17:48E-1 et seq. or a health maintenance organization authorized to transact business pursuant to N.J.S.A. 26:2J-1 et seq.

“Certified organized delivery system” means an organized delivery system that is compensated on a basis which does not entail the assumption of more than de minimis financial risk by the organized delivery system and that is certified by the DHSS in accordance with N.J.S.A. 17:48H-1 et seq.

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Comprehensive health care services” means the basic benefits provided under a health benefits plan, including medical and surgical services provided by licensed health care providers who may include, but are not limited to, family physicians, internists, cardiologists, psychiatrists, rheumatologists, dermatologists, orthopedists, obstetricians, gynecologists, neurologists, endocrinologists, radiologists, nephrologists,

emergency services physicians, ophthalmologists, pediatricians, pathologists, general surgeons, osteopathic physicians, physical therapists and chiropractors. Basic benefits may also include inpatient or outpatient services rendered at a licensed hospital, covered services performed at an ambulatory surgical facility and ambulance services.

“Consumer Price Index” means the medical component of the Consumer Price Index for all Urban Consumers, as reported by the United States Department of Labor, shown as the average index for New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton-region combined as published by the Commissioner in the New Jersey Register.

“Department” means the New Jersey Department of Banking and Insurance.

“Financial risk” means exposure to financial loss that is attributable to the liability of an organized delivery system for the payment of claims or other losses arising from covered benefits for treatment or health care services other than those performed directly by the person or organized delivery system liable for payment, including a loss sharing arrangement. A payment method wherein a provider accepts reimbursement in the form of a capitation payment for which it undertakes to provide health care services on a prepayment basis shall not per se be considered financial risk. A financial risk shall exist if, under an agreement between the organized delivery system and the carrier, the financial obligations of the organized delivery system for payment of benefits or for providing treatment or health care services does or potentially may exceed any payments that may be received from the carrier. Financial obligation shall include the attendant administrative costs related to providing the treatment or services.

“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 subchapter, 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 N.J.S.A. 39:6A-1 et seq. or hospital confinement indemnity coverage.

“Licensed organized delivery system” means an organized delivery system that is compensated on a basis which entails the assumption of financial risk by the organized delivery system and that is or should be licensed in accordance with N.J.S.A. 17:48H-1 et seq. and this subchapter.

“Limited health care services” means a health service or benefit which a carrier has elected to subcontract for as a

separate service, which may include, but shall not be limited to, substance abuse services, vision care services, mental health services, podiatric care services, chiropractic services or rehabilitation services. Limited health care services shall not include pharmaceutical services, case management services or employee assistance plan services.

“NAIC” means the National Association of Insurance Commissioners.

“Organized delivery system” or “system” means an organization with defined governance that:

1. Is organized for the purpose of and has the capability of contracting with a carrier, directly or indirectly, to provide, or arrange to provide, under its own management substantially all or a substantial portion of the comprehensive health care services or benefits under the carrier’s benefits plan on behalf of the carrier, which may or may not include the payment of hospital and ancillary benefits; or

2. Is organized for the purpose of acting on behalf of a carrier, directly or indirectly, to provide, or arrange to provide, limited health care services that the carrier elects to subcontract for as a separate category of benefits and services apart from its delivery of benefits under its comprehensive benefits plan, which limited services are provided on a separate contractual basis and under different terms and conditions than those governing the delivery of benefits and services under the carrier’s comprehensive benefits plan. This shall include any agreement to subcontract any separate health care service or benefit, unless expressly excluded herein. An organized delivery system shall not include:

i. An entity otherwise authorized or licensed in this State to provide comprehensive or limited health care services on a prepayment or other basis in connection with a health benefits plan or a carrier;

ii. An entity regulated under N.J.S.A. 18A:64G-1 et seq.; and

iii. Any professional corporation, professional association; or independent practice association, to the extent such entity’s shareholders are comprised solely of providers, and the entity performs no duties or services beyond those for which its shareholders are otherwise licensed in this State.

“Provider” means a physician, health care professional, health care facility, or any other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

“Reserve liabilities” means an amount sufficient to provide for:

1. All claims incurred, whether reported or unreported, which are unpaid and for which the system is or may

become liable, including the expense of adjustment or settlement of those claims;

2. Continuing health care services for which a consideration has been received, or a consideration is due but unpaid; and

3. Continuing health care services under the contract to persons who, on the date of termination of the contract, are confined in an inpatient facility until discharge from the facility.

Amended by R.2013 d.048, effective March 18, 2013 (operative January 1, 2014).

See: 44 N.J.R. 376(a), 45 N.J.R. 651(a).

Deleted definition “DHSS”.

11:22-4.3 License requirement

(a) An organized delivery system that receives compensation on a basis that entails the assumption of financial risk shall submit an application for licensure to the Commissioner.

1. This subchapter shall apply to any contract renewed on or after October 21, 2002. Notwithstanding the obligations imposed by N.J.S.A. 17:48H-1 et seq. and this subchapter regarding licensure requirements, nothing in this subsection shall operate to impair any contract in force as of October 21, 2002 for a period not to exceed 24 months.

(b) An organized delivery system that receives compensation on a basis that entails the assumption of financial risk, but meets the criteria set forth in this subsection, may apply to the Commissioner for an exemption from the licensure requirements based on the system’s current contractual arrangements. Any organized delivery system seeking an application for exemption shall file the information set forth in Exhibit A in the Appendix to this subchapter, incorporated herein by reference, with a non-refundable filing fee in the amount of \$1,000, payable to the Treasurer, State of New Jersey.

1. The Commissioner may grant the exemption for such period of time that he or she determines that the financial risk of the organized delivery system is de minimis because the organized delivery system’s exposure to financial loss is limited in amount or likelihood to the degree that it reasonably will not prevent the system from satisfying the liabilities imposed under the terms of its contracts. In making this determination, the Commissioner shall consider various factors in conjunction with the terms of contract with the carrier, including, but not limited to:

i. The existence of stop loss insurance maintained by the organized delivery system from an insurer(s) acceptable to the Commissioner;

ii. Whether the carrier has taken a deduction or credit against the liability it is required to maintain pursuant to law for any risk transferred to the organized delivery system; and

iii. The nature of the risk assumed and the type of coverage related to that risk; and/or

iv. Any limit on the organized delivery system's liability.

v. In any event, the financial risk shall be deemed de minimis if the total annual compensation received by the organized delivery system from any one carrier is less than \$250,000.

2. The Commissioner may revoke the organized delivery system's exemption from licensure, after notice and an opportunity for hearing, if he or she determines that the system's contracts no longer meet the requirements for exemption set forth in this subsection. Any hearing shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and Uniform Administrative Procedure Rules, N.J.A.C. 1:1. Upon revocation of the exemption, the system shall be required to obtain licensure from the Department within 90 days.

(c) An organized delivery system that is granted an exemption from licensure shall apply to and obtain certification as an organized delivery system from the Department pursuant to N.J.S.A. 17:48H-1 et seq.

(d) A licensed organized delivery system shall not directly issue health benefits plans.

Amended by R.2013 d.048, effective March 18, 2013 (operative January 1, 2014).

See: 44 N.J.R. 376(a), 45 N.J.R. 651(a).

In (c), substituted "Department" for "DHSS".

11:22-4.4 Application procedures

(a) An application for a license to operate an organized delivery system shall be filed with the Commissioner, and shall contain a completed application, containing the information and in the format set forth in Exhibit A in the Appendix to this subchapter, incorporated herein by reference. In addition, the application shall be accompanied by:

1. A non-refundable application fee in the amount of \$2,500, payable to the Treasurer, State of New Jersey; and

2. Any additional information as may be required from a particular applicant by the Commissioner.

(b) In addition to the filing fee set forth in (a)2 above, the applicant shall be assessed and shall pay on demand the amount necessary to reimburse the Department for expenses incurred in obtaining a risk assessment report on the applicant from a rating agency determined to be acceptable by the Commissioner.

Amended by R.2013 d.048, effective March 18, 2013 (operative January 1, 2014).

See: 44 N.J.R. 376(a), 45 N.J.R. 651(a).

In (a)2, deleted "or the Commissioner of DHSS" from the end.

11:22-4.5 Application review procedures

(a) The Commissioner shall review an application for licensure and notify the applicant of any deficiencies contained therein within 60 days of receipt. An applicant shall address any deficiencies in its application within 60 days of notice thereof.

(b) Upon receipt and review of a complete application that contains all of the information set forth in N.J.A.C. 11:22-4.4, the Commissioner shall issue a license to an organized delivery system if he or she finds that the system meets the following standards:

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

2. The persons who are to perform the health care services are properly qualified;

3. The organized delivery system has demonstrated the ability to assure that health care services will be provided in a manner which will assure the availability and accessibility of the services;

4. The standard forms of provider agreements to be used by the organized delivery system are acceptable, and comply with all requirements set forth at N.J.A.C. 11:24C-4 and 11:24B-2;

5. The applicant is financially sound and may reasonably be expected to meet its obligations to enrollees, contract holders and carriers. In making this determination, the Commissioner shall consider:

i. The financial soundness of the applicant's compensation arrangements for the provision of health care services;

ii. The adequacy of working capital, other sources of funding (including an acceptable capital and surplus guarantee from a parent or affiliate) and provisions for contingencies;

iii. Whether any deposit of cash or securities, or any other evidence of financial protection submitted, meets the requirements set forth in N.J.S.A. 17:48H-1 et seq. and this subchapter; and

iv. The standards set forth in N.J.A.C. 11:2-27;

6. Any deficiencies identified by the Commissioner have been corrected;

7. The applicant certifies that it is familiar and will comply with all requirements of law pertaining to licensed organized delivery systems set forth in N.J.S.A. 17:48H-1 et seq. and this subchapter; and

8. Any other factors determined by the Commissioner to be relevant regarding a particular applicant have been addressed to the satisfaction of the Commissioner.

(c) The Department may defer the review of an application accepted after November 1 until the most recent financial information becomes available if, based on the information provided in the application, the Department determines that it is necessary to review more recent financial information to evaluate properly the applicant's financial position.

(d) An applicant shall be notified of the decision on an application within 90 days of receipt of a complete application that contains all of the information set forth in N.J.A.C. 11:22-4.4, or within 90 days of the beginning of the review period set forth in (c) above.

(e) The Commissioner may deny an application for a license if the applicant fails to meet any of the standards provided in this subchapter or on any other reasonable grounds. If the license is denied, the Commissioner shall notify the applicant and shall set forth the reasons for the denial in writing. An existing organized delivery system seeking licensure whose application is denied may request a hearing by notice to the Commissioner within 30 days of receiving the notice of denial. The hearing shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and Uniform Administrative Procedure Rules, N.J.A.C. 1:1. Upon such denial, the applicant shall submit to the Commissioner a plan for bringing the organized delivery system into compliance or providing for the closing of its business.

Amended by R.2003 d.186, effective May 5, 2003.

See: 34 N.J.R. 3593(a), 35 N.J.R. 1918(a).

Rewrote (c).

Amended by R.2013 d.048, effective March 18, 2013 (operative January 1, 2014).

See: 44 N.J.R. 376(a), 45 N.J.R. 651(a).

In (a) and new (e), deleted ", in consultation with the Commissioner of DHSS," following "Commissioner"; in (b)4, inserted ", and comply with all requirements set forth at N.J.A.C. 11:24C-4 and 11:24B-2"; deleted (e); and recodified former (f) as new (e).

11:22-4.6 Notice of change in documents

(a) A licensed organized delivery system shall not materially modify any matter or document furnished pursuant to N.J.A.C. 11:22-4.4 unless the system files with the Commissioner a notice of the change or modification, together with any additional information to explain the change or modification, at least 60 days prior to the use or adoption of the change, and a filing fee in the amount of \$250.00. If the Commissioner fails to affirmatively approve or disapprove the change or modification within 60 days of submission of the notice and any supporting information required by the Commissioner, the notice of modification shall be deemed approved. The Commissioner may extend the 60-day review period for not more than 30 additional days

by giving written notice of the extension before the expiration of the 60-day period. If a change or modification is disapproved, the Commissioner shall notify the system in writing and specify the reason for the disapproval.

(b) Prior to entering into any contract with a carrier, a licensed organized delivery system shall file a copy of the contract with the Commissioner for approval. The filing shall be made no later than 60 days prior to the date that the contract is intended to be in effect. The Commissioner shall either approve the contract or state in writing the reasons for disapproval within 60 days of receipt of the filing. Contracts shall be subject to the following standards:

1. The terms shall be fair and reasonable;
2. Charges or fees for service performed shall be reasonable;
3. Expenses incurred and payment received shall be allocated to the system in conformity with customary accounting practices consistently applied;
4. The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and
5. The system's net worth following any transaction shall be reasonable in relation to its outstanding liabilities and adequate to its financial needs.

(c) All contracts between a carrier and a licensed organized delivery system shall satisfy the following requirements:

1. The funds being transferred from the carrier to the organized delivery system shall be first utilized to pay for treatment or services, and attendant administrative costs, for which the system has contracted;
2. The carrier shall have the right to periodic inspection of the books and records of the organized delivery system with respect to the use of the funds received from the carrier under the terms of the contract;
3. Payments under the contract shall be made no less frequently than monthly and no payment to the organized delivery system shall be made by the carrier prior to the first day of the month to which the payment relates;
4. The terms under which the carrier may withhold payments shall be specified;
5. The information to be reported to, and the frequency of such reporting, by the ODS to the carrier for the carrier to determine any applicable credit to the carrier's reserves from the transfer of risk to the ODS shall be specified;

6. Contain a provision that the written agreement, including any written amendments thereto, constitutes the entire agreement between the parties; and

7. Any changes shall be null and void unless made by written amendment signed by the parties, and filed with and approved by the Commissioner.

11:22-4.7 Examinations

(a) The Commissioner may conduct an examination of a licensed organized delivery system as often as he or she deems necessary in order to protect the interests of providers, contract holders, enrollees, and the residents of this State, but not less frequently than once every five years, except that an examination shall be conducted three years after the organized delivery system is initially licensed in this State. A licensed organized delivery system shall make its relevant books and records available for examination by the Commissioner, and retain its records related to the next examination, for not less than seven years. The reasonable expenses of the examination shall be borne by the licensed organized delivery system being examined.

(b) Where the system is domiciled in another state, and subject to regulation in a manner substantially similar to that provided under N.J.S.A. 17:48H-1 et seq. and this subchapter, the Commissioner may accept the report of an examination made by the Commissioner of that state in lieu of conducting examination pursuant to this section.

11:22-4.8 Net worth, deposits and bond

(a) Except as provided in (i) below, a licensed organized delivery system shall, at all times, have and maintain a minimum net worth, determined on a statutory accounting basis, in an amount equal to the greater of:

1. Two percent of the annual compensation received by the organized delivery system for all of its contracts, but in no event less than \$100,000; or

2. An amount equal to the sum of eight percent of the annual health care expenditures (not including those expenditures paid on a capitated basis and those made on a managed hospital payment basis), as reported for the most recent four calendar quarters, plus four percent of the annual hospital expenditures paid on a managed hospital payment basis for the most recent four calendar quarters.

i. The amounts set forth in (a) above may be adjusted by the Commissioner to the extent the applicant demonstrates there is a limitation on its exposure to financial loss that results from a contract with a carrier that provides that any liabilities of the system may be

satisfied by means of reductions or offsets against monies due to the system from the carrier, and which reductions or offsets the Commissioner finds will not adversely affect the system's ability to meet its contractual obligations.

ii. The minimum net worth requirements shall be phased-in over 48 months, so that an ODS shall maintain 25 percent of the minimum net worth required in (a) above at the end of the 12th month after it was issued a license; 50 percent of the minimum net worth required at the end of the 24th month following the month it was issued a license; 75 percent of the minimum net worth required at the end of the 36th month following the month it was issued a license; and 100 percent of the minimum net worth required at the end of the 48th month following the month it was issued a license.

(b) A licensed organized delivery system shall establish and maintain a segregated account with respect to the financial risk assuming operations of its business. Such segregated account shall include the income, disbursements, assets and liabilities associated with the financial risk assuming operations of the system. The segregated account shall, at all times, contain assets in an amount at least equal to the sum of its liabilities, including its reserve liabilities, plus the minimum net worth requirement set forth in (a) above. Such assets shall be segregated as separate and distinct funds, independent of all other funds of the organized delivery system. Assets in the segregated account shall be first utilized to provide treatment or services, including attendant administrative expenses, according to the terms of contracts with carriers under which the ODS assumes financial risk.

(c) Assets in the segregated account equal to its liabilities, including its reserve liabilities, and minimum net worth as set forth above, at any point in time, shall be held in cash or publicly traded securities with one year or less to maturity.

(d) Except for payment of benefits under the contract, including attendant administrative expenses, funds in the segregated account, which fair market value, together with that of other amounts withdrawn from the segregated account within the immediately preceding 12 months, that exceeds 10 percent of the total net worth of the segregated account as of December 31 immediately preceding, shall not be withdrawn except upon 45 days prior written notice to the Commissioner, and the withdrawal has not been disapproved prior to the expiration of the 45 day period. Notice of intent to withdraw monies shall contain the information and be in the format of Exhibit C in the Appendix to this subchapter, incorporated herein by reference. In no event may the net worth of the segregated account fall below the minimum net worth requirement set forth in (a) above.

(e) A licensed organized delivery system shall deposit with the Commissioner in accordance with the procedures set forth in N.J.A.C. 11:2-32, cash, securities, or any combination of these or other measures that is acceptable to the Commissioner in an amount equal to 50 percent of the highest calendar quarterly compensation of the most recent four quarters, but in no event less than \$25,000, which amount shall be adjusted annually in accordance with changes in the Consumer Price Index. The deposit shall be deemed an admitted asset of the system in the determination of net worth. The deposit amount, above the \$25,000 minimum, shall be payable over a two-year period, with 50 percent of the required amount above the minimum required amount payable at the end of the 12th month after it was issued a license.

(f) All income from deposits shall be an asset of the licensed organized delivery system. A licensed organized delivery system may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value, except that a security may not be substituted unless it has been approved by the Commissioner.

(g) If a licensed organized delivery system is placed in rehabilitation or liquidation, the deposit shall be treated as an asset subject to the provisions of N.J.S.A. 17B:32-31 et seq.

(h) A licensed organized delivery system shall maintain in force a fidelity bond in its own name on its officers and employees, in an amount not less than \$100,000.

(i) Any organized delivery system that pursuant to the terms of the contract, accepts risk in an amount represented by 50 percent or more of any carrier's consideration received to provide services or benefits, shall satisfy all net worth and financial requirements set forth in N.J.A.C. 8:38-11.

(j) For purposes of determining net worth and deposit requirements set forth in this section, "compensation" shall mean amounts paid to the ODS by a carrier or other ODS for specified health care benefits (for example, hospital/medical, dental, radiology, etc.) provided to the policyholders or members of the carrier pursuant to agreements whereby the ODS assumes financial risk.

(k) For purposes of determining net worth and deposit requirements set forth in this section, "health care expenditures" means amounts paid for provider services provided under a contractual arrangement and includes salaries, including fringe benefits, paid to providers for delivery of health care services; capitation payments paid by the ODS to providers for delivery of health care services; and fees paid to providers on a fee-for-service basis for delivery of health care services, including capitated referrals; and net of reinsurance recoveries. Annual health care expenditures do not include expenses for the time of providers devoted to administrative tasks.

Amended by R.2003 d.186, effective May 5, 2003.
See: 34 N.J.R. 3593(a), 35 N.J.R. 1918(a).

In (a), substituted "Two" for "Six" in 1, added 2ii; in (e), added the third sentence; added (j) and (k).

Public Notice: Increase in Medical Component of the Consumer Price Index.

See: 36 N.J.R. 1837(a).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 37 N.J.R. 1090(a).

Public Notice: Department of Banking and Insurance; Division of Insurance; Office of the Commissioner: minimum net worth requirements for Organized Delivery Systems: increase in medical component of the Consumer Price Index.

See: 38 N.J.R. 1607(b).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 39 N.J.R. 1322(a).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 40 N.J.R. 1937(a).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 41 N.J.R. 1529(a).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 42 N.J.R. 674(b).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 43 N.J.R. 752(a).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 44 N.J.R. 599(b).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 45 N.J.R. 701(c).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 46 N.J.R. 2046(c).

11:22-4.9 Financial reports

(a) A licensed organized delivery system shall file an annual report for the segregated account established pursuant to N.J.A.C. 11:22-4.8(b) with the Commissioner, on or before March 1 of each year, for the immediately preceding calendar year, completed as prescribed by the National Association of Insurance Commissioners (NAIC) Health Annual Statement Instructions, and completed on a statutory accounting principles basis, in accordance with the NAIC Accounting Practices and Procedures Manual, effective January 1, 2001, incorporated herein by reference, as amended and supplemented (NAIC, 2301 McGee Street, Kansas City, MO 64108). The annual report shall be submitted using the NAIC health blank in effect at the time of the calendar year reported. Annual statements shall be accompanied by a fee in the amount of \$100.00.

(b) A licensed organized delivery system shall submit, no later than June 1, audited annual financial reports for the immediately preceding calendar year for the segregated account established pursuant to N.J.A.C. 11:22-4.8(b), and shall also file a report with respect to all of its operations, completed on a generally accepted accounting principles basis, certified by an independent certified public accountant, in accordance with N.J.A.C. 11:2-26. In addition, a statement by a qualified actuary setting forth the actuary's opinion as to the adequacy of reserves shall be filed with the annual report filed pursuant to (a) above, which shall satisfy the requirements set forth in N.J.A.C. 8:38-11.6(a)2.

(c) A licensed organized delivery system shall file quarterly reports for the segregated account established pursuant to N.J.A.C. 11:22-4.8(b) with the Commissioner, no later than 45 days following the close of each of the first three calendar quarters (that is, May 15, August 15, and November 15, respectively), completed as prescribed by the NAIC Health Annual Statement Instructions, and completed on a statutory accounting principles basis, in accordance with the NAIC Accounting Practices and Procedures Manual, effective January 1, 2001, incorporated herein by reference, as amended and supplemented. The quarterly report shall be submitted using the NAIC health blank in effect at the time of the quarter submitted.

11:22-4.10 Treatment as domestic insurer

Regardless of the state in which it is incorporated, pursuant to N.J.S.A. 17:48H-16 and 26 a licensed organized delivery system shall be treated as a domestic insurer subject to N.J.S.A. 17:27A-1 et seq. and 17B:32-31 et seq.

New Rule, R.2008 d.179, effective July 7, 2008.

See: 40 N.J.R. 1604(a), 40 N.J.R. 4221(a).

Former N.J.A.C. 11:22-4.10, Suspension or revocation, recodified to N.J.A.C. 11:22-4.11.

11:22-4.11 Suspension or revocation

(a) The Commissioner may suspend or revoke the license issued to an organized delivery system upon a finding that:

1. The licensed organized delivery system is operating in contravention of its basic organizational documents;
2. The licensed organized delivery system is unable to fulfill its obligations to the carriers with whom it contracts;
3. The net worth of the licensed organized delivery system is less than that required by this subchapter, or the licensed organized delivery system has failed to correct any deficiency in its net worth as required by the Commissioner;
4. The continued operation of the licensed organized delivery system would be hazardous to the health and welfare of the enrollees or contract holders with whom it has contracted to provide health care services or detrimental to a carrier with whom it has contracted to provide the services;
5. The licensed organized delivery system has failed to file any report required by N.J.S.A. 17:48H-1 et seq. or this subchapter;
6. The licensed organized delivery system has failed to provide the health care services for which it has been licensed or has provided health care services which are in contravention of the contract or contracts filed with the Commissioner;
7. The licensed organized delivery system is unable to maintain the standards set forth in this subchapter;

8. The licensed organized delivery system has failed to comply with the provisions of N.J.S.A. 26:2S-1 et seq.;

9. The licensed organized delivery system has otherwise failed to comply with N.J.S.A. 17:48H-1 et seq., or with other applicable law, including this subchapter; or

10. There are other reasonable grounds that warrant suspension or revocation.

(b) If the Commissioner has cause to believe that grounds exist for the suspension or revocation of a license, the Commissioner shall notify the licensed organized delivery system, in writing, specifically stating the grounds for suspension or revocation and fixing a time for a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. If a license is revoked, the licensed organized delivery system shall submit a plan to the Commissioner within 15 days of the revocation, for the winding up of its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of its business. The Commissioner may, by written order, permit such further operation of the system as the Commissioner finds to be in the best interest of individuals receiving health care services from the system.

(c) The Commissioner shall notify all carriers with contracts with the system that are on file with the Department of the proceedings.

Recodified from N.J.A.C. 11:22-4.10 by R.2008 d.179, effective July 7, 2008.

See: 40 N.J.R. 1604(a), 40 N.J.R. 4221(a).

Former N.J.A.C. 11:22-4.11, Plan for insolvency, recodified to N.J.A.C. 11:22-4.12.

11:22-4.12 Plan for insolvency

In connection with the plan for insolvency required as part of an application for licensure, a licensed organized delivery system shall maintain insurance to cover the expenses to be paid for continued benefits following a determination of insolvency, or make other arrangements acceptable to the Commissioner to ensure that benefits are continued for the period determined in the insolvency plan.

Recodified from N.J.A.C. 11:22-4.11 by R.2008 d.179, effective July 7, 2008.

See: 40 N.J.R. 1604(a), 40 N.J.R. 4221(a).

Former N.J.A.C. 11:22-4.12, Confidentiality, recodified to N.J.A.C. 11:22-4.13.

11:22-4.13 Confidentiality

(a) Any data or information relating to the diagnosis, treatment or health of an enrollee, prospective enrollee or contract holder obtained by a licensed organized delivery system from the carrier, contract holder, enrollee, prospective enrollee or any provider shall be confidential and shall not be disclosed to any person except as provided by N.J.S.A. 17:48H-30.

(b) In addition to (a) above, the following documents shall be confidential and shall not be considered public documents pursuant to the "Right-to-Know" law, N.J.S.A. 47:1A-2:

1. Pending applications for a license;
2. In biographical affidavits, the affiant's social security number and residence address;
3. The applicant's business plan;
4. Compensation formulas and fee schedules; and
5. With respect to an examination of a licensed ODS, all information as set forth in N.J.S.A. 17:23-24f and N.J.A.C. 11:1-36.6.

Recodified from N.J.A.C. 11:22-4.12 by R.2008 d.179, effective July 7, 2008.

See: 40 N.J.R. 1604(a), 40 N.J.R. 4221(a).

Former N.J.A.C. 11:22-4.13, Penalties, recodified to N.J.A.C. 11:22-4.14.

11:22-4.14 Penalties

Failure to comply with the provisions of this subchapter shall result in the imposition of penalties as provided in N.J.S.A. 17:48H-22, 17:48H-29, 17B:30-17, 17:27A-1 et seq., 26:2S-1 et seq., 17B:30-23 et seq. and 17B:30-26 et seq.

Amended by R.2006 d.199, effective June 5, 2006.

See: 37 N.J.R. 3779(a), 38 N.J.R. 2501(a).

Substituted "17B:30-23 et seq. and 17B:30-26 et seq." for "and P.L. 1999, c. 154, and P.L. 1999, c. 155".

Recodified from N.J.A.C. 11:22-4.13 by R.2008 d.179, effective July 7, 2008.

See: 40 N.J.R. 1604(a), 40 N.J.R. 4221(a).

APPENDIX**EXHIBIT A****ORGANIZED DELIVERY SYSTEM****LICENSURE AND EXEMPTION FROM LICENSURE
APPLICATION****INSTRUCTIONS**

A checklist of documents to be submitted by an organized delivery system that assumes financial risk and seeks licensure or exemption from licensure pursuant to N.J.S.A. 17:48H-11 follows.

The application asks the applicant to specify whether it seeks licensure or expects to file for exemption. Where exemption is requested, the applicant should complete the application including an explanation as to how the exposure to financial loss is limited in amount or likelihood.

The checklist of required documents is divided into three sections:

Part A - the Application Cover Sheet,
organizational information and
standard forms of contracts;

Part B - financial information;

Part C – quality of care information,

Additional information may be required for review by the Commissioner of Banking and Insurance or the Commissioner of Health and Senior Services as deemed necessary in the course of reviewing the information submitted.

Pursuant to N.J.S.A. 17:48H-35, documents provided by the applicant that are deemed by the Commissioner of Banking and Insurance and the Commissioner of Health and Senior Services to be proprietary shall be confidential and shall not be considered public documents. The applicant is asked to identify those documents submitted with the application that it believes to be proprietary in nature by marking them confidential.

When preparing your response, please number each item to correspond with the section and the number of the item on the checklist.

Submit two (2) copies of your application (Parts A, B and C) to:

New Jersey Department of Banking and Insurance
Office of Life and Health
Attn: Organized Delivery System License
20 West State St.
P.O. Box 325
Trenton, NJ 08625-0325

ORGANIZED DELIVERY SYSTEM**LICENSURE AND EXEMPTION FROM LICENSURE
APPLICATION****CHECKLIST OF DOCUMENTS REQUIRED****PART A**

1. The completed Application Cover Sheet (form enclosed).
2. The completed Irrevocable Consent to Jurisdiction of the Commissioner and New Jersey Courts (form enclosed).
3. The completed Appointment of Attorney for the State of New Jersey appointing the Commissioner of Banking and Insurance as attorney for service of process (form enclosed).
4. A copy of the applicant organization's basic organization documents which shall include but not be limited to, articles of incorporation, articles of association, partnership agreement, management agreement, trust agreement or other applicable documents as appropriate to the applicant's form of business entity and all amendments to those documents.
5. A copy of the executed bylaws, rules and regulations, or similar documents, regulating the conduct of the applicant's internal affairs.
6. Biographical Affidavits of the persons who are to be responsible for the conduct of the affairs of the applicant. (form enclosed) This shall include but not be limited to:
 - a) Members of the board of directors, executive committee or other governing board or committee, the principal officers, medical director, if applicable, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant;
 - b) In the case of a partnership or association, the names of the partners or members;
 - c) Each person who has loaned funds to the applicant for the operation of its business; and
 - d) A statement of any criminal convictions or civil, enforcement or regulatory action, including actions relating to professional licenses, taken against any person who is a member of the board, the executive committee or other governing board or committee or the principal officers, or the person who is responsible for the conduct of the affairs of the applicant.
7. A business plan consisting of:
 - a) An organizational chart;
 - b) A statement generally describing the applicant, its facilities, personnel, and the health care services to be offered by the organized delivery system;
 - c) A list of the geographical areas in which the services are to be performed and approximate numbers of providers who will provide the services;
 - d) A description of any administrative services for which the applicant will be responsible;
 - e) A list of any affiliate of the applicant that provides services to the applicant in this State and a description of any material transaction between the affiliate and the applicant;
 - f) A description of any arrangements between the applicant and any other organized delivery system or subcontractor for services associated with the provision of health care services;
 - g) A description of any reinsurance or stop loss arrangements;
 - h) A plan, in the event of insolvency of the organized delivery system, for continuation of the health care services to be provided for under the contracts;
 - i) A description of the means by which the organized delivery system will be compensated under contracts with carriers;
 - j) A description of the arrangement for the applicant's reporting of data to the carriers and a description of the carriers' oversight responsibilities.

8. A copy of the standard form of any provider agreement made or to be made between the applicant and any providers relative to the provision of health care services.
9. A copy of the form of any contract between the applicant and any other ODS or subcontractor for services associated with the provision of health care services.
10. A copy of the form of any contract made or to be made between the applicant and any carrier for the provision of or arrangement to provide health care services, which contract shall contain provisions establishing the respective duties of the carrier and the applicant with respect to compliance with N.J.S.A. 26:2S-1 et seq.
11. A list of all administrative, civil or criminal actions and proceedings to which the applicant, or any of its affiliates, or persons who are responsible for the conduct of the affairs of the applicant or affiliate, have been subject and the resolution of those actions and proceedings. If a license, certificate or other authority to operate has been refused, suspended or revoked by any jurisdiction, the applicant shall provide a copy of any orders, proceedings and determinations relating thereto.
12. A list of all states in which the applicant has been or currently is doing business as described in the application.

9. Contact Person _____

10. Phone Number () _____

11. Toll Free Number () _____

12. Fax Number () _____

13. E-Mail Address _____

14. Resident Status _____ Resident of New Jersey
 _____ County in which Home Office is located for NJ
 Residents
 _____ Non-Resident of New Jersey

Certification

I (Name and Title) certify that I am authorized to file this certification on behalf of the applicant, the information set forth in the enclosed application and herein is true to the best of information, knowledge and belief, and that the Department of Banking and Insurance and Department of Health and Senior Services may rely on the information set forth in the application and herein in determining whether to grant a license pursuant to N.J.S.A. 17:48H-1 et seq.

I further certify that _____ is familiar and will comply with the requirements set forth in N.J.S.A.
(Name of Applicant)
17:48H-1 et seq. and N.J.A.C. 11:22-3.

Signature of Applicant

Full Legal Name (Type or Print)

Title

Date

IRREVOCABLE CONSENT TO JURISDICTION OF THE COMMISSIONER AND NEW JERSEY COURTS

THE STATE OF _____)

)KNOW ALL MEN BY THESE PRESENTS:

COUNTY OF _____)

That _____ of
(name of applicant)

_____ is filing herewith its application for a license or a certificate (circle as
(domiciliary city and state)

appropriate) to operate as an organized delivery system in the State of New Jersey,

That, upon issuance of said license by the Commissioner of Banking and Insurance;

_____ shall consent to the jurisdiction of the
(name of applicant)

Commissioner of Banking and Insurance and all New Jersey courts in relation to any transactions or other activity subject to regulation under N.J.S.A. 17B:48H-1 et seq. and all other applicable New Jersey statutes or rules; and

That such consent to the jurisdiction of the Commissioner of Banking and Insurance and the New Jersey courts shall be and remain irrevocable for as long as

_____ possesses a license from the Commissioner of Banking and Insurance or
(name of applicant)
engages in business as an organized delivery system in or from the State of New Jersey, and until all contractual obligations in the State of New Jersey are satisfied.

Witness our hands and the impress of the seal of said applicant, this _____ day of _____, 20_____.

(Corporate Seal--if applicable)

Attest:

(Signature) President
(or authorized representative)

(Print or Type Name)

(Signature) Secretary
(or authorized representative)

(Print or Type Name)

Appointment of Attorney for the State of New Jersey

KNOW ALL MEN BY THESE PRESENTS: That the _____ of the _____ of _____ in the _____ of _____, desiring to do business in the State of New Jersey in conformity with the laws thereof, hereby, constitutes and appoints the Commissioner of Banking and Insurance of New Jersey, and his or her successor in office, to be its true and lawful Attorney, upon whom all original process in any action or legal proceeding against said _____ may be served. And the said _____ hereby stipulates and agrees that any original process against it, which is served upon said Attorney, shall be of the same legal force and validity as if served upon said _____, and that the authority of said Attorney shall continue in force irrevocable so long as any liability of said _____ remains outstanding in New Jersey.

IN WITNESS WHEREOF, the said _____ has caused these presents to be subscribed by its President, and attested by its Secretary, and its corporate seal to be hereunto affixed, this _____ day of _____ 20_____.

(Corporate Seal--if applicable)

President
(or authorized representative)

(Print or Type Name)

Attest:

Secretary
(or authorized representative)

(Print or Type Name)

BIOGRAPHICAL AFFIDAVIT

(Print or Type)

Full Name and Address of Applicant (Do not use Group Names) _____

In connection with the above-named applicant, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS 'NO' OR 'NONE', SO STATE.

1. Affiant's Full Name* (Initials not acceptable). _____

2. Have you ever had your name changed? _____ If yes, give the reason for the change.

a) Other names used at any time. _____

3. Affiant's Social Security Number*. _____

4. Date and place of birth. _____

5. Affiant's business address. _____
Business telephone. _____

6. List your residences for the last ten (10) years starting with your current address, giving:
DATE ADDRESS CITY and STATE

7. Education: dates, names, locations and degrees.
a) College. _____

b) Graduate Studies. _____

c) Others. _____

_____ These items may be submitted on a separate form to maintain confidentiality.

8. List of memberships in professional societies and associations. _____

9. Present or proposed position with the applicant. _____

10. List complete employment record (up to and including present jobs, positions, directorates or officerships) for the past twenty (20) years, giving:

DATE	EMPLOYER and ADDRESS	TITLE

11. Present employer may be contacted. _____ Yes _____ No
Former employers may be contacted. _____ Yes _____ No

12. Have you ever been in a position that required a fidelity bond? _____ If any claims were made on the bond, give details.

a) Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? _____ If yes, give details. _____

13. List any professional, occupational and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past (state date license issued, issuer of license, date terminated, reasons for termination).

14. During the last ten (10) years, have you ever been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked? _____ If yes, give details. _____

15. List any insurers, prepaid dental plans, health service corporations or health maintenance organizations, in which you control directly or indirectly or own legally or beneficially 10% or more of the outstanding stock (in voting power). _____

If any of the stock is pledged or hypothecated in any way, give details. _____

16. Will you or members of your immediate family subscribe to or own, beneficially or of record, shares of stock of the applicant-organized delivery system or its affiliates? _____. If any of the shares or stock are pledged or hypothecated in any way, give details. _____

17. Have you ever been adjudged a bankrupt? _____

18. Have you ever been convicted or had a sentence imposed or suspended or had pronouncement of a sentence suspended or been pardoned for conviction of or pleaded guilty or *nolo contendere* to an information or indictment, charging any felony, or charging a misdemeanor involving embezzlement, theft, larceny or mail fraud, or charging a violation of any corporate securities statute or any insurance law, or have you been a subject of any disciplinary proceedings of any federal or state regulatory agency? _____ If yes, give details. _____

a) Has any company been so charged, allegedly as a result of any action or conduct on your part? _____ If yes, give details. _____

19. Have you ever been an officer, director, trustee, investment committee member, key employee or controlling stockholder of any insurer, prepaid dental plans, health service corporations or health maintenance organizations, which, while you occupied such a position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation or conservatorship? _____

20. Has the certificate of authority or license to do business of any insurer, prepaid dental plans, health service corporations or health maintenance organizations, of which you were an officer or director or key management person ever been suspended or revoked while you occupied such position? _____ If yes, give details. _____

Dated and signed this _____ day of _____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to be best of my knowledge and belief.

(Signature of Affiant)

State of _____

County of _____

Personally appeared before me the above named _____ personally known to me, who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____ of _____ 20_____.

(Notary Public)

My Commission Expires _____

ORGANIZED DELIVERY SYSTEM
LICENSURE AND EXEMPTION FROM LICENSURE
APPLICATION

CHECKLIST OF DOCUMENTS REQUIRED

PART B

1. A copy of the applicant's most recent financial statements audited by an independent certified public accountant. If the financial affairs of the applicant's parent company are audited by an independent certified public accountant, but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, audited by an independent certified public accountant, shall be submitted. A consolidated financial statement of the applicant and its parent company shall satisfy this requirement unless the Commissioner determines that additional or more recent financial information is required.
2. A copy of the applicant's financial plan, including:
 - a) A three-year projection of anticipated operating results, on a statutory basis in accordance with the NAIC Accounting Practices and Procedures Manual (or for one year beyond the anticipated "break-even" year). The projections shall be on a quarterly basis for the first year, and on an annual basis for the subsequent years;
 - b) A description of the assumptions used in the projections that shall include an explanation of each line item;
 - c) A statement of the sources of working capital and any other sources of funding and provisions for contingencies.
3. A copy of each reinsurance or stop loss contract.

**ORGANIZED DELIVERY SYSTEM
LICENSURE AND EXEMPTION FROM LICENSURE
APPLICATION**

CHECKLIST OF DOCUMENTS REQUIRED

PART C

1. With respect to each contract made or to be made between the applicant and any other person who will provide comprehensive or limited health care services:
 - a) A list of all participating providers by county, municipality and zip code, accompanied by maps of the service area identifying the location of these providers by address. This list shall include the names of all health care professionals, physicians (by specialty and with hospital affiliation, if applicable), hospitals, health care facilities, and ancillary providers to provide health care services, including affiliates as listed in "c" below (the persons who are to provide the health care services, and the geographical area in which they are located and in which the services are to be performed);
 - b) The criteria regarding geographic accessibility and availability of the health care provider network as related to the carrier's enrollment projections and the criteria to be used to maintain the appropriate numbers and types of providers as enrollment increases;
 - c) A list of any affiliate of the applicant that provides services to the applicant in this State and a description of any material transaction between the affiliate and the applicant;
 - d) A detailed description of all health care services and/or benefits to be offered or proposed to be offered and a detailed description of all administrative services for which the applicant will be responsible;
 - e) A description and a flow chart of the complaint and appeal procedures as delineated in N.J.A.C. 8:38A-4.6, if applicable;
 - f) A description and a flow chart of the continuous quality improvement program as delineated in N.J.A.C. 8:38A-3.8, if applicable;
 - g) A description and a flow chart of the utilization management program, including the process for appealing utilization management determinations as delineated in N.J.A.C. 8:38A-3.4 – 3.7, 4.11 and 4.12, if applicable;
 - h) A description and a flow chart of the provider credentialing program as delineated in N.J.A.C. 8:38A-4.5;
 - i) A description of the arrangement for the applicant's reporting of data to the carrier and a description of the arrangement for the carrier's oversight responsibilities;
 - j) A description of the method by which enrollees and providers will be informed of changes in the health care delivery system and/or network, if applicable;
 - k) A plan, in the event of the insolvency of the organized delivery system, for continuation of the health care services to be provided for under the contract;
 - l) A description of the means by which the organized delivery system shall be compensated for each contract entered into with a carrier;
 - m) A description and a flow chart of how emergency/urgent medical services will be available 24 hours a day, seven days a week; and
 - n) The attached tables immediately following.

**TABLE 1: SUMMARY OF PHYSICIANS BY COUNTY
(INDICATE NUMBER OF PROVIDERS IN EACH COUNTY)**

Type of Provider	New Jersey Counties																					STATE-WIDE
	A T L	B E R	B U R	C A M	C A P	C U M	E S S	G L O	H U D	H U N	M E R	M I D	M O N	M O R	O C E	P A S	S A L	S O M	S U S	U N I	W A R	
A. PRIMARY CARE PHYSICIANS																						
1. Family Practice																						
2. General Practice																						
3. Internal Medicine																						
4. Pediatrics																						
Subtotal																						
B. SPECIALTY CARE PHYSICIANS																						
1. Cardiologist																						
2. Dermatologist																						
3. Endocrinologist																						
4. Immunologist/Allergist																						
5. Infectious Disease Specialist																						
6. Gastroenterologist																						
7. General Surgeon																						
8. Nephrologist																						
9. Neurologist																						
10. Obstetrician/Gynecologist																						
11. Oncologist/Hematologist																						
12. Ophthalmologist																						
13. Orthopedist																						
14. Oral Surgeon																						
15. Otolaryngologist																						
16. Physiatrist																						
17. Psychiatrist																						
18. Pulmonologist																						
19. Urologist																						
20. Other MD/DO Only (Please Specify)																						
Subtotal																						

22-30.0.13

Supp. 1-22-08

**TABLE 3: SUMMARY OF ANCILLARY, TERTIARY AND SPECIALIZED PROVIDERS BY COUNTY
(INDICATE NUMBER OF PROVIDERS IN EACH COUNTY)**

Type of Provider	New Jersey Counties																					STATE - WIDE
	A T L	B E R	B U R	C A M	C A P	C U M	E S S	G L O	H U D	H U N	M E R	M I D	M O N	M O R	O C E	P A S	S A L	S O M	S U S	U N I	W A R	
A. ANCILLARY PROVIDERS																						
1. Optometrists																						
2. Physical Therapy Centers																						
3. Psychologists																						
4. Occupational Therapy Centers																						
5. Speech Therapy Centers																						
6. Audiology Centers																						
7. Laboratory Centers																						
8. Diagnostic Radiology Centers																						
9. Home Health Agencies																						
10. MRI Centers																						
11. Other (Please Specify)																						
B. TERTIARY AND SPECIALTY																						
1. Level I and II Trauma Centers																						
2. Perinatal Service Facilities																						
3. Tertiary Pediatric Centers																						
4. Inpatient Adult Psychiatric Facilities																						
5. Outpatient Adult Psychiatric Centers																						
6. Inpatient Pediatric Psychiatric Facilities																						

EXHIBIT B**ORGANIZED DELIVERY SYSTEMS****EXAMPLES**

Example 1.

Nature of Services

Carrier contracts with Contractor to provide and/or arrange for the provision of certain mental health and substance abuse services to individuals covered by the Carrier's benefit plans.

Method of Payment

Carrier pays Contractor an administrative fee on a per Member Per Month basis. The Carrier is responsible for depositing amounts to pay for mental health and substance abuse services into a bank account designated by a claims administrator. The carrier is responsible for adequately funding the account, which will be used to pay claims for services received by covered persons. Providers are paid on a fee for service basis.

Determination

The Contractor is an Organized Delivery System providing limited health care services. However, the Contractor receives only an administrative fee and the Carrier is responsible for all claim costs, the Contractor does not assume financial risk. Therefore, the Contractor must apply to the Department of Health and Senior Services for Certification as an Organized Delivery System.

Example 2.

Nature of Services

Carrier contracts with Contractor to provide and/or arrange for the provision of certain mental health and substance abuse services to individuals covered by the Carrier's benefit plans.

Method of Payment

Carrier pays Contractor an administrative fee on a Per Member Per Month basis subject to adjustments based on a comparison of actual claim costs to target claim costs. The Carrier is responsible for depositing amounts to pay for mental health and substance abuse services into a bank account designated by an administrator. Such funds will be used to pay claims for services received by covered persons. Providers are paid on a fee for service basis.

Determination

The Contractor is an Organized Delivery System providing limited health care services. Since the Contractor shares the risk for claim costs through adjustments to the administrative fee, the Contractor does assume financial risk. Therefore, the Contractor must apply to the Department of Banking & Insurance for licensure as an Organized Delivery System or, upon demonstration that the risk is de minimis, exemption from licensure. If the Department of Banking & Insurance agrees that the risk is de minimis, the Carrier will be required to obtain Certification as an Organized Delivery System from the Department of Health & Senior Services.

Example 3.

Nature of Services

Carrier contracts with a physician hospital organization ("PHO") for comprehensive health care services. The PHO contracts with hospitals and physicians to provide a network for delivery of services. In some cases the PHO does not contract directly with physicians, but instead contracts with individual practice associations ("IPA"), which in turn contract with physicians other than its shareholders to provide services.

Method of Payment

Carrier pays the PHO a Per Member Per Month fee. The PHO reimburses the hospitals on a reduced fee for service basis or on a case rate basis. Generally, the physicians are paid on a capitation basis, however specialists are reimbursed on a reduced fee for service basis. The IPAs, which are paid a Per Member per Month fee, pay physicians on a capitation basis, and also reimburse specialists on a reduced fee for service basis.

Determination

The PHO is an Organized Delivery System providing comprehensive health care services and assuming financial risk. Therefore, the PHO must apply to the Department of Banking and Insurance for licensure as an Organized Delivery System. The IPAs, which indirectly provide a network of providers to the carrier, are also risk assuming and must apply for licensure as Organized Delivery Systems.

EXHIBIT C

Organized Delivery System

Request for Withdrawal of Funds from Segregated Account

Name of Organized Delivery System: _____

Contact information of individual to whom correspondence concerning this request should be addressed:

Name _____

Title _____

Address _____

Telephone Number _____

Fax Number _____

Amount of proposed withdrawal: _____

The proposed date of withdrawal: _____

Form of payment (cash or other assets): _____

The amounts and dates and forms of payment for all withdrawals (including withdrawals made pursuant to N.J.A.C.11:22-4.8(d) which did not exceed 10% of total net worth of the segregated account) made within the period of 12 months preceding the proposed date of withdrawal.

For the quarter immediately preceding:

Total Assets in Segregated Account at end of quarter: _____

Net Worth of Segregated Account at end of quarter: _____

Required Net Worth at end of quarter: _____

For the quarter following the withdrawal:

Projected assets in Segregated Account at end of quarter: _____

Projected Net Worth of Segregated Account at end of quarter: _____

Projected required Net Worth at end of quarter: _____

A brief statement as to the effect of the proposed withdrawal upon the organized delivery system's net worth and the reasonableness of net worth in relation to the organized delivery system's outstanding liabilities and the adequacy of net worth relative to the organized delivery system's financial needs.

Signature and certification:

SIGNATURE

Pursuant to the requirements of N.J.A.C. 11:22-4.8(d), _____ has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the ____ day of _____, 20____.

(SEAL) _____
Name of Applicant

BY _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached notice dated _____, 20____, for and on behalf of _____; that (s)he is the _____ of such company
(Name of Company) (Title of Officer)

and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

SUBCHAPTER 5. MINIMUM STANDARDS FOR HEALTH BENEFIT PLANS, PRESCRIPTION DRUG PLANS AND DENTAL PLANS

Amended 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).
Rewrote (a).

11:22-5.1 Purpose and scope

(a) This subchapter establishes minimum standards for health benefit plans, prescription drug plans and dental plans.

(b) This subchapter applies to all insurance companies, health service corporations, medical service corporations, hospital service corporations, dental service corporations, dental plan organizations, prepaid prescription service organizations and health maintenance organizations that deliver or issue for delivery health benefit plans, prescription drug plans or dental plans in this State.

Amended by R.2006 d.189, effective May 15, 2006.
See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

In (a), inserted “, prescription drug plans and dental plans” two times; and in (b), inserted “dental service corporations, dental plan organizations, prepaid prescription service organizations” and “, prescription drug plans or dental plans”.

11:22-5.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

“Brand name drug” means a prescription drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right.

“Capitation” means a fixed per member, per month payment or percentage of premium payment for which the provider assumes the risk for the cost of contracted services without regard to the type, value or frequency of the services provided.