

**CHAPTER 22**  
**HEALTH BENEFIT PLANS**

**Authority**

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

**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**

Chapter 22, Health Benefit Plans, expires on April 26, 2011.

**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).

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.

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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.

"Dental plan" means a benefits plan which pays dental expense benefits or provides dental services and supplies and is delivered or issued for delivery in this State by or through any carrier in this State.

"Department" means the Department of Banking and Insurance.

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits or provides hospital and medical 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 chapter, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" or "provider" means an individual or entity which, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professional 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.

APPENDIX B

IMPACT OF NEGOTIATED FEES

PROVIDER NEGOTIATION LAW (N.J.S.A. 52:17B-196 et seq.)

- A. COMPANY NAME \_\_\_\_\_ B. NAIC # \_\_\_\_\_
- C. YR \_\_\_\_\_ D. HLTH \_\_\_\_\_ DNTH \_\_\_\_\_
- E. NAME \_\_\_\_\_ SIGNATURE W6D \_\_\_\_\_
- F. TITLE \_\_\_\_\_ G. AFFILIATION \_\_\_\_\_
- H. ADDRESS \_\_\_\_\_
- I. PHONE \_\_\_\_\_ J. FAX \_\_\_\_\_
- K. E-MAIL \_\_\_\_\_
- L. NEGOTIATION ID: \_\_\_\_\_
- M. SPECIALTY \_\_\_\_\_
- N. PROCEDURES \_\_\_\_\_
- O. FEE METHOD \_\_\_\_\_ P. EFFECTIVE DATE \_\_\_\_\_
- Q. TOTAL NEG CLAIMS \_\_\_\_\_
- R. % NEG INCREASE/DECREASE \_\_\_\_\_
- S. TOTAL NON NEG CLAIMS \_\_\_\_\_
- T. % NON NEG INCREASE/DECREASE \_\_\_\_\_

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INSTRUCTIONS

IMPACT OF NEGOTIATED FEES

PROVIDER NEGOTIATION LAW (N.J.S.A. 52:17B-196 et seq.)

- A. The full legal name of the company for which the report is being completed
- B. The 8-digit (group and company) NAIC number
- C. The year for which the report is being completed
- D. Indicate by a check whether the report is for health benefit plans or for dental plans
- E. The name and signature of the person completing the report
- F. The title of the person completing the report
- G. The affiliation of the person completing the report. If an employee, so indicate. If an employee of an affiliate, the name of the affiliate. If a consultant or employee of a consulting firm, the name of the consulting firm
- H. The mailing address of the person completing the report. If a post office box, a street address must also be provided
- I. The phone number of the person completing the report
- J. The fax number of the person completing the report
- K. The e-mail address of the person completing the report
- L. A carrier assigned ID for the negotiation
- M. Specialty of physician or dentist (provider)

- N. Procedures for which rates were negotiated
- O. Method of compensation (for example, capitation, UCR, fee schedule)
- P. Effective date of the negotiated rate
- Q. Total claims in the reporting period for procedures in N and providers subject to this negotiation
- R. Percentage increase over previous year of the amount per claim or procedure for amount in Q
- S. Total claims in reporting period for the procedures in N for providers not subject to this or any other negotiation for these procedures
- T. Percentage increase over previous year of the amount per claim or procedure for amount in S.

Return an original and one copy of this form to:

New Jersey Department of Banking and Insurance  
 Life and Health Actuarial Bureau  
 Provider Negotiation Reports  
 20 West State Street  
 PO Box 325  
 Trenton, NJ 08625-0325

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If additional space is needed to complete this report, attach additional page(s) to the form.

**NOTE:** If only one group of physicians negotiated a rate for a given set of procedures, then the amount in Q plus the amount in S would equal the total amount that the carrier paid for that procedure in the accounting period.

Simple Example:

- M. OB
- N. Uncomplicated delivery incl. pre-natal care
- O. Flat fee
- P. 1/1/2003
- Q. \$2,200,000 (1,000 procedures at \$2,200 performed by negotiated providers)
- R. 10% (negotiated increase was from \$2,000 to \$2,200)
- S. \$20,400,000 (10,000 procedures at \$2,040 performed by non-negotiated providers)
- T. 2% (Carriers non-negotiated increase was \$2,000 to \$2,040)