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 ser-

vice 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.

(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).

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 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.

11:22-4.11 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.

11:22-4.12 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.

11:22-4.13 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".