INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans
Carrier/Provider Joint Negotiation Agreements

Adopted New Rules: 11:22-7

Proposed: November 3, 2003 at 35 N.J.R. 5036(a).

Adopted: July 1, 2004 by Holly C. Bakke, Commissioner, Department of Banking and Insurance.

Filed: July 1, 2004 as R. 2004 d.295, **with substantive and technical changes** not requiring additional public notice and opportunity for comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1 and 17:1-15e, and 52:17B-196, et seq.

Effective Date: August 2, 2004.

Expiration Date: November 6, 2005.

Summary of Public Comments and Agency Responses:

The Department received comments from Delta Dental Plan of New Jersey, Southshore Health Services, Inc., Health Net of the Northeast, Inc., Amerigroup New Jersey, Inc., and the New Jersey Association of Health Plans.

COMMENT: One commenter pointed out the Legislature's recognition in enacting N.J.S.A. 52:17B-196 et seq. (the Act) of an emergent need to address the anti-competitive environment caused by the power of the dominant carriers in a given area to unilaterally impose unrealistically low reimbursements to physicians that adversely affect the quality of health care throughout many parts of the State. The commenter expressed its disappointment that the only rules proposed to date implementing the Act

are those establishing standards and procedures for carriers to report to the Department the information required by N.J.S.A. 52:17B-199(b). The commenter stated that if these rules are adopted, data will not begin to be acquired until May 15 for the first quarter of the year, and a full year's worth of data will not be acquired until March 1, 2005, three years and two months after the enactment of the Act. The commenter added that the Act will be in existence for only six years. The commenter also stated that, in addition to these rules, the Attorney General is also required to adopt rules implementing the Act. The commenter suggested that the Department revise its rules to gather data on an historical, rather than prospective, basis, reducing by one year the implementation of the Act. The commenter further requested that the Attorney General adopt its rules immediately.

RESPONSE: The Department does not believe that it would be appropriate to impose a retroactive data collection requirement on carriers. As some of the other commenters stated, carriers do not now collect data on the number of covered lives, and to request that such data be compiled for past periods would impose an unreasonable burden on carriers. With respect to the rules to be proposed by the Office of the Attorney General, [see the notice of proposal published elsewhere in this issue of the New Jersey Register.]

COMMENT: One commenter stated that the Act clearly states at N.J.S.A. 52:17B-201 that providers will not be permitted to jointly negotiate with Medicaid health plans, and the Department's rules should be revised to reflect that fact.

RESPONSE: The Department does not believe that it is necessary for its rules on reporting covered lives to repeat the exemption in the statute for Medicaid health plans. Since the statute does not apply to these plans, the rules implementing the statute similarly do not apply.

COMMENT: Two comments addressed the requirement at proposed N.J.A.C. 11:22-7.3(a) that carriers report quarterly to the Department the number of covered persons enrolled in a dental plan or health benefits plan during that quarter. One commenter stated that collection and reporting of this information is currently impossible because there are no authorized joint negotiation representatives. The commenter requested that the Department modify the requirement to require collection and submission of information pertaining to the impact of this law only when a negotiation representative has been authorized by the Attorney General to act on behalf of two or more independent physicians or dentists. The second commenter stated that this reporting requirement should be annual at least until such time as joint negotiations become commonplace.

RESPONSE: The Department does not believe that the suggested changes are necessary. N.J.S.A. 52:17B-199b authorizes the Department to collect data that is necessary to determine, on an annual basis, the average number of covered lives, and the geographical distribution of covered lives, per quarter per county for every carrier in the State. This authority is not conditioned on the authorization of a negotiation representative. Moreover, such data is necessary to enable the Attorney General to

determine whether a carrier has substantial market share, which would permit negotiation of fees and fee-related matters with that carrier.

COMMENT: One commenter requested clarification as to whether the "covered lives" referred to in the rules means risk (as opposed to self-funded) contracts.

RESPONSE: For clarification purposes, the Department is adding a definition of "covered lives" to mean "covered persons for purposes of required reporting of the number of such persons." The definition of “covered person” refers to health benefit plans and dental plans, which are defined to include insured plans only, not self-funded plans. Therefore, the Department believes it is clear that “covered lives” as used in Appendix A only refers to insured plans and does not include self-funded plans. Also, in the definition of "health benefits plan," the Department is adding "Medicare" before "risk contracts" to further clarify that Medicare supplement coverage and Medicare risk contracts are excluded from the definition, and not other types of risk contracts.

COMMENT: One commenter requested clarification on the following regarding proposed Appendix B: (1) whether an Appendix B report needs to be filed if the carrier had no negotiations with a joint negotiation representative; (2) in R, if the Department is contemplating using the first year of negotiated rates with the joint negotiation representative as the baseline, and is actually looking for the increase in the second year; and (3) in Instruction S, what the universe of "providers not subject to this or other negotiations" is (that is, providers in the same service area, or in the carrier's entire network).

RESPONSE: In response to the first question, a carrier does not need to submit an Appendix B report if it had no negotiations with a joint negotiation representative. With respect to the second question, the answer is no, the Department is looking for the extent and impact of joint negotiation in the prior year. Finally, Instruction S refers to providers in the entire network, not only to those in the same service area.

Federal Standards Statement

A Federal standards analysis is not required because these adopted new rules, which require carriers to provide the Department with the number of covered persons enrolled in dental or health benefits plans and with data reflecting the effects of provider negotiations conducted pursuant to the Act, are not subject to any Federal requirements or standards.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***):

SUBCHAPTER 7. CARRIER/PROVIDER JOINT NEGOTIATION AGREEMENTS

11:22-7.2 Definitions

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

. . .

"Covered lives" means covered persons for purposes of required reporting of the number of such persons.

. . .

"Health benefits plan" means a plan that pays or provides hospital, medical or dental expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For purposes of this subchapter, health benefits plan shall not include the following plans, policies, or contracts: Medicare supplement coverage and ***Medicare*** risk contracts; accident only, specified disease or other limited benefits; credit; disability; long-term care; Civilian Health and Medical Programs of the Uniformed Services (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.); dental or vision care coverage only; or hospital expense or confinement indemnity coverage only.

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APPENDIX A

CARRIER REPORT
AVERAGE COVERED LIVES BY COUNTY
PROVIDER NEGOTIATION LAW (N.J.S.A. 52:17B-196 et seq.)

A. COMPANY NAME_____ B. NAIC # _____

C. YR _____ QTR _____ D. HLTH ____ DNTL _____

E. NAME _____ SIGNATURE _____

F. TITLE _____ G. AFFILIATION _____

H. ADDRESS _____

_____

I. PHONE _____ J. FAX _____

K. E-MAIL _____

L. AVG METHOD B/E _____ MO _____ OTH _____

M. FAMILY EXACT _____ EST. _____

N. COUNTY EXACT _____ PH _____ OTHER_____

O. FILE NAME (App A) _____

P. FILE NAME (5 Digit) _____

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CARRIER REPORT
AVERAGE COVERED LIVES BY COUNTY
PROVIDER NEGOTIATION LAW (N.J.S.A. 52:17B-196 et seq.)

COMPANY _____ NAIC #_____ YR ___ QTR ____

COUNTY	COMM NET	COMM NON NET	MEDICAID	TOTAL
Atlantic				
Bergen				
Burlington				
Camden				
Cape May				
Cumberland				
Essex				
Gloucester				
Hudson				
Hunterdon				
Mercer				
Middlesex				
Monmouth				
Morris				
Ocean				
Passaic				
Salem				
Somerset				
Sussex				
Union				
Warren				
TOTAL				

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INSTRUCTIONS
CARRIER REPORT - AVERAGE COVERED LIVES BY COUNTY
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 and quarter 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 given
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. Indicate the method used to calculate the average covered persons in the quarter:
   B/E - Arithmetic average of the beginning and end of the quarter
   MO - Arithmetic average of monthly enrollment
   OTH - Other, describe

M. Method used to determine number of covered spouses and children:
   Exact, exact count; Est., Estimated; describe
N. Method used to determine county of covered person:
   Exact, county of residence; PH (policyholder), county where the policy (including a group policy to an employer) is issued; Other, describe
O. The name of the Excel file that contains the electronic version of this report
P. The name of the Excel file that contains covered lives by five-digit zip code

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INSTRUCTIONS FOR PAGE 2
CARRIER REPORT - AVERAGE COVERED LIVES BY COUNTY

Provide the number of lives covered by a health benefits plan or dental plan as defined in this rule, and type of coverage, for each county.

Comm Net: (Commercial Network): Covered by a commercial (including individual or SEH) contract that provides differences in cost sharing based on use of a provider network, including HMO, PPO and POS.

Comm Non Net (Commercial Non-Network): Covered by a commercial indemnity contract that does not have differences in cost sharing based on use of a provider network.

Medicaid: For purposes of this report only, all Family Care and Kid Care programs are considered to be Medicaid.

Lives covered under coverages supplemental to Medicare, including risk contracts, Medicare Plus Choice, or demonstration projects, are not included.

Lives covered under multiple contracts (e.g., a medical contract and a separate Rx contract) should not be double counted.

———————————————————————

Return an original and one copy of this report to:

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

An electronic version of the quarterly enrollment report shall be submitted on either a CD-ROM or floppy diskette.

In addition to Page 2, the carrier must prepare this report in electronic form by five-digit zip code rather than county.

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

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 ____ DNTL _____

E. NAME _____ SIGNATURE _____

F. TITLE _____ G. AFFILIATION _____

H. ADDRESS _____

_____

I. PHONE _____ J. FAX _____

K. E-MAIL _____

L. NEGOTIATION ID: _____

M. SPECIALITY _____

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 (e.g., 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 & 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)