

**INSURANCE  
DEPARTMENT OF BANKING AND INSURANCE  
DIVISION OF INSURANCE**

**Health Benefit Plans  
Carrier/Provider Joint Negotiation Agreements**

**Proposed New Rules: N.J.A.C. 11:22-7**

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance

Authority: N.J.S.A. 17:1-8.1 and 17:1-15e, and P.L. 2001, c. 371

Calendar Reference: See Summary below for explanation of exception to calendar requirements

Proposal Number: PRN 2003-446

Submit comments by January 2, 2004 to:

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Assistant Commissioner  
Legislative and Regulatory Affairs  
Department of Banking and Insurance  
PO Box 325  
Trenton, NJ 08625-0325  
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The agency proposal follows:

**Summary**

P.L. 2001, c. 371 (the Act) (codified at N.J.S.A. 52:17B-196 et seq.), was enacted on January 8, 2002, and became effective 90 days thereafter. The Act authorizes independent physicians and dentists licensed in this State to jointly negotiate and enter into contractual arrangements with carriers on non-fee-related matters affecting patient care, fees, and fee-related matters. The Act expires six years after the effective date,

but expiration shall not impair contracts negotiated prior to, and in effect on, the expiration date.

The Act requires that a joint negotiation representative, acting on behalf of two or more independent physicians or dentists, obtain the approval of the State Attorney General prior to engaging in negotiations with a carrier. The Act also requires the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, to adopt rules and regulations to effectuate the purposes of the Act.

The Act (at N.J.S.A. 52:17B-199b) additionally authorizes the Department of Banking and Insurance (Department), in consultation with the Department of Health and Senior Services, to collect and investigate such information as it reasonably believes is necessary to determine, on an annual basis: (1) the average number of covered lives and geographical distribution of covered lives per quarter per county for every carrier in the State; and (2) the impact of the provisions of the Act related to joint negotiations involving fees and fee-related matters on average physician or dentist fees in the State. The Act requires that this information be provided annually to the Attorney General.

The purpose of these new rules is to implement the Act by establishing standards and procedures for carriers to report to the Department the information required by N.J.S.A. 52:17B-199b. The proposed new rules contain the following provisions:

N.J.A.C. 11:22-7.1 contains the purpose and scope of the new rules.

N.J.A.C. 11:22-7.2 contains definitions of terms used throughout the rules.

N.J.A.C. 11:22-7.3 establishes specific standards and procedures for carrier maintenance and reporting of information required by the Act.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

### **Social Impact**

These proposed new rules merely require carriers to report to the Department quarterly the number of covered lives enrolled in certain health benefits plans, and to report annually the impact of provider negotiations conducted pursuant to the Act. Accordingly, these proposed rules would have no direct social impact on carriers, providers or consumers. However, these proposed rules may have a positive indirect social impact on carriers, providers and consumers because the reporting requirements contained in these rules are one component of a legislative plan intended to stimulate competition in the health care and dental services markets, thereby providing benefits for consumers, providers and carriers.

### **Economic Impact**

These proposed rules should have no direct adverse economic impact on carriers in that the information required to be reported to the Department is readily available to carriers, and should not require additional personnel. Likewise, these proposed rules would have no direct economic impact on providers or consumers.

The broader legislative scheme permitting negotiations between carriers and providers may have a direct favorable impact on less dominant carriers in the health care and dental services markets because there will be greater competition among carriers to enter into agreements with providers. Larger carriers may be unfavorably impacted because they would have to negotiate payment terms with providers rather than unilaterally impose them. Providers may be favorably impacted because they will have the opportunity to negotiate more favorable contract terms, including fees, with carriers. Consumers may also be favorably impacted because, depending on the terms of the carrier/provider agreement, their costs for health care and dental services may decrease.

### **Federal Standards Statement**

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

### **Jobs Impact**

The Department does not anticipate that these proposed rules will directly result in the generation or loss of jobs. However, the legislative plan permitting provider/carrier negotiations may result in the generation of jobs for health care and

dental service providers because they will be able to negotiate more favorable agreements with carriers.

### **Agriculture Industry Impact**

The Department does not believe that these proposed new rules will have any impact on the agriculture industry in the State.

### **Regulatory Flexibility Analysis**

These proposed new rules may apply to "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the rules apply to small businesses, such small businesses will be health carriers authorized to transact business in this State. The rules will require such small business health carriers to provide the Department with quarterly reports concerning the number of covered persons enrolled in dental or health benefits plans, and with an annual report regarding the impact of provider negotiations conducted pursuant to the Act. The proposed rules provide no different reporting, recordkeeping or compliance requirements based on carrier size, and the Department believes that different requirements based on carrier size would undermine the pro-competitive and other purposes of the Act , and would not be appropriate or feasible. The Department does not anticipate that small business health carriers will need to hire additional employees or obtain professional services to comply with the requirements of these proposed rules. Moreover, the direct benefits that small business health carriers may gain from

carrier/provider negotiations far outweigh any inconvenience they may experience as a result of compliance with these rules.

### **Smart Growth Impact**

These proposed new rules have no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

**Full text** of the proposed new rules follows:

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

##### 11:22-7.1 Purpose and Scope

(a) The purpose of this subchapter is to implement N.J.S.A. 52:17B-196 et seq., which provides for joint negotiations regarding non fee-related matters, fees and fee-related matters by physicians and dentists with carriers. This subchapter establishes standards and procedures for carriers to report to the Department certain information concerning the number of a carrier's covered lives and the impact of provider negotiations conducted pursuant to N.J.S.A. 52:17B-196 et seq.

(b) This subchapter shall apply to all insurance companies, health service corporations, hospital service corporations, medical service corporations and health maintenance organizations authorized to issue health benefits plans in this State. This subchapter shall also apply to all dental service corporations and dental plan organizations authorized to issue dental plans in this State.

## 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:

"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.

"Covered person" means a person on whose behalf a carrier, which offers a health benefits or dental plan, is obligated to pay benefits or provide services pursuant to that plan.

"Covered service" means a health care or dental 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 provide services subject to contractual provisions such as deductible, coinsurance and copayment.

"Department" means the New Jersey Department of Banking and Insurance.

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

"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 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.

#### 11:22-7.3 Quarterly and annual reports

(a) Every carrier shall report to the Department quarterly the number of covered persons enrolled in a dental plan or health benefits plan during that quarter in a format set forth in this subchapter as Appendix A, incorporated herein by reference. Instructions for completing this report are included in Appendix A. Due dates for the reports are as follows: May 15 for the first quarter, August 15 for the second quarter, November 15 for the third quarter, and March 1 for the fourth quarter.

(b) Every carrier shall report to the Department annually the impact of provider negotiations conducted pursuant to N.J.S.A. 52:17B-196 et seq. in a format set forth in this subchapter as Appendix B, incorporated herein by reference. Instructions for completing this report are included in Appendix B. The due date for this report shall be March 1.

(c) The reports described in (a) and (b) above shall be submitted to the Department by the due dates referenced in those subsections 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

(d) An original and one copy of each report described in subsections (a) and (b) above shall be submitted in hard copy. An electronic version of the quarterly enrollment report shall be provided on one of the following media:

1. CD-ROM, or
2. Floppy diskette.

(e) Every carrier shall maintain in electronic form a quarterly report on the distribution of covered persons by five-digit zip code as directed in the instructions found in Appendix A.

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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) \_\_\_\_\_

**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

**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

**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.

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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 \_\_\_\_\_

**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.

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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

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)