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.

"DHSS" means the New Jersey Department of Health and Senior Services.

"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.

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 DHSS pursuant to N.J.S.A. 17:48H–1 et seq.

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

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 or the Commissioner of DHSS.

(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.

11:22–4.5 Application review procedures

(a) The Commissioner, in consultation with the Commissioner of DHSS, 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;

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 shall refer all standard forms of provider agreements, quality assurance programs and utilization management programs to be used by the organized delivery system to the Commissioner of DHSS for review pursuant to standards and requirements established by DHSS. The Commissioner shall consult with the Commissioner of DHSS regarding provider agreements, quality assurance programs and utilization management programs in determining whether the applicant for a license:

1. Has demonstrated the potential ability to assure that health care services will be provided in a manner that will assure the availability and accessibility of the services;

2. Has adequate arrangements for an ongoing quality assurance program, where applicable;

3. Has established acceptable forms for provider agreements to be used by the system; and

4. Has demonstrated that the persons who are to perform the health care services are properly qualified.

(f) The Commissioner, in consultation with the Commissioner of DHSS, 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).

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.