"Allowable expense" means the usual, customary and reasonable item of expense for a covered service when the item of expense is covered at least in part by the health benefits plan.

"Carrier" means any insurance company operating pursuant to Title 17B of the New Jersey statutes and authorized to issue health benefits plans in this State.

"Coinsurance" means the percentage of the allowable expenses payable by the covered person.

"Coinsurance differential" means the difference in the coinsurance percentage applicable to in-network and out-of-network benefits.

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

"Copayment" means a specified dollar amount a covered person must pay for specified covered services.

"Covered person" means a person on whose behalf the carrier is obligated to pay benefits pursuant to the health benefits plan.

"Covered service" means a service provided to a covered person under a health benefits plan for which a carrier is obligated to pay benefits.

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

"Emergency care" means covered services that are provided by any health care provider for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that absence of immediate attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Evidence of coverage" means any certificate, agreement or contract which includes a statement of the essential benefits, limitations, exclusions and services of the health benefits plan, and which is issued to the covered person by the carrier.

"Formulary" means a list of prescription medications that are preferred for use by a health plan.

"Health benefits plan" means a policy, contract or evidence of coverage delivered or issued for delivery in this State that pays benefits and/or arranges for the provision of covered healthcare services and supplies. For purposes of this regulation, health benefits plan shall not include accident only, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services provided pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, and personal injury protection issued pursuant to N.J.S.A. 39:6A–1 et seq.

"Health care provider" means any physician, hospital, facility, or 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.

"Preferred provider" means a health care provider or group of health care providers who have entered into selective contracting arrangements with a carrier or a preferred provider organization.

"Preferred provider organization" or "PPO" means an entity other than a carrier that contracts with preferred providers to establish selective contracting arrangements.

"Selective contracting arrangement" or "SCA" means an arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
Rewrote "Emergency care", "Evidence of coverage", "Health benefits plan" and "Health care provider"; and inserted "Formulary".

11:4–37.3 Standards for selective contracting arrangements

(a) For purposes of paying for covered services under a health benefits plan, a selective contracting arrangement entered into by a carrier shall meet the following criteria:

1. The selective contracting arrangement shall include a mechanism for the review or control of utilization of covered services;

2. The selective contracting arrangement shall provide for an adequate number of preferred providers by specialty to render covered services in the geographic service area(s) where it functions;

3. The selective contracting arrangement shall include a procedure for resolving complaints and grievances of covered persons;

4. The selective contracting arrangement shall provide that information pertaining to the diagnosis, treatment or health of any covered person receiving health care benefits shall be confidential and shall not be disclosed to any person except as follows:

i. To the extent that it may be necessary to carry out the purposes of this subchapter;

ii. Upon the express consent of the covered person;

iii. Pursuant to statute or regulation;

iv. Pursuant to court order for the production of evidence or the discovery thereof;

v. In the event of a claim or litigation between such covered person and the carrier wherein such data or information is pertinent; or

vi. As otherwise required by law.

(b) Health benefits plans utilizing selective contracting arrangements shall meet the following criteria:

1. The health benefits plan utilizing a selective contracting arrangement shall provide that covered persons shall not be held financially liable for payments to preferred providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered services, if the carrier fails to pay for the covered services for any reason.

2. If a covered person is in need of emergency care as defined herein, the health benefits plan utilizing a selective contracting arrangement shall include a mechanism which reimburses emergency care as if the covered person had been treated by a preferred provider;

3. The carrier shall provide each covered person with a current evidence of coverage within 30 days of enrollment date and no later than 30 days after any policy or contract changes, including at least:

i. A description of all complaint and grievance procedures, including the address and telephone numbers of the complaint offices of the carrier or PPO, the Department of Health and Senior Services and the Department of Banking and Insurance;

ii. A clear and complete summary of the essential features and services of the PPO coverage, including limitations, exclusions and procedures for accessing out-of-network services; and

iii. A statement of the covered person's rights, which shall include at least the right:

(1) To be provided with information concerning the carrier's and PPO's policies and procedures regarding products, services, providers, appeals procedures and other information about the organization and the care provided;

(2) To be provided with instructions regarding the selection and procedures for changing a primary care physician. Such selection shall be effected by the carrier within 15 days of receipt;

(3) To seek treatment from the available and accessible specialists included in the network of participating providers following an authorized referral if required; and

(4) To obtain a current directory of preferred providers in the PPO network upon request, including addresses and telephone numbers, and a listing of providers who accept covered persons who speak languages other than English;

4. The carrier issuing health benefits plans utilizing a selective contracting arrangement shall provide that subsequent changes in coverage shall be evidenced in a separate document issued to the covered person;

5. The carrier utilizing a selective contracting arrangement may provide in its health benefits plan for direct payment to the preferred provider for covered services rendered, and shall establish either the methodology to determine the amount or the actual amount of payment to the preferred provider whichever is applicable;

6. The carrier utilizing a selective contracting arrangement for a health benefits plan shall include a mechanism which provides that the coinsurance differential, if any, applicable to covered services rendered by a preferred provider, as opposed to covered services rendered by other health care providers, shall be no greater than 30 percent of the allowable expense, provided deductibles and copayments are equivalent for both in-network and out-of-network benefits. If deductibles and copayments for in-network and out-of-network benefits are not equivalent, the 30 percent maximum coinsurance differential shall be adjusted to reflect the differences. In no event shall the maximum coinsurance percent for medical services or supplies be greater than 40 percent. Carriers shall submit to the Department as part of their SCA application and any subsequent plan filings a completed Actuarial Justification of Benefit Differentials form attached hereto as an Appendix.

(c) Health benefits plans that utilize selective contracting arrangements and provide prescription drug benefits through use of a formulary, shall meet the following criteria:

1. The formulary shall be developed by a pharmacy and therapeutics committee composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee shall consist of at least two-thirds licensed and actively practicing physicians and pharmacists, and shall consist of at

least one pharmacist. If the carrier contracts with a third party to develop the formulary, the carrier shall be responsible for guaranteeing that the third party complies with all requirements relating to formularies as set forth in this subsection.

2. All drugs in a formulary shall be approved under the Federal Food, Drug and Cosmetic Act (21 U.S.C. §§ 301 et seq.).

3. A formulary shall include more than one drug used to treat each covered disease state where more than one drug is available.

4. A drug may be excluded from a formulary only if, based on the compendia listed in (c)6 below, it does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome of treatment for the specific condition for which the drug is intended over other drugs included in the formulary, and there is a written explanation of the basis for the exclusion that is available to providers and covered persons upon request.

5. Every health benefits plan utilizing selective contracting arrangements that provides benefits for formulary drugs shall also provide benefits for nonformulary drugs. Increased benefits may apply to formulary drugs provided the difference between the total benefit value of formulary drug coverage and the total benefit value of nonformulary drug coverage does not exceed 30 percent. Compliance with this requirement shall be demonstrated by submitting to the Department as part of the SCA application and any subsequent plan filings a completed Actuarial Justification of Benefit Differentials form (incorporated herein by reference as the Appendix to this subchapter) appropriately modified to reflect prescription benefits rather than medical benefits. There shall be no difference in benefit level between formulary and nonformulary drugs obtained from nonparticipating providers.

6. The carrier shall establish an approval process to enable health care providers and covered persons to obtain coverage of nonformulary drugs at the same level as formulary drugs where the prescribing health care provider certifies the medical necessity of the drug.

i. A nonformulary drug shall be considered medically necessary if:

(1) It is approved under the Federal Food, Drug and Cosmetic Act (21 U.S.C. §§ 301 et seq.); or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia—Drug Information, or it is recommended by a clinical study or review article in a major-peer reviewed professional journal; and

(2) The prescribing health care provider states that all formulary drugs used to treat each disease state has been ineffective in the treatment of the covered person's disease or condition, or all such drugs have caused or are reasonably expected to cause adverse or harmful reactions in the covered person.

ii. The approval process for nonformulary drugs shall provide that the carrier respond to the prescribing health care provider by telephone or other telecommunication device within one business day of a request for prior authorization. Failure to respond within one business day shall be deemed an approval of the request. Initial denials shall also be provided to the prescribing health care provider and covered person in writing within five business days of receipt of the request for approval of a nonformulary drug, and shall include the clinical reason for the denial. Such denials are appealable to the Independent Health Care Appeals Program in the Department of Health and Senior Services pursuant to P.L. 1997, c.192, section 11.

7. The carrier shall publish and distribute, at least quarterly, either its current formulary or a list of nonformularies to all preferred providers. Such list shall clearly indicate whether the drugs included are formulary or nonformulary. Alternatively, the carrier may annually distribute new formularies or a list of nonformularies, and quarterly updates, to all preferred providers. The current formulary or list of nonformulary drugs shall be provided by the carrier to covered persons upon request.

8. The contract and evidence of coverage form shall disclose the existence of the drug formulary, describe the approval process to obtain coverage of nonformulary drugs as formulary drugs and describe the process to appeal a denial of a request for approval of a nonformulary drug, including the right to appeal to the Independent Health Care Appeals Program in the Department of Health and Senior Services pursuant to P.L. 1997, c.192, section 11. The contract and evidence of coverage form shall state that a copy of the formulary will be provided by the carrier to a covered person upon request.

9. The carrier shall file its formulary with the Department of Health and Senior Services at the address set forth at N.J.A.C. 11:4-37.4(b)2 by August 13, 1998. All amendments to the formulary shall be filed with the Department of Health and Senior Services on a quarterly basis.

10. On or before March 31 of each year, the carrier shall file with the Department of Health and Senior Services at the address set forth at N.J.A.C. 11:4-37.4(b)2 a report summarizing all formulary appeals and their resolutions for the preceding year on forms prescribed by the Department of Health and Senior Services.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
Rewrote (b) and (c).

11:4-37.4 Selective contracting arrangement approval and amendment procedures

(a) No carrier shall issue health benefits plans utilizing selective contracting arrangements unless the carrier has entered into such arrangements directly with preferred providers or has contracted with preferred provider organizations.

(b) For purposes of obtaining the Commissioner's approval under this subchapter, a carrier issuing health benefits plans utilizing a selective contracting arrangement shall submit four copies of a complete selective contracting arrangement approval application on a form to be provided by the Department. The items set forth at (c) 14 and 15 below shall be set forth separately from the remainder of the items to be included in the approval application.

1. Two copies of the entire application shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Managed Care Bureau, 11th Floor
Life and Health Division
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

2. Two copies of the entire application, together with the appropriate filing fee set forth at N.J.A.C. 11:4-37.8, shall be submitted to the Department of Health and Senior Services at the following address:

New Jersey Department of Health and Senior Services
Office of Managed Care
John Fitch Plaza, Room 600
PO Box 360
Warren and Market Streets
Trenton, NJ 08625-0360

(c) A complete selective contracting arrangement approval or amendment application shall include the following:

1. A narrative description of the health benefits plan(s) to be offered, including, but not limited to, the nature of the plan, the market for the plan and a description of the geographic areas to be served.

2. A statement that the carrier is either entering into a selective contracting arrangement directly with preferred providers, or is contracting with a PPO. In the latter case, the carrier shall include the following:

i. The identity and a description of the PPO that will operate and/or administer the selective contracting arrangement;

ii. A description of the relationship between the carrier and the PPO, and a copy of the contract between the carrier and the PPO; and

iii. A certification signed by a senior officer of the PPO that the PPO does not engage in the business of insurance in this State, and in no way assumes risk in the provision of services for the treatment of injury or illness or preventative care for any person or on behalf of any person other than its own employees;

3. A description and map of the geographic area to be served, identified by county. If sub-areas of counties are to be proposed as boundaries of the service area, the map should also include zip codes;

4. A description of the procedures by which covered services and other benefits may be obtained by covered persons using the selective contracting arrangement;

5. If the carrier is contracting directly with the preferred providers, a narrative description of the financial arrangements between the carrier and the preferred providers. If the carrier is contracting with the PPO, a narrative description of the financial arrangements between the carrier and the PPO, including the manner in which the PPO compensates its providers, a flow diagram of the complete billing and payment cycle that includes all intermediary steps for each method of reimbursement used (for example, capitation, fee for service) from the time services are rendered until the provider is paid;

6. A copy of every standard agreement, including all versions of variable text, establishing the selective contracting arrangements that will be utilized in the health benefits plan, including the agreement(s) the carrier or PPO has entered into with health care providers, classes of health care providers or any other entity for the provision of administrative or health care services. The agreement(s) shall include a description of the responsibilities of the contracting parties as they relate to the administration, financing and delivery of health care services;

7. Evidence that providers shall maintain licensure, certification and adequate malpractice coverage.

i. With respect to physicians and dentists, malpractice insurance shall be at least $1,000,000 per occurrence and $3,000,000 in the aggregate per year;

ii. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

iii. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

8. A description of the criteria and method used to select preferred providers, including any credentialing plan;

9. The names and addresses of preferred providers by specialty, county, municipality and zip code, accompanied by maps of the geographic service areas identifying the location of these providers, and a copy of the provider directory to be distributed to covered persons;

10. A description of any provisions which allow covered persons to obtain covered services from a health care provider that is not a preferred provider;

11. A description of the utilization review program, including:

i. A description of the criteria and methods to be used in utilization control, particularly the criteria for determining over- and under-utilization; and

ii. A description of the mechanisms for evaluating the success or failure of the utilization review program;

12. A description of the quality assurance program. At a minimum, this shall include:

i. A clear description of how quality of care will be monitored and controlled;

ii. The criteria used to define and measure quality;

iii. The criteria used to determine the success or failure of the quality assurance program; and

iv. A description of the staff and their qualifications that will be responsible for the quality assurance program;

13. A description of the complaint and grievance system available to covered persons, including procedures for the registration and resolution of grievances;

14. A copy of every standard form policy or contract, including all variations of variable text, to be issued by the carrier to the contractholders of health benefits plans, which shall include the requirements set forth at N.J.A.C. 11:4-37.3(b)1, 2 and 3;

15. A copy of every standard form of evidence of coverage to be issued by the carrier to covered persons, setting forth the carrier's contractual obligations to pay for covered services provided to covered persons, which shall include the requirements set forth at N.J.A.C. 11:4-37.3(b)1, 2 and 3;

16. A description of the incentives for covered persons to use the services of preferred providers;

17. A provider agreement of the PPO or carrier stating in substance that:

Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, payment by the health carrier or intermediary that is other than what the provider believed to be in accordance with the reimbursement provision of the provider agreement or is otherwise inadequate, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services;

18. An organizational chart of the carrier or PPO depicting the area responsible for managing selective contracting arrangements;

19. A listing and biographical affidavit of the officers and directors (NAIC Form #280), if any, of the carrier or PPO responsible for managing the selective contracting arrangement;

20. The address of the office of the carrier or PPO responsible for managing the selective contracting arrangement;

21. A copy of the basic organization documents of the PPO if the carrier is contracting with a PPO, including the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto, together with a copy of the bylaws, rules and policies or similar documents regulating the conduct of the internal affairs of the PPO;

22. A copy of the PPO's audited financial statement most recent to the time of application if the carrier is contracting with a PPO; and

23. The following three-year pro-forma information:

i. Enrollment projections indicating the number of covered persons by rating status (that is, single, husband/wife, parent/child and family) and number of covered persons for each county. This data is to be provided quarterly for the first year, and annually for the remaining two years; and

ii. Financial projections for the PPO if the carrier is contracting with a PPO, including balance sheet, revenue and expense statement and a cash-flow statement limited to the selective contracting arrangement business only.

(d) Any changes in the items listed at N.J.A.C. 11:4–37.3 and this section made either during the approval process or at any time after the arrangement has been approved shall be reported in writing to the Department within 30 days, at the following address:

New Jersey Department of Banking and Insurance
Managed Care Bureau, 11th Floor
Life and Health Division
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

(e) The Commissioner, in consultation with the Commissioner of Health and Senior Services as necessary, shall review these documents and grant approval, within 60 days of the carrier's filing its complete application or a complete amendment to its application pursuant to this section to those carriers whose selective contracting arrangements are determined to meet the criteria set forth in this subchapter. The Commissioner may extend the 60–day time frame an additional 30 days for good cause shown and shall provide notice to the carrier of such extension. A decision to deny approval shall be accompanied by a written explanation by the Department of the reasons for denial. A carrier whose selective contracting arrangement has been denied approval may request an administrative hearing pursuant to the procedures at N.J.A.C. 11:4–37.6.

(f) The approval of a selective contracting arrangement issued under this subchapter by the Commissioner, in consultation with the Commissioner of Health and Senior Services shall remain in force for a period of three years excepting suspension or revocation pursuant to this subchapter.

(g) A carrier shall apply for triennial renewal of the Department's approval of its selective contracting arrangement on forms provided by the Department at least 60 days prior to the expiration of the previous three-year approved period. Applications for renewal of the Department's approval shall be subject to the filing fee set forth at N.J.A.C. 11:4–37.8. If the Department has not issued a written notice of disapproval within 60 days of receipt of a complete renewal application, which clearly sets forth the reasons for disapproval of the renewal application, the renewal application shall be deemed approved.

(h) A carrier shall complete an annual report on a form provided by the Commissioner. The report shall be submitted to the Department no later than May 1 of each year, and shall include information for the previous calendar year regarding membership, number of employer contracts and plan experience.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
Rewrote the section.
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Added (h).

11:4–37.5 Confidentiality

(a) The following data or information submitted to the Department under this subchapter shall not be confidential and may be released by the Department and the Department of Health and Senior Services, but only upon written, specified request:

1. The carrier's narrative description of the health benefits plan(s) to be offered;

2. The identity of the PPO that will operate or administer the SCA;

3. The certification signed by a senior officer of the PPO that the PPO does not engage in the business of insurance in this State, and in no way assumes risk;

4. The description and map of the geographic area to be served;

5. The description of the procedures by which covered services and other benefits may be obtained by covered persons;

6. The standard agreements establishing the selective contracting arrangements that will be used in the health benefits plan, not including the agreement(s) the carrier or PPO has entered into with health care providers, classes of health care providers or any other entity for the provision of administrative or health care services;

7. The evidence that providers maintain the required licensure, certification and malpractice coverage;

8. The names and addresses of preferred providers by specialty, county, municipality and zip code; maps of the geographic service areas identifying the location of the providers; and provider directories to be distributed to covered persons;

9. The description of any provisions which allow covered persons to obtain covered services from a health care provider that is not a preferred provider;

10. The description of the complaint and grievance system available to covered persons, including procedures for the registration and resolution of grievances;

11. The standard form policies and contracts, including variables, to be issued by the carrier to the contractholders of health benefits plans;

12. The standard evidence of coverage forms to be issued by the carrier to covered persons setting forth the

carrier's contractual obligations to pay for covered services provided to covered persons;

13. The description of the incentives for covered persons to use the services of preferred providers;

14. The provisions within the health benefits plan for holding covered persons financially harmless for payment denials by or on behalf of the carrier for improper utilization of covered services caused by preferred providers;

15. The organizational chart of the carrier or PPO depicting the area responsible for managing selective contracting arrangements;

16. The listing and biographical affidavit of the officers and/or directors (NAIC Form #280) responsible for managing the SCA; and

17. The PPO's most recent audited financial statement if the carrier is contracting with a PPO.

(b) All data or information submitted to the Department under this subchapter, except for those items included in (a) above, is confidential and shall not be disclosed by the Department to any person other than employees and representatives of the Department and the Department of Health and Senior Services.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
Rewrote (a).

11:4-37.6 Denial, suspension and revocation

(a) The approval of a selective contracting arrangement issued by the Department under this subchapter may be denied, suspended or revoked if the Commissioner determines that:

1. The selective contracting arrangement criteria set forth in this subchapter are not being met;

2. Payment for covered services provided under the selective contracting arrangement is not in accordance with the terms of the approved arrangement;

3. The arrangement for the payment of covered services fails to meet the requirements of these rules; or

4. Any false or misleading information is submitted by the carrier seeking approval.

(b) If the Commissioner believes that any of the conditions set forth in subsection (a) above exist, the Commissioner shall notify the carrier by directing a notice by certified mail or personal delivery to the last known business or mailing address of the carrier. The notice shall include:

1. A description of the condition(s) in (a) above alleged to exist;

2. A statement that the carrier may within 20 days correct the condition(s) alleged to exist; and

3. A statement advising the carrier of the procedure for requesting a hearing.

(c) A carrier requesting a hearing pursuant to (b)3 above shall submit the hearing request to the Department at the following address:

New Jersey Department of Banking and Insurance
Managed Care Bureau, 11th Floor
Life and Health Division
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

The hearing request shall include:

1. The name, address and telephone number of a contact person familiar with the matter;

2. A copy of the Commissioner's written allegations;

3. A statement requesting a hearing; and

4. A concise statement describing the factual and legal bases for which the carrier believes that the Commissioner's allegations are erroneous; and

5. All relevant documents in support of the hearing request.

(d) The Commissioner may, after receipt of a properly completed request for a hearing, provide an informal conference between the carrier and such personnel of the Department or Department of Health and Senior Services as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

(e) The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

1. If the Commissioner concludes that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

2. In a matter which has been determined to be a contested case, if the Commissioner concludes that there are no good-faith disputed issues of material fact and the matter may be decided on the documents filed, the Commissioner may notify the carrier in writing of the final disposition of the matter.

(f) In addition, or as an alternative to suspension or revocation, the Commissioner may impose such other penalties as provided by law.

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).

In (c), changed names and address.

11:4–37.7 Monitoring; auditing

(a) The Commissioner, in consultation with the Commissioner of Health and Senior Services, as necessary shall monitor and conduct periodic audits or examinations of the carrier's selective contracting arrangements at the expense of the carrier as necessary to ensure compliance with the approval criteria set forth in this subchapter.

(b) All records of the carrier relating to selective contracting arrangements shall be disclosed upon request of and in a format acceptable to the Commissioner. If such records are maintained in a coded or semi-coded manner, a legend for the codes shall be provided to the Commissioner.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
In (a), inserted "at the expense of the carrier" following "arrangements".

11:4–37.8 Filing and review fees

(a) Every carrier shall pay a $1,500 filing fee for filing each of the following with the Department:

1. A selective contracting arrangement approval application pursuant to N.J.A.C. 11:4–37.4; and

2. A triennial renewal application of a selective contracting arrangement pursuant to N.J.A.C. 11:4–37.4(g).

(b) The approval application and renewal application fees of $1,500 shall be payable to the "New Jersey Department of Health and Senior Services."

(c) Every carrier, in addition to complying with the filing and review fee requirements set forth in this section, shall be subject to any fees that may be applicable as set forth in N.J.A.C. 11:1–32.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
In (a), decreased filing fees from $3,000 to $1,500, inserted "approval application" in 1, deleted a former 2, and recodified former 3 as 2; and rewrote (b).

11:4–37.9 Penalties

Carriers failing to comply with the requirements of this subchapter may be subject to penalties authorized by law.

New Rule, R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).

		APPENDIX—Actuarial Justification of Benefit Differentials (SCA) or (HMO)							
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
IN-NETWORK BENEFITS (IN)									
	Hospital Copay/Day								
	Doctor's Office Visit Copay								
OUT-OF-NETWORK BENEFITS (OON)									
	Coinsurance								
	Deductible								
	Out-of-Pocket Limit								
(1)	Starting Claim Cost (per member per month)								
– (2)	Adjustment for Hospital Copay								
– (3)	Adjustment for Doctor Copay								
= (4)	Adjusted Claim Cost								
(5)	Value of Deductible								
x (6)	Impact of 3x Family Deductible								
= (7)	Adjusted Value of Deductible								
(8)	Adjusted Claim Cost = (4) – (7)								
x (9)	Coinsurance								
= (10)	Adjusted Claim Cost								
+ (11)	Impact of Out-of-Pocket Limit								
= (12)	Adjusted Claim Cost								
(13)	Provider Discount								
(14)	Net Claim Cost (Line 12: 100% – Line 13)								
(15)	Benefit Ratio (Line 14/Line 1)								
(16)	Benefit Differential (Line 15 IN – Line 15 OON) (as a %)								