

20 West State Street  
P.O. 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  
Warren and Market Streets  
P.O. Box 360  
Trenton, NJ 08625-0360

(c) A complete selective contracting arrangement approval 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 services and/or supplies, the market for the plan and a description of the geographic area to be served;

2. A statement that the carrier is entering into a selective contracting arrangement directly with network providers, or is contracting with a licensed or certified ODS, an HMO, or a PPO for prescription drug coverage. Where the carrier is contracting with a licensed or certified ODS, an HMO, or a PPO, the carrier shall include the following:

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

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

iii. A description of any risk transfer to the ODS, HMO or PPO;

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. If the carrier is contracting directly with network providers, a description of the criteria and method used to select network providers, including any credentialing plan;

5. If the carrier is contracting directly with network providers or a PPO, the names and addresses of network 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;

6. If the carrier is contracting directly with network providers or with a PPO, 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;

7. If the carrier is contracting directly with network providers or with a PPO, 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; and

8. The provider agreement of the PPO, licensed or certified ODS, or carrier shall state 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 or 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.

(d) 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 to those carriers whose selective contracting arrangements are determined to meet the criteria set forth in this subchapter. The Commis-

sioner shall notify a carrier of any deficiencies in its application within the 60-day period and the carrier shall have 60 days from such notice to respond to the deficiency notice. Carriers that do not respond within the 60-day period shall have their applications deemed withdrawn. A final 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. 11:4-37.5.

(e) 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).

Amended by R.2006 d.189, effective May 15, 2006.  
See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

In (a), substituted "network" for "preferred" and "a licensed or certified ODS, an HMO, or a PPO for prescription drug benefits" for "preferred provider organizations"; in (b), deleted the last sentence in the introductory paragraph; in (b)1 and (b)2, updated address; rewrote (c); deleted (d); redesignated (e) as (d) and rewrote newly designated (d); deleted (f) and (g) and redesignated (h) as (e).

#### 11:4-37.5 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  
Valuation Bureau, 11th Floor  
Office of Life and Health  
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;
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.

Recodified from N.J.A.C. 11:4-37.6 and amended by R.2006 d.189, effective May 15, 2006.

See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

Section was "Confidentiality". Updated address in (c) and deleted "and" from the end of (c)3.

#### 11:4-37.6 (Reserved)

Recodified by R.2006 d.189, effective May 15, 2006.

See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

Former N.J.A.C. 11:4-37.6 recodified as N.J.A.C. 11:4-37.5; section was "Denial, suspension and revocation".

#### 11:4-37.7 (Reserved)

Repealed by R.2006 d.189, effective May 15, 2006.

See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

Section was "Monitoring; auditing."

#### 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

		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
<b>IN-NETWORK BENEFITS (IN)</b>									
	Hospital Copay/Day								
	Doctor's Office Visit Copay								
<b>OUT-OF-NETWORK BENEFITS (OON)</b>									
	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 %)								