

**NEW JERSEY'S REGULATION OF
MANAGED CARE DELIVERY SERVICES
AND
HEALTH CARE THIRD PARTY ADMINISTRATORS**

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Introduction

Following the wave of enhanced regulatory scrutiny of managed care-related entities on a national basis, New Jersey has substantially tightened its hold on health care third-party administrators and health care delivery systems and related entities. Any "benefits payer," even one that is not a health insurer or health maintenance organization ("HMO"), which bears financial risk is subject to direct regulation through implementation of new licensing requirements for organized delivery systems ("ODSs"), among other things. Even a person or entity that merely processes claims and pays claims on behalf of a benefits payer without the assumption of financial risk for the payment of health or dental benefits must now secure a license as a "third party administrator," or "TPA," under a 2001 New Jersey statute. *See* N.J.S.A. 17B:27B-1 *et seq.* (L. 2001, c. 267, eff. 12-13-2001), discussed below.

The good news is that dual licensing as an ODS and a TPA is not required. Thus, an ODS which is required to become and, indeed, has become licensed as such need not submit to the torture twice, even if the ODS also acts as a TPA in certain instances. The bad news is that determining whether the provider of health care services is required to be licensed as an ODS (as opposed to merely certified as an ODS by the Department of Health and Senior Services and is exempted from licensure by the Department of Banking and Insurance)¹ which requires licensure is not an easy process, to say the least. As will be clarified below, the key to determining whether licensure versus certification as an ODS is mandated is whether more than *de minimus* "financial risk" is assumed by the benefits payer or provider. The fact that not one but two New Jersey regulatory agencies -- the Department of Banking and Insurance ("DOBI") and Department of Health and Senior Services ("DHSS") -- are implicated does not serve to simplify the process.

What Constitutes An Organized Delivery System?

An ODS is an entity that, among other things, has the capacity to contract with insurers, HMOs and medical hospital and health service corporations (collectively, "carriers") to provide or arrange for the provision of health care services to individuals covered under one or more of a carrier's health benefit plans delivered in New Jersey.

The term "organized delivery system" is defined at N.J.S.A. 17:48H-1 *et seq.* as well as at N.J.A.C. 11:22-4.2 as follows:

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 benefit plans. 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 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.

Licensing Requirement for ODSs which Assume Financial Risk

Pursuant to N.J.S.A. 17:48H-1 *et seq.* and N.J.A.C. 11:22-4.3(a), an ODS that receives compensation on a basis that entails the assumption of "financial risk" shall submit an application for licensure to the Commissioner of the DOBI or, alternatively, an application for an exemption from the licensing requirement. *See* N.J.A.C. 11:22-4.3(b) governing the exemption process. Significantly, the licensing requirement applies to any contract between an ODS and a carrier or provider executed on or after October 21, 2002.² Although applications for ODS licensure are filed with the DOBI, that Commissioner must consult with the Commissioner of the DHSS. Thus, there is a dual regulatory oversight role even at this stage of the process.³

When Is An ODS License Required?

Whether DOBI licensure as an ODS is required, as opposed to DHSS Certification and DOBI exemption, depends on the cost of benefits to be provided by applicant, the monthly capitation rate, the time restrictions on the benefits and the scope of coverage. Pursuant to N.J.S.A. 17:48H-11(a):

An organized delivery system which receives compensation on the basis that entails the assumption of financial risks shall submit an application for licensure to the Commissioner of Banking and Insurance.

The Statute further provides in subsection (b):

An organized delivery system which receives compensation on the basis that entails assumption of financial risk, but meets the criteria set forth in this subsection, may apply to the Commissioner for an exemption from licensure requirements of this Act based on the system's current contractual arrangements. N.J.S.A. 17:48H-11(b) (Emphasis added).

An ODS may continue to operate during the pendency of its application, but in no case longer than 12 months after the date of submission of the application to the DOBI, unless the Commissioner, by regulation, extends the 12-month limitation.⁴

The regulations which implement N.J.S.A. 17:48H-1, *et seq.*, define the term "financial risk" as follows:

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 healthcare 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 from which it undertakes to provide healthcare 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 healthcare services does or potentially may exceed any payments that may be received from the carrier. Financial obligations shall include the attendant administrative costs related to providing the treatment or services.

N.J.S.A. 17:48H-1.

Alternatively, N.J.A.C. 8:38-1.2 (regulating HMOs) also defines “financial risk” as:

participation in financial gains or losses accruing pursuant to a contractual arrangement, based on aggregate measures of medical expenditures or utilization.⁵

Thus, whether a fee arrangement contemplates both upside and downside risks or just upside risk, “assumption of risk rules” and the related prohibitions or restrictions are triggered and, likely, sufficient financial risk is assumed such that licensure as an ODS is mandated under New Jersey law.

1. Capitation Fee Arrangements

“Capitation” is defined as 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.” N.J.S.A. 17:48H-1. Further, Department of Banking and Insurance Bulletin No. 00-17, issued on December 27, 2000 by the Commissioner, states, in pertinent part, that:

... ‘financial risk’ shall exist, if, under the agreement between the ODS and the carrier, the financial obligations of the ODS for payments of benefits or for providing treatment or services does or may exceed any payments (capitation or otherwise) that may be received from the carrier.

Thus, both by statutory definition and DOBI interpretation, capitation service contracts infer “financial risk” as seems to be contemplated at N.J.S.A. 17:48H-1. Accordingly, despite the underscored language at N.J.S.A. 17:48H-1, it would appear that most capitation fee arrangements would entail sufficient assumption of financial risk as to require licensure as an ODS.

2. Fee-For-Service Arrangements

A fee-for-service arrangement normally would not contemplate an assumption of risk. However, fee-for-service arrangements with “kickers” for either upside or downside risk or both are commonplace and can constitute an “assumption of risk”, either within the prohibition applicable to secondary contractors or, alternatively, within the licensing requirement for an ODS. The determinative point is whether risk is actually ceded to the contracting provider, not the nature of the base fee.

When Will Exemption From ODS Licensure Be Granted?

The Commissioner of the DOBI can grant an application for exemption from licensure as an ODS for such period of time that he or she determines that the financial risk of the ODS is “de minimis” because the ODS’s exposure to financial loss is limited in an amount or likelihood to the degree that it reasonably will not prevent the ODS 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 mandated by the organized delivery system from an insurer(s) acceptable to 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;
- (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.

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 \$250,000.00.

The Commissioner of the DOBI may revoke the ODS's exemption from licensure, after notice and an opportunity for hearing, if he or she determines that the ODS'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 the Uniform Administrative Procedure Rules codified at N.J.A.C. 1:1. Upon revocation of the exemption, the ODS shall be required to obtain licensure from the DOBI within ninety (90) days thereafter.

An ODS that is granted an exemption from licensure shall apply to and obtain certification as an ODS from the DHSS pursuant to N.J.S.A. 17:48H-1, *et seq.* Finally, under no circumstance may a licensed ODS directly issue health benefit plans.

When Will Licensure Be Granted to an ODS?

The standards against which the Commissioners must determine whether licensure is appropriate are clearly identified in the regulations at N.J.A.C. 11:22-4.5(b) as follows:

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 ODS 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 end use, contract holders and carriers;⁶
6. any deficiencies identified by the Commissioners 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 the subchapter; and
8. any other factors determined by the Commissioners to be relevant regarding a particular applicant have been addressed to the satisfaction of the Commissioner.

The ODS Application Process

1. Interplay Between DOBI and DHSS

The application for licensure consists of three parts: (A) the application cover sheet, organizational information and standard forms of contracts; (B) financial information; and (C) quality of information. Although Part B requires at the time of application a copy of the applicant's most recent financial statements audited by an independent certified public accountant (N.J.A.C. 11:22 App. Part B), under some circumstances, audited financial statements of an applicant's parent consolidated with the applicant are acceptable.⁷

The relevant provider agreement, quality assurance programs and utilization management programs to be utilized by the ODS will be referred by the DOBI for review by the DHSS pursuant to the standards and requirements established by the DHSS once it adopts implementing regulations. The two Departments will consult to determine whether the applicant for a license has met the standards set forth at 1 through 4 above. N.J.A.C. 11:22-4.5(e).

2. The Timing of Applications

ODS licensure is a time-consuming process. Accordingly, applicants should allow ample time before entering into contracts where they bear financial risk. The Commissioners of the DOBI and DHSS have an initial 60-day period from receipt of an application to review it for deficiencies. The applicant then has 60 days from the date of notice of the deficiencies to address such deficiencies. N.J.A.C. 11:22-4.5. Applicants should keep in mind that both Departments' staff may defer the review of an application received after November 1 until the most recent financial information becomes available if the Departments deem it necessary to review more recent financial information to properly evaluate the applicant's financial position. *See* N.J.A.C. 11:22-4.5(c).

3. Denial Of An Application

If the standards set forth above have not been satisfied, then the Commissioner of the DOBI, in consultation with the Commissioner of DHSS, can deny an application for a license. A written denial shall notify the applicant of the reasons therefor. An applicant whose license has been denied may request a hearing by notice to the Commissioner of the DOBI within thirty days of receiving the notice of denial. Any hearing conducted must be in accordance with the Administrative Procedure Act as well as the Uniform Administrative Procedure Rules. Upon denial of the application, an applicant whose operation was ongoing prior to implementation of the current regulatory scheme will present the Commissioner of the DOBI with a plan for bringing the ODS into compliance or providing for the closure of business. N.J.A.C. 11:22-4.5(f).

If ODS Licensure Is Not Required And An Exemption Is Granted, How Is Certification Secured?

An ODS which does not accept financial risk is exempt from licensure as an ODS, but is required to seek and secure certification with the DHSS. Proposed rules interpreting N.J.S.A. 17:48H-1 have not yet been adopted by the DHSS. However, the proposal pending since February 3, 2003 establishes procedures and standards for submission by ODS of an application for certification; establishes the procedures and standards by which the DHSS will review an application for certification; establishes procedures and standards for modification, renewal and revocation of the certification (in the event that the ODS should enter into a contract accepting financial risk); establishes standards for winding-up of an ODS's business in the event of revocation; and establishes fees relevant to certification applications, modifications and renewals. The DHSS has made a number of interpretive rulings in an effort to clarify which entities should be filing for certification. In accordance with the proposed rules, an ODS is an entity with defined governance that has the capacity to contract with carriers for the provision of healthcare services to the carrier's covered persons. Excluded from this definition, however, are licensed healthcare facilities (including laboratories) and healthcare professionals.

1. Is Certification Always Required?

Pursuant to the proposed rules, not all ODSs are required to file for certification simply by virtue of the fact that they are not required to be licensed in accordance with the statutes or rules promulgated by DOBI. The proposed rules specify that an ODS is only required to be certified if it contracted directly with a carrier. Thus, where there may be

multiple ODSs involved in an arrangement, only the ODS that contracts directly with the carrier is required to be certified. The regulatory commentary attached to the proposed regulations at 35 NJR 545 provides clear examples. For instance, if a preferred provider organization (“PPO”) contracts with individual practice associations, (“IPAs”) in order to form a network, and then leases the network to a carrier, the PPO must be certified, but the individual IPAs do not have to be certified on the basis of that particular contract. To the extent that an IPA contracts directly with another carrier under another contract, however, that IPA may be required to be certified because of the other contracting arrangement.

Even if an ODS contracts directly with a carrier, there may be some situations in which the ODS will not be required to be certified. Once again, the regulatory commentary is instructive on this point and states that the following entities that meet the definition of an ODS are not required to file for certification, even though they may contract with a carrier:

- an entity licensed as a carrier;
- an entity regulated by N.J.S.A. 18A:64G-1, *et seq.* (which established the University of Medicine and Dentistry of New Jersey);
- an entity that solely provides pharmaceutical services;
- an entity that solely provides case management services (as that term is defined by the proposed regulations); and
- an entity that solely provides employee assistance plans.

Further, an entity composed of healthcare professionals that contracts directly with a carrier solely for the performance of healthcare services by healthcare professionals, within their respective scopes of licenses, may not need to be certified in order to contract with the carrier if all of the healthcare professionals are shareholders or employees of that entity (for instance, a professional corporation or professional association formed in accordance with the Professional Service Corporation Act, N.J.S.A. 17-1, *et seq.*).

The standards on which the DHSS will base its review of an ODS application, whether for certification or for licensing (ultimately granted by the DOBI), are substantially similar and are related to the function that the ODS states it will perform under its contract with the carrier(s).

2. A Functional Approach To Certification

In order to administer health benefit plans, carriers, whether managed care plans or not, engage in a variety of activities that can be, and have been, contracted out to other entities, some of whom meet the definition of an ODS, some of whom do not. For example, carriers may have to engage in, or contract for, network recoupment and retention, credentialing or recredentialing of participating providers, utilization management, complaints handling and investigation, appeals handling and review, formation and maintenance of protocol and practice committees, claims administration, and marketing, among other specified activities. If an ODS specifies that it performs, or desires to perform, an activity on behalf of a carrier in addition to the delivery of healthcare services, the DHSS will hold the ODS to substantially the same standards that apply to the carrier on whose behalf the ODS intends to perform. An ODS that contracts with multiple types of providers will have to meet the most stringent standards applicable to the business of the carriers with whom it contracts.

This approach, labeled a “functional approach,” is reasonable given the diverse nature of the ODSs and the diverse nature of the activities in which ODSs may engage on behalf of a carrier. Certain ODSs are large and, thus, have both the capacity and willingness to perform the activities that a carrier may be required to perform with respect to the carrier’s health benefit plans that are managed care plans. Other ODSs are interested in being more specialized and taking on only some portion of a carrier’s activities (for instance, providing a network of healthcare providers for mental health services, establishing and administering utilization management guidelines and clinical criteria for mental health services, addressing complaints, and handling the first stage of appeals related to the provision of mental health services, and managing the fees and fee pools allocated to the healthcare providers in its network, to

name a few). Yet other ODSs are interested in authoring the healthcare services that those providers who are affiliated with the ODS are licensed to provide, and collecting data therefrom, but may choose to limit their other activities to the provision of support services to affiliated healthcare providers. Not all ODSs are interested in taking on administrative duties of the carrier. For that matter, many carriers are unwilling to delegate administrative activities.

3. A Review of the Proposed Regulations Governing Certification

Proposed N.J.A.C. 8:38B-1 sets forth general provisions of the new subchapter governing certification and establishes the scope of the subchapter and definitions that will apply throughout. This proposed new subchapter also establishes the compliance timeframes applicable for the chapter. It further addresses the matter of suspension or revocation of a certification, and recommendations to suspend or revoke a license, and addresses other penalties for noncompliance. The proposed subchapter establishes confidentiality standards, both with respect to the standards ODSs are expected to meet regarding member information, and those documents submitted to the DHSS that will be maintained as “confidential” or “proprietary”.

Proposed N.J.A.C. 8:38B-2 establishes the procedures and standards for submitting a complete application for certification, as well as the basic standards for completing an application for licensing as an ODS specific to DHSS’s review provided in consultation with the DOBI. The proposed new subchapter also establishes procedures and standards for submitting a complete application for a certification application, including whether modification of the certification is required, and further establishes procedures and standards for submitting a complete application to renew a certification.

Proposed N.J.A.C. 8:38B-4 sets forth the standards for contracts between most ODSs and carriers (referred to in the proposed rules as “management agreements”). The subchapter applies to all contracts between carriers and ODSs and establishes standards for management agreements that are similar in many respects to standards for primary and secondary contracts addressed at N.J.A.C. 8:38-15 and 8:38A-4.5. However, the proposed rules attempt to clarify those elements that are necessary for the management agreement to assure that the rights of the providers and covered persons are adequately protected, without requiring some of the same detail that may otherwise may be required for a provider agreement or a contract for a health benefits plan. Interestingly, the Rule clarifies that there are certain provisions that the DHSS will not approve if it is set forth in the management agreement.

N.J.A.C. 8:38B-5 sets forth the standards for provider agreements. The proposed standards are substantially related to those currently established for provider agreements pursuant to N.J.A.C. 8:38-15 and 8:38A-4.15, the terms of which depend upon the nature of the healthcare provider.

The appendix to the new proposed rules is quite voluminous and contains nine exhibits. Perhaps the most useful is Exhibit 2, which sets forth an application checklist to be submitted with all applications. We highly recommend review of these exhibits if you believe your entity may be required to apply for certification.

TPA Licensing: A Brand New Regulatory Scheme

On or after January 1, 2002, no person shall act as, offer to act as, or hold himself out to be, a third party administrator in New Jersey unless that person is either licensed or registered by the DOBI in accordance with the terms of N.J.S.A. 17B:27B-1, *et seq.* N.J.S.A. 17B:27B-2(a) (the “TPA Act”). To date, the DOBI has not yet adopted implementing regulations contemplated by the terms of the TPA Act. An application form is available in draft form (relied upon pending proposed and adopted regulations). The application form is to be considered for informational purposes only. We suggest you contact the DOBI if you wish to file an application before implementing regulations and a final form of application have been duly promulgated.

Although regulations have not been proposed, a Bulletin was issued by the DOBI in February 2003. Bulletin No. 02-03 was intended to notify all administrators of health and dental benefit plans and third party billing services for healthcare providers currently operating in New Jersey of the provisions of the TPA Act.

1. The TPA Act

The TPA Act defines a TPA as a person or entity that processes claims and pays claims on behalf of a benefits payer without assuming financial risk for the payment of health or dental benefits. A TPA expressly includes:

- (1) an entity not licensed as an insurer and not affiliated with or a subsidiary of an insurer, that processes claims on behalf of the benefit payer;
- (2) an entity that is a subsidiary or affiliate of an insurer that processes claims on behalf of the insurer; or
- (3) an entity that is a subsidiary or affiliate of an insurer that only processes claims on behalf of benefit payers other than insurers.

Pursuant to the TPA Act, a TPA expressly excludes an employee, affiliate or subsidiary of a benefits payer formed for the purpose of processing and paying claims solely on behalf of the benefits payer, a collection agency or bureau, or a pharmacy benefit manager. The TPA Act defines “benefits payer” to mean an insurer authorized to issue health benefit plans in New Jersey, or any other person that assumes financial risk for the payment of health or dental benefits and is obligated to pay claims for such benefits to providers or other claimants. “Insurers” include HMOs and related managed care entities.

Pursuant to the TPA Act, licensing is required of a TPA if:

- (1) the TPA is not licensed as an insurer and is not an affiliate or subsidiary of an insurer, or
- (2) it is an affiliate or subsidiary of an insurer that only processes or pays claims on behalf of a benefit payer other than insurers.

See N.J.S.A. 17B:27B-2. On the other hand, a TPA is required to be registered (as opposed to licensed) with the Commissioner of the DOBI if it is a subsidiary or affiliate of an insurer that processes claims on behalf of both the insurer and benefits payer other than the insurer.

The TPA Act also defines and regulates “third party billing services,” which are defined in the TPA Act as: the person or entity that is paid by a healthcare provider to process claims or claims payments on behalf of the healthcare provider. Third party billing services are required to be certified by the DOBI as opposed to registered or licensed as TPAs.

2. An Interim Licensing and Registration Process and Notice to DOBI

During the interim period before adoption of regulations, parties who previously have acted as TPAs or certified billing services may continue to operate in New Jersey as long as such entities notify the DOBI’s Life and Health Division of their name, address, telephone number and contact person. See DOBI Bulletin #2003-02.

N.J.S.A. 17B:27B-4 governs standards for licensure and requires, among other things, that the applicant file with the Commissioner of the DOBI an application for licensure. Applicant’s must submit: The standard contract forms to be used by the applicant, a statement that adequate financial arrangements with the benefits payer for which it would perform its services and that adequate arrangements for complying with the provisions of N.J.S.A.17B:30-23, *et seq.* (the “Unfair Settlement Practices Act”) are in place; and, further, a statement that the compensation arrangements made between the applicant and benefits payer do not result in the assumption of financial risk by the applicant.

The terms of the written agreement between TPAs and benefits payers are governed by N.J.S.A. 17B:27B-6 and must be filed with the Commissioner of the DOBI. A description of the services should be provided by the administrator, and the means by which the administrator is to be compensated as well as a description of the responsibilities of the benefits payer to the administrator with respect to claims to be paid by the administrator on behalf of a benefits payer must be disclosed in the application. Importantly, with respect to the adjudication of claims, a TPA required to adjudicate claims under a health benefits plan must disclose its commissions, fees or

charges that the benefits payer will pay the administrator, which commissions, fees or charges shall not be based solely on the number or amount of claims denied by the administrator. Interestingly, this provision is not intended to prohibit an administrator from receiving performance-based compensation as long as the compensation is not predicated on denial of claims or coverage. N.J.S.A. 17B:27B-8.

Because TPAs act in a fiduciary capacity on behalf of the benefits payers, the receipt and transmittal of the benefits payer's funds are required to be kept in a separate account and shall not be commingled with other funds. If the account is jointly held by the administrator and the benefits payer, it shall be deposited in a state or federally chartered insurance depository institution, and the administrator shall provide a monthly accounting of all transactions in that account. A benefits payer shall have the responsibility to make funds necessary to pay the claims available to the administrator in a timely manner which is clearly set forth in the terms of the contract, and a TPA shall not be liable to any party for the failure of the benefits payer to make funds available to pay claims. A TPA shall also maintain in force a fidelity bond in its own name on its officers and employees, in an amount to be established in the regulations once adopted. Implementing regulations governing TPAs are expected within a few months.

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¹ An entity which is subject to ODS certification only and who also acts as a TPA will be required to secure a TPA license. It is only a licensed ODS that is exempted from separate TPA licensing.

² As to contracts executed as of October 21, 2002, licensing requirements will not be fully phased in for a period not to exceed twenty-four months. N.J.A.C. 11:22-4.3(a)(1).

³ The application fee is \$2,500 payable to the Treasurer of the State of New Jersey. N.J.A.C. 11:22-4.4(a)(1). Additionally, the applicant shall be assessed and shall pay on demand an amount necessary to reimburse both Departments for expenses incurred in obtaining a risk assessment report on the applicant from a rating agency determined to be acceptable by the Commissioner of DOBI. *Id.* at subsection 4.4(b).

⁴ In the event that an application is denied, the applicant shall be treated as an organized delivery system whose license has been revoked pursuant to Sections 23 and 24 of the Health Care Quality Act, N.J.S.A. 17:48H-33.1, *et seq.*

⁵ That same law separately defines the term "financial incentive arrangement" to mean a formal mechanism instituted by an HMO or a secondary contractor that exposes a provider, or a group of providers, to risk or reward based upon meeting or failing to meet prescribed standards.

⁶ 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 acceptance 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, satisfies the requirements set forth at N.J.S.A. 17:48H-1 *et seq.*, and (iv) the standards set forth at N.J.A.C. 11:2-27.

⁷ A recent regulatory proposal would amend N.J.A.C. 11:22-1.9 to permit carriers with a minimum amount of health care business in New Jersey to request an exemption from the requirement to file an audited annual report. Even so, the current regulatory scheme allows the Department to review the audited consolidated financial statements of an applicant for a license as an ODS with its parent. *See* N.J.S.A. 17:48H-12(j).