

CHANGE IN NEW JERSEY REGULATION OF MANAGED CARE ORGANIZED DELIVERY SERVICES, HEALTH CARE THIRD PARTY ADMINISTRATORS AND THIRD PARTY BILLING SERVICES: AN UPDATE

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Introduction To Organized Delivery Systems, Third Party Administrators and Third Party Billing Services

In 2000-2001, in keeping with the national trend, New Jersey began implementation of a complicated system designed to enhance regulatory scrutiny of managed care-related entities.² Since that time, the administrative agencies tasked with implementation of these new laws have been busy fine-tuning the vast maze of statutes and regulations designed to render the managed care system accountable to the public it serves.

State laws and statutes define and address the conduct and regulatory monitoring of organized delivery systems (“ODSs”), third party administrators (“TPAs”), and third party billing services (“TPBSs”). An ODS, as defined under New Jersey law,³ is any entity which, among other things, has 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. An ODS may accept financial risk if it secures appropriate licensure. Otherwise, it must seek certification of its status from the New Jersey Department of Banking and Insurance (“NJDOBI”).

A TPA, on the other hand, is a person or entity that processes claims and pays claims for health or dental benefits on behalf of a benefits payor without assuming financial risk for those payments. Pursuant to statutes⁴ and newly adopted regulations,⁵ TPAs must either be licensed or registered by the NJDOBI before they can operate as such. New Jersey law also requires a person or entity paid by a health care provider to process claims or claims payments on behalf of a health care provider to register as a TPBS.⁶ Note, however, that employees, affiliates or subsidiaries of health care providers fall outside the regulatory definition of TPBS.⁷

New Developments

Since initial enactment of the statutes governing ODSs, TPAs and TPBSs, the regulations governing ODSs have been substantially amended (particularly with regard to net worth and deposit requirements), regulations to implement the statute addressing TPAs and TPBSs have finally been adopted, and the dual regulatory oversight by the NJDOBI and the New Jersey Department of Health and Senior Services (“NJDHSS”) is no longer necessary as operations of the Office of Managed Care (“OMC”) within the NJDHSS have been moved to the NJDOBI.⁸ The transfer was completed by October 31, 2005, and the OMC was integrated into the existing organization of the NJDOBI.⁹ Since the transfer involved all of the entities that dealt with the OMC and its organizational structure within NJDHSS, and each entity implicated also dealt with the NJDOBI and its organizational structure, the transition was smooth. Most of the staff and management of the OMC was integrated into the NJDOBI’s Life and Health Insurance Division under the Valuations Bureau, and the Consumer Protection Services Division, Managed Care Complaints and Appeals. Significantly, the transition and consolidation means that entities no longer need to make duplicate submissions of applications, notices and reports (including selective contracting and ODS applications) to the NJDOBI and DHSS. Provision of only one copy to NJDOBI will be required. Moreover, one administrative agency, the NJDOBI, controls the process, which tends to promote both efficiency and consistency in implementation of the law.

ODS, TPA and TPBS

Since 2001, when ODSs were first required to seek either certification or registration, an ODS which bears financial risk has been subject to direct regulation via licensing through the NJDOBI. Even a person or entity that does not bear financial risk (but which otherwise satisfied the definition of an ODS) is required to seek certification from the NJDOBI, and an exemption from licensure. Finally, a person or entity that merely processes claims and pays claims on behalf of a benefits payor, without the assumption of financial risk for the payment of health and dental benefits, must now secure a license as a TPA. TPAs may not, under any circumstances, accept financial risk.¹⁰ A person or

entity that is paid by a health care provider to process claims or claims payments on behalf of a health care provider is termed a “third party billing service” and is required to register under the law as such.¹¹

While dual regulation by two separate regulatory bodies, the NJDOBI and NJDHSS, is no longer required because of consolidation of the OMC within the NJDOBI, duplicative filings with the NJDOBI as an ODS and as a TPA may, under some circumstances, be required. This is a distinct change from what the law appeared to be before amendment of the ODS regulations and implementation of the TPA regulations.

The Assumption of Financial Risk Requires a Greater Degree of Regulatory Scrutiny

New Jersey statutes provide for the licensure of ODSs that assume “financial risks” and for the certification of those ODSs that do not assume “financial risks,” as those terms are defined.¹² For most purposes, “financial risk” shall be deemed to exist if, under the agreement between the ODS and the carrier, the financial obligations of the ODS for payment of benefits or for providing treatment or services does, or potentially may, exceed any payments (capitation or otherwise) that may be received from the carrier. A “financial obligation” shall include attendant administrative costs related to providing treatment or services.

Generally speaking, an ODS is a person or entity contracting with the carrier (which includes insurers, hospital service corporations, medical service corporations, health service corporations and health maintenance organizations) authorized to transact business in New Jersey, to provide the comprehensive services or benefits under the carrier’s benefit plan on behalf of the carrier, or to provide limited health care services that the carrier elects to subcontract as a separate category of benefits or services apart from its benefits under its comprehensive benefits plan. An example of such limited benefits can include vision or eye care.

Phased-In Implementation of the ODS Law

While licensing and certification was phased-in over a one year period,¹³ as of January 18, 2001, no person or entity could operate as an ODS without obtaining either certification or, in the case of an ODS, which receives compensation based upon the assumption of financial risk, a license in New Jersey.¹⁴

As the development of implementing regulations for ODS licensure and certification took some time, licenses or certifications were not granted until final rules were promulgated. The applications were permitted to satisfy the requirements of New Jersey law,¹⁵ and permitted entities to operate for the twelve-month phase-in period.

Changes to the Regulations Governing ODSs

Since original adoption of the law, there have been various changes to the licensing and certification requirements.¹⁶ Notably, amendments were adapted to the regulations addressing ODSs that assume financial risk with regard to net worth and deposit requirements.¹⁷ The significant deposit and net worth requirements originally employed under the original regulations ensured that an ODS had financial ability to meet its contractual obligations. Accordingly, the NJDOBI permitted phase-in of the net worth requirements over a forty-eight month period, and of any deposit requirements above the \$25,000 limit, over two years, similar to that which has been permitted for HMOs.¹⁸ The requirements vary depending upon the amount of the ODS’s quarterly compensation, which is indicative of business size, and the risk assumed. The amount ultimately required shall be adjusted annually in accordance with changes in the Consumer Price Index.¹⁹ In addition, there is a waiver of net worth and deposit requirements insofar as the licensure requirement is waived if the ODS assumes risks that are *de minimus* (and, thus, is certified as opposed to licensed).²⁰

Moreover, in the commentary accompanying the 2003 Rule Adoption Notice, the NJDOBI clarified that the Rules do not require duplicative deposit and net worth requirements in that the amounts required to be maintained as a deposit are considered assets of the ODS and, thus, would be counted in determining its net worth to satisfy the net worth requirement. Notably, the 2003 Rule Amendments reduced the net worth of an ODS from 6% to 2% of its annual compensation. This reduction is also consistent with the HMO Rules. The Department considered, but ultimately did not agree, to further reduce the net worth requirement because it recognized that health care providers have suffered great financial burdens due to recent insolvencies of ODSs and similar entities. Hence, substantial financial strength must be demonstrated. Hospitals and other health care providers require the assurance that entities

with which they contract are appropriately funded and have sufficient reserves to pay their claims. Net worth serves as a barometer of an ODS's financial ability. Unlike insurers,²¹ an ODS is not assessed to pay into an insolvency fund to provide additional protection to subscribers and providers in the event of its insolvency. The NJDOBI did not believe that financial requirements should be in excess of those applicable to any entity from which the risk is assumed because such an approach could preclude the utilization of ODSs by carriers, and would not implement the expressed intent of the Legislature.²² Additionally, the NJDOBI expressly commented that the Regulation,²³ which provides that an ODS that accepts risks in an amount represented by 50% or more of any carrier's consideration received to provide services or benefits, should satisfy all net worth and financial requirements applicable to HMOs.²⁴ Accordingly, to the extent that an ODS assumes more than 50% of a carrier's risk, it now must satisfy all of the net worth and deposit requirements of an HMO. Significantly, the periodic submission of financial data, including audited financial statements and quarterly reports, deemed burdensome by some ODSs, is deemed essential to the NJDOBI in order to put it in the best position to determine the financial condition of the ODS.

An ODS must establish a plan to provide for the continuation of its services in the event of an insolvency.²⁵ This could be accomplished either through insurance or other arrangements acceptable to the Commissioner. Despite this plan, the rehabilitation or liquidation of an ODS is expressly governed under New Jersey law.²⁶ The payment of claims and the priority of those payments would be governed by that statute.

Finally, ODSs, like insurers and HMOs, are accountable to the public by virtue of New Jersey's so-called "Prompt Payment Law."²⁷ All of these measures are intended to strengthen the services which ODSs provide to carriers, HMOs and, ultimately, the insureds.

The Long Awaited TPA Regulations

Regulations adopted March 10, 2005 and effective April 4, 2005, set forth the requirements for TPAs of health and dental benefits subject to licensure or registration and TPBSs subject to certification.²⁸ Pending adoption of the implementing regulations, and pursuant to the terms of a prior Bulletin issued in January of 2002,²⁹ the NJDOBI requested that TPAs and third party billing services that had responded to the prior Bulletin, as well as any operating in the State at the time of adoption of the regulations that had not previously responded, complete and return the registration form by May 27, 2005, so that the NJDOBI would have current information.³⁰ Since that time, the Department has developed application materials, and applications for both TPAs and TPBSs have been accepted and reviewed, and registration or licensure (whichever is appropriate) has been permitted.

a. *What is a Third Party Administrator?*

A "TPA" is defined as a person or entity that:

Processes and pays claims on behalf of a benefits payor without the assumption of financial risk for the payment of health or dental benefits.

TPAs shall include:

An entity not licensed in New Jersey as an insurer that is not an affiliate or a subsidiary of a New Jersey licensed insurer, that processes claims on behalf of a benefits payor; an entity that is an affiliate or subsidiary of a New Jersey licensed insurer that processes claims on behalf of that insurer and any other benefits payors; and an entity that is a subsidiary or affiliate of a New Jersey licensed insurer that only processes claims on behalf of benefits payors other than insurers.³¹

Employees, affiliates or subsidiaries of a benefits payor formed for the purpose of processing and paying claims solely on behalf of the benefits payer are expressly not included within the definition of a TPA. Significantly (and clearly a departure from what was perceived prior to adoption of the TPA regulations), TPAs shall include ODSs³² who are acting as TPAs, which are certified by the NJDHSS (now the NJDOBI), but shall not include those ODSs licensed by the NJDOBI. This means that every TPA that is either not licensed in New Jersey as an insurer or an ODS and is not an affiliate or a subsidiary of an insurer licensed in New Jersey, or an affiliate or a subsidiary of a

New Jersey licensed insurer, and only processes or pays claims on behalf of benefits payors other than insurers, shall be licensed by the Commissioner of the NJDOBI.³³ Every TPA that is a subsidiary or affiliate of an insurer licensed in New Jersey that processes claims on behalf of both that insurer and benefits payors other than that insurer need only be registered (as opposed to licensed) with the Commissioner.³⁴

Temporary licenses and registrations were issued by the Commissioner to those parties required to secure such status on or before July 3, 2005.³⁵ After July 3, 2005, parties who did not apply for temporary initial licensure or registration must apply for and obtain licensure or registration prior to operating in the State of New Jersey. The application and certification form can be located on the NJDOBI website.³⁶ Applications which have not been approved or disapproved, or in which the applicant has not been notified that an application is incomplete, shall be deemed approved within one year from the date of issuance of a temporary initial registration or license.³⁷ TPAs are also deemed to be acting in a fiduciary capacity on behalf of benefits payers in the receipt and transmittal of funds, and shall assume the responsibility attendant to such fiduciary as established by law.³⁸ Thus, a significant fidelity bond in the amount of the greater of \$100,000 or 1% of the total amounts received from the benefits payers in the previous calendar year for the purposes of paying claims on behalf of benefits payers is required.³⁹

b. What is a Third Party Billing Service?

A “Third Party Billing Service” is defined as:

the person or entity that is paid by a healthcare provider to process claims or claim payments on behalf of the healthcare provider, and that it is not an employee, affiliate or subsidiary of the healthcare provider.⁴⁰

All TPBSs operating in New Jersey prior to April 4, 2005 (the effective date of the adopted new rules) were required to file an application for temporary initial certification with the Commissioner by August 2, 2005.⁴¹ TPBSs that did not file for temporary initial certification are now required to apply for and obtain certification prior to operating in New Jersey. The application and certification form can also be found on the Department’s website. As with TPAs, applications for TPBS certification that have not been approved, disapproved or where the applicant has not been notified that the application is complete within one year from the date of issuance of a temporary initial certification, are deemed approved.⁴²

As with TPAs, the Commissioner’s standards for approval of TPBSs are imposed by regulation.⁴³ Appropriate financial controls and adequate arrangements to comply with New Jersey’s Trade Practices Act as to the electronic receipt and transmission of transactions are required to be demonstrated by all TPBS applicants who accept payments from benefit payers.⁴⁴ All contract forms between TPBSs and their client must be submitted to the NJDOBI for review prior to certification.⁴⁵ Finally, like a TPA, a TPBS also serves in a fiduciary capacity on behalf of its client in the receipt and transmittal of funds with responsibility attendant to a fiduciary as established by law.⁴⁶ No fidelity bond, however, is required, presumably because an entity that accepts funds on behalf of benefit payers is required to submit financial statements to the NJDOBI, as well as to demonstrate the existence of adequate financial controls. Moreover, separate accounts for such funds are required.⁴⁷

CONCLUSION

The high degree of regulatory monitoring and stringent financial requirements for ODSs and TPAs ensure a high degree of accountability to benefit payers and, ultimately, to the consumers of health care services. On balance, it appears that the benefits outweigh the burdens.

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² Borrelli, Cynthia J., “New Jersey’s Regulation of Managed Care Delivery Services and Health Care Third Party Administrators,” FORC Quarterly Journal of Insurance Law and Regulation, Vol. XV, Edition V, March 1, 2004.

³ N.J.S.A. 17:48H-1 *et seq.*

⁴ N.J.S.A. 17B:27B-1 *et seq.*

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- ⁵ See N.J.A.C. 11:23-1.1, *et seq.*, adopted by R. 2005 d.113, eff. 4/4/2005.
- ⁶ N.J.S.A. 17B:27B-1.
- ⁷ N.J.A.C. 11:23-1.2.
- ⁸ This transfer complies with an Order signed on June 30, 2005 by Acting Governor Richard J. Codey, which went into effect on August 29, 2005.
- ⁹ NJDOBI Bulletin No. 05-23 (October 28, 2005).
- ¹⁰ N.J.A.C. 11:23-2.3(a)6.
- ¹¹ N.J.S.A. 17B: 27B-1 and N.J.A.C. 11:23-1.2.
- ¹² N.J.S.A. 17:48H-1 *et seq.*, enacted January 18, 2000.
- ¹³ N.J.S.A. 17:48H-2.
- ¹⁴ Pursuant to N.J.S.A. 17:48H-3 and N.J.S.A. 17:48H-11, implementation was phased in over a twelve-month period so that an ODS could continue to operate for a period of up to twelve-months after the submission of the application to DOBI and DHSS for either certification or licensure, as appropriate, at the time.
- ¹⁵ N.J.S.A. 17:48H-3 and 11, respectively N.J.S.A. 17:48H-3 and 11, respectively.
- ¹⁶ N.J.S.A. 17:48H-1 *et seq.*
- ¹⁷ N.J.A.C. 11:22-4.5 and 4.8, respectively.
- ¹⁸ N.J.A.C. 8:38-11.1 and 11.4, respectively.
- ¹⁹ N.J.S.A. 17:48H-12.
- ²⁰ N.J.A.C. 11:22-4.3(b).
- ²¹ See N.J.S.A. 17B:32A-1, *et seq.* creating the New Jersey Life and Health Insurance Guaranty Association, which, in part, provides financial protection to certain policyholders and claimants of “insolvent insurers,” defined to exclude “HMOs.”
- ²² N.J.S.A. 17:48H-1 *et seq.*
- ²³ N.J.A.C. 11:22-4.8(i).
- ²⁴ N.J.A.C. 8:38-11.
- ²⁵ N.J.A.C. 11:22-4.11
- ²⁶ N.J.S.A. 17B:32-31 *et seq.*
- ²⁷ See N.J.A.C. 11:22-1.1 implementing N.J.S.A. 17B:30-26 – 34, which sets standards for the payment of claims relating to health benefit and dental plans and which imposes interest at the rate of 10% on claims not paid within 30 or 40 days (depending upon whether the claim was electronically submitted or submitted via mail or telecopy) of submission of a clean claim. N.J.A.C. 11:22-1.1(b) expressly renders this law applicable to ODSs.
- ²⁸ N.J.A.C. 11:23-1, *et seq.*; N.J.S.A. 17B:27B-1 *et seq.*
- ²⁹ DOBI Bulletin No. 02-03.
- ³⁰ On January 17, 2002, the DOBI issued Bulletin No. 02-03, advising TPAs and third party billing services that they could continue to operate in the State until regulations implementing N.J.S.A. 17B:27B-1 *et seq.* were adopted. The Bulletin further requested that TPAs and TPBSs operating in the State notify the NJDOBI of their name, address, telephone number and contact person.
- ³¹ N.J.A.C. 11:23-1.2.
- ³² As defined by N.J.S.A. 17:48H-1.
- ³³ N.J.A.C. 11:23-2.1(b).
- ³⁴ N.J.A.C. 11:23-2.1(c).
- ³⁵ N.J.A.C. 11:23-2.2(a).
- ³⁶ www.njdobi.org/tpapage.htm.
- ³⁷ The standards for approval of applications are vigorous and include a review of the applicant’s standard contract forms, compensation arrangements with benefit payers, and adequate financial arrangements with benefits payers that comply with N.J.S.A. 17B:30-23 *et seq.* and, if applicable, N.J.A.C. 11:22-1 and 3. See N.J.A.C. 11:23-2.3(a), 3.1 and 3.3.
- ³⁸ N.J.A.C. 11:23-3.4(a).
- ³⁹ N.J.A.C. 11:23-3.4(c).
- ⁴⁰ N.J.A.C. 11:23-1.2.
- ⁴¹ N.J.A.C. 11:23-5.1(b).
- ⁴² N.J.A.C. 11:23-5.4(b).
- ⁴³ N.J.A.C. 11:23-5.4(a).
- ⁴⁴ N.J.A.C. 11:23-5.4 and N.J.S.A. 17B:30-23.
- ⁴⁵ N.J.A.C. 11:23-5.6.

⁴⁶ N.J.A.C. 11:23-5.7(a).

⁴⁷ N.J.S.A. 17B:27B-18; N.J.S.A. 17B:27B-21; and N.J.A.C. 11:23-5.7.