52:17B-196

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 371
NJSA: 52:17B-196 ("Health Care Accountability Act")
BILL NO: S1033/1098 (Substituted for A2169)
SPONSOR(S): Bark and others
DATE INTRODUCED: February 28, 2000
COMMITTEE: **ASSEMBLY:** Health
SENATE: Health
AMENDED DURING PASSAGE: Yes
DATE OF PASSAGE: **ASSEMBLY:** January 7, 2002
SENATE: December 4, 2000
DATE OF APPROVAL: January 8, 2002
FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Senate Committee Substitute for S1033/1098 (1R) enacted)
(Amendments during passage denoted by superscript numbers)

S1033/S1098

SPONSORS STATEMENT (S1033): (Begins on page 8 of original bill) Yes
SPONSORS STATEMENT (S1098): (Begins on page 13 of original bill) Yes
COMMITTEE STATEMENT: **ASSEMBLY**: Yes
SENATE: Yes
FLOOR AMENDMENT STATEMENTS: Yes
LEGISLATIVE FISCAL ESTIMATE: No

A2169/2241/464

SPONSORS STATEMENT (A2169): (Begins on page 8 of original bill) Yes
SPONSORS STATEMENT (A2241): (Begins on page 13 of original bill) Yes
SPONSORS STATEMENT (A464): (Begins on page 8 of original bill) Yes
COMMITTEE STATEMENT: **ASSEMBLY**: Yes
SENATE: No
FLOOR AMENDMENT STATEMENTS: No
LEGISLATIVE FISCAL ESTIMATE: No
FINAL VERSION: (Assembly Committee Substitute) Yes

VETO MESSAGE: No
GOVERNOR'S PRESS RELEASE ON SIGNING: No

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or mailto:refdesk@njstatelib.org
REPORTS: No
HEARINGS: Yes

974.90 New Jersey. Legislature. Senate. Health Committee.
H434 Public hearing on S1033 and S1098, held May 5, 2000
2000f Trenton, 2000

NEWSPAPER ARTICLES: No

Pennsylvania Senate Bill 1052 (1999) (Referred to sponsor's statement to S1098)
Texas Senate Bill 1468 (1999) (Referred to in sponsor's statement to S1033)

SENATE, No. 1033

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED FEBRUARY 28, 2000

Sponsored by:
Senator MARTHA W. BARK
District 8 (Atlantic, Burlington and Camden)
Senator DONALD T. DIFRANCESCO
District 22 (Middlesex, Morris, Somerset and Union)

Co-Sponsored by:
Senators Allen, Gormley and Bennett

SYNOPSIS

Allows physicians to jointly negotiate with health benefits plans over contractual terms and conditions.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 11/14/2000)

AN ACT providing for certain joint negotiations by physicians with health benefits plans and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization which is authorized to issue health benefits plans in this State.

"Covered person" means a person on whose behalf a carrier which offers a health benefits plan is obligated to pay benefits or provide services pursuant to the plan.

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

"Health benefits plan" means a plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Physician" means a person who is licensed to practice medicine or surgery, including podiatric medicine, by the State Board of Medical Examiners in accordance with the provisions of Title 45 of the Revised Statutes.

"Physicians' representative" means a third party, including a physician engaging in joint negotiations under this act, that is authorized by two or more physicians to negotiate on their behalf with a health benefits plan over the terms and conditions of a contract that affects those physicians.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan in accordance with specific guidelines, for the purpose of determining whether, or to what extent, a health care service that has been provided or is proposed to be provided to a covered person is to be covered under the health benefits plan.

2. Two or more competing physicians who are practicing in the service area of a health benefits plan may meet and communicate in order to jointly negotiate one or more of the following terms or conditions of a contract with the health benefits plan:

a. practices and procedures to assess and improve the delivery of effective, cost-efficient preventive health care services, including, but not limited to, childhood immunizations, prenatal care, and mammograms and other cancer-screening tests or procedures;

b. practices and procedures to encourage early detection and effective, cost-efficient management of diseases and illnesses in children;

c. practices and procedures to assess and improve the delivery of women's medical and health care, including, but not limited to, care for menopause and osteoporosis;

d. clinical criteria for effective, cost-efficient disease management programs, including management programs for diabetes, asthma and cardiovascular disease;

e. practices and procedures to encourage and promote patient education and treatment compliance, including involvement by a parent with a child's health care;

f. practices and procedures to identify, correct and prevent potentially fraudulent activities;

g. practices and procedures for the effective, cost-efficient use of outpatient surgery;

h. clinical practice guidelines and coverage criteria;

i. administrative procedures, including, but not limited to, methods and timing of payment to physicians for services;

j. procedures for resolving disputes between physicians and the health benefits plan;

k. procedures for referring patients;

l. the formulation and application of physician reimbursement methodology;

m. quality assurance activities;

n. utilization management procedures;

o. criteria used by the health benefits plan to select and terminate physicians; or

p. the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit physician rights to jointly petition the federal or State government, as applicable, to change the regulation.

3. Except as provided in section 4 of this act, two or more competing physicians who are practicing in the service area of a health benefits plan shall not meet and communicate in order to

jointly negotiate any of the following terms or conditions of a contract with the health benefits plan:

a. the fee or price for a physician service, including those determined by the application of a reimbursement methodology;

b. the conversion factors in a resource-based relative value scale or similar reimbursement methodology;

c. the amount of a discount on the price of a service provided by a physician; or

d. the dollar amount of capitation or fixed payment for physician services provided to a covered person.

4. a. Notwithstanding the provisions of section 3 of this act to the contrary, two or more competing physicians who are practicing in the service area of a health benefits plan may jointly negotiate any of the terms or conditions of a contract with the health benefits plan that are specified in that section upon a finding by the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, that the health benefits plan has substantial market power in its service area and that any of the terms or conditions pose an actual or potential threat to the quality and availability of patient care among covered persons.

b. The Department of Banking and Insurance, in consultation with the Department of Health and Senior Services, shall have the authority to collect and investigate such information as it reasonably believes is necessary to determine, on an annual basis:

(1) the average number of covered lives per month per county by every health benefits plan in the State; and

(2) the impact of the provisions of this section on average physician fees in the State.

The Department of Banking and Insurance shall provide this information to the Attorney General on an annual basis.

c. The provisions of this subsection shall not apply to a health benefits plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.) or the Children's Health Care Coverage Program under P.L.1997, c.272 (C.30:4I-1 et seq.).

5. The exercise of joint negotiation rights by two or more competing physicians who are practicing in the service area of a health benefits plan pursuant to sections 2 and 4 of this act shall conform to the following criteria:

a. the physicians may communicate with each other concerning any contractual term or condition to be negotiated with the health benefits plan;

b. the physicians may communicate with the physicians' representative authorized to negotiate on their behalf with the health benefits plan concerning any contractual term or condition;

c. the physicians' representative shall be the sole party authorized to negotiate with the health benefits plan on behalf of the physicians as a group;

d. the physicians may, at the option of each physician, agree to be bound by the terms and conditions negotiated by the physicians' representative; and

e. when communicating or negotiating with a physicians' representative, a health benefits plan may offer different contractual terms or conditions to, or may contract with, individual competing physicians.

6. A person or entity which proposes to act as a physicians' representative shall satisfy the following requirements:

a. Before entering into negotiations with a health benefits plan on behalf of two or more competing physicians over a contractual term or condition, the physicians' representative shall submit to the Attorney General, for his approval pursuant to section 7 of this act, on a form and in a manner prescribed by the Attorney General, a report which identifies:

(1) the representative's name and business address;

(2) the names and business addresses of each physician who will be represented by the identified representative;

(3) the ratio of the physicians requesting joint representation to the total number of physicians who are practicing within the geographic service area of the health benefits plan;

(4) the health benefits plan with which the representative proposes to enter into negotiations on behalf of the identified physicians;

(5) the intended subject matter of the proposed negotiations with the identified health benefits plan;

(6) the representative's plan of operation and procedures to ensure compliance with the provisions of this act;

(7) the anticipated effect of the proposed joint negotiations on the quality and availability of health care among covered persons; and

(8) the anticipated benefits of a contract between the identified physicians and health benefits plan.

The physicians' representative, upon submitting the report, shall pay a fee to the Attorney General in an amount, as determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this act.

b. After the physicians' representative and the health benefits plan identified pursuant to subsection a. of this section have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the physicians' representative shall submit

to the Attorney General, for his approval in accordance with the provisions of section 7 of this act, a copy of the proposed contract between the physicians identified pursuant to subsection a. of this section and the health benefits plan, as well as any plan of action which the physicians' representative and the health benefits plan may formally agree to for the purpose of implementing the terms and conditions of the contract.

c. Within 14 days after a health benefits plan notifies a physicians' representative of its decision to decline or terminate negotiations entered into pursuant to this act, or after the date that a physicians' representative requests that a health benefits plan enter into such negotiations to which request the plan fails to respond, the physicians' representative shall report to the Attorney General that the negotiations have ended, on a form and in a manner to be prescribed by the Attorney General. The physicians' representative may resume negotiations with the health benefits plan no later than 60 days after reporting to the Attorney General that the negotiations have ended, on the basis of the report submitted to the Attorney General pursuant to subsection a. of this section and approved by the Attorney General in accordance with the provisions of section 7 of this act. After that date, the physicians' representative shall be required to submit a new report and pay an additional fee to the Attorney General pursuant to subsection a. of this section, in order to engage in negotiations with the health benefits plan under this act.

7. a. The Attorney General shall provide written approval or disapproval of a report or a proposed contract furnished by a physicians' representative pursuant to section 6 of this act no later than 30 days after receipt of the report or proposed contract, as applicable. If the Attorney General fails to provide written approval or disapproval within this time period, the physicians' representative may petition a court of competent jurisdiction for an order to require the Attorney General to take such action. If the Attorney General disapproves the report or the proposed contract, he shall forward a written explanation of any deficiencies therein to the physicians' representative along with a statement of the specific remedial measures by which those deficiencies may be corrected. A physicians' representative shall not engage in negotiations with a health benefits plan over any contractual term or condition unless the report furnished by the physicians' representative has been approved in writing by the Attorney General, nor shall a proposed contract between two or more competing physicians and a health benefits plan be implemented unless the Attorney General has approved the contract.

b. The Attorney General shall approve a report or a proposed contract furnished by a physicians' representative pursuant to section 6 of this act if the Attorney General determines that the report or

proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations over a contractual term or condition or the proposed contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician distribution by specialty and its effect on competition in the geographic service area of the health benefits plan. The Attorney General shall not approve a report furnished by a physicians' representative pursuant to section 6 of this act if the physicians' representative proposes to engage in negotiations with a health benefits plan on behalf of more than 10% of the total number of physicians practicing in the geographic service area of the health benefits plan, unless the Attorney General determines, consistent with the provisions of this act, that conditions relating to the quality and availability of health care among covered persons in the geographic service area of the health benefits plan support the inclusion of a higher percentage of practicing physicians in those joint negotiations.

c. The Attorney General's written approval of a report which is furnished by a physicians' representative under section 6 of this act shall be effective for all subsequent negotiations between the physicians' representative and the identified health benefits plan, subject to the provisions of subsection c. of section 6 of this act.

8. a. The provisions of this act shall not be construed to permit two or more physicians to:

(1) jointly engage in a coordinated cessation, reduction or limitation of the health care services which they provide;

(2) meet or communicate in order to jointly negotiate a requirement that at least one of the physicians, as a condition of participating in a health benefits plan, be allowed to participate in all of the products offered by the health benefits plan; or

(3) jointly negotiate with a health benefits plan to exclude, limit or otherwise restrict a non-physician health care provider from participating in a health benefits plan based substantially on the fact that the health care provider is not a physician, unless that exclusion, limitation or restriction is otherwise permitted by law.

b. Prior to entering into negotiations with a health benefits plan on behalf of two or more competing physicians over a contractual term or condition, a physicians' representative shall notify the physicians in writing of the provisions of this section and advise them as to their potential legal liability if they engage in a joint action that is not authorized under this act.

9. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

10. This act shall take effect 90 days after enactment, except that the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance as shall be necessary to implement the act.

STATEMENT

The purpose of this bill is to provide physicians with the right to engage in joint negotiations over the terms and conditions of their contracts with health benefits plans. The bill is modeled generally after legislation which was enacted into law in Texas (Senate Bill No. 1468, on June 20, 1999).

A "physician" is defined in the bill as a person licensed to practice medicine or surgery, including podiatric medicine, by the State Board of Medical Examiners.

The bill permits physicians who are practicing in the geographic service area of a health benefits plan to jointly negotiate with the plan, through a physicians' representative who is approved by the Attorney General to act on their behalf, over the terms and conditions of a proposed contract, which, if agreed to by the parties to the negotiation, must be approved by the Attorney General before being implemented. These terms and conditions include:

- practices and procedures to assess and improve the delivery of effective, cost-efficient preventive health care services;
- practices and procedures to encourage early detection and effective, cost-efficient management of diseases and illnesses in children;
- practices and procedures to assess and improve the delivery of women's medical and health care;
- clinical criteria for effective, cost-efficient disease management programs;
- practices and procedures to encourage and promote patient education and treatment compliance;
- practices and procedures to identify, correct and prevent potentially fraudulent activities;
- practices and procedures for the effective, cost-efficient use of outpatient surgery;
- clinical practice guidelines and coverage criteria;

- administrative procedures, including, but not limited to, methods and timing of payment to physicians for services;
- procedures for resolving disputes between physicians and the plan;
- patient referral procedures;
- the formulation and application of physician reimbursement methodology;
- quality assurance activities;
- utilization management procedures;
- physician selection and termination criteria used by the plan; and
- the inclusion or alteration of a contractual term or condition with the plan, except when the inclusion or alteration is required by a federal or State regulation regarding that term or condition.

In addition, the bill provides that the following terms and conditions of a proposed contract may be subject to such joint negotiations if the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, finds that the health benefits plan has substantial market power within its service area and that any of the terms or conditions pose an actual or potential threat to the quality and availability of health care among covered persons:

- the fee or price for a service provided by a physician, including those determined by the application of a reimbursement methodology;
- the conversion factors in a resource-based relative value scale or similar reimbursement methodology;
- the amount of a discount on the price of a physician service; and
- the dollar amount of capitation or fixed payment for physician services provided to a covered person.

The bill stipulates that a physicians' representative shall not enter into negotiations with a health benefits plan on behalf of more than 10% of the total number of physicians practicing in the geographic service area of the health benefits plan, unless the Attorney General determines, consistent with the provisions of this bill, that conditions relating to the quality and availability of health care among covered persons in the geographic service area of the plan support the inclusion of a higher percentage of practicing physicians in those joint negotiations.

Also, the bill explicitly prohibits physicians from:

- jointly engaging in a coordinated cessation, reduction or limitation of health care services;
- meeting or communicating in order to jointly negotiate a requirement that at least one of the physicians, as a condition of participating in a health benefits plan, be allowed to participate in all of the products offered by the health benefits plan; or
- jointly negotiating with a health benefits plan to exclude, limit or otherwise restrict a non-physician health care provider from participating in a health benefits plan based substantially on the fact

that the health care provider is not a physician, unless that exclusion, limitation or restriction is otherwise permitted by law.

SENATE, No. 1098

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MARCH 16, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator ROBERT W. SINGER
District 30 (Burlington, Monmouth and Ocean)

Co-Sponsored by:
Senators Adler and Bennett

SYNOPSIS

"Health Care Provider Joint Negotiation Act."

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 11/13/2000)

AN ACT authorizing health care providers to enter into joint negotiations with health insurance carriers and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. This act shall be known and may be cited as the "Health Care Provider Joint Negotiation Act."

2. The Legislature finds and declares that:

a. Active, robust and fully competitive markets for health care services provide the best opportunity for the residents of this State to receive high-quality health care services at an appropriate cost;

b. A substantial amount of health care services in this State is purchased for the benefit of patients by health insurance carriers engaged in the financing of health care services or is otherwise delivered subject to the terms of agreements between carriers and health care providers;

c. Health insurance carriers are able to control the flow of patients to health care providers through compelling financial incentives for patients in their health benefits plans to utilize only the services of providers with whom the carriers have contracted;

d. Carriers also control the health care services rendered to patients through utilization management and other managed care tools and associated coverage and payment policies;

e. The power of health insurance carriers in the markets of this State for health care services has become great enough to create a competitive imbalance, reducing levels of competition and threatening the availability of high-quality, cost-effective health care;

f. In many areas of this State, the health care insurance market is dominated by one or two health insurance carriers, with some carriers controlling over 50% of an area's market;

g. Carriers are often able to virtually dictate the terms of the contracts that they offer physicians and other health care providers and commonly offer these contracts on a take-it-or-leave-it basis;

h. The power of carriers to unilaterally impose provider contract terms jeopardizes the ability of physicians and other health care providers to deliver the superior quality health care services traditionally available in this State;

i. Physicians and other health care providers do not have sufficient market power to reject unfair provider contract terms offered by carriers that impede their ability to deliver medically appropriate care without undue delay or difficulties;

j. Inadequate reimbursement and other unfair payment terms offered by carriers adversely affect the quality of patient care and access to

care by reducing the resources that health care providers can devote to patient care and decreasing the time that providers are able to spend with their patients;

k. Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical progress by diverting capital needed for reinvestment in the health care delivery system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and expansion of medical services, all to the detriment of the residents of this State;

l. The inevitable collateral reduction and migration of the health care work force will also have negative consequences for the economy of this State;

m. Empowering independent health care providers to jointly negotiate with health insurance carriers as provided in this act will help restore the competitive balance and improve competition in the markets for health care services in this State, thereby providing benefits for consumers, health care providers and less dominant carriers;

n. This act is necessary and proper, and constitutes an appropriate exercise of the authority of this State to regulate the business of insurance and the delivery of health care services;

o. The pro-competitive and other benefits of the joint negotiations and related joint activity authorized by this act, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical progress, and improving communications, outweigh any potential anti-competitive effects of this act; and

p. It is the intention of the Legislature to authorize independent health care providers to jointly negotiate with health insurance carriers and to qualify such joint negotiations and related joint activities for the State-action exemption to the federal antitrust laws through the articulated State policy and active supervision provided under this act.

3. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Carrier affiliate" means a carrier that is affiliated with another entity by either the carrier or entity having a 5% or greater, direct or indirect, ownership or investment interest in the other through equity or debt, or by other means.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier offering

the plan is obligated to pay benefits or provide services pursuant to the health benefits plan.

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

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier, except in the case of a self-funded health benefits plan. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan, and includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes, and medical equipment suppliers.

"Health care service" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, injury, disease or illness, including, but not limited to: the professional and technical component of professional services; supplies, drugs and biologicals; diagnostic x-rays, laboratory and other diagnostic tests; preventive screening services and tests, including pap smears and mammograms; x-ray, radium and radioactive isotope therapy; surgical dressings; devices for the reduction of fractures; durable medical equipment; braces; trusses; artificial limbs and eyes; dialysis services; home health services; and hospital and other health care facility services.

"Health maintenance organization" means a health maintenance organization operating pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.).

"Joint negotiation" means negotiation with a carrier by two or more independent health care providers acting together as part of a formal group or other entity.

"Joint negotiation representative" means a representative selected by two or more independent health care providers to engage in joint negotiations with a carrier on their behalf.

"Point-of-service plan" means a health benefits plan that allows a covered person to receive covered services from out-of-network

health care providers but may require that a subscriber pay a higher deductible or copayment and higher premium for the plan.

"Preferred provider organization" means a health benefits plan other than a health maintenance organization or a point-of-service plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with members of the provider network and financial incentives for covered persons to use those health care providers.

"Provider contract" means an agreement between a health care provider and a carrier setting forth the terms and conditions under which the provider is to deliver health care services to covered persons of the carrier. This term does not include employment contracts between a carrier and a health care professional.

"Provider network" means a group of health care providers who have provider contracts with a carrier.

"Self-funded health benefits plan" means a health benefits plan that provides for the assumption of the cost, or spreads the risk of loss, resulting from health care services provided to covered persons by an employer, union or other sponsor, substantially out of the current revenues, assets or other funds of the sponsor.

"Subscriber" means, in the case of a group contract, a person whose employment or other status, except family status, is the basis for eligibility for enrollment by the carrier or, in the case of an individual contract, the person in whose name the contract is issued.

"Third party administrator" means an entity that provides utilization management, provider network credentialing or other administrative services for a carrier or a self-funded health benefits plan.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

4. Independent health care providers may jointly negotiate with a carrier and engage in related joint activity, as provided in sections 7 and 8 of this act, regarding non-fee-related matters which may affect patient care, including, but not limited to any of the following:

a. the definition of medical necessity and other conditions of coverage;

b. utilization management criteria and procedures;

c. clinical practice guidelines;

d. preventive care and other medical management policies;

e. patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

f. drug formularies and standards and procedures for prescribing off-formulary drugs;

g. quality assurance programs;

h. respective health care provider and carrier liability for the treatment or lack of treatment of covered persons;

i. the methods and timing of payments, including, but not limited to, interest and penalties for late payments;

j. other administrative procedures, including, but not limited to, covered persons eligibility verification systems and claim documentation requirements;

k. credentialing standards and procedures for the selection, retention and termination of participating health care providers;

l. mechanisms for resolving disputes between the carrier and health care providers, including, but not limited to, the appeals process for utilization management and credentialing determinations; or

m. the health benefits plans sold or administered by the carrier in which the health care providers are required to participate.

5. a. When a carrier has substantial market power over independent health care providers, the providers may jointly negotiate with the carrier and engage in related joint activity, as provided in sections 7 and 8 of this act regarding fees and fee-related matters, including, but not limited to, any of the following:

(1) the amount of payment or the methodology for determining the payment for a health care service;

(2) the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care services;

(3) the amount of any discount on the price of a health care service;

(4) the procedure code or other description of a health care service covered by a payment;

(5) the amount of a bonus related to the provision of health care services or a withholding from the payment due for a health care service; or

(6) the amount of any other component of the reimbursement methodology for a health care service.

b. A carrier has substantial market power over health care providers when:

(1) the carrier's market share in the comprehensive health care insurance market or a relevant segment of that market, alone or in combination with the market shares of one or more carrier affiliates, exceeds either 15% of the total number of covered persons in the geographic service area of the providers seeking to jointly negotiate

or 25,000 covered persons, whichever is less; or

(2) the Attorney General determines that the market power of the carrier in the relevant product and geographic markets for the services of the providers seeking to jointly negotiate significantly exceeds the countervailing market power of the providers acting individually.

c. As used in this act:

(1) "Comprehensive health care insurance market" includes all health benefits plans which provide comprehensive coverage, alone or in combination with other plans sold together as a package, including, but not limited to, indemnity, health maintenance organization, preferred provider organization and point-of-service plans, and including self-funded health benefits plans which provide comprehensive coverage; and

(2) "Relevant market segments in the comprehensive health care insurance market" includes the following:

(a) carrier health benefits plans and self-funded health benefits plans;

(b) within the carrier product category, private health insurance, Medicare health maintenance organization contracts and preferred provider organization and point-of-service plans and Medicaid health maintenance organization contracts;

(c) within the private health insurance category, indemnity, health maintenance organization, preferred provider organization and point-of-service plans; and

(d) such other segments as the Attorney General determines are appropriate for purposes of determining whether a carrier has substantial market power.

d. (1) By March 31 of each year, the Commissioner of Banking and Insurance shall calculate the number of covered persons of each carrier and its affiliates in the comprehensive health care insurance market and in each relevant market segment for each county. The commissioner shall make these calculations by averaging quarterly data from the preceding year unless the commissioner determines that it would be more appropriate to use other data and information. The commissioner may recalculate the number of covered persons earlier than the required annual recalculation when the commissioner deems it appropriate to do so.

(2) Recipients of benefits under Medicare, Medicaid or other governmental programs shall not be counted as covered persons in the health care insurance market unless they receive their governmental program coverage through a health maintenance organization or another carrier health benefits plan.

(3) When calculating the market power of a carrier or carrier affiliate that has third party administrator products, the covered lives of the carriers and self-funded health benefits plans for whom the carrier or carrier affiliate provides administrative services shall be

treated as the covered persons of the carrier or carrier affiliate.

(4) The commissioner's calculation of covered persons shall be used for purposes of determining the market power of carriers in the comprehensive health care insurance market from the date of the determination until the next annual determination or until the commissioner recalculates the determination, whichever is earlier.

(5) In cases where the relevant geographic market is multiple counties, the commissioner's calculations for those counties shall be aggregated when counting the covered persons of the carrier whose market power is being evaluated.

(6) The commissioner shall collect and investigate information necessary to calculate the covered persons of carriers and their affiliates.

6. The following requirements shall apply to the exercise of joint negotiation rights and related activity under this act:

a. Health care providers shall select the members of their joint negotiation group by mutual agreement.

b. Health care providers shall designate a joint negotiation representative as the sole party authorized to negotiate with the carrier on behalf of the health care providers as a group.

c. Health care providers may communicate with each other and their joint negotiation representative with respect to the matters to be negotiated with the carrier.

d. Health care providers may agree upon a proposal to be presented by their joint negotiation representative to the carrier.

e. Health care providers may agree to be bound by the terms and conditions negotiated by their joint negotiation representative.

f. The health care providers' joint negotiation representative may provide the health care providers with the results of negotiations with the carrier and an evaluation of any offer made by the carrier.

g. The health care providers' joint negotiation representative may reject a contract proposal by a carrier on behalf of the health care providers as long as the health care providers remain free to individually contract with the carrier.

h. The health care providers' joint negotiation representative shall advise the health care providers of the provisions of this act and shall inform the health care providers of the potential for legal action against health care providers who violate federal antitrust law.

i. Health care providers may not negotiate the inclusion or alteration of terms and conditions to the extent the terms or conditions are required or prohibited by federal or State statute or regulation. This subsection shall not be construed to limit the right of health care providers to jointly petition federal or State government for a change in the statute or regulation.

7. a. Before engaging in any joint negotiation with a carrier, health care providers shall obtain the Attorney General's approval to proceed with the negotiations by submitting to the Attorney General a petition seeking approval, which shall include:

(1) the name and business address of the health care providers' joint negotiation representative;

(2) the names and business addresses of the health care providers petitioning to jointly negotiate;

(3) the name and business address of any carrier with which the petitioning providers seek to jointly negotiate;

(4) the proposed subject matter of the negotiations or discussions with the carrier;

(5) the proportionate relationship of the health care providers to the total population of health care providers in the relevant geographic service area of the providers, by providers, provider type and specialty;

(6) in the case of a petition seeking approval of joint negotiations regarding one or more fee or fee-related terms, a statement of the reasons why the carrier has substantial market power over the health care providers;

(7) a statement of the pro-competitive and other benefits of the proposed negotiations;

(8) the health care provider's joint negotiation representative's plan of operation and procedures to ensure compliance with this act; and

(9) such other data, information and documents as the petitioners desire to submit in support of their petition.

b. The health care providers shall supplement a petition submitted under subsection a. of this section as new information becomes available that indicates that the subject matter of the proposed negotiations with the carrier has or will materially change and shall obtain the Attorney General's approval of material changes. The petition seeking approval shall include:

(1) the Attorney General's file reference for the original petition for approval of joint negotiations;

(2) the proposed new subject matter;

(3) the information required by paragraphs (6) and (7) of subsection a. of this section with respect to the proposed new subject matter; and

(4) such other data, information and documents as the petitioners desire to submit in support of their petition.

c. No provider contract terms negotiated under this act shall be effective until the terms are approved by the Attorney General. The petition seeking approval shall be jointly submitted to the Attorney General by the health care providers and the carrier who are parties to the contract. The petition shall include:

(1) the Attorney General's file reference for the original petition for

approval of joint negotiations;

(2) the negotiated provider contract terms;

(3) a statement of the pro-competitive and other benefits of the negotiated provider contract terms; and

(4) such other data, information and documents as the petitioners desire to submit in support of their petition.

d. Joint negotiations approved under this act may continue until the carrier notifies the joint negotiation representative for the health care providers that it declines to negotiate or is terminating negotiations. If the carrier notifies the joint negotiation representative for the health care providers that it desires to resume negotiations within 60 days of the end of prior negotiations, the health care providers may renew the previously approved negotiations without obtaining a separate approval of the renewal from the Attorney General.

8. a. The Attorney General shall either approve or disapprove a petition under section 7 of this act within 30 days after the filing. If disapproved, the Attorney General shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies may be corrected.

b. (1) The Attorney General shall approve a petition under subsections a. and b. of section 7 of this act if:

(i) the pro-competitive and other benefits of the joint negotiations outweigh any anti-competitive effects; and

(ii) in the case of a petition seeking approval to jointly negotiate one or more fee or fee-related terms, the carrier has substantial market power over the health care providers.

(2) The Attorney General shall approve a petition under subsection c. of section 7 of this act if:

(i) the pro-competitive and other benefits of the contract terms outweigh any anti-competitive effects; and

(ii) the contract terms are consistent with other applicable statutes and regulations.

(3) The pro-competitive and other benefits of joint negotiations or negotiated provider contract terms may include, but shall not be limited to:

(i) restoration of the competitive balance in the market for health care services;

(ii) protections for access to quality patient care;

(iii) promotion of the health care infrastructure and medical advancement; and

(iv) improved communications between health care providers and carriers.

(4) When weighing the anti-competitive effects of provider contract terms, the Attorney General may consider whether the terms:

(i) provide for excessive payments; or

(ii) contribute to the escalation of the cost of providing health care services.

c. For the purpose of enabling the Attorney General to make the findings and determinations required by this section, the Attorney General may require the submission of such supplemental information as the Attorney General deems necessary for that purpose.

9. a. In the case of a petition under subsections a. or b. of section 7 of this act, the Attorney General shall notify the carrier of the petition and provide the carrier with the opportunity to submit written comments within a specified time frame that does not extend beyond the date by which the Attorney General is required to act on the petition.

b. (1) Except as provided in subsection a. of this section, the Attorney General shall not be required to provide public notice of a petition under subsections a., b. or c. of section 7 of this act in order to hold a public hearing on the petition or to otherwise accept public comment on the petition.

(2) The Attorney General may, at his discretion, publish notice of a petition for approval of provider contract terms in the New Jersey Register and receive written comment from interested persons, so long as the opportunity for public comment does not prevent the Attorney General from acting on the petition within the time period set forth in this act.

10. a. Within 30 days from the mailing by the Attorney General of a notice of disapproval of a petition under section 7 of this act, the petitioners may make a written application to the Attorney General for a hearing.

b. Upon receipt of a timely written application for a hearing, the Attorney General shall schedule and conduct a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The hearing shall be held within 30 days of the application unless the petitioner seeks an extension.

c. If the Attorney General does not issue a written approval or disapproval of a petition under section 7 of this act within the required time period, the parties to the petition shall have the right to petition the court for a mandamus order requiring the Attorney General to approve or disapprove the petition.

d. The sole parties with respect to any petition under section 7 of this act shall be the petitioners and the Attorney General. Notwithstanding any other provision of law to the contrary, the Attorney General shall not be required to treat any other person as a party and no other person shall be entitled to appeal the Attorney General's determination.

11. a. All information and documents and copies thereof obtained by or disclosed to the Attorney General or any other person in a petition under section 7 of this act, or pursuant to a request for supplemental information under subsection c. of section 8 of this act, shall be treated confidentially, shall not be subject to subpoena and shall not be made public or otherwise disclosed by the Attorney General or any other person without the written consent of the petitioners to whom the information pertains, except as provided in subsection b. of this section.

b. (1) In the case of a petition under subsections a. or b. of section 7 of this act, the Attorney General may disclose the information required to be submitted pursuant to paragraphs (1) through (4) of subsection a. and paragraphs (1) and (2) of subsection b. of section 7 of this act.

(2) The Attorney General may disclose provider contracts negotiated under this act provided that the Attorney General removes or redacts those provider contract provisions that contain payment rates and fees. The Attorney General may disclose payment rates and fees to the commissioner, the insurance department of another state, a law enforcement official of this State or any other state or agency of the federal government, so long as the agency or office receiving the information agrees in writing to treat the information confidentially and in a matter consistent with this act.

12. A carrier shall negotiate in good faith with health care providers regarding the terms of provider contracts pursuant to this act.

13. Nothing contained in this act shall be construed to:

a. prohibit or restrict activity by health care providers that is sanctioned under federal or State law;

b. affect governmental approval of, or otherwise restrict activity by, health care providers that is not prohibited under federal antitrust law;

c. require approval of provider contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974," Pub.L.93-406 (29 U.S.C. s.1144(a)); or

d. expand a health care provider's scope of practice or require a carrier to contract with any type or specialty of health care provider.

14. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

15. This act shall take effect on the 60th day after enactment; however, the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance as is necessary to implement the act.

STATEMENT

This bill, which is designated the "Health Care Provider Joint Negotiation Act," would permit independent physicians and other health care providers to engage in joint negotiations over the terms and conditions of their contracts with health insurance carriers. The bill is generally modeled after Pennsylvania Senate Bill No. 1052 of 1999.

Specifically, the bill provides that independent health care providers may jointly negotiate with a carrier and engage in related joint activity, as provided in the bill, regarding non-fee-related matters which may affect patient care, including, but not limited to any of the following:

-- the definition of medical necessity and other conditions of coverage;

-- utilization management criteria and procedures;

-- clinical practice guidelines;

-- preventive care and other medical management policies;

-- patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

-- drug formularies and standards and procedures for prescribing off-formulary drugs;

-- quality assurance programs;

-- respective health care provider and carrier liability for the treatment or lack of treatment of covered persons;

-- the methods and timing of payments, including, but not limited to, interest and penalties for late payments;

-- other administrative procedures, including, but not limited to, covered persons eligibility verification systems and claim documentation requirements;

-- credentialing standards and procedures for the selection, retention and termination of participating health care providers;

-- mechanisms for resolving disputes between the carrier and health care providers, including, but not limited to, the appeals process for utilization management and credentialing determinations; or

-- the health benefits plans sold or administered by the carrier in which the health care providers are required to participate.

The bill further provides that when a carrier has substantial market power over independent health care providers, the providers may jointly negotiate with the carrier and engage in related joint activity as

provided in the bill regarding fees and fee-related matters, including, but not limited to, any of the following:

-- the amount of payment or the methodology for determining the payment for a health care service;

-- the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care services;

-- the amount of any discount on the price of a health care service;

-- the procedure code or other description of a health care service covered by a payment;

-- the amount of a bonus related to the provision of health care services or a withholding from the payment due for a health care service; or

-- the amount of any other component of the reimbursement methodology for a health care service.

The bill provides for the following requirements in regard to the exercise of joint negotiation rights and related activity:

-- Health care providers shall select the members of their joint negotiation group by mutual agreement;

-- Health care providers shall designate a joint negotiation representative as the sole party authorized to negotiate with the carrier on behalf of the health care providers as a group;

-- Health care providers may communicate with each other and their joint negotiation representative with respect to the matters to be negotiated with the carrier;

-- Health care providers may agree upon a proposal to be presented by their joint negotiation representative to the carrier;

-- Health care providers may agree to be bound by the terms and conditions negotiated by their joint negotiation representative;

-- The health care providers' joint negotiation representative may provide the health care providers with the results of negotiations with the carrier and an evaluation of any offer made by the carrier;

-- The health care providers' joint negotiation representative may reject a contract proposal by a carrier on behalf of the health care providers as long as the health care providers remain free to individually contract with the carrier;

-- The health care providers' joint negotiation representative shall advise the health care providers of the provisions of this bill and shall inform the health care providers of the potential for legal action against health care providers who violate federal antitrust law; and

-- Health care providers may not negotiate the inclusion or alteration of terms and conditions to the extent the terms or conditions are required or prohibited by federal or State statute or regulation; however, this provision shall not be construed to limit the right of health care providers to jointly petition federal or State government for a change in the statute or regulation.

From a procedural standpoint, the bill provides that:

--before engaging in any joint negotiation with a carrier, health care providers shall obtain the Attorney General's approval to proceed with the negotiations by submitting to the Attorney General a petition seeking approval, which includes the information specified in the bill;

--no provider contract terms negotiated under the bill shall be effective until the terms are approved by the Attorney General, and the petition seeking approval shall be jointly submitted to the Attorney General by the health care providers and the carrier who are parties to the contract;

--the Attorney General shall approve or disapprove a petition filed pursuant to the bill within 30 days after its filing; and, if disapproved, the Attorney General shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies may be corrected; and

--the Attorney General shall approve a petition to allow joint negotiations if the pro-competitive and other benefits of the joint negotiations outweigh any anti-competitive effects; and, in the case of a petition seeking approval to jointly negotiate one or more fee or fee-related terms, the carrier has substantial market power over the health care providers as determined by the Attorney General in a manner specified in the bill; and

--the Attorney General shall approve a petition to implement provider contract terms negotiated under the bill if the pro-competitive and other benefits of the contract terms outweigh any anti-competitive effects, and the contract terms are consistent with other applicable statutes and regulations, as determined by the Attorney General according to criteria set forth in the bill.

The bill requires that a carrier negotiate in good faith with health care providers regarding the terms of provider contracts pursuant to this bill.

Nothing contained in this bill shall be construed to:

--prohibit or restrict activity by health care providers that is sanctioned under federal or State law;

--prohibit or require governmental approval of, or otherwise restrict activity by, health care providers that is not prohibited under federal antitrust law;

--require approval of provider contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974;" or

--expand a health care provider's scope of practice or require a carrier to contract with any type or specialty of health care provider.

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, Nos. 1033 and 1098

STATE OF NEW JERSEY

209th LEGISLATURE

ADOPTED NOVEMBER 9, 2000

Sponsored by:
Senator MARTHA W. BARK
District 8 (Atlantic, Burlington and Camden)
Senator DONALD T. DIFRANCESCO
District 22 (Middlesex, Morris, Somerset and Union)
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator ROBERT W. SINGER
District 30 (Burlington, Monmouth and Ocean)

Co-Sponsored by:
Senators Allen, Gormley, Bennett and Adler

SYNOPSIS

Allows physicians and dentists to jointly negotiate with carriers over contractual terms and conditions.

CURRENT VERSION OF TEXT

Substitute as adopted by the Senate Health Committee.

AN ACT providing for joint negotiations by physicians and dentists with carriers and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that:

a. Active, robust and fully competitive markets for health care and dental services provide the best opportunity for the residents of this State to receive high-quality health care and dental services at an appropriate cost;

b. A substantial amount of health care and dental services in this State is purchased for the benefit of patients by health and dental insurance carriers engaged in the financing of health care and dental services or is otherwise delivered subject to the terms of agreements between carriers and physicians and dentists;

c. Carriers are able to control the flow of patients to physicians and dentists through compelling financial incentives for patients in their health and dental benefits plans to utilize only the services of physicians and dentists with whom the carriers have contracted;

d. Carriers also control the health care and dental services rendered to patients through utilization management and other managed care tools and associated coverage and payment policies;

e. Carriers are often able to virtually dictate the terms of the contracts that they offer physicians and dentists and commonly offer these contracts on a take-it-or-leave-it basis;

f. The power of carriers to unilaterally impose provider contract terms jeopardizes the ability of physicians and dentists to deliver the superior quality health care and dental services traditionally available in this State;

g. Physicians and dentists do not have sufficient market power to reject unfair provider contract terms offered by carriers that impede their ability to deliver medically appropriate care without undue delay or difficulties;

h. Inadequate reimbursement and other unfair payment terms offered by carriers adversely affect the quality of patient care and access to care by reducing the resources that physicians and dentists can devote to patient care and decreasing the time that physicians and dentists are able to spend with their patients;

i. Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical progress by diverting capital needed for reinvestment in the health care delivery system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and expansion of medical services, all to the detriment of the residents of this State;

j. The inevitable collateral reduction and migration of the health

care work force will also have negative consequences for the economy of this State;

k. Empowering independent physicians and dentists to jointly negotiate with carriers as provided in this act will help restore the competitive balance and improve competition in the markets for health care and dental services in this State, thereby providing benefits for consumers, physicians and dentists and less dominant carriers;

l. This act is necessary and proper, and constitutes an appropriate exercise of the authority of this State to regulate the business of insurance and the delivery of health care and dental services;

m. The pro-competitive and other benefits of the joint negotiations and related joint activity authorized by this act, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical progress, and improving communications, outweigh any potential anti-competitive effects of this act; and

n. It is the intention of the Legislature to authorize independent physicians and dentists to jointly negotiate with carriers and to qualify such joint negotiations and related joint activities for the State-action exemption to the federal antitrust laws through the articulated State policy and active supervision provided under this act.

2. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization which is authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Covered person" means a person on whose behalf a carrier which offers a health benefits or dental plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care or dental service provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provide services.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Dentist" means a person who is licensed to practice dentistry by the New Jersey State Board of Dentistry in accordance with the provisions of Title 45 of the Revised Statutes.

"Health benefits plan" means a plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage

and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Joint negotiation representative" means a representative selected by two or more independent physicians or dentists to engage in joint negotiations with a carrier on their behalf.

"Physician" means a person who is licensed to practice medicine and surgery by the State Board of Medical Examiners in accordance with the provisions of Title 45 of the Revised Statutes.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care or dental services under a health benefits or dental plan in accordance with specific guidelines, for the purpose of determining whether, or to what extent, a health care or dental service that has been provided or is proposed to be provided to a covered person is to be covered under the health benefits or dental plan.

3. Two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with a carrier and engage in related joint activity, as provided in this act, regarding non-fee-related matters which may affect patient care, including, but not limited to, any of the following:

a. the definition of medical necessity and other conditions of coverage;

b. utilization management criteria and procedures;

c. clinical practice guidelines;

d. preventive care and other medical management policies;

e. patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

f. drug formularies and standards and procedures for prescribing off-formulary drugs;

g. quality assurance programs;

h. respective physician or dentist and carrier liability for the treatment or lack of treatment of covered persons;

i. the methods and timing of payments;

j. other administrative procedures, including, but not limited to, eligibility verification systems and claim documentation requirements for covered persons;

k. credentialing standards and procedures for the selection, retention and termination of participating physicians or dentists;

l. mechanisms for resolving disputes between the carrier and physicians or dentists, including, but not limited to, the appeals

process for utilization management and credentialing determinations;

m. the health benefits or dental plans sold or administered by the carrier in which the physicians or dentists are required to participate;

n. the formulation and application of reimbursement methodology;

o. the terms and conditions of physician or dentist contracts, including, but not limited to, all products clauses, and the duration and renewal provisions of the contract; and

p. the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit a physician's or dentist's rights to jointly petition the federal or State government, as applicable, to change the regulation.

4. a. Upon a finding by the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, that the carrier has substantial market power in its service area and that any of the terms or conditions of the contract with the carrier pose an actual or potential threat to the quality and availability of patient care among covered persons, two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with the carrier and engage in related joint activity, as provided in this act regarding fees and fee-related matters, including, but not limited to, any of the following:

(1) the amount of payment or the methodology for determining the payment for a health care or dental service, including, but not limited to, cost of living increases;

(2) the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care or dental services;

(3) the amount of any discount on the price of a health care or dental service;

(4) the procedure code or other description of a health care or dental service covered by a payment and the appropriate grouping of the procedure codes;

(5) the amount of a bonus related to the provision of health care or dental services or a withholding from the payment due for a health care or dental service; and

(6) the amount of any other component of the reimbursement methodology for a health care or dental service.

b. The Department of Banking and Insurance, in consultation with the Department of Health and Senior Services, shall have the authority to collect and investigate such information as it reasonably believes is necessary to determine, on an annual basis:

(1) the average number of covered lives and geographical distribution of covered lives per quarter per county for every carrier in the State; and

(2) the impact of the provisions of this section on average physician or dentist fees in the State.

The Department of Banking and Insurance shall provide this information to the Attorney General on an annual basis.

5. The exercise of joint negotiation rights by two or more independent physicians or dentists who are practicing in the service area of a carrier pursuant to this act shall conform to the following criteria:

a. the physicians or dentists may communicate with each other concerning any contractual term or condition to be negotiated with the carrier;

b. the physicians or dentists may communicate with the joint negotiation representative authorized to negotiate on their behalf with the carrier concerning any contractual term or condition;

c. the joint negotiation representative shall be the sole party authorized to negotiate with the carrier on behalf of the physicians or dentists as a group;

d. the physicians or dentists may, at the option of each physician or dentist, agree to be bound by the terms and conditions negotiated by the joint negotiation representative; and

e. when communicating or negotiating with a joint negotiation representative, a carrier may offer different contractual terms or conditions to, or may contract with, individual independent physicians or dentists.

6. The provisions of this act shall not apply to a health benefits or dental plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the Children's Health Care Coverage Program under P.L.1997, c.272 (C.30:4I-1 et seq.) or the FamilyCare Health Coverage Program under P.L.2000, c.71 (C.30:4J-1 et seq.).

7. A person or entity which proposes to act as a joint negotiation representative shall satisfy the following requirements:

a. Before entering into negotiations with a carrier on behalf of two or more independent physicians or dentists, the joint negotiation representative shall submit to the Attorney General, for his approval pursuant to section 8 of this act, on a form and in a manner prescribed by the Attorney General, a petition which identifies:

(1) the representative's name and business address;

(2) the names and business addresses of each physician or dentist who will be represented by the identified representative;

(3) the ratio of the physicians or dentists requesting joint representation to the total number of physicians or dentists who are practicing within the geographic service area of the carrier;

(4) the carrier with which the representative proposes to enter into negotiations on behalf of the identified physicians or dentists;

(5) the intended subject matter of the proposed negotiations with the identified carrier;

(6) the representative's plan of operation and procedures to ensure compliance with the provisions of this act;

(7) the anticipated effect of the proposed joint negotiations on the quality and availability of health or dental care among covered persons;

(8) the anticipated benefits of a contract between the identified physicians or dentists and carrier;

(9) such other data, information and documents as the petitioners desire to submit in support of their petition; and

(10) such other data, information and documents as the Attorney General deems necessary.

The joint negotiation representative, upon submitting the petition, shall pay a fee to the Attorney General in an amount, as determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this act.

b. After the joint negotiation representative and the carrier identified pursuant to subsection a. of this section have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the joint negotiation representative shall submit to the Attorney General, for his approval in accordance with the provisions of section 8 of this act, a copy of the proposed contract between the physicians or dentists identified pursuant to subsection a. of this section and the carrier, as well as any plan of action which the joint negotiation representative and the carrier may formally agree to for the purpose of implementing the terms and conditions of the contract.

c. Within 14 days after either party notifies the other party of its decision to decline or terminate negotiations entered into pursuant to this act, or after the date that a joint negotiation representative requests that a carrier enter into such negotiations to which request the plan fails to respond, the joint negotiation representative shall report to the Attorney General that the negotiations have ended, on a form and in a manner to be prescribed by the Attorney General. The joint negotiation representative may resume negotiations with the carrier no later than 60 days after reporting to the Attorney General that the negotiations have ended, on the basis of the petition submitted to the Attorney General pursuant to subsection a. of this section and approved by the Attorney General in accordance with the provisions of section 8 of this act. After that date, the joint negotiation

representative shall be required to submit a new petition and pay an additional fee to the Attorney General pursuant to subsection a. of this section, in order to engage in negotiations with the carrier under this act.

8. a. The Attorney General shall provide written approval or disapproval of a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act no later than 30 days after receipt of the petition or proposed contract, as applicable. If the Attorney General fails to provide written approval or disapproval within this time period, the joint negotiation representative may petition a court of competent jurisdiction for an order to require the Attorney General to take such action. If the Attorney General disapproves the petition or the proposed contract, he shall forward a written explanation of any deficiencies therein to the joint negotiation representative along with a statement of the specific remedial measures by which those deficiencies may be corrected.

A joint negotiation representative shall not engage in negotiations with a carrier over any contractual term or condition unless the petition furnished by the joint negotiation representative has been approved in writing by the Attorney General, nor shall a proposed contract between two or more independent physicians or dentists and a carrier be implemented unless the Attorney General has approved the contract.

b. The Attorney General shall approve a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act if the Attorney General determines that the petition or proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations over a contractual term or condition or the proposed contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician or dentist distribution by specialty and its effect on competition in the geographic service area of the carrier.

c. The Attorney General's written approval of a petition which is furnished by a joint negotiation representative under section 7 of this act shall be effective for all subsequent negotiations between the joint negotiation representative and the identified carrier, subject to the provisions of subsection c. of section 7 of this act.

d. In the case of a petition submitted pursuant to subsection a. of section 7 of this act, the Attorney General shall notify the carrier of the petition and provide the carrier with the opportunity to submit written comments within a specified time frame that does not extend beyond the date by which the Attorney General is required to act on the petition.

9. a. Within 30 days from the mailing by the Attorney General of a notice of disapproval of a petition submitted under section 7 of this act, the petitioners may make a written application to the Attorney General for a hearing.

b. Upon receipt of a timely written application for a hearing, the Attorney General shall schedule and conduct a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The hearing shall be held within 30 days of the application unless the petitioner seeks an extension.

c. The sole parties with respect to any petition under section 7 of this act shall be the petitioners, and notwithstanding any other provision of law to the contrary, the Attorney General shall not be required to treat any other person as a party and no other person shall be entitled to appeal the Attorney General's determination.

10. All information, including documents and copies thereof, obtained by or disclosed to the Attorney General or any other person in a petition under section 7 of this act, shall be treated confidentially and shall be deemed proprietary and shall not be made public or otherwise disclosed by the Attorney General or any other person without the written consent of the petitioners to whom the information pertains.

11. A carrier and a joint negotiation representative shall negotiate in good faith regarding the terms and conditions of physician or dentist contracts pursuant to this act.

12. a. The provisions of this act shall not be construed to:

(1) permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services which they provide;

(2) permit two or more physicians or dentists to meet or communicate in order to jointly negotiate a requirement that at least one of the physicians or dentists, as a condition of participation with a carrier, be allowed to participate in all of the products offered by the carrier;

(3) permit two or more physicians or dentists to jointly negotiate with a carrier to exclude, limit or otherwise restrict a non-physician or non-dentist health care provider from participating in the carrier's health benefits or dental plan based substantially on the fact that the health care provider is not a physician or dentist, unless that exclusion, limitation or restriction is otherwise permitted by law;

(4) prohibit or restrict activity by physicians or dentists that is sanctioned under federal or State law or subject such activity to the requirements of this act;

(5) affect governmental approval of, or otherwise restrict activity by, physicians or dentists that is not prohibited under federal antitrust law; or

(6) require approval of physician or dentist contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974," Pub.L.93-406 (29 U.S.C. s.1144(a)).

b. Prior to entering into negotiations with a carrier on behalf of two or more independent physicians or dentists over a contractual term or condition, a joint negotiation representative shall notify the physicians or dentists in writing of the provisions of this act and advise them as to their potential for legal action against physicians or dentists who violate federal antitrust law.

13. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than four years after the effective date of this act on its implementation.

The report shall include the number of petitions submitted for approval to engage in joint negotiations and the outcome of the petitions and the negotiations, an assessment of the effect the joint negotiations provided for in this act has had in restoring the competitive balance in the market for health care or dental services and in protecting access to quality patient care, and such other information that the Attorney General deems appropriate. The report shall also include the Attorney General's recommendations as to whether the provisions of this act shall be expanded to include other types of health care professionals and facilities.

14. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

15. This act shall take effect 90 days after enactment, except that the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance as shall be necessary to implement the act.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, Nos. 1033 and 1098

STATE OF NEW JERSEY

DATED: NOVEMBER 1, 2000

The Senate Health Committee reports without recommendation a Senate Committee Substitute for Senate Bill Nos.1033 and 1098.

The purpose of this substitute is to provide physicians and dentists with the right to engage in joint negotiations over the terms and conditions of their contracts with health and dental insurance carriers, that is, health, hospital and medical service corporations, commercial health insurers, health maintenance organizations, dental service corporations and dental plan organizations.

The substitute permits two or more independent physicians or dentists who are practicing in the geographic service area of a carrier to jointly negotiate with the carrier and engage in related joint activity over the terms and conditions of a proposed contract. The negotiations would be carried out through a joint negotiation representative selected by the physicians or dentists to act on their behalf.

The terms and conditions that may be the subject of the negotiations include non-fee-related matters which may affect patient care, such as any of the following:

- the definition of medical necessity and other conditions of coverage;
- utilization management criteria and procedures;
- clinical practice guidelines;
- preventive care and other medical management policies;
- patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;
- drug formularies and standards and procedures for prescribing off-formulary drugs;
- quality assurance programs;
- respective physician or dentist and carrier liability for the treatment or lack of treatment of covered persons;
- the methods and timing of payments;
- other administrative procedures, including, but not limited to, eligibility verification systems and claim documentation requirements for covered persons;

- credentialing standards and procedures for the selection, retention and termination of participating physicians or dentists;
- mechanisms for resolving disputes between the carrier and physicians or dentists, including, but not limited to, the appeals process for utilization management and credentialing determinations;
- the health benefits or dental plans sold or administered by the carrier in which the physicians or dentists are required to participate;
- the formulation and application of reimbursement methodology;
- the terms and conditions of physician or dentist contracts, including, but not limited to, all products clauses, and the duration and renewal provisions of the contract; and
- the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit a physician's or dentist's rights to jointly petition the federal or State government, as applicable, to change the regulation.

In addition, the substitute provides that the following terms and conditions of a proposed contract concerning fees and fee-related matters may be subject to joint negotiations if the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, finds that the carrier has substantial market power in its service area and that any of the terms or conditions of the contract with the carrier pose an actual or potential threat to the quality and availability of patient care among covered persons. These matters include, but are not limited to, any of the following:

- the amount of payment or the methodology for determining the payment for a health care or dental service, including, but not limited to, cost of living increases;
- the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care or dental services;
- the amount of any discount on the price of a health care or dental service;
- the procedure code or other description of a health care or dental service covered by a payment and the appropriate grouping of the procedure codes;
- the amount of a bonus related to the provision of health care or dental services or a withholding from the payment due for a health care or dental service; and
- the amount of any other component of the reimbursement methodology for a health care or dental service.

The substitute requires that a person or entity which proposes to act as a joint negotiation representative shall submit a petition to the

Attorney General, for his approval. The petition shall identify the representative, the physicians or dentists who the representative will represent, the intended subject matter of the proposed negotiations and other information specified in the substitute. Upon submitting the petition, the representative shall pay a fee to the Attorney General, in an amount determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this substitute.

After the joint negotiation representative and the carrier have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the representative shall submit a copy of the proposed contract between the physicians or dentists and the carrier to the Attorney General, for his approval. The Attorney General shall provide written approval or disapproval of a petition or a proposed contract furnished by the representative no later than 30 days after receipt of the petition or proposed contract.

The substitute provides that a joint negotiation representative shall not engage in negotiations with a carrier unless the representative's petition has been approved in writing by the Attorney General, and a proposed contract between physicians or dentists and a carrier negotiated under this substitute shall not be implemented unless the Attorney General has approved the contract. The substitute further provides that either party may decline to negotiate or terminate negotiations. In either event, the representative shall so notify the Attorney General.

The Attorney General shall approve a petition or a proposed contract if he determines that the petition or proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations or contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician or dentist distribution by specialty and its effect on competition in the geographic service area of the carrier.

The substitute provides that its provisions shall not be construed to:

(1) permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services which they provide;

(2) permit two or more physicians or dentists to meet or communicate in order to jointly negotiate a requirement that at least one of the physicians or dentists, as a condition of participation with a carrier, be allowed to participate in all of the products offered by the carrier;

(3) permit two or more physicians or dentists to jointly negotiate with a carrier to exclude, limit or otherwise restrict a non-physician or non-dentist health care provider from participating in the carrier's

health benefits or dental plan based substantially on the fact that the health care provider is not a physician or dentist, unless that exclusion, limitation or restriction is otherwise permitted by law;

(4) prohibit or restrict activity by physicians or dentists that is sanctioned under federal or State law or subject such activity to the requirements of this act;

(5) affect governmental approval of, or otherwise restrict activity by, physicians or dentists that is not prohibited under federal antitrust law; or

(6) require approval of physician or dentist contract terms to the extent that the terms are exempt from State regulation under ERISA.

Finally, the substitute provides that its provisions shall not apply to a health benefits or dental plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for Medicaid, NJ KidCare or NJ FamilyCare.

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, Nos. 1033 and 1098

with Senate Floor Amendments
(Proposed By Senator CODEY)

ADOPTED: DECEMBER 4, 2000

These amendments require the Attorney General, in consultation with the Commissioners of Health and Senior Services and Banking and Insurance, to include in their report to the Legislature and the Governor on the implementation of the bill, an assessment of the impact this bill has had on health insurance premiums. The report shall be prepared no later than four years after the effective date of the bill.

The amendments also provide that the provisions of the bill shall sunset in six years The Attorney General, in consultation with the commissioners, is rrequired to report to the Governor and the Legislature in five years with his recommendation as to whether this bill should be made permanent. Amendments also clarify that the expiration of this bill shall not impair any contract negotiated pursuant to this bill that is in effect on the date of expiration.

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, Nos. 1033 and 1098

STATE OF NEW JERSEY

209th LEGISLATURE

ADOPTED NOVEMBER 9, 2000

Sponsored by:
Senator MARTHA W. BARK
District 8 (Atlantic, Burlington and Camden)
Senator DONALD T. DIFRANCESCO
District 22 (Middlesex, Morris, Somerset and Union)
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator ROBERT W. SINGER
District 30 (Burlington, Monmouth and Ocean)

Co-Sponsored by:
Senators Allen, Gormley, Bennett, Adler, Assemblymen Chatzidakis, Asselta, Doria, Conaway, Conners, LeFevre, Gusciora, Assemblywoman Weinberg, Assemblymen Geist, Cohen, Munoz and Assemblywoman Gill

SYNOPSIS

Allows physicians and dentists to jointly negotiate with carriers over contractual terms and conditions.

CURRENT VERSION OF TEXT

As amended by the Senate on December 4, 2000.

(Sponsorship Updated As Of: 1/8/2002)

AN ACT providing for joint negotiations by physicians and dentists with carriers and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that:

a. Active, robust and fully competitive markets for health care and dental services provide the best opportunity for the residents of this State to receive high-quality health care and dental services at an appropriate cost;

b. A substantial amount of health care and dental services in this State is purchased for the benefit of patients by health and dental insurance carriers engaged in the financing of health care and dental services or is otherwise delivered subject to the terms of agreements between carriers and physicians and dentists;

c. Carriers are able to control the flow of patients to physicians and dentists through compelling financial incentives for patients in their health and dental benefits plans to utilize only the services of physicians and dentists with whom the carriers have contracted;

d. Carriers also control the health care and dental services rendered to patients through utilization management and other managed care tools and associated coverage and payment policies;

e. Carriers are often able to virtually dictate the terms of the contracts that they offer physicians and dentists and commonly offer these contracts on a take-it-or-leave-it basis;

f. The power of carriers to unilaterally impose provider contract terms jeopardizes the ability of physicians and dentists to deliver the superior quality health care and dental services traditionally available in this State;

g. Physicians and dentists do not have sufficient market power to reject unfair provider contract terms offered by carriers that impede their ability to deliver medically appropriate care without undue delay or difficulties;

h. Inadequate reimbursement and other unfair payment terms offered by carriers adversely affect the quality of patient care and access to care by reducing the resources that physicians and dentists can devote to patient care and decreasing the time that physicians and dentists are able to spend with their patients;

i. Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical progress by diverting capital needed for reinvestment in the health care delivery

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate floor amendments adopted December 4, 2000.

system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and expansion of medical services, all to the detriment of the residents of this State;

j. The inevitable collateral reduction and migration of the health care work force will also have negative consequences for the economy of this State;

k. Empowering independent physicians and dentists to jointly negotiate with carriers as provided in this act will help restore the competitive balance and improve competition in the markets for health care and dental services in this State, thereby providing benefits for consumers, physicians and dentists and less dominant carriers;

l. This act is necessary and proper, and constitutes an appropriate exercise of the authority of this State to regulate the business of insurance and the delivery of health care and dental services;

m. The pro-competitive and other benefits of the joint negotiations and related joint activity authorized by this act, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical progress, and improving communications, outweigh any potential anti-competitive effects of this act; and

n. It is the intention of the Legislature to authorize independent physicians and dentists to jointly negotiate with carriers and to qualify such joint negotiations and related joint activities for the State-action exemption to the federal antitrust laws through the articulated State policy and active supervision provided under this act.

2. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization which is authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Covered person" means a person on whose behalf a carrier which offers a health benefits or dental plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care or dental service provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provide services.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Dentist" means a person who is licensed to practice dentistry by the New Jersey State Board of Dentistry in accordance with the provisions of Title 45 of the Revised Statutes.

"Health benefits plan" means a plan which pays or provides

hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Joint negotiation representative" means a representative selected by two or more independent physicians or dentists to engage in joint negotiations with a carrier on their behalf.

"Physician" means a person who is licensed to practice medicine and surgery by the State Board of Medical Examiners in accordance with the provisions of Title 45 of the Revised Statutes.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care or dental services under a health benefits or dental plan in accordance with specific guidelines, for the purpose of determining whether, or to what extent, a health care or dental service that has been provided or is proposed to be provided to a covered person is to be covered under the health benefits or dental plan.

3. Two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with a carrier and engage in related joint activity, as provided in this act, regarding non-fee-related matters which may affect patient care, including, but not limited to, any of the following:

a. the definition of medical necessity and other conditions of coverage;

b. utilization management criteria and procedures;

c. clinical practice guidelines;

d. preventive care and other medical management policies;

e. patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

f. drug formularies and standards and procedures for prescribing off-formulary drugs;

g. quality assurance programs;

h. respective physician or dentist and carrier liability for the treatment or lack of treatment of covered persons;

i. the methods and timing of payments;

j. other administrative procedures, including, but not limited to, eligibility verification systems and claim documentation requirements for covered persons;

k. credentialing standards and procedures for the selection, retention and termination of participating physicians or dentists;

l. mechanisms for resolving disputes between the carrier and physicians or dentists, including, but not limited to, the appeals process for utilization management and credentialing determinations;

m. the health benefits or dental plans sold or administered by the carrier in which the physicians or dentists are required to participate;

n. the formulation and application of reimbursement methodology;

o. the terms and conditions of physician or dentist contracts, including, but not limited to, all products clauses, and the duration and renewal provisions of the contract; and

p. the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit a physician's or dentist's rights to jointly petition the federal or State government, as applicable, to change the regulation.

4. a. Upon a finding by the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, that the carrier has substantial market power in its service area and that any of the terms or conditions of the contract with the carrier pose an actual or potential threat to the quality and availability of patient care among covered persons, two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with the carrier and engage in related joint activity, as provided in this act regarding fees and fee-related matters, including, but not limited to, any of the following:

(1) the amount of payment or the methodology for determining the payment for a health care or dental service, including, but not limited to, cost of living increases;

(2) the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care or dental services;

(3) the amount of any discount on the price of a health care or dental service;

(4) the procedure code or other description of a health care or dental service covered by a payment and the appropriate grouping of the procedure codes;

(5) the amount of a bonus related to the provision of health care or dental services or a withholding from the payment due for a health care or dental service; and

(6) the amount of any other component of the reimbursement methodology for a health care or dental service.

b. The Department of Banking and Insurance, in consultation with the Department of Health and Senior Services, shall have the authority to collect and investigate such information as it reasonably believes is

necessary to determine, on an annual basis:

(1) the average number of covered lives and geographical distribution of covered lives per quarter per county for every carrier in the State; and

(2) the impact of the provisions of this section on average physician or dentist fees in the State.

The Department of Banking and Insurance shall provide this information to the Attorney General on an annual basis.

5. The exercise of joint negotiation rights by two or more independent physicians or dentists who are practicing in the service area of a carrier pursuant to this act shall conform to the following criteria:

a. the physicians or dentists may communicate with each other concerning any contractual term or condition to be negotiated with the carrier;

b. the physicians or dentists may communicate with the joint negotiation representative authorized to negotiate on their behalf with the carrier concerning any contractual term or condition;

c. the joint negotiation representative shall be the sole party authorized to negotiate with the carrier on behalf of the physicians or dentists as a group;

d. the physicians or dentists may, at the option of each physician or dentist, agree to be bound by the terms and conditions negotiated by the joint negotiation representative; and

e. when communicating or negotiating with a joint negotiation representative, a carrier may offer different contractual terms or conditions to, or may contract with, individual independent physicians or dentists.

6. The provisions of this act shall not apply to a health benefits or dental plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the Children's Health Care Coverage Program under P.L.1997, c.272 (C.30:4I-1 et seq.) or the FamilyCare Health Coverage Program under P.L.2000, c.71 (C.30:4J-1 et seq.).

7. A person or entity which proposes to act as a joint negotiation representative shall satisfy the following requirements:

a. Before entering into negotiations with a carrier on behalf of two or more independent physicians or dentists, the joint negotiation representative shall submit to the Attorney General, for his approval pursuant to section 8 of this act, on a form and in a manner prescribed by the Attorney General, a petition which identifies:

(1) the representative's name and business address;

(2) the names and business addresses of each physician or dentist who will be represented by the identified representative;

(3) the ratio of the physicians or dentists requesting joint representation to the total number of physicians or dentists who are practicing within the geographic service area of the carrier;

(4) the carrier with which the representative proposes to enter into negotiations on behalf of the identified physicians or dentists;

(5) the intended subject matter of the proposed negotiations with the identified carrier;

(6) the representative's plan of operation and procedures to ensure compliance with the provisions of this act;

(7) the anticipated effect of the proposed joint negotiations on the quality and availability of health or dental care among covered persons;

(8) the anticipated benefits of a contract between the identified physicians or dentists and carrier;

(9) such other data, information and documents as the petitioners desire to submit in support of their petition; and

(10) such other data, information and documents as the Attorney General deems necessary.

The joint negotiation representative, upon submitting the petition, shall pay a fee to the Attorney General in an amount, as determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this act.

b. After the joint negotiation representative and the carrier identified pursuant to subsection a. of this section have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the joint negotiation representative shall submit to the Attorney General, for his approval in accordance with the provisions of section 8 of this act, a copy of the proposed contract between the physicians or dentists identified pursuant to subsection a. of this section and the carrier, as well as any plan of action which the joint negotiation representative and the carrier may formally agree to for the purpose of implementing the terms and conditions of the contract.

c. Within 14 days after either party notifies the other party of its decision to decline or terminate negotiations entered into pursuant to this act, or after the date that a joint negotiation representative requests that a carrier enter into such negotiations to which request the plan fails to respond, the joint negotiation representative shall report to the Attorney General that the negotiations have ended, on a form and in a manner to be prescribed by the Attorney General. The joint negotiation representative may resume negotiations with the carrier no later than 60 days after reporting to the Attorney General that the negotiations have ended, on the basis of the petition submitted

to the Attorney General pursuant to subsection a. of this section and approved by the Attorney General in accordance with the provisions of section 8 of this act. After that date, the joint negotiation representative shall be required to submit a new petition and pay an additional fee to the Attorney General pursuant to subsection a. of this section, in order to engage in negotiations with the carrier under this act.

8. a. The Attorney General shall provide written approval or disapproval of a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act no later than 30 days after receipt of the petition or proposed contract, as applicable. If the Attorney General fails to provide written approval or disapproval within this time period, the joint negotiation representative may petition a court of competent jurisdiction for an order to require the Attorney General to take such action. If the Attorney General disapproves the petition or the proposed contract, he shall forward a written explanation of any deficiencies therein to the joint negotiation representative along with a statement of the specific remedial measures by which those deficiencies may be corrected.

A joint negotiation representative shall not engage in negotiations with a carrier over any contractual term or condition unless the petition furnished by the joint negotiation representative has been approved in writing by the Attorney General, nor shall a proposed contract between two or more independent physicians or dentists and a carrier be implemented unless the Attorney General has approved the contract.

b. The Attorney General shall approve a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act if the Attorney General determines that the petition or proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations over a contractual term or condition or the proposed contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician or dentist distribution by specialty and its effect on competition in the geographic service area of the carrier.

c. The Attorney General's written approval of a petition which is furnished by a joint negotiation representative under section 7 of this act shall be effective for all subsequent negotiations between the joint negotiation representative and the identified carrier, subject to the provisions of subsection c. of section 7 of this act.

d. In the case of a petition submitted pursuant to subsection a. of section 7 of this act, the Attorney General shall notify the carrier of the petition and provide the carrier with the opportunity to submit

written comments within a specified time frame that does not extend beyond the date by which the Attorney General is required to act on the petition.

9. a. Within 30 days from the mailing by the Attorney General of a notice of disapproval of a petition submitted under section 7 of this act, the petitioners may make a written application to the Attorney General for a hearing.

b. Upon receipt of a timely written application for a hearing, the Attorney General shall schedule and conduct a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The hearing shall be held within 30 days of the application unless the petitioner seeks an extension.

c. The sole parties with respect to any petition under section 7 of this act shall be the petitioners, and notwithstanding any other provision of law to the contrary, the Attorney General shall not be required to treat any other person as a party and no other person shall be entitled to appeal the Attorney General's determination.

10. All information, including documents and copies thereof, obtained by or disclosed to the Attorney General or any other person in a petition under section 7 of this act, shall be treated confidentially and shall be deemed proprietary and shall not be made public or otherwise disclosed by the Attorney General or any other person without the written consent of the petitioners to whom the information pertains.

11. A carrier and a joint negotiation representative shall negotiate in good faith regarding the terms and conditions of physician or dentist contracts pursuant to this act.

12. a. The provisions of this act shall not be construed to:

(1) permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services which they provide;

(2) permit two or more physicians or dentists to meet or communicate in order to jointly negotiate a requirement that at least one of the physicians or dentists, as a condition of participation with a carrier, be allowed to participate in all of the products offered by the carrier;

(3) permit two or more physicians or dentists to jointly negotiate with a carrier to exclude, limit or otherwise restrict a non-physician or non-dentist health care provider from participating in the carrier's health benefits or dental plan based substantially on the fact that the health care provider is not a physician or dentist, unless that exclusion, limitation or restriction is otherwise permitted by law;

(4) prohibit or restrict activity by physicians or dentists that is sanctioned under federal or State law or subject such activity to the requirements of this act;

(5) affect governmental approval of, or otherwise restrict activity by, physicians or dentists that is not prohibited under federal antitrust law; or

(6) require approval of physician or dentist contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974," Pub.L.93-406 (29 U.S.C. s.1144(a)).

b. Prior to entering into negotiations with a carrier on behalf of two or more independent physicians or dentists over a contractual term or condition, a joint negotiation representative shall notify the physicians or dentists in writing of the provisions of this act and advise them as to their potential for legal action against physicians or dentists who violate federal antitrust law.

13. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than four years after the effective date of this act on its implementation.

The report shall include the number of petitions submitted for approval to engage in joint negotiations and the outcome of the petitions and the negotiations, an assessment of the effect the joint negotiations provided for in this act has had in restoring the competitive balance in the market for health care or dental services and in protecting access to quality patient care, [1]an assessment of the impact this act has had on health insurance premiums in the State,[1] and such other information that the Attorney General deems appropriate. The report shall also include the Attorney General's recommendations as to whether the provisions of this act shall be expanded to include other types of health care professionals and facilities.

[1]The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than five years after the effective date of this act with his recommendation as to whether this act shall be made permanent.[1]

14. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

15. This act shall take effect 90 days after enactment [1][, except that the] and shall expire six years after the effective date, but the

expiration of this act shall not impair any contract negotiated pursuant to this act that is in effect on the date of expiration. The[1] Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance [1]of the effective date[1] as shall be necessary to implement the act.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, Nos. 1033 and 1098

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Health Committee reports without recommendation Senate Bill Nos. 1033 and 1098(SCS/1R).

This committee substitute is intended to provide physicians and dentists with the right to engage in joint negotiations over the terms and conditions of their contracts with health and dental insurance carriers, that is, health, hospital and medical service corporations, commercial health insurers, health maintenance organizations, dental service corporations and dental plan organizations.

The substitute permits two or more independent physicians or dentists who are practicing in the geographic service area of a carrier to jointly negotiate with the carrier and engage in related joint activity over the terms and conditions of a proposed contract. The negotiations would be carried out through a joint negotiation representative selected by the physicians or dentists to act on their behalf.

The terms and conditions that may be the subject of the negotiations include non-fee-related matters which may affect patient care, such as any of the following:

- the definition of medical necessity and other conditions of coverage;
- utilization management criteria and procedures;
- clinical practice guidelines;
- preventive care and other medical management policies;
- patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;
- drug formularies and standards and procedures for prescribing off-formulary drugs;
- quality assurance programs;
- respective physician or dentist and carrier liability for the treatment or lack of treatment of covered persons;
- the methods and timing of payments;
- other administrative procedures, including, but not limited to,

eligibility verification systems and claim documentation requirements for covered persons;

- credentialing standards and procedures for the selection, retention and termination of participating physicians or dentists;
- mechanisms for resolving disputes between the carrier and physicians or dentists, including, but not limited to, the appeals process for utilization management and credentialing determinations;
- the health benefits or dental plans sold or administered by the carrier in which the physicians or dentists are required to participate;
- the formulation and application of reimbursement methodology;
- the terms and conditions of physician or dentist contracts, including, but not limited to, all products clauses, and the duration and renewal provisions of the contract; and
- the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit a physician's or dentist's rights to jointly petition the federal or State government, as applicable, to change the regulation.

In addition, the substitute provides that the following terms and conditions of a proposed contract concerning fees and fee-related matters may be subject to joint negotiations if the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, finds that the carrier has substantial market power in its service area and that any of the terms or conditions of the contract with the carrier pose an actual or potential threat to the quality and availability of patient care among covered persons. These matters include, but are not limited to, any of the following:

- the amount of payment or the methodology for determining the payment for a health care or dental service, including, but not limited to, cost of living increases;
- the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care or dental services;
- the amount of any discount on the price of a health care or dental service;
- the procedure code or other description of a health care or dental service covered by a payment and the appropriate grouping of the procedure codes;
- the amount of a bonus related to the provision of health care or dental services or a withholding from the payment due for a health care or dental service; and
- the amount of any other component of the reimbursement methodology for a health care or dental service.

The substitute requires that a person or entity which proposes to

act as a joint negotiation representative shall submit a petition to the Attorney General, for his approval. The petition shall identify the representative, the physicians or dentists who the representative will represent, the intended subject matter of the proposed negotiations and other information specified in the substitute. Upon submitting the petition, the representative shall pay a fee to the Attorney General, in an amount determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this substitute.

After the joint negotiation representative and the carrier have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the representative shall submit a copy of the proposed contract between the physicians or dentists and the carrier to the Attorney General, for his approval. The Attorney General shall provide written approval or disapproval of a petition or a proposed contract furnished by the representative no later than 30 days after receipt of the petition or proposed contract.

The substitute provides that a joint negotiation representative shall not engage in negotiations with a carrier unless the representative's petition has been approved in writing by the Attorney General, and a proposed contract between physicians or dentists and a carrier negotiated under this substitute shall not be implemented unless the Attorney General has approved the contract. The substitute further provides that either party may decline to negotiate or terminate negotiations. In either event, the representative shall so notify the Attorney General.

The Attorney General shall approve a petition or a proposed contract if he determines that the petition or proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations or contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician or dentist distribution by specialty and its effect on competition in the geographic service area of the carrier.

The substitute provides that its provisions shall not be construed to:

(1) permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services which they provide;

(2) permit two or more physicians or dentists to meet or communicate in order to jointly negotiate a requirement that at least one of the physicians or dentists, as a condition of participation with a carrier, be allowed to participate in all of the products offered by the carrier;

(3) permit two or more physicians or dentists to jointly negotiate with a carrier to exclude, limit or otherwise restrict a non-physician or non-dentist health care provider from participating in the carrier's

health benefits or dental plan based substantially on the fact that the health care provider is not a physician or dentist, unless that exclusion, limitation or restriction is otherwise permitted by law;

(4) prohibit or restrict activity by physicians or dentists that is sanctioned under federal or State law or subject such activity to the requirements of this act;

(5) affect governmental approval of, or otherwise restrict activity by, physicians or dentists that is not prohibited under federal antitrust law; or

(6) require approval of physician or dentist contract terms to the extent that the terms are exempt from State regulation under ERISA.

The substitute provides that its provisions shall not apply to a health benefits or dental plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for Medicaid, NJ KidCare or NJ FamilyCare.

The substitute requires the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, to report to the Governor and the Legislature no later than four years after its effective date on its implementation, and to include in that report an assessment of the impact that the substitute has had on health insurance premiums in the State. The report shall also include the Attorney General's recommendations as to whether the provisions of the substitute shall be expanded to include other types of health care professionals and facilities.

The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, is further directed to report to the Governor and the Legislature no later than five years after the effective date of the substitute with his recommendation as to whether the provisions of the substitute shall be made permanent.

The substitute, which takes effect 90 days after enactment, is to expire six years after the effective date; however, it stipulates that its expiration shall not impair any contract negotiated pursuant to the substitute that is in effect on the date of expiration.

This substitute is identical to the Assembly Committee Substitute for Assembly Bill Nos. 2169, 2241 and 464 (Asselta/Doria/Chatzidakis/Conaway/Conners), which the committee also reported without recommendation on this date.

ASSEMBLY, No. 2169

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MARCH 2, 2000

Sponsored by:
Assemblyman LARRY CHATZIDAKIS
District 8 (Atlantic, Burlington and Camden)

SYNOPSIS

Allows physicians to jointly negotiate with health benefits plans over contractual terms and conditions.

CURRENT VERSION OF TEXT

As introduced.

AN ACT providing for certain joint negotiations by physicians with health benefits plans and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization which is authorized to issue health benefits plans in this State.

"Covered person" means a person on whose behalf a carrier which offers a health benefits plan is obligated to pay benefits or provide services pursuant to the plan.

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

"Health benefits plan" means a plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Physician" means a person who is licensed to practice medicine or surgery, including podiatric medicine, by the State Board of Medical Examiners in accordance with the provisions of Title 45 of the Revised Statutes.

"Physicians' representative" means a third party, including a physician engaging in joint negotiations under this act, that is authorized by two or more physicians to negotiate on their behalf with a health benefits plan over the terms and conditions of a contract that affects those physicians.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan in accordance with specific guidelines, for the purpose of determining whether, or to what extent, a health care service that has been provided or is proposed to be provided to a covered person is to be covered under the health benefits plan.

2. Two or more competing physicians who are practicing in the service area of a health benefits plan may meet and communicate in order to jointly negotiate one or more of the following terms or conditions of a contract with the health benefits plan:

a. practices and procedures to assess and improve the delivery of effective, cost-efficient preventive health care services, including, but not limited to, childhood immunizations, prenatal care, and mammograms and other cancer-screening tests or procedures;

b. practices and procedures to encourage early detection and effective, cost-efficient management of diseases and illnesses in children;

c. practices and procedures to assess and improve the delivery of women's medical and health care, including, but not limited to, care for menopause and osteoporosis;

d. clinical criteria for effective, cost-efficient disease management programs, including management programs for diabetes, asthma and cardiovascular disease;

e. practices and procedures to encourage and promote patient education and treatment compliance, including involvement by a parent with a child's health care;

f. practices and procedures to identify, correct and prevent potentially fraudulent activities;

g. practices and procedures for the effective, cost-efficient use of outpatient surgery;

h. clinical practice guidelines and coverage criteria;

i. administrative procedures, including, but not limited to, methods and timing of payment to physicians for services;

j. procedures for resolving disputes between physicians and the health benefits plan;

k. procedures for referring patients;

l. the formulation and application of physician reimbursement methodology;

m. quality assurance activities;

n. utilization management procedures;

o. criteria used by the health benefits plan to select and terminate physicians; or

p. the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit physician rights to jointly petition the federal or State government, as applicable, to change the regulation.

3. Except as provided in section 4 of this act, two or more competing physicians who are practicing in the service area of a health benefits plan shall not meet and communicate in order to jointly negotiate any of the following terms or conditions of a contract with

the health benefits plan:

a. the fee or price for a physician service, including those determined by the application of a reimbursement methodology;

b. the conversion factors in a resource-based relative value scale or similar reimbursement methodology;

c. the amount of a discount on the price of a service provided by a physician; or

d. the dollar amount of capitation or fixed payment for physician services provided to a covered person.

4. a. Notwithstanding the provisions of section 3 of this act to the contrary, two or more competing physicians who are practicing in the service area of a health benefits plan may jointly negotiate any of the terms or conditions of a contract with the health benefits plan that are specified in that section upon a finding by the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, that the health benefits plan has substantial market power in its service area and that any of the terms or conditions pose an actual or potential threat to the quality and availability of patient care among covered persons.

b. The Department of Banking and Insurance, in consultation with the Department of Health and Senior Services, shall have the authority to collect and investigate such information as it reasonably believes is necessary to determine, on an annual basis:

(1) the average number of covered lives per month per county by every health benefits plan in the State; and

(2) the impact of the provisions of this section on average physician fees in the State.

The Department of Banking and Insurance shall provide this information to the Attorney General on an annual basis.

c. The provisions of this subsection shall not apply to a health benefits plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.) or the Children's Health Care Coverage Program under P.L.1997, c.272 (C.30:4I-1 et seq.).

5. The exercise of joint negotiation rights by two or more competing physicians who are practicing in the service area of a health benefits plan pursuant to sections 2 and 4 of this act shall conform to the following criteria:

a. the physicians may communicate with each other concerning any contractual term or condition to be negotiated with the health benefits plan;

b. the physicians may communicate with the physicians'

representative authorized to negotiate on their behalf with the health benefits plan concerning any contractual term or condition;

c. the physicians' representative shall be the sole party authorized to negotiate with the health benefits plan on behalf of the physicians as a group;

d. the physicians may, at the option of each physician, agree to be bound by the terms and conditions negotiated by the physicians' representative; and

e. when communicating or negotiating with a physicians' representative, a health benefits plan may offer different contractual terms or conditions to, or may contract with, individual competing physicians.

6. A person or entity which proposes to act as a physicians' representative shall satisfy the following requirements:

a. Before entering into negotiations with a health benefits plan on behalf of two or more competing physicians over a contractual term or condition, the physicians' representative shall submit to the Attorney General, for his approval pursuant to section 7 of this act, on a form and in a manner prescribed by the Attorney General, a report which identifies:

(1) the representative's name and business address;

(2) the names and business addresses of each physician who will be represented by the identified representative;

(3) the ratio of the physicians requesting joint representation to the total number of physicians who are practicing within the geographic service area of the health benefits plan;

(4) the health benefits plan with which the representative proposes to enter into negotiations on behalf of the identified physicians;

(5) the intended subject matter of the proposed negotiations with the identified health benefits plan;

(6) the representative's plan of operation and procedures to ensure compliance with the provisions of this act;

(7) the anticipated effect of the proposed joint negotiations on the quality and availability of health care among covered persons; and

(8) the anticipated benefits of a contract between the identified physicians and health benefits plan.

The physicians' representative, upon submitting the report, shall pay a fee to the Attorney General in an amount, as determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this act.

b. After the physicians' representative and the health benefits plan identified pursuant to subsection a. of this section have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the physicians' representative shall submit to the Attorney General, for his approval in accordance with the

provisions of section 7 of this act, a copy of the proposed contract between the physicians identified pursuant to subsection a. of this section and the health benefits plan, as well as any plan of action which the physicians' representative and the health benefits plan may formally agree to for the purpose of implementing the terms and conditions of the contract.

c. Within 14 days after a health benefits plan notifies a physicians' representative of its decision to decline or terminate negotiations entered into pursuant to this act, or after the date that a physicians' representative requests that a health benefits plan enter into such negotiations to which request the plan fails to respond, the physicians' representative shall report to the Attorney General that the negotiations have ended, on a form and in a manner to be prescribed by the Attorney General. The physicians' representative may resume negotiations with the health benefits plan no later than 60 days after reporting to the Attorney General that the negotiations have ended, on the basis of the report submitted to the Attorney General pursuant to subsection a. of this section and approved by the Attorney General in accordance with the provisions of section 7 of this act. After that date, the physicians' representative shall be required to submit a new report and pay an additional fee to the Attorney General pursuant to subsection a. of this section, in order to engage in negotiations with the health benefits plan under this act.

7. a. The Attorney General shall provide written approval or disapproval of a report or a proposed contract furnished by a physicians' representative pursuant to section 6 of this act no later than 30 days after receipt of the report or proposed contract, as applicable. If the Attorney General fails to provide written approval or disapproval within this time period, the physicians' representative may petition a court of competent jurisdiction for an order to require the Attorney General to take such action. If the Attorney General disapproves the report or the proposed contract, he shall forward a written explanation of any deficiencies therein to the physicians' representative along with a statement of the specific remedial measures by which those deficiencies may be corrected. A physicians' representative shall not engage in negotiations with a health benefits plan over any contractual term or condition unless the report furnished by the physicians' representative has been approved in writing by the Attorney General, nor shall a proposed contract between two or more competing physicians and a health benefits plan be implemented unless the Attorney General has approved the contract.

b. The Attorney General shall approve a report or a proposed contract furnished by a physicians' representative pursuant to section 6 of this act if the Attorney General determines that the report or proposed contract demonstrates that the benefits which are likely to

result from the proposed joint negotiations over a contractual term or condition or the proposed contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician distribution by specialty and its effect on competition in the geographic service area of the health benefits plan. The Attorney General shall not approve a report furnished by a physicians' representative pursuant to section 6 of this act if the physicians' representative proposes to engage in negotiations with a health benefits plan on behalf of more than 10% of the total number of physicians practicing in the geographic service area of the health benefits plan, unless the Attorney General determines, consistent with the provisions of this act, that conditions relating to the quality and availability of health care among covered persons in the geographic service area of the health benefits plan support the inclusion of a higher percentage of practicing physicians in those joint negotiations.

c. The Attorney General's written approval of a report which is furnished by a physicians' representative under section 6 of this act shall be effective for all subsequent negotiations between the physicians' representative and the identified health benefits plan, subject to the provisions of subsection c. of section 6 of this act.

8. a. The provisions of this act shall not be construed to permit two or more physicians to:

(1) jointly engage in a coordinated cessation, reduction or limitation of the health care services which they provide;

(2) meet or communicate in order to jointly negotiate a requirement that at least one of the physicians, as a condition of participating in a health benefits plan, be allowed to participate in all of the products offered by the health benefits plan; or

(3) jointly negotiate with a health benefits plan to exclude, limit or otherwise restrict a non-physician health care provider from participating in a health benefits plan based substantially on the fact that the health care provider is not a physician, unless that exclusion, limitation or restriction is otherwise permitted by law.

b. Prior to entering into negotiations with a health benefits plan on behalf of two or more competing physicians over a contractual term or condition, a physicians' representative shall notify the physicians in writing of the provisions of this section and advise them as to their potential legal liability if they engage in a joint action that is not authorized under this act.

9. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1

et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

10. This act shall take effect 90 days after enactment, except that the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance as shall be necessary to implement the act.

STATEMENT

The purpose of this bill is to provide physicians with the right to engage in joint negotiations over the terms and conditions of their contracts with health benefits plans. The bill is modeled generally after legislation which was enacted into law in Texas (Senate Bill No. 1468, on June 20, 1999).

A "physician" is defined in the bill as a person licensed to practice medicine or surgery, including podiatric medicine, by the State Board of Medical Examiners.

The bill permits physicians who are practicing in the geographic service area of a health benefits plan to jointly negotiate with the plan, through a physicians' representative who is approved by the Attorney General to act on their behalf, over the terms and conditions of a proposed contract, which, if agreed to by the parties to the negotiation, must be approved by the Attorney General before being implemented. These terms and conditions include:

- practices and procedures to assess and improve the delivery of effective, cost-efficient preventive health care services;
- practices and procedures to encourage early detection and effective, cost-efficient management of diseases and illnesses in children;
- practices and procedures to assess and improve the delivery of women's medical and health care;
- clinical criteria for effective, cost-efficient disease management programs;
- practices and procedures to encourage and promote patient education and treatment compliance;
- practices and procedures to identify, correct and prevent potentially fraudulent activities;
- practices and procedures for the effective, cost-efficient use of outpatient surgery;
- clinical practice guidelines and coverage criteria;
- administrative procedures, including, but not limited to, methods and timing of payment to physicians for services;
- procedures for resolving disputes between physicians and the plan;
- patient referral procedures;

- the formulation and application of physician reimbursement methodology;
- quality assurance activities;
- utilization management procedures;
- physician selection and termination criteria used by the plan; and
- the inclusion or alteration of a contractual term or condition with the plan, except when the inclusion or alteration is required by a federal or State regulation regarding that term or condition.

In addition, the bill provides that the following terms and conditions of a proposed contract may be subject to such joint negotiations if the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, finds that the health benefits plan has substantial market power within its service area and that any of the terms or conditions pose an actual or potential threat to the quality and availability of health care among covered persons:

- the fee or price for a service provided by a physician, including those determined by the application of a reimbursement methodology;
- the conversion factors in a resource-based relative value scale or similar reimbursement methodology;
- the amount of a discount on the price of a physician service; and
- the dollar amount of capitation or fixed payment for physician services provided to a covered person.

The bill stipulates that a physicians' representative shall not enter into negotiations with a health benefits plan on behalf of more than 10% of the total number of physicians practicing in the geographic service area of the health benefits plan, unless the Attorney General determines, consistent with the provisions of this bill, that conditions relating to the quality and availability of health care among covered persons in the geographic service area of the plan support the inclusion of a higher percentage of practicing physicians in those joint negotiations.

Also, the bill explicitly prohibits physicians from:

- jointly engaging in a coordinated cessation, reduction or limitation of health care services;
- meeting or communicating in order to jointly negotiate a requirement that at least one of the physicians, as a condition of participating in a health benefits plan, be allowed to participate in all of the products offered by the health benefits plan; or
- jointly negotiating with a health benefits plan to exclude, limit or otherwise restrict a non-physician health care provider from participating in a health benefits plan based substantially on the fact that the health care provider is not a physician, unless that exclusion, limitation or restriction is otherwise permitted by law.

ASSEMBLY, No. 2241

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MARCH 20, 2000

Sponsored by:
Assemblyman NICHOLAS ASSELTA
District 1 (Cape May, Atlantic and Cumberland)
Assemblyman JOSEPH V. DORIA, JR.
District 31 (Hudson)

Co-Sponsored by:
Assemblymen Conaway, LeFevre, Gusciora and Assemblywoman Gill

SYNOPSIS

"Health Care Provider Joint Negotiation Act."

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 6/15/2001)

AN ACT authorizing health care providers to enter into joint negotiations with health insurance carriers and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. This act shall be known and may be cited as the "Health Care Provider Joint Negotiation Act."

2. The Legislature finds and declares that:

a. Active, robust and fully competitive markets for health care services provide the best opportunity for the residents of this State to receive high-quality health care services at an appropriate cost;

b. A substantial amount of health care services in this State is purchased for the benefit of patients by health insurance carriers engaged in the financing of health care services or is otherwise delivered subject to the terms of agreements between carriers and health care providers;

c. Health insurance carriers are able to control the flow of patients to health care providers through compelling financial incentives for patients in their health benefits plans to utilize only the services of providers with whom the carriers have contracted;

d. Carriers also control the health care services rendered to patients through utilization management and other managed care tools and associated coverage and payment policies;

e. The power of health insurance carriers in the markets of this State for health care services has become great enough to create a competitive imbalance, reducing levels of competition and threatening the availability of high-quality, cost-effective health care;

f. In many areas of this State, the health care insurance market is dominated by one or two health insurance carriers, with some carriers controlling over 50% of an area's market;

g. Carriers are often able to virtually dictate the terms of the contracts that they offer physicians and other health care providers and commonly offer these contracts on a take-it-or-leave-it basis;

h. The power of carriers to unilaterally impose provider contract terms jeopardizes the ability of physicians and other health care providers to deliver the superior quality health care services traditionally available in this State;

i. Physicians and other health care providers do not have sufficient market power to reject unfair provider contract terms offered by carriers that impede their ability to deliver medically appropriate care without undue delay or difficulties;

j. Inadequate reimbursement and other unfair payment terms offered by carriers adversely affect the quality of patient care and access to

care by reducing the resources that health care providers can devote to patient care and decreasing the time that providers are able to spend with their patients;

k. Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical progress by diverting capital needed for reinvestment in the health care delivery system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and expansion of medical services, all to the detriment of the residents of this State;

l. The inevitable collateral reduction and migration of the health care work force will also have negative consequences for the economy of this State;

m. Empowering independent health care providers to jointly negotiate with health insurance carriers as provided in this act will help restore the competitive balance and improve competition in the markets for health care services in this State, thereby providing benefits for consumers, health care providers and less dominant carriers;

n. This act is necessary and proper, and constitutes an appropriate exercise of the authority of this State to regulate the business of insurance and the delivery of health care services;

o. The pro-competitive and other benefits of the joint negotiations and related joint activity authorized by this act, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical progress, and improving communications, outweigh any potential anti-competitive effects of this act; and

p. It is the intention of the Legislature to authorize independent health care providers to jointly negotiate with health insurance carriers and to qualify such joint negotiations and related joint activities for the State-action exemption to the federal antitrust laws through the articulated State policy and active supervision provided under this act.

3. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Carrier affiliate" means a carrier that is affiliated with another entity by either the carrier or entity having a 5% or greater, direct or indirect, ownership or investment interest in the other through equity or debt, or by other means.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier offering

the plan is obligated to pay benefits or provide services pursuant to the health benefits plan.

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

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier, except in the case of a self-funded health benefits plan. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan, and includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes, and medical equipment suppliers.

"Health care service" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, injury, disease or illness, including, but not limited to: the professional and technical component of professional services; supplies, drugs and biologicals; diagnostic x-rays, laboratory and other diagnostic tests; preventive screening services and tests, including pap smears and mammograms; x-ray, radium and radioactive isotope therapy; surgical dressings; devices for the reduction of fractures; durable medical equipment; braces; trusses; artificial limbs and eyes; dialysis services; home health services; and hospital and other health care facility services.

"Health maintenance organization" means a health maintenance organization operating pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.).

"Joint negotiation" means negotiation with a carrier by two or more independent health care providers acting together as part of a formal group or other entity.

"Joint negotiation representative" means a representative selected by two or more independent health care providers to engage in joint negotiations with a carrier on their behalf.

"Point-of-service plan" means a health benefits plan that allows a covered person to receive covered services from out-of-network

health care providers but may require that a subscriber pay a higher deductible or copayment and higher premium for the plan.

"Preferred provider organization" means a health benefits plan other than a health maintenance organization or a point-of-service plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with members of the provider network and financial incentives for covered persons to use those health care providers.

"Provider contract" means an agreement between a health care provider and a carrier setting forth the terms and conditions under which the provider is to deliver health care services to covered persons of the carrier. This term does not include employment contracts between a carrier and a health care professional.

"Provider network" means a group of health care providers who have provider contracts with a carrier.

"Self-funded health benefits plan" means a health benefits plan that provides for the assumption of the cost, or spreads the risk of loss, resulting from health care services provided to covered persons by an employer, union or other sponsor, substantially out of the current revenues, assets or other funds of the sponsor.

"Subscriber" means, in the case of a group contract, a person whose employment or other status, except family status, is the basis for eligibility for enrollment by the carrier or, in the case of an individual contract, the person in whose name the contract is issued.

"Third party administrator" means an entity that provides utilization management, provider network credentialing or other administrative services for a carrier or a self-funded health benefits plan.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

4. Independent health care providers may jointly negotiate with a carrier and engage in related joint activity, as provided in sections 7 and 8 of this act, regarding non-fee-related matters which may affect patient care, including, but not limited to any of the following:

a. the definition of medical necessity and other conditions of coverage;

b. utilization management criteria and procedures;

c. clinical practice guidelines;

d. preventive care and other medical management policies;

e. patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

f. drug formularies and standards and procedures for prescribing off-formulary drugs;

g. quality assurance programs;

h. respective health care provider and carrier liability for the treatment or lack of treatment of covered persons;

i. the methods and timing of payments, including, but not limited to, interest and penalties for late payments;

j. other administrative procedures, including, but not limited to, covered persons eligibility verification systems and claim documentation requirements;

k. credentialing standards and procedures for the selection, retention and termination of participating health care providers;

l. mechanisms for resolving disputes between the carrier and health care providers, including, but not limited to, the appeals process for utilization management and credentialing determinations; or

m. the health benefits plans sold or administered by the carrier in which the health care providers are required to participate.

5. a. When a carrier has substantial market power over independent health care providers, the providers may jointly negotiate with the carrier and engage in related joint activity, as provided in sections 7 and 8 of this act regarding fees and fee-related matters, including, but not limited to, any of the following:

(1) the amount of payment or the methodology for determining the payment for a health care service;

(2) the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care services;

(3) the amount of any discount on the price of a health care service;

(4) the procedure code or other description of a health care service covered by a payment;

(5) the amount of a bonus related to the provision of health care services or a withholding from the payment due for a health care service; or

(6) the amount of any other component of the reimbursement methodology for a health care service.

b. A carrier has substantial market power over health care providers when:

(1) the carrier's market share in the comprehensive health care insurance market or a relevant segment of that market, alone or in combination with the market shares of one or more carrier affiliates, exceeds either 15% of the total number of covered persons in the geographic service area of the providers seeking to jointly negotiate

or 25,000 covered persons, whichever is less; or

(2) the Attorney General determines that the market power of the carrier in the relevant product and geographic markets for the services of the providers seeking to jointly negotiate significantly exceeds the countervailing market power of the providers acting individually.

c. As used in this act:

(1) "Comprehensive health care insurance market" includes all health benefits plans which provide comprehensive coverage, alone or in combination with other plans sold together as a package, including, but not limited to, indemnity, health maintenance organization, preferred provider organization and point-of-service plans, and including self-funded health benefits plans which provide comprehensive coverage; and

(2) "Relevant market segments in the comprehensive health care insurance market" includes the following:

(a) carrier health benefits plans and self-funded health benefits plans;

(b) within the carrier product category, private health insurance, Medicare health maintenance organization contracts and preferred provider organization and point-of-service plans and Medicaid health maintenance organization contracts;

(c) within the private health insurance category, indemnity, health maintenance organization, preferred provider organization and point-of-service plans; and

(d) such other segments as the Attorney General determines are appropriate for purposes of determining whether a carrier has substantial market power.

d. (1) By March 31 of each year, the Commissioner of Banking and Insurance shall calculate the number of covered persons of each carrier and its affiliates in the comprehensive health care insurance market and in each relevant market segment for each county. The commissioner shall make these calculations by averaging quarterly data from the preceding year unless the commissioner determines that it would be more appropriate to use other data and information. The commissioner may recalculate the number of covered persons earlier than the required annual recalculation when the commissioner deems it appropriate to do so.

(2) Recipients of benefits under Medicare, Medicaid or other governmental programs shall not be counted as covered persons in the health care insurance market unless they receive their governmental program coverage through a health maintenance organization or another carrier health benefits plan.

(3) When calculating the market power of a carrier or carrier affiliate that has third party administrator products, the covered lives of the carriers and self-funded health benefits plans for whom the carrier or carrier affiliate provides administrative services shall be

treated as the covered persons of the carrier or carrier affiliate.

(4) The commissioner's calculation of covered persons shall be used for purposes of determining the market power of carriers in the comprehensive health care insurance market from the date of the determination until the next annual determination or until the commissioner recalculates the determination, whichever is earlier.

(5) In cases where the relevant geographic market is multiple counties, the commissioner's calculations for those counties shall be aggregated when counting the covered persons of the carrier whose market power is being evaluated.

(6) The commissioner shall collect and investigate information necessary to calculate the covered persons of carriers and their affiliates.

6. The following requirements shall apply to the exercise of joint negotiation rights and related activity under this act:

a. Health care providers shall select the members of their joint negotiation group by mutual agreement.

b. Health care providers shall designate a joint negotiation representative as the sole party authorized to negotiate with the carrier on behalf of the health care providers as a group.

c. Health care providers may communicate with each other and their joint negotiation representative with respect to the matters to be negotiated with the carrier.

d. Health care providers may agree upon a proposal to be presented by their joint negotiation representative to the carrier.

e. Health care providers may agree to be bound by the terms and conditions negotiated by their joint negotiation representative.

f. The health care providers' joint negotiation representative may provide the health care providers with the results of negotiations with the carrier and an evaluation of any offer made by the carrier.

g. The health care providers' joint negotiation representative may reject a contract proposal by a carrier on behalf of the health care providers as long as the health care providers remain free to individually contract with the carrier.

h. The health care providers' joint negotiation representative shall advise the health care providers of the provisions of this act and shall inform the health care providers of the potential for legal action against health care providers who violate federal antitrust law.

i. Health care providers may not negotiate the inclusion or alteration of terms and conditions to the extent the terms or conditions are required or prohibited by federal or State statute or regulation. This subsection shall not be construed to limit the right of health care providers to jointly petition federal or State government for a change in the statute or regulation.

7. a. Before engaging in any joint negotiation with a carrier, health care providers shall obtain the Attorney General's approval to proceed with the negotiations by submitting to the Attorney General a petition seeking approval, which shall include:

(1) the name and business address of the health care providers' joint negotiation representative;

(2) the names and business addresses of the health care providers petitioning to jointly negotiate;

(3) the name and business address of any carrier with which the petitioning providers seek to jointly negotiate;

(4) the proposed subject matter of the negotiations or discussions with the carrier;

(5) the proportionate relationship of the health care providers to the total population of health care providers in the relevant geographic service area of the providers, by providers, provider type and specialty;

(6) in the case of a petition seeking approval of joint negotiations regarding one or more fee or fee-related terms, a statement of the reasons why the carrier has substantial market power over the health care providers;

(7) a statement of the pro-competitive and other benefits of the proposed negotiations;

(8) the health care provider's joint negotiation representative's plan of operation and procedures to ensure compliance with this act; and

(9) such other data, information and documents as the petitioners desire to submit in support of their petition.

b. The health care providers shall supplement a petition submitted under subsection a. of this section as new information becomes available that indicates that the subject matter of the proposed negotiations with the carrier has or will materially change and shall obtain the Attorney General's approval of material changes. The petition seeking approval shall include:

(1) the Attorney General's file reference for the original petition for approval of joint negotiations;

(2) the proposed new subject matter;

(3) the information required by paragraphs (6) and (7) of subsection a. of this section with respect to the proposed new subject matter; and

(4) such other data, information and documents as the petitioners desire to submit in support of their petition.

c. No provider contract terms negotiated under this act shall be effective until the terms are approved by the Attorney General. The petition seeking approval shall be jointly submitted to the Attorney General by the health care providers and the carrier who are parties to the contract. The petition shall include:

(1) the Attorney General's file reference for the original petition for

approval of joint negotiations;

(2) the negotiated provider contract terms;

(3) a statement of the pro-competitive and other benefits of the negotiated provider contract terms; and

(4) such other data, information and documents as the petitioners desire to submit in support of their petition.

d. Joint negotiations approved under this act may continue until the carrier notifies the joint negotiation representative for the health care providers that it declines to negotiate or is terminating negotiations. If the carrier notifies the joint negotiation representative for the health care providers that it desires to resume negotiations within 60 days of the end of prior negotiations, the health care providers may renew the previously approved negotiations without obtaining a separate approval of the renewal from the Attorney General.

8. a. The Attorney General shall either approve or disapprove a petition under section 7 of this act within 30 days after the filing. If disapproved, the Attorney General shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies may be corrected.

b. (1) The Attorney General shall approve a petition under subsections a. and b. of section 7 of this act if:

(i) the pro-competitive and other benefits of the joint negotiations outweigh any anti-competitive effects; and

(ii) in the case of a petition seeking approval to jointly negotiate one or more fee or fee-related terms, the carrier has substantial market power over the health care providers.

(2) The Attorney General shall approve a petition under subsection c. of section 7 of this act if:

(i) the pro-competitive and other benefits of the contract terms outweigh any anti-competitive effects; and

(ii) the contract terms are consistent with other applicable statutes and regulations.

(3) The pro-competitive and other benefits of joint negotiations or negotiated provider contract terms may include, but shall not be limited to:

(i) restoration of the competitive balance in the market for health care services;

(ii) protections for access to quality patient care;

(iii) promotion of the health care infrastructure and medical advancement; and

(iv) improved communications between health care providers and carriers.

(4) When weighing the anti-competitive effects of provider contract terms, the Attorney General may consider whether the terms:

(i) provide for excessive payments; or

(ii) contribute to the escalation of the cost of providing health care services.

c. For the purpose of enabling the Attorney General to make the findings and determinations required by this section, the Attorney General may require the submission of such supplemental information as the Attorney General deems necessary for that purpose.

9. a. In the case of a petition under subsections a. or b. of section 7 of this act, the Attorney General shall notify the carrier of the petition and provide the carrier with the opportunity to submit written comments within a specified time frame that does not extend beyond the date by which the Attorney General is required to act on the petition.

b. (1) Except as provided in subsection a. of this section, the Attorney General shall not be required to provide public notice of a petition under subsections a., b. or c. of section 7 of this act in order to hold a public hearing on the petition or to otherwise accept public comment on the petition.

(2) The Attorney General may, at his discretion, publish notice of a petition for approval of provider contract terms in the New Jersey Register and receive written comment from interested persons, so long as the opportunity for public comment does not prevent the Attorney General from acting on the petition within the time period set forth in this act.

10. a. Within 30 days from the mailing by the Attorney General of a notice of disapproval of a petition under section 7 of this act, the petitioners may make a written application to the Attorney General for a hearing.

b. Upon receipt of a timely written application for a hearing, the Attorney General shall schedule and conduct a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The hearing shall be held within 30 days of the application unless the petitioner seeks an extension.

c. If the Attorney General does not issue a written approval or disapproval of a petition under section 7 of this act within the required time period, the parties to the petition shall have the right to petition the court for a mandamus order requiring the Attorney General to approve or disapprove the petition.

d. The sole parties with respect to any petition under section 7 of this act shall be the petitioners and the Attorney General. Notwithstanding any other provision of law to the contrary, the Attorney General shall not be required to treat any other person as a party and no other person shall be entitled to appeal the Attorney General's determination.

11. a. All information and documents and copies thereof obtained by or disclosed to the Attorney General or any other person in a petition under section 7 of this act, or pursuant to a request for supplemental information under subsection c. of section 8 of this act, shall be treated confidentially, shall not be subject to subpoena and shall not be made public or otherwise disclosed by the Attorney General or any other person without the written consent of the petitioners to whom the information pertains, except as provided in subsection b. of this section.

b. (1) In the case of a petition under subsections a. or b. of section 7 of this act, the Attorney General may disclose the information required to be submitted pursuant to paragraphs (1) through (4) of subsection a. and paragraphs (1) and (2) of subsection b. of section 7 of this act.

(2) The Attorney General may disclose provider contracts negotiated under this act provided that the Attorney General removes or redacts those provider contract provisions that contain payment rates and fees. The Attorney General may disclose payment rates and fees to the commissioner, the insurance department of another state, a law enforcement official of this State or any other state or agency of the federal government, so long as the agency or office receiving the information agrees in writing to treat the information confidentially and in a matter consistent with this act.

12. A carrier shall negotiate in good faith with health care providers regarding the terms of provider contracts pursuant to this act.

13. Nothing contained in this act shall be construed to:

a. prohibit or restrict activity by health care providers that is sanctioned under federal or State law;

b. affect governmental approval of, or otherwise restrict activity by, health care providers that is not prohibited under federal antitrust law;

c. require approval of provider contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974," Pub. L. 93-406 (29 U.S.C. s.1144(a)); or

d. expand a health care provider's scope of practice or require a carrier to contract with any type or specialty of health care provider.

14. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

15. This act shall take effect on the 60th day after enactment; however, the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance as is necessary to implement the act.

STATEMENT

This bill, which is designated the "Health Care Provider Joint Negotiation Act," would permit independent physicians and other health care providers to engage in joint negotiations over the terms and conditions of their contracts with health insurance carriers. The bill is generally modeled after Pennsylvania Senate Bill No. 1052 of 1999.

Specifically, the bill provides that independent health care providers may jointly negotiate with a carrier and engage in related joint activity, as provided in the bill, regarding non-fee-related matters which may affect patient care, including, but not limited to any of the following:

-- the definition of medical necessity and other conditions of coverage;

-- utilization management criteria and procedures;

-- clinical practice guidelines;

-- preventive care and other medical management policies;

-- patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

-- drug formularies and standards and procedures for prescribing off-formulary drugs;

-- quality assurance programs;

-- respective health care provider and carrier liability for the treatment or lack of treatment of covered persons;

-- the methods and timing of payments, including, but not limited to, interest and penalties for late payments;

-- other administrative procedures, including, but not limited to, covered persons eligibility verification systems and claim documentation requirements;

-- credentialing standards and procedures for the selection, retention and termination of participating health care providers;

-- mechanisms for resolving disputes between the carrier and health care providers, including, but not limited to, the appeals process for utilization management and credentialing determinations; or

-- the health benefits plans sold or administered by the carrier in which the health care providers are required to participate.

The bill further provides that when a carrier has substantial market power over independent health care providers, the providers may jointly negotiate with the carrier and engage in related joint activity as

provided in the bill regarding fees and fee-related matters, including, but not limited to, any of the following:

-- the amount of payment or the methodology for determining the payment for a health care service;

-- the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care services;

-- the amount of any discount on the price of a health care service;

-- the procedure code or other description of a health care service covered by a payment;

-- the amount of a bonus related to the provision of health care services or a withholding from the payment due for a health care service; or

-- the amount of any other component of the reimbursement methodology for a health care service.

The bill provides for the following requirements in regard to the exercise of joint negotiation rights and related activity:

-- Health care providers shall select the members of their joint negotiation group by mutual agreement;

-- Health care providers shall designate a joint negotiation representative as the sole party authorized to negotiate with the carrier on behalf of the health care providers as a group;

-- Health care providers may communicate with each other and their joint negotiation representative with respect to the matters to be negotiated with the carrier;

-- Health care providers may agree upon a proposal to be presented by their joint negotiation representative to the carrier;

-- Health care providers may agree to be bound by the terms and conditions negotiated by their joint negotiation representative;

-- The health care providers' joint negotiation representative may provide the health care providers with the results of negotiations with the carrier and an evaluation of any offer made by the carrier;

-- The health care providers' joint negotiation representative may reject a contract proposal by a carrier on behalf of the health care providers as long as the health care providers remain free to individually contract with the carrier;

-- The health care providers' joint negotiation representative shall advise the health care providers of the provisions of this bill and shall inform the health care providers of the potential for legal action against health care providers who violate federal antitrust law; and

-- Health care providers may not negotiate the inclusion or alteration of terms and conditions to the extent the terms or conditions are required or prohibited by federal or State statute or regulation; however, this provision shall not be construed to limit the right of health care providers to jointly petition federal or State government for a change in the statute or regulation.

From a procedural standpoint, the bill provides that:

-- before engaging in any joint negotiation with a carrier, health care providers shall obtain the Attorney General's approval to proceed with the negotiations by submitting to the Attorney General a petition seeking approval, which includes the information specified in the bill;

-- no provider contract terms negotiated under the bill shall be effective until the terms are approved by the Attorney General, and the petition seeking approval shall be jointly submitted to the Attorney General by the health care providers and the carrier who are parties to the contract;

-- the Attorney General shall approve or disapprove a petition filed pursuant to the bill within 30 days after its filing; and, if disapproved, the Attorney General shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies may be corrected; and

-- the Attorney General shall approve a petition to allow joint negotiations if the pro-competitive and other benefits of the joint negotiations outweigh any anti-competitive effects; and, in the case of a petition seeking approval to jointly negotiate one or more fee or fee-related terms, the carrier has substantial market power over the health care providers as determined by the Attorney General in a manner specified in the bill; and

-- the Attorney General shall approve a petition to implement provider contract terms negotiated under the bill if the pro-competitive and other benefits of the contract terms outweigh any anti-competitive effects, and the contract terms are consistent with other applicable statutes and regulations, as determined by the Attorney General according to criteria set forth in the bill.

The bill requires that a carrier negotiate in good faith with health care providers regarding the terms of provider contracts pursuant to this bill.

Nothing contained in this bill shall be construed to:

-- prohibit or restrict activity by health care providers that is sanctioned under federal or State law;

-- prohibit or require governmental approval of, or otherwise restrict activity by, health care providers that is not prohibited under federal antitrust law;

-- require approval of provider contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974;" or

-- expand a health care provider's scope of practice or require a carrier to contract with any type or specialty of health care provider.

ASSEMBLY, No. 464

STATE OF NEW JERSEY

209th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

Sponsored by:
Assemblyman HERBERT CONAWAY, JR.
District 7 (Burlington and Camden)
Assemblyman JACK CONNERS
District 7 (Burlington and Camden)

Co-Sponsored by:
Assemblywoman Weinberg

SYNOPSIS

Permits joint negotiations by physicians with health benefits plans over terms and conditions of their contracts.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

(Sponsorship Updated As Of: 9/22/2000)

AN ACT permitting joint negotiations by physicians with health benefits plans over contractual terms and conditions and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that:

a. Joint negotiation by competing physicians of certain terms and conditions of contracts with health benefits plans will result in procompetitive effects in the absence of any express or implied threat of retaliatory joint action, such as a boycott or strike, by physicians;

b. Although joint negotiations over fee-related terms may, in some circumstances, yield anticompetitive effects, there are instances in which health benefits plans dominate the market to such an extent that fair negotiations between physicians and a health benefits plan are unobtainable absent any joint action on behalf of physicians; and, in these instances, health benefits plans are able to virtually dictate the terms of the contracts that they offer to physicians; and

c. It is, therefore, necessary and appropriate to authorize joint negotiations by physicians on fee-related and other issues to address this imbalance between physicians and health benefits plans.

2. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

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

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

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Physician" means a person licensed to practice medicine or surgery, including podiatric medicine, by the State Board of Medical Examiners pursuant to Title 45 of the Revised Statutes.

"Physicians' representative" means a third party, including a physician who engages in joint negotiations pursuant to this act, which is authorized by two or more physicians to negotiate on their behalf with a health benefits plan over contractual terms and conditions affecting those physicians.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

3. Two or more competing physicians within the service area of a health benefits plan may meet and communicate for the purpose of jointly negotiating one or more of the following terms or conditions of a contract with the health benefits plan:

a. practices and procedures to assess and improve the delivery of effective, cost-efficient preventive health care services, including childhood immunizations, prenatal care, and mammograms and other cancer-screening tests or procedures;

b. practices and procedures to encourage early detection and effective, cost-efficient management of diseases and illnesses in children;

c. practices and procedures to assess and improve the delivery of women's medical and health care, including care for menopause and osteoporosis;

d. clinical criteria for effective, cost-efficient disease management programs, including management programs for diabetes, asthma and cardiovascular disease;

e. practices and procedures to encourage and promote patient education and treatment compliance, including parental involvement with a child's health care;

f. practices and procedures to identify, correct and prevent potentially fraudulent activities;

g. practices and procedures for the effective, cost-efficient use of outpatient surgery;

h. clinical practice guidelines and coverage criteria;

i. administrative procedures, including methods and timing of payment to physicians for services;

j. procedures for resolving disputes between physicians and the health benefits plan;

k. patient referral procedures;

l. the formulation and application of physician reimbursement methodology;

m. quality assurance activities;

n. utilization management procedures;

o. physician selection and termination criteria used by the health benefits plan; or

p. the inclusion or alteration of any term or condition of a contract with the health benefits plan, except when the inclusion or alteration is required by a federal or State regulation regarding the term or condition in question; however, that restriction shall not limit physician rights to jointly petition the federal or State government, as applicable, for a change in the regulation.

4. Except as provided in section 5 of this act, two or more competing physicians within the service area of a health benefits plan shall not meet and communicate for the purpose of jointly negotiating any of the following terms or conditions of a contract with the health benefits plan:

a. the fee or price for a service provided by a physician, including those determined by the application of any reimbursement methodology;

b. the conversion factors in a resource-based relative value scale or similar reimbursement methodology;

c. the amount of any discount on the price of a service to be provided by a physician; or

d. the dollar amount of capitation or fixed payment for services provided by a physician to a covered person.

5. a. Two or more competing physicians within the service area of a health benefits plan may jointly negotiate any of the terms or conditions of a contract with the health benefits plan that are specified in section 4 of this act upon a finding by the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, that the health benefits plan has substantial market power within its service area and that any of those terms or conditions have already had, or threaten to have, an adverse effect on the quality and availability of patient care among covered persons.

b. The Department of Banking and Insurance, in consultation with the Department of Health and Senior Services, shall have the authority to collect and investigate such information as is necessary to determine, on an annual basis:

(1) the average number of covered lives per month per county by every health benefits plan in the State; and

(2) the impact of the provisions of this section on average physician fees in the State.

The Department of Banking and Insurance shall provide this information to the Attorney General on an annual basis.

c. The provisions of this subsection shall not apply to a health benefits plan which the Commissioner of Human Services certifies to the Attorney General as providing covered services exclusively or primarily to persons eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) or the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.).

6. The exercise of joint negotiation rights by two or more competing physicians within the service area of a health benefits plan pursuant to sections 3 and 5 of this act shall conform to the following criteria:

a. the physicians may communicate with each other with respect to any contractual term or condition to be negotiated with the health benefits plan;

b. the physicians may communicate with the physicians' representative authorized to negotiate on their behalf with the health benefits plan over any contractual term or condition;

c. the physicians' representative is the sole party authorized to negotiate with the health benefits plan on behalf of the physicians as a group;

d. at the option of each physician, the physicians may agree to be bound by the terms and conditions negotiated by the physicians' representative; and

e. a health benefits plan communicating or negotiating with a physicians' representative may offer different contractual terms or conditions to, or may contract with, individual competing physicians.

7. A person or entity proposing to act as a physicians' representative shall comply with the following requirements:

a. Before entering into negotiations with a health benefits plan on behalf of two or more competing physicians over any contractual term or condition, the physicians' representative shall submit to the Attorney General, for his approval in accordance with the provisions of section 8 of this act, on a form and in a manner prescribed by the Attorney General, a report which identifies:

(1) the representative's name and business address;

(2) the names and business addresses of the physicians who will be represented by the identified representative;

(3) the ratio of the physicians requesting joint representation to the total number of physicians practicing in the geographic service area of the health benefits plan;

(4) the health benefits plan with which the representative intends to negotiate on behalf of the identified physicians;

(5) the proposed subject matter of the negotiations with the identified health benefits plan;

(6) the representative's plan of operation and procedures to ensure compliance with the provisions of this act;

(7) the expected impact of the proposed joint negotiations on the quality and availability of patient care among covered persons; and

(8) the expected benefits of a contract between the identified physicians and health benefits plan.

The report shall be accompanied by a fee to be paid by the physicians' representative to the Attorney General in an amount, as determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this act.

b. After the physicians' representative and health benefits plan identified pursuant to subsection a. of this section have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the physicians' representative shall submit to the Attorney General, for his approval in accordance with the provisions of section 8 of this act, a copy of the proposed contract between the physicians identified pursuant to subsection a. of this section and the health benefits plan, as well as any plan of action which may be formally agreed to by the physicians' representative and health benefits plan to implement the terms and conditions of the contract.

c. No later than the 14th day after a health benefits plan notifies a physicians' representative of its decision to decline or terminate negotiations entered into in accordance with the provisions of this act, or after the date that a physicians' representative requests that a health benefits plan enter into such negotiations to which request the plan fails to respond, the physicians' representative shall report to the Attorney General that the negotiations have ended, on a form and in a manner prescribed by the Attorney General. The physicians' representative may resume negotiations with the health benefits plan no later than the 60th day after reporting to the Attorney General that the negotiations have ended, on the basis of the report submitted to the Attorney General pursuant to subsection a. of this section and approved by the Attorney General in accordance with the provisions of section 8 of this act. After that date, the physicians' representative shall be required to submit a new report and pay an additional fee to the Attorney General in accordance with the provisions of subsection a. of this section, in order to engage in negotiations with the health benefits plan pursuant to this act.

8. a. The Attorney General shall provide written approval or disapproval of a report or proposed contract furnished by a physicians'

representative pursuant to section 7 of this act no later than the 30th day after receipt thereof. If the Attorney General fails to provide written approval or disapproval within this time period, the physicians' representative may petition a court of competent jurisdiction for an order requiring the Attorney General to take such action. If the Attorney General disapproves the report or proposed contract, he shall furnish a written explanation of any deficiencies therein to the physicians' representative along with a statement of specific remedial measures by which the deficiencies may be corrected. A physicians' representative shall not enter into negotiations with a health benefits plan over any contractual term or condition unless the report furnished by the physicians' representative has been approved in writing by the Attorney General, nor shall a proposed contract between two or more competing physicians and a health benefits plan be implemented unless the contract has been approved by the Attorney General.

b. The Attorney General shall approve a report or proposed contract furnished by a physicians' representative pursuant to section 7 of this act if the Attorney General determines that the report or proposed contract has demonstrated that the likely benefits resulting from the proposed joint negotiations over any contractual term or condition or the proposed contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result therefrom. In making this determination, the Attorney General shall consider physician distribution by specialty and its effect on competition in the geographic service area of the health benefits plan. The Attorney General shall not approve a report furnished by a physicians' representative pursuant to section 7 of this act if the physicians' representative proposes to enter into negotiations with a health benefits plan on behalf of more than 10% of the total number of physicians practicing in the geographic service area of the health benefits plan, unless the Attorney General determines, consistent with the provisions of this act, that conditions relating to the quality and availability of patient care among covered persons in the geographic service area of the health benefits plan support the inclusion of a higher percentage of practicing physicians in those joint negotiations.

c. Written approval by the Attorney General of a report furnished by a physicians' representative pursuant to section 7 of this act shall be effective for all subsequent negotiations between the physicians' representative and the identified health benefits plan, subject to the provisions of subsection c. of section 7 of this act.

9. a. The provisions of this act shall not be construed to permit two or more physicians to:

(1) jointly engage in a coordinated cessation, reduction or limitation of health care services;

(2) meet or communicate for the purpose of jointly negotiating a

requirement that at least one of the physicians, as a condition of participation in a health benefits plan, be allowed to participate in all of the products offered by the health benefits plan; or

(3) jointly negotiate with a health benefits plan to exclude, limit or otherwise restrict any non-physician health care provider from participation in a health benefits plan based substantially on the fact that the health care provider is not a physician, unless that exclusion, limitation or restriction is otherwise permitted by law.

b. Prior to entering into negotiations with a health benefits plan on behalf of two or more competing physicians over any contractual term or condition, a physicians' representative shall notify those physicians in writing of the provisions of this section and advise them as to their potential legal liability if they engage in any joint action that is not authorized under the provisions of this act.

10. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

11. This act shall take effect on the 90th day after enactment, except that the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

STATEMENT

This bill would give physicians the right to engage in joint negotiations over the terms and conditions of their contracts with health benefits plans. The bill is generally modeled after Texas Senate Bill No. 1468 which was enacted on June 20, 1999 and thereby became the first law of its kind in the nation.

For the purposes of this bill, "physician" is defined as a person licensed to practice medicine or surgery, including podiatric medicine, by the State Board of Medical Examiners pursuant to Title 45 of the Revised Statutes.

This bill would permit physicians in the geographic service area of a health benefits plan to jointly negotiate with the plan, through a physicians' representative who is approved by the Attorney General to act on their behalf, over the terms and conditions of a proposed contract, which, if agreed to by the parties to the negotiation, must then be approved by the Attorney General before being implemented.

These terms and conditions would include:

- practices and procedures to assess and improve the delivery of effective, cost-efficient preventive health care services;
- practices and procedures to encourage early detection and effective, cost-efficient management of diseases and illnesses in children;
- practices and procedures to assess and improve the delivery of women's medical and health care;
- clinical criteria for effective, cost-efficient disease management programs;
- practices and procedures to encourage and promote patient education and treatment compliance;
- practices and procedures to identify, correct and prevent potentially fraudulent activities;
- practices and procedures for the effective, cost-efficient use of outpatient surgery;
- clinical practice guidelines and coverage criteria;
- administrative procedures, including methods and timing of payment to physicians for services;
- procedures for resolving disputes between physicians and the plan;
- patient referral procedures;
- the formulation and application of physician reimbursement methodology;
- quality assurance activities;
- utilization management procedures;
- physician selection and termination criteria used by the plan; and
- the inclusion or alteration of any term or condition of a contract with the plan, except when the inclusion or alteration is required by a federal or State regulation regarding the term or condition in question.

In addition, the bill provides that the following terms and conditions of a proposed contract may be subject to such joint negotiations if the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, finds that the health benefits plan has substantial market power within its service area and that any of those terms or conditions have already had, or threaten to have, an adverse effect on the quality and availability of patient care among covered persons:

- the fee or price for a service provided by a physician, including those determined by the application of any reimbursement methodology;
- the conversion factors in a resource-based relative value scale or similar reimbursement methodology;
- the amount of any discount on the price of a service to be provided by a physician; and
- the dollar amount of capitation or fixed payment for services provided by a physician to a covered person.

The bill stipulates that a physicians' representative shall not enter into negotiations with a health benefits plan on behalf of more than 10% of the total number of physicians practicing in the geographic service area of the health benefits plan, unless the Attorney General determines, consistent with the provisions of this bill, that conditions relating to the quality and availability of patient care among covered persons in the geographic service area of the health benefits plan support the inclusion of a higher percentage of practicing physicians in those joint negotiations.

Also, the bill explicitly prohibits physicians from:

- jointly engaging in a coordinated cessation, reduction or limitation of health care services;
- meeting or communicating for the purpose of jointly negotiating a requirement that at least one of the physicians, as a condition of participation in a health benefits plan, be allowed to participate in all of the products offered by the health benefits plan; or
- jointly negotiating with a health benefits plan to exclude, limit or otherwise restrict any non-physician health care provider from participation in a health benefits plan based substantially on the fact that the health care provider is not a physician, unless that exclusion, limitation or restriction is otherwise permitted by law.

This bill should be viewed in the context of a growing trend nationwide among physicians to seek to organize as a way to achieve a level playing field with powerful managed care organizations. On June 23, 1999, the House of Delegates of the 152-year old American Medical Association, the nation's largest physician organization, voted at its annual meeting to support an effort to organize physicians who are salaried employees and medical residents, and to support pending federal legislation to grant an exemption from federal anti-trust law that would allow self-employed physicians to bargain collectively.

This bill is premised on a conviction that the only effective way for physicians to prevent managed care plans from unfairly restricting the ability of these health care professionals to care for their patients without undue interference is to gain the leverage that comes from joint negotiations.

ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, Nos. 2169, 2241 and 464

STATE OF NEW JERSEY

209th LEGISLATURE

ADOPTED JUNE 4, 2001

Sponsored by:
Assemblyman LARRY CHATZIDAKIS
District 8 (Atlantic, Burlington and Camden)
Assemblyman NICHOLAS ASSELTA
District 1 (Cape May, Atlantic and Cumberland)
Assemblyman JOSEPH V. DORIA, JR.
District 31 (Hudson)
Assemblyman HERBERT CONAWAY, JR.
District 7 (Burlington and Camden)
Assemblyman JACK CONNERS
District 7 (Burlington and Camden)

Co-Sponsored by:
Assemblymen LeFevre, Gusciora, Assemblywoman Weinberg, Assemblymen Geist, Cohen, Munoz and Assemblywoman Gill

SYNOPSIS

Allows physicians and dentists to jointly negotiate with carriers over contractual terms and conditions.

CURRENT VERSION OF TEXT

Substitute as adopted by the Assembly Health Committee.

(Sponsorship Updated As Of: 11/30/2001)

AN ACT providing for joint negotiations by physicians and dentists with carriers and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that:

a. Active, robust and fully competitive markets for health care and dental services provide the best opportunity for the residents of this State to receive high-quality health care and dental services at an appropriate cost;

b. A substantial amount of health care and dental services in this State is purchased for the benefit of patients by health and dental insurance carriers engaged in the financing of health care and dental services or is otherwise delivered subject to the terms of agreements between carriers and physicians and dentists;

c. Carriers are able to control the flow of patients to physicians and dentists through compelling financial incentives for patients in their health and dental benefits plans to utilize only the services of physicians and dentists with whom the carriers have contracted;

d. Carriers also control the health care and dental services rendered to patients through utilization management and other managed care tools and associated coverage and payment policies;

e. Carriers are often able to virtually dictate the terms of the contracts that they offer physicians and dentists and commonly offer these contracts on a take-it-or-leave-it basis;

f. The power of carriers to unilaterally impose provider contract terms jeopardizes the ability of physicians and dentists to deliver the superior quality health care and dental services traditionally available in this State;

g. Physicians and dentists do not have sufficient market power to reject unfair provider contract terms offered by carriers that impede their ability to deliver medically appropriate care without undue delay or difficulties;

h. Inadequate reimbursement and other unfair payment terms offered by carriers adversely affect the quality of patient care and access to care by reducing the resources that physicians and dentists can devote to patient care and decreasing the time that physicians and dentists are able to spend with their patients;

i. Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical progress by diverting capital needed for reinvestment in the health care delivery system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and expansion of medical services, all to the detriment of the residents of this State;

j. The inevitable collateral reduction and migration of the health

care work force will also have negative consequences for the economy of this State;

k. Empowering independent physicians and dentists to jointly negotiate with carriers as provided in this act will help restore the competitive balance and improve competition in the markets for health care and dental services in this State, thereby providing benefits for consumers, physicians and dentists and less dominant carriers;

l. This act is necessary and proper, and constitutes an appropriate exercise of the authority of this State to regulate the business of insurance and the delivery of health care and dental services;

m. The pro-competitive and other benefits of the joint negotiations and related joint activity authorized by this act, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical progress, and improving communications, outweigh any potential anti-competitive effects of this act; and

n. It is the intention of the Legislature to authorize independent physicians and dentists to jointly negotiate with carriers and to qualify such joint negotiations and related joint activities for the State-action exemption to the federal antitrust laws through the articulated State policy and active supervision provided under this act.

2. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization which is authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Covered person" means a person on whose behalf a carrier which offers a health benefits or dental plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care or dental service provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provide services.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Dentist" means a person who is licensed to practice dentistry by the New Jersey State Board of Dentistry in accordance with the provisions of Title 45 of the Revised Statutes.

"Health benefits plan" means a plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage

and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Joint negotiation representative" means a representative selected by two or more independent physicians or dentists to engage in joint negotiations with a carrier on their behalf.

"Physician" means a person who is licensed to practice medicine and surgery by the State Board of Medical Examiners in accordance with the provisions of Title 45 of the Revised Statutes.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care or dental services under a health benefits or dental plan in accordance with specific guidelines, for the purpose of determining whether, or to what extent, a health care or dental service that has been provided or is proposed to be provided to a covered person is to be covered under the health benefits or dental plan.

3. Two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with a carrier and engage in related joint activity, as provided in this act, regarding non-fee-related matters which may affect patient care, including, but not limited to, any of the following:

a. the definition of medical necessity and other conditions of coverage;

b. utilization management criteria and procedures;

c. clinical practice guidelines;

d. preventive care and other medical management policies;

e. patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

f. drug formularies and standards and procedures for prescribing off-formulary drugs;

g. quality assurance programs;

h. respective physician or dentist and carrier liability for the treatment or lack of treatment of covered persons;

i. the methods and timing of payments;

j. other administrative procedures, including, but not limited to, eligibility verification systems and claim documentation requirements for covered persons;

k. credentialing standards and procedures for the selection, retention and termination of participating physicians or dentists;

l. mechanisms for resolving disputes between the carrier and physicians or dentists, including, but not limited to, the appeals

process for utilization management and credentialing determinations;

m. the health benefits or dental plans sold or administered by the carrier in which the physicians or dentists are required to participate;

n. the formulation and application of reimbursement methodology;

o. the terms and conditions of physician or dentist contracts, including, but not limited to, all products clauses, and the duration and renewal provisions of the contract; and

p. the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit a physician's or dentist's rights to jointly petition the federal or State government, as applicable, to change the regulation.

4. a. Upon a finding by the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, that the carrier has substantial market power in its service area and that any of the terms or conditions of the contract with the carrier pose an actual or potential threat to the quality and availability of patient care among covered persons, two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with the carrier and engage in related joint activity, as provided in this act regarding fees and fee-related matters, including, but not limited to, any of the following:

(1) the amount of payment or the methodology for determining the payment for a health care or dental service, including, but not limited to, cost of living increases;

(2) the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care or dental services;

(3) the amount of any discount on the price of a health care or dental service;

(4) the procedure code or other description of a health care or dental service covered by a payment and the appropriate grouping of the procedure codes;

(5) the amount of a bonus related to the provision of health care or dental services or a withholding from the payment due for a health care or dental service; and

(6) the amount of any other component of the reimbursement methodology for a health care or dental service.

b. The Department of Banking and Insurance, in consultation with the Department of Health and Senior Services, shall have the authority to collect and investigate such information as it reasonably believes is necessary to determine, on an annual basis:

(1) the average number of covered lives and geographical distribution of covered lives per quarter per county for every carrier in the State; and

(2) the impact of the provisions of this section on average physician or dentist fees in the State.

The Department of Banking and Insurance shall provide this information to the Attorney General on an annual basis.

5. The exercise of joint negotiation rights by two or more independent physicians or dentists who are practicing in the service area of a carrier pursuant to this act shall conform to the following criteria:

a. the physicians or dentists may communicate with each other concerning any contractual term or condition to be negotiated with the carrier;

b. the physicians or dentists may communicate with the joint negotiation representative authorized to negotiate on their behalf with the carrier concerning any contractual term or condition;

c. the joint negotiation representative shall be the sole party authorized to negotiate with the carrier on behalf of the physicians or dentists as a group;

d. the physicians or dentists may, at the option of each physician or dentist, agree to be bound by the terms and conditions negotiated by the joint negotiation representative; and

e. when communicating or negotiating with a joint negotiation representative, a carrier may offer different contractual terms or conditions to, or may contract with, individual independent physicians or dentists.

6. The provisions of this act shall not apply to a health benefits or dental plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the Children's Health Care Coverage Program under P.L.1997, c.272 (C.30:4I-1 et seq.) or the FamilyCare Health Coverage Program under P.L.2000, c.71 (C.30:4J-1 et seq.).

7. A person or entity which proposes to act as a joint negotiation representative shall satisfy the following requirements:

a. Before entering into negotiations with a carrier on behalf of two or more independent physicians or dentists, the joint negotiation representative shall submit to the Attorney General, for his approval pursuant to section 8 of this act, on a form and in a manner prescribed by the Attorney General, a petition which identifies:

(1) the representative's name and business address;

(2) the names and business addresses of each physician or dentist who will be represented by the identified representative;

(3) the ratio of the physicians or dentists requesting joint

representation to the total number of physicians or dentists who are practicing within the geographic service area of the carrier;

(4) the carrier with which the representative proposes to enter into negotiations on behalf of the identified physicians or dentists;

(5) the intended subject matter of the proposed negotiations with the identified carrier;

(6) the representative's plan of operation and procedures to ensure compliance with the provisions of this act;

(7) the anticipated effect of the proposed joint negotiations on the quality and availability of health or dental care among covered persons;

(8) the anticipated benefits of a contract between the identified physicians or dentists and carrier;

(9) such other data, information and documents as the petitioners desire to submit in support of their petition; and

(10) such other data, information and documents as the Attorney General deems necessary.

The joint negotiation representative, upon submitting the petition, shall pay a fee to the Attorney General in an amount, as determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this act.

b. After the joint negotiation representative and the carrier identified pursuant to subsection a. of this section have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the joint negotiation representative shall submit to the Attorney General, for his approval in accordance with the provisions of section 8 of this act, a copy of the proposed contract between the physicians or dentists identified pursuant to subsection a. of this section and the carrier, as well as any plan of action which the joint negotiation representative and the carrier may formally agree to for the purpose of implementing the terms and conditions of the contract.

c. Within 14 days after either party notifies the other party of its decision to decline or terminate negotiations entered into pursuant to this act, or after the date that a joint negotiation representative requests that a carrier enter into such negotiations to which request the plan fails to respond, the joint negotiation representative shall report to the Attorney General that the negotiations have ended, on a form and in a manner to be prescribed by the Attorney General. The joint negotiation representative may resume negotiations with the carrier no later than 60 days after reporting to the Attorney General that the negotiations have ended, on the basis of the petition submitted to the Attorney General pursuant to subsection a. of this section and approved by the Attorney General in accordance with the provisions of section 8 of this act. After that date, the joint negotiation representative shall be required to submit a new petition and pay an

additional fee to the Attorney General pursuant to subsection a. of this section, in order to engage in negotiations with the carrier under this act.

8. a. The Attorney General shall provide written approval or disapproval of a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act no later than 30 days after receipt of the petition or proposed contract, as applicable. If the Attorney General fails to provide written approval or disapproval within this time period, the joint negotiation representative may petition a court of competent jurisdiction for an order to require the Attorney General to take such action. If the Attorney General disapproves the petition or the proposed contract, he shall forward a written explanation of any deficiencies therein to the joint negotiation representative along with a statement of the specific remedial measures by which those deficiencies may be corrected.

A joint negotiation representative shall not engage in negotiations with a carrier over any contractual term or condition unless the petition furnished by the joint negotiation representative has been approved in writing by the Attorney General, nor shall a proposed contract between two or more independent physicians or dentists and a carrier be implemented unless the Attorney General has approved the contract.

b. The Attorney General shall approve a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act if the Attorney General determines that the petition or proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations over a contractual term or condition or the proposed contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician or dentist distribution by specialty and its effect on competition in the geographic service area of the carrier.

c. The Attorney General's written approval of a petition which is furnished by a joint negotiation representative under section 7 of this act shall be effective for all subsequent negotiations between the joint negotiation representative and the identified carrier, subject to the provisions of subsection c. of section 7 of this act.

d. In the case of a petition submitted pursuant to subsection a. of section 7 of this act, the Attorney General shall notify the carrier of the petition and provide the carrier with the opportunity to submit written comments within a specified time frame that does not extend beyond the date by which the Attorney General is required to act on the petition.

9. a. Within 30 days from the mailing by the Attorney General of a notice of disapproval of a petition submitted under section 7 of this act, the petitioners may make a written application to the Attorney General for a hearing.

b. Upon receipt of a timely written application for a hearing, the Attorney General shall schedule and conduct a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The hearing shall be held within 30 days of the application unless the petitioner seeks an extension.

c. The sole parties with respect to any petition under section 7 of this act shall be the petitioners, and notwithstanding any other provision of law to the contrary, the Attorney General shall not be required to treat any other person as a party and no other person shall be entitled to appeal the Attorney General's determination.

10. All information, including documents and copies thereof, obtained by or disclosed to the Attorney General or any other person in a petition under section 7 of this act, shall be treated confidentially and shall be deemed proprietary and shall not be made public or otherwise disclosed by the Attorney General or any other person without the written consent of the petitioners to whom the information pertains.

11. A carrier and a joint negotiation representative shall negotiate in good faith regarding the terms and conditions of physician or dentist contracts pursuant to this act.

12. a. The provisions of this act shall not be construed to:

(1) permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services which they provide;

(2) permit two or more physicians or dentists to meet or communicate in order to jointly negotiate a requirement that at least one of the physicians or dentists, as a condition of participation with a carrier, be allowed to participate in all of the products offered by the carrier;

(3) permit two or more physicians or dentists to jointly negotiate with a carrier to exclude, limit or otherwise restrict a non-physician or non-dentist health care provider from participating in the carrier's health benefits or dental plan based substantially on the fact that the health care provider is not a physician or dentist, unless that exclusion, limitation or restriction is otherwise permitted by law;

(4) prohibit or restrict activity by physicians or dentists that is sanctioned under federal or State law or subject such activity to the requirements of this act;

(5) affect governmental approval of, or otherwise restrict activity by, physicians or dentists that is not prohibited under federal antitrust

law; or

(6) require approval of physician or dentist contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974," Pub.L.93-406 (29 U.S.C. s.1144(a)).

b. Prior to entering into negotiations with a carrier on behalf of two or more independent physicians or dentists over a contractual term or condition, a joint negotiation representative shall notify the physicians or dentists in writing of the provisions of this act and advise them as to their potential for legal action against physicians or dentists who violate federal antitrust law.

13. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than four years after the effective date of this act on its implementation.

The report shall include the number of petitions submitted for approval to engage in joint negotiations and the outcome of the petitions and the negotiations, an assessment of the effect the joint negotiations provided for in this act has had in restoring the competitive balance in the market for health care or dental services and in protecting access to quality patient care, an assessment of the impact this act has had on health insurance premiums in the State, and such other information that the Attorney General deems appropriate. The report shall also include the Attorney General's recommendations as to whether the provisions of this act shall be expanded to include other types of health care professionals and facilities.

The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than five years after the effective date of this act with his recommendation as to whether this act shall be made permanent.

14. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

15. This act shall take effect 90 days after enactment and shall expire six years after the effective date, but the expiration of this act shall not impair any contract negotiated pursuant to this act that is in effect on the date of expiration. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance of the effective date as shall be necessary to implement the act.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 2169, 2241 and 464

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Health Committee reports without recommendation an Assembly Committee Substitute for Assembly Bill Nos. 2169, 2241 and 464.

This committee substitute is intended to provide physicians and dentists with the right to engage in joint negotiations over the terms and conditions of their contracts with health and dental insurance carriers, that is, health, hospital and medical service corporations, commercial health insurers, health maintenance organizations, dental service corporations and dental plan organizations.

The substitute permits two or more independent physicians (including podiatrists) or dentists who are practicing in the geographic service area of a carrier to jointly negotiate with the carrier and engage in related joint activity over the terms and conditions of a proposed contract. The negotiations would be carried out through a joint negotiation representative selected by the physicians or dentists to act on their behalf.

The terms and conditions that may be the subject of the negotiations include non-fee-related matters which may affect patient care, such as any of the following:

- the definition of medical necessity and other conditions of coverage;
- utilization management criteria and procedures;
- clinical practice guidelines;
- preventive care and other medical management policies;
- patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;
- drug formularies and standards and procedures for prescribing off-formulary drugs;
- quality assurance programs;
- respective physician or dentist and carrier liability for the treatment or lack of treatment of covered persons;
- the methods and timing of payments;
- other administrative procedures, including, but not limited to, eligibility verification systems and claim documentation requirements for covered persons;

- credentialing standards and procedures for the selection, retention and termination of participating physicians or dentists;
- mechanisms for resolving disputes between the carrier and physicians or dentists, including, but not limited to, the appeals process for utilization management and credentialing determinations;
- the health benefits or dental plans sold or administered by the carrier in which the physicians or dentists are required to participate;
- the formulation and application of reimbursement methodology;
- the terms and conditions of physician or dentist contracts, including, but not limited to, all products clauses, and the duration and renewal provisions of the contract; and
- the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit a physician's or dentist's rights to jointly petition the federal or State government, as applicable, to change the regulation.

In addition, the substitute provides that the following terms and conditions of a proposed contract concerning fees and fee-related matters may be subject to joint negotiations if the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, finds that the carrier has substantial market power in its service area and that any of the terms or conditions of the contract with the carrier pose an actual or potential threat to the quality and availability of patient care among covered persons. These matters include, but are not limited to, any of the following:

- the amount of payment or the methodology for determining the payment for a health care or dental service, including, but not limited to, cost of living increases;
- the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care or dental services;
- the amount of any discount on the price of a health care or dental service;
- the procedure code or other description of a health care or dental service covered by a payment and the appropriate grouping of the procedure codes;
- the amount of a bonus related to the provision of health care or dental services or a withholding from the payment due for a health care or dental service; and
- the amount of any other component of the reimbursement methodology for a health care or dental service.

The substitute requires that a person or entity which proposes to act as a joint negotiation representative shall submit a petition to the

Attorney General, for his approval. The petition shall identify the representative, the physicians or dentists who the representative will represent, the intended subject matter of the proposed negotiations and other information specified in the substitute. Upon submitting the petition, the representative shall pay a fee to the Attorney General, in an amount determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this substitute.

After the joint negotiation representative and the carrier have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the representative shall submit a copy of the proposed contract between the physicians or dentists and the carrier to the Attorney General, for his approval. The Attorney General shall provide written approval or disapproval of a petition or a proposed contract furnished by the representative no later than 30 days after receipt of the petition or proposed contract.

The substitute provides that a joint negotiation representative shall not engage in negotiations with a carrier unless the representative's petition has been approved in writing by the Attorney General, and a proposed contract between physicians or dentists and a carrier negotiated under this substitute shall not be implemented unless the Attorney General has approved the contract. The substitute further provides that either party may decline to negotiate or terminate negotiations. In either event, the representative shall so notify the Attorney General.

The Attorney General shall approve a petition or a proposed contract if he determines that the petition or proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations or contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician or dentist distribution by specialty and its effect on competition in the geographic service area of the carrier.

The substitute provides that its provisions shall not be construed to:

(1) permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services which they provide;

(2) permit two or more physicians or dentists to meet or communicate in order to jointly negotiate a requirement that at least one of the physicians or dentists, as a condition of participation with a carrier, be allowed to participate in all of the products offered by the carrier;

(3) permit two or more physicians or dentists to jointly negotiate with a carrier to exclude, limit or otherwise restrict a non-physician or non-dentist health care provider from participating in the carrier's

health benefits or dental plan based substantially on the fact that the health care provider is not a physician or dentist, unless that exclusion, limitation or restriction is otherwise permitted by law;

(4) prohibit or restrict activity by physicians or dentists that is sanctioned under federal or State law or subject such activity to the requirements of this act;

(5) affect governmental approval of, or otherwise restrict activity by, physicians or dentists that is not prohibited under federal antitrust law; or

(6) require approval of physician or dentist contract terms to the extent that the terms are exempt from State regulation under ERISA.

The substitute provides that its provisions shall not apply to a health benefits or dental plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for Medicaid, NJ KidCare or NJ FamilyCare.

The substitute requires the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, to report to the Governor and the Legislature no later than four years after its effective date on its implementation, and to include in that report an assessment of the impact that the substitute has had on health insurance premiums in the State. The report shall also include the Attorney General's recommendations as to whether the provisions of this act shall be expanded to include other types of health care professionals and facilities.

The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, is further directed to report to the Governor and the Legislature no later than five years after the effective date of the substitute with his recommendation as to whether the provisions of the substitute shall be made permanent.

The substitute, which takes effect 90 days after enactment, is to expire six years after the effective date; however, it stipulates that its expiration shall not impair any contract negotiated pursuant to the substitute that is in effect on the date of expiration.

This substitute is identical to the Senate Committee Substitute (1R) for Senate Bill Nos. 1033 and 1098 (Bark/DiFrancesco/Matheussen/Singer), which the committee also reported without recommendation on this date.

§§1-14 -
C.52:17B-196
to 52:17B-209
§15 - Note to §§1-14

P.L. 2001, CHAPTER 371, ***approved January 8, 2002***
Senate Committee Substitute ***(First Reprint)*** for
Senate, Nos. 1033 and 1098

AN ACT providing for joint negotiations by physicians and dentists with carriers and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that:

a. Active, robust and fully competitive markets for health care and dental services provide the best opportunity for the residents of this State to receive high-quality health care and dental services at an appropriate cost;

b. A substantial amount of health care and dental services in this State is purchased for the benefit of patients by health and dental insurance carriers engaged in the financing of health care and dental services or is otherwise delivered subject to the terms of agreements between carriers and physicians and dentists;

c. Carriers are able to control the flow of patients to physicians and dentists through compelling financial incentives for patients in their health and dental benefits plans to utilize only the services of physicians and dentists with whom the carriers have contracted;

d. Carriers also control the health care and dental services rendered to patients through utilization management and other managed care tools and associated coverage and payment policies;

e. Carriers are often able to virtually dictate the terms of the contracts that they offer physicians and dentists and commonly offer these contracts on a take-it-or-leave-it basis;

f. The power of carriers to unilaterally impose provider contract terms jeopardizes the ability of physicians and dentists to deliver the superior quality health care and dental services traditionally available in this State;

g. Physicians and dentists do not have sufficient market power to reject unfair provider contract terms offered by carriers that impede their ability to deliver medically appropriate care without undue delay or difficulties;

h. Inadequate reimbursement and other unfair payment terms offered by carriers adversely affect the quality of patient care and access to care by reducing the resources that physicians and dentists

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate floor amendments adopted December 4, 2000.

can devote to patient care and decreasing the time that physicians and dentists are able to spend with their patients;

i. Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical progress by diverting capital needed for reinvestment in the health care delivery system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and expansion of medical services, all to the detriment of the residents of this State;

j. The inevitable collateral reduction and migration of the health care work force will also have negative consequences for the economy of this State;

k. Empowering independent physicians and dentists to jointly negotiate with carriers as provided in this act will help restore the competitive balance and improve competition in the markets for health care and dental services in this State, thereby providing benefits for consumers, physicians and dentists and less dominant carriers;

l. This act is necessary and proper, and constitutes an appropriate exercise of the authority of this State to regulate the business of insurance and the delivery of health care and dental services;

m. The pro-competitive and other benefits of the joint negotiations and related joint activity authorized by this act, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical progress, and improving communications, outweigh any potential anti-competitive effects of this act; and

n. It is the intention of the Legislature to authorize independent physicians and dentists to jointly negotiate with carriers and to qualify such joint negotiations and related joint activities for the State-action exemption to the federal antitrust laws through the articulated State policy and active supervision provided under this act.

2. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization which is authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Covered person" means a person on whose behalf a carrier which offers a health benefits or dental plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care or dental service provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provide services.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for

delivery in this State by or through a dental carrier.

"Dentist" means a person who is licensed to practice dentistry by the New Jersey State Board of Dentistry in accordance with the provisions of Title 45 of the Revised Statutes.

"Health benefits plan" means a plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Joint negotiation representative" means a representative selected by two or more independent physicians or dentists to engage in joint negotiations with a carrier on their behalf.

"Physician" means a person who is licensed to practice medicine and surgery by the State Board of Medical Examiners in accordance with the provisions of Title 45 of the Revised Statutes.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care or dental services under a health benefits or dental plan in accordance with specific guidelines, for the purpose of determining whether, or to what extent, a health care or dental service that has been provided or is proposed to be provided to a covered person is to be covered under the health benefits or dental plan.

3. Two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with a carrier and engage in related joint activity, as provided in this act, regarding non-fee-related matters which may affect patient care, including, but not limited to, any of the following:

a. the definition of medical necessity and other conditions of coverage;

b. utilization management criteria and procedures;

c. clinical practice guidelines;

d. preventive care and other medical management policies;

e. patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

f. drug formularies and standards and procedures for prescribing off-formulary drugs;

g. quality assurance programs;

h. respective physician or dentist and carrier liability for the

treatment or lack of treatment of covered persons;

i. the methods and timing of payments;

j. other administrative procedures, including, but not limited to, eligibility verification systems and claim documentation requirements for covered persons;

k. credentialing standards and procedures for the selection, retention and termination of participating physicians or dentists;

l. mechanisms for resolving disputes between the carrier and physicians or dentists, including, but not limited to, the appeals process for utilization management and credentialing determinations;

m. the health benefits or dental plans sold or administered by the carrier in which the physicians or dentists are required to participate;

n. the formulation and application of reimbursement methodology;

o. the terms and conditions of physician or dentist contracts, including, but not limited to, all products clauses, and the duration and renewal provisions of the contract; and

p. the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit a physician's or dentist's rights to jointly petition the federal or State government, as applicable, to change the regulation.

4. a. Upon a finding by the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, that the carrier has substantial market power in its service area and that any of the terms or conditions of the contract with the carrier pose an actual or potential threat to the quality and availability of patient care among covered persons, two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with the carrier and engage in related joint activity, as provided in this act regarding fees and fee-related matters, including, but not limited to, any of the following:

(1) the amount of payment or the methodology for determining the payment for a health care or dental service, including, but not limited to, cost of living increases;

(2) the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care or dental services;

(3) the amount of any discount on the price of a health care or dental service;

(4) the procedure code or other description of a health care or dental service covered by a payment and the appropriate grouping of the procedure codes;

(5) the amount of a bonus related to the provision of health care or dental services or a withholding from the payment due for a health care or dental service; and

(6) the amount of any other component of the reimbursement methodology for a health care or dental service.

b. The Department of Banking and Insurance, in consultation with the Department of Health and Senior Services, shall have the authority to collect and investigate such information as it reasonably believes is necessary to determine, on an annual basis:

(1) the average number of covered lives and geographical distribution of covered lives per quarter per county for every carrier in the State; and

(2) the impact of the provisions of this section on average physician or dentist fees in the State.

The Department of Banking and Insurance shall provide this information to the Attorney General on an annual basis.

5. The exercise of joint negotiation rights by two or more independent physicians or dentists who are practicing in the service area of a carrier pursuant to this act shall conform to the following criteria:

a. the physicians or dentists may communicate with each other concerning any contractual term or condition to be negotiated with the carrier;

b. the physicians or dentists may communicate with the joint negotiation representative authorized to negotiate on their behalf with the carrier concerning any contractual term or condition;

c. the joint negotiation representative shall be the sole party authorized to negotiate with the carrier on behalf of the physicians or dentists as a group;

d. the physicians or dentists may, at the option of each physician or dentist, agree to be bound by the terms and conditions negotiated by the joint negotiation representative; and

e. when communicating or negotiating with a joint negotiation representative, a carrier may offer different contractual terms or conditions to, or may contract with, individual independent physicians or dentists.

6. The provisions of this act shall not apply to a health benefits or dental plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the Children's Health Care Coverage Program under P.L.1997, c.272 (C.30:4I-1 et seq.) or the FamilyCare Health Coverage Program under P.L.2000, c.71 (C.30:4J-1 et seq.).

7. A person or entity which proposes to act as a joint negotiation representative shall satisfy the following requirements:

a. Before entering into negotiations with a carrier on behalf of two or more independent physicians or dentists, the joint negotiation representative shall submit to the Attorney General, for his approval pursuant to section 8 of this act, on a form and in a manner prescribed by the Attorney General, a petition which identifies:

(1) the representative's name and business address;

(2) the names and business addresses of each physician or dentist who will be represented by the identified representative;

(3) the ratio of the physicians or dentists requesting joint representation to the total number of physicians or dentists who are practicing within the geographic service area of the carrier;

(4) the carrier with which the representative proposes to enter into negotiations on behalf of the identified physicians or dentists;

(5) the intended subject matter of the proposed negotiations with the identified carrier;

(6) the representative's plan of operation and procedures to ensure compliance with the provisions of this act;

(7) the anticipated effect of the proposed joint negotiations on the quality and availability of health or dental care among covered persons;

(8) the anticipated benefits of a contract between the identified physicians or dentists and carrier;

(9) such other data, information and documents as the petitioners desire to submit in support of their petition; and

(10) such other data, information and documents as the Attorney General deems necessary.

The joint negotiation representative, upon submitting the petition, shall pay a fee to the Attorney General in an amount, as determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this act.

b. After the joint negotiation representative and the carrier identified pursuant to subsection a. of this section have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the joint negotiation representative shall submit to the Attorney General, for his approval in accordance with the provisions of section 8 of this act, a copy of the proposed contract between the physicians or dentists identified pursuant to subsection a. of this section and the carrier, as well as any plan of action which the joint negotiation representative and the carrier may formally agree to for the purpose of implementing the terms and conditions of the contract.

c. Within 14 days after either party notifies the other party of its decision to decline or terminate negotiations entered into pursuant to this act, or after the date that a joint negotiation representative requests that a carrier enter into such negotiations to which request the plan fails to respond, the joint negotiation representative shall

report to the Attorney General that the negotiations have ended, on a form and in a manner to be prescribed by the Attorney General. The joint negotiation representative may resume negotiations with the carrier no later than 60 days after reporting to the Attorney General that the negotiations have ended, on the basis of the petition submitted to the Attorney General pursuant to subsection a. of this section and approved by the Attorney General in accordance with the provisions of section 8 of this act. After that date, the joint negotiation representative shall be required to submit a new petition and pay an additional fee to the Attorney General pursuant to subsection a. of this section, in order to engage in negotiations with the carrier under this act.

8. a. The Attorney General shall provide written approval or disapproval of a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act no later than 30 days after receipt of the petition or proposed contract, as applicable. If the Attorney General fails to provide written approval or disapproval within this time period, the joint negotiation representative may petition a court of competent jurisdiction for an order to require the Attorney General to take such action. If the Attorney General disapproves the petition or the proposed contract, he shall forward a written explanation of any deficiencies therein to the joint negotiation representative along with a statement of the specific remedial measures by which those deficiencies may be corrected.

A joint negotiation representative shall not engage in negotiations with a carrier over any contractual term or condition unless the petition furnished by the joint negotiation representative has been approved in writing by the Attorney General, nor shall a proposed contract between two or more independent physicians or dentists and a carrier be implemented unless the Attorney General has approved the contract.

b. The Attorney General shall approve a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act if the Attorney General determines that the petition or proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations over a contractual term or condition or the proposed contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician or dentist distribution by specialty and its effect on competition in the geographic service area of the carrier.

c. The Attorney General's written approval of a petition which is furnished by a joint negotiation representative under section 7 of this act shall be effective for all subsequent negotiations between the joint

negotiation representative and the identified carrier, subject to the provisions of subsection c. of section 7 of this act.

d. In the case of a petition submitted pursuant to subsection a. of section 7 of this act, the Attorney General shall notify the carrier of the petition and provide the carrier with the opportunity to submit written comments within a specified time frame that does not extend beyond the date by which the Attorney General is required to act on the petition.

9. a. Within 30 days from the mailing by the Attorney General of a notice of disapproval of a petition submitted under section 7 of this act, the petitioners may make a written application to the Attorney General for a hearing.

b. Upon receipt of a timely written application for a hearing, the Attorney General shall schedule and conduct a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The hearing shall be held within 30 days of the application unless the petitioner seeks an extension.

c. The sole parties with respect to any petition under section 7 of this act shall be the petitioners, and notwithstanding any other provision of law to the contrary, the Attorney General shall not be required to treat any other person as a party and no other person shall be entitled to appeal the Attorney General's determination.

10. All information, including documents and copies thereof, obtained by or disclosed to the Attorney General or any other person in a petition under section 7 of this act, shall be treated confidentially and shall be deemed proprietary and shall not be made public or otherwise disclosed by the Attorney General or any other person without the written consent of the petitioners to whom the information pertains.

11. A carrier and a joint negotiation representative shall negotiate in good faith regarding the terms and conditions of physician or dentist contracts pursuant to this act.

12. a. The provisions of this act shall not be construed to:

(1) permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services which they provide;

(2) permit two or more physicians or dentists to meet or communicate in order to jointly negotiate a requirement that at least one of the physicians or dentists, as a condition of participation with a carrier, be allowed to participate in all of the products offered by the carrier;

(3) permit two or more physicians or dentists to jointly negotiate

with a carrier to exclude, limit or otherwise restrict a non-physician or non-dentist health care provider from participating in the carrier's health benefits or dental plan based substantially on the fact that the health care provider is not a physician or dentist, unless that exclusion, limitation or restriction is otherwise permitted by law;

(4) prohibit or restrict activity by physicians or dentists that is sanctioned under federal or State law or subject such activity to the requirements of this act;

(5) affect governmental approval of, or otherwise restrict activity by, physicians or dentists that is not prohibited under federal antitrust law; or

(6) require approval of physician or dentist contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974," Pub.L.93-406 (29 U.S.C. s.1144(a)).

b. Prior to entering into negotiations with a carrier on behalf of two or more independent physicians or dentists over a contractual term or condition, a joint negotiation representative shall notify the physicians or dentists in writing of the provisions of this act and advise them as to their potential for legal action against physicians or dentists who violate federal antitrust law.

13. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than four years after the effective date of this act on its implementation.

The report shall include the number of petitions submitted for approval to engage in joint negotiations and the outcome of the petitions and the negotiations, an assessment of the effect the joint negotiations provided for in this act has had in restoring the competitive balance in the market for health care or dental services and in protecting access to quality patient care, [1]an assessment of the impact this act has had on health insurance premiums in the State,[1] and such other information that the Attorney General deems appropriate. The report shall also include the Attorney General's recommendations as to whether the provisions of this act shall be expanded to include other types of health care professionals and facilities.

[1]The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than five years after the effective date of this act with his recommendation as to whether this act shall be made permanent.[1]

14. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1

et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

15. This act shall take effect 90 days after enactment [1][, except that the] and shall expire six years after the effective date, but the expiration of this act shall not impair any contract negotiated pursuant to this act that is in effect on the date of expiration. The[1] Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance [1]of the effective date[1] as shall be necessary to implement the act.

Allows physicians and dentists to jointly negotiate with carriers over contractual terms and conditions.

CHAPTER 371

AN ACT providing for joint negotiations by physicians and dentists with carriers and supplementing Title 52 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.52:17B-196 Findings, declarations relative to joint negotiations by physicians and dentists with carriers.

1. The Legislature finds and declares that:

a. Active, robust and fully competitive markets for health care and dental services provide the best opportunity for the residents of this State to receive high-quality health care and dental services at an appropriate cost;

b. A substantial amount of health care and dental services in this State is purchased for the benefit of patients by health and dental insurance carriers engaged in the financing of health care and dental services or is otherwise delivered subject to the terms of agreements between carriers and physicians and dentists;

c. Carriers are able to control the flow of patients to physicians and dentists through compelling financial incentives for patients in their health and dental benefits plans to utilize only the services of physicians and dentists with whom the carriers have contracted;

d. Carriers also control the health care and dental services rendered to patients through utilization management and other managed care tools and associated coverage and payment policies;

e. Carriers are often able to virtually dictate the terms of the contracts that they offer physicians and dentists and commonly offer these contracts on a take-it-or-leave-it basis;

f. The power of carriers to unilaterally impose provider contract terms jeopardizes the ability of physicians and dentists to deliver the superior quality health care and dental services traditionally available in this State;

g. Physicians and dentists do not have sufficient market power to reject unfair provider contract terms offered by carriers that impede their ability to deliver medically appropriate care without undue delay or difficulties;

h. Inadequate reimbursement and other unfair payment terms offered by carriers adversely affect the quality of patient care and access to care by reducing the resources that physicians and dentists can devote to patient care and decreasing the time that physicians and dentists are able to spend with their patients;

i. Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical progress by diverting capital needed for reinvestment in the health care delivery system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and expansion of medical services, all to the detriment of the residents of this State;

j. The inevitable collateral reduction and migration of the health care work force will also have negative consequences for the economy of this State;

k. Empowering independent physicians and dentists to jointly negotiate with carriers as provided in this act will help restore the competitive balance and improve competition in the markets for health care and dental services in this State, thereby providing benefits for consumers, physicians and dentists and less dominant carriers;

l. This act is necessary and proper, and constitutes an appropriate exercise of the authority of this State to regulate the business of insurance and the delivery of health care and dental services;

m. The pro-competitive and other benefits of the joint negotiations and related joint activity authorized by this act, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical progress, and improving communications, outweigh any potential anti-competitive effects of this act; and

n. It is the intention of the Legislature to authorize independent physicians and dentists to jointly negotiate with carriers and to qualify such joint negotiations and related joint activities for the State-action exemption to the federal antitrust laws through the articulated State policy and active supervision provided under this act.

C.52:17B-197 Definitions relative to joint negotiations by physicians and dentists with carriers.

2. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization which is authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Covered person" means a person on whose behalf a carrier which offers a health benefits or dental plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care or dental service provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provide services.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Dentist" means a person who is licensed to practice dentistry by the New Jersey State Board of Dentistry in accordance with the provisions of Title 45 of the Revised Statutes.

"Health benefits plan" means a plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: Medicare supplement coverage and risk contracts, accident only, specified disease or other limited benefit, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), dental or vision care coverage only, or hospital expense or confinement indemnity coverage only.

"Joint negotiation representative" means a representative selected by two or more independent physicians or dentists to engage in joint negotiations with a carrier on their behalf.

"Physician" means a person who is licensed to practice medicine and surgery by the State Board of Medical Examiners in accordance with the provisions of Title 45 of the Revised Statutes.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care or dental services under a health benefits or dental plan in accordance with specific guidelines, for the purpose of determining whether, or to what extent, a health care or dental service that has been provided or is proposed to be provided to a covered person is to be covered under the health benefits or dental plan.

C.52:17B-198 Joint negotiations regarding non-fee related matters.

3. Two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with a carrier and engage in related joint activity, as provided in this act, regarding non-fee-related matters which may affect patient care, including, but not limited to, any of the following:

a. the definition of medical necessity and other conditions of coverage;

b. utilization management criteria and procedures;

c. clinical practice guidelines;

d. preventive care and other medical management policies;

e. patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals;

f. drug formularies and standards and procedures for prescribing off-formulary drugs;

g. quality assurance programs;

h. respective physician or dentist and carrier liability for the treatment or lack of treatment of covered persons;

i. the methods and timing of payments;

j. other administrative procedures, including, but not limited to, eligibility verification systems and claim documentation requirements for covered persons;

k. credentialing standards and procedures for the selection, retention and termination of

participating physicians or dentists;

l. mechanisms for resolving disputes between the carrier and physicians or dentists, including, but not limited to, the appeals process for utilization management and credentialing determinations;

m. the health benefits or dental plans sold or administered by the carrier in which the physicians or dentists are required to participate;

n. the formulation and application of reimbursement methodology;

o. the terms and conditions of physician or dentist contracts, including, but not limited to, all products clauses, and the duration and renewal provisions of the contract; and

p. the inclusion or alteration of a contractual term or condition, except when the inclusion or alteration is required by a federal or State regulation concerning that term or condition; however, the restriction shall not limit a physician's or dentist's rights to jointly petition the federal or State government, as applicable, to change the regulation.

C.52:17B-199 Joint negotiations regarding fees, fee related matters.

4. a. Upon a finding by the Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, that the carrier has substantial market power in its service area and that any of the terms or conditions of the contract with the carrier pose an actual or potential threat to the quality and availability of patient care among covered persons, two or more independent physicians or dentists who are practicing in the service area of a carrier may jointly negotiate with the carrier and engage in related joint activity, as provided in this act regarding fees and fee-related matters, including, but not limited to, any of the following:

(1) the amount of payment or the methodology for determining the payment for a health care or dental service, including, but not limited to, cost of living increases;

(2) the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care or dental services;

(3) the amount of any discount on the price of a health care or dental service;

(4) the procedure code or other description of a health care or dental service covered by a payment and the appropriate grouping of the procedure codes;

(5) the amount of a bonus related to the provision of health care or dental services or a withholding from the payment due for a health care or dental service; and

(6) the amount of any other component of the reimbursement methodology for a health care or dental service.

b. The Department of Banking and Insurance, in consultation with the Department of Health and Senior Services, shall have the authority to collect and investigate such information as it reasonably believes is necessary to determine, on an annual basis:

(1) the average number of covered lives and geographical distribution of covered lives per quarter per county for every carrier in the State; and

(2) the impact of the provisions of this section on average physician or dentist fees in the State.

The Department of Banking and Insurance shall provide this information to the Attorney General on an annual basis.

C.52:17B-200 Criteria for exercise of joint negotiation rights.

5. The exercise of joint negotiation rights by two or more independent physicians or dentists who are practicing in the service area of a carrier pursuant to this act shall conform to the following criteria:

a. the physicians or dentists may communicate with each other concerning any contractual term or condition to be negotiated with the carrier;

b. the physicians or dentists may communicate with the joint negotiation representative authorized to negotiate on their behalf with the carrier concerning any contractual term or condition;

c. the joint negotiation representative shall be the sole party authorized to negotiate with the carrier on behalf of the physicians or dentists as a group;

d. the physicians or dentists may, at the option of each physician or dentist, agree to be bound by the terms and conditions negotiated by the joint negotiation representative; and

e. when communicating or negotiating with a joint negotiation representative, a carrier may offer different contractual terms or conditions to, or may contract with, individual independent physicians or dentists.

C.52:17B-201 Inapplicability of act.

6. The provisions of this act shall not apply to a health benefits or dental plan which is certified by the Commissioner of Human Services to the Attorney General as providing covered services exclusively or primarily to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the Children's Health Care Coverage Program under P.L.1997, c.272 (C.30:4I-1 et seq.) or the FamilyCare Health Coverage Program under P.L.2000, c.71 (C.30:4J-1 et seq.).

C.52:17B-202 Requirements to act as joint negotiation representative.

7. A person or entity which proposes to act as a joint negotiation representative shall satisfy the following requirements:

a. Before entering into negotiations with a carrier on behalf of two or more independent physicians or dentists, the joint negotiation representative shall submit to the Attorney General, for his approval pursuant to section 8 of this act, on a form and in a manner prescribed by the Attorney General, a petition which identifies:

(1) the representative's name and business address;

(2) the names and business addresses of each physician or dentist who will be represented by the identified representative;

(3) the ratio of the physicians or dentists requesting joint representation to the total number of physicians or dentists who are practicing within the geographic service area of the carrier;

(4) the carrier with which the representative proposes to enter into negotiations on behalf of the identified physicians or dentists;

(5) the intended subject matter of the proposed negotiations with the identified carrier;

(6) the representative's plan of operation and procedures to ensure compliance with the provisions of this act;

(7) the anticipated effect of the proposed joint negotiations on the quality and availability of health or dental care among covered persons;

(8) the anticipated benefits of a contract between the identified physicians or dentists and carrier;

(9) such other data, information and documents as the petitioners desire to submit in support of their petition; and

(10) such other data, information and documents as the Attorney General deems necessary.

The joint negotiation representative, upon submitting the petition, shall pay a fee to the Attorney General in an amount, as determined by the Attorney General, which shall be reasonable and necessary to cover the costs associated with carrying out the provisions of this act.

b. After the joint negotiation representative and the carrier identified pursuant to subsection a. of this section have reached an agreement on the contractual terms or conditions that were the subject matter of their negotiations, the joint negotiation representative shall submit to the Attorney General, for his approval in accordance with the provisions of section 8 of this act, a copy of the proposed contract between the physicians or dentists identified pursuant to subsection a. of this section and the carrier, as well as any plan of action which the joint negotiation representative and the carrier may formally agree to for the purpose of implementing the terms and conditions of the contract.

c. Within 14 days after either party notifies the other party of its decision to decline or terminate negotiations entered into pursuant to this act, or after the date that a joint negotiation representative requests that a carrier enter into such negotiations to which request the plan fails

to respond, the joint negotiation representative shall report to the Attorney General that the negotiations have ended, on a form and in a manner to be prescribed by the Attorney General. The joint negotiation representative may resume negotiations with the carrier no later than 60 days after reporting to the Attorney General that the negotiations have ended, on the basis of the petition submitted to the Attorney General pursuant to subsection a. of this section and approved by the Attorney General in accordance with the provisions of section 8 of this act. After that date, the joint negotiation representative shall be required to submit a new petition and pay an additional fee to the Attorney General pursuant to subsection a. of this section, in order to engage in negotiations with the carrier under this act.

C.52:17B-203 Powers, duties of Attorney General.

8. a. The Attorney General shall provide written approval or disapproval of a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act no later than 30 days after receipt of the petition or proposed contract, as applicable. If the Attorney General fails to provide written approval or disapproval within this time period, the joint negotiation representative may petition a court of competent jurisdiction for an order to require the Attorney General to take such action. If the Attorney General disapproves the petition or the proposed contract, he shall forward a written explanation of any deficiencies therein to the joint negotiation representative along with a statement of the specific remedial measures by which those deficiencies may be corrected.

A joint negotiation representative shall not engage in negotiations with a carrier over any contractual term or condition unless the petition furnished by the joint negotiation representative has been approved in writing by the Attorney General, nor shall a proposed contract between two or more independent physicians or dentists and a carrier be implemented unless the Attorney General has approved the contract.

b. The Attorney General shall approve a petition or a proposed contract furnished by a joint negotiation representative pursuant to section 7 of this act if the Attorney General determines that the petition or proposed contract demonstrates that the benefits which are likely to result from the proposed joint negotiations over a contractual term or condition or the proposed contract, as applicable, outweigh the disadvantages attributable to a reduction in competition that may result from the proposed joint negotiations. In making his determination, the Attorney General shall consider physician or dentist distribution by specialty and its effect on competition in the geographic service area of the carrier.

c. The Attorney General's written approval of a petition which is furnished by a joint negotiation representative under section 7 of this act shall be effective for all subsequent negotiations between the joint negotiation representative and the identified carrier, subject to the provisions of subsection c. of section 7 of this act.

d. In the case of a petition submitted pursuant to subsection a. of section 7 of this act, the Attorney General shall notify the carrier of the petition and provide the carrier with the opportunity to submit written comments within a specified time frame that does not extend beyond the date by which the Attorney General is required to act on the petition.

C.52:17B-204 Application for hearing.

9. a. Within 30 days from the mailing by the Attorney General of a notice of disapproval of a petition submitted under section 7 of this act, the petitioners may make a written application to the Attorney General for a hearing.

b. Upon receipt of a timely written application for a hearing, the Attorney General shall schedule and conduct a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The hearing shall be held within 30 days of the application unless the petitioner seeks an extension.

c. The sole parties with respect to any petition under section 7 of this act shall be the petitioners, and notwithstanding any other provision of law to the contrary, the Attorney General shall not be required to treat any other person as a party and no other person shall be entitled to appeal the Attorney General's determination.

C.52:17B-205 Confidentiality of information.

10. All information, including documents and copies thereof, obtained by or disclosed to the Attorney General or any other person in a petition under section 7 of this act, shall be treated confidentially and shall be deemed proprietary and shall not be made public or otherwise disclosed by the Attorney General or any other person without the written consent of the petitioners to whom the information pertains.

C.52:17B-206 Good faith negotiation required.

11. A carrier and a joint negotiation representative shall negotiate in good faith regarding the terms and conditions of physician or dentist contracts pursuant to this act.

C.52:17B-207 Construction of act.

12. a. The provisions of this act shall not be construed to:

(1) permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services which they provide;

(2) permit two or more physicians or dentists to meet or communicate in order to jointly negotiate a requirement that at least one of the physicians or dentists, as a condition of participation with a carrier, be allowed to participate in all of the products offered by the carrier;

(3) permit two or more physicians or dentists to jointly negotiate with a carrier to exclude, limit or otherwise restrict a non-physician or non-dentist health care provider from participating in the carrier's health benefits or dental plan based substantially on the fact that the health care provider is not a physician or dentist, unless that exclusion, limitation or restriction is otherwise permitted by law;

(4) prohibit or restrict activity by physicians or dentists that is sanctioned under federal or State law or subject such activity to the requirements of this act;

(5) affect governmental approval of, or otherwise restrict activity by, physicians or dentists that is not prohibited under federal antitrust law; or

(6) require approval of physician or dentist contract terms to the extent that the terms are exempt from State regulation under section 514(a) of the "Employee Retirement Income Security Act of 1974," Pub.L.93-406 (29 U.S.C. s.1144(a)).

b. Prior to entering into negotiations with a carrier on behalf of two or more independent physicians or dentists over a contractual term or condition, a joint negotiation representative shall notify the physicians or dentists in writing of the provisions of this act and advise them as to their potential for legal action against physicians or dentists who violate federal antitrust law.

C.52:17B-208 Report to Governor, Legislature by Attorney General.

13. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than four years after the effective date of this act on its implementation.

The report shall include the number of petitions submitted for approval to engage in joint negotiations and the outcome of the petitions and the negotiations, an assessment of the effect the joint negotiations provided for in this act has had in restoring the competitive balance in the market for health care or dental services and in protecting access to quality patient care, an assessment of the impact this act has had on health insurance premiums in the State, and such other information that the Attorney General deems appropriate. The report shall also include the Attorney General's recommendations as to whether the provisions of this act shall be expanded to include other types of health care professionals and facilities.

The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, shall report to the Governor and the Legislature no later than five years after the effective date of this act with his recommendation as to whether this act shall be made permanent.

C.52:17B-209 Rules, regulations.

14. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968,

c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

15. This act shall take effect 90 days after enactment and shall expire six years after the effective date, but the expiration of this act shall not impair any contract negotiated pursuant to this act that is in effect on the date of expiration. The Attorney General, in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, may take such anticipatory administrative action in advance of the effective date as shall be necessary to implement the act.

Approved January 8, 2002.