(c) HMOs shall, upon request, provide a written document to consumers setting forth the information required to be disclosed to members.

1. The HMO shall not be required to provide the consumer with the same level of detail that is provided to members in the provider directory pursuant to (d)6 below, but the HMO shall provide at least the following information:

i. The number of medical providers categorized by specialty by county in the carrier's network;

ii. The number of hospitals categorized by county in the HMO's network;

iii. The approximate percentage of the medical providers in the HMO's network that are board certified, and the date on which the calculation of the percentage was last performed;

iv. The waiting time criteria that the HMO utilizes in its selection of providers for participation in the HMO's network, if any, including a statement that no such criteria apply in those instances in which the HMO does not consider patient waiting times for appointments for routine and urgent care in selecting participating providers;

v. A statement that consumers can check with providers directly to find out if the provider is a participating provider; and

vi. A statement that the consumer may obtain more detailed information, including a current provider directory (if not already included), and the process by which consumers may obtain the information free of charge.

(1) HMOs that elect to make their lists of participating providers available through an electronic database accessible to the public shall not substitute electronic access to the information as the only means by which consumers may obtain the information free of charge.

2. The information provided to consumers may be in a single document or multiple documents, except that when an HMO uses multiple documents for its provider lists, the HMO shall cross reference in each provider lists all other lists of health care providers for which the HMO is required to provide coverage, or benefits therefor, pursuant to statute or rule.

(d) The statement of the member's rights shall include at least the right:

1. To available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions. The statement shall include a reminder that the "911" emergency response system should be called whenever a member has a potentially life-threatening condition. This information shall also be provided on the membership identification cards;

2. To be treated with courtesy and consideration, and with respect for the member's dignity and need for privacy;

3. To be provided with information concerning the HMO's policies and procedures regarding products, services, providers, appeals procedures and other information about the organization and the care provided;

4. To choose a primary care provider within the limits of the covered benefits and availability and included as participating providers in the plan network;

5. To be afforded a choice of specialists among participating network providers following an authorized referral, subject to their availability to accept new patients;

6. To obtain a current directory of participating providers in the HMO network upon request, including addresses and telephone numbers, and a listing of providers who accept members who speak languages other than English;

7. To obtain assistance and referral to providers with experience in treatment of patients with chronic disabilities;

8. To receive from the member's physician(s) or provider, in terms that the member understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, whether or not these are covered benefits. If the member is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the member's medical record;

9. To be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract;

10. To formulate and have advance directives implemented;

11. To all the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands;

12. To prompt notification, as required in this chapter, of termination or changes in benefits, services or provider network; and

13. To file a complaint or appeal with the HMO or the Departments of Health and Senior Services and Banking and Insurance and to receive an answer to those complaints within a reasonable period of time.

(e) The HMO shall establish and implement written policies and procedures regarding the responsibilities of members, such as financial responsibilities, including copayments and deductibles. A complete statement of these responsibilities shall be included in the member's benefit handbook.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Rewrote (b)3; inserted a new (c); and recodified former (c) and (d) as (d) and (e).

SUBCHAPTER 10. MEDICAL RECORDS

8:38–10.1 Policies and procedures

(a) The HMO shall develop and implement a policy for the transfer of medical records of members whenever the following occur:

1. Change of physician or other provider;
2. Disenrollment of member from HMO; or
3. Other circumstances where requested by members or former members;

(b) Transfer of members' medical records as maintained by the HMO shall be completed within 30 days of the occurrence of events specified at (a)1, 2, or 3 above.

8:38–10.2 Confidentiality of medical records

Any data or information pertaining to the diagnosis, treatment, or health of any member or applicant obtained from the member or from any provider by any HMO shall be held in confidence. The data or information shall not be disclosed to any person, except to the extent that it may be necessary to carry out the purposes of this chapter, or upon the express consent of the member or applicant; or pursuant to state or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such member and the HMO wherein such data or information is pertinent as otherwise provided by law. An HMO shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health organization is entitled to claim. An HMO may also release aggregate data related to the diagnosis, treatment, or health of all or groups of members or applicants where the identity of every member is kept confidential and cannot be determined by the manner in which the data is released and presented.

8:38–10.3 Maintenance of medical records

Any medical records directly maintained by the HMO shall be organized in a uniform format across all records subject to the requirements of applicable law. The HMO shall have policies governing the contents of medical records.

8:38–10.4 Copies of medical records

Members or their legally authorized representatives shall have a right to inspect and obtain a copy of their medical records maintained by the HMO. Charges for copies of medical records shall be based upon actual costs, not to exceed prevailing community rates for photocopying.

8:38–10.5 Medical record retention

Medical records maintained by HMO's shall be protected against loss, destruction, or unauthorized use and retained for at least 10 years or until the member reaches age 23 years, whichever is longer.

SUBCHAPTER 11. FINANCIAL STANDARDS AND REPORTING

8:38–11.1 Minimum net worth

(a) In order to obtain a certificate of authority, an HMO shall have a minimum net worth, determined on a SAP basis, of at least $1,500,000 in cash or cash equivalents, as adjusted annually by the CPI, together with such other guarantees and assets as the Commissioner and Commissioner of Banking and Insurance may determine appropriate to assure the solvency of the HMO, based on its business plan, beginning on July 1, 1997.

(b) Except as (d) below applies, in order to maintain its certificate of authority, an HMO shall maintain at all times a minimum net worth, determined on a SAP basis, equal to the greater of:

1. $1,000,000 adjusted annually by the CPI, beginning on July 1, 1997;
2. Two percent of the annual premium revenues as reported by the HMO on its most recent annual financial statement filed with the Commissioner and Commissioner of Banking and Insurance for the first $150,000,000 of premium reported and one percent of the annual premium in excess of the first $150,000,000 of premium reported;
3. An amount equal to the sum of three months of uncovered health care expenditures, as reported on the financial statement filed most recently with the Commissioner and Commissioner of Banking and Insurance; or
4. An amount equal to the sum of eight percent of the annual health care expenditures (not including those expenditures paid on a capitated basis to a provider and those made on a managed hospital payment basis), as reported on the four quarterly financial statements most recently filed with the Commissioner and Commissioner of Banking and Insurance, plus four percent of the annual hospital expenditures paid on a managed hospital payment basis, as reported in the four quarterly financial statements most recently filed with the Commissioner and Commissioner of Banking and Insurance. If an HMO is issued an initial certificate of authority on or after July 1, 1997, its minimum net worth shall be phased in over a 48 month period, running from the date that its new certificate of authority is effective, as follows:

i. Twenty-five percent of the amount required in (b)4 above, or the greater of (b)1, 2 or 3 above, whichever is greatest, until the end of the 23rd month following the month in which its new certificate of authority was effective;

ii. Fifty percent of the amount required in (b)4 above, or the greater of (b)1, 2 or 3 above, whichever is greatest from months 24 through 35;

iii. Seventy-five percent of the amount required in (b)4 above, or the greater of (b)1, 2 or 3 above, whichever is greatest, from months 36 through 47; and

iv. One hundred percent of the amount required in (b)4 above beginning in the 48th month following the month in which its new certificate of authority was effective.

(c) In order to maintain its certificate of authority, a minimum of 60 percent of an HMO's admitted assets shall be cash, cash equivalents, investments as set forth at N.J.S.A. 17B:20–1a, or other forms of investments acceptable to the Commissioner considering the amount of the HMO's assets and the proportion of admitted assets to the HMO's minimum net worth requirement.

(d) Every HMO shall submit a capital and surplus (minimum net worth) guarantee on a form established and available from the Department of Banking and Insurance, executed by an affiliate or parent of the HMO that is not in an unsafe or unsound financial condition, consistent with N.J.A.C. 11:2–27, Determination of Insurers in a Hazardous Financial Condition, incorporated herein by reference, except that an HMO that has no such parent or affiliate available to execute a capital and surplus guarantee shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that other additional financial resources are available to the HMO to maintain the HMO's minimum net worth requirement. All guarantors shall satisfy the following requirements:

1. The guarantor shall have liquid assets, letters of credit or a similar instrument available to support the guarantee in a manner and amount acceptable to the Commissioner of Banking and Insurance.

2. If the guarantor is publicly held, the HMO shall submit the guarantor's quarterly and annual Securities and Exchange Commission (SEC) filing no later than 15 days after such filing has been made with the SEC. If not publicly held, the HMO shall submit the guarantor's unaudited quarterly financial statement no later than 45 days after the end of the calendar quarter.

3. All guarantors shall meet the following requirements:

i. The guarantor shall be a United States corporation actively engaged in business for a period of not less than five years;

ii. The guarantor shall have a satisfactory evaluation from Dun and Bradstreet, Standard and Poor's, Duff and Phelps or Moody's for at least three years;

iii. The guarantor shall have a net worth of at least $25 million; and

iv. If the guarantor fails to meet any of the requirements in (d)3i through iii above, a letter of credit or other form of financial security acceptable to the Commissioner of Banking and Insurance shall be required.

(e) In determining net worth, a debt shall not be considered fully subordinated unless the subordination clause states that:

1. Principal and/or interest shall be paid to the lender only from free and divisible surplus as verified by the audited financial statement of the HMO;

2. Upon the dissolution or liquidation of the HMO, no payment shall be made with respect to the surplus note or other note made with that lender unless and until all other liabilities of the HMO have been paid in full; and

3. Written approval shall be obtained from the Commissioner of Banking and Insurance prior to any full or partial repayment of any principal or interest under the note.

(f) Any debt incurred by a note meeting the requirements of (e) above and which is otherwise acceptable to the Commissioner of Banking and Insurance shall not be considered a liability, but shall be reported as equity by the HMO.

(g) The interest expenses relating to the repayment of any fully subordinated debt shall be a covered expenditure.

(h) Every HMO shall be subject to the standards and corrective actions set forth at N.J.A.C. 11:2–27, Determination of Insurers in a Hazardous Financial Condition, which shall be in addition to the requirements of N.J.A.C. 8:38–11.6(f).

(i) No HMO shall enter into transactions for loans or other transfers of funds from or to the HMO without providing at least 30 days prior written notice of the transaction to the Commissioner and the Commissioner of Banking and Insurance.

1. The Commissioner of Banking and Insurance may disapprove the transaction if, in the Commissioner's opinion, the transaction will adversely affect the HMO and cause it to be in a hazardous financial condition, in accordance with N.J.A.C. 11:2–27.

2. The Commissioner or the Commissioner of Banking and Insurance may disapprove the transaction pending receipt of additional information from the HMO.

3. The disapproval shall specify in writing the reasons for the disapproval.

i. If the disapproval includes a request for additional information, the disapproval shall include the date by which the additional information is due from the HMO.

ii. An HMO shall have no less than five business days in which to respond to a disapproval with a request for more information.

4. If the Commissioner or Commissioner of Banking and Insurance does not disapprove of the transaction within 30 days of the date that the written notice is received by the Department of Banking and Insurance, the transaction shall be deemed approved.

i. With respect to filings for which additional information has been requested, if the Commissioner or the Commissioner of Banking and Insurance does not disapprove the transaction within 30 days following receipt by the Department of Banking and Insurance of the additional information as requested, the transaction shall be deemed approved.

(j) No HMO shall pay out dividends except in accordance with N.J.S.A. 17:27A–4 and N.J.A.C. 11:1–35.

Public Notice: Increase in medical component of the Consumer Price Index.
See: 29 N.J.R. 2484(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 30 N.J.R. 1330(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 31 N.J.R. 801(a).
Amended by R.1999 d.201, effective June 21, 1999.
See: 31 N.J.R. 610(a), 31 N.J.R. 1631(a).
In (b)4, inserted "to a provider" following "basis"; inserted a new (c); rewrote former (c) as (d); deleted former (d); in (i), deleted ", in accordance with N.J.S.A. 26:2J–5" at the end of the introductory paragraph; and in (j), substituted ", adversely impact compliance with other provisions of this chapter, or" for "and" following "HMO".
Public Notice: Increase in medical component of the Consumer Price Index.
See: 32 N.J.R. 1259(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 33 N.J.R. 1145(a).
Amended by R.2001 d.126, effective April 16, 2001.
See: 33 N.J.R. 159(a), 33 N.J.R. 1196(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 34 N.J.R. 1556(b).
Amended by R.2002 d.265, effective August 19, 2002.
See: 34 N.J.R. 885(a), 34 N.J.R. 3014(a).
Rewrote (j).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 35 N.J.R. 1596(a).

8:38–11.2 Investments

Except as approved by the Commissioner of Banking and Insurance in accordance with N.J.S.A. 26:2J–5a(1) and (3), all investments of HMOs shall be subject to and in compliance with N.J.S.A. 17B:20–1 et seq.

8:38–11.3 Reserve liabilities

(a) An HMO shall maintain at all times reserve liabilities in an amount sufficient to provide for:

1. All claims incurred, whether reported or unreported, which are unpaid and for which the HMO is or may become liable, including the expense of adjustment or settlement of those claims;

2. Continued health care services to members for which a consideration has been received, or a consideration is due but unpaid; and

3. Continued health care services under the HMO contract to members who, on the date of termination of the HMO contract, are confined in an inpatient facility until discharge from the facility.

Amended by R.1999 d.201, effective June 21, 1999.
See: 31 N.J.R. 610(a), 31 N.J.R. 1631(a).
Added (a)3.

8:38–11.4 Minimum deposits

(a) In order to obtain a certificate of authority, every HMO shall deposit with the Commissioner of Banking and Insurance no less than $300,000, adjusted annually by the CPI beginning on July 1, 1997 in accordance with N.J.A.C. 11:2–32, Custodial Deposits.

(b) In order to maintain a certificate of authority, every HMO shall annually adjust the deposit specified in (a) above to equal 20 percent of its minimum net worth, except that such deposit shall be no less than $300,000 and no more than $1,000,000 (as the minimum and maximum amounts are adjusted by the CPI).

(c) The deposit required by (a) above, adjusted in accordance with (b) above, shall be subject to the following:

1. The deposit shall be and remain an admitted asset of the HMO for purposes of determining net worth of the HMO.

2. The Commissioner of Banking and Insurance shall use the deposit for administrative costs directly attributable to the rehabilitation, conservation or liquidation of the HMO.

3. All interest and other investment income derived from the deposit made shall be paid to the HMO annually upon written request.

4. An HMO may withdraw the deposit, or any part thereof, after making a substitute deposit of cash, securities, or other instruments permissible under N.J.A.C. 11:2–32, of equal amount and value.

(d) Every HMO shall, except as (d)4iii below may apply, maintain a deposit with the Commissioner of Banking and Insurance. The deposit shall be held in trust as a restricted asset to offset reserves required pursuant to N.J.A.C. 8:38–11.3(a)1. The deposit shall be made in accordance with N.J.A.C. 11:2–32 except that the HMO may request permission from the Commissioner to use a custodian other than the custodian appointed pursuant to N.J.A.C. 11:2–32.3(a). Notwithstanding the requirements of N.J.A.C. 11:2–32.3(b), the securities deposited with the custodian may be those which constitute eligible investments for life insurance companies pursuant to N.J.S.A. 17B:20–1a.

1. The required deposit amount shall be the equivalent of 50 percent of the highest calendar quarterly premium of the most recent four quarters.

i. The initial or incremental premium-based deposit due following June 21, 1999 may be payable over a two-year (two-deposit) period pursuant to a plan approved by the Commissioner. HMOs may request an additional maximum one-year extension. An extension request shall be in writing and filed with the HMO's quarterly report due March 1 of the second year of the two-year phase-in period. The Commissioner shall grant an extension if the HMO is determined to be in "hazardous financial condition" as that term is defined at N.J.A.C. 11:2–27.2.

ii. Recalculation of the deposit amount shall occur no more frequently than annually.

2. The deposit and the accumulated investment income thereof shall be and remain an admitted asset of the HMO for purposes of determining net worth of the HMO.

3. The Commissioner of Banking and Insurance shall use this deposit of the HMO for costs of rehabilitation and/or liquidation of the HMO.

4. An HMO may withdraw its deposit or any part thereof, subject to the prior written approval of the Commissioner of Banking and Insurance, if:

i. A substitute deposit of cash, securities or other instruments permissible under paragraph (d) above is made of equal amount and value;

ii. The fair market value of the deposit exceeds the amount required to be held on deposit determined in accordance with (d)1 above; or

iii. The required deposit amount is reduced by the Commissioner of Banking and Insurance as a result of discontinuance or sale of a line of business.

5. All income from the deposit made shall be an asset of the HMO, and the HMO may withdraw the income from such deposit on an annual basis, if the deposit and accumulated investment income exceeds the amount required to be held on deposit, subject to the prior written approval of the Commissioner of Banking and Insurance.

6. The HMO shall record the dedicated reserve for accounting purposes as "Assets as Restricted Cash and Other Assets."

(e) HMOs shall determine when incremental deposits are necessary (based on the most recently filed SAP annual financial report) to assure that the required amount of deposits are maintained and shall make any necessary incremental deposit annually by June 30.

Public Notice: Increase in medical component of the Consumer Price Index.
See: 29 N.J.R. 2484(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 30 N.J.R. 1330(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 31 N.J.R. 801(a).
Amended by R.1999 d.201, effective June 21, 1999.
See: 31 N.J.R. 610(a), 31 N.J.R. 1631(a).
In (b), substituted a reference to minimum net worth for a reference to net worth; and rewrote (d).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 32 N.J.R. 1259(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 33 N.J.R. 1145(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 34 N.J.R. 1556(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 35 N.J.R. 1596(a).

8:38–11.5 Plan for continuation of services upon declaration of insolvency

(a) In order to obtain and maintain a certificate of authority, an HMO shall submit a plan to the Commissioner and the Commissioner of Banking and Insurance, which assures continuation of services and benefits to members when the HMO is declared by a court of competent jurisdiction to be insolvent and placed in rehabilitation or liquidation.

1. Such plan shall assure the continuation of services and benefits to all members for the duration of the contract period for which premiums or other consideration has been paid and for any applicable grace period.

2. Such plan shall assure the continuation of services and benefits under the HMO contract to members who, on the date of the declaration of insolvency, are confined in an inpatient facility until their discharge from the facility, or their contractual benefits are otherwise exhausted, whichever occurs first.

(b) In determining whether such a plan is acceptable for the issuance or continuance of a certificate of authority, the Commissioner and the Commissioner of Banking and Insurance may require one or more of the following:

1. The purchase of insurance by the HMO to cover the expenses to pay for continued covered benefits to members following a judicial declaration of the HMO's insolvency;

2. Additional deposits;

3. Acceptable letters of credit; and/or

4. Other arrangements guaranteeing that benefits shall be continued.

Amended by R.1999 d.201, effective June 21, 1999.
See: 31 N.J.R. 610(a), 31 N.J.R. 1631(a).
Rewrote (a); and in (b), inserted "or continuance" following "issuance" and inserted a reference to the Commissioner in the introductory

paragraph, and substituted a reference to judicial declarations for a reference to determinations in 1.

8:38–11.6 Financial reporting requirements

(a) Every HMO shall submit, no later than March 1, an annual report for the immediately preceding calendar year, completed as prescribed by the NAIC Annual Statement Instructions for Health Maintenance Organizations, and completed on a SAP basis, in accordance with the NAIC Accounting Practices and Procedures Manual, effective January 1, 2001, incorporated herein by reference, as amended and supplemented (NAIC, 2301 McGee Street, Kansas City, MO 64108).

1. HMOs shall submit the annual report for calendar year 1996 (reported in March 1997) and thereafter using the current format established for any year by the National Association of Insurance Commissioners for HMOs, more commonly referred to as the "NAIC blank" for HMOs, the forms of which are available for purchase through several independent insurance service companies throughout the United States.

2. Every HMO shall submit with the annual report a certification of and an opinion by a member of the American Academy of Actuaries or an active fellow of the Society of Actuaries that the reserves required by N.J.A.C. 8:38–11.3 and included on the HMO's SAP annual report are sufficient.

i. The actuarial certification shall identify the specific methodology used to determine the reserves, and shall specify whether and how the methodology has changed since the last report.

ii. The workpapers prepared by the actuary in support of the certification shall be made available to the Department of Banking and Insurance upon request.

(b) Every HMO shall submit, no later than June 1, audited annual financial reports for the immediately preceding calendar year for the HMO and any company that is a financial guarantor for the HMO, completed on a SAP basis; except that any financial guarantor that is not an insurer or HMO shall submit audited annual financial reports as set forth herein on a GAAP basis.

1. The annual audited financial report shall include:

i. A report of an independent certified public accountant;

ii. A balance sheet reporting admitted assets, liabilities, capital and surplus;

iii. A statement of operations;

iv. A statement of cash flows;

v. A statement of changes in capital and surplus; and

vi. Notes to financial statements in accordance with the NAIC Annual Statement Instructions.

2. The annual report shall be certified by an independent public accountant. The Commissioner of Banking and Insurance shall not recognize any person or firm as a qualified independent public accountant unless they are in good standing with the American Institute of Certified Public Accountants, and in all states in which the accountant is licensed to practice. Except as otherwise provided in this paragraph, an independent certified public accountant shall be recognized as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants and Rules and Regulations, Code of Ethics and Rules of Professional Conduct of the New Jersey Board of Public Accountancy or similar code.

i. No partner or other person responsible for rendering a report may act in that capacity for more than seven consecutive years. Following any period of service, such person shall be disqualified from acting in that or a similar capacity for the same company for a period of two years. An HMO may make application to the Commissioner of Banking and Insurance for relief from the above rotation requirement on the basis of unusual circumstances. The Commissioner of Banking and Insurance may consider the following factors in determining if the relief should be granted:

(1) The number of partners, expertise of the partners or the number of HMO clients in the currently registered firm; and

(2) The premium volume of the HMO;

ii. The Commissioner of Banking and Insurance shall not recognize as a qualified independent certified public accountant, nor accept any annual audited financial report, prepared in whole or in part by, any natural person who:

(1) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organization Act, 18 U.S.C. §§ 1961 through 1968, or any dishonest conduct or practices under Federal or state law, or similar conduct under any foreign law;

(2) Has been found to have violated the insurance laws of this State with respect to any previous reports submitted under this subchapter; or

(3) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this subchapter.