CHAPTER 38

HEALTH MAINTENANCE ORGANIZATIONS

Authority

N.J.S.A. 26:2J–1 et seq.

Source and Effective Date

R.1994 d.365, effective July 18, 1994.
See: 26 N.J.R. 1624(a), 26 N.J.R. 2896(a).

Executive Order No. 66(1978) Expiration Date

Chapter 38, Health Maintenance Organizations, expires on July 18, 1997.

Chapter Historical Note

Chapter 38, Health Maintenance Organizations, was adopted as R.1974 d.320, effective November 20, 1974. See: 6 N.J.R. 8(b), 6 N.J.R. 473(a). Pursuant to Executive Order No. 66(1978), Chapter 38 expired on April 3, 1994, and subsequently was adopted as new rules by R.1994 d.365. Expired Subchapter 4, Qualifications and Regulations, was not included in the adoption of new rules. See: Source and Effective Date. See, also, section annotations for specific rulemaking activity.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:38–1.1 Health care services

(a) Health care services include basic health care services and any additional health care related services deemed necessary by the commissioner for the obtaining and maintenance of optimal health.

(b) In addition to basic health services, a health maintenance organization (either "group practice HMO" or "individual practice association") may provide any supplemental health care services which are in conformity with applicable laws and regulations.

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).
Amended by R.1989 d.180 effective April 3, 1989.
See: 21 N.J.R. 6(a), 21 N.J.R. 895(a).
Reference added to either group HMO or individual association.

8:38–1.2 Basic health care services

(a) Basic health care services includes the following minimal services to be provided or arranged by the HMO (either "group practice HMO" or "individual practice association"):

1. Health professional services:

i. Periodic examinations and office visits by a physician in order to facilitate patient management plans;

ii. Periodic screening examinations and disease detection studies;

iii. Obstetrical care (pre and postnatal care of mother);

iv. Regular pediatric care, including newborn care and immunizations as medically necessary;

v. Services of a surgeon;

vi. Anesthesia;

vii. Inpatient medical care in hospital and/or skilled nursing facility;

viii. Diagnostic and therapeutic radiology;

ix. Consultations and specialists' services as requested by the attending physician;

x. Twenty-four-hour a day emergency services, seven days a week;

xi. Short-term physical medicine (including physical therapy);

xii. Out-of-area medical services when indicated for accidental injury or emergency illness;

xiii. Diagnostic laboratory services;

xiv. Short-term (not to exceed 20 visits) outpatient evaluative and crisis intervention mental health services.

2. Institutional services;

i. Inpatient hospital care, including semiprivate room accommodation and other inpatient hospital services, medications as appropriately ordered by a physician and supplies that are usually provided by the hospital;

ii. Skilled nursing facility services (a minimum of 30 days during any contract year);

iii. Home health services (a minimum of 60 home care visits during any contract year); and

iv. Emergency and out-of-area hospital services when indicated for accidental injury or emergency illness.

3. Supportive services;

i. Ambulance services when authorized by a member of the staff;

ii. Health education services which shall include education in the appropriate and effective use of health services (through information about these services, including recommendations of generally accepted medical standards for the frequency of use of such services) and in the contribution each enrollee can make to the maintenance of his or her own health (through instruction in personal health care measures);

iii. Nutritional education and counseling;

iv. Medical social services which shall include appropriate assistance in dealing with the physical, emotional and economic impact of illness and disability through services such as pre and posthospitalization planning, referral to services provided through community health and social welfare agencies, and related family counseling; and

v. Preventive health services (including voluntary family planning services, infertility services and children's eye examinations conducted to determine the need for vision correction).

As amended, R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–1.3 Supplemental health care services

(a) Supplemental health care services include, but are not limited to, the following additional health services which are not considered under basic health care services:

1. Vision care not included as a basic health service;

2. Dental health services;

3. Mental health services not included as a basic health service;

4. The provision of long-term physical medicine and rehabilitative service (including physical therapy);

5. Podiatry services;

6. Provision of prescription drugs, corrective lenses or prostheses;

7. Services of facilities for long-term care; and

8. Extension of home health care of extended care not included as a basic health service.

As amended, R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–1.4 Establishment and operation of an HMO

(a) To establish and operate a health maintenance organization, the following conditions shall be met:

1. Certificate of need (N.J.S.A. 26:2H–7): Any HMO constructing a new health care facility, expanding or changing an existing health care facility, or instituting new health services, must comply with the provisions of N.J.S.A. 26:2H–7.

2. All requirements specified in Chapter 337, Laws of New Jersey, 1973, must be met.

3. A certificate of authority must be issued before commencement of operation of an HMO.

4. Evidence of compliance with the following requirements must be furnished to the Commissioner of the Department of Health on request:

i. There must be sufficient licensed primary care physicians, medical specialists and licensed optometrists associated with or available to the HMO to provide basic health care services. The number of providers is contingent upon enrollment size and prevailing standards;

ii. The professional staff must include sufficient licensed nurses, and other professionals such as nutritionists, health educators, and others to provide basic health care services;

iii. The HMO must have sufficient clinical space, equipment and furnishings to meet health care needs. The group practice HMO must be readily accessible geographically and transportation-wise to enrollees;

iv. The applicant must provide evidence of the availability of institutional services, including hospital and skilled nursing facility, to the enrollees to meet basic health care services;

v. Plans for an appropriate evaluative mechanism must be provided. This will refer to quality and quantity of ambulatory health care services, and utilization of hospital and extended care facility beds and other services;

vi. The health maintenance organization must provide a mechanism for communication between the plan and enrollees. This may be done by a panel, which has consumer representation, or by some other appropriate mechanism;

vii. Basic eye care services and supplemental vision care services shall be provided by licensed optometrists as well as by ophthalmologists, as medically appropriate. There shall be sufficient licensed optometrists associated with or available to the HMO to assure that, unless referral to an ophthalmologist is determined by the primary care physician to be medically required and outside the scope of practice of an optometrist, the enrollee can choose to have vision care services provided by a licensed optometrist.

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).
Amended by R.1989 d.180, effective April 3, 1989.
See: 21 N.J.R. 6(a), 21 N.J.R. 895(a).
(a)4.vii added, requiring provision of eye care by licensed optometrists as well as ophthalmologists.
Notice of Petition for Rulemaking concerning health maintenance organizations.
See: 22 N.J.R. 2607(a).
Receipt of Notice of Petition for rulemaking and notice of agency action on Health Maintenance Organizations.
See: 23 N.J.R. 779(a).

SUBCHAPTER 2. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

8:38–2.1 Scope

The following rules jointly developed by the Commissioner of Health and the Commissioner of Insurance govern the establishment of health maintenance organizations in New Jersey pursuant to the authority set forth in P.L. 1973 c.337, 83.

8:38–2.2 Application

An application, on forms provided by the health department, accompanied by a filing fee of $100.00 payable to New Jersey Department of Health shall be completed by the responsible officers of each entity desiring to obtain a certificate of authority as an HMO. Such fee shall not be returnable.

8:38–2.3 Certificate of need

When the establishment or operation of a health care facility or any change in or expansion of a health care facility or involves the institution of new health care services as defined in Section 7 of the Health Care Facilities Planning Act (P.L. 1971, c.136), said HMO shall comply with all pertinent provisions of P.L. 1971, c.136.

8:38–2.4 Supporting documents

(a) The application for a certificate of authority shall be accompanied by the following:

1. A copy of the basic organizational document of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto;

2. A copy of the bylaws, rules and regulations or similar document regulating the conduct of the internal affairs of the applicant;

3. A list of names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant;

4. A copy of any contract made or to be made between any providers or persons listed in paragraph 3 of this subsection and the applicant;

5. A copy of any contract made or to be made with an insurer or a hospital or medical service corporation;

6. A copy of the form of evidence of coverage to be issued to the enrollee;

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

8. Recent financial statements showing the applicant's assets, liabilities and sources of financial support;

9. A general description of the proposed method of marketing and financing and a statement as to the sources of funding;

10. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the commissioner and his successors in office and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action of proceeding against the health maintenance organization on a cause of action arising in this State may be served;

11. A statement reasonably describing the geographic area or areas to be served;

12. A general description of the complaint procedures to be utilized as required under Section 12 of P.L. 1973, c.337;

13. A general description of the procedures and programs to be implemented to meet the quality of health care requirements in Section 4.2 of P.L. 1973, c.337;

14. A general description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation;

15. Such other information as the commissioner may require to make the determinations required by Section 4 of P.L. 1973, c.337.

8:38–2.5 Licensure

The HMO shall comply with the licensure provisions of P.L. 1971, c.136.

8:38–2.6 Enrollee removal

(a) An enrollee may not have his or her membership in an HMO cancelled except for the following reasons:

1. Failure to pay the charge for such coverage.

2. Failure to abide by the rules and regulations of the HMO.

(b) Before an enrollee can be terminated for failure to abide by the rules and regulations, the HMO must document such violations and present this documentation to the commissioner for review and approval.

R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

SUBCHAPTER 3. ISSUANCE OF CERTIFICATE OF AUTHORITY

8:38–3.1 Scope

(a) Prior to issuance of a certificate of authority, both the commissioner and, the Commissioner of Insurance must be satisfied that several conditions have been met. Among these are:

1. That the health maintenance organization is financially sound and may reasonably be expected to meet its obligation to enrollees and prospective enrollees; and

2. That the organization's arrangements for health care services and the schedule of charges to enrollees used in connection therewith are financially sound.

(b) Sections 2 and 3 of this Subchapter will serve as minimum standards for determining such financial soundness.

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–3.2 Protection against insolvency

(a) Enrollees of a health maintenance organization will be deemed protected against financial loss provided that the health maintenance organization has deposited with the commissioner as of the beginning of each calendar quarter, cash or a form of guaranty or security in an amount equal to the anticipated payments to providers of health services during the calendar quarter then beginning. Only those payments to providers from funds of the organization which vary directly with the volume of services provided (that is, "fee-for-service" payments) need be considered. Salaries to physicians, "capitation" to providers, payments to providers by insurance companies, hospital or medical service corporations, or other such corporations need not be considered. Furthermore, whenever a provider has agreed by contract to look solely to the health maintenance organization for payment for any health services rendered to the enrollee, these payments may be disregarded in computing the deposit. However, except as hereafter provided in paragraph 2 of this subsection, that deposit may not thereby be reduced to less than 25 per cent of anticipated "fee-for-service" payments to providers from funds of the organization for the calendar quarter then beginning. At time of initial authorization by the commissioner, the deposit must be based on anticipated payments in the next full calendar quarter:

1. These deposits may be treated as assets of the organization, to the extent that they would be assets if actually held by the organization, and any investment return on the assets will be credited to the organization. However, in the event of insolvency of the organization, these deposits will be applied by the commissioner, initially for the protection of enrollees in the health maintenance organization, and only after all such costs have been satisfied may the balance, if any, of the deposit be applied to meet obligations to other creditors of the organization.

2. This deposit may be waived in its entirety or reduced in amount below the 25 per cent level at the discretion of the commissioner upon application by a health maintenance organization, in the event that the commissioner is satisfied that the assets of the organization or its contracts with insurers, hospital or medical service corporations, individual or institutional health care providers, governments (including loans and loan guarantees), or other organizations are sufficient to adequately protect the enrollees against financial loss. If any health maintenance organization is unable to meet any payment owed by the organization, the health maintenance organization must notify the commissioner within 30 days after payment is due.

(b) Quarterly financial reports, on forms prescribed by the commissioner shall be submitted to the Department of Health and Insurance.

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–3.3 Charges to enrollees

In order for charges to enrollees to be considered financially sound, they must be accompanied by certification of a qualified actuary which would state that the charges make adequate provision for claim costs, operating expenses and maintenance of at least the required deposit, if any. Details as to assumptions and methods of calculation must accompany certification.

8:38–3.4 (Reserved)

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–3.5 Provider contract termination

(a) The HMO shall establish a policy governing termination of providers. The policy shall include at least:

1 through 3. (Reserved)

4. Assurance of continued coverage of services at the contract price by a terminated provider for up to 120 calendar days in cases where it is medically necessary for the member to continue treatment with the terminated provider. In cases of the pregnancy of a member, medical necessity shall be deemed to have been demonstrated and coverage of services by the terminated provider shall continue to the postpartum evaluation of the member, up to six weeks after delivery. The policy shall clearly state that the determination as to the medical necessity of a member's continued treatment with a terminated provider shall be subject to the appeal procedures set forth at N.J.A.C. 8:38–8.5 through 8.7.

(b) (Reserved)

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

8:38–3.6 Complaint and appeal system

(a) through (d) (Reserved)

(e) No member or provider who exercises the right to file a complaint and/or appeal under this section shall be subject to disenrollment or otherwise penalized solely due to such complaint and/or appeal.

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

SUBCHAPTER 4. MEDICAL DIRECTOR

8:38–4.1 Designation of a medical director

(a) (Reserved)

(b) The medical director or his or her designee shall be designated to serve as the medical director for medical services provided to the HMO's New Jersey members. This physician shall be licensed to practice medicine in New Jersey and may also serve as the overall medical director of the HMO as required in (a) above.

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

SUBCHAPTER 5. HEALTH CARE SERVICES

8:38–5.1 through 8:38–5.2 (Reserved)

8:38–5.3 Emergency and urgent care services

(a) (Reserved)

(b) Emergency and urgent care services shall include, but are not limited to:

1 through 4. (Reserved)

5. Upon a member's arrival in a hospital, coverage of a medical screening examination, as required under Federal

law and as specified in N.J.A.C. 8:43G–12, as necessary to determine whether an emergency medical condition exists.

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

SUBCHAPTER 6. PROVIDER NETWORK

8:38–6.1 through 8:38–6.2 (Reserved)

8:38–6.3 Institutional services

(a) The HMO shall maintain contracts or other arrangements acceptable to the Department with institutional providers which have the capability to meet the medical needs of members and are geographically accessible. The network of providers shall include:

1 through 2. (Reserved)

3. Tertiary and specialized services as follows:

i. The HMO shall have a contract or otherwise agree to cover medically necessary trauma services at a reasonable cost with all Level I or II trauma centers designated by the New Jersey Department of Health and Senior Services pursuant to N.J.A.C. 8:33P. The member may not be balance billed for any covered trauma services provided by such designated trauma centers.

ii through iii. (Reserved)

4 through 5. (Reserved)

(b) through (c) (Reserved)

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

SUBCHAPTER 7. (RESERVED)

SUBCHAPTER 8. UTILIZATION MANAGEMENT

8:38–8.1 Utilization management program

(a) The HMO shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care and services. The program shall be under the direction of the medical director or his or her designee, who shall be a physician, and shall be based on a written plan that is reviewed at least annually. The plan shall identify at least:

1 through 6. (Reserved)

7. System for providers and members to appeal utilization management determinations in accordance with the procedures set forth at N.J.A.C. 8:38–8.4 through 8.7; and

8. (Reserved)

(b) (Reserved)

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

8:38–8.2 Utilization management staff availability

(a) A registered professional nurse or physician shall be immediately available by phone seven days a week, 24 hours a day, to render utilization management determinations for providers.

(b) (Reserved)

(c) All members must have immediate phone access seven days a week, 24 hours a day, to their primary care provider or his or her authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician on the utilization management staff must be available to respond to inquiries concerning emergency or urgent care.

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

8:38–8.3 Utilization management determinations

(a) (Reserved)

(b) All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The determination shall be directly communicated by the physician to the provider or, if this is not possible, the provider shall be supplied with the physician's name, telephone number, and where he or she can be reached. The physician shall be available immediately in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the HMO's New Jersey members. Such determinations shall be made in accordance with clinical and medical necessity criteria developed pursuant to N.J.A.C. 8:38–8.1(b) and the evidence of coverage.

(c) (Reserved)

(d) An HMO shall not retroactively deny reimbursement for a covered service provided to a member by a provider who relied upon the written or oral authorization of the HMO or its agents prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

(e) (Reserved)

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

8:38–8.4 Appeals of utilization management determinations

(a) (Reserved)

(b) Nothing in the HMO's policies, procedures or provider agreement shall prohibit a member or provider (on behalf of a member) from discussing or exercising the right to an appeal available under N.J.A.C. 8:38–8.5 through 8.7.

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

8:38–8.5 (Reserved)

8:38–8.6 Formal internal utilization management appeal process (Stage 2)

(a) through (e) (Reserved)

(f) If the stage 2 appeal is denied, the HMO shall provide the member and/or provider with written notification of the denial and the reasons therefor together with a written notification of his or her right to proceed to an external (stage 3) appeal. This notification shall include specific instructions as to how the member and/or provider may arrange for an external appeal and shall also include any forms required to initiate such an appeal.

(g) (Reserved)

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

8:38–8.7 External appeals process

(a) Any HMO member, and any provider acting on behalf of a member, with the member's consent, who is dissatisfied with the results of the internal appeal process set forth at N.J.A.C. 8:38–8.5 through 8.6 above, shall have the right to pursue his or her appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below (stage 3 appeal). Except as set forth in N.J.A.C. 8:38–8.6 (g), the right to an external appeal under this section shall be contingent upon the member's full compliance with both stages of the HMO internal appeal process set forth at N.J.A.C. 8:38–8.5 and 8.6.

(b) To initiate an external appeal, a member and/or provider shall, within 30 business days from receipt of the written determination of the stage 2 internal appeal panel under N.J.A.C. 8:38–8.6(f), file a written request with the Department. The request shall be filed on the forms provided to the member in accordance with N.J.A.C. 8:38–8.6(f), and shall include both the fee specified in (c) below and a general release executed by the member for all medical records pertinent to the appeal. The request shall be mailed to the following address:

Office of Managed Care
Division of Health Care Systems Analysis
CN 360
Trenton, New Jersey 08625–0360

(c) The fee for filing an appeal shall be $25.00, payable by check or money order to the "New Jersey Department of Health and Senior Services". Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by the member through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI, or New Jersey Unemployment Assistance.

(d) Upon receipt of the appeal, together with the executed release and the appropriate fee, the Department shall immediately assign the appeal to an IURO in accordance with N.J.A.C. 8:38–8.8, for review.

(e) Upon receipt of the request for appeal from the Department, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that:

1. The individual was or is a member of the HMO;

2. The service which is the subject of the complaint or appeal reasonably appears to be a covered service under the benefits provided by contract to the member;

3. Except as set forth at N.J.A.C. 8:38–8.6(g), the member has fully complied with both the stage 1 and stage 2 appeals available pursuant to N.J.A.C. 8:38–8.5 and 8.6; and

4. The member has provided all information required by the IURO and Department to make the preliminary determination including the appeal form and a copy of any information provided by the HMO regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the HMO and any other relevant health care provider.

(f) Upon completion of the preliminary review, the IURO shall immediately notify the member and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefor.

(g) Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the HMO's utilization management determination, the member was deprived of medically necessary covered services. In reaching this determination the IURO shall take into consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the HMO pursuant to N.J.A.C. 8:38–8.1(b).

(h) The full review referenced in (g) above shall initially be conducted by a registered professional nurse or a physician licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.

(i) The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event the IURO shall, prior to the conclusion of the preliminary review, provide written notice to the member and/or provider, to the Department, and to the HMO setting forth the status of its review and the specific reasons for the delay.

(j) If the IURO determines that the member was deprived of medically necessary covered services, the IURO shall recommend to the member and/or provider who filed the appeal, the HMO and the Department, the appropriate covered health care services the member should receive.

(k) Within 10 business days of the receipt of the determination of the IURO as set forth in (j) above, the HMO shall submit a written report to the IURO, the member and/or provider who filed the appeal, and the Department indicating whether it will accept and implement or reject the recommendations of the IURO. In the case of a rejection, the HMO shall specifically indicate in writing each and every basis for its rejection of the IURO's recommendation.

(*l*) Nothing in this section shall limit the authority of the Division of Medical Assistance and Health Services (DMAHS) or the Department of Human Services (DHS) to adopt in any contract to provide HMO services to Medicaid recipients, its own process for appeals of utilization management determinations. At the request of the Commissioner of Human Services, the Commissioner shall adopt, in accordance with N.J.S.A. 52:14B–1 et seq. and N.J.A.C. 1:30, any such appeals process proposed by DMAHS or DHS as the exclusive appeals process for all Medicaid HMO members, if he or she find that it meets or exceeds the standards set forth in this chapter.

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

8:38–8.8 General requirements for independent utilization review organizations

(a) The Department shall, from time to time, enter into contracts with as many independent utilization review organizations as it deems necessary to conduct the external appeals provided for under N.J.A.C. 8:38–8.7. The physician reviewers of the IUROs selected by the Department shall be experienced in managed care utilization review. The contracts shall set forth all terms which the Department deems necessary to ensure a member's right of appeal under N.J.A.C. 8:38–8.7 including, but not limited to, an assessment of separate costs to the HMO for the initial IURO review under N.J.A.C. 8:38–8.7(e) and the full review under N.J.A.C. 8:38–8.7(g).

(b) As a part of the contract process set forth in (a) above, all IUROs shall submit to the Department and shall maintain current, a list identifying all HMOs, health insurers, health care facilities and other health care providers with whom the IURO maintains any health related business arrangements. This list shall include a brief description of the nature of any such arrangement.

(c) Upon receipt of any request for an external appeal under N.J.A.C. 8:38–8.7(d) above, the Department shall assign that appeal to one of the approved IUROs on a random basis. The Commissioner reserves the right to deny any assignment to any IURO if, in his or her determination, such an assignment would result in a conflict of interest or would otherwise create an appearance of impropriety. In reaching such a determination, the Commissioner shall take into consideration the list required of IUROs in (a) above.

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

SUBCHAPTER 9. MEMBER RIGHTS AND RESPONSIBILITIES

8:38–9.1 Policies and procedures

(a) through (b) (Reserved)

(c) 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 through 7. (Reserved)

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 through 11. (Reserved)

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

13. (Reserved)

(d) (Reserved)

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

SUBCHAPTERS 10 THROUGH 12. (RESERVED)

SUBCHAPTER 13. LICENSING OF REPRESENTATIVES AND ADVERTISING

8:38–13.1 through 8:38–13.3 (Reserved)

8:38–13.4 Disclosure of provider compensation arrangements

(a) Every HMO shall make the following disclosure statement in all applications for enrollment and member handbooks:

DIFFERENT PROVIDERS IN OUR NETWORK HAVE AGREED TO BE PAID IN DIFFERENT WAYS BY US. YOUR PROVIDER MAY BE PAID EACH TIME S/HE TREATS YOU ("FEE-FOR-SERVICE"), OR MAY BE PAID A SET FEE EACH MONTH FOR EACH MEMBER WHETHER OR NOT THE MEMBER ACTUALLY RECEIVES SERVICES ("CAPITATION"), OR MAY RECEIVE A SALARY.

(The following statement shall be added if the HMO contracts directly or indirectly with providers to participate in financial incentive arrangements. For example, this includes financial incentive arrangements between an intermediate entity and a physician or physician group):

THESE PAYMENT METHODS MAY INCLUDE FINANCIAL INCENTIVE AGREEMENTS TO PAY SOME PROVIDERS MORE ("BONUSES") OR LESS ("WITHHOLDS") BASED ON MANY FACTORS: MEMBER SATISFACTION, QUALITY OF CARE, AND CONTROL OF COSTS AND USE OF SERVICES AMONG THEM.

In addition, each HMO shall make the following statement:

"IF YOU DESIRE ADDITIONAL INFORMATION ABOUT HOW OUR PRIMARY CARE PHYSICIANS OR ANY OTHER PROVIDERS IN OUR NETWORK ARE COMPENSATED, PLEASE CALL US (OR HMO NAME) AT [NUMBER] OR WRITE; [ADDRESS]."

(b) The HMO may propose alternate stylistic language for the statement in (a) above which may be utilized only with the prior written approval from both the Departments of Health and Senior Services and Banking and Insurance. Any modification must be written in plain language and cannot substantively alter the meaning and/or intent of the above section.

(c) All statements are required in (a) and (b) above shall be prominently displayed and printed in at least the same point and print as used for other material contained in the application and handbook other than captions or headings.

(d) HMOs shall be required to provide information in response to requests made pursuant to the disclosure requirement set forth in (a) above with respect to provider compensation by disclosing the method by which a specific provider is compensated. An HMO shall not be required to state the dollar amount of compensation or otherwise provide more specific information about the compensation arrangement it has with a specific provider.

(e) HMOs shall provide a copy of this disclosure statement to all members and prospective members upon March 15, 1997 and be allowed up to July 13, 1997 to bring their applications for enrollment and member handbooks into compliance and to begin distributing such revised member handbooks to current and new members.

New Rule, R.1997 d.68, effective February 18, 1997 (operative March 15, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

SUBCHAPTER 14. INDEMNITY BENEFITS OFFERED BY A HEALTH MAINTENANCE ORGANIZATION

Authority
N.J.S.A. 26:2J–21.

Source and Effective Date

R.1996 d.194, effective April 15, 1996.
See: 27 N.J.R. 4981(a), 28 N.J.R. 1981(c).

8:38–14.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the standards by which HMOs may offer and deliver a contract for a point of service product in New Jersey.

(b) This subchapter applies to all HMOs authorized to transact business in this State for the purposes of providing health care services in accordance with N.J.S.A. 26:2J–1 et seq.

8:38–14.2 Definitions

The following words and terms, when used in this subchapter, shall have the meanings set forth at N.J.S.A. 26:2J–1 et seq., and as specified below, unless the context clearly indicates otherwise:

"Carrier" means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17–4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48–1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A–1 et seq., or a health service corporation transacting business in accordance with N.J.S.A. 17:48E–1 et seq.

"Gatekeeper system" means a system in which a member is permitted to access service and/or obtain indemnity benefits for covered services only when the service is either rendered by the member's primary care provider, or the member's access to services and/or benefits is approved by the primary care provider or the HMO, as specified under the HMO's contract with the subscriber or contractholder.

"Group health contract" means a contract, filed by or with the New Jersey Department of Insurance or the Small Employer Health Benefits Program Board of Directors, as appropriate, issued by a carrier to a group of persons for the provision of indemnity benefits for expenses for covered services incurred in preventing or treating acute or chronic injury or illness of members, as specified in the contract. The term "group health contract" shall not include any contract issued on a form which has been disapproved or withdrawn from filing by the Department of Insurance, or determined incomplete by the Small Employer Health Benefits Program Board of Directors, as appropriate.

"Insurer" means any insurance company authorized to transact the business of insurance in New Jersey.

"Indemnity" means the payment of expenses, in whole or in part, as they are incurred by a member for the delivery of covered services, in which the level of payment for expenses incurred, and the charge made for the expenses incurred, is not negotiated between the health care provider and the HMO, and there is no contractual arrangement between the health care provider and the HMO holding the enrollee harmless for any amount of the expense not paid by the HMO. Payment of the expense may be made directly to the health care provider upon assignment by the member, or the member may be reimbursed for the expense incurred.

"Master policy" means the document issued by a carrier to an HMO evidencing coverage of the subscribers and members of the HMO, or a class of subscribers and members of the HMO, under a group health contract.

"Out–of–network covered services" means indemnity benefits for covered services rendered to an HMO member by someone other than the HMO's contracted health care providers.

"Point of service contract" or "POS contract" means a contractual arrangement between an HMO and a subscriber or member whereby the HMO makes provision for the rendering of covered services to its members through a network of health care providers as well as an out-of-network covered services option.

"Reinsurance–type contract" means a contract between an insurer and an HMO whereby the insurer agrees to indemnify the HMO for all expenses incurred by the HMO's members under a POS contract for out-of-network covered services, and further, the insurer agrees that it will indemnify the HMO's members for expenses incurred for out-of-network covered services for the duration of the period for which premiums are or have been paid by the contractholders or subscribers to the HMO, should the HMO be placed into conservation, rehabilitation or liquidation.

"Subscriber" means any person who has primary coverage for the provision of health care services to or on behalf of one or more members paid for by either the contractholder or the subscriber.

8:38–14.3 General standards

(a) Except as set forth in (b) below, an HMO shall not enter into any arrangement for the provision of out-of-network covered services to any subscriber or member that is not in compliance with this subchapter.

(b) An HMO providing out-of-network covered services under an arrangement approved by the Department of Insurance on or before April 15, 1996 shall bring the arrangement and any contracts issued under that arrangement into compliance with this subchapter beginning on the first 12 month anniversary date of each of the subscriber contracts occurring on or after October 12, 1996.

(c) An HMO shall not offer or provide any POS contract to groups of 50 or more until the form of that contract, along with applicable evidence of coverage forms, has been filed and approved or deemed approved, by the Departments of Health and Insurance; an HMO shall not offer or

provide a POS contract by rider, amendment or endorsement of any HMO contract.

1. If not disapproved within 60 days of the date of receipt by the Departments, the form shall be deemed filed, if not affirmatively approved prior thereto.

2. Disapproval of the form shall be in writing, and shall specify the reasons for the disapproval.

3. An HMO whose form has been disapproved shall have 60 days following the date of the initial disapproval within which to correct any deficiencies set forth in the notice of disapproval, and shall have 30 days following the date of notice of any subsequent disapproval within which to correct deficiencies. A resubmission of a form shall be deemed approved upon the expiration of 30 days following resubmission of the filing to the Departments of Health and Insurance unless the Departments of Health and Insurance approve or disapprove the resubmission within the 30 day period.

4. If an HMO does not respond to a notice of disapproval within the required timeframe, the matter shall be considered closed by the Departments of Health and Insurance; if the HMO desires further consideration of its form, it shall submit the form anew to the Departments of Health and Insurance.

(d) Contemporaneous with the submission of the POS contract form, the HMO shall make an informational rate filing with the Department of Insurance meeting the requirements of this subchapter.

(e) Submissions of forms and rates to the Department of Insurance shall be made to (and accompanied by the appropriate service fees, if any, specified at N.J.A.C. 11:1–32):

Managed Care Bureau
Life and Health Division
New Jersey Department of Insurance
CN 325
20 West State Street
Trenton, NJ 08625–0325

(f) The requirements of this subchapter shall be in addition to, and not in lieu of, more specific standards that may be established for compliance with the Individual Health Coverage Program, N.J.S.A. 17B:27A–2 et seq., and the Small Employer Health Benefits Program, N.J.S.A. 17B:27A–17 et seq., and rules promulgated pursuant thereto.

8:38–14.4 Out–of–network benefit restrictions under an HMO POS contract with a reinsurance-type or group master policy arrangement

(a) An HMO may offer a POS contract with or without a gatekeeper system for out-of-network covered services, except that any POS contract that is offered without a gatekeeper system for out-of-network covered services shall meet the following:

1. The deductible for the out-of-network covered services shall be no less than $250.00 per person per benefit period, or $500.00 per family per benefit period, and the coinsurance requirement shall be no less than 20 percent for the next $5,000 of covered charges for covered services per individual per benefit period, and no less than 20 percent for the next $10,000 of covered charges for covered services per family per benefit period; or

2. The deductible and coinsurance requirements are otherwise designed so that, in combination, there is a substantial disincentive to accessing out-of-network covered services, as determined satisfactory to the Commissioner of Insurance, consistent with (a)1 above.

(b) Notwithstanding that an HMO elects to utilize a gatekeeper system for out-of-network covered services, the HMO shall provide that the deductible and coinsurance requirements for the access of out-of-network covered services are otherwise designed so that, in combination, there is a reasonable disincentive to accessing such out-of-network covered services, as determined satisfactory to the Commissioner of Insurance.

(c) Notwithstanding (a) and (b) above, the actuarial value of the out-of-network covered services shall not vary by more than 30 percent from the actuarial value of the in-network covered services under any POS contract, as further specified at N.J.A.C. 11:4–37.3(b)6.

8:38–14.5 POS under a reinsurance-type contract arrangement

(a) The reinsurance-type contract shall cover the entire cost of the out-of-network covered services, and shall not provide for any deductible, coinsurance, copayment, or other type of mechanism by which any portion of the out-of-network covered services become self-funded by the HMO.

1. The HMO may elect not to include benefits for emergency and out-of-area care under the reinsurance-type contract.

2. If the HMO elects to include benefits for emergency and out-of-area care under the reinsurance-type contract, the HMO and the carrier or insurer may specify a deductible or other mechanism by which the HMO shall self-fund some portion of the emergency and/or out-of-area care benefits only.

(b) The reinsurance-type contract shall include a provision by which the carrier or insurer agrees to indemnify members directly, subject to the terms of the HMO's contract with its subscribers and contractholders, if the HMO is placed into conservation, rehabilitation or liquidation.

(c) The reinsurance-type contract shall be specific to the HMO's POS contract(s); stop loss or excess risk insurance, insolvency insurance, general letters of guaranty by parent or affiliate corporations and similar such forms of insurance and guarantees shall not be considered acceptable reinsurance-type contracts in compliance with this subchapter.

(d) An HMO shall not report the reinsurance-type contract as an offset to its reserves for out-of-network covered services unless the carrier or insurer from whom the reinsurance-type contract is purchased and the transaction meet the requirements of N.J.A.C. 11:2–28, Credit for reinsurance.

(e) The informational rate filing shall specify the premium and premium rating methodology for all services covered under the POS contract, including the cost to the HMO of purchasing the reinsurance-type contract to provide indemnity benefits for the out-of-network covered services.

(f) Every reinsurance-type contract shall be submitted on an informational basis to the Department of Health and the Department of Insurance prior to the date of marketing of any POS contract for which the reinsurance-type contract is being purchased.

8:38–14.6 POS under a group health contract master policy arrangement

(a) The master policy form, certificate form and any other form that becomes a part of the group health contract and rates, as applicable, shall be submitted by the carrier in duplicate in accordance with N.J.S.A. 17B:27–26 et seq., 17:48–1 et seq., 17:48A–1 et seq., or 17:48E–1 et seq., and N.J.A.C. 11:4–40, for filing to:

Health Bureau
Life and Health Division
New Jersey Department of Insurance
CN 325
20 West State Street
Trenton, NJ 08625–0325

(b) The master policy form shall comply with all applicable insurance laws in this State.

(c) The master policy form and certificate form shall clearly indicate that the contract shall be used in conjunction with an HMO service contract, wherein the group policyholder is an HMO and the insureds are a class of HMO subscribers and members.

(d) The master policy shall provide indemnity benefits for all of the out-of-network covered services, except that the HMO and carrier may elect not to insure the HMO's emergency and out-of-area care through the master policy.

(e) The POS contract and evidence of coverage shall specify all of the covered services under the POS contract, clearly indicating when services covered vary between the network and out-of-network covered services (for instance, due to differences between mandates between HMOs and carriers).

(f) The certificate to be delivered to HMO members and the evidence of coverage to be delivered to HMO members may be contained in a single document, in which instance, the document shall be submitted by the HMO to the Managed Care Bureau of the Department of Insurance, and the carrier shall include a statement in its form submission to the Health Bureau of the Department of Insurance that the certificate shall be combined with the evidence of coverage and shall be submitted by the HMO in accordance with this subchapter, which statement shall be certified to by a duly authorized officer of the carrier.

(g) The informational rate filing submitted by the HMO shall specify the premium and premium rating methodology for all services covered under the POS contract, including the cost to the HMO of purchasing the master policy to provide indemnity benefits for the out-of-network covered services.

8:38–14.7 POS under a dual contract arrangement

(a) No HMO shall enter into a dual contracting arrangement until both the HMO contract forms and rates thereof and the indemnity policy forms and rates thereof, as applicable, have been submitted to the Department of Insurance for filing, each with unique identifying numbers for the dual contract arrangement product; neither riders, amendments nor endorsements of an HMO contract or an indemnity policy shall be filed for use as a dual contracting arrangement.

(b) An indemnity policy designed to provide benefits for out-of-network covered services in conjunction with an HMO's network-based arrangement shall be subject to the following:

1. The policy form shall specify that it shall be issued and delivered in conjunction with an HMO contract, and shall contain reciprocal language incorporating the other contract;

2. The policy form shall not be designed, nor shall it be offered, as a stand-alone policy;

3. The policy form shall require execution of the indemnity policy by the contractholder; and

4. The policy form, application, certificate and other documents that make up the contract, as well as the rating formula, shall be filed by the Department of Insurance as required by N.J.S.A. 17B:27–49, 17:48–1 et seq., 17:48A–1 et seq., or 17:48E–1 et seq. and N.J.A.C. 11:4–40, as appropriate for the carrier.

(c) An HMO contract designed to provide services on a network-based arrangement in conjunction with a carrier's indemnity policy shall be subject to the following:

1. The contract form shall specify that it shall be issued and delivered in conjunction with an indemnity policy, and shall contain reciprocal language incorporating the other contract;

2. The contract form shall not be designed nor offered as a stand-alone contract;

3. The contract form shall require execution of the HMO contract by the contractholder; and

4. The contract form, application, certificate and other documents that make up the contract, as well as the rating formula, shall be submitted to the Department of Health and the Department of Insurance for filing, and the forms shall not be used until so filed by the Department of Health and Department of Insurance.

(d) The HMO informational rate filing shall specify, by formula, the portion of the dual contract arrangement's full premium that shall be charged by the HMO for the network-based covered services; any modifications thereof shall be on a prospective basis only.

(e) The carrier's rate filing, if a rate filing is required pursuant to statute, shall specify, by formula, the portion of the dual contract arrangement's full premium that shall be charged by the carrier for the out-of-network covered services.

(f) Descriptive material (evidences of coverage, certificates, booklets) required to be provided to enrollees shall specify how both the HMO provisions and the indemnity provisions apply to the services and expenses covered under the dual contract arrangement.

(g) The HMO shall submit a detailed description to the Department of Health and the Department of Insurance specifying the responsibilities of the HMO and the carrier to one another, both administratively and financially, prior to implementation of any dual contracting arrangement. Arrangements established by an HMO and carrier to implement a dual contract that have the effect of violating the HMO or insurance laws of this State shall not be permitted.

8:38–14.8 Network variations

(a) Neither HMOs nor carriers shall restrict utilization of any HMO's network or offer any alternative or substitute network of providers, whether or not the providers are or are not within an approved network of the HMO or carrier (for the purpose of offering rate differentials or for any other purpose) until the network restriction or alternative or substitute network is approved by the Department of Health and the Department of Insurance as a stand-alone secondary network adequate for the purposes intended.

(b) HMOs shall submit requests for approval of secondary networks as a modification of the HMO's original certificate of authority, and shall clearly identify the purpose of every secondary network. An application for modification of a certificate of authority shall include the following:

1. A nonrefundable fee of $100.00;

2. A copy of every form of contract between the HMO and all providers to be included in the secondary network;

3. A copy of the form of the individual and group contract, if any, which is to be issued to employers, unions, trustees or other organizations pursuant to utilization of the secondary network;

4. A description of the proposed method of marketing and financing of the secondary network;

5. A description and map of the geographic area to be served by the secondary network identified by county or zip codes, if sub-areas of counties are to be proposed as boundaries of the service area;

6. Enrollment projections presented on a quarterly basis for the first three years of operation for each county or sub-area proposed as the service area, including a description of the demographic characteristics of the population by at least gender and age;

7. A list of all providers under the proposed secondary network by county, municipality and zip code, accompanied by maps of the service area identifying the location of these providers, with the list segregated by primary care providers, specialists, hospitals and ancillary providers, if any, including the name, address and hospital affiliation of every provider, as applicable; and

8. Such other information as the Commissioner of Health or the Commissioner of Insurance may require to determine that a modification of the certificate of authority is appropriate.

(c) The Department of Health and the Department of Insurance shall approve a modification of a certificate of authority based upon a proposed secondary network upon a submission of a complete application to amend the certificate of authority in accordance with (b) above, and a determination by the Department of Health and the Department of Insurance that the secondary network is adequate to serve the purposes intended, as specified by the HMO, with respect to availability of services, product design (including integration with other networks established by the HMO, if integration will or may occur) and financial stability of the HMO. In making this determination, the criteria for adequacy which apply to establishment of any network by an HMO shall apply to establishment of a secondary network.

8:38–14.9 Penalties

An HMO determined to be acting in violation of this subchapter shall be subject to any and all penalties and fines available under law (assessed per contract), including revocation, in whole or in part, of its certificate of authority. Prior to any revocation of a certificate of authority, the HMO shall have an opportunity to request a hearing, in accordance with the provisions of the Administrative Procedure Act, N.J.S.A. 52:14B–1 and 14 and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.