

include a provision whereby the provider is required to hold the carrier's members harmless for the cost of any service or supply covered by the carrier, subject to (b)6i and ii above, whether or not the provider believes the compensation received is adequate;

8. That providers shall not discriminate in their treatment of HMO patients;

9. That providers shall comply with the HMO's quality assurance and utilization review programs;

10. That providers shall maintain licensure, certification and adequate malpractice coverage.

i. With respect to a physician and dentist malpractice insurance shall be at least \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year.

ii. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year.

iii. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year;

11. That patient information shall be kept confidential, but that the HMO and the provider shall have a mutual right to a member's medical records, as well as timely and appropriate communication of patient information, so that both the providers and the HMO may perform their respective duties efficiently and effectively for the benefit of the member;

12. The process for an internal provider complaint and grievance procedure to be used by participating providers, pursuant to N.J.A.C. 11:24-3.7; and

13. That the provider shall have the right to communicate openly with a patient about all diagnostic testing and treatment options.

(c) In addition to (b) above, all primary care provider contracts and contracts with specialists shall specify:

1. The responsibility, if any, of the provider with respect to acquiring and maintaining hospital admission privileges; and

2. The mutual responsibility of the provider and HMO to assure 24 hour, seven-day a week emergency and urgent care coverage to members, and the procedures to assure proper utilization of such coverage consistent with the requirements of N.J.A.C. 11:24-5.2.

(d) In addition to (b) above, all health care facility contracts shall specify:

1. The responsibility of the health care facility to follow clear procedures for granting of admitting and attending privileges to physicians, and to notify the HMO when such procedures are no longer appropriate;

2. The admission authorization procedures for members;

3. The procedures for notifying the HMO when members present at emergency rooms; and

4. The procedures for billing and payment, schedules, and negotiated arrangements.

(e) No contract with any provider shall impose obligations or responsibilities upon a provider which require the provider to violate the statutes or rules governing licensure of that provider if the provider is to comply with the terms of the contract.

(f) In addition to (b) through (e) above, the contract between an HMO and a secondary contractor shall specify that the HMO is a third party beneficiary of the secondary contractor's contract(s) with the health care providers, and a secondary contractor's contract(s) with health care providers shall provide that the HMO shall have privity of contract with the health care providers such that the HMO shall have standing to enforce the secondary contractor's contract(s) with the health care providers in the absence of enforcement by the secondary contractor.

(g) In lieu of (f) above, the HMO shall contract separately with each health care provider under contract with the secondary contractor, and such contracts shall be in accordance with (b) through (e) above.

Petition for Rulemaking.

See: 30 N.J.R. 1640(b).

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).

11:24-15.3 Review and approval

(a) The form(s) of the provider agreement(s), and any amendments thereto, shall be submitted to the Department at the address specified at N.J.A.C. 11:24-11.6(i), for prior approval by the Department.

(b) Provider agreements in effect upon May 1, 2000 shall be deemed withdrawn on May 1, 2001 if not in compliance with this subchapter.

Amended by R.2000 d.183, effective May 1, 2000.

See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

Rewrote the section.

Administrative correction.

See: 32 N.J.R. 2238(a).

11:24-15.4 Penalties

Every person acting as a secondary contractor in violation of this subchapter shall be subject to penalty and fine by the Department under the insurance laws of this state as an

unauthorized insurer in accordance with N.J.S.A. 17:51-1 et seq., or 17B:33-1 et seq., as may be appropriate.

SUBCHAPTER 16. (RESERVED)

SUBCHAPTER 17. PLAN DOCUMENTS FOR GROUP CONTRACTS

11:24-17.1 Scope and applicability

(a) This subchapter shall apply to all HMO health benefits plans that are not standard health benefits plans promulgated by the Small Employer Health Benefits Program Board of Directors and which are not otherwise subject to the Small Employer Health Benefits Program Act, N.J.S.A. 17B:27A-17 et seq., and rules promulgated thereunder, with respect to terms and conditions of contracts and certificates (evidences of coverage) issued to small employers, as that term is defined by the Small Employer Health Benefits Program Act.

(b) This subchapter shall apply to all HMO health benefits plans that are not standard health benefits plans promulgated by the Individual Health Coverage Program Board of Directors or otherwise subject to the Individual Health Coverage Program Act, N.J.S.A. 17B:27A-2 et seq., and rules promulgated thereunder with respect to terms and conditions of the contract or policy forms issued on a nongroup basis under the Individual Health Coverage Program Act.

11:24-17.2 General requirements

(a) The HMO shall provide a written contract to the contractholder and an evidence of coverage to each subscriber, which evidence of coverage may be incorporated into the member handbook required pursuant to N.J.A.C. 11:24-9.1.

1. The contract, evidence of coverage and member handbook shall conform to the Life and Health Insurance Policy Simplification Act, N.J.S.A. 17B:17-17 et seq. as demonstrated by the submission of a readability certification with a Flesch score for each form.

(b) All documents required to be delivered or issued for delivery in accordance with (a) above shall be delivered or issued for delivery no later than 30 days following the date of enrollment of the group, or notice to the HMO of enrollment of a subscriber within the group.

(c) No plan document shall be delivered or issued for delivery unless the form thereof has been filed with the Department, and approved, or deemed approved, by the Department.

11:24-17.3 Terms and conditions for plan documents

(a) Every plan document shall contain the following:

1. Information about the HMO and how to contact and obtain information from the HMO, including, but not limited to, the HMO's legal name, its trade name, and phone, fax and e-mail numbers by which consumers and members may contact the HMO, including at least one number that is a toll-free number for members;

2. The eligibility requirements for the health benefits plan;

3. A specific description of benefits and services available within the service area under the health benefits plan, including emergency services, and out-of-area benefits and services;

4. A specific description of amounts that must be paid by members upon receipt of health care services, including copayments, deductibles, and coinsurance, as applicable, and with respect to POS contracts, an explanation of the member's obligation to pay charges for out-of-network services that exceed what the HMO determines are usual, customary and reasonable;

5. A description of the grounds for termination of a member and group;

6. A description of the claims procedures for members for out-of-network services;

7. A complete description of the HMO's method for resolving member complaints or grievances, and the process for appealing a utilization management decision, including all time frames applicable to the processes for making and resolving the complaint, grievance or appeal;

8. A description of continuation of coverage for those individuals who are in a health care facility at the time of termination of the group contract;

9. A description of how coverage under the health benefits plan may be continued pursuant to applicable Federal or State law (COBRA and/or N.J.S.A. 17B:27A-27) in the event of both member termination and group termination;

10. A description of the extension of benefits for those members who become totally disabled; and

11. A description of the service area.

11:24-17.4 Specific standards for required provisions

(a) With respect to information about the HMO, the name, address and telephone number of the HMO shall be included, with a telephone number by which members may contact the HMO without incurring toll charges.

(b) With respect to eligibility requirements, the plan documents shall state what conditions must be met in order to enroll as a subscriber or a subscriber's dependent, the limiting age for subscribers and dependents, if any, including the effects of Medicare upon continued eligibility of the subscriber or dependent for some or all of the covered services