"Network" means all participating providers under contract or other agreement acceptable to the Department to furnish health care services to members of the HMO.

"Net worth" means the excess of the admitted assets over total liabilities of an HMO.

"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.

"Participating provider" means a provider which, under contract or other arrangement acceptable to the Department with the HMO or with its contractor or subcontractor, in accordance with the provisions of this chapter, has agreed to provide health care services to members with an expectation of receiving payment, other than a copayment or deductible, directly or indirectly from the HMO.

"Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

"Plan documents" mean contract, evidence of coverage, certificate, and member handbook, collectively.

"Point of service contract" means a contractual arrangement between an HMO and a member, subscriber or contract holder 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.

"Post-service claim" means any claim for a benefit that is not a "pre-service claim."

"Pre-service claim" means any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"Primary care provider (PCP)" means an individual participating provider who supervises, coordinates and provides initial and basic care to members and maintains continuity of care and meets the qualifications in N.J.A.C. 11:24-6.2.

"Primary contractor" means a provider that agrees directly with an HMO to provide one or more services or supplies directly to an HMO's members.

"Provider" means a physician or other health care professional, hospital facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

"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 contract holders or subscribers to the HMO, should the HMO be placed into conservation, rehabilitation or liquidation.

"SAP" means Statutory Accounting Practices.

"Secondary contractor" means a person who agrees to arrange for the provision of one or more services or supplies for an HMO's members. A primary contractor may also be a secondary contractor when acting as a broker or administrator for the rendering of services or supplies that, in scope of licensure, type or quantity, the primary contractor (provider) alone could not offer directly to members.

"Secondary network" means a distinct delivery system developed by an HMO to be offered with one or more of its products in addition to, as an alternative to, or a substitute for, the delivery system(s) for which the HMO obtained its initial certificate of authority.

"Service area" means the geographic area for which the HMO has been issued a certificate of authority, in accordance with this chapter.

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

"Uncovered health care expenditures" means costs to the HMO for health care services that are the obligation of the HMO for which a member may be liable in the event of an HMO's insolvency and for which no alternative arrangements (that guarantee, insure or provide assumption by a person or organization other than the HMO for the provision of services or benefits) have been made that are acceptable to the Commissioner.

"Urgent care" means a non-life-threatening condition that requires care by a provider within 24 hours.

"Urgent care claim" means any claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or that, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a member should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system

may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization or ambulatory care procedures and retrospective review.

Amended by R.1998 d.458, effective September 8, 1998.
See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).
Inserted "Claims", "Clean claim" and "Contested claim".
Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In "Emergency", substituted "a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to" for "absence of immediate medical attention could reasonably" following "such that" in the first sentence; in "Health maintenance organization (HMO)", substituted a reference to members for a reference to enrollees; rewrote "Independent utilization review organization (IURO)" and "Utilization management"; inserted "Plan documents" and "Secondary network"; and in "Provider", inserted a reference to other health care professionals.
Amended by R.2001 d.8, effective January 2, 2001 (operative July 1, 2001).
See: 32 N.J.R. 211(a), 33 N.J.R. 46(a).
Inserted "Formulary" and "Health benefits plan".
Amended by R.2002 d.265, effective August 19, 2002.
See: 34 N.J.R. 885(a), 34 N.J.R. 3014(a).
Deleted "Clean claim" and "Contested claim".
Public Notice: Increase in medical component of the Consumer Price Index.
See: 40 N.J.R. 1937(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 41 N.J.R. 1275(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 42 N.J.R. 674(c).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 43 N.J.R. 751(b).
Amended by R.2012 d.035, effective February 6, 2012.
See: 43 N.J.R. 2411(a), 44 N.J.R. 274(b).
In the introductory paragraph, substituted a colon for a period at the end; added definitions "Adverse benefit determination", "Final internal adverse benefit determination", "Post-service claim", "Pre-service claim" and "Urgent care claim"; and rewrote definition "Claims".
Public Notice: Increase in medical component of the Consumer Price Index.
See: 44 N.J.R. 599(c).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 45 N.J.R. 701(b).

Case Notes

Health maintenance organization's (HMO's) asset purchase agreement with for-profit corporation and health services agreement with limited liability corporation that was to facilitate administration of medical services to HMO enrollees were not contracts with providers as required for confidentiality under the HMO Act; corporations not "providers" since they were not authorized to furnish health care services and internal management of HMO still maintained ultimate responsibility for the affairs of the HMO. HIP of New Jersey, Inc. v. New Jersey Dept. of Banking and Ins., 707 A.2d 1044, 309 N.J.Super. 538.

SUBCHAPTER 2. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

11:24-2.1 Certificate of need and licensing

Any health maintenance organization (HMO) which proposes the establishment and/or operation of a health care facility or any change in or expansion of a health care facility, or the institution of new health care services as defined in the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) shall comply with all pertinent provisions of the Act, as amended and N.J.A.C. 8:33, Certificate of Need application and Renewal process, and all applicable health planning and licensing rules and regulations.

11:24-2.2 Application for a new or amended certificate of authority

(a) Any person, organization or corporation desiring to establish and/or operate an HMO shall apply to the Commissioner for a certificate of authority, pursuant to N.J.S.A. 26:2J-1 et seq. Applications for a certificate of authority may be obtained from:

New Jersey Department of Banking and Insurance
Valuations Bureau
Life and Health Division
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

1. Two copies of the entire application shall be submitted to the Department at the above address; and

2. If the applicant proposes to be a Medicaid program participant, one copy of the application shall be submitted to:

New Jersey Department of Human Services
Office of Managed Health Care
Division of Medical Assistance and Health Services
PO Box 712
Trenton, NJ 08625-0712

(b) The applicant shall submit to the Department a nonrefundable fee of $100.00, or as specified in N.J.S.A. 26:2J-23, as may be amended, payable to the New Jersey Department of Banking and Insurance for the filing of an application for a certificate of authority as an HMO, or for any renewal or amendments thereto.

(c) The application for a certificate of authority shall be deemed complete only when filed on forms prescribed by the Department and when accompanied by the following:

1. A copy of the basic organizational documents 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 policies or similar documents regulating the conduct of the internal affairs of the applicant;

3. A list of persons who are to be responsible for the conduct of the affairs of the HMO including names, addresses, official positions and a biographical affidavit for each person, including all officers and directors;

4. A specimen copy of the contract between the HMO and each participating provider, and an attestation by the HMO's CEO as to the execution of contracts by participating providers consistent with the information submitted by the HMO to demonstrate network adequacy and made in accordance with N.J.A.C. 11:24-15, including a description of any compensation program involving incentive or disincentive payment arrangements permitted under the laws of this State. As required by N.J.S.A. 26:2J-26, any copies of any contract made between the HMO and any provider, insurer, hospital or medical service corporation shall be considered confidential;

i. Executed signature pages shall be made available to the Department upon request, but such documents shall otherwise remain confidential;

5. A copy of any merger or acquisition documents of the applicant or the applicant's parent if the merger or acquisition is with respect to the parent, management agreements for administrative services, and asset sale agreements.

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

7. A copy of the form of the individual and group contract, if any, which is to be issued to subscribers and contract holders;

8. The most recent audited financial statements (or other documentation as specified by N.J.A.C. 11:24-11 for newly-formed applicants) showing the applicant's assets, liabilities, sources of financial support, a statement as to the sources of funding and all other financial requirements as delineated in N.J.A.C. 11:24-11;

9. A description of the proposed method of marketing and financing;

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

11. A description and map of the geographic area to be served, identified by county. If sub-areas of counties are to be proposed as boundaries of the service area, the map should also include zip codes;

notice is received by the Department, the transaction shall be deemed approved.

i. With respect to filings for which additional information has been requested, if the Commissioner does not disapprove the transaction within 30 days following receipt by the Department 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).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 36 N.J.R. 1836(d).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 37 N.J.R. 1089(b).
Public Notice: Department of Banking and Insurance; Division of Insurance; Office of the Commissioner: Minimum net worth requirements for Health Maintenance Organizations: increase in medical component of the Consumer Price Index.
See: 38 N.J.R. 1607(c).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 39 N.J.R. 1322(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 40 N.J.R. 1937(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 41 N.J.R. 1275(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 42 N.J.R. 674(c).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 43 N.J.R. 751(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 44 N.J.R. 599(c).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 45 N.J.R. 701(b).

11:24-11.2 Investments

Except as approved by the Commissioner 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.

11:24-11.3 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.

11:24-11.4 Minimum deposits

(a) In order to obtain a certificate of authority, every HMO shall deposit with the Commissioner 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 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. The deposit shall be held in trust as a restricted asset to offset reserves required pursuant to N.J.A.C. 11:24-11.3(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 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, 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 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.

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).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 36 N.J.R. 1836(d).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 36 N.J.R. 1089(b).
Public Notice: Department of Banking and Insurance; Division of Insurance; Office of the Commissioner: Minimum net worth requirements for Health Maintenance Organizations: increase in medical component of the Consumer Price Index.
See: 38 N.J.R. 1607(c).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 39 N.J.R. 1322(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 40 N.J.R. 1937(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 41 N.J.R. 1275(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 42 N.J.R. 674(c).

Public Notice: Increase in medical component of the Consumer Price Index.
See: 43 N.J.R. 751(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 44 N.J.R. 599(c).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 45 N.J.R. 701(b).

11:24-11.5 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, 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 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