# CHAPTER 24A

# HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, AND MEDICAL SERVICE CORPORATIONS

**Authority**

N.J.S.A. 26:2S-1 et seq.

**Source and Effective Date**

R.2011 d.097, effective March 1, 2011.
See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

**Chapter Expiration Date**

Chapter 24A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, expires on March 1, 2016.

**Chapter Historical Note**

Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was adopted as R.2000 d.183, effective May 1, 2000. See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

Pursuant to Reorganization Plan No. 005-2005, Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was transferred to the Department of Banking and Insurance, effective August 29, 2005. See: 37 N.J.R. 2737(a).

Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was readopted by R.2005 d.418, effective October 27, 2005. See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).

Pursuant to Reorganization Plan No. 005-2005, Chapter 38A of Title 8, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was recodified as Chapter 24A of Title 11, effective October 6, 2006. See: 37 N.J.R. 2737(a), 38 N.J.R. 4721(a).

Chapter 24A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was readopted as R.2011 d.097, effective March 1, 2011. As a part of R.2011 d.097, the chapter Appendix was repealed, effective April 4, 2011. See: Source and Effective Date. See, also, section annotations.

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## SUBCHAPTER 1. GENERAL PROVISIONS

### 11:24A-1.1 Scope and purpose

(a) The purpose of this chapter is to set forth the minimum standards which carriers, as defined at N.J.A.C. 11:24A-1.2, must meet in order to be in compliance with the requirements of the Health Care Quality Act, P.L. 1997, c.192, enacted August 8, 1997.

(b) A carrier shall comply with each of the subchapters of this chapter as appropriate to the types of health benefits plans delivered or issued for delivery by the carrier in this State.

(c) The provisions of this chapter shall apply to any services or functions of a carrier that the carrier may subcontract to another entity just as if the carrier were performing those services or functions itself, and no carrier shall be relieved of assuring full compliance with any applicable provision because one or more functions or services are subcontracted.

(d) A carrier that complies with this chapter shall not be relieved of its obligation to comply with all applicable Federal, State and local laws, rules and regulations.

**11:24A-1.2 Definitions**

For the purposes of this chapter, the words and terms set forth below shall have the following meanings, unless the word or term is further defined within a subchapter of this chapter, or the context clearly indicates otherwise.

"Act" means the Health Care Quality Act, P.L. 1997, c.192 (as codified: N.J.S.A. 26:2S-1 et seq.; 26:2J-4.16, 18.1 and 24; 17:48-6r, 17:48A-7p, 17:48E-35.15, 17B:26-2.1n, 17B:27-46.1q, 17B:27A-2.3 and 17B:27A-19.5; and 34:13A-31).

"Carrier" means a insurance company authorized to transact the business of insurance in this State and doing a health insurance business in accordance with N.J.S.A. 17B:17-1 et seq., a hospital service corporation authorized to do business pursuant to N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to do business pursuant to N.J.S.A. 17:48A-1 et seq. or a health service corporation authorized to do business pursuant to N.J.S.A. 17:48E-1 et seq.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Continuous quality improvement" or "CQI" means an ongoing and systematic effort to measure, evaluate, and improve either a carrier's process of providing quality health care services to covered persons with respect to managed care plans, or the carrier's process of performing utilization management functions with respect to health benefits plans in which utilization management has been incorporated.

"Contract holder" means an employer or organization that purchases a contract or policy for the provision of health care services covered under the terms of the policy or contract or for the payment of benefits therefor.

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

"Department" means the New Jersey Department of Banking and Insurance.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Financial incentive arrangement" means a formal mechanism instituted by a carrier or a secondary contractor that exposes a provider, or group of providers, to risk or reward based upon meeting or failing to meet prescribed standards.

"Financial risk" means participation in financial gains or losses accruing pursuant to a contractual arrangement, based on aggregate measures of medical expenditures or utilization.

"Gatekeeper system" means a system in which a covered person's level of benefits for all or a specified set of health care services under a policy or contract is dependent upon the covered person obtaining appropriate referrals for the services through a primary care provider or the carrier.

"Health benefits plan" means a policy or contract for the payment of benefits for hospital and medical expenses or the provision of hospital and medical services delivered or issued for delivery in this state by a carrier.

The term "health benefits plan" specifically includes:

1. Medicare supplement coverage and risk contracts for the provision of health care services covered by Medicare to the extent that state regulation of such contracts or policies is not otherwise preempted by Federal law; and

2. Any other policy or contract not otherwise specifically excluded by statute or this definition.

The term "health benefits plan" specifically excludes:

1. Accident only policies;

2. Credit health policies;

3. Disability income policies;

4. Long-term care policies;

5. CHAMPUS supplement coverage;

6. Hospital confinement indemnity coverage;

7. Coverage arising out of a workers' compensation law or similar such law;

8. Automobile medical payment insurance or personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq.; and

9. Coverage for medical expenses contained in a liability insurance policy.

"IHC Program" means the Individual Health Coverage Program set forth at N.J.S.A. 17B:27A-2 et seq., and any rules promulgated pursuant thereto.

"Independent Health Care Appeals Program" means the external appeals process for a covered person or provider on