i. Submission of a description of a continuing education program by an HMO in accordance with (e)2 above shall in no way serve as a substitute for the submission and approval process set forth for the continuing education requirements of N.J.A.C. 11:17–3.4.

3. Submissions shall be made to the addresses set forth at N.J.A.C. 8:38–11.6(i) and (j) with respect to the Departments of Banking and Insurance and Human Services.

(f) Every HMO shall maintain records for each Medicaid marketing representative specifying the registration of the Medicaid marketing representative, certification of completion of all initial and continuing education programs, and a copy of the notice of termination of registration filed with the Department of Banking and Insurance, which records shall be available for inspection by the Departments of Health and Senior Services, Human Services and Banking and Insurance within a reasonable time following request.

1. HMOs shall maintain records of terminated Medicaid marketing representatives for no less than three years following the date of termination of their registration.

(g) The requirements set forth in this section are in addition to any standards and requirements which may be established by the Department of Human Services for the Medicaid program.

(h) The requirements set forth herein in this section in addition to the requirements of N.J.A.C. 11:17–2.9.

8:38–13.3 Advertising and marketing

Except to the extent that HMOs shall be specifically exempted by reference by a provision of an applicable statute or rule, HMOs, producers and Medicaid marketing representatives shall comply with statutes and rules regulating the marketing, advertising, solicitation and sale of health insurance, and enforcement thereof by the Commissioner of Banking and Insurance, including, but not limited to, N.J.A.C. 11:2–11 and 11:4–17.

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 ("WITHOLDS") 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.

8:38–13.5 Trade and claims practices and coordination of benefits

(a) HMOs shall be subject to all of the provisions of the Trade Practice Act, N.J.S.A. 17B:30–1 et seq., any amendments thereto, and all rules promulgated thereunder, except to the extent that HMOs have been specifically excluded by reference from a provision of the applicable statutes or rules.

(b) HMOs that elect to coordinate their benefits with those of other benefits or coverages available to members

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may do so subject to compliance with N.J.A.C. 11:4–28, Coordination of Benefits. HMOs that do not comply with N.J.A.C. 11:4–28 shall provide primary coverage to all members.

8:38–13.6 Penalties

Every producer or Medicaid marketing representative found to be in violation of this subchapter shall be subject to penalties and fines (per contract) in accordance with N.J.A.C. 11:17D, including suspension or revocation, in whole or in part, of his or her producer license or registration privilege pursuant to N.J.S.A. 17:22A–17.

SUBCHAPTER 14. INDEMNITY BENEFITS OFFERED BY A HEALTH MAINTENANCE ORGANIZATION

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 (Reserved)

Repealed by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).
Section was "Definitions".

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 Banking and 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 Department and the Department of Banking 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 Department and the Department of Banking and Insurance unless the Departments 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 time frame, the matter shall be considered closed by the Departments; if the HMO desires further consideration of its form, it shall submit the form anew to the Department and the Department of Banking and Insurance.

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

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

Managed Care Bureau
Life and Health Division
New Jersey Department of Banking and 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.

Amended by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).
Substituted "Department of Banking and Insurance" for "Department of Insurance" throughout.

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 is offered without a gatekeeper system for out-of-network covered services shall meet the following: