

CHAPTER 24

HEALTH MAINTENANCE ORGANIZATIONS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, 17B:30-54, 26:2J-21, and 26:2S-18.

Source and Effective Date

R.2008 d.60, effective February 15, 2008.
See: 39 N.J.R. 3466(a), 40 N.J.R. 1668(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 24, Health Maintenance Organizations, expires on February 15, 2015. See: 43 N.J.R. 1203(a).

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.

Chapter 38, Health Maintenance Organizations, was adopted as R.1994 d.365, effective July 18, 1994. See: 26 N.J.R. 1624(a), 26 N.J.R. 2896(a).

Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, was adopted as R.1996 d.194, effective April 15, 1996. See: 27 N.J.R. 4981(a), 28 N.J.R. 1981(c).

Pursuant to Executive Order No. 66(1978), Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, of Chapter 38, was readopted as R.1997 d.68, effective January 17, 1997. As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider Network, Subchapter 7, Continuous Quality Improvement, Subchapter 8, Utilization Management, Subchapter 9, Member Rights and Responsibilities, Subchapter 10, Medical Records, Subchapter 11, Financial Standards and Reporting, Subchapter 12, Rehabilitation, Conservation and Liquidation, Subchapter 13, Licensing of Representatives and Advertising, and Subchapter 15, Provider Agreements and Risk Transference, were adopted as new rules. All repeals, amendments, and other new rules became operative July 1, 1997. See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

Subchapter 17, Plan Documents for Group Contracts, was adopted as new rules by R.2000 d.183, effective May 1, 2000. See 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

Subchapter 18, Drug Formularies, was adopted as new rules 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).

Chapter 38, Health Maintenance Organizations, expired on July 16, 2002.

Chapter 38, Health Maintenance Organizations, was adopted as new rules by R.2002 d.265, effective August 19, 2002. See: 34 N.J.R. 885(a), 34 N.J.R. 3014(a).

Pursuant to Reorganization Plan No. 005-2005, Chapter 38 of Title 8, Health Maintenance Organizations, was recodified as Chapter 24 of Title 11, effective October 6, 2006. See: 37 N.J.R. 2737(a), 38 N.J.R. 4721(a).

Chapter 24, Health Maintenance Organizations, was readopted as R.2008 d.60, effective February 15, 2008. See: Source and Effective Date. See, also, section annotations.

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APPENDIX. ACTUARIAL JUSTIFICATION OF BENEFIT DIFFERENTIALS—FORMULARY DRUG BENEFIT**SUBCHAPTER 1. SCOPE AND DEFINITIONS****11:24-1.1 Scope**

(a) The rules in this chapter were developed by the Commissioner of Health and Senior Services in collaboration with the Commissioner of Banking and Insurance and govern the establishment and operation of health maintenance organizations in New Jersey pursuant to the authority set forth in N.J.S.A. 26:2J-1 et seq. These rules are only applicable to managed care plans that constitute a health maintenance organization as defined herein and in N.J.S.A. 26:2J-1 et seq.

(b) The provisions of these rules shall apply, except where in conflict with:

1. Any individual contract issued by a health maintenance organization (HMO) to the extent that the contract is formulated in accordance with the provisions of the New Jersey Individual Health Coverage Program established pursuant to N.J.S.A. 17B:27A-1 et seq.; or

2. Any contract issued to a small employer by a HMO to the extent that the contract is formulated in accordance with the provisions of the New Jersey Small Employer Health Coverage Program established pursuant to N.J.S.A. 17B:27A-17 et seq.

(c) The provisions of these rules shall apply to any services of the HMO which are subcontracted to other entities.

(d) Nothing contained in these rules shall be construed to limit the authority of the Division of Medical Assistance and

3. Annual filing fees for any one member shall not exceed \$75.00.

(d) Upon receipt of the appeal, together with the executed release, the Department shall immediately assign the appeal to an IURO in accordance with N.J.A.C. 11:24-8.8, 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. 11:24-8.6(f), the member has fully complied with the internal appeal process available pursuant to N.J.A.C. 11:24-8.5 and, if applicable, 8.6; and

4. The member has provided all information required by the IURO and the 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. The IURO shall additionally notify the member and/or provider of his or her right to submit in writing, within five business days of the member's or provider's receipt of the notice of acceptance of his or her appeal, any additional information to be considered in the IURO's review. The IURO shall provide the HMO with any such additional information within one business day of receipt of the information.

(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 final internal adverse benefit determination, the member was deprived of coverage 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. 11:24-8.1(b).

(h) The IURO shall refer all appeals for full review, as referenced in (g) above, to an expert 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

decisions of the IURO shall be approved by the medical director of the IURO, who shall be a physician licensed to practice in New Jersey.

(i) The IURO shall complete its review and issue its 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 45 days from receipt of the request for IURO review.

1. Notwithstanding (i) above, if the appeal involves care for an urgent or emergency case, an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal. If the IURO's determination of the appeal provided within no more than 48 hours was not in writing, the IURO shall provide written confirmation of its determination within 48 hours of providing the verbal determination.

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

(k) The IURO's determination shall be binding on the HMO and the member, except to the extent that other remedies are available to either party under State or Federal law. The HMO shall provide benefits (including payment on the claim) pursuant to the IURO's determination without delay, regardless of whether the HMO intends to seek judicial review of the external review decision, unless there is a judicial decision stating otherwise. 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, member and provider if the provider made the appeal on behalf of the member with the member's consent and the Department indicating how the HMO will implement the IURO's determination.

1. The HMO shall specify its intentions sooner if the medical exigencies of the case warrant a more rapid response.

(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.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

In (b), substituted a reference to 60 days for a reference to 30 business days in the first sentence; in (c), rewrote the second sentence; and rewrote (i) and (k).

Amended by R.2012 d.035, effective February 6, 2012.
See: 43 N.J.R. 2411(a), 44 N.J.R. 274(b).

Rewrote the section.

Case Notes

Beneficiary's claims under 29 U.S.C.S. § 1132(a)(1)(B) and (3) that insurers had improperly classified eating disorders as non-biologically based mental illnesses under Employee Retirement Income Security Act plans were not subject to Burford abstention based on the availability of review of benefit denials by an Independent Utilization Review Organization under N.J.A.C. 11:24-8.7; the mere availability of state administrative review did not warrant abstention. *DeVito v. Aetna, Inc.*, 536 F.Supp.2d 523, 2008 U.S. Dist. LEXIS 15615, 43 Employee Benefits Cas. (BNA) 2247 (D.N.J. 2008).

11:24-8.8 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. 11:24-8.7. 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. 11:24-8.7 including, but not limited to, an assessment of separate costs to the HMO for the initial IURO review under N.J.A.C. 11:24-8.7(e) and the full review under N.J.A.C. 11:24-8.7(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. 11:24-8.7(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.

(d) An IURO must have external review accreditation from a nationally recognized private accrediting organization, such as URAC.

Amended by R.2012 d.035, effective February 6, 2012.
See: 43 N.J.R. 2411(a), 44 N.J.R. 274(b).
Added (d).

11:24-8.9 (Reserved)

New Rule, R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Repealed by R.2012 d.035, effective February 6, 2012.
See: 43 N.J.R. 2411(a), 44 N.J.R. 274(b).

Section was "Department review of HMO actions on IURO recommendations".

SUBCHAPTER 9. MEMBER RIGHTS AND RESPONSIBILITIES; DISCLOSURES TO CONSUMERS

11:24-9.1 Policies and procedures

(a) The HMO shall establish and implement written policies and procedures regarding the rights of members and the implementation of these rights.

(b) The HMO shall provide each member with a current copy of a member's benefit handbook, including at least:

1. A complete statement of the member's rights;
2. A description of all complaint and grievance procedures, including the address and telephone numbers of the complaint offices of the HMO and of the Department; and
3. A clear and complete summary of the evidence of coverage, including limitations, exclusions, and procedures for accessing out of network services, as required by N.J.S.A. 26:2J-8(b), and the responsibility of the subscriber to pay copayments, deductibles and coinsurance, as appropriate, in terms relevant to the type of product(s) purchased.
 - i. HMOs shall clearly distinguish any differences in the member's financial responsibility for accessing services within and outside of the HMO's network.
 - ii. HMOs shall explain the member's responsibility to pay for charges incurred that are not covered under or authorized pursuant to the policy or contract.
 - iii. With respect to point of service contracts, HMOs shall explain the member's responsibility to pay for charges that exceed what the HMO determines are customary and reasonable (usual and customary, or usual, customary and reasonable, as appropriate) for services that are covered under the out-of-network component of the contract.

(c) HMOs shall, upon request, provide a written document to consumers setting forth the information required to be disclosed to members.

1. The HMO shall not be required to provide the consumer with the same level of detail that is provided to members in the provider directory pursuant to (d)6 below, but the HMO shall provide at least the following information:

- i. The number of medical providers categorized by specialty by county in the carrier's network;
- ii. The number of hospitals categorized by county in the HMO's network;
- iii. The approximate percentage of the medical providers in the HMO's network that are board certified, and the date on which the calculation of the percentage was last performed;
- iv. The waiting time criteria that the HMO utilizes in its selection of providers for participation in the HMO's network, if any, including a statement that no such criteria apply in those instances in which the HMO does not consider patient waiting times for appointments for routine and urgent care in selecting participating providers;
- v. A statement that consumers can check with providers directly to find out if the provider is a participating provider; and
- vi. A statement that the consumer may obtain more detailed information, including a current provider directory (if not already included), and the process by which consumers may obtain the information free of charge.

(1) HMOs that elect to make their lists of participating providers available through an electronic database accessible to the public shall not substitute electronic access to the information as the only means by which consumers may obtain the information free of charge.

2. The information provided to consumers may be in a single document or multiple documents, except that when an HMO uses multiple documents for its provider lists, the HMO shall cross reference in each provider lists all other lists of health care providers for which the HMO is required to provide coverage, or benefits therefor, pursuant to statute or rule.

(d) 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. To be treated with courtesy and consideration, and with respect for the member's dignity and need for privacy;

3. To be provided with information concerning the HMO's policies and procedures regarding products, services, providers, appeals procedures and other information about the organization and the care provided;

4. To choose a primary care provider within the limits of the covered benefits and availability and included as participating providers in the plan network;

5. To be afforded a choice of specialists among participating network providers following an authorized referral, subject to their availability to accept new patients;

6. To obtain a current directory of participating providers in the HMO network upon request, including addresses and telephone numbers, and a listing of providers who accept members who speak languages other than English;

7. To obtain assistance and referral to providers with experience in treatment of patients with chronic disabilities;

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. To be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract;

10. To formulate and have advance directives implemented;

11. To all the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands;

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

13. To file a complaint or appeal with the HMO or the Department and to receive an answer to those complaints within a reasonable period of time.

(e) The HMO shall establish and implement written policies and procedures regarding the responsibilities of members, such as financial responsibilities, including copayments and deductibles. A complete statement of these responsibilities shall be included in the member's benefit handbook.