Substituted "Department of Banking and Insurance" for "Department of Insurance" throughout.

8:38–14.8 Network variations

(a) Neither HMOs nor carriers shall restrict utilization of any HMO's network or offer any alternative or substitute network of providers, whether or not the providers are or are not within an approved network of the HMO or carrier (for the purpose of offering rate differentials or for any other purpose) until the network restriction or alternative or substitute network is approved by the Department and the Department of Banking and Insurance as a stand-alone secondary network adequate for the purposes intended.

(b) HMOs shall submit requests for approval of secondary networks as a modification of the HMO's original certificate of authority, and shall clearly identify the purpose of every secondary network. An application for modification of a certificate of authority shall include the following:

1. A nonrefundable fee of $100.00;

2. A copy of every form of contract between the HMO and all providers to be included in the secondary network;

3. A copy of the form of the individual and group contract, if any, which is to be issued to employers, unions, trustees or other organizations pursuant to utilization of the secondary network;

4. A description of the proposed method of marketing and financing of the secondary network;

5. A description and map of the geographic area to be served by the secondary network identified by county or zip codes, if sub-areas of counties are to be proposed as boundaries of the service area;

6. Enrollment projections presented on a quarterly basis for the first three years of operation for each county or sub-area proposed as the service area, including a description of the demographic characteristics of the population by at least gender and age;

7. A list of all providers under the proposed secondary network by county, municipality and zip code, accompanied by maps of the service area identifying the location of these providers, with the list segregated by primary care providers, specialists, hospitals and ancillary providers, if any, including the name, address and hospital affiliation of every provider, as applicable; and

8. Such other information as the Commissioner or the Commissioner of Banking and Insurance may require to determine that a modification of the certificate of authority is appropriate.

(c) The Department and the Department of Banking and Insurance shall approve a modification of a certificate of authority based upon a proposed secondary network upon a submission of a complete application to amend the certificate of authority in accordance with (b) above, and a determination by the Department and the Department of Banking and Insurance that the secondary network is adequate to serve the purposes intended, as specified by the HMO, with respect to availability of services, product design (including integration with other networks established by the HMO, if integration will or may occur) and financial stability of the HMO. In making this determination, the criteria for adequacy which apply to establishment of any network by an HMO shall apply to establishment of a secondary network.

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.

8:38–14.9 Penalties

An HMO determined to be acting in violation of this subchapter shall be subject to any and all penalties and fines available under law (assessed per contract), including revocation, in whole or in part, of its certificate of authority. Prior to any revocation of a certificate of authority, the HMO shall have an opportunity to request a hearing, in accordance with the provisions of the Administrative Procedure Act, N.J.S.A. 52:14B–1 and 14 and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

SUBCHAPTER 15. PROVIDER AGREEMENTS AND RISK TRANSFERENCE

8:38–15.1 Assumption of financial risk or risk-sharing

(a) No person shall assume financial risk, in whole or in part, for the cost or provision of, or arrangements for, one or more health services to others unless the person is:

1. An authorized payor as defined at N.J.A.C. 8:38–1.2;

2. A provider actually performing the health services (including providing supplies) within the scope of his or her license; or

3. An employer with respect to its own employees, and dependents of those employees.

(b) A secondary contract shall not be considered to have assumed financial risk for the delivery of health care services to residents of this State for which licensure as an authorized payor would otherwise be required if the secondary contractor enters into a contractual agreement with an authorized payor to provide the delivery of health care services to the individuals covered by the authorized payor which meets the requirements of N.J.A.C. 8:38–15.2 and 15.3

(c) Contracts with secondary contractors shall not contain provisions that cede some or all of the financial risk of the

authorized payor to the secondary contractors, whether through compensation formula, stop loss insurance requirements or other means, except in accordance with N.J.A.C. 8:38–15.2, and an HMO shall not reduce its reserves on the basis of a contractual agreement with any secondary contractors.

8:38–15.2 Minimum standards for provider agreements

(a) Both primary contractor and secondary contractor agreements shall be consistent with laws regarding confidentiality of information and with professional licensing standards and shall comply with the standards of (b) through (e) below.

(b) All provider contracts shall specify:

1. The term of the contract and reasons for which the contract may be terminated by one or more parties to the contract, including the procedures for notice and effectuation of such termination, and opportunities, if any to cure any deficiencies prior to termination;

2. That no provider may be terminated or penalized solely because of filing a complaint or appeal as permitted by these rules;

3. The method of reimbursement, including the method, events and timing of application of any penalties, bonuses or other types of compensation arrangements.

i. To the extent that some portion of the provider compensation is tied to the occurrence of a pre-determined event, or the nonoccurrence of a pre-determined event, the event shall be clearly specified, and the HMO shall include in its contracts a right of each provider to receive a periodic accounting (no less frequently than annually) of the funds held.

ii. The contract shall include a process whereby a provider may appeal a decision denying the provider additional compensation, in whole or in part, in accordance with any compensation arrangement tied to the occurrence or nonoccurrence of a pre-determined event.

iii. Capitation shall not be used as the sole method of reimbursement to providers who primarily provide supplies (for instance, prescription drugs or durable medical equipment) rather than services;

4. The services and/or supplies to be provided by the provider and covered by the HMO;

5. A provision whereby the provider shall hold the member harmless for the cost of any service or supply covered by the HMO, whether or not the provider believes its compensation for the service or supply from the HMO (directly or through a secondary contractor) is made in accordance with the reimbursement provision of the provider agreement, or is otherwise inadequate.

i. Members shall not be held harmless for payment of required copayments, deductibles or coinsurance, if any.

ii. Providers shall not balance bill members who have obtained covered services or supplies through the HMO network mechanism.

iii. An HMO contractual agreement with a secondary contractor shall provide that the secondary contractor's contract with its network providers shall include a provision whereby the provider is required to hold the HMO's members harmless for the cost of any service or supply covered by the HMO, subject to (b)5i and ii above, whether or not the provider believes the compensation received is adequate;

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

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

8. 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; and

9. 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.

10. The process for an internal provider complaint and grievance procedure to be used by participating providers, pursuant to N.J.A.C. 8:38–3.6(b).

(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. 8:38–5.2.

(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.

8:38–15.3 Review and approval

(a) The form(s) of the provider agreement(s), and any amendments thereto, shall be submitted to the Departments of Health and Senior Services and Banking and Insurance, at the addresses specified at N.J.A.C. 8:38–11.6(i), for prior approval.

(b) Provider agreements in effect upon July 1, 1997 that are not in compliance with the requirements of this subchapter shall be brought into compliance by July 1, 1998, or the first date of renewal specified within the provider agreement occurring after July 1, 1997, whichever date is earlier.

8:38–15.4 Penalties

Every person acting as a secondary contractor in violation of this subchapter shall be subject to penalty and fine by the Department of Banking and Insurance 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.