CHAPTER 38

HEALTH MAINTENANCE ORGANIZATIONS

Authority

N.J.S.A. 26:2H–1 et seq.

Source and Effective Date

R.1997 d. 68, effective January 17, 1997.
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

Executive Order No. 66(1978) Expiration Date

Chapter 38, Health Maintenance Organizations, expires on January 17, 2002.

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. See: Source and Effective Date. As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider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. New rules 8:38–3.5(a)4; 8:38–3.6(e); 8:38–4.1(b); 8:38–5.3(b)5; 8:38–6.3(a)3i; 8:38–8.1(a)7; 8:38–8.2(a) and (c); 8:38–8.3(b) and (d); 8:38–8.4(b); 8:38–8.6(f); 8:38–8.7; 8:38–8.8; 8:38–9.1(c)1, 8 and 12; and 8:38–13.4, became operative March 15, 1997; all repeals, amendments, and other new rules became operative July 1, 1997.

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SUBCHAPTER 1. SCOPE AND DEFINITIONS

8:38–1.1 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 Health Services of the Department of Human Services to impose, in any contract to provide HMO services to New Jersey Medicaid recipients, standards that exceed those set forth in this chapter.

8:38–1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Authorized payor" means a person licensed and authorized to transact business in this State as a health maintenance organization, an insurer doing a health insurance business, a hospital service corporation, a medical service corporation, a health services corporation, a dental service corporation, a dental plan organization or a fraternal benefit society.

"Basic comprehensive health care services" means the following services: preventive care, emergency care, inpatient and outpatient hospital and provider care, diagnostic laboratory and diagnostic and therapeutic radiological services and other services set forth in N.J.A.C. 8:38–5, including all services listed at N.J.A.C. 8:38–5.2.

"Capitation" means a fixed payment for the provision of medical services not based on frequency or severity of services or supplies provided.

"Carrier" means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17–4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48–1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A–1 et seq., or a health service corporation transacting business in accordance with N.J.S.A. 17:48E–1 et seq.

"Claims" means a request for payment of charges for services rendered or supplies provided by a provider to a member.

"Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim.

"Commissioner" means the State Commissioner of Health and Senior Services or his or her designee.

"Commissioner of Banking and Insurance" means the Commissioner of the New Jersey Department of Banking and Insurance or his or her designee.

"Consumer Price Index" or "CPI" means the medical component of the Consumer Price Index for All Urban Consumers, as reported by the United States Department of Labor, shown as an average index for the New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton region combined as published by the Commissioner of Banking and Insurance in the New Jersey Register.

"Contested claim" means a claim that has not been adjudicated because it has a material defect or impropriety.

"Continuous quality improvement" means an ongoing and systematic effort to measure, evaluate, and improve an organization's process to continually improve the quality of health care services provided to members.

"Contract holder" means an employer or organization which purchases a contract for services.

"Department" means the New Jersey Department of Health and Senior Services.

"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 layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical 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.

"Evidence of coverage" means a statement of the essential features and services of the HMO coverage which is given to the subscriber by the HMO or by the group contract holder.

"External quality review organization (EQRO)" means an organization approved by the Department pursuant to this chapter to perform external quality audits of HMOs.

"Financial incentive arrangement" means a formal mechanism instituted by an HMO 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.

"Formulary" means a list of prescription medications that are preferred for use through the provision of differential benefits or other means.

"GAAP" means Generally Accepted Accounting Principles.

"Gatekeeper system" means a system in which a member is permitted to access service and/or obtain indemnity benefits for covered services only when the service is rendered by the member's primary care provider, or the member's access to services and/or benefits is approved by the primary care provider or the HMO, as specified under the HMO's contract with the subscriber or contractholder.

"Group health contract" means a contract, filed by or with the New Jersey Department of Banking and Insurance or the Small Employer Health Benefits Program Board of Directors, as appropriate, issued by a carrier to a group of persons for the provision of indemnity benefits for expenses for covered services incurred in preventing or treating acute or chronic injury or illness of members, as specified in the contract. The term "group health contract" shall not include any contract issued on a form which has been disapproved or withdrawn from filing by the Department of Banking and Insurance, or determined incomplete by the Small Employer Health Benefits Program Board of Directors, as appropriate.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State. Health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the United States Government, Medicare supplement, coverage for Medicaid services pursuant to a contract with the State of New Jersey, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A–1 et seq.) or hospital confinement indemnity coverage.

"Health care expenditures" means the cost, on an incurred basis, of health care services and supplies rendered by a participating provider or a nonparticipating provider which are the responsibility of the HMO in accordance with the contracts the HMO has issued to contract holders.

"Health center" means a facility owned or leased by an HMO, used by members to receive medical and ancillary services including but not limited to: lab, radiology, and pharmacy.

"Health maintenance organization (HMO)" means any individual or entity that undertakes to provide or arrange for basic comprehensive health care services through an organized system that combines the delivery and financing of health care on a prepaid basis to members.

"Indemnity" means the payment of expenses, in whole or in part, as they are incurred by a member for the delivery of covered services, in which the level of payment for expenses incurred, and the charge made for the expenses incurred, is not negotiated between the health care provider and the HMO, and there is no contractual arrangement between the health care provider and the HMO holding the enrollee harmless for any amount of the expense not paid by the HMO. Payment of the expense may be made directly to the health care provider upon assignment by the member, or the member may be reimbursed for the expense incurred.

"Independent utilization review organization (IURO)" means an independent organization, comprised of physicians and other health care professionals representative of the active practitioners in New Jersey, with which the Department contracts in accordance with N.J.A.C. 8:38–8.8 to conduct independent medical necessity or appropriateness of services appeal reviews brought by a member or provider on behalf of the member, with the member's consent.

"Insurer" means any insurance company authorized to transact the business of insurance in New Jersey."

"Managed hospital payment" means agreements between the HMO and a hospital under which the financial risk primarily related to the degree of utilization rather than to the cost of services is transferred to the hospital.

"Master policy" means the document issued by a carrier to an HMO evidencing coverage of the subscribers and members of the HMO, or a class of subscribers and members of the HMO, under a group health contract.

"Medicaid marketing representative" means any person who is registered as a limited insurance representative pursuant to N.J.S.A. 17:22A–16 and who is authorized to solicit, negotiate or effect contracts with Medicaid recipients as an agent for a Medicaid-contracting HMO, and performs no other service for the HMO that would otherwise require that person to be authorized and licensed as an insurance producer.

"Medical screening examination" means an examination and evaluation within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel pursuant to requirements in N.J.A.C. 8:43G–12, which are necessary to determine whether or not an emergency medical condition exists.

"Member" means an individual who is enrolled in an HMO.

"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.

"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. 8:38–6.2.

"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 Commissioners of Health and Senior Services and Banking and Insurance.

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

"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.

Public Notice: Increase in medical component of the Consumer Price Index.
See: 29 N.J.R. 2484(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 30 N.J.R. 1330(a).
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".
Public Notice: Increase in medical component of the Consumer Price Index.
See: 31 N.J.R. 801(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 32 N.J.R. 1259(a).
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".

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

8:38–2.1 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.

8:38–2.2 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 State Department of Health and Senior Services
Office of Managed Care
PO Box 360
Trenton, NJ 08625–0360
or
New Jersey Department of Banking and Insurance
Managed Care 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;

2. One copy of the entire application (excluding signed provider agreement pages) shall be submitted to the Department of Banking and Insurance at the above address; and

3. 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 Health and Senior Services 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. 8:38–15, 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 or Department of Banking and Insurance 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. 8:38–11 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. 8:38–11;

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;

12. 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. The enrollment projections should be accompanied by a description of the demographic characteristics of the population, including at least sex and age;

13. A description of the methods used by the HMO to facilitate access to services for culturally and linguistically diverse members;

(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 Departments of Health and Senior Services and Banking and Insurance 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.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Rewrote (b)3; inserted a new (c); and recodified former (c) and (d) as (d) and (e).

SUBCHAPTER 10. MEDICAL RECORDS

8:38–10.1 Policies and procedures

(a) The HMO shall develop and implement a policy for the transfer of medical records of members whenever the following occur:

1. Change of physician or other provider;

2. Disenrollment of member from HMO; or

3. Other circumstances where requested by members or former members;

(b) Transfer of members' medical records as maintained by the HMO shall be completed within 30 days of the occurrence of events specified at (a)1, 2, or 3 above.

8:38–10.2 Confidentiality of medical records

Any data or information pertaining to the diagnosis, treatment, or health of any member or applicant obtained from the member or from any provider by any HMO shall be held in confidence. The data or information shall not be disclosed to any person, except to the extent that it may be necessary to carry out the purposes of this chapter, or upon the express consent of the member or applicant; or pursuant to state or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such member and the HMO wherein such data or information is pertinent as otherwise provided by law. An HMO shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health organization is entitled to claim. An HMO may also release aggregate data related to the diagnosis, treatment, or health of all or groups of members or applicants where the identity of every member is kept confidential and cannot be determined by the manner in which the data is released and presented.

8:38–10.3 Maintenance of medical records

Any medical records directly maintained by the HMO shall be organized in a uniform format across all records subject to the requirements of applicable law. The HMO shall have policies governing the contents of medical records.

8:38–10.4 Copies of medical records

Members or their legally authorized representatives shall have a right to inspect and obtain a copy of their medical records maintained by the HMO. Charges for copies of medical records shall be based upon actual costs, not to exceed prevailing community rates for photocopying.

8:38–10.5 Medical record retention

Medical records maintained by HMO's shall be protected against loss, destruction, or unauthorized use and retained for at least 10 years or until the member reaches age 23 years, whichever is longer.

SUBCHAPTER 11. FINANCIAL STANDARDS AND REPORTING

8:38–11.1 Minimum net worth

(a) In order to obtain a certificate of authority, an HMO shall have a minimum net worth, determined on a SAP basis, of at least $1,500,000 in cash or cash equivalents, as adjusted annually by the CPI, together with such other guarantees and assets as the Commissioner and Commissioner of Banking and Insurance may determine appropriate to assure the solvency of the HMO, based on its business plan, beginning on July 1, 1997.

(b) Except as (d) below applies, in order to maintain its certificate of authority, an HMO shall maintain at all times a minimum net worth, determined on a SAP basis, equal to the greater of:

1. $1,000,000 adjusted annually by the CPI, beginning on July 1, 1997;

2. Two percent of the annual premium revenues as reported by the HMO on its most recent annual financial statement filed with the Commissioner and Commissioner of Banking and Insurance for the first $150,000,000 of premium reported and one percent of the annual premium in excess of the first $150,000,000 of premium reported;

3. An amount equal to the sum of three months of uncovered health care expenditures, as reported on the financial statement filed most recently with the Commissioner and Commissioner of Banking and Insurance; or

4. An amount equal to the sum of eight percent of the annual health care expenditures (not including those expenditures paid on a capitated basis to a provider and those made on a managed hospital payment basis), as reported on the four quarterly financial statements most recently filed with the Commissioner and Commissioner of Banking and Insurance, plus four percent of the annual hospital expenditures paid on a managed hospital payment basis, as reported in the four quarterly financial statements most recently filed with the Commissioner and Commissioner of Banking and Insurance. If an HMO is issued an initial certificate of authority on or after July 1, 1997, its minimum net worth shall be phased in over a 48 month period, running from the date that its new certificate of authority is effective, as follows:

i. Twenty-five percent of the amount required in (b)4 above, or the greater of (b)1, 2 or 3 above, whichever is greatest, until the end of the 23rd month following the month in which its new certificate of authority was effective;

ii. Fifty percent of the amount required in (b)4 above, or the greater of (b)1, 2 or 3 above, whichever is greatest from months 24 through 35;

iii. Seventy-five percent of the amount required in (b)4 above, or the greater of (b)1, 2 or 3 above, whichever is greatest, from months 36 through 47; and

iv. One hundred percent of the amount required in (b)4 above beginning in the 48th month following the month in which its new certificate of authority was effective.

(c) In order to maintain its certificate of authority, a minimum of 60 percent of an HMO's admitted assets shall be cash, cash equivalents, investments as set forth at N.J.S.A. 17B:20–1a, or other forms of investments acceptable to the Commissioner considering the amount of the HMO's assets and the proportion of admitted assets to the HMO's minimum net worth requirement.

(d) Every HMO shall submit a capital and surplus (minimum net worth) guarantee on a form established and available from the Department of Banking and Insurance, executed by an affiliate or parent of the HMO that is not in an unsafe or unsound financial condition, consistent with N.J.A.C. 11:2–27, Determination of Insurers in a Hazardous Financial Condition, incorporated herein by reference, except that an HMO that has no such parent or affiliate available to execute a capital and surplus guarantee shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that other additional financial resources are available to the HMO to maintain the HMO's minimum net worth requirement. All guarantors shall satisfy the following requirements:

1. The guarantor shall have liquid assets, letters of credit or a similar instrument available to support the guarantee in a manner and amount acceptable to the Commissioner of Banking and Insurance.

2. If the guarantor is publicly held, the HMO shall submit the guarantor's quarterly and annual Securities and Exchange Commission (SEC) filing no later than 15 days after such filing has been made with the SEC. If not publicly held, the HMO shall submit the guarantor's unaudited quarterly financial statement no later than 45 days after the end of the calendar quarter.

3. All guarantors shall meet the following requirements:

i. The guarantor shall be a United States corporation actively engaged in business for a period of not less than five years;

ii. The guarantor shall have a satisfactory evaluation from Dun and Bradstreet, Standard and Poor's, Duff and Phelps or Moody's for at least three years;

iii. The guarantor shall have a net worth of at least $25 million; and

iv. If the guarantor fails to meet any of the requirements in (d)3i through iii above, a letter of credit or other form of financial security acceptable to the Commissioner shall be required.

(e) In determining net worth, a debt shall not be considered fully subordinated unless the subordination clause states that:

1. Principal and/or interest shall be paid to the lender only from free and divisible surplus as verified by the audited financial statement of the HMO;

2. Upon the dissolution or liquidation of the HMO, no payment shall be made with respect to the surplus note or other note made with that lender unless and until all other liabilities of the HMO have been paid in full; and

3. Written approval shall be obtained from the Commissioner of Banking and Insurance prior to any full or partial repayment of any principal or interest under the note.

(f) Any debt incurred by a note meeting the requirements of (e) above and which is otherwise acceptable to the Commissioner of Banking and Insurance shall not be considered a liability, but shall be reported as equity by the HMO.

(g) The interest expenses relating to the repayment of any fully subordinated debt shall be a covered expenditure.

(h) Every HMO shall be subject to the standards and corrective actions set forth at N.J.A.C. 11:2–27, Determination of Insurers in a Hazardous Financial Condition, which shall be in addition to the requirements of N.J.A.C. 8:38–11.6(f).

(i) No HMO shall enter into transactions for loans or other transfers of funds from or to the HMO without providing at least 30 days prior written notice of the transaction to the Commissioner and the Commissioner of Banking and Insurance.

1. The Commissioner of Banking and Insurance may disapprove the transaction if, in the Commissioner's opinion, the transaction will adversely affect the HMO and cause it to be in a hazardous financial condition, in accordance with N.J.A.C. 11:2–27.

2. The Commissioner or the Commissioner of Banking and Insurance may disapprove the transaction pending receipt of additional information from the HMO.

3. The disapproval shall specify in writing the reasons for the disapproval.

i. If the disapproval includes a request for additional information, the disapproval shall include the date by which the additional information is due from the HMO.

ii. An HMO shall have no less than five business days in which to respond to a disapproval with a request for more information.

4. If the Commissioner or Commissioner of Banking and Insurance does not disapprove of the transaction within 30 days of the date that the written notice is received by the Department of Banking and Insurance, the transaction shall be deemed approved.

i. With respect to filings for which additional information has been requested, if the Commissioner or the Commissioner of Banking and Insurance does not disapprove the transaction within 30 days following receipt by the Department of Banking and Insurance of the additional information as requested, the transaction shall be deemed approved.

(j) No HMO shall pay out dividends without the prior written approval of the Commissioner of Banking and Insurance. The Commissioner of Banking and Insurance may disapprove the payment of the dividend if payment will adversely impact the HMO, adversely impact compliance with other provisions of this chapter, or cause it to be in a hazardous financial condition in accordance with N.J.A.C. 11:2–27.

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).

8:38–11.2 Investments

Except as approved by the Commissioner of Banking and Insurance 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.

8:38–11.3 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.

8:38–11.4 Minimum deposits

(a) In order to obtain a certificate of authority, every HMO shall deposit with the Commissioner of Banking and Insurance 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 of Banking and Insurance 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 of Banking and Insurance. The deposit shall be held in trust as a restricted asset to offset reserves required pursuant to N.J.A.C. 8:38–11.3(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 of Banking and Insurance 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 of Banking and Insurance, 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 of Banking and Insurance 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 of Banking and Insurance.

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).

8:38–11.5 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 and the Commissioner of Banking and Insurance, 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 and the Commissioner of Banking and Insurance 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

4. Other arrangements guaranteeing that benefits shall be continued.

Amended by R.1999 d.201, effective June 21, 1999.
See: 31 N.J.R. 610(a), 31 N.J.R. 1631(a).
Rewrote (a); and in (b), inserted "or continuance" following "issuance" and inserted a reference to the Commissioner in the introductory paragraph, and substituted a reference to judicial declarations for a reference to determinations in 1.

8:38–11.6 Financial reporting requirements

(a) Every HMO shall submit, no later than March 1, an annual report for the immediately preceding calendar year, completed on a SAP basis, as prescribed by the NAIC Annual Statement Instructions manual including all supplemental schedules.

1. HMOs shall submit the annual report for calendar year 1996 (reported in March 1997) and thereafter using the current format established for any year by the National Association of Insurance Commissioners for HMOs, more commonly referred to as the "NAIC blank" for HMOs, the forms of which are available for purchase through several independent insurance service companies throughout the United States.

2. Every HMO shall submit with the annual report a certification of and an opinion by a member of the American Academy of Actuaries or an active fellow of the Society of Actuaries that the reserves required by N.J.A.C. 8:38–11.3 and included on the HMO's SAP annual report are sufficient.

i. The actuarial certification shall identify the specific methodology used to determine the reserves, and shall specify whether and how the methodology has changed since the last report.

ii. The workpapers prepared by the actuary in support of the certification shall be made available to the Department of Banking and Insurance upon request.

(b) Every HMO shall submit, no later than June 1, audited annual financial statements for the immediately preceding calendar year for the HMO and any company that is a financial guarantor for the HMO, completed on a GAAP basis.

1. The annual GAAP balance sheet assets for the HMO (only) shall agree with Column 1 of Schedule F–1, Analysis of Assets of the HMOs annual SAP report (using the NAIC blank format).

2. Every difference between the annual SAP and GAAP reports shall be explained on a supplementary schedule submitted at the time the annual GAAP report is submitted.

3. The annual GAAP report shall be certified by an independent public accountant.

4. Any internal control letter prepared by the independent public accountant shall also be submitted with the annual GAAP report.

(c) Every HMO shall submit, no later than March 1 annually, the New Jersey—Specific Annual Supplement, available from either the Department of Banking and Insurance or the Department of Health and Senior Services, for the preceding calendar year, completed in accordance with SAP.

(d) Every HMO shall submit quarterly reports no later than 45 days following the close of each calendar quarter (that is, May 15, August 15, November 15 and February 15, respectively), completed in accordance with SAP.

1. HMOs shall submit the quarterly report for the first quarter of calendar year 1996 (reported May 15, 1996) and thereafter using the NAIC blank for HMOs in effect at the time of the quarter reported.

2. Prior to the first quarterly report for calendar year 1996, HMOs shall submit quarterly SAP reports providing all of the information required in the NAIC blank, but may elect to use either the format acceptable to the Department of Banking and Insurance (the 1987 version of the NAIC blank) or the format for the NAIC blank in effect at the time of the quarter reported.

3. The quarterly reports shall also include Section E(iv), "Membership by County," Section M, "Analysis of Minimum Net Worth Requirements" of the New Jersey-Specific Annual Supplement, and any other data requested of a particular HMO by the Commissioner or the Commissioner of Banking and Insurance, attached to the last page of the quarterly report.

4. Every HMO shall submit with the quarterly financial report a certification of, and an opinion by, a member of the American Academy of Actuaries or an active fellow of the Society of Actuaries that the reserves required by N.J.A.C. 8:38–11.3 and included on the HMO's annual report are sufficient.

i. The actuarial certification shall identify the specific methodology used to determine the reserves, and shall specify whether and how the methodology has changed since the last report.

ii. The workpapers prepared by the actuary in support of the certification shall be made available to the Department of Banking and Insurance upon request.

5. The quarterly reports shall include a certification identifying all of the HMO's current reinsurance, insolvency and stop loss insurance arrangements, which shall include the identity of all reinsurers and insurers, policy periods, appropriate deductibles and coverage limits, the face page of all inforce policies, and a statement as to whether any of these risks are self-funded.

(e) Both the NAIC blank and the New Jersey—Specific Annual Supplement, including those sections required to be completed on a quarterly basis, shall be completed in their entirety; if a specific schedule is not applicable to the HMO, that should be so indicated using "N/A" or "None".

(f) With respect to completion of the New Jersey—Specific Annual Supplement, if an HMO's actual net worth calculated in Section M of the New Jersey—Specific Annual Supplement for the reporting period is less than 125 percent of the required minimum net worth for the HMO as required pursuant to N.J.A.C. 8:38–11.1, the HMO shall include with its then-current report a detailed plan of action demonstrating how the minimum net worth shall be maintained, specifying marketing and financial projections.

1. The plan of action shall include documentation of supporting assumptions made by the HMO.

2. The plan of action shall include discussions of alternate funding sources and shall specifically discuss parental or affiliate guarantees.

3. The plan of action shall be subject to review and approval of the Commissioner of Banking and Insurance.

(g) With respect to completing the annual and quarterly SAP reports, the HMO shall segregate assets into categories of "Admitted Assets" and "Non-Admitted Assets."

1. Non-admitted assets shall not be recognized by the Department of Banking and Insurance, and, thus, shall be excluded by the HMO in determining the HMO's minimum statutory net worth, solvency, deposits and reserves.

2. The following are examples of non-admitted assets that shall be excluded: deposits in suspended depositories; notes receivable not fully secured by collateral; cash advanced to or in the hands of officers or agents; loans or personal security (endorsed or not) that are not secured by collateral; travel advances; net book value of equipment or furniture (except certain electronic data processing or medical equipment, or other similar items approved by the Department of Banking and Insurance); prepaid expenses; any checks that cannot be deposited (post-dated, insufficiency of funds, etc.); premiums and accounts receivable more than 90 days due; and investments with questionable statutory or unverifiable values.

3. Notwithstanding (g)2 above, leaseholds shall be considered as admitted assets for staff or group model HMOs.

(h) The annual and quarterly Revenue and Expense Statements (Report #2–NAIC) shall include separate supplemental pages for "Commercial only," "Medicare," "Medicaid" and any other publicly funded program.

(i) Annual and quarterly reports shall not be accepted unless completed in accordance with this subchapter and additional instructions that may be obtained from the Department of Banking and Insurance at the address specified at (j) below.

(j) Every HMO shall submit two copies each of its reports to:

Chief
N.J. Department of Banking and Insurance
Life and Health Division
Managed Care Bureau
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

and

Director
N.J. Department of Health and Senior Services
Office of Managed Care
John Fitch Plaza
PO Box 360
Trenton, NJ 08625–0360

(k) Every HMO that has a contract with the Department of Human Services to provide coverage to the Medicaid population, or some segment thereof, also shall submit one copy of its reports to:

Executive Director
Office of Managed Health Care
Division of Medical Assistance and Health Services
N.J. Department of Human Services
Quakerbridge Plaza, Building 5
PO Box 712
Trenton, NJ 08625–0712

Amended by R.1999 d.201, effective June 21, 1999.
See: 31 N.J.R. 610(a), 31 N.J.R. 1631(a).
Rewrote (a)2; in (b), substituted a reference to June 1 for a reference to May 1 in the introductory paragraph, and added 4; in (d), rewrote 3, and added 4 and 5; inserted a new (h); recodified former (h) through (j) as (i) through (k); in the new (i), changed an internal reference; and in the new (j), substituted a reference to the Director for a reference to the Chief and made an address change for the Department of Health and Senior Services.

8:38–11.7 Reporting of compensation arrangements with health care providers involving incentive or disincentive programs

(a) In conjunction with the submission of the New Jersey—Specific Annual Supplement made in accordance with N.J.A.C. 8:38–11.6(c), every HMO shall submit aggregate reports on compensation arrangements between the HMO and providers under contract with the HMO (directly or through a secondary contractor) using the edition of HEDIS Table XIX (Primary Care Physician Payment Arrangement), Table XX (Specialist Payment Arrangement), and Table XXI (Mental Health Provider Payment Arrangement) for Medicaid in effect at the time of submission. Such tables are available from the National Commission on Quality Assurance, 1350 New York Avenue, Suite 700, Washington, DC 20005.

1. An HMO operating multiple lines of business (Medicaid, Medicare, and commercial, including any administrative service only business unless the health care providers have contracted with the self-funded arrangement) shall submit information separately for Medicaid, Medicare and commercial business if the HMO has different compensation arrangements for these lines of business.

(b) In conjunction with the submission of the New Jersey—Specific Annual Supplement made in accordance with N.J.A.C. 8:38–11.6(c), every HMO that uses financial incentive or disincentive arrangements in its compensation packages with providers under contract with the HMO (directly or through a secondary contractor) and/or utilization review organizations shall provide a certified explanation as to their accounting of the financial incentive or disincentive arrangements on the forms prescribed by the Commissioner of Banking and Insurance completed in accordance with the instructions for those forms pursuant to N.J.A.C. 8:38–11.6(h).

1. The explanation shall be certified to by the Chief Financial Officer of the HMO.

8:38–11.8 Rating

(a) Prior to issuing or amending any contracts for coverage, an HMO shall submit a certification, including an actuarial opinion certified by a member of the American Academy of Actuaries or an active fellow of the Society of Actuaries, for filing with the Commissioner of Banking and Insurance demonstrating that the rates to be used by the HMO are not excessive, inadequate or unfairly discriminatory (except as (a)1 below applies), specifying the rating methodology the HMO shall use.

1. Except as (a)2 below may apply, the Commissioner of Banking and Insurance shall find that a filing that uses one of the three following rating methodologies produces rates that are not unfairly discriminatory without further actuarial certification or demonstration:

i. Community rating that does not consider the age, gender, geography, occupation or health status of any specific member covered under a contract form when determining premiums of that specific member;

ii. Community rating by class that does not take into consideration the health status of any specific member covered under a contract form when determining premiums for that specific member; or

iii. Prospective experience rating by group that does not take into consideration the health status of a covered member of a specific (employment-based) group when determining premiums for that specific member, but which does segregate the group's health history and claims experience from other groups covered under the same contract form for purposes of establishing premiums for the group on a prospective basis.

2. Notwithstanding (a)1 above, every HMO shall comply with N.J.S.A. 17B:27A–2 et seq. and 17B:27A–17 et seq. when establishing rating methodologies for their individual and small employer group contracts.

8:38–11.9 Subrogation and third party claims

(a) An HMO group contract for covered services may contain subrogation provisions or provisions that require the return to the HMO by a member of benefits paid (or comparable dollar amounts for services provided) for illness or injury up to the amount a covered person receives from a third party through settlement, a satisfied judgment or other means, as compensation for the medical costs of such illness or injury, subject to the following:

1. Repayment by the member shall be required only where the amounts received from the third party through settlement, judgment or other means are specifically identified as amounts paid for health benefits which have been paid or provided by the HMO under the group contract under which the member is covered;

2. The repayment shall not exceed the amount of benefits paid (or comparable cost of services provided) by the HMO under the contract under which the member is covered for the particular illness or injury; and

3. The group contract shall allow the member to deduct from the repayment to the HMO the reasonable pro-rata expenses incurred in effecting the third party payment.

(b) Subrogation shall only be applicable when third party liability benefits may exist, subject to the restrictions set forth in (a) above and (c) below.

(c) No HMO contract shall include a provision for subrogation with respect to benefits that may exist under the personal injury protection provisions of any automobile insurance policy issued in New Jersey in accordance with N.J.S.A. 39:6A–4, 4.3 or 9.1.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In (a)1, substituted "or" for "of" following "judgement".

SUBCHAPTER 12. REHABILITATION, CONSERVATION AND LIQUIDATION

8:38–12.1 Rehabilitation, conservation and liquidation generally

(a) An HMO shall cease new enrollment, except for addition of family members of current members, upon receipt of notice of the filing of a petition by the Commissioner of Banking and Insurance for an order authorizing rehabilitation of the HMO pursuant to N.J.S.A. 17B:32–31 et seq., Life and Health Insurers Rehabilitation and Liquidation Act, if enrollment has not ceased prior to that date, until such time as the petition may be denied.

(b) Participating health care providers, whether or not subject to a total or partial hold harmless provision of their participation contract with the HMO, and nonparticipating health care providers incurring expenses for rendering services to the HMO's members that are covered within the terms of the HMO's contract with the member shall have class 3 claims against the HMO as specified in N.J.S.A 17B:32–71 (which follow the class 3 claims of members or subscribers and their beneficiaries), and shall not bill or otherwise pursue any legal action against a member of an HMO against whom an order or rehabilitation of liquidation has been issued.

(c) Neither the reformation of member or provider contracts, restructuring of liabilities, or transfer of all or a portion of the HMO's business to another HMO that may occur in the course of the rehabilitation or liquidation of an HMO shall alter the applicability of (a) or (b) above unless the Commissioner of Banking and Insurance or a court of

competent jurisdiction specifically orders that (a) or (b) or both be altered so as to facilitate the reformation, restructuring or transfer of business.

8:38–12.2 Alternate methodology for assuring continuation of services to HMO members

(a) The Commissioner of Banking and Insurance may order carriers and other HMOs to offer the members of an insolvent HMO an opportunity to become insured or to enroll with the carriers and other HMOs, during no less than a 30–day open enrollment period to be determined by the Commissioner of Banking and Insurance, except as (b) below may apply.