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 As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider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.

"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.

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

"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.

"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 absence of immediate attention could reasonably be expected 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.

"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 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 enrollees.

"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 organization with which the Department contracts in accordance with N.J.A.C. 8:38–8.8 to conduct independent reviews of final decisions by the HMO to deny, reduce or terminate covered benefits, which are contested by the member or provider on behalf of the member.

"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.

"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 any physician, 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.

"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 the prospective, concurrent or retrospective assessment of the necessity and appropriateness of clinical services provided, or proposed to be provided, to a member.

Public Notice:. Increase in medical component of the Consumer Price Index.
See: 29 N.J.R. 2484(b).

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 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
CN 360
Trenton, NJ 08625–0360

or

New Jersey Department of Banking and Insurance
Managed Care Bureau
Division of Life and Health Division
20 West State Street
CN 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 application proposes to be a Medicaid program participant, one copy shall be submitted to:

New Jersey Department of Human Services
Office of Managed Health Care
Division of Medical Assistance and Health Services
CN 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 biographical information;

4. A copy of the signed contract between the HMO and each participating provider in accordance with N.J.A.C. 8:38–15, including a description of any compensation program involving incentive or disincentive payment arrangements. As required by N.J.S.A. 26:2J–26, copies of any contract made between the HMO and any provider, insurer, hospital or medical service corporation shall be considered confidential;

5. A copy of the form of evidence of coverage to be issued to the subscriber;

6. A copy of the form of the individual and group contract, if any, which is to be issued to subscribers and contract holders;

7. 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;

8. A description of the proposed method of marketing and financing;

9. 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 appli-

cant 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;

10. 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;

11. 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;

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

13. A description of the complaint and appeal procedures delineated in N.J.A.C. 8:38–3.6;

14. A description of the continuous quality improvement program delineated in N.J.A.C. 8:38–7;

15. A description of the utilization management program, including the process for appealing utilization management determinations delineated in N.J.A.C. 8:38–8;

16. A list of all participating providers by county, municipality and zip code, accompanied by maps of the service area identifying the location of these providers. This list shall include all PCPs, specialists, hospitals and ancillary providers. The list of PCPs and specialists shall include the individual's name, address and, if applicable, hospital affiliation;

17. The criteria regarding geographic accessibility and availability of its health care provider network and why the applicant believes these criteria meet or exceed the rules in this chapter. This shall be related to the applicant's enrollment projections, the access guidelines contained in this chapter, and the applicant's experience;

18. The criteria to be used to maintain the appropriate numbers and types of providers as enrollment increases in accordance with N.J.A.C. 8:38–6;

19. The criteria used to ensure access to specialized services identified in N.J.A.C. 8:38–6;

20. A description of the method of informing affected members and providers of changes in the health care delivery network, as delineated in N.J.A.C. 8:38–3.5;

21. A description of the mechanism by which members and providers will be afforded an opportunity to participate in matters of policy and operation through establishment of advisory panels, by the use of advisory referendum on major policy decisions, or through the use of other mechanisms;

22. A statement from the applicant attesting that it or any affiliated entity operating as an HMO or regulated health insurance business has been in substantial compliance with all applicable state and Federal regulations for the last 12 months in any state in which approval to operate has been granted by the official state licensing and/or certification agency. A description and explanation of any enforcement action or settlement thereof affecting the HMO or its affiliate must be submitted including and not limited to fines, suspension of marketing, or revocation of a license or certificate to do business. The Commissioner may request further information from the applicant or from the official state or Federal agency to determine compliance; and

23. Such other information as the Commissioner or the Commissioner of Banking and Insurance may require, on a case by case basis, from a specific applicant, to make the determinations required by N.J.S.A. 26:2J–4.

8:38–2.3 Issuance of a certificate of authority

(a) A certificate of authority to establish and operate an HMO to service commercial enrollees shall be issued upon approval of the Commissioner and the Commissioner of Banking and Insurance.

(b) A certificate of authority to establish and operate an HMO to service both Medicaid and commercial enrollees shall not be approved for purposes of serving Medicaid enrollees until such time that the Commissioner has received and considered the recommendation of the Department of Human Services, Division of Medical Assistance and Health Services on the applicant's compliance with the State and Federal requirements of a contract between the applicant and the Department of Human Services.

(c) Issuance of a certificate of authority shall be granted upon demonstration of compliance, to the satisfaction of the Commissioner of Health and Senior Services and Commissioner of Banking and Insurance, with these rules and the requirements in N.J.S.A. 26:2J–1 et seq.

(d) Prior to issuance of a certificate of authority, a site visit may be conducted by the Departments of Health and Senior Services, Banking and Insurance and/or Human Services to determine compliance with this chapter.

8:38–2.4 Comprehensive assessment reviews

(a) After issuance of a certificate of authority, the HMO shall undergo a comprehensive assessment review by the Department on a triennial basis.

(b) The comprehensive assessment review conducted by the Department may include an on-site review and shall be based upon the Department's review of the following:

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 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) 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.

(d) An HMO that has a certificate of authority on or before July 1, 1997 shall come into compliance no later than December 28, 1997.

(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, in accordance with N.J.S.A. 26:2J–5.

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 and 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).

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 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; and

2. Continued health care services to members for which a consideration has been received, or a consideration is due but unpaid.

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 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 made in accordance with N.J.A.C. 11:2–32 and held in trust as a restricted asset to offset reserves required pursuant to N.J.A.C. 8:38–11.2.

1. The required deposit amount shall be the equivalent of either: two thirds of the highest cost for non-capitated covered services for a calendar quarter in the last four quarters plus capitation due but unpaid; or two thirds of the highest cost for non-capitated covered services for a calendar quarter in the last four quarters multiplied by the average number of days for payment of all claims by the HMO during that calendar year and divided by 62, plus capitation due but unpaid, whichever amount is less.

i. Recalculation of the deposit amount shall occur no more frequently than annually.

ii. The average number of days to pay all claims shall be the median number of days the HMO utilized to pay all claims (from date received until date paid) as evidenced by a calendar year lag study (triangle study) filed with the Department of Banking and Insurance with the annual report.

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 N.J.A.C. 11:2–32 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 or eliminated by the Commissioner of Banking and Insurance as a result of other guarantees provided by the HMO's parent or affiliate, reinsurance, stop loss insurance or other arrangements which are satisfactory to the Commissioner of Banking and Insurance, or as the result of the HMO becoming a member of a statutorily-authorized guaranty association covering contracts of HMOs.

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."

7. The initial deposit shall be made by July 1, 1997.

(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).

8:38–11.5 Insolvency plan

(a) In order to obtain and maintain a certificate of authority, an HMO shall establish a plan, to the satisfaction of the Commissioner of Banking and Insurance, for assuring continuation of services and benefits to members in case the HMO becomes or is determined to be insolvent.

1. Such plan shall assure the continuation of services or benefits to all members for the duration of the contract period for which premiums or other consideration has been paid or for which premium or other consideration is due but unpaid.

2. Such plan shall assure the continuation of services and benefits under the HMO contract to members who, on the date of the 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 of a certificate of authority, 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 determination of the HMO's insolvency;

2. Additional deposits;

3. Acceptable letters of credit; and/or

4. Other arrangements guaranteeing that benefits shall be continued.

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. Prior to the 1996 annual SAP report, HMOs shall submit annual SAP reports providing all of the information required in the NAIC blank, but may elect to use either the current format acceptable to the Department of Banking and Insurance (the 1987 version of the NAIC blank) or the more current format of the NAIC blank.

(b) Every HMO shall submit, no later than May 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.

(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," and Section M, "Analysis of Minimum Net Worth Requirements" of the New Jersey—Specific Annual Supplement, attached to the last page of the quarterly report.

(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.