

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.
Sec: 29 N.J.R. 2484(b).

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(a)1.

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(b).

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.