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).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B–5.1c, Chapter 38, Health Maintenance Organizations, expires on July 16, 2002. See: 34 N.J.R. 885(a).

Chapter Historical Note

Chapter 38, Health Maintenance Organizations, was adopted as R.1974 d.320, effective November 20, 1974. See: 6 N.J.R. 8(b), 6 N.J.R. 473(a). Pursuant to Executive Order No. 66(1978), Chapter 38 expired on April 3, 1994.

Chapter 38, Health Maintenance Organizations, was adopted as R.1994 d.365, effective July 18, 1994. See: 26 N.J.R. 1624(a), 26 N.J.R. 2896(a). Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, was adopted as R.1996 d.194, effective April 15, 1996. See: 27 N.J.R. 4981(a), 28 N.J.R. 1981(c).

Pursuant to Executive Order No. 66(1978), Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, of Chapter 38, was readopted as R.1997 d.68, effective January 17, 1997. 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 As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider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.

Law Review Journal Commentary

A patients' bill of rights - Be careful what you ask for. William F. Megna and Charles B. Lynch, 211 N.J.Law. 34 (2001).

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.

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".
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;

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

1. HMOs shall submit requests for approval of secondary networks, and shall clearly identify the purpose of every secondary network. An application for modification of a certificate of authority shall include the following:

i. A specimen copy of every form of a contract between the HMO and all providers to be included in the secondary network, with a statement as to whether the contract was previously approved for use with the HMO's standard network;

ii. A specimen copy of the form of the individual and group contract and evidence of coverage, if any, which is to be issued to employers, unions, trustees or other organizations pursuant to utilization of the secondary network, with a statement as to whether the contract was previously approved for use with the HMO's standard network;

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

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

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

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

vii. The proposed rates for the secondary network; and

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

2. The Commissioner shall approve an amendment for a secondary network based upon a determination that the secondary network is adequate to serve the purposes intended, as specified by the HMO, with respect to availability of services, product design (including integration with other networks established by the HMO, if integration will or may occur) and financial stability of the HMO. In making this determination, the criteria that apply to establishment of any network by an HMO shall apply to establishment of a secondary network.

(e) In reviewing the proposed amendment to a certificate of authority, the Commissioner and Commissioner of Banking and Insurance shall determine whether the HMO has demonstrated compliance with all applicable rules of this chapter. The Commissioners shall also examine and evaluate the compliance record of the HMO for the period beginning 12 months prior to receipt of written notice, and may deny such application for a finding of non-compliance leading to an enforcement action pursuant to N.J.A.C. 8:38–2.13.

(f) If the amendment to the certificate of authority is for the purpose of expanding the HMO's enrollment to include Medicaid enrollees, the amendment shall not be approved 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 HMO's compliance with the State and Federal requirements of execution of a contract between the HMO and the Department of Human Services.

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), rewrote the introductory paragraph, and substituted "of" for "or" in 2; inserted a new (d); and recodified former (d) and (e) as (e) and (f).

8:38–2.7 Notice of changes in HMO operations

(a) Following issuance of a certificate of authority, the HMO shall notify the Departments of Health and Senior Services and Banking and Insurance, in writing, of any substantial change to items identified at N.J.A.C. 8:38–2.2(c)1 through 24, at least 30 days prior to the date when such change is expected to occur. The Department shall deem such change approved within 30 days from the date of receipt of notice of the change unless the Department notifies the HMO otherwise. Substantial changes include, but are not limited to:

1. Any change or reduction in the provider network that adversely impacts network adequacy requirements identified at N.J.A.C. 8:38–6;

2. The subcontracting of any major functions not specified at N.J.A.C. 8:38–2.6(a) to another entity;

3. The nonrenewal of a hospital provider's contract which shall be reported in accord with N.J.A.C. 8:38–3.5(b); and

4. The establishment of a new group health center in a county or service area that has previously received certificate of authority approval for initiation of group health center services in that area.

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), rewrote the introductory paragraph and 2.

8:38–2.8 Approval of a point of service (POS) plan

In addition to the requirements set forth in N.J.A.C. 8:38–2.7, any HMO proposing to enter into an arrangement for the provision of out-of-network covered services to members shall also comply with the requirements delineated in N.J.A.C. 8:38–14.

8:38–2.9 Changes in ownership interests

(a) Certificates of authority shall not be assignable or transferable in whole or in part. Accordingly, the holder of record of any certificate of authority to operate in New Jersey shall, as a condition thereof, comply with all of the requirements of this section regarding changes in ownership interests. For the purposes of this subchapter, changes in ownership interests shall refer to changes in the ownership of the holder of record of any certificate of authority and/or changes in ownership of any individual, corporation or other entity which, through the ownership of voting securities, by contract or by any other means, has the authority to, or does in fact, direct or cause the direction of the management and/or the policies of the HMO which is the subject of the certificate of authority at issue.

(b) Any transaction or series of transactions requiring the filing of SEC forms 13g or 13d pursuant to the Securities and Exchange Act of 1934 or otherwise resulting in a change of five percent of more of ownership interests, shall be reported to the Commissioner in accordance with the provisions of N.J.A.C. 8:38–2.7 no later than 10 days following the occurrence thereof.

(c) Any proposed transaction or proposed series of transactions which would result in a change in ownership interests in the holder of record of a certificate of authority, or its parent company held by one party or entity or an affiliated group of parties or entities, of 10 percent or greater shall, in addition to the reporting requirement of (b) above, require the filing of an amendment to the certificate of authority in accordance with the provisions of N.J.A.C. 8:38–2.6.

(d) Any proposed transaction or proposed series of transactions which would result in a change in the controlling ownership of a holder of a certificate of authority, as that term is defined in (e) below, shall require the issuance of an amended certificate of authority in accordance with N.J.A.C. 8:38–2.6. Where the individual, corporation or other entity acquiring a controlling ownership interest in the holder of record of any certificate of authority to operate in New Jersey is itself the holder of a valid certificate of authority to operate in New Jersey, then the acquiring party may satisfy the requirements of this subsection by filing for and obtaining an amendment to its certificate of authority in accordance with N.J.A.C. 8:38–2.6(c) above.

(e) For the purposes of this subchapter, a controlling ownership interest shall exist in any individual, corporation or other entity which, through ownership of voting securities, by contract or by any other means, has the authority to or does in fact direct or cause the direction of the management and/or the policies of the HMO which is the subject of the certificate of authority at issue. A change in the controlling ownership interest shall be presumed to occur in, but shall not be limited to, any transaction involving the sale, exchange or other transfer of all or substantially all assets or equity interests.

(f) With respect to any change in ownership interest referenced in (c) above, the Commissioner or the Commissioner of Banking and Insurance may request from the holder of record of the certificate of authority at issue, any additional information which he or she determines to be necessary to verify the percentage of ownership interests affected. If upon the evaluation of any such additional information the Commissioner determines that the transaction does in fact involve a change in the controlling ownership interest as that term is defined in (e) above, then he or she shall direct the affected parties to comply with the terms of (d) above.

(g) With respect to any change in ownership requiring an amendment to the certificate of authority under (c) or (d) above, the Commissioner and the Commissioner of Banking and Insurance shall, in addition to all other applicable provisions of this chapter and N.J.S.A. 26:2J–1 et seq., take into consideration the following factors in reaching his or her decision to approve or deny the application:

1. After the change of ownership, the HMO would not be able to satisfy the requirements for the issuance of a certificate of authority;

2. The effect of the change in ownership would be to substantially lessen competition among HMOs in this State or tend to create a monopoly therein;

3. The financial condition of the acquiring party is such as might jeopardize the financial stability of the HMO, or adversely affect the provision of health care services to subscribers or members;

4. The proposed change in ownership is determined to be unfair and unreasonable to subscribers or members and/or is not in the public interest; or

5. The competence, experience and integrity of those persons who would control the operation of the HMO are such that it would not be in the interest of subscribers or members and of the public to permit those individuals to effect the merger or other acquisition of control. Evidence of such findings may include, but is not limited to, a criminal conviction or plea of guilty for a charge of fraud, embezzlement, misappropriation of property, or other related crime, or a civil judgment or administrative sanction for such causes, or a Federal or state action for revocation of a license, certificate of authority, or permit to operate or manage an HMO or other insurance business or a health care facility.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In (c), inserted "in the holder of record of a certificate of authority, or its parent company" following "interests"; and in (d), changed N.J.A.C. reference.

8:38–2.10 Surrender of a certificate of authority

(a) In the event that an HMO voluntarily ceases operation, it shall provide at least 90 business days advance notice to all members, employers, providers and the Departments of Health and Senior Services and Banking and Insurance. The notice shall identify the storage location of medical records, where applicable, and procedures for obtaining copies of such records.

(b) The HMO shall provide a plan at least 90 business days in advance of the surrender to the Department to assure continuity of coverage and medical care and assistance to members, as necessary, in accordance with N.J.A.C. 8:38–12.2.

(c) When the surrender is due to an acquisition or merger, the certificate of authority shall remain active and obligations of the surrendering HMO shall remain in effect until the termination notices and requirements of the IHC and SEH programs are met and all liabilities of the HMO surrendering its certificate of authority are assumed by the surviving entity, or are otherwise extinguished.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In (b), changed N.J.A.C. reference; and added (c).

8:38–2.11 Registered agent

Each HMO shall maintain an office in New Jersey and provide the Department with the name and address of its registered agent or else 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. The HMO shall assure in writing that it submits to New Jersey jurisdiction for all New Jersey laws and regulations and that it shall submit to inspections by Department of Health and Senior Services and/or Department of Banking and Insurance staff at any out of state site.

8:38–2.12 Examinations

(a) The Department and the Department of Banking and Insurance may conduct an examination of the HMO annually, but in no case less than once every three years, concerning the quality of health care services and other affairs of the HMO, including providers with whom such organization has contracts, agreements, or other arrangements. This examination may include, but not be limited to, the review of documents, patient records, information required in N.J.A.C. 8:38–3.6, and conferences with providers and members. The HMO shall be assessed an amount authorized at N.J.S.A. 26:2J–18, as may be amended, to offset the expenses of examination under this section. The fee shall be remitted within 90 days following the date of the assessment.

(b) The Department shall incorporate the annual examination process as described above into the comprehensive assessment review process.

(c) The Department may conduct special examinations at any time to ascertain whether the HMO is in compliance with this chapter and all applicable State and Federal statutes and regulations. A report of this examination shall be provided to the HMO within 30 business days of completion of the special examination. Any violations resulting from this examination shall be identified and responded to in accordance with N.J.A.C. 8:38–2.13.

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), deleted "annual fee of $1000" following "assessed an" in the third sentence, and rewrote the fourth sentence.

8:38–2.13 Violations

(a) A violation may be cited by the Commissioner of Health and Senior Services and/or Banking and Insurance or their designees upon determination that the HMO does not comply with the rules in this chapter and N.J.S.A. 26:2J–1 et seq.

(b) At the conclusion of an examination, or within 30 business days thereafter, the Department shall provide the HMO with a written summary of violations of this chapter and any factual findings used as a basis to determine that a violation has occurred.

(c) The Department or the Department of Banking and Insurance may require that the HMO submit a written plan of correction specifying how each violation that has been cited will be corrected along with the time frames for completion of each corrective action. A single plan of correction may address all events associated with a given violation. The plan of correction, where required, shall be submitted by the HMO within 20 business days of receipt of the notice of violations, or sooner, if the Commissioner determines that the violations jeopardize the safety of enrollees. The plan of correction shall be reviewed by the Department and shall be approved where the plan demonstrates to the satisfaction of the Department that compliance will be achieved within a reasonable time period. If the plan is not approved, the Departments of Health and Senior Services and Banking and Insurance may request that an amended plan of correction be submitted within five business days.

(d) The summary of violations and the written plan of correction shall not be released as public information until such time that the Department has received the plan of

correction or, in the event no plan of correction is submitted, 20 business days of receipt of the summary of violations by the HMO, whichever is sooner. Unless otherwise documented, the Department will presume receipt of the summary of violations by the HMO by the third business day if sent by regular mail.

8:38–2.14 Enforcement remedies available

(a) The Commissioner may impose the following enforcement remedies against an HMO for violations of regulations in this chapter or other statutory requirements:

1. A monetary penalty may be imposed for each violation in an amount determined by the Commissioner, which shall be in amounts as authorized by N.J.S.A. 26:2J–24 (not less than $250.00 and not greater than $10,000 for each day that the carrier is in violation, based on the severity of the violation, as determined by the Commissioner on a case-by-case basis), as amended from time to time. The Department shall provide the HMO with reasonable notice in writing of the intent to levy the penalty, and a reasonable time, as determined by the Commissioner, within which to correct the violation. Any such penalty may be recovered in a summary proceeding pursuant to the Penalty Enforcement Law (N.J.S.A. 2A:58 et seq.);

2. Suspension of a certificate of authority pursuant to N.J.S.A. 26:2J–19, which may include the suspension of marketing and enrollment;

3. Revocation of a certificate of authority pursuant to N.J.S.A. 26:2J–19;

4. An order to cease and desist pursuant to N.J.S.A. 26:2J–24;

5. Institution of a proceeding to obtain injunctive relief pursuant to N.J.S.A. 26:2J–24;

6. Other remedies for violations of statutes, as provided by State or federal law.

(b) The Commissioner shall serve notice to the HMO of any proposed enforcement remedy under this section, setting forth the specific violations, charges or reasons for the action. Such notice shall be served on the HMO or its registered agent in person or by certified mail.

(c) The assessment of civil monetary penalties, or revocation of a certificate of authority, shall become effective 30 days after the date of mailing or the date on which such notice was personally served on an HMO, unless the HMO files with the Department a written answer to the charges and gives written notice to the Department of its desire for a hearing, in accordance with N.J.A.C. 8:38–2.15. In such cases, the HMO may request an abeyance of the enforcement remedy until an administrative hearing has been concluded and a final decision is rendered by the Commissioner. The Commissioner may grant the abeyance where he or she determines that such action would not endanger the health, safety, and welfare of HMO members. Hearings shall be conducted in accordance with N.J.A.C. 8:38–2.15.

(d) Upon the imposition of an order to suspend marketing and enrollment, or following the suspension of a certificate of authority, the HMO shall not enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees.

(e) Upon the revocation of the certificate of authority, the HMO shall notify all members and providers and follow procedures in N.J.S.A. 26:2J–19d.

(f) The Commissioner or the Commissioner of Banking and Insurance may issue an order directing an HMO or a representative of an HMO to cease and desist from engaging in any act or practice in violation of the provisions of this chapter and N.J.S.A. 26:2J–1 et seq. Within 20 days after service of such an order, the HMO may request a hearing on the question of whether acts or practices in violation of this chapter and N.J.S.A. 26:2J–1 et seq. have occurred.

(g) The Commissioner may institute a proceeding to obtain injunctive relief, in accordance with New Jersey Court Rules, if the Commissioner elects not to issue a cease and desist order, or in the event of non-compliance with a cease and desist order pursuant to N.J.S.A. 26:2J–24(d).

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, rewrote the first sentence.

8:38–2.15 Hearings

(a) Pursuant to N.J.S.A. 26:2J–22, if the Commissioner proposes to suspend, revoke, or deny a certificate of authority, or issues a cease and desist order, the Commissioner shall notify the HMO and the Commissioner of Banking and Insurance in writing, specifically stating the grounds for such denial, suspension, revocation, or order and fixing a time of at least 20 days thereafter for a hearing on the matter.

(b) If the Commissioner levies a civil penalty, the HMO has a right to request a hearing on the matter, which must be filed within 20 days of receipt of the notice.

(c) The hearing will be conducted through the Office of Administrative Law in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(d) After such hearing or upon failure of the HMO to request a hearing, the Commissioner shall make a final determination based on written findings and make such findings available to the HMO and the Commissioner of Banking and Insurance.

(e) The recommendations and findings of the Commissioner of Banking and Insurance shall be conclusive and binding upon the Commissioner in relation to suspension, revocation, or denial of a certificate of authority when the matter concerns the following:

1. Insurance business; and/or

2. Requirements in N.J.A.C. 8:38–11 through 15.

SUBCHAPTER 3. GENERAL REQUIREMENTS

8:38–3.1 Compliance with laws and rules

(a) The HMO shall comply with the provisions of the New Jersey Health Maintenance Organizations Act, N.J.S.A. 26:2J–1 et seq.

(b) The HMO shall comply with applicable Federal, state, and local laws, rules and regulations.

8:38–3.2 Nondiscriminatory enrollment practices

(a) Except as provided in N.J.A.C. 8:38–3.4(a), an HMO shall not refuse to renew the coverage of a member covered under a contract for basic health care services, or alter the terms of, or cancel, an existing contract solely on the basis of the following:

1. The health of the member;

2. The age of the member;

3. The sex of the member;

4. The frequency of the member's use of the health care services of the HMO;

5. The filing of a complaint or appeal by the member as permitted by these rules; or

6. Other reasons prohibited by the Trade Practices Act, N.J.S.A. 17B–30–1 et seq., or the New Jersey Law Against Discrimination, N.J.S.A. 10:5–1.1 et seq.

(b) In accordance with N.J.S.A. 17B:48E–20, contracts of an HMO which provide coverage of a family member or dependents of a member shall also provide coverage to a newborn child of a member from the moment of birth until 31 days after the date of birth as if that child were enrolled, without additional premium for these 31 days. The coverage for newly-born children shall consist of coverage of at least injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(c) Contracts of an HMO which provide coverage of a member but do not provide coverage for a family member or dependent of the member shall nevertheless provide for coverage of newborn children of the member from the moment of birth until 31 days after the date of birth as if that child were enrolled, unless the contracts are such as provide no dependent coverage whatsoever for the member's class. The coverage for newly-born children shall consist of coverage of at least injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, provided application and payment of the required premium are submitted to the HMO to include coverage for a newly-born child within 31 days from the date of birth. The services under this section must be authorized by the HMO.

8:38–3.3 Open enrollment

(a) After an HMO has been in operation for 24 months, it shall have an annual open enrollment period for its group contracts for basic health care services of at least one month during which it accepts members up to the limits of its capacity, as determined by the HMO, in the order in which they apply for membership. Such requirement for annual open enrollment is not applicable to contracts executed pursuant to N.J.S.A. 17B:27A–18 and 19.

(b) Notwithstanding (a) above, HMOs providing or arranging for basic health care services on a group contract basis may limit the open enrollment to all members of the group or groups covered by such contracts.

(c) The HMO shall notify its subscribers in writing, both at the time of enrollment and through a notice in the promotional material which it distributes to prospective members, that, unless the member moves his or her place of residence outside of the HMO's designated service area, a person's choice of health benefits plan generally will determine his or her coverage until the next annual open enrollment period, regardless of the continued availability of a particular health care provider who contracts with the HMO.

8:38–3.4 Member contract termination

(a) A member shall not have his or her membership in an HMO cancelled except for the following reasons:

1. Failure to pay the premiums and other applicable charges for such coverage, including copayment coinsurance and deductibles;

2. Failure to abide by the rules and/or policies and procedures of the HMO;

3. Fraud or material misrepresentation affecting coverage, including misuse of a member identification card; or

4. The group of which the individual is a member is not renewed in accordance with the HMO's underwriting guidelines or is cancelled for failure to pay premiums.

(b) Before a member's coverage can be terminated for (a)1 and 2 above, the member shall be given written notice of the violation and a reasonable opportunity to come into compliance. Following any decision to terminate a member's coverage, the HMO shall notify the member of his or right to appeal such decision as set forth in N.J.A.C. 8:38–3.6.

8:38–3.5 Provider contract termination

(a) The HMO shall establish a policy governing termination of health care professionals and other providers. The policy shall include at least:

1. Standards by which the HMO will provide notice to the provider of termination of his or her participation in the time and manner specified in the provider's contract.

i. In instances in which the contract is terminated prior to the contract's renewal date, the HMO shall provide heath care professionals with at least 90-days written notice of the termination, specifying the health care professional's right to a hearing before a panel appointed by the HMO.

(1) The HMO shall provide in writing the reasons for the termination, if requested by the health care professional, within no more than 15 days of receipt of the request if the reason is not otherwise stated in the written notice of termination.

ii. HMOs shall not be required to provide 90–days prior written notice and the opportunity for a hearing for terminations of health care professionals based on: nonrenewal of the contract, a determination of fraud, breach of contract by the health care professional, or the opinion of the HMO's medical director that the health care professional represents an imminent danger to a patient or the public health, safety and welfare.

(1) An HMO that terminates a contract based on a determination of fraud shall report the fraud, with the basis for the determination of fraud, to the appropriate administrative agency (that is, the health care professional's licensing entity, such as the Board of Medical Examiners, the Board of Pharmacy, the Board of Chiropractic, and the Division of Criminal Justice).

(2) An HMO that terminates a contract based on a determination that the health care professional represents an imminent danger to the patient or the public health, safety and welfare shall report the determination to the appropriate State licensing board, and reports to the State Board of Medical Examiners shall be subject to N.J.S.A. 45:9–19.5.

2. Methods by which the termination policy shall be made known to providers upon initial participation and at the time of renewal of the provider's contract.

(b) HMOs shall provide written notification to each member at least 30 business days prior to the termination or withdrawal from the HMO's provider network of a member's PCP and any other physician or provider from which the member is currently receiving a course of treatment.

1. The 30–day prior notice to members may be waived in cases of immediate termination of a provider based on breach of contract by the provider, a determination of fraud, or where the HMO's medical director is of the opinion that the provider is an imminent danger to a patient or the public health, safety or welfare.

(c) The HMO shall assure continued coverage of covered services at the contract price by a terminated health care professional for up to four months in cases where it is medically necessary for the member to continue treatment with the terminated health care professional except as set forth below.

1. In cases of the pregnancy of a member, medical necessity shall be deemed to have been demonstrated and coverage of services by the terminated health care professional shall continue to the postpartum evaluation of the member, up to six weeks after delivery.

2. In the case of care post-operative care, coverage of services by the terminated health care professional shall continue for a period of up to six months.

3. In the case of oncological treatment, coverage of services by the terminated health care professional shall continue for a period up to one year.

4. In the case of psychiatric treatment, coverage of services by the terminated health care professional **shall** continue for a period of up to one year.

5. The HMO is not required to continue coverage for services obtained through a terminated health care professional in those instances in which the health care professional has been terminated based upon: the opinion of the HMO's medical director that the health care professional is an imminent danger to a patient or the public health, safety and welfare, a determination of fraud, or a breach of contract by the health care professional, or the health care professional is the subject of disciplinary action by the State Board of Medical Examiners.

6. The determination as to the medical necessity of a member's continued treatment with a terminated health care professional shall be subject to the appeal procedures set forth at N.J.A.C. 8:38–8.5 through 8.7.

(d) The HMO shall include in its agreements with providers, other than hospital providers, that, regardless of which party terminates the agreement, or the reasons for the termination, the HMO and the provider shall abide by the terms of the provider agreement, including reimbursement terms, for four months following the date of the termination, but the agreement may state that the provider has no obligation under the agreement to provide, and the HMO has no obligation to reimburse at the contracted rate, services which are not medically necessary to be provided by the provider on and after the 31st day following the date of termination.

(e) In the event that a hospital's contract is not renewed, or is terminated by either party, the hospital and the HMO shall continue to abide by the terms of the most current contract for a period of four months from a severance date mutually agreed upon by both parties as required by N.J.S.A. 26:2J–11.1. In such an event, the HMO shall provide written notification within the first 15 business days of the four month extension to all health care providers with which it has contracted and members who reside in the county in which the hospital is located or in an adjacent county within the HMO's service area. The notice to members shall also advise them of available options with respect to their health care coverage.

2. The committee shall provide notice of its action on a complete application to the provider in writing.

3. If the committee's acceptance of a complete application does not constitute the offer of a contract to the applicant by the HMO, the committee shall set forth in its notice the remaining procedures to be completed prior to the applicant becoming a participating provider, if at all.

(c) The HMO may establish the factors to be considered by the committee in determining whether an application is complete and whether to accept or reject a complete application.

1. The factors considered by the committee shall be in writing, and shall be available for review by applicants upon request.

2. The formulas or methods of weighting of factors as specified by the HMO shall be confidential information.

(d) The HMO may establish its own application forms, but if it does not elect to establish its own form, the HMO shall make available, upon request, a written notice of what information it requires to be submitted to determine an application is complete.

(e) All applications, notices and guidelines required by this section shall be reviewable upon request by the Department.

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

SUBCHAPTER 4. MEDICAL DIRECTOR

8:38–4.1 Designation of a medical director

(a) The HMO shall designate a physician to serve as medical director.

(b) The medical director or his or her designee shall be designated to serve as the medical director for medical services provided to the HMO's New Jersey members. This physician shall be licensed to practice medicine in New Jersey and may also serve as the overall medical director of the HMO as required in (a) above.

8:38–4.2 Medical director's responsibility

(a) The medical director shall be responsible for the direction, provision, and quality of medical services provided to members, including, but not limited to:

1. Defining responsibilities and inter-relationships of professional services;

2. Coordinating, supervising and overseeing the functioning of professional services;

3. Evaluating the medical aspects of provider contracts;

4. Overseeing the continuing in-service education of professional staff;

5. Providing clinical direction and leadership to the continuous quality improvement and utilization management programs;

6. Establishing policies and procedures covering all health care services provided to members;

7. Establishing a committee that has the following responsibilities:

i. Establishing mechanisms for ensuring review of provider credentials;

ii. Delineating qualifications of participating providers;

iii. Reviewing credentials of physicians and other providers who do not meet the HMO's established credentialing standards; and

iv. Establishing a system for verification of provider's credentials, recertification, performance reviews and obtaining information about any disciplinary action against the provider available from the New Jersey Board of Medical Examiners or any other state licensing board applicable to the provider, or the Federal Clearinghouse established pursuant to the Health Care Quality Improvement Act, P.L. 99–660 (42 U.S.C. § 1101 et seq.);

8. Implementing a procedure that provides participating providers an opportunity to review and comment on all applicable medical, surgical and dental protocols of the HMO applicable to the area of practice of the provider; and

9. Implementing a system through which a member may readily change his or her PCP outside of an annual open enrollment period, and is made aware of this right, which system shall be applicable to all of the HMO's contracts including its POS contracts, regardless of whether referral through the PCP is required in order to access specialty care in-network or to receive benefits out-of-network.

i. An HMO shall make the selection of a new PCP effective no later than 14 days following the date of the selection when such change is discretionary, and shall make the selection of a new provider immediately effective when change of the PCP is necessitated by termination of the PCP from the network.

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), added 8 and 9.

SUBCHAPTER 5. HEALTH CARE SERVICES

8:38–5.1 Provision of health care services

(a) The HMO shall, at a minimum, provide or arrange for the provision to its members all basic comprehensive health care services and all other services enumerated in this subchapter and in N.J.S.A. 26:2J–1 et seq., as it may be amended from time to time.

1. If the HMO refers a member out of network, the service or supply shall be covered as an in-network service or supply, such that the HMO is fully responsible for payment to the provider and the member is only responsible for any applicable in-network level copay, coinsurance or deductible for the service or supply.

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

8:38–5.2 Basic comprehensive health care services

(a) The HMO shall provide or arrange for the provision of the following basic comprehensive health services as medically necessary:

1. Periodic examinations and office visits to a primary care provider for routine and urgent care;

2. Diagnostic and disease detection studies, including laboratory and radiological services;

3. Prenatal care and obstetric care:

i. In accordance with P.L. 1995, c.138, obstetric care includes 48 hours of inpatient care following a vaginal delivery or a minimum of 96 hours of inpatient care following a caesarean section.

ii. Notwithstanding the provisions of (a)3i above, a member agreement that provides health care services for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours and 96 hours, respectively, of inpatient care unless such inpatient care is determined to be medically necessary by the attending physician or is requested by the mother.

4. Regular pediatric care including newborn care and immunizations as set forth at N.J.A.C. 8:57–8, Childhood Immunization Insurance Coverage;

5. Radiation therapy;

6. Consultations and specialists' services as requested by the primary care provider;

7. In accordance with N.J.S.A. 26:2J–4.3(4), out-of-hospital physical examinations, including related x-rays and diagnostic tests, to include, at a minimum, the following:

i. For members who are less than two years of age, up to six examinations during the first two years of life; for members who are minors of two years of age or older, one examination at age three, six, nine, 12, 15 and 18 years; and

ii. For members who are adults less than 40 years of age, one examination every five years; for members who are 40 or more years of age but less than 60 years of age, one examination every three years; and for members who are 60 years of age or older, one examination every two years;

8. Screening examinations prescribed at N.J.S.A. 26:2J–1 et seq., including:

i. Pap smears in accordance with N.J.S.A. 26:2J–4.12; and

ii. Mammograms in accordance with N.J.S.A. 26:2J–4.4;

9. Physical medicine and rehabilitation services including, but not limited to physical therapy;

10. Equipment and supplies for the treatment of diabetes in accordance with P.L. 1995, c.331;

11. Outpatient evaluative, crisis intervention and short term therapeutic mental health services;

12. Outpatient substance abuse care;

13. Medically necessary eye care services for detection and treatment of disease or injury to the eye and children's eye examinations conducted to determine the need for vision correction;

14. Inpatient hospital care, including semi-private room accommodations, physicians' and surgeons' services, anesthesia, lab, x-ray and other diagnostic services, drugs and medication, therapeutic services and other services and supplies that are usually provided by the hospital;

15. Outpatient surgical care;

16. Inpatient psychiatric care;

17. Inpatient substance abuse care (a minimum of 30 days during any contract year) in a facility licensed to provide residential alcohol and drug abuse services;

18. Skilled nursing care (a minimum of 30 days during any contract year) in a licensed long term care facility;

19. Home health services (a minimum of 60 home care visits during any contract year); and

20. Hospice services from a Medicare certified hospice agency.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Rewrote (a)4.

8:38–5.3 Emergency and urgent care services

(a) The HMO shall establish written policies and procedures governing the provision of emergency and urgent care which shall be distributed to each subscriber at the time of initial enrollment.

(b) Emergency and urgent care services shall include, but are not limited to:

1. Medical and psychiatric care, which shall be available 24 hours a day, seven days a week;

2. Coverage for trauma services at any designated Level I or II trauma center as medically necessary. Such coverage shall continue at least until, in the judgment of the attending physician, the member is medically stable, no longer requires critical care, and can be safely transferred to another facility. If the HMO requests transfer to a hospital participating in the HMO network, the transfer shall be effected in accordance with Federal regulations at 42 C.F.R. 489.20 and 489.24;

3. Coverage for out-of-service area medical care when medically necessary for urgent or emergency conditions where the member cannot reasonably access in-network services;

4. Prehospital care and hospital services regardless of location when medically necessary for injury or emergency illness; and

5. Upon a member's arrival in a hospital, coverage of a medical screening examination, as required under Federal law and as specified in N.J.A.C. 8:43G–12, as necessary to determine whether an emergency medical condition exists.

8:38–5.4 Supportive services

(a) The HMO shall provide or arrange for the provision of the following supportive services:

1. Ambulance or invalid coach services, as defined at N.J.A.C. 8:40, when authorized by the HMO for non-emergency medical transport;

2. Health education services and diabetes self-management education in accordance with P.L. 1995, c.331;

3. Nutritional education and counseling;

4. Medical social services; and

5. Preventive health services, including voluntary family planning services, and infertility services.

8:38–5.5 Health promotion programs

(a) In accordance with N.J.S.A. 26:2J–4.6, HMOs shall offer, directly or through written agreement, a health promotion program which includes, but is not limited to, the following tests and services:

1. Annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level for all persons 20 years of age and older;

2. A glaucoma eye test every five years for all persons 35 years of age or older;

3. An annual stool examination for presence of blood for all persons 40 years of age or older;

4. A left-sided colon examination of 35 to 60 centimeters every five years for all persons 45 years of age or older;

5. A pap smear every two years for all women 20 years of age or older;

6. An annual mammogram examination for all women 40 years of age or older as well as a baseline mammography for women who are at least 35 but less than 40 years of age;

7. Recommended immunizations for all adults; and

8. An annual consultation, for all persons 20 years of age or older, with a health care provider to discuss lifestyle behaviors that promote health and well-being, including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

(b) An HMO shall not be required to offer services to members delineated above for which the value exceeds:

1. $128.00 a year for each person between the ages of 20 to 39, inclusive;

2. $148.00 a year for each man age 40 and over and $241.00 a year for each woman age 40 and over, except that for persons 45 years of age or older, the value of a left-sided colon examination shall not be included in this amount; however, no HMO shall be required to provide services to members for a left-sided colon examination with a value in excess of $154.00.

(c) The Commissioner, in consultation with the Department of the Treasury, shall adjust the threshold amounts in (b) above annually in direct proportion to the increase or decrease in the consumer price index for all urban consumers in the New York City and Philadelphia areas as reported by the United States Department of Labor. The adjustment shall become effective on July 1 of the year in which it is reported.

8:38–5.6 Wilm's tumor

In accordance with N.J.S.A. 26:2J–4.1, the HMO shall provide health care services to any member for the treatment of Wilm's tumor, including, but not limited to, autologous bone marrow transplants when standard chemotherapy

treatment is unsuccessful, notwithstanding that any such treatment may be deemed experimental or investigational.

8:38–5.7 Health care services for prescribed drugs

(a) HMOs which provide pharmacy services, prescription drugs or a prescription drug plan shall comply with the requirements set forth at N.J.S.A. 26:2J–4.7.

(b) In accordance with N.J.S.A. 26:2J–4.5, an HMO which provides health care services for prescribed drugs approved by the Federal Food and Drug Administration (FDA) shall also provide health care services for prescribed drugs which have not been approved by the FDA if it is recognized to be medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:

1. The American Medical Association drug Evaluations;

2. The American Hospital Formulary Service Drug Information;

3. The United States Pharmacopeia Drug Information; or

4. A clinical study or review article in a major-peer reviewed professional journal.

(c) Notwithstanding the provisions of this section, coverage shall not be required for any experimental or investigational drug or any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Health care services provided pursuant to this section shall be determined and provided to the same extent as other services under the enrollee plan for drugs prescribed for treatments which have been approved by the FDA.

(d) Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug.

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), inserted a reference to prescription drugs and prescription drug plans.

SUBCHAPTER 6. PROVIDER NETWORK

8:38–6.1 Health care service network

(a) Each HMO shall maintain primary, specialty, ancillary, and institutional services sufficient to meet the requirements in N.J.A.C. 8:38–5.

(b) Nothing contained in this subchapter shall preclude the New Jersey Department of Human Services, Division of Medical Assistance and Health Services from requiring higher standards for services to Medicaid recipients pursuant to a contract for services between the Division of Medical Assistance and Health Services and the HMO.

8:38–6.2 Primary, specialty and ancillary providers

(a) The HMO shall maintain an adequate network of primary care providers, specialists, and other ancillary health care personnel to serve the enrolled population at all times. For certificate of authority applications to initiate operations within a service area, this adequacy shall be evaluated based on enrollment projections at the end of 12 months of operation. At a minimum, the network of providers shall include:

1. Medical and other professional staff, as follows:

i. There shall be a sufficient number of licensed primary care providers (PCPs) under contract with the HMO to provide basic comprehensive health care services;

ii. There shall be a sufficient number of licensed medical specialists available to HMO members to provide medically necessary specialty care. The HMO shall have a policy assuring access to the specialists identified in (a)1ii(1) through (13) below within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or approved sub-county service area:

(1) Cardiologist;

(2) Dermatologist;

(3) Endocrinologist;

(4) ENT;

(5) General surgeon;

(6) Neurologist;

(7) Obstetrician/gynecologist;

(8) Oncologist;

(9) Ophthalmologist;

(10) Orthopedist;

(11) Oral surgeon;

(12) Psychiatrist; and

(13) Urologist;

iii. For specialists not identified in (a)1ii above, the HMO shall have a policy assuring access to such specialists within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or approved sub-county service area;

(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 of Banking and Insurance 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).
Amended by R.2001 d.126, effective April 16, 2001.
See: 33 N.J.R. 159(a), 33 N.J.R. 1196(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 34 N.J.R. 1556(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 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. 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.

i. The contract shall not provide financial incentives to the provider for the withholding of covered health care services that are medically necessary, but this shall not prohibit or limit the use of capitated payment arrangements between a carrier and provider.

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

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

iv. Notwithstanding (b)5i above, capitation shall not be used as the sole method of reimbursement to providers who primarily provide supplies (for instance, prescription drugs or durable medical equipment) rather than services;

6. The services and/or supplies to be provided by the provider and for which benefits will be paid by the carrier;

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

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

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

iii. An HMO's contractual agreement with a secondary contractor shall provide that the secondary contractor's contract with its network providers shall include a provision whereby the provider is required to hold the carrier's members harmless for the cost of any service or supply covered by the carrier, subject to (b)6i and ii above, whether or not the provider believes the compensation received is adequate;

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

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

10. That providers shall maintain licensure, certification and adequate malpractice coverage.

i. With respect to a physician and dentist malpractice insurance shall be at least $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

ii. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

iii. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year;

11. That patient information shall be kept confidential, but that the HMO and the provider shall have a mutual right to a member's medical records, as well as timely and appropriate communication of patient information, so that both the providers and the HMO may perform their respective duties efficiently and effectively for the benefit of the member;

12. The process for an internal provider complaint and grievance procedure to be used by participating providers, pursuant to N.J.A.C. 8:38–3.7; and

13. That the provider shall have the right to communicate openly with a patient about all diagnostic testing and treatment options.

(c) In addition to (b) above, all primary care provider contracts and contracts with specialists shall specify:

1. The responsibility, if any, of the provider with respect to acquiring and maintaining hospital admission privileges; and

2. The mutual responsibility of the provider and HMO to assure 24 hour, seven-day a week emergency and urgent care coverage to members, and the procedures to assure proper utilization of such coverage consistent with the requirements of N.J.A.C. 8:38–5.2.

(d) In addition to (b) above, all health care facility contracts shall specify:

1. The responsibility of the health care facility to follow clear procedures for granting of admitting and attending privileges to physicians, and to notify the HMO when such procedures are no longer appropriate;

2. The admission authorization procedures for members;

3. The procedures for notifying the HMO when members present at emergency rooms; and

4. The procedures for billing and payment, schedules, and negotiated arrangements.

(e) No contract with any provider shall impose obligations or responsibilities upon a provider which require the provider to violate the statutes or rules governing licensure of that provider if the provider is to comply with the terms of the contract.

(f) In addition to (b) through (e) above, the contract between an HMO and a secondary contractor shall specify that the HMO is a third party beneficiary of the secondary contractor's contract(s) with the health care providers, and a secondary contractor's contract(s) with health care providers shall provide that the HMO shall have privity of contract with the health care providers such that the HMO shall have standing to enforce the secondary contractor's contract(s) with the health care providers in the absence of enforcement by the secondary contractor.

(g) In lieu of (f) above, the HMO shall contract separately with each health care provider under contract with the secondary contractor, and such contracts shall be in accordance with (b) through (e) above.

Petition for Rulemaking.
See: 30 N.J.R. 1640(b).
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).

8:38–15.3 Review and approval

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

(b) Provider agreements in effect upon May 1, 2000 shall be deemed withdrawn on May 1, 2001 if not in compliance with this subchapter.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Rewrote the section.
Administrative correction.
See: 32 N.J.R. 2238(a).

8:38–15.4 Penalties

Every person acting as a secondary contractor in violation of this subchapter shall be subject to penalty and fine by the Department of Banking and Insurance under the insurance laws of this state as an unauthorized insurer in accordance with N.J.S.A. 17:51–1 et seq., or 17B:33–1 et seq., as may be appropriate.

SUBCHAPTER 16. CLAIMS PAYMENTS

Authority

N.J.S.A. 17B:30–1 et seq., 26:2J–5.1 and 26:2J–15.

Source and Effective Date

R.1998 d.458, effective September 8, 1998.
See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).

8:38–16.1 Prompt investigation and settlement of claims

(a) An HMO shall establish and maintain an auditable system for recording of all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur, which shall also include an identifier of the office handling the claim on behalf of the HMO.

(b) An HMO shall pay clean claims promptly but no later than 60 calendar days after the date the HMO receives written or electronic notice of the claim.

1. If, for whatever reason, a claim is submitted electronically and in written form, the date of the earlier submission of the claim shall be the date of notice from which the HMO shall calculate the 60–day period.

2. Notwithstanding (b)1 above, if an HMO and a provider have agreed in writing to the submission of claims by a specific mode of transmission, the HMO shall calculate the 60–day period beginning on the date that the claim is received in the agreed-upon mode.

(c) An HMO shall provide written or electronic notice to the provider of a determination by the HMO that the claim is a contested claim promptly but no later than 45 calendar days following the date that the HMO receives written or electronic notice of the claim.

1. The written or electronic notice shall comply with N.J.A.C. 8:38–16.3.

(d) If an HMO determines that a part of a claim is a contested claim, the HMO shall provide written or electronic notice of that determination to the person submitting the claim promptly but no later than 45 calendar days following the date that the HMO receives written or electronic notice of the claim, and shall proceed to pay the portion of the claim determined by the HMO to be a clean claim promptly, but no later than 60 calendar days following the date that the HMO received written or electronic notice of the claim.

1. The written or electronic notice shall comply with N.J.A.C. 8:38–16.3.

(e) In no instance shall an HMO contest a claim or a portion of a claim because the claim fails to provide certain information if the information determined to be lacking has no factual impact upon the HMO's ability to adjudicate the claim.

(f) If an HMO determines that a claim provides sufficient information for the HMO to deny the claim, the HMO shall provide written or electronic notice of this determination to the person submitting the claim or member, if different from the person submitting the claim, promptly but in no instance later than 60 calendar days following the date that the HMO receives written or electronic notice of the claim, including the following information:

1. All of the reasons of which the HMO is aware for denial of the claim;

2. The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered; and

3. The address of the office responsible for handling the claim, and a means by which the office may be contacted without toll charges exceeding the charges that otherwise apply for the provider or member to place a call in his or her area code.

8:38–16.2 Effective notices and payments

(a) Except as (a)1 below applies, written notice of a claim shall be effective upon the date that the claim is received at the address provided by the HMO to the providers or its members for receipt of claims of the type submitted.

1. If a provider and an HMO agree to administer claims by electronic transmission, then the HMO shall have constructive notice of the claim as of the date the claim is posted to the electronic transfer system.

(b) Payment from the HMO shall be effective as of the date that:

1. A draft or other valid instrument equivalent to payment is placed in the United States mail in a properly addressed, postage-paid envelope;

2. The date the HMO posts the item to an electronic transfer system; or

3. The date of delivery of the draft or other valid instrument equivalent to payment if (b)1 or 2 do not otherwise apply.

(c) Payment and notices distributed by an HMO's subcontractor, secondary contractor or primary contract or shall be effective when made in compliance with (b) above and (d) below, as appropriate.

(d) Notices from the HMO shall be effective as of the date that the notice is:

1. Placed in the United States mail in a properly addressed, postage-paid envelope;

2. Posted to an electronic system; or

3. Delivered, if (c)1 or 2 otherwise do not apply.

8:38–16.3 Contents of a notice of a contested claim

(a) The HMO shall specify in its notice of a contested claim at least the following information:

1. The name, address, telephone number and facsimile number of the HMO's office handling the claim or other designated claims representative knowledgeable about the claim with which the person submitting the claim, provider or member (as applicable) should communicate to resolve problems with the claim;

2. The date of the service, the type of service, the provider of the service, and the name of the person to whom the service was rendered to the extent that this information is known to the HMO;

3. The specific information needed by the HMO to make a determination that the claim is a clean claim; and

4. The date the claim was received.

(b) In addition to (a) above, the HMO shall include in a notice regarding a claim that the HMO has determined is in part a contested claim, a statement specifying those portions of the claim that are considered to be a clean claim, and the amounts payable with respect to the clean claim portion.

(c) Requests for information made by an HMO on a contested claim shall be reasonable and relevant to the determination of whether the claim is a clean claim or claim that will be denied.

(d) HMOs may use the form set forth as Exhibit 1 in the Appendix to this chapter, entitled "Notice of Contested Claim," incorporated herein by reference, to satisfy the requirements of (a) through (c) above.

8:38–16.4 Overdue payments

(a) HMOs shall add 10 percent simple interest per annum to all overdue payments made by the HMO to a provider or member, with the interest first accruing as of the date that the claim is overdue.

(b) Payment for a clean claim or portion of a claim determined clean shall be overdue if the HMO makes payment on the claim later than 60 calendar days following the date that the claim was received by the HMO.

(c) Payment for a contested claim, or contested portion of a claim that is subsequently perfected shall be overdue if the HMO makes payment on the claim later than 90 calendar days following the date that the HMO receives all of the information required to perfect the claim.

(d) Payment of a claim previously denied incorrectly shall be overdue if payment by the HMO is made more than 10 calendar days following the date that the previously denied claim is determined a clean claim, or a portion of the claim is determined a clean claim, unless specified otherwise by an order of the Commissioner or a court of competent jurisdiction regarding any challenge of the denial of the claim.

8:38–16.5 Use of intermediaries

An HMO's use of subcontractors, secondary contractors or primary contractors to perform one or more of the HMO's claims handling functions shall not in any way mitigate an HMO's responsibility to comply with all of the terms of this subchapter.

8:38–16.6 Contracts currently in effect

(a) A contractual arrangement in effect as of October 1, 1998 which is inconsistent with this subchapter (unless more favorable to participating providers) shall be read and interpreted to be in compliance with N.J.S.A. 26:2J–5.1 and this subchapter as of October 1, 1998, but shall be amended as expeditiously as possible by the HMO as is necessary for the contractual arrangement to become physically compliant.

(b) HMOs shall administer, or assure the administration of, all contractual arrangements for its network in order to be in compliance as of October 1, 1998, and any claims not settled as of October 1, 1998 shall be treated in accordance with this subchapter.

8:38–16.7 Penalties

HMOs that fail to comply with the terms of this subchapter shall be subject to penalty and fine of no less than $250.00 nor no more than $10,000 per day of violation, as set forth at N.J.S.A. 26:2J–24, and penalties and fines in accordance with N.J.S.A. 17B:30–1 et seq., in addition to any other remedies available under law.

SUBCHAPTER 17. PLAN DOCUMENTS FOR GROUP CONTRACTS

Authority

N.J.S.A. 26:2J–21 and 26:2S–1 et seq.

Source and Effective Date

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

8:38–17.1 Scope and applicability

(a) This subchapter shall apply to all HMO health benefits plans that are not standard health benefits plans promulgated by the Small Employer Health Benefits Program Board of Directors and which are not otherwise subject to the Small Employer Health Benefits Program Act, N.J.S.A. 17B:27A–17 et seq., and rules promulgated thereunder, with respect to terms and conditions of contracts and certificates (evidences of coverage) issued to small employers, as that term is defined by the Small Employer Health Benefits Program Act.

(b) This subchapter shall apply to all HMO health benefits plans that are not standard health benefits plans promulgated by the Individual Health Coverage Program Board of Directors or otherwise subject to the Individual Health Coverage Program Act, N.J.S.A. 17B:27A–2 et seq., and rules promulgated thereunder with respect to terms and conditions of the contract or policy forms issued on a nongroup basis under the Individual Health Coverage Program Act.

8:38–17.2 General requirements

(a) The HMO shall provide a written contract to the contractholder and an evidence of coverage to each subscriber, which evidence of coverage may be incorporated into the member handbook required pursuant to N.J.A.C. 8:38–9.1.

1. The contract, evidence of coverage and member handbook shall conform to the Life and Health Insurance Policy Simplification Act, N.J.S.A. 17B:17–17 et seq. as demonstrated by the submission of a readability certification with a Flesch score for each form.

(b) All documents required to be delivered or issued for delivery in accordance with (a) above shall be delivered or issued for delivery no later than 30 days following the date of enrollment of the group, or notice to the HMO of enrollment of a subscriber within the group.

(c) No plan document shall be delivered or issued for delivery unless the form thereof has been filed with the Department and the Department of Banking and Insurance, and approved, or deemed approved, by the Department of Banking and Insurance.

8:38–17.3 Terms and conditions for plan documents

(a) Every plan document shall contain the following:

1. Information about the HMO and how to contact and obtain information from the HMO, including, but not limited to, the HMO's legal name, its trade name, and phone, fax and e-mail numbers by which consumers and members may contact the HMO, including at least one number that is a toll-free number for members;

2. The eligibility requirements for the health benefits plan;

3. A specific description of benefits and services available within the service area under the health benefits plan, including emergency services, and out-of-area benefits and services;

4. A specific description of amounts that must be paid by members upon receipt of health care services, including copayments, deductibles, and coinsurance, as applicable, and with respect to POS contracts, an explanation of the member's obligation to pay charges for out-of-network services that exceed what the HMO determines are usual, customary and reasonable;

5. A description of the grounds for termination of a member and group;

6. A description of the claims procedures for members for out-of-network services;

7. A complete description of the HMO's method for resolving member complaints or grievances, and the process for appealing a utilization management decision, including all time frames applicable to the processes for making and resolving the complaint, grievance or appeal;

8. A description of continuation of coverage for those individuals who are in a health care facility at the time of termination of the group contract;

9. A description of how coverage under the health benefits plan may be continued pursuant to applicable Federal or State law (COBRA and/or N.J.S.A. 17B:27A–27) in the event of both member termination and group termination;

10. A description of the extension of benefits for those members who become totally disabled; and

11. A description of the service area.

8:38–17.4 Specific standards for required provisions

(a) With respect to information about the HMO, the name, address and telephone number of the HMO shall be included, with a telephone number by which members may contact the HMO without incurring toll charges.

(b) With respect to eligibility requirements, the plan documents shall state what conditions must be met in order to enroll as a subscriber or a subscriber's dependent, the limiting age for subscribers and dependents, if any, including the effects of Medicare upon continued eligibility of the subscriber or dependent for some or all of the covered services under the health benefits plan, and a clear statement regarding the coverage of newborns.

1. The statement regarding newborns shall be consistent with N.J.A.C. 8:38–3.2.

2. There shall be a provision regarding special enrollment periods for employees and dependents, consistent with the requirements of the Health Insurance Portability and Accountability Act, Pub. L. 104–191, and the laws of this State regarding group health insurance, N.J.S.A. 17B:27–54 et seq.

3. All other provisions regarding eligibility shall be consistent with Federal and State laws, including eligibility of children also eligible for Medicaid, and dependency established as a matter of court order.

(c) With respect to the description of benefits and services, the descriptions shall be consistent with the rules in this chapter regarding required benefits and services, emergency services, and out-of-area services, and shall set forth any limitations and exclusions that may apply with respect to services and the receipt of services.

1. Statements regarding limitations and exclusions shall include any limitations or exclusions due to preexisting conditions, waiting periods or affiliation periods, or a member's refusal of treatment.

2. In no instance shall an HMO include statements in the plan documents requiring or suggesting that a member may only obtain emergency services through a participating or otherwise affiliated provider.

(d) With respect to member termination, the provision shall not be inconsistent with N.J.A.C. 8:38–3.4, nor may the HMO cancel or nonrenew a member's coverage solely on the basis of the items set forth at N.J.A.C. 8:38–3.2(a).

(e) With respect to the claims processing information, the information shall include, but not be limited to, the requirements for filing proper proof of loss, any time limit on the filing of claims or payment of claims, explanations of how disputed claims may be resolved, any restrictions on assignment of a claim, and whether a standard claim form is required to be used.

(f) With respect to the continuation of coverage of a member when the member is admitted to the health care facility on the date that the group health benefits plan is terminated, the provision shall specify that the HMO shall continue to provide benefits for the member until the date of the member's discharge from the health care facility, or exhaustion of the member's benefits under the terms of the health benefits plan, whichever occurs first, and in no event shall the provisions be inconsistent with the standards of N.J.A.C. 11:2–13.

(g) With respect to coordination of benefits, if the HMO will coordinate benefits under the health benefit plan, the HMO shall comply with N.J.A.C. 11:4–28; otherwise, the HMO shall include a statement that coverage under the health benefits plan shall be primary coverage for all members.

(h) With respect to the extension of benefits for total disability, the provisions shall not be inconsistent with N.J.S.A. 17B:27–51.12.

(i) With respect to the entire contract provision, the HMO shall include a statement that the contract, all applications and any amendments thereto constitute the entire agreement between the parties, and the HMO shall not include any portion of its charter, bylaws or other documents as part of the contract or plan document unless set forth in full in the contract or attached to it.

(j) With respect to the term of the coverage, termination of the group contract and renewal, the HMO shall include a provision that specifies the date or occurrence upon which coverage becomes effective, the anniversary date of the contract, conditions upon which cancellation or termination may be effected by the HMO, the contractholder and/or the subscriber, and the conditions for and any restrictions upon renewal.

(k) With respect to the grace period, the HMO shall provide for a grace period of no less than 30 days for the payment of any premium other than the initial premium, during which time the coverage shall remain in effect.

1. The provision shall specify that the HMO shall remain liable for providing the services and benefits covered under the health benefits plan, the contractholder

remains liable for payment of the required premium, and the members remain liable for any copayments, deductibles, coinsurance or other costs that may be applicable under the terms of the health benefits plan.

2. The provision shall specify that if the premium is not paid during the grace period, coverage is automatically terminated at the end of the grace period, effective as of the end of the grace period, and that the HMO shall provide notice of the effective date of the termination to the contractholder no more than 30 days following the effective date of the termination.

(*l*) With respect to the conformity of law provision, the HMO shall provide that any portion of the contract that is not otherwise in conformity with the laws of this State, including but not limited to, N.J.S.A. 26:2J–1 et seq., 26:2S–1 et seq., and rules promulgated pursuant thereto, and 17B:27–49 et seq., as amended by P.L. 1997, c. 146, shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable laws and regulations of this State.

8:38–17.5 Standards for optional provisions

(a) If an HMO intends to coordinate benefits under the health benefits plan, the plan documents shall include a statement specifying that coordination may occur, and an explanation of how coordination will be achieved.

1. Coordination of benefits shall be accomplished in accordance with N.J.A.C. 11:4–28, and the explanation of coordination of benefits shall not be inconsistent with those rules.

2. If an HMO fails to include a provision regarding coordination of benefits consistent with N.J.A.C. 11:4–28, the health benefits plan shall be primary coverage for all members.

(b) If an HMO will allow reinstatement of the group health benefits plan, and/or coverage for a member, the plan documents shall include any terms and conditions for reinstatement.

(c) If an HMO may seek subrogation for injuries caused by third parties, the plan documents shall contain a provision setting forth the HMO's intent, but the provisions shall not be inconsistent with N.J.A.C. 8:38–11.9.

8:38–17.6 Compliance

Forms of plan documents in effect on May 1, 2000 shall be deemed withdrawn on May 1, 2001 if not in compliance with this subchapter.

SUBCHAPTER 18. DRUG FORMULARIES

Authority

N.J.S.A. 26:2J–43e and 26:2J–43h.

Source and Effective Date

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).

8:38–18.1 Development of formulary

(a) A formulary provided pursuant to a health benefits plan issued by an HMO shall be developed by a pharmacy and therapeutics committee composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee shall consist of at least two-thirds licensed and actively practicing physicians and pharmacists, and shall consist of at least one pharmacist. If the HMO contracts with a third party to develop the formulary, the HMO shall be responsible for guaranteeing that the third party complies with all requirements relating to formularies as set forth in this subchapter.

(b) All drugs in a formulary shall be approved under the Federal Food, Drug and Cosmetic Act (21 U.S.C. §§ 301 et seq.).

(c) A formulary shall include more than one medication used to treat each covered disease state where more than one medication is available.

(d) A medication may be excluded from a formulary only if, based on the compendia listed in N.J.A.C. 8:38–18.2(c)1, it does not have a significant clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome of treatment for the specific condition for which the medication is intended over other medications included in the formulary, and there is a written explanation of the basis for the exclusion that is available to providers and covered persons upon request.

8:38–18.2 Nonformulary medications

(a) Every health benefits plan issued by an HMO that provides benefits for formulary medications shall also provide benefits for nonformulary medications. Increased benefits may apply to formulary medications provided the difference between the total benefit value of formulary medication coverage and the total benefit value of nonformulary medication coverage does not exceed 30 percent. Compliance with this requirement shall be demonstrated by submitting to the Department of Banking and Insurance a completed Actuarial Justification of Benefit Differentials form (incorporated herein by reference as the Appendix to this subchapter).

(b) The HMO shall establish an approval process to enable health care providers and covered persons to obtain coverage of nonformulary medications at the same level as formulary medications where the prescribing health care provider certifies the medical necessity of the medication.

(c) A nonformulary medication shall be considered medically necessary if:

1. It is approved under the Federal Food, Drug and Cosmetic Act (21 U.S.C. §§ 301 et seq.); or its use is supported by one or more citations included or approved for inclusion in the American Hospital Formulary Service Drug Information or the United States Pharmacopoeia—Drug Information, or it is recommended by a clinical study or review article in a major peer reviewed professional journal; and

2. The prescribing health care provider states that all formulary medications used to treat a disease state have been ineffective in the treatment of the covered person's disease or condition, or all such medications have caused **or are** reasonably expected to cause adverse or harmful reactions in the covered person.

(d) The approval process for nonformulary medications shall provide that the HMO approve or deny the request by communicating such approval or denial to the prescribing health care provider by telephone or other telecommunication device within five business days of a request for prior authorization. Failure to approve or deny the request within five business days shall be deemed an approval of the request. Initial denials shall also be provided to the prescribing health care provider and covered person in writing within five business days of receipt of the request for approval of a nonformulary medication, and shall include the clinical reason for the denial. Such denials are appealable to the Independent Health Care Appeals Program in the Department of Health and Senior Services pursuant to N.J.S.A. 26:2S–11.

(e) The HMO shall file with the Department of Health and Senior Services and the Department of Banking and Insurance a report summarizing all formulary appeals and their resolutions for the preceding year on forms prescribed by the Department of Health and Senior Services. Such report shall be included as a separate page with the HMO's annual report filed pursuant to N.J.S.A. 26:2J–9.

Number of Scripts per member per year
Brand
Generic
Composite
Ingredients cost including dispensing fees
Brand
Generic
Composite
Copays/Coinsurance/Deductible/OOP
Brand copay
Generic copay
Coinsurance
Deductible
Out-of-pocket limit (excl. ded)
Calculation
(1) Starting claim cost PMPM
– (2) Adjustment for brand copay

8:38–18.3 Distribution of formulary

(a) The HMO shall publish and distribute, at least quarterly, either its current formulary or a list of nonformularies, to all network providers in electronic or paper form. Such list shall clearly indicate whether the medications included are formulary or nonformulary. Alternatively, the HMO may annually distribute new formularies or a list of nonformularies, and quarterly updates, to all network providers. Publication of a current formulary or list of nonformularies on the internet shall satisfy the requirements of this subsection.

(b) The current formulary or list of nonformulary medications shall be provided by the HMO to covered persons and contractholders upon request.

(c) The contract and evidence of coverage form shall disclose the existence of the formulary, describe the approval process to obtain coverage of nonformulary medications as formulary medications and describe the process to appeal a denial of a request for approval of a nonformulary medication, including the right to appeal to the Independent Health Care Appeals Program in the Department of Health and Senior Services pursuant to N.J.S.A. 26:2S–11. The contract and evidence of coverage form shall state that a copy of the formulary will be provided by the HMO to a covered person and contractholder upon request.

8:38–18.4 Operative date

(a) This subchapter shall become operative on July 1, 2001.

(b) All noncomplying HMO contract forms submitted for approval pursuant to N.J.A.C. 11:4–40 shall be deemed withdrawn effective July 1, 2001.

APPENDIX

Actuarial Justification of Benefit Differentials

Formulary Drug Benefit

Use Percent	Formulary	Non Formulary

			Use Percent	Formulary	Non Formulary
–	(3)	Adjustment for generic copay			
=	(4)	Adjustment claim cost			
	(5)	Value of deductible			
x	(6)	Impact of 3x family deductible			
=	(7)	Adjusted value of deductible			
(4)–(7)	(8)	Adjusted claim cost			
x	(9)	Coinsurance			
=	(10)	Adjusted claim cost			
+	(11)	Impact of out-of-pocket limit			
=	(12)	Adjusted claim cost			
	(13)	Formulary discount			
(12) x {1-(13)}	(14)	Net claim cost			
(14)/(1)	(15)	Benefit ratio			
(15 in)–(15 oon)	(16)	Benefit differential			

APPENDIX

Exhibit 1

Notice of Contested Claim

The information below is with respect to a single patient (see Part B) identified on a claim filed by your office with us on ___/___/___. Those services marked with an asterisk (*) under the column "HMO Payment" are contested. The reasons for which the claim, or a portion of the claim, is contested and the information we need to make a final determination on the claim are set forth in Part D. Please contact the individual(s) identified in Part E if you have additional questions regarding this notice. If there are portions of a claim which we are not contesting, the "HMO Payment" column indicates the amount we are paying or will pay you for the services rendered, and the "Patient Copay" column indicates whether a copayment should have been collected by you from the patient. The information contained in Parts A, B and C are derived from the claim filed by your office.

Part A: Service information

	Procedure codes	Date of service	Provider	Billed amount	HMO Payment	Patient Copay
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Part B: Patient Information

Name: _____

Age: _____ Gender: M / F

SSN: _____

Address: _____

_____

Phone (Home): _____

Subscriber Name and SSN: _____

_____

Part C: Provider Information

Name: _____

HMO ID: _____

Address: _____

_____

Phone: _____ FAX: _____

Patient Acct # (if any): _____

Part D: Reasons for contesting the claim, or portion of a claim, and additional information needed

Specific services, if listed, are listed by number in the order stated in Part A:

_____

_____

_____

_____

_____

Additional pages are attached.

Part E: HMO and Contact Person Information

HMO Name: _____
Address: _____

Contact: _____
Title (as applicable): _____
Address: _____

Phone: _____ FAX: _____
E-mail: _____

New Rule, R.1998 d.458, effective September 8, 1998.
See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).