CHAPTER 38

HEALTH MAINTENANCE ORGANIZATIONS

Authority

N.J.S.A. 26:2J–1 et seq.

Source and Effective Date

R.1994 d.365, effective July 18, 1994.
See: 26 N.J.R. 1624(a), 26 N.J.R. 2896(a).

Executive Order No. 66(1978) Expiration Date

Chapter 38, Health Maintenance Organizations, expires on July 18, 1997.

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, and subsequently was adopted as new rules by R.1994 d.365. Expired Subchapter 4, Qualifications and Regulations, was not included in the adoption of new rules. See: Source and Effective Date. See, also, section annotations for specific rulemaking activity.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:38–1.1 Health care services

(a) Health care services include basic health care services and any additional health care related services deemed necessary by the commissioner for the obtaining and maintenance of optimal health.

(b) In addition to basic health services, a health maintenance organization (either "group practice HMO" or "individual practice association") may provide any supplemental health care services which are in conformity with applicable laws and regulations.

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).
Amended by R.1989 d.180 effective April 3, 1989.
See: 21 N.J.R. 6(a), 21 N.J.R. 895(a).
Reference added to either group HMO or individual association.

8:38–1.2 Basic health care services

(a) Basic health care services includes the following minimal services to be provided or arranged by the HMO (either "group practice HMO" or "individual practice association"):

1. Health professional services:

i. Periodic examinations and office visits by a physician in order to facilitate patient management plans;

ii. Periodic screening examinations and disease detection studies;

iii. Obstetrical care (pre and postnatal care of mother);

iv. Regular pediatric care, including newborn care and immunizations as medically necessary;

v. Services of a surgeon;

vi. Anesthesia;

vii. Inpatient medical care in hospital and/or skilled nursing facility;

viii. Diagnostic and therapeutic radiology;

ix. Consultations and specialists' services as requested by the attending physician;

x. Twenty-four-hour a day emergency services, seven days a week;

xi. Short-term physical medicine (including physical therapy);

xii. Out-of-area medical services when indicated for accidental injury or emergency illness;

xiii. Diagnostic laboratory services;

xiv. Short-term (not to exceed 20 visits) outpatient evaluative and crisis intervention mental health services.

2. Institutional services;

i. Inpatient hospital care, including semiprivate room accommodation and other inpatient hospital services, medications as appropriately ordered by a physician and supplies that are usually provided by the hospital;

ii. Skilled nursing facility services (a minimum of 30 days during any contract year);

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

iv. Emergency and out-of-area hospital services when indicated for accidental injury or emergency illness.

3. Supportive services;

i. Ambulance services when authorized by a member of the staff;

ii. Health education services which shall include education in the appropriate and effective use of health services (through information about these services, including recommendations of generally accepted medical standards for the frequency of use of such services) and in the contribution each enrollee can make to the maintenance of his or her own health (through instruction in personal health care measures);

iii. Nutritional education and counseling;

iv. Medical social services which shall include appropriate assistance in dealing with the physical, emotional and economic impact of illness and disability through services such as pre and posthospitalization planning, referral to services provided through community health and social welfare agencies, and related family counseling; and

v. Preventive health services (including voluntary family planning services, infertility services and children's eye examinations conducted to determine the need for vision correction).

As amended, R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–1.3 Supplemental health care services

(a) Supplemental health care services include, but are not limited to, the following additional health services which are not considered under basic health care services:

1. Vision care not included as a basic health service;

2. Dental health services;

3. Mental health services not included as a basic health service;

4. The provision of long-term physical medicine and rehabilitative service (including physical therapy);

5. Podiatry services;

6. Provision of prescription drugs, corrective lenses or prostheses;

7. Services of facilities for long-term care; and

8. Extension of home health care of extended care not included as a basic health service.

As amended, R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–1.4 Establishment and operation of an HMO

(a) To establish and operate a health maintenance organization, the following conditions shall be met:

1. Certificate of need (N.J.S.A. 26:2H–7): Any HMO constructing a new health care facility, expanding or changing an existing health care facility, or instituting new health services, must comply with the provisions of N.J.S.A. 26:2H–7.

2. All requirements specified in Chapter 337, Laws of New Jersey, 1973, must be met.

3. A certificate of authority must be issued before commencement of operation of an HMO.

4. Evidence of compliance with the following requirements must be furnished to the Commissioner of the Department of Health on request:

i. There must be sufficient licensed primary care physicians, medical specialists and licensed optometrists associated with or available to the HMO to provide basic health care services. The number of providers is contingent upon enrollment size and prevailing standards;

ii. The professional staff must include sufficient licensed nurses, and other professionals such as nutritionists, health educators, and others to provide basic health care services;

iii. The HMO must have sufficient clinical space, equipment and furnishings to meet health care needs. The group practice HMO must be readily accessible geographically and transportation-wise to enrollees;

iv. The applicant must provide evidence of the availability of institutional services, including hospital and skilled nursing facility, to the enrollees to meet basic health care services;

v. Plans for an appropriate evaluative mechanism must be provided. This will refer to quality and quantity of ambulatory health care services, and utilization of hospital and extended care facility beds and other services;

vi. The health maintenance organization must provide a mechanism for communication between the plan and enrollees. This may be done by a panel, which has consumer representation, or by some other appropriate mechanism;

vii. Basic eye care services and supplemental vision care services shall be provided by licensed optometrists as well as by ophthalmologists, as medically appropriate. There shall be sufficient licensed optometrists associated with or available to the HMO to assure that, unless referral to an ophthalmologist is determined by the primary care physician to be medically required and outside the scope of practice of an optometrist, the enrollee can choose to have vision care services provided by a licensed optometrist.

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).
Amended by R.1989 d.180, effective April 3, 1989.
See: 21 N.J.R. 6(a), 21 N.J.R. 895(a).
(a)4.vii added, requiring provision of eye care by licensed optometrists as well as ophthalmologists.
Notice of Petition for Rulemaking concerning health maintenance organizations.
See: 22 N.J.R. 2607(a).
Receipt of Notice of Petition for rulemaking and notice of agency action on Health Maintenance Organizations.
See: 23 N.J.R. 779(a).

SUBCHAPTER 2. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

8:38–2.1 Scope

The following rules jointly developed by the Commissioner of Health and the Commissioner of Insurance govern the establishment of health maintenance organizations in New Jersey pursuant to the authority set forth in P.L. 1973 c.337, 83.

8:38–2.2 Application

An application, on forms provided by the health department, accompanied by a filing fee of $100.00 payable to New Jersey Department of Health shall be completed by the responsible officers of each entity desiring to obtain a certificate of authority as an HMO. Such fee shall not be returnable.

8:38–2.3 Certificate of need

When the establishment or operation of a health care facility or any change in or expansion of a health care facility or involves the institution of new health care services as defined in Section 7 of the Health Care Facilities Planning Act (P.L. 1971, c.136), said HMO shall comply with all pertinent provisions of P.L. 1971, c.136.

8:38–2.4 Supporting documents

(a) The application for a certificate of authority shall be accompanied by the following:

1. A copy of the basic organizational document 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 regulations or similar document regulating the conduct of the internal affairs of the applicant;

3. A list of names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant;

4. A copy of any contract made or to be made between any providers or persons listed in paragraph 3 of this subsection and the applicant;

5. A copy of any contract made or to be made with an insurer or a hospital or medical service corporation;

6. A copy of the form of evidence of coverage to be issued to the enrollee;

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

8. Recent financial statements showing the applicant's assets, liabilities and sources of financial support;

9. A general description of the proposed method of marketing and financing and a statement as to the sources of funding;

10. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the commissioner and his successors in office and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action of proceeding against the health maintenance organization on a cause of action arising in this State may be served;

11. A statement reasonably describing the geographic area or areas to be served;

12. A general description of the complaint procedures to be utilized as required under Section 12 of P.L. 1973, c.337;

13. A general description of the procedures and programs to be implemented to meet the quality of health care requirements in Section 4.2 of P.L. 1973, c.337;

14. A general description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation;

15. Such other information as the commissioner may require to make the determinations required by Section 4 of P.L. 1973, c.337.

8:38–2.5 Licensure

The HMO shall comply with the licensure provisions of P.L. 1971, c.136.

8:38–2.6 Enrollee removal

(a) An enrollee may not have his or her membership in an HMO cancelled except for the following reasons:

1. Failure to pay the charge for such coverage.

2. Failure to abide by the rules and regulations of the HMO.

(b) Before an enrollee can be terminated for failure to abide by the rules and regulations, the HMO must document such violations and present this documentation to the commissioner for review and approval.

R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

SUBCHAPTER 3. ISSUANCE OF CERTIFICATE OF AUTHORITY

8:38–3.1 Scope

(a) Prior to issuance of a certificate of authority, both the commissioner and, the Commissioner of Insurance must be satisfied that several conditions have been met. Among these are:

1. That the health maintenance organization is financially sound and may reasonably be expected to meet its obligation to enrollees and prospective enrollees; and

2. That the organization's arrangements for health care services and the schedule of charges to enrollees used in connection therewith are financially sound.

(b) Sections 2 and 3 of this Subchapter will serve as minimum standards for determining such financial soundness.

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–3.2 Protection against insolvency

(a) Enrollees of a health maintenance organization will be deemed protected against financial loss provided that the health maintenance organization has deposited with the commissioner as of the beginning of each calendar quarter, cash or a form of guaranty or security in an amount equal to the anticipated payments to providers of health services during the calendar quarter then beginning. Only those payments to providers from funds of the organization which vary directly with the volume of services provided (that is, "fee-for-service" payments) need be considered. Salaries to physicians, "capitation" to providers, payments to providers by insurance companies, hospital or medical service corporations, or other such corporations need not be considered. Furthermore, whenever a provider has agreed by contract to look solely to the health maintenance organization for payment for any health services rendered to the enrollee, these payments may be disregarded in computing the deposit. However, except as hereafter provided in paragraph 2 of this subsection, that deposit may not thereby be reduced to less than 25 per cent of anticipated "fee-for-service" payments to providers from funds of the organization for the calendar quarter then beginning. At time of initial authorization by the commissioner, the deposit must be based on anticipated payments in the next full calendar quarter:

1. These deposits may be treated as assets of the organization, to the extent that they would be assets if actually held by the organization, and any investment return on the assets will be credited to the organization. However, in the event of insolvency of the organization, these deposits will be applied by the commissioner, initially for the protection of enrollees in the health maintenance organization, and only after all such costs have been satisfied may the balance, if any, of the deposit be applied to meet obligations to other creditors of the organization.

2. This deposit may be waived in its entirety or reduced in amount below the 25 per cent level at the discretion of the commissioner upon application by a health maintenance organization, in the event that the commissioner is satisfied that the assets of the organization or its contracts with insurers, hospital or medical service corporations, individual or institutional health care providers, governments (including loans and loan guarantees), or other organizations are sufficient to adequately protect the enrollees against financial loss. If any health maintenance organization is unable to meet any payment owed by the organization, the health maintenance organization must notify the commissioner within 30 days after payment is due.

(b) Quarterly financial reports, on forms prescribed by the commissioner shall be submitted to the Department of Health and Insurance.

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).

8:38–3.3 Charges to enrollees

In order for charges to enrollees to be considered financially sound, they must be accompanied by certification of a qualified actuary which would state that the charges make adequate provision for claim costs, operating expenses and maintenance of at least the required deposit, if any. Details as to assumptions and methods of calculation must accompany certification.

8:38–3.4 (Reserved)

Amended by R.1976 d.162, effective May 26, 1976.
See: 8 N.J.R. 115(a), 8 N.J.R. 281(b).