CHAPTER 24A

HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS AND MEDICAL SERVICE CORPORATIONS

Authority

N.J.S.A. 26:2S-1 et seq.

Source and Effective Date

R.2011 d.097, effective March 1, 2011.
See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 24A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, expires on March 1, 2018. See: 43 N.J.R. 1203(a).

Chapter Historical Note

Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was adopted as R.2000 d.183, effective May 1, 2000. See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

Pursuant to Reorganization Plan No. 005-2005, Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was transferred to the Department of Banking and Insurance, effective August 29, 2005. See: 37 N.J.R. 2737(a).

Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was readopted as R.2005 d.418, effective October 27, 2005. See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).

Pursuant to Reorganization Plan No. 005-2005, Chapter 38A of Title 8, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was recodified as Chapter 24A of Title 11, effective October 6, 2006. See: 37 N.J.R. 2737(a), 38 N.J.R. 4721(a).

Chapter 24A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was readopted as R.2011 d.097, effective March 1, 2011. As a part of R.2011 d.097, the chapter Appendix was repealed, effective April 4, 2011. See: Source and Effective Date. See, also, section annotations.

Chapter 24A, Health Care Quality Act Application To Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was renamed Health Care Quality Act Application To Insurance Companies, Health Service Corporations, Hospital Service Corporations and Medical Service Corporations by R.2012 d.035, effective February 6, 2012. See: 43 N.J.R. 2411(a), 44 N.J.R. 274(b).

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SUBCHAPTER 1. GENERAL PROVISIONS

11:24A-1.1 Scope and purpose

(a) The purpose of this chapter is to set forth the minimum standards which carriers, as defined at N.J.A.C. 11:24A-1.2, must meet in order to be in compliance with the requirements of the Health Care Quality Act, P.L. 1997, c.192, enacted August 8, 1997.

(b) A carrier shall comply with each of the subchapters of this chapter as appropriate to the types of health benefits plans delivered or issued for delivery by the carrier in this State.

(c) The provisions of this chapter shall apply to any services or functions of a carrier that the carrier may subcontract to another entity just as if the carrier were performing those services or functions itself, and no carrier shall be relieved of assuring full compliance with any applicable provision because one or more functions or services are subcontracted.

(d) A carrier that complies with this chapter shall not be relieved of its obligation to comply with all applicable Federal, State and local laws, rules and regulations.

11:24A-1.2 Definitions

For the purposes of this chapter, the words and terms set forth below shall have the following meanings, unless the word or term is further defined within a subchapter of this chapter, or the context clearly indicates otherwise:

"Act" means the Health Care Quality Act, P.L. 1997, c.192 (as codified: N.J.S.A. 26:2S-1 et seq.; 26:2J-4.16, 18.1 and 24; 17:48-6r, 17:48A-7p, 17:48E-35.15, 17B:26-2.1n, 17B:27-46.1q, 17B:27A-2.3 and 17B:27A-19.5; and 34:13A-31).

"Adverse benefit determination" means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because the carrier determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the carrier has rescinded the coverage.

"Carrier" means a insurance company authorized to transact the business of insurance in this State and doing a health insurance business in accordance with N.J.S.A. 17B:17-1 et seq., a hospital service corporation authorized to do business pursuant to N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to do business pursuant to N.J.S.A. 17:48A-1 et seq. or a health service corporation authorized to do business pursuant to N.J.S.A. 17:48E-1 et seq.

"Claim" means a request by a covered person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person, for payment relating to health care services or supplies covered under a health benefits plan issued by a carrier.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Continuous quality improvement" or "CQI" means an ongoing and systematic effort to measure, evaluate, and improve either a carrier's process of providing quality health care services to covered persons with respect to managed care plans, or the carrier's process of performing utilization management functions with respect to health benefits plans in which utilization management has been incorporated.

"Contract holder" means an employer or organization that purchases a contract or policy for the provision of health care services covered under the terms of the policy or contract or for the payment of benefits therefor.

"Covered person" means the person on whose behalf a carrier is obligated to pay benefits or provide health care services pursuant to the health benefits plan.

"Department" means the New Jersey Department of Banking and Insurance.

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

"Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a carrier at the completion of the internal appeal process, an adverse benefit determination with respect to which the carrier has waived its right to an internal review of the appeal, an adverse benefit determination for which the carrier did not comply with the requirements of N.J.A.C. 11:24A-3.4 or 3.5 and an adverse benefit determination for which the covered person or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.

"Financial incentive arrangement" means a formal mechanism instituted by a carrier 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.

"Gatekeeper system" means a system in which a covered person's level of benefits for all or a specified set of health care services under a policy or contract is dependent upon the covered person obtaining appropriate referrals for the services through a primary care provider or the carrier.

"Health benefits plan" means a policy or contract for the payment of benefits for hospital and medical expenses or the provision of hospital and medical services delivered or issued for delivery in this state by a carrier.

(b) Carriers who are the subject of an appeal through the Independent Health Care Appeals Program shall be responsible for paying the cost of the appeal.

1. The carrier shall be responsible to pay the per case cost that is applicable on the date that the preliminary review of the appeal is completed by the IURO.

2. The carrier shall submit payment to the IURO for the appeal no later than 30 days following the date that the IURO renders its determination on the appeal in writing to the Department.

Amended by R.2005 d.418, effective November 21, 2005.
See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).
In (a)1, rewrote "8-7" as "8.7"; in (b)2, substituted "determination on the appeal" for "final recommendation."

11:24A-5.2 Department review of carrier actions on IURO recommendations

(a) The Department shall periodically review records of carrier reports submitted pursuant to N.J.A.C. 11:24A-3.7 to determine whether a carrier exhibits a pattern of noncompliance with the recommendations of an IURO as well as possible violations of patient rights or other applicable laws.

(b) If the Department determines that a carrier exhibits a pattern of noncompliance with the recommendations of an IURO, the Department shall review:

1. Whether the carrier's noncompliance is with a specific set of recommendations;

2. Whether the carrier's noncompliance is with a specific IURO (in the event more than one IURO participates in the Independent Health Care Appeals Program); and

3. The carrier's utilization management program, if any.

(c) If the Department determines that the carrier's utilization management program is not in compliance with the utilization management standards set forth at N.J.A.C. 11:24A-3.4 and 4.11, as applicable, or other relevant laws, the Department take action(s) as deemed appropriate, in the discretion of the Commissioner, if any, pursuant to N.J.A.C. 11:24A-2.7.

(d) If the Department determines that the carrier is in violation of patient rights or other applicable regulations, the Department shall take action(s) as deemed appropriate, in the discretion of the Commissioner, if any, pursuant to N.J.A.C. 11:24A-2.7.

(e) A pattern of noncompliance shall mean the occurrence of multiple incidents of refusal to follow the recommendations of the IURO, in whole or in part, within a 12 month period, when such recommendations require the carrier to provide services or benefits therefor to a covered person.