CHAPTER 38

HEALTH MAINTENANCE ORGANIZATIONS

Authority

N.J.S.A. 26:2H–1 et seq.

Source and Effective Date

R.1997 d. 68, effective January 17, 1997.
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

Executive Order No. 66(1978) Expiration Date

Chapter 38, Health Maintenance Organizations, expires on January 17, 2002.

Chapter Historical Note

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

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

Pursuant to Executive Order No. 66(1978), Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, of Chapter 38, was readopted as R.1997 d.68, effective January 17, 1997. See: Source and Effective Date. As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider Network, Subchapter 7, Continuous Quality Improvement, Subchapter 8, Utilization Management, Subchapter 9, Member Rights and Responsibilities, Subchapter 10, Medical Records, Subchapter 11, Financial Standards and Reporting, Subchapter 12, Rehabilitation, Conservation and Liquidation, Subchapter 13, Licensing of Representatives and Advertising, and Subchapter 15, Provider Agreements and Risk Transference, were adopted as new rules. New rules 8:38–3.5(a)4; 8:38–3.6(e); 8:38–4.1(b); 8:38–5.3(b)5; 8:38–6.3(a)3i; 8:38–8.1(a)7; 8:38–8.2(a) and (c); 8:38–8.3(b) and (d); 8:38–8.4(b); 8:38–8.6(f); 8:38–8.7; 8:38–8.8; 8:38–9.1(c)1, 8 and 12; and 8:38–13.4, became operative March 15, 1997; all repeals, amendments, and other new rules became operative July 1, 1997.

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SUBCHAPTER 1. SCOPE AND DEFINITIONS

8:38–1.1 Scope

(a) The rules in this chapter were developed by the Commissioner of Health and Senior Services in collaboration with the Commissioner of Banking and Insurance and govern the establishment and operation of health maintenance organizations in New Jersey pursuant to the authority set forth in N.J.S.A. 26:2J–1 et seq. These rules are only applicable to managed care plans that constitute a health maintenance organization as defined herein and in N.J.S.A. 26:2J–1 et seq.

(b) The provisions of these rules shall apply, except where in conflict with:

1. Any individual contract issued by a health maintenance organization (HMO) to the extent that the contract is formulated in accordance with the provisions of the New Jersey Individual Health Coverage Program established pursuant to N.J.S.A. 17B:27A–1 et seq.; or

2. Any contract issued to a small employer by a HMO to the extent that the contract is formulated in accordance with the provisions of the New Jersey Small Employer Health Coverage Program established pursuant to N.J.S.A. 17B:27A–17 et seq.

(c) The provisions of these rules shall apply to any services of the HMO which are subcontracted to other entities.

(d) Nothing contained in these rules shall be construed to limit the authority of the Division of Medical Assistance and Health Services of the Department of Human Services to impose, in any contract to provide HMO services to New Jersey Medicaid recipients, standards that exceed those set forth in this chapter.

8:38–1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Authorized payor" means a person licensed and authorized to transact business in this State as a health maintenance organization, an insurer doing a health insurance business, a hospital service corporation, a medical service corporation, a health services corporation, a dental service corporation, a dental plan organization or a fraternal benefit society.

"Basic comprehensive health care services" means the following services: preventive care, emergency care, inpatient and outpatient hospital and provider care, diagnostic laboratory and diagnostic and therapeutic radiological services and other services set forth in N.J.A.C. 8:38–5, including all services listed at N.J.A.C. 8:38–5.2.

"Capitation" means a fixed payment for the provision of medical services not based on frequency or severity of services or supplies provided.

"Carrier" means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17–4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48–1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A–1 et seq., or a health service corporation transacting business in accordance with N.J.S.A. 17:48E–1 et seq.

"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 absence of immediate attention could reasonably be expected to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Evidence of coverage" means a statement of the essential features and services of the HMO coverage which is given to the subscriber by the HMO or by the group contract holder.

"External quality review organization (EQRO)" means an organization approved by the Department pursuant to this chapter to perform external quality audits of HMOs.

"Financial incentive arrangement" means a formal mechanism instituted by an HMO or a secondary contractor that exposes a provider, or group of providers, to risk or reward based upon meeting or failing to meet prescribed standards.

"Financial risk" means participation in financial gains or losses accruing pursuant to a contractual arrangement, based on aggregate measures of medical expenditures or utilization.

"GAAP" means Generally Accepted Accounting Principles.

"Gatekeeper system" means a system in which a member is permitted to access service and/or obtain indemnity benefits for covered services only when the service is rendered by the member's primary care provider, or the member's access to services and/or benefits is approved by the primary care provider or the HMO, as specified under the HMO's contract with the subscriber or contractholder.

"Group health contract" means a contract, filed by or with the New Jersey Department of Banking and Insurance or the Small Employer Health Benefits Program Board of Directors, as appropriate, issued by a carrier to a group of persons for the provision of indemnity benefits for expenses for covered services incurred in preventing or treating acute or chronic injury or illness of members, as specified in the contract. The term "group health contract" shall not include any contract issued on a form which has been disapproved or withdrawn from filing by the Department of Banking and Insurance, or determined incomplete by the Small Employer Health Benefits Program Board of Directors, as appropriate.

"Health care expenditures" means the cost, on an incurred basis, of health care services and supplies rendered by a participating provider or a nonparticipating provider which are the responsibility of the HMO in accordance with the contracts the HMO has issued to contract holders.

"Health center" means a facility owned or leased by an HMO, used by members to receive medical and ancillary services including but not limited to: lab, radiology, and pharmacy.

"Health maintenance organization (HMO)" means any individual or entity that undertakes to provide or arrange for basic comprehensive health care services through an organized system that combines the delivery and financing of health care on a prepaid basis to enrollees.

"Indemnity" means the payment of expenses, in whole or in part, as they are incurred by a member for the delivery of covered services, in which the level of payment for expenses

incurred, and the charge made for the expenses incurred, is not negotiated between the health care provider and the HMO, and there is no contractual arrangement between the health care provider and the HMO holding the enrollee harmless for any amount of the expense not paid by the HMO. Payment of the expense may be made directly to the health care provider upon assignment by the member, or the member may be reimbursed for the expense incurred.

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

"Insurer" means any insurance company authorized to transact the business of insurance in New Jersey."

"Managed hospital payment" means agreements between the HMO and a hospital under which the financial risk primarily related to the degree of utilization rather than to the cost of services is transferred to the hospital.

"Master policy" means the document issued by a carrier to an HMO evidencing coverage of the subscribers and members of the HMO, or a class of subscribers and members of the HMO, under a group health contract.

"Medicaid marketing representative" means any person who is registered as a limited insurance representative pursuant to N.J.S.A. 17:22A–16 and who is authorized to solicit, negotiate or effect contracts with Medicaid recipients as an agent for a Medicaid-contracting HMO, and performs no other service for the HMO that would otherwise require that person to be authorized and licensed as an insurance producer.

"Medical screening examination" means an examination and evaluation within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel pursuant to requirements in N.J.A.C. 8:43G–12, which are necessary to determine whether or not an emergency medical condition exists.

"Member" means an individual who is enrolled in an HMO.

"Network" means all participating providers under contract or other agreement acceptable to the Department to furnish health care services to members of the HMO.

"Net worth" means the excess of the admitted assets over total liabilities of an HMO.

"Out-of-network covered services" means indemnity benefits for covered services rendered to an HMO member by someone other than the HMO's contracted health care providers.

"Participating provider" means a provider which, under contract or other arrangement acceptable to the Department with the HMO or with its contractor or subcontractor, in accordance with the provisions of this chapter, has agreed to provide health care services to members with an expectation of receiving payment, other than a copayment or deductible, directly or indirectly from the HMO.

"Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

"Point of service contract" means a contractual arrangement between an HMO and a member, subscriber or contract holder whereby the HMO makes provision for the rendering of covered services to its members through a network of health care providers as well as an out-of-network covered services option.

"Primary care provider (PCP)" means an individual participating provider who supervises, coordinates and provides initial and basic care to members and maintains continuity of care and meets the qualifications in N.J.A.C. 8:38–6.2.

"Primary contractor" means a provider that agrees directly with an HMO to provide one or more services or supplies directly to an HMO's members.

"Provider" means any physician, hospital, facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

"Reinsurance-type contract" means a contract between an insurer and an HMO whereby the insurer agrees to indemnify the HMO for all expenses incurred by the HMO's members under a POS contract for out-of-network covered services, and further, the insurer agrees that it will indemnify the HMO's members for expenses incurred for out-of-network covered services for the duration of the period for which premiums are or have been paid by the contract holders or subscribers to the HMO, should the HMO be placed into conservation, rehabilitation or liquidation."

"SAP" means Statutory Accounting Practices.

"Secondary contractor" means a person who agrees to arrange for the provision of one or more services or supplies for an HMO's members. A primary contractor may also be a secondary contractor when acting as a broker or administrator for the rendering of services or supplies that, in scope of licensure, type or quantity, the primary contractor (provider) alone could not offer directly to members.

"Service area" means the geographic area for which the HMO has been issued a certificate of authority, in accordance with this chapter.

"Subscriber" means, in the case of a group contract, an individual whose employment or other status, except family status, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the person in whose name the contract is issued.

"Uncovered health care expenditures" means costs to the HMO for health care services that are the obligation of the HMO for which a member may be liable in the event of an HMO's insolvency and for which no alternative arrangements (that guarantee, insure or provide assumption by a person or organization other than the HMO for the provision of services or benefits) have been made that are acceptable to the Commissioners of Health and Senior Services and Banking and Insurance.

"Urgent care" means a non-life-threatening condition that requires care by a provider within 24 hours.

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

Public Notice: Increase in medical component of the Consumer Price Index.
See: 29 N.J.R. 2484(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 30 N.J.R. 1330(a).
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".
Public Notice: Increase in medical component of the Consumer Price Index.
See: 31 N.J.R. 801(a).

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 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
Division of 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 application proposes to be a Medicaid program participant, one copy shall be submitted to:

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

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

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

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

7. The most recent audited financial statements (or other documentation as specified by N.J.A.C. 8:38–11 for newly-formed applicants) showing the applicant's assets, liabilities, sources of financial support, a statement as to the sources of funding and all other financial requirements as delineated in N.J.A.C. 8:38–11;

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

9. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his or her successors in office, and duly authorized designees, as the true and lawful attorney of such 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;

10. A description and map of the geographic area to be served, identified by county. If sub-areas of counties are to be proposed as boundaries of the service area, the map should also include zip codes;

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

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

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

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

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

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

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

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

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

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

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

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

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

8:38–2.3 Issuance of a certificate of authority

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

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

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

(d) Prior to issuance of a certificate of authority, a preoperational audit shall be conducted by the Departments of Health and Senior Services, Banking and Insurance and/or Human Services to evaluate the HMO's ability to perform essential functions including, but not limited to, claims processing, utilization management and quality assurance protocols, adequacy of accounting and information systems, operational and financial controls, and network adequacy. The applicant shall bear all reasonable costs associated with conducting the preoperational audit, including, but not limited to, outside consultant and subcontractor fees.

Amended by R.1999 d.201, effective June 21, 1999.
See: 31 N.J.R. 610(a), 31 N.J.R. 1631(a).
Rewrote (d).

8:38–2.4 Comprehensive assessment reviews

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

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