

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 As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider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.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. SCOPE AND DEFINITIONS

- 8:38-1.1 Scope
- 8:38-1.2 Definitions

SUBCHAPTER 2. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

- 8:38-2.1 Certificate of need and licensing
- 8:38-2.2 Application for a new or amended certificate of authority
- 8:38-2.3 Issuance of a certificate of authority
- 8:38-2.4 Comprehensive assessment reviews
- 8:38-2.5 Denial of a certificate of authority
- 8:38-2.6 Amendment to an approved certificate of authority

- 8:38-2.7 Notice of changes in HMO operations
- 8:38-2.8 Approval of a point of service (POS) plan
- 8:38-2.9 Changes in ownership interests
- 8:38-2.10 Surrender of a certificate of authority
- 8:38-2.11 Registered agent
- 8:38-2.12 Examinations
- 8:38-2.13 Violations
- 8:38-2.14 Enforcement remedies available
- 8:38-2.15 Hearings

SUBCHAPTER 3. GENERAL REQUIREMENTS

- 8:38-3.1 Compliance with laws and rules
- 8:38-3.2 Nondiscriminatory enrollment practices
- 8:38-3.3 Open enrollment
- 8:38-3.4 Member contract termination
- 8:38-3.5 Provider contract termination
- 8:38-3.6 Hearings for provider terminations
- 8:38-3.7 Complaint and appeal system
- 8:38-3.8 Submission of documents and data
- 8:38-3.9 Provider application for participation and the review panel

SUBCHAPTER 4. MEDICAL DIRECTOR

- 8:38-4.1 Designation of a medical director
- 8:38-4.2 Medical director's responsibilities

SUBCHAPTER 5. HEALTH CARE SERVICES

- 8:38-5.1 Provision of health care services
- 8:38-5.2 Basic comprehensive health care services
- 8:38-5.3 Emergency and urgent care services
- 8:38-5.4 Supportive services
- 8:38-5.5 Health promotion programs
- 8:38-5.6 Wilm's tumor
- 8:38-5.7 Health care services for prescribed drugs

SUBCHAPTER 6. PROVIDER NETWORK

- 8:38-6.1 Health care service network
- 8:38-6.2 Primary, specialty and ancillary providers
- 8:38-6.3 Institutional services

SUBCHAPTER 7. CONTINUOUS QUALITY IMPROVEMENT

- 8:38-7.1 Continuous quality improvement program
- 8:38-7.2 External quality audit
- 8:38-7.3 Performance and outcome measures
- 8:38-7.4 Healthcare Data Committee

SUBCHAPTER 8. UTILIZATION MANAGEMENT

- 8:38-8.1 Utilization management program
- 8:38-8.2 Utilization management staff availability
- 8:38-8.3 Utilization management determinations
- 8:38-8.4 Appeals of utilization management determinations
- 8:38-8.5 Informal internal utilization management appeal process (Stage 1)
- 8:38-8.6 Formal internal utilization management appeal process (Stage 2)
- 8:38-8.9 Department review of HMO actions on IURO recommendations

SUBCHAPTER 9. MEMBER RIGHTS AND RESPONSIBILITIES; DISCLOSURES TO CONSUMERS

- 8:38-9.1 Policies and procedures

SUBCHAPTER 10. MEDICAL RECORDS

- 8:38-10.1 Policies and procedures
- 8:38-10.2 Confidentiality of medical records

- 8:38-10.3 Maintenance of medical records
- 8:38-10.4 Copies of medical records
- 8:38-10.5 Medical record retention

SUBCHAPTER 11. FINANCIAL STANDARDS AND REPORTING

- 8:38-11.1 Minimum net worth
- 8:38-11.2 Investments
- 8:38-11.3 Reserve liabilities
- 8:38-11.4 Minimum deposits
- 8:38-11.5 Plan for continuation of services upon declaration of insolvency
- 8:38-11.6 Financial reporting requirements
- 8:38-11.7 Reporting of compensation arrangements with health care providers involving incentive or disincentive programs
- 8:38-11.8 Rating
- 8:38-11.9 Subrogation and third party claims

SUBCHAPTER 12. REHABILITATION, CONSERVATION AND LIQUIDATION

- 8:38-12.1 Rehabilitation, conservation and liquidation generally
- 8:38-12.2 Alternate methodology for assuring continuation of services to HMO members

SUBCHAPTER 13. LICENSING OF REPRESENTATIVES AND ADVERTISING

- 8:38-13.1 General applicability of producer licensing requirements
- 8:38-13.2 Medicaid marketing representatives
- 8:38-13.3 Advertising and marketing
- 8:38-13.4 Disclosure of provider compensation arrangements
- 8:38-13.5 Trade and claims practices and coordination of benefits
- 8:38-13.6 Penalties

SUBCHAPTER 14. INDEMNITY BENEFITS OFFERED BY A HEALTH MAINTENANCE ORGANIZATION

- 8:38-14.1 Purpose, scope and applicability
- 8:38-14.2 Requirement to offer a point of services contract
- 8:38-14.3 General standards
- 8:38-14.4 Out-of-network benefit restrictions under an HMO POS contract with a reinsurance-type or group master policy arrangement
- 8:38-14.5 POS under a reinsurance-type contract arrangement
- 8:38-14.6 POS under a group health contract master policy arrangement
- 8:38-14.7 POS under a dual contract arrangement

SUBCHAPTER 15. PROVIDER AGREEMENTS AND RISK TRANSFERENCE

- 8:38-15.1 Assumption of financial risk or risk-sharing
- 8:38-15.2 Minimum standards for provider agreements
- 8:38-15.3 Review and approval
- 8:38-15.4 Penalties

SUBCHAPTER 16. CLAIMS PAYMENTS

- 8:38-16.1 Prompt investigation and settlement of claims
- 8:38-16.2 Effective notices and payments
- 8:38-16.3 Contents of a notice of a contested claim
- 8:38-16.4 Overdue payments
- 8:38-16.5 Use of intermediaries
- 8:38-16.6 Contracts currently in effect
- 8:38-16.7 Penalties

SUBCHAPTER 17. PLAN DOCUMENTS FOR GROUP CONTRACTS

- 8:38-17.1 Scope and applicability
- 8:38-17.2 General requirements
- 8:38-17.3 Terms and conditions for plan documents
- 8:38-17.4 Specific standards for required provisions
- 8:38-17.5 Standards for optional provisions

SUBCHAPTER 18. DRUG FORMULARIES

- 8:38-18.1 Development of formulary
- 8:38-18.2 Nonformulary medications
- 8:38-18.3 Distribution of formulary
- 8:38-18.4 Operative date

APPENDIX

APPENDIX. EXHIBIT 1

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.