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ADOPTION SECTION

INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Notice of Readoption

Health Maintenance Organizations

Readoption: N.J.A.C. 11:24

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17B:30-54, 26:2J-21, and 26:2S-18.

Authorized By: Kenneth E. Kobylowski, Commissioner, Department of Banking and Insurance.

Effective Date: January 14, 2015.

New Expiration Date: January 14, 2022.

Take notice that pursuant to the provisions of Executive Order No. 66 (1978) and N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 11:24 will expire on February 15, 2015. The rules set forth in this chapter govern health maintenance organizations (HMOs). The rules contain the criteria for the establishment, maintenance, denial, and withdrawal of an HMO's certificate of authority in this State. The rules also establish general standards for HMO operations related to the provision of services and the enrollment and termination of members, as well as handling applications from and termination of health care providers from an HMO's network. The rules further require that the HMO designate a medical director to oversee a number of its operations, and set forth the medical director's various responsibilities. The rules describe the minimum health care services that an HMO member contract must contain. The rules additionally establish the minimum standards for an HMO's network of health care providers. The rules also

set forth certain requirements regarding continuous quality improvement programs and use of performance and outcome measures. The rules further require that HMOs have a utilization management program under the direction of the medical director, and that the program meet certain standards. An Appendix to the rules contains an Explanation of an Individual's Right to Appeal Health Insurance Determinations. The rules also contain the standard disclosure requirements that HMOs must make to members and other consumers. The rules establish standards for the maintenance and handling of medical records. The rules also establish financial standards and related reporting requirements for HMOs. The rules additionally address the solvency of HMOs, and contain provisions related to the rehabilitation, conservation, and liquidation of HMOs. The rules establish standards for the licensing of agents and brokers (producers) employed by or acting on behalf of HMOs, contain certain disclosure requirements regarding provider compensation arrangements, and clarify that certain other Department rules relating to marketing, trade practices, and claims handling apply to HMOs. The rules also set forth the standards by which HMOs may develop and offer a point-of-service (POS) product, and procedures for obtaining approval of such products. The rules establish standards for the transfer of risk between HMOs, health care providers, and intermediary organizations, and specify when such a transfer of risk is, or is not, permissible. The rules also set forth basic requirements for HMO plan documents, such as enrollment contracts, certificates, evidences of coverage, and handbooks. Finally, the rules establish standards for the development and use of drug formularies by HMOs, and an appendix to the rules contains the Actuarial Justification of Benefit Differentials – Formulary Drug Benefit form. The rules are necessary, reasonable, and proper for the purpose for which they were originally promulgated. Therefore, pursuant to

N.J.S.A. 52:14B-5.1.c(1), these rules are readopted and shall continue in effect for a seven-year period.