INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Maintenance Organizations
Proposed Readoption with Amendments: N.J.A.C. 11:24

Authorized By: Steven M. Goldman, Commissioner, Department of Banking and Insurance.

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

Calendar Reference: See Summary below for an explanation of the exception to the rulemaking calendar requirements.

Proposal Number: PRN 2007-271

Submit comments by October 19, 2007 to:

Robert J. Melillo, Chief
Legislative and Regulatory Affairs
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
Email: legsregs@dobi.state.nj.us

The agency proposal follows:

Summary

Chapter 38 of Title 8 of the New Jersey Administrative Code (N.J.A.C. 8:38) previously contained the rules governing Health Maintenance Organizations (HMOs). In June 2005, Acting Governor Richard J. Codey issued Reorganization Plan 005-2005, reiterated under N.J.S.A. 26:2S-1, to provide for the transfer, consolidation and reorganization of the Office of Managed Care, which was responsible for the licensing and regulation of HMOs, from the Department of Health and Senior Services (DHSS) to the Department of Banking and Insurance (Department). As a result of that reorganization plan, the rules governing HMOs at Chapter 38 of Title 8 were

recodified in Chapter 24 of Title 11 (N.J.A.C. 11:24) effective October 6, 2006 (see 38 N.J.R. 4721(a)).

Pursuant to N.J.S.A. 52:14B-5.1 and N.J.A.C. 1:30-6.4, N.J.A.C. 11:24 expires on August 19, 2007. Pursuant to N.J.S.A. 52:14B-5.1c, as this notice of proposed readoption of Chapter 24 was submitted to the Office of Administrative Law prior to the expiration date, that date is extended 180 days to February 15, 2008. An administrative review has been conducted, and a determination made that all subchapters contained in Chapter 24 should be continued because the rules are necessary, reasonable, adequate, efficient, and responsive for the purposes for which they were promulgated. Accordingly, the Department intends to readopt all 18 subchapters contained in Chapter 24. The Department proposes to amend Subchapter 5 to make it consistent with the requirement in the Health Claims Authorization, Processing and Payment Act (HCAPPA) (P.L. 2005, c. 352) enacted on January 12, 2006 and effective July 11, 2006 regarding carrier reimbursement for all medically necessary emergency and urgent care services covered under a health benefits plan in accordance with the provider agreement, when applicable, and to provide a Federal law citation not currently included in the subchapter. The remaining subchapters are being proposed for readoption without change. The Department intends to propose in the near future certain additional amendments, repeals and/or new rules to the chapter, including those necessitated by recent revisions to the Health Care Quality Act, N.J.S.A.26:2S-1, et seq. (HCQA), made by P.L. 2005, c. 352. In the interim, carriers, health care providers and other interested parties may refer to the Department's Bulletins Nos. 06-16 and 06-17 for guidance relating to the implementation of P.L. 2005, c. 352.

Several significant changes have been made to the HMO rules since they were initially adopted. Chapter 38 was originally adopted by DHSS in November of 1974, and implemented

certain provisions of then recently enacted N.J.S.A. 26:2J-1 et seq. governing HMOs. Chapter 38 expired in April of 1994 and was adopted anew in July 1994. In April 1996, Subchapter 14, which addressed the provision of point-of-service (POS) policies by HMOs, was added to the rules.

In 1997, DHSS in consultation with the Department, together with a task force composed of numerous interested parties and stakeholders, rewrote Chapter 38. The changes expanded substantially the regulatory oversight of HMOs by both DHSS and the Department, enhancing both patient and provider protections. The new rules consisted of Subchapters 1 through 13 and 15. The new rules became effective January 17, 1997, with delayed operative dates of March 15 and July 1, 1997 for substantial portions of the new and amended rules.

In September 1998, DHSS added Subchapter 16 regarding claims payments by HMOs, operative October 1998. This subchapter implemented N.J.S.A. 26:2J-5.1, enacted in 1991. N.J.S.A. 26:2J-5.1 has since been repealed; claims payment by HMOs is discussed more fully below.

In August 1997, the HCQA (P.L. 1997, c. 192) was enacted and became effective in February 1998. The HCQA required that further significant amendments be made to the rules. The DHSS, in consultation with the Department, again worked with a task force composed of interested parties and stakeholders to amend the rules to implement the HCQA. These amendments and new rules, including a new Subchapter 17 relating to plan documents for group contracts, became effective on May 1, 2000, with delayed operative dates for some provisions.

In January 2001, Subchapter 18 was added. This subchapter, substantially developed by the Department in consultation with DHSS, regulates the use of formularies by HMOs. The subchapter became operative on July 1, 2001.

The rules again expired on July 16, 2002, and DHSS readopted the chapter in August 2002. The readoption included the repeal of Subchapter 16, which addressed claims payments by HMOs, because the principal statute upon which that subchapter was based was repealed in 1999 by P.L. 1999, c. 154, the Health Information Electronic Data Interchange Technology Act (HINT) and its companion legislation, P.L. 1999, c. 155. The new legislation established a new regulatory framework regarding claims handling and prompt payment of claims, and provided the Department with regulatory authority regarding the enforcement of claims payment issues. The Department adopted prompt payment rules at N.J.A.C. 11:22-1, effective January 2001. DHSS also repealed those portions of Subchapters 11 and 17 regarding the limited right of HMOs to perform subrogation and otherwise recover for third party claims. This repeal resulted from a New Jersey Supreme Court decision, *Perriera v. Rediger,* 169 N.J. 399 (2001), which prohibited subrogation by health insurers. DHSS's 2002 readoption also included miscellaneous amendments. As stated above, the rules were recodified as N.J.A.C. 11:24 effective October 2006; these recodified rules are now being proposed for readoption. Chapter 24 has had no changes made to it since it was recodified in October 2006.

A summary of the subchapters of the proposed readoption of Chapter 24 follows:

Subchapter 1 sets forth the scope of application of the chapter, as well as definitions used throughout the chapter.

Subchapter 2 contains the criteria for establishment, maintenance, denial and withdrawal of an HMO's certificate of authority in this State.

Subchapter 3 establishes general standards for HMO operations related to the provision of services, enrollment and termination of members, as well as dealing with applications from and termination of health care providers from an HMO's network.

Subchapter 4 requires that the HMO designate a medical director to oversee a number of its operations, and sets forth the medical director's various responsibilities.

Subchapter 5 describes the minimum health care services that an HMO member contract must contain. The amendment proposed at N.J.A.C. 11:24-5.3(c) will make that section consistent with language included in the HCAPPA regarding covered emergency and urgent care services provided in a Level I or II trauma center or hospital. The amendment proposed at N.J.A.C. 11:24-5.3(b)5 will provide a Federal law citation not currently contained in the rule.

Subchapter 6 establishes the minimum standards for an HMO's network of health care providers.

Subchapter 7 sets forth certain requirements regarding continuous quality improvement programs and use of performance and outcome measures.

Subchapter 8 requires that HMOs have a utilization management program under the direction of the medical director, and that the program meet certain standards.

Subchapter 9 contains the standard disclosure requirements that HMOs must make to members and other consumers.

Subchapter 10 establishes standards for the maintenance and handling of medical records.

Subchapter 11 establishes financial standards and related reporting requirements for HMOs.

Subchapter 12 addresses the solvency of HMOs, and contains provisions related to the rehabilitation, conservation and liquidation of HMOs.

Subchapter 13 establishes standards for the licensing of agents and brokers (producers) employed by or acting on behalf of HMOs, contains certain disclosure requirements regarding

provider compensation arrangements, and clarifies that certain other Department rules relating to marketing, trade practices and claims handling apply to HMOs.

Subchapter 14 sets forth the standards by which HMOs may develop and offer a point-of-service (POS) product, and procedures for obtaining approval of such products.

Subchapter 15 establishes standards for the transfer of risk between HMOs, health care providers and intermediary organizations, and specifies when such a transfer of risk is, or is not, permissible.

Subchapter 16 is reserved.

Subchapter 17 sets forth basic requirements for HMO plan documents, such as enrollment contracts, certificates, evidences of coverage and handbooks.

Subchapter 18 establishes standards for the development and use of drug formularies by HMOs. The Appendix to Subchapter 18 contains the Actuarial Justification of Benefit Differentials -- Formulary Drug Benefit form.

As the Department has provided a 60-day comment period on this notice of proposal pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

HMOs, their members and providers will continue to be favorably impacted by the rules proposed for readoption. Chapter 24 establishes standards for HMO licensing and operations. The chapter benefits consumers because it ensures provider network adequacy and quality of care, monitors access to and appropriate utilization of health care services, and requires that HMOs maintain and provide written policies and procedures regarding member rights and the

transfer of medical records. Consumers should benefit from the proposed amendment at N.J.A.C. 11:24-5.3(b)6 that conforms that rule to the HCAPPA requirement that HMOs reimburse providers for all covered medically necessary emergency and urgent health care services provided in a Level I or II trauma center or hospital. This is true because, by eliminating the potential for confusion created by the inconsistency between the current rule text and the HCAPPA, providers will be more confident they will receive appropriate reimbursement and, consequently, more likely to administer all such treatment. The chapter also favorably impacts providers because it addresses certain issues relating to the HMO/provider relationship, including establishing minimum standards for provider agreements. HMOs themselves are favorably impacted by this chapter because the standards they are required to meet provide a certain degree of stability in the marketplace, and also provide an avenue for making HMOs attractive to other markets, including federal programs, employers in other states, or employers that seek only administrative services.

Economic Impact

The proposed readoption of this chapter could result in both favorable and unfavorable economic impacts on HMOs, consumers and providers. The economic impact of this chapter on HMOs since its initial adoption has been uncertain. It is highly probable that those HMOs that were in existence at the time of the original adoption of this chapter experienced at least some negative impact due to the chapter's newly-established financial and administrative requirements. HMOs may also have incurred additional costs when amendments to this chapter were adopted in 2000 implementing the Health Care Quality Act and necessitating that HMOs comply with disclosure, utilization management, utilization appeals and continuous quality

improvement requirements. Some HMOs may have incurred increased administrative and medical costs related to the standards regarding formularies, especially the prohibition on the use of closed formularies. HMOs may experience a negative impact by the Department's proposed amendment at N.J.A.C. 11:24-5 requiring HMOs to reimburse hospitals and physicians for all medically necessary emergency and urgent health care services covered under the health benefits plan. While the Department is not able to accurately discern the extent to which any costs incurred by an HMO are attributable to compliance with this chapter's requirements or to the HMO's own business practices, it is likely that this chapter has had some adverse impact on the HMO industry that will continue following readoption of the chapter. Nevertheless, as stated above in the Social Impact statement, HMO compliance with these requirements could result in increasing their attractiveness in other markets, thereby resulting in a positive economic impact.

The impact of this chapter on consumers and/or providers has been equally uncertain, but can probably best be described as mixed. Consumers would have been negatively impacted by any costs that HMOs passed on to them. Consumers would also have been unfavorably impacted by any premium increases that occurred since these rules have been in effect. Consumers and providers experienced a positive economic impact resulting from the increased accountability and public awareness of HMO operations through greater controls on utilization management program standards, utilization management appeals and continuous quality improvement programs. In addition, all interested parties have benefited from the collection and dissemination of information by HMOs related to consumer satisfaction and treatment outcomes, which has resulted in an improvement in HMO quality of care and outcome measures. Providers will further benefit from the proposed amendment at N.J.A.C. 11:24-5 because it ensures that they will be reimbursed for all covered medically necessary emergency and urgent health care

services provided in a Level I or II trauma center or a hospital. Providers could additionally experience either a favorable or unfavorable impact depending on whether their rates of reimbursement increase or decrease.

Federal Standards Statement

Certain aspects of an HMO's operation would be regulated by Federal law if an HMO elects to become Federally qualified, serves as a carrier for Medicare programs, provides services to the Federal Employee Health Benefits Plan, or provides administrative services only for self-funded arrangements. Federal law preempts application of State law in some instances (for example, with respect to the covered services or benefits, required health care providers, and some aspects of grievance and appeals handling for Medicare products). In those instances where there may be an overlap between Federal and State law, but there is no preemption of State law (for example, time frames for responding to member complaints for certain types of products offered by HMOs), the rules proposed for readoption are neither inconsistent with, nor more stringent than, any Federal statutes or rules, including 29 CFR 2510, 2520, 2560 and 2590; 42 CFR 417, 422, 438 and 457; and 45 CFR 144, 146 and 148. These rules were promulgated by the Federal government in accordance with various amendments to Sections 1102 and 1871 of the Social Security Act (42 U.S.C. §§1302 and 1395hh), or are based on provisions within the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. §§1002 et seq.) and subsequent amendments thereto, including the Health Insurance Portability and Accountability Act (HIPAA) (Pub. Law 104-191) and its subsequent amendments. Thus, no analysis is required. The rules proposed for readoption do not apply to administrative services provided to self-funded arrangements, and, thus, no analysis of the federal standards is required.

Jobs Impact

The rules proposed for readoption will not result in the generation or loss of any jobs.

Agriculture Industry Impact

The rules proposed for readoption will have no impact on the agriculture industry.

Regulatory Flexibility Analysis

Some of the HMOs required to comply with the rules proposed for readoption may be "small businesses" as that term is defined at N.J.S.A. 52:14B-16-1 et seq. Further, the rules proposed for readoption include numerous reporting, recordkeeping and compliance requirements, including but not limited to, financial and solvency data and reports, member information data, complaints and appeals data, internal performance indicators, continuous quality improvement plans and revisions, external quality review organization reports, notices of changes in operations, consumer and member disclosures, and various types of forms review and maintenance. The attendant cost to HMOs for complying with these requirements is discussed above in the Economic Impact statement. While the Department does not believe that HMOs will find it necessary to employ outside professionals or consultants to comply with these rules, all HMOs regardless of size are required to strictly comply with the requirements of this chapter because to allow otherwise would be detrimental to the protections afforded consumers by these rules. The rules, however, provide some flexibility to small business in that certain requirements are phased in based on the growth of the HMO's business in New Jersey (for example, financial requirements, external quality review organization requirements).

Smart Growth Impact

The rules proposed for readoption with amendments will have no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:24.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets **[**thus**]**)

SUBCHAPTER 5. HEALTH CARE SERVICES

11:24-5.3 Emergency and urgent care services

(a) (No change.)

(b) Emergency and urgent care services shall include, but are not limited to:

1. - 4. (No change.)

5. Upon a member's arrival in a hospital, coverage of a medical screening examination, as required **[**under**]** **by the** Federal **[**law**]** **Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd,** and as specified in N.J.A.C. 8:43G-12 **[**as necessary to determine whether an emergency medical condition exists**]**.

(c) With respect to services provided pursuant to (b)2 or 5 above, carriers shall reimburse hospitals and physicians for all medically necessary emergency and urgent health care services covered under the health benefits plan, including all tests necessary to

determine the nature of an illness or injury, in accordance with the provider agreement when applicable.

inoregs/bbHMO