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BANKING AND INSURANCE

DIVISION OF INSURANCE

Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations

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

Proposed Repeals: N.J.A.C. 11:24A-1.3 and 11:24A Appendix

Authorized By: Thomas B. Considine, Commissioner, New Jersey Department of Banking and Insurance.

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

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

Proposal Number: PRN 2010-304.

Submit written comments by February 4, 2011 to:

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The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) proposes to readopt N.J.A.C. 11:24A, which implements the provisions of the Health Care Quality Act (HCQA), P.L. 1997, c. 192 (substantially codified at N.J.S.A. 26:2S-1 et seq.). Pursuant to N.J.S.A. 52:14B-5.1c, the rules in N.J.A.C. 11:24A are scheduled to expire on October 27, 2010. In accordance with N.J.S.A. 52:14B-5.1c, the submission of this notice of proposal to the Office of Administrative Law extends the expiration date of N.J.A.C. 11:24A 180 days to April 25, 2011. The Department is proposing to repeal certain provisions contained in this chapter, which are explained in the Summary below.

By way of background, on June 30, 2005, Acting Governor Codey filed Reorganization Plan 005-2005 with the Senate and Assembly to provide for the transfer, consolidation and reorganization of the Office of Managed Care from the Department of Health and Senior Services (DHSS) to the Department. Public Notice of Reorganization Plan 005-2005 was published in the New Jersey Register on August 2, 2005, at 37 N.J.R. 2737(a). Reorganization Plan 005-2005 became effective on August 29, 2005. Among other things, Reorganization Plan 005-2005 transferred from the Commissioner of DHSS to the Commissioner of the Department the authority to interpret, implement, administer and enforce numerous laws, including the HCQA, and laws subsequently enacted that directly amend or supplement the HCQA. Consequently, authority to readopt rules promulgated pursuant to the HCQA and to adopt proposed amendments

thereto and new rules no longer resides with DHSS, but rests with the Department. Accordingly, N.J.A.C. 8:38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was recodified as N.J.A.C. 11:24A, effective October 6, 2006 (see 37 N.J.R. 2737(a) and 38 N.J.R. 4721(a)), and it is the Commissioner of the Department that is proposing to readopt the rules that are now codified at N.J.A.C. 11:24A.

The HCQA established certain standards that must be met by various classes of carriers (insurers doing a health insurance business, hospital service corporations, medical service corporations, health service corporations, and health maintenance organizations (HMOs) offering health benefits plans in New Jersey), but is primarily focused upon carriers offering managed care plans or other health benefits plans with utilization management (UM) features. At the time the HCQA was enacted, it established an Independent Health Care Appeals Program (IHCAP), and required that the DHSS engage in certain data gathering and reporting activities. The HCQA also authorized the DHSS to promulgate rules to implement the provisions of the statute, in consultation with the Department. The HCQA empowered the DHSS to establish standards for non-HMO carriers offering managed care plans and health benefits plans with UM features that are consistent with the standards established for HMOs, as the DHSS believed appropriate for the types of policies and carriers involved. The Department has reviewed N.J.A.C. 11:24A and, with the exception of the proposed amendments and repeals described below, has determined the existing rules to be

necessary, reasonable and proper for the purposes for which they were originally promulgated.

Carriers, health care providers and consumers should take note that the Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148) was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act (Reconciliation Act) (Public Law 111-152) was enacted on March 30, 2010. The Federal Departments of Health and Human Services, Treasury, and Labor are issuing regulations to implement the PPACA and the Reconciliation Act. On July 22, 2010, the Obama Administration released interim final rules that allow patient appeals of health insurance coverage decisions as required under PPACA. Some of the rules included in N.J.A.C. 11:24A conflict with the new Federal requirements, and will need to be amended to comply with them. However, the interim rules provide that the Departments are using their authority under the Public Health Service Act (PHS Act, 42 U.S.C. § 201, section 2719(c)) to treat existing State external review processes as meeting the minimum standards during a transition period for plan years (in the individual market, policy years) beginning before July 1, 2011. New Jersey has been notified that the State's external review processes have been deemed compliant with the Federal law and regulations' external review requirements until July 1, 2011; however, another interim final rule, Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule, issued on June 28, 2010, does not include a safe harbor, but does

include a requirement that conflicts with N.J.A.C. 11:24A-4.11(b)2. Consequently, the Department is proposing to amend N.J.A.C. 11:24A-4.11(b)2 now to conform with Federal interim final rules that became effective on September 23, 2010 prohibiting preauthorization for emergency and/or urgent care services (see 26 CFR Parts 54 and 602, 29 CFR Part 2590 and 45 CFR Parts 144, 146 and 147). The Department intends to propose further amendments to this chapter in the future.

A summary of the subchapters of N.J.A.C. 11:24A follows:

N.J.A.C. 11:24A-1 sets forth the scope and purpose of the chapter, definitions used in the chapter, and compliance time frames that carriers must meet. The Department is proposing to repeal N.J.A.C. 11:24A-1.3, Compliance time frames, because it contains references to an outdated compliance date of July 30, 2000.

N.J.A.C. 11:24A-2 sets forth general provisions that are applicable to all carriers offering health benefits plans, as that term is defined. The subchapter includes the requirement that carriers submit a form, referred to as the HCQA Registration Form, to the Department providing information about certain features that a carrier includes in all of the health benefits plans that the carrier intends to offer in New Jersey. The subchapter specifies certain disclosures that all carriers are required to provide to subscribers, including descriptions of cost-sharing requirements, how services may be obtained, and use of emergency response systems in New Jersey. The subchapter includes statements that, to the extent such disclosures are contained in forms filed with the Department (such as policy forms and marketing material), such forms will be deemed approved by the Department for purposes of compliance with the HCQA. The

subchapter details certain rights that carriers must extend to covered persons, and requires carriers to have policies and procedures in place to assure that these rights are preserved and that covered persons are made aware of them. The subchapter establishes standards regarding emergency and urgent care services at various hospital settings. The subchapter also sets forth procedures regarding violations of the chapter. The Department is proposing to amend N.J.A.C. 11:24A-2.2, HCQA Registration Form. This form was originally intended to capture information from carriers who had a product with a UM component, but no network. It was subsequently determined by the Department that this form was not necessary if the information submitted in this form was already obtained by the Department in Selective Contracting Arrangement (SCA) applications. Accordingly, this section is being amended to include language indicating that by providing the required information in a carrier's SCA application, the requirements of this section have been satisfied. The Department is additionally proposing to delete a reference to the Department of Banking and Insurance in the violations section at N.J.A.C. 11:24A-2.7 that is no longer necessary.

N.J.A.C. 11:24A-3 establishes standards and procedures for carriers offering health benefits plans with UM features. The subchapter sets forth additional disclosure requirements that carriers must provide to covered persons when UM features are included in health benefits plans, particularly regarding the right of the covered person to appeal adverse UM determinations made by the carrier, including the opportunity to bring the appeal to the Independent Health Care Appeal Process (IHCAP) in the event that the covered person continues to be dissatisfied with the outcome of the carrier's

determinations. The subchapter sets forth a requirement that the carrier designate a physician licensed to practice medicine in New Jersey to serve as the carrier's medical director with respect to the carrier's health benefits plans with UM features, and specifies the minimum activities for which the medical director is to be responsible. The subchapter requires that carriers establish a UM program that has the capacity to evaluate the effectiveness of the carrier's UM features, assures that medical guidelines and protocols used by the carrier are consistent with generally accepted standards, and assures that covered persons have access to UM personnel in a reasonable manner. In addition, the subchapter requires that the UM program link into a continuous quality improvement program, which should result in revised operations, policies or procedures for the UM program as necessary or appropriate. The subchapter establishes certain standards that a carrier's internal appeal mechanism must meet in order to address appeals of covered persons (or health care providers acting on behalf of a covered person with the covered person's consent) regarding the carrier's adverse UM determinations. The subchapter specifies standards and procedures that carriers must meet in complying with decisions of the IHCAP. The Department is proposing to delete N.J.A.C. 11:24A-3.4(c)2 imposing certain requirements on carriers that require preauthorization for emergency and urgent care services. This change is necessary for consistency with the proposed elimination of the preauthorization requirement applicable in certain instances for emergency and urgent care services at N.J.A.C. 11:24A-4.11(b)2. The Department is also proposing to amend N.J.A.C. 11:24A-3.6(b) by deleting the reference to the chapter Appendix, which is the appeals program

application, and the application itself. The Department is proposing to delete the Appendix, add a reference at N.J.A.C. 11:24A-3.6(b) to the Department's website where the application can be accessed, and include in subsection (b) a summary of the information requested in the application. The Department is adding a reference to the Department's website where the application can be accessed. The Department is further proposing to amend N.J.A.C. 11:24A-3.8(b) by deleting an outdated calendar reference.

N.J.A.C. 11:24A-4 sets forth provisions that are applicable to carriers offering managed care plans. Managed care plans essentially are network-based health benefits plans. The subchapter establishes additional disclosure requirements that carriers must provide to covered persons covered under a managed care plan, as well as to other consumers who might be interested in becoming covered under a managed care plan. These additional disclosures must include such information as the general method of compensation to health care providers, lists of in-network health care providers and their respective certifications and affiliations. The subchapter sets forth a requirement that the carrier designate a physician licensed to practice medicine in New Jersey to serve as the carrier’s medical director for the managed care plan’s UM program, and sets forth other duties for which the medical director, or the medical director’s designee, are responsible with respect to the managed care plan. These responsibilities include overseeing medical services when the managed care plan includes a gatekeeper system, provider credentialing functions, and methods by which network health care providers may have input in the carrier’s medical guidelines and protocols. The

subchapter requires the carrier to establish a complaint mechanism capable of addressing and resolving complaints presented by both covered persons and health care providers. The subchapter establishes standards for carriers in terms of their handling of applications from providers interested in participation in the carrier's network. The subchapter establishes standards and procedures that carriers must employ when terminating health care providers in certain circumstances, including some details about assuring that covered persons do not immediately lose access to terminating health care providers, particularly when the covered person is undergoing a course of treatment. The subchapter sets forth standards for network adequacy with respect to multiple categories of health care providers and certain health care services. The subchapter requires that carriers offering managed care plans have a UM program, including a UM appeal mechanism. While incorporating the same provisions applicable to HMOs in N.J.A.C. 11:24-3 with respect to the standards for the UM program and UM appeal process, the subchapter also adds specific requirements regarding access by covered members to their primary care providers. The subchapter requires carriers to have a continuous quality improvement program, and incorporates substantially the provisions of N.J.A.C. 11:24A-3 with respect to this subject. However, in addition, N.J.A.C. 11:24A-4 establishes standards for carriers to obtain independent evaluations of various aspects of their operations from quality review organizations. The subchapter also requires carriers to report quality outcome measures upon the request of the Department. The subchapter establishes certain standards for contracts between carriers and health care providers, whether the contracts are written directly or through

an intermediary party (vendor). The subchapter sets forth certain requirements for carriers to assure that at least some of the managed care plans they make available in the market do not require a gatekeeper system.

The Department is proposing to make some "housekeeping" changes to this subchapter, such as eliminating outdated calendar references that appear in some of the sections. The Department is also proposing to amend N.J.A.C. 11:24A-4.2 requiring carriers to make certain disclosures to covered persons. N.J.A.C. 11:24A-4.2(a) and (b) require a carrier to annually provide to covered persons a current directory of participating providers and information regarding its financial arrangements with its providers and the possible financial arrangements between its providers and the health care facilities with which the providers are affiliated. The Department is proposing to amend these subsections to require that carriers annually provide written notice to covered persons that this information is available on the carrier's website, along with instructions as to how the website can be accessed. The written notice will also notify those covered persons without internet access that, upon request, they may obtain the information from the carrier in writing. The Department is proposing to amend N.J.A.C. 11:24A-4.10, Network adequacy, by eliminating an outdated calendar reference and amending outdated references to the Department of Health and Senior Services. The Department is proposing to delete N.J.A.C. 11:24A-4.13(e) regarding the DHSS's establishment of a Healthcare Data Committee (HeDaC) to assist the DHSS in developing a performance measurement and assessment system for monitoring the quality of care provided to covered persons in various types of managed care plans.

The HeDaC has been inoperative for quite some time; accordingly, this subsection is outdated and no longer necessary. Consistent with the proposed elimination of N.J.A.C. 11:24A-4.13(e), the Department further proposes to delete current N.J.A.C. 11:24A-4.16(a), which sets forth the purposes for which the Department may use the information collected by the HeDaC. Finally, the Department is proposing to delete an outdated calendar reference at N.J.A.C. 11:24A-4.15(g).

N.J.A.C. 11:24A-5 sets forth general requirements for the IHCAP, focusing on the Department's operation of the IHCAP.

Because the Department has provided a 60-day comment period for this notice of proposal, this notice is excepted from the rulemaking calendar requirements pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

The Department's purpose in proposing to readopt the rules at N.J.A.C. 11:24A with amendments is to assure the continued implementation and interpretation of the HCQA, which governs this dynamic market with the main purpose of promoting consumer protection by assuring that consumers have access to appropriate providers and coverage for medically necessary covered services. The Department believes that the rules proposed for readoption with amendments will further the goals of the HCQA, as well as bring the tenets of the HCQA and its subsequent amendments in line with the tenets of the Health Maintenance Organization Act and its subsequent amendments (codified at N.J.S.A. 26:2J-2 et seq.), as well as the Organized Delivery Systems Act,

and its subsequent amendments (codified at N.J.S.A. 17:48H-1 et seq.). The Department believes that the rules proposed for readoption with amendments and repeals will have a positive social impact.

The proposed amendments and repeals will have no effect on the purpose for which these rules were originally adopted. Rather, most of the proposed amendments either merely remove outdated calendar and Department references or serve to streamline certain existing processes described in the chapter. One amendment eliminates the potential for preauthorization of emergency and urgent care services. Other amendments include removing a redundant filing process at N.J.A.C. 11:24A-2.2, which previously required carriers to submit an HCQA Registration Form to the Department even if the information on that form was already submitted to the Department by the carrier in an SCA application. The Department is also proposing to delete from the chapter's Appendix the Independent Health Care Appeals Program application form, and instead include a reference to the Department's website where the application may be accessed. The amendments also eliminate the requirement that carriers annually provide covered persons with a written directory of participating providers and written information about financial arrangements concerning the carrier's participating providers. This requirement is being replaced with a requirement that carriers provide annually a written notice to covered persons that this information is available on the carrier's website, and that covered persons without internet access may obtain the information in writing upon request. The Department anticipates that these changes will have a positive impact on carriers and covered persons alike. Eliminating

or streamlining the reporting and notice requirements imposed on carriers described above will make it less administratively burdensome and costly for carriers to comply with this chapter without reducing the quality of care currently provided to covered persons. Eliminating preauthorization requirements for emergency and urgent care services, and providing a less cumbersome and more efficient method of accessing provider directories, will positively impact covered persons.

Economic Impact

The Department believes that many carriers incurred some costs related to compliance with N.J.A.C. 11:24A. Most carriers have probably incurred increases in administrative costs associated with some of the disclosure requirements included in this chapter. The rules in this chapter closely mirrored what was already required for HMOs, and were similar to what was already in existence for non-HMO carriers through the SCA rules at N.J.A.C. 11:4-37. However, the rules in this chapter established some standards that were more detailed or stringent than those imposed by N.J.A.C. 11:4-37, such as requiring somewhat greater accountability in the utilization management and continuous quality improvement mechanisms that apply to managed care products. Also, the requirements regarding a two-stage internal appeal program were entirely new for non-HMO carriers. While carriers may have had mechanisms to address appeals of adverse utilization management and/or benefits decisions, those mechanisms were not necessarily structured in the manner that the rules of this chapter required. While the extent of the financial impact on any particular carrier depended substantially upon the business practices of the carrier prior to the adoption of this

chapter and any subsequent amendments, it is probably accurate to state that this chapter had at least some adverse economic impact upon carriers offering managed care products. However, it is also possible that the increased regulatory controls, combined with the requirement to enhance consumer and provider awareness, may have allowed some carriers to maintain or increase their market shares while still keeping some controls on medical costs, resulting in a positive economic impact for these carriers. The proposed amendments to this chapter should have a positive impact on carriers in that they eliminate certain redundant filing requirements and reporting and disclosure requirements, thereby reducing carrier costs. The amendment prohibiting preauthorization for emergency and urgent care services should not have a detrimental impact on carriers because it is only eliminating the potential for a covered person or provider to notify the carrier that they are seeking such services in advance, does not impact payment of benefits for those services, and conforms with Federal requirements.

The economic impact that N.J.A.C. 11:24A has had on health care providers and consumers is equally unclear, and probably can be best described as mixed. While the Department has no empirical data that directly links any cost increases or decreases to N.J.A.C. 11:24A, the Department believes that some modest increases in premiums may have been associated with the adoption of N.J.A.C. 11:24A, and, if so, such cost increases were probably due to increased administrative costs for carriers associated with compliance with this chapter. However, the Department also believes that there was (and continues to be) a positive economic impact felt directly by some consumers

and health care providers, and indirectly by others, resulting from the increased accountability and public awareness of the operations of carriers offering managed care products through greater controls on utilization management program standards, utilization management appeal programs (including the implementation of the Independent Health Care Appeal Program), and continuous quality improvement programs. The Department does not believe any substantial additional economic impact is likely to result from the readoption of N.J.A.C. 11:24A, although the Department acknowledges that the on-going costs of compliance will remain in effect for all current carriers as well as any new entrants into the market. Costs related to compliance with N.J.A.C. 11:24A that are currently being passed on by carriers to consumers and health care providers will likely continue to be passed on accordingly. No increase in the passing along of these costs is expected. The proposed amendments to this chapter should have no impact on health care providers or consumers.

The economic impact upon the Department in implementing and monitoring N.J.A.C. 11:24A has been modestly adverse. Given increased oversight responsibility with respect to those carriers offering managed care products, the Department now receives and investigates a number of complaints and appeals related to such carriers and their managed care products, and expends resources in those endeavors accordingly. These activities will continue with the readoption of N.J.A.C. 11:24A. The proposed amendments to this chapter are not likely to impact the Department.

Federal Standards Analysis

Covered persons have a right to appeal certain determinations by carriers pursuant to both Federal and State law. The United States Department of Labor (USDOL) proposed rules at 29 CFR 2560-503-1, pursuant to sections 503 and 505 of Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1133 and 1135, requiring that "employee benefit plan," as defined in ERISA, have in place reasonable claims procedures. The regulation became effective July 1, 2002 (and all coverage subject to the regulations was to be in compliance no later than January 2003). In accordance with the Federal regulation, a principal tenet for demonstrating a reasonable claim procedure is the ability of the claimant to appeal an adverse claim determination. Because of the manner in which the Federal regulations define "claim" and "group health plan," the Federal regulations and New Jersey's rules requiring carriers subject to the HCQA (including HMOs) to establish an internal UM appeal system, overlap in terms of their applicability, although there are areas in which each law applies distinctly. For instance, the Federal regulations do not apply to any coverage not otherwise subject to ERISA, while New Jersey rules do, and conversely, the State rules apply only to those products defined as health benefits plans, while the Federal regulations apply to other types of health coverage (for instance, disability policies).

The Federal regulations do not preempt State rules, except when compliance with the State rules would make it impossible for the regulated entity to comply with the Federal regulations as well. Paragraph 1e of New Jersey's Executive Order No. 2 signed by Governor Chris Christie on January 20, 2010, permits New Jersey State

agency rules to exceed the requirements of Federal law when required by State statute or in circumstances where exceeding the requirements of Federal law or regulation is necessary in order to achieve a New Jersey specific public policy goal. N.J.A.C. 11:24A currently contains some standards that are more stringent than the current USDOL regulations in order to strike a balance between those carriers that have to struggle to make their systems compliant with both the State and Federal laws, and those carriers that would not need to change their systems at all because of the Federal regulations. Accordingly, the current standards contained in N.J.A.C. 11:24A enable carriers to comply with those USDOL regulations and with the HCQA. Further, because the more stringent standards of N.J.A.C. 11:24A have been in place in New Jersey since at least May of 2000 (since 1997 with respect to HMOs), the Department does not consider the more stringent features as representing any particular hardship for carriers doing business in the State. However, as the Department stated in the Summary above, on July 22, 2010, the Obama Administration released interim final rules that allow patient appeals of health insurance coverage decisions as required under the Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148, enacted on March 23, 2010) and the Health Care and Education Reconciliation Act (Reconciliation Act) (Public Law 111-152, enacted on March 30, 2010). The Federal Departments of Health and Human Services, Treasury, and Labor are issuing regulations to implement the PPACA and the Reconciliation Act. Many of the rules currently included in N.J.A.C. 11:24A, while more stringent than current USDOL regulations, are less stringent than the new Federal requirements, and will need to be strengthened to comply with them.

While the Federal interim final rules implementing some of the requirements of the PPACA and the Reconciliation Act provide states with ample time to enact legislation and/or adopt rules that comply with the Federal requirements, other Federal requirements become effective more immediately. Consequently, the Department is proposing to amend N.J.A.C. 11:24A-4.11(b)2, which is in conflict with the Federal interim final rules that became effective on September 23, 2010 prohibiting preauthorization for emergency and/or urgent care services (See 26 CFR Parts 54 and 602, 29 CFR Part 2590 and 45 CFR Parts 144, 146 and 147, Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule, June 28, 2010). The Department intends to propose further amendments to this chapter in the future to comply with the more rigorous Federal requirements.

Jobs Impact

The Department does not anticipate that the rules proposed for readoption with amendments, or the proposed repeals, will result in the creation or loss of any jobs.

Agriculture Industry Impact

The Department does not expect the rules proposed for readoption with amendments, or the proposed repeals, to have any impact upon the agricultural industry.

Regulatory Flexibility Analysis

The rules proposed for readoption with amendments do impose certain reporting, recordkeeping and compliance requirements on carriers and it is possible, but not likely, that some carriers may be "small businesses" as that term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., in that they are resident in New Jersey, employ fewer than 100 people, and are not dominant in their industry. Accordingly, the Department is providing a Regulatory Flexibility analysis.

Numerous reporting, recordkeeping and compliance requirements are set forth within the rules at N.J.A.C. 11:24A, including the following: complaints data, appeals data, internal performance indicators, continuous quality improvement plans and revisions, external quality review organization reports, consumer and member disclosures, submission for review of forms of contracts for issue to contract holders, and forms of contracts with intermediaries and health care providers. The Department is proposing to amend some of these requirements as discussed above in the Summary and impact statements.

The Department does not believe that N.J.A.C. 11:24A as originally adopted, or as amended on readoption in 2005, required carriers to obtain professional services in order to comply with the rules. In general, the current rules address the on-going operational issues of the carriers with respect to one aspect of their business. The professional services that an entity might need to engage in order to comply with N.J.A.C. 11:24A are of a nature that such services should already be available to the carrier as a matter of its daily operations. Additionally, the proposed amendments will

alleviate to some extent certain reporting and recordkeeping requirements imposed by these rules.

As noted in the Economic Impact above, the Department has no certainty as to the costs a small business in this industry might incur as a result of compliance with N.J.A.C. 11:24A. While the Department speculates that most carriers, including ones that might be classified as small businesses, probably incur some costs in order to comply with N.J.A.C. 11:24A, there is no data available to the Department that tracks the costs of such compliance separate and apart from other costs related to the carriers' various operations.

The Department does not offer regulatory flexibility to carriers with respect to reporting, recordkeeping, or other compliance requirements, even when the carrier meets the definition of a "small business" because the Department does not believe that the resultant reduction in consumer protection is warranted or desirable. Further, the Department does not believe that such regulatory flexibility would be consistent with the legislative intent behind enactment of the HCQA, and that such flexibility may be prejudicial to the interests of consumers, health care providers, and the health care delivery system generally.

Smart Growth Impact

The Department does not expect the rules proposed for readoption with amendments, or the proposed repeals, to have any impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact

The Department does not expect the rules proposed for readoption with amendments, or the proposed repeals, to have any impact on housing affordability because the rules proposed for readoption with amendments and the proposed repeals address standards that must be met by certain health insurance carriers offering health benefits plans in New Jersey, particularly managed care plans and other health benefits plans with utilization management features.

Smart Growth Development Impact

The Department does not expect the rules proposed for readoption with amendments, or the proposed repeals, to evoke a change in the housing production in Planning Areas 1 and 2, or within the designated centers, under the State Development and Redevelopment Plan in New Jersey because the rules proposed for readoption with amendments and the proposed repeals address standards that must be met by certain health insurance carriers offering health benefits plans in New Jersey, particularly managed care plans and other health benefits plans with utilization management features.

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

Full text of the rule proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:24A-1.3 and 11:24A Appendix.

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

11:24A-2.2 HCQA Registration Form

(a) Carriers shall complete and submit to the Department the HCQA Registration Form, available from the Department upon request, describing, if required, the carrier's internal appeal process, by which covered persons, or a provider on behalf of a covered person (with the covered person's consent), may appeal a carrier's UM decision, and the carrier's notice to covered persons of the right to appeal a carrier's final UM decision to the Independent Health Care Appeals Program. **A carrier's Selective Contracting Arrangement (SCA) application filed with the Department pursuant to N.J.A.C. 11:4-37 shall meet the requirements of this section.**

1. – 3. (No change.)

(b) – (c) (No change.)

11:24A-2.7 Violations

(a) The Commissioner may issue an order directing a carrier to cease and desist from an act or omission that violates a provision of the rules of this chapter that are applicable to the carrier, which order shall serve as constructive written notice to the carrier of an intent to levy a penalty for the violation of the rules, notwithstanding that a specific statement to that effect is not included in the order, if the order is followed by a written notice in compliance with (b)3 below.

1. A carrier shall have the right to request a hearing on the order within 20 days following the date of service of the order on the carrier, which shall be conducted in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. (No change.)

ii. When requesting a hearing, the carrier shall notify [both] the Department [and the Department of Banking and Insurance] of the request, providing the information set forth in (a)1i above.

2. - 4. (No change.)

(b) – (c) (No change.)

11:24A-3.4 Utilization management program

(a) – (b) (No change.)

(c) The carrier shall provide access to UM services as follows:

1. (No change.)

[2. If the carrier requires preauthorization for use of emergency departments or for reimbursement of services rendered under an emergency or urgent situation, the carrier shall have a registered professional nurse or physician immediately available by phone seven days a week, 24 hours a day to render UM determinations to providers.]

(d) – (f) (No change.)

11:24A-3.6 Independent health care appeals process

(a) (No change.)

(b) To initiate an appeal through the Independent Health Care Appeals Program, a covered person or provider acting on behalf of a covered person with the covered person's consent shall, within 60 days from the date of receipt of the carrier's final determination, or the last date of filing of an appeal by the covered person or provider in the situation in which the covered person or provider acting on behalf of a covered person with the covered person's consent believes the carrier has failed to meet required time frames, file an application with the Department[, as set forth in Exhibit 1 of the chapter Appendix, incorporated herein by reference]. **The application form can be accessed on the Department's website at http://www.state.nj.us/dobi/chap352/352ihcapform.doc. The application requests the name of the covered person/subscriber, the person filing the appeal, the name of the provider, information regarding any prior appeal(s), a summary of the appeal issues and authorization by the covered person for release of information.**

1. – 2. (No change.)

(c) – (k) (No change.)

11:24A-3.8 Continuous quality improvement

(a) (No change.)

(b) [No later than June 30, 2000, a] **A** carrier shall set forth its system for its CQI program in a plan reviewable upon request by the Department specifying the following:

1. - 9. (No change.)

(c) – (f) (No change.)

11:24A-4.2 Disclosures to covered persons

(a) Carriers shall provide to a covered person no later than the effective date of coverage[, and at least annually thereafter] a current directory of participating providers. **Carriers shall, annually thereafter, provide written notice to covered persons that the carrier's current directory is available on its website, and provide instructions for accessing the website. Carriers' websites shall prominently display clear instructions as to how to access the directory. The notice shall also state that covered persons without internet access may obtain, upon request, a written current directory pursuant to the requirements set forth at N.J.A.C. 11:24A-4.3.**

1. - 5. (No change.)

(b) In addition to the requirements of N.J.A.C. 11:24A-2.3 and 3.2, a carrier shall provide a statement to covered persons in a handbook or certificate, no later than the effective date of the subscriber's coverage[, and at least annually thereafter,] regarding its financial arrangements with its providers, and the possible financial arrangements between its providers and the health care facilities with which the

providers are affiliated. **Carriers shall, annually thereafter, provide written notice to covered persons that the financial arrangements information is available on its website, and provide instructions for accessing the website. Carriers' websites shall prominently display clear instructions as to how to access the financial arrangements information. The notice shall also state that covered persons without internet access may obtain, upon request, written financial arrangements information pursuant to the requirements set forth at N.J.A.C. 11:24A-4.3.**

1. - 4. (No change.)

(c) – (f) (No change.)

11:24A-4.7 Provider application for participation

(a) [No later than August 29, 2000 a] **A** carrier shall establish a committee to review applications submitted by licensed providers to become members of the carrier's network.

1. - 4. (No change.)

(b) – (e) (No change.)

11:24A-4.10 Network adequacy

(a) [Except with respect to any selective contracting arrangement approved on or before May 1, 2000 pursuant to N.J.A.C. 11:4-37, a] **A** carrier shall maintain an

adequate network, as set forth in (b) below, of PCPs, specialists and other ancillary providers to assure that covered persons are able to access services in-network and take full advantage of the in-network benefits levels when the policy or contract specifies that there is a differential between the in-network and out-of-network benefits levels for one or more covered services, or the policy or contract is subject to a gatekeeper system.

1. - 2. (No change.)

(b) The carrier shall meet the following requirements for network adequacy:

1. - 2. (No change.)

3. For institutional providers, the carrier shall maintain contracts or other arrangements acceptable to the Department sufficient to meet the medical needs of covered persons, and maintain geographic accessibility of the services provided through institutional providers, subject to no less than the following:

i. - ii. (No change.)

iii. The carrier shall have a contract or otherwise agree to cover medically necessary trauma services at a reasonable cost with all Level I or II trauma centers designated by the Department **of Health and Senior Services**, with the provision of benefits at the in-network level.

iv. - v. (No change.)

vi. The carrier shall have a contract or arrangement with at least one home health agency licensed by the Department **of Health and Senior Services** to serve each county where 1,000 or more covered persons reside.

vii. (No change.)

(c) – (f) (No change.)

11:24A-4.11 Utilization management program

(a) (No change.)

(b) In addition to (a) above, the carrier shall comply with the following:

1. (No change.)

2. For contracts or policies in which emergency and/or urgent care services are covered, [and preauthorization may be required, the carrier shall establish a mechanism to ensure that covered persons have immediate access to their PCP or his or her authorized on-call back-up provider, and that all covered persons have access to a registered nurse or physician on the UM staff to respond to inquiries concerning emergency or urgent care seven days per week, 24 hours per day] **carriers shall not require covered persons or health care providers to obtain preauthorization for such services**.

11:24A-4.13 Continuous quality improvement

(a) – (d) (No change.)

[(e) The Department shall establish a Healthcare Data Committee (HeDaC) to assist the Department in developing a performance measurement and assessment system for monitoring the quality of care provided to covered persons as described in N.J.A.C. 11:24A-3.8, the quality of care provided to the covered persons of carriers subject to this subchapter, and the quality of care provided to members of HMOs.

1. The HeDaC shall include no more than 15 and no less than 12 members who shall be appointed by, and serve at the pleasure of, the Commissioner. The members shall include providers, consumers, at least four insurer representatives, no more than two HMO representatives, and two other persons representing the interests of carriers. In addition to the above, a representative of the New Jersey State Health Benefits Commission, the Departments and the Department of Human Services shall serve as additional ex-officio members. The HeDaC shall be chaired by the Commissioner or his or her designee. Additional experts may be invited to participate on an invitational ad hoc basis as needed.

2. The HeDaC shall advise the Commissioner on the development of a uniform data reporting system to obtain reliable, standardized and comparable information from all carriers subject to this subchapter, and HMOs. In the process of developing this system, the HeDaC shall address the following:

i. The relevance, validity and reliability of each measure selected to be an indicator of performance;

ii. The protection of confidentiality of patient-specific information;

iii. The cost and difficulty of data collection;

iv. The measures to reduce duplicative reporting of information to state agencies; and

v. The public release of data in formats useful to purchasers and/or consumers.

3. The HeDaC shall advise the Commissioner as to the data reporting established pursuant to (e)2 above that should be applicable to carriers that are subject to N.J.A.C. 11:24A-3.8, if any, and shall advise the Commissioner as to the appropriate data reporting to obtain from such carriers.]

11:24A-4.15 Minimum standards for provider contracts

(a) – (f) (No change.)

[(g) Provider agreements in effect on May 1, 2000 that are not in compliance with the requirements of this subchapter shall be deemed withdrawn on May 1, 2001.]

11:24A-4.16 Reporting of [quality outcome measures and] compensation arrangements

[(a) Carriers shall comply with the reporting requirements established by the HeDaC, which shall be promulgated by the Department in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., which shall include independent consumer satisfaction survey results and an analysis of quality outcomes of health care services.

1. The Department may use the information collected to:

i. Assist carriers and their providers in quality improvement efforts;

ii. Obtain information on the performance of carriers for regulatory oversight;

iii. Support efforts to inform consumers about carrier performance with respect to managed care health benefits plans;

iv. Promote the standardization of data reporting by carriers and providers; and

v. Any other purpose consistent with this chapter and N.J.S.A. 26:2S-1 et seq.

2. The performance and outcome measures shall include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction.

3. When possible, the performance measures shall be designed to incorporate data routinely collected or available to the Department from other sources.

4. When appropriate, the Department shall make statistically valid adjustments to account for demographic variations among carriers.

5. Carriers shall have an opportunity to comment on the compilation and interpretation of the data before its release to consumers.

6. Each carrier shall provide the Department with a mailing list of covered persons, upon request, so that the Department may conduct or arrange for periodic member satisfaction surveys using a select sample of the carrier' covered persons.

7. Carriers shall submit data established by the HeDaC and other information required by this subsection as the Department may request from time to time.

8. The Department shall ensure the confidentiality of patient-specific information, and shall make every attempt to reduce duplicative reporting of information to agencies in New Jersey.]

[(b)] **(a)** (No change in text.)