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December 12, 2019

FINAL ADMINISTRATIVE DETERMINATION

[redacted]

Re: The Plastic Surgery Center, PA

Dear Ms. D[redacted]:

At its meeting of November 20, 2019, the State Health Benefits Commission ("Commission") considered whether your client, The Plastic Surgery Center (the "Center"), has standing to appear before it to challenge the reimbursement for services provided by Dr. Andrew Elkwood and Dr. Lisa Schneider for services performed at the Center for M.K., a covered dependent and member of the State Health Benefits Program ("SHBP").

In a June 27, 2019 letter addressed to the Appeals Coordinator for the SHBC, your firm requested a Commission appeal on behalf of the Center, noting that all internal appeals to Horizon Blue Cross Blue Shield of New Jersey ("Horizon") had been exhausted. A response letter from the Appeals Coordinator dated July 11, 2019 stated that the Commission could not accept an appeal from a provider and/or attorney, as appeals must come from the member directly.

In a letter dated July 29, 2019, your firm advised the Appeals Coordinator for the SHBC of your disagreement with the determination that all appeals must come from the member. Your firm explained that the Center is the assignee for the member, M.K., and has the member's right to appeal adverse determinations. Your firm also asserted that pursuant to Karasina v. State, No. A-6338-08T1, 2010 N.J. Super. Unpub. LEXIS 2222 (App. Div. Sep. 8, 2010), medical providers are interested persons under the Administrative Procedures Act, N.J.S.A. 52:14B-1 to -25, and therefore have standing to appeal.

In a letter dated August 22, 2019, the Acting Secretary for the Commission stated that the Commission does not recognize an assignment of benefits as legal representation of the member and reasserted that providers do not have standing to appeal to the Commission, citing N.J.A.C. 17:9-1.3(a).

In a letter dated October 23, 2019 your firm stated that the response letter dated August 22, 2019 would be considered a Final Administrative Determination, and the Center would present the case the Superior Court of New Jersey, Appellate Division pursuant to Rule 2:2-3 (a)(2).

On October 30, 2019, the Center filed a notice of appeal with the Appellate Division based on the August 22 2019 letter, which you state was not received until September 30, 2019.

At the regularly scheduled Commission meeting, on November 20, 2019, the Commission considered the Center's request to appeal the reimbursement and your presentation on behalf of the Center, where you reasserted the positions in the July 29, 2019 letter, and also cited Gregory Surgical Services, LLC v. Horizon Blue Cross Blue Shield of New Jersey, Inc., No. 06-0462, 2009 U.S. Dist. LEXIS 22182 (D.N.J. Mar. 18, 2009), and Kindred Hospitals East, LLC v. Horizon Healthcare Services, Inc., No. 17-8467, 2019 U.S. Dist. LEXIS 24960 (D.N.J. Feb. 14, 2019). After consideration, the Commission voted to deny the Center's request for standing to appeal before the Commission

Thereafter, the Commission directed the Secretary to draft a Final Administrative Determination for its consideration. The Commission herein sets forth its findings of fact and conclusions of law and issues this Final Administrative Determination

Findings of Fact

The SHBP offers a Preferred Provider Organization (PPO) plan called NJ DIRECT, which is a self-insured plan administered by Horizon Blue Cross Blue Shield of New Jersey ("Horizon"). In accord with the contract between Horizon and the SHBP, Horizon offers plan participants a network of providers from whom they may select their care. These providers include in-network doctors, in-network hospitals and other medical providers who provide services to participants pursuant to the terms of the plan. Horizon provides this network of providers to the SHBP by entering contracts with individual hospitals, physicians and other providers for their services. In-network providers are under contract with Horizon to provide services to NJ DIRECT participants at the agreed upon charge that has been negotiated between them. These rates are discounted from the provider's normal charge and the provider must agree not to charge the patient the difference between these amounts (balance billing).

There are many benefits to plan participants and the SHBP when medical services are provided by in-network providers. Benefits are provided at lower cost to the plan and its members, there is no balance billing to members, and the plan maintains oversight of participating providers to ensure quality medical care is offered. In return, providers are paid directly by the plan for their services and they benefit from increased patient volume as a result of referrals from the plan. Participating providers are also permitted to request a claims review directly from the plan. While NJ DIRECT is a PPO that provides the participants with less costly care when an in-network provider is selected, the plan also allows members the option of using out-of-network providers subject to the member's payment of co-insurance and limited to the reimbursement of reasonable and customary costs. As stated on page 23 of the NJ DIRECT Member Guidebook ("Guidebook") for Plan Year 2019:

> NJ DIRECT includes an option for using out-of-network providers. When you exercise this out-of-network option, you will be responsible for deductibles and a percentage of coinsurance based on a reasonable and customary fee schedule, and any amount exceeding the reasonable and customary allowances for all services.

Members who choose to utilize out-of-network providers are responsible for any amounts exceeding the reimbursement provided by NJ DIRECT, as stated on page 19 of the Guidebook, under the section entitled Reasonable and Customary Allowances (for Out-of- Network Services):

> Except where noted, NJ DIRECT covers only reasonable and customary allowances, which are determined by the FAIR Health benchmark charge data or a similar nationally recognized database. This schedule is based on actual charges by physicians in a specific geographic area for a specific service. In other instances, such as Ambulatory Surgery Centers (ASC's), the NJ DIRECT ZERO and the CWA Unity DIRECT, CWA Unity DIRECT2019, NJ DIRECT and NJ DIRECT2019 plans, the out-of-network allowance is derived from an alternate nationally recognized source, based on a percentage of the Centers for Medicare and Medicaid Services ("CMS") allowance. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay.
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> In some instances the out-of-network allowance is derived from an alternate nationally recognized source. One example is Ambulatory Surgery Centers ("ASC's"). The out-of-network plan allowance used for ASC's is based on a percentage of the Centers for Medicare and Medicaid Services (CMS) allowance.

Out-of-network providers are not limited in the amount that they may charge plan members for their services. There are very few market forces that limit what an out-of-network provider can charge. Because these charges can become inflated, the plan's reimbursement to non-participating providers at 70-80% of the reasonable and customary allowance, is often significantly more than what is provided for the same service performed by their in-network counterparts. Further, allowing out-of-network providers to appeal reimbursement amounts undermines Horizon's ability to recruit in-network providers. If a provider can appeal to receive additional payments beyond what the plan prescribes, it removes one of the important incentives for providers to participate in the network.

Additionally, because a charge based system is used to generate reasonable and customary allowances, there is an incentive for out-of-network providers to artificially inflate charges beyond their reasonable cost. Furthermore, if out-of-network providers do not pursue collection of copayments or coinsurance, the cost differential to members between using in-network and out-of-network providers is negated thus undermining an important element of plan design.

The reasonable and customary allowance for out-of-network ASCs has been set by the SHBC at 160% of the CMS allowance. The Center does not contract with Horizon and is therefore considered an out-of-network provider for NJ DIRECT members. Members who choose to have services performed at the Center have the option of having those services performed at an in-network hospital. In selecting to have the services performed at the Center, the member chooses to be responsible for the co-insurance and any charge above the reasonable and customary allowance.

On December 16, 2014, member M.K. underwent a surgical procedure at the Center, the reimbursement of which is the subject of this appeal. After the First-Level and Second-Level Medical Appeal of Claim Denials were exhausted through Horizon, an External Review was completed on June 28, 2018. Then, on

June 27, 2019, the Center requested an appeal to the Commission, as the assignee of M.K., and on its own behalf. By letter dated July 29, 2019, an assignment of benefits agreement between M.K. and the Center dated September 17, 2014 was submitted as evidence that the Center is the assignee of M.K. in regards to the claim at issue. The member, M.K., has not requested an appeal to the Commission.

On November 20, 2019, the Commission voted to deny the Center standing to request an appeal regarding the reimbursement for the December 16, 2014 procedures. At which time the Commission directed the Secretary to draft a Final Administrative Determination for its consideration.

Conclusions of Law

The Commission reached the following conclusions of law:

First, the Center does not have standing to bring an appeal on behalf of the member based on an assignment of benefits. As an initial matter, the Commission cannot accept, without more, the proffered assignment of benefits as proof that the member assigned all rights to receive payment for the December 16, 2014 procedure to the Center. The assignment is a general, boilerplate agreement dated September 17, 2014, three months before the December 16, 2014 procedure that lacks specificity and is not time-limited. Regardless, even if the Commission could accept the assignment as evidence of assignment of this claim, the Commission does not recognize an assignment of benefits as legal representation of a member.

N.J.S.A. 52:14-17.29 provides that when a member of the SHBP chooses to use the services of an out-of-network provider, such as the Center, "the participant shall receive reimbursement . . . at the rate of 70% of reasonable and customary charges." (emphasis added). This plain statutory language requires reimbursement be made only to SHBP members and thus does not permit the assignment of claims to providers.

Further, in accordance with the SHBP's contract with Horizon, assignments of benefits are not permitted. The Commission contracts with health insurers and offers various benefit plans to program participants. See N.J.S.A. 52:14-17.29; N.J.S.A. 52:14-17.28. The statute provides that the Commission has discretion to "negotiate with and arrange for the purchase, on such terms as it deems to be in the best interests of the State and its employees...contracts providing hospital, surgical, obstetrical, and other covered health care services and benefits..." N.J.S.A. 52:14-17.28(a). The Commission offers participants in the SHBP the option to select a medical plan from among several options. The plans offered are subject to certain mandatory coverages and applicable co-pays, deductibles and maximums as set forth in the governing law, the Commission's regulations and the various Plan Guidebooks. The Commission is not required to provide the same benefits as private insurers, nor is every medical service or supply required of private insurers to be provided under the plan. The Commission, being vested with the exclusive authority and jurisdiction to determine the extent and limitations of coverage, is restricted in its discretion only by the legislative purpose of the health benefits statute and certain coverages that are statutorily required.

Pursuant to a contract between Horizon and the SHBC, Horizon is responsible for the payment of claims in accord with the governing law, the Commission's regulations and the Plan Handbook. Under N.J.A.C. 17:9-2.14, the Commission has adopted by reference all of the policy provisions in the contract "to the exclusion of all other possible coverages. The plan handbook supplements the master contracts and

contains the specific provisions for services to be covered and those which are excluded. No benefits may be paid unless they are "stipulated in the contracts held by the [Commission]." N.J.S.A. 52:14-17.29(D).

The Guidebook provides, on page 52 under the heading "Authorization to Pay Provider" that "[t]he member will be paid for all services rendered by non-participating providers." (emphasis added). Thus, the contracts provide for payment directly to the member and, in affirmatively stating the method of payment, prohibits an assignment of the right to be paid to an out-of-network or non-participating provider. Such non-assignment clauses have been affirmed by the Appellate Division. See Somerset Orthopedic Associates v. Horizon, 345 N.J. Super. 410 (App. Div. 2001); N.J. Dental Ass'n v. Horizon, No. A-4449-10T1, 2011 N.J. Super. Unpub. LEXIS 3076 (App. Div. Dec. 20, 2011). In Somerset, the court explained the important public policy reasons for prohibiting assignments:

> Horizon's ability to control costs and hence provide affordable health care coverage is directly related to the number of medical providers participating in its program. Thus, inherent in its statutory mandate to control costs is a directive to Horizon to encourage broad participation in its network of plan medical providers. Undoubtedly, non- profit health service corporations such as Horizon rely on anti-assignment clauses as an important inducement to medical providers to join their insurance networks. Obviously, medical providers would have less reason to join if non-participating physicians could garner the same advantages without subjecting themselves to the contractual constraints. Indeed, such a "participation inducement" has been widely recognized by courts of other states that have considered [this] precise issue…
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> [Id. at 421].

Thus, with regard to the ability to assign the benefit to be paid, the SHBP plan document and the law are clear that no assignment is permitted and the Center does not have standing to appeal the reimbursement amount on behalf of the member.

Second, the Center does not have standing in its own right as a provider to bring an appeal before the Commission. Only members can appear before the Commission, as stated in the regulations governing the program and the Guidebook and affirmed in In re A Declaratory Ruling from the State Health Benefits Commission, No. A-3402-12T2, 2015 N.J. Super. Unpub. LEXIS 392 (App. Div. Feb. 27 2015). N.J.A.C. 17:9-1.3(a), in relevant part, states:

> Any member of the SHBP who disagrees with the decision of the claims administrator and has exhausted all appeals within the plan, may request that the matter be considered by the Commission.

The term "member" is defined in N.J.A.C. 19:9-1.8 as "any individual covered under the SHBP, regardless of whether the person is a subscriber or a dependent." The Guidebook on page 53, under the section entitled "First Level Medical Appeal" states that the "member, physician, or authorized representative" may request an internal medical appeal to Horizon. This process is further explained in the State Health Benefits Program Medical Appeals Procedure Claims Policy brochure, which covers "[members], physicians or other authorized representatives acting on behalf of the member with the member's written

consent to pursue an appeal of any adverse benefit determination involving medical judgment." Further, the Guidebook states, on page 59, under the section entitled Commission Appeals states:

> Once all appeal options have been exhausted through Horizon BCBSNJ, the member may appeal to the State Health Benefits Commission/School Employees' Health Benefits Commission (Commission). If dissatisfied with a final Horizon BCBSNJ decision on an administrative appeal, you have one (1) year following receipt of the initial adverse benefit determination letter to request a Commission Appeal. Only the member or the member's legal representative may appeal, in writing, to the Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Thus, internal medical appeals to Horizon are only available to the member or, if an adverse determination involves medical judgment, then a physician acting on behalf of the member with written consent from the member. A physician may not appeal on their own behalf to Horizon. Commission appeals are only available to the member and not a physician in any capacity.

The public policy of the SHBP further supports the conclusion that the Center does not have standing to appeal to the Commission. "The purpose of the [SHBP] is to provide comprehensive health benefits for eligible public employees and their families at tolerable cost." Heaton v. State Health Benefits Comm'n, 264 N.J. Super. 141, 151 (App. Div. 1993). NJ DIRECT is designed to encourage the use of in-network providers by not requiring payment of co-insurance and providing for no balance billing to members. The SHBP has a significant policy interest in ensuring that the plan design and coverage provisions for out-of-network providers is enforced and that members pay the co-insurance to their out-of-network providers. Here, the members who responded to Horizon's inquires reported that they were not balance billed by the Center and that the Center represented to them that it would accept whatever payment was received from the SHBP as payment in full for the services rendered. Such practices undermine the public policy expressed by the Legislature as they eliminate the financial incentives to use in-network providers and increase the cost of the plan for all SHBP members and public employers alike. Thus, to grant standing to an out-of-network provider that allows it to appeal a reimbursement policy that the member is not objecting to would be inimical to the purpose of the SHBP, and may even serve to facilitate fraud against the program by permitting providers and members to consort to waive the co-insurance requirements set forth under the governing law.

In support of your argument that the Center has standing to bring an appeal before the Commission you cite Karasina, 2010 N.J. Super. Unpub. LEXIS 2222, Gregory Surgical Services, 2009 U.S. Dist. LEXIS 22182, and Kindred Hospital East, 2019 U.S. Dist. LEXIS 24960. However, your reliance on these cases does not establish that the Center has standing before the Commission. First, the cited cases are unpublished and not binding on the Commission. Second, the cited case are inapplicable to this determination because they do not address the question of whether a provider has standing before the Commission. Rather, they concern dismissal for failure to exhaust administrative remedies of an out-of-network provider's claim against Horizon, in connection with treatment of an SHBP member, where no appeal had been brought before the Commission. This distinction is important because a right for an out-of-network provider to an appeal before the Commission does not follow merely because an administrative remedy exists.

For example, you argue that based on Karasina, the Center is an "interested person" under the Administrative Procedures Act ("APA") and therefore has standing to appeal adverse decisions. However, as noted by the court in Karasina, the APA provides that "an agency upon the request of any interested person may in its discretion make a declaratory ruling with respect to the applicability to any person, property or state of facts of any statute or rule enforced or administered by that agency." 2010 N.J. Super. Unpub. LEXIS 2222, at *4 (citing N.J.S.A. 52:14B-8). The Center has made no such request for a declaratory ruling. Further, even if there was request for a declaratory ruling, the Commission has discretion and may decline to hear a petition for declaratory relief or may render an adverse decision, whereby the Center may seek review in the Appellate Division. Id. at *5. These are the administrative remedies available to the Center as recognized by the court in Karasina. Ibid. None of these remedies provide the provider a right of appeal to the Commission. Therefore, whether the Center is or is not an "interested person" under the APA does not provide it with standing before the Commission for appeal of an initial decision, as opposed to judicial review of a final decision. See In re Camden County, 170 N.J. 439, 446-48 (2002) (noting that a person who has suffered economic detriment as a result of an administrative agency action can gain standing for judicial review of the agency's final decision).

Likewise, the decision in Gregory Surgical Services and Kindred Hospital East do not apply to this appeal because they only address failure to exhaust administrative remedies and do not address standing before the Commission for appeal of an initial decision.

Based on the above findings of facts and conclusions of law, the Commission has concluded that the Center does not have standing to come before the Commission as a provider or as the assignee of member benefits to appeal the reimbursement made to SHBP members for services provided by the Center.

The Commission is able to reach its findings of fact and conclusions of law, based on the foregoing undisputed facts and the foregoing conclusions of law, without the need for an administrative hearing. Accordingly, this correspondence shall constitute the Final Administrative Determination of the State Health Benefits commission.

You have the right, if you wish, to appeal this final administrative action to the Superior Court of New Jersey, Appellate Division within 45 days of the date of this letter in accordance with the Rules Governing the Courts of the State of New Jersey.

Sincerely,

Nicole Ludwig

Nicole Ludwig
Acting Secretary
State Health Benefits Commission