New Jersey Doctor-Patient Alliance
PO Box 12
Franklin Lakes, NJ 07417
(973) 942-1315
www.doctorpatientalliance.org

October 31, 2017

BY ELECTRONIC (legsregs@dobi.nj.gov) AND CERTIFIED DELIVERY
Denise M. Illes
Chief – Office of Regulatory Affairs
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

Re: Proposed Amendments to N.J.A.C. 11:24 and N.J.A.C. 11:24A (PRN 2017-230)

Dear Chief Illes:

The New Jersey Doctor-Patient Alliance ("NJDPA") appreciates this opportunity to submit comments on the proposed amendments to N.J.A.C. §§ 11:24 and 11:24A as presented in PRN 2017-230 on September 5, 2017 (the "Proposed Amendments"). By way of background, NJDPA is a not-for-profit social welfare organization representing doctors across all specialties, medical professionals, and their patients.

The NJDPA currently has over 170 licensed physicians as members who all share in DOBI's concern with network adequacy and enhancing patient access to high quality health care. With these goals in mind, it is NJDPA's belief that gaps in coverage should not exist in commercial health care plans. If such gaps exist, it is incumbent upon the HMO or carrier to ensure that its networks are adequate and that beneficiaries and participants have reasonable access to quality health care. Regrettably, not all HMOs or carriers take this obligation seriously enough to outweigh their own fiscal concerns, and opt instead to withhold payments from the provider, leaving the beneficiary vulnerable to being balance-billed while adverse benefit determination appeals are being pursued, thereby creating a potential conflict between the representative provider and the patient during the course of said appeals. This all-too-common situation necessitates action on part of DOBI to regulate and require external review of network inadequacy claims as it is both a consumer protection and patient care concern.

NJDPA believes that it shares many common goals with DOBI in ensuring that commercial provider networks are adequate and accessible, and looks forward to partnering with the agency to ensure patients receive the high level of benefits to which they are entitled. In this spirit, NJDPA submits our comments below related to the Proposed Amendments to N.J.A.C. §§ 11:24 and 11:24A as presented in PRN 2017-230:

I. Establish Specific Standards for Appealing "In-Plan Exceptions"

NJDPA applauds DOBI's efforts to provide an avenue of recourse for "in-plan exception" denials by expressly amending the definition of "adverse benefit determination" to include the

New Jersey Doctor-Patient Alliance
PO Box 12
Franklin Lakes, NJ 07417
(973)942-1315
www.doctorpatientalliance.org

denial of a request for an in-plan exception. It is reasonably clear from the language of the Proposed Amendments that it is DOBI's intent to subject denials of "in-plan exceptions" to the internal and external appeals processes already guaranteed under state and federal law. Functionally speaking, what this means is that patients may appeal denials of "in-plan exceptions" sought in good faith through the process of appealing adverse benefits determinations established under, inter alia, N.J.A.C. §§ 11:24-8.4 and 11:24A-3.5, et seq.

However, NJDPA is concerned that without express language setting forth specific requirements in appealing a plan's denial of an "in-plan exception" as a new type of adverse benefit determination, carriers and HMOs will simply adopt rules and practices in evaluating good faith appeals which work to undermine and frustrate the appeals process. As such, NJDPA proposes two (2) essential requirements for DOBI to consider including in promulgating regulations for the "in-plan exception".

1. *Amend N.J.A.C. § 11:24-8.4 and N.J.A.C. § 11:24A-3.5 to require carriers and HMOs to maintain the status quo by providing interim coverage of treatment when faced with good faith appeals of "in-plan exception" denials unless and until such appeals are fully exhausted.*

Carriers and HMOs already have an obligation by law to provide, at a minimum, adequate networks to serve their respective enrolled member populations at all times. See generally 45 C.F.R. §§ 156.230, N.J.A.C. §§ 11:24-6.2 and N.J.A.C. §§ 11:24A-4.10, et seq. (providing for minimum network adequacy standards). If a member requests an "in-plan exception" in good faith because the member or its representative has a good faith basis to believe that the HMO or carrier's network "does not have providers who are qualified, accessible, and available to perform the medically necessary covered service," then the member's good faith request should not unreasonably delay their ability to receive treatment on a covered basis while avenues of appeal are pursued. Requiring a patient to pay the out-of-network cost-sharing amounts would pose an insurmountable burden to many individuals, and this could negatively impact the patient's health.

To address this concern, NJDPA recommends that DOBI amend N.J.A.C. § 11:24-8.4 and N.J.A.C. § 11:24A-3.5 to provide that once the request for an "in-plan exception" is denied and becomes an adverse benefit determination, the member shall nevertheless receive medically necessary covered services on a prospective, "in-network" basis (i.e., the same level of cost-sharing as with a participating provider) unless and until the internal and external appeals process is fully exhausted. Moreover, because the ongoing burden is on the HMO or carrier to demonstrate network adequacy at all relevant times, NJDPA recommends that DOBI require HMOs and carriers to demonstrate from the beginning of the appeals process that their networks are adequate with respect to the insured at issue. Carriers or HMOs can demonstrate this by providing verifiable documentary support evidencing that such networks are "adequate" during Stage 1 or Stage 2 appeals.

NEW JERSEY DOCTOR-PATIENT ALLIANCE

New Jersey Doctor-Patient Alliance
PO Box 12
Franklin Lakes, NJ 07417
(973)942-1315
www.doctorpatientalliance.org

Unless and until the HMO or carrier satisfies its burden of proof that its networks are indeed adequate to serve the appealing member, it is NJDPA's belief that such members (and by extension their providers) who request the exception in good faith should be held harmless from incurring greater costs than if the service was obtained from in-network providers during the appeals process. To do otherwise would place significant undue pressure on patients to entirely forego utilizing out-of-network providers due to unreasonable delays even where there is no other "qualified, adequate, and available" in-network provider, thereby undermining the spirit of the Proposed Amendments and the issues they seek to redress.

2. Promulgate rules which ensure disclosure of relevant network adequacy documentation during appeals

Another difficulty universally experienced by patients and their representative providers in appealing "in-plan exception" denials is being denied access to documentation relevant to the question of network adequacy. There has already been significant litigation over whether carriers or HMOs must turn over documentation to providers (and by extension their patients) which evidence the methodology used by such HMO or carrier to determine network adequacy, notwithstanding the HMO or carrier's argument that such documentation contains confidential and proprietary information. See, e.g., Capital Health Sys., Inc. v. Horizon Healthcare Servs., Inc., 230 N.J. 73, 83, 165 A.3d 729, 735 (2017) (overturning Appellate Division's rescission of discovery orders compelling production of relevant, but otherwise confidential, documentation related to, among other things, network adequacy concerns). Currently, the language contained in N.J.A.C. § 11:24-8.4(c) and N.J.A.C. § 11:24A-3.5(f), is very broad and non-specific as follows: "[a] carrier [or HMO] must provide the covered person and/or the provider acting on behalf of the covered person, free of charge, with any new or additional evidence or rationale, which will be relied upon, considered or utilized, or generated by the carrier [or HMO] (or at the direction of the carrier [or HMO]) in connection with the pre-service or post-service claim."

In the context of appealing network adequacy challenges or "in-plan exception denials", such non-specific language is not enough to guarantee that the covered person or provider is provided with a reasonable opportunity to respond prior to when the final internal adverse benefit determination is provided. As such, NJDPA recommends that the Proposed Amendments specify the type of documentation that must be reasonably produced to patients and their providers as to network adequacy. For starters, such documentation should include the type of documentation relied upon by DOBI in approving the carrier's or HMO's plan pursuant to N.J.S.A. § 26:2S-18, including such documentation relied on by DOBI in evaluating the carrier or HMO's compliance with N.J.A.C. §§ 11:24-6.2 and/or N.J.A.C. §§ 11:24A-4.10, et seq.

II. Defining What Constitutes a "Qualified, Accessible, and Available" Provider

As a threshold matter, NJDPA is aware of the network adequacy standards provided by regulation in N.J.A.C. §§ 11:24-6.2 and/or N.J.A.C. §§ 11:24A-4.10, et seq. However, those

New Jersey Doctor-Patient Alliance
PO Box 12
Franklin Lakes, NJ 07417
(973)942-1315
www.doctorpatientalliance.org

standards to not provide sufficient guidance as to the meaning of a "qualified, accessible, and available" provider. For example, it is clear that "the carrier shall have a sufficient number of the medical specialists, as applicable to the services covered in-network, to assure access within 45 miles or one-hour driving time, whichever is less, of 90 percent of covered persons within each county or approved sub-county service area." N.J.A.C. § 11:24A-4.10(b)(2). Unfortunately, this standard relates only to *general* vs. specific network adequacy requirements. In practice, what is accessible to a 35-year-old patient, may not be accessible to an 85-year-old patient. Furthermore, if a patient had a previously negative experience with the only in-network provider near her home, it would seem that the provider, though physically available, is not practically available to the patient. There are subjective determinations that should be considered in the interests of patient care that should be recognized by the Proposed Amendments. The network may be seen as "adequate" from the carrier's perspective based on the standards contained in N.J.A.C. §§ 11:24-6.2 and/or N.J.A.C. §§ 11:24A-4.10, et seq., but certainly not from the patient's perspective who is left without adequate coverage in their particular situation.

As such, it is of paramount importance that DOBI clarifies or specifically defines exactly what constitutes a "qualified, accessible, and available" provider, and NJDPA urges DOBI to adopt definitions which employ a mixed objective-subjective standard that focuses on the individual patient's point of view in appealing adverse benefit determinations for denials of "in-plan exceptions." In the absence of such definitions, it is NJDPA's understandable fear that HMOs and carriers will define such terms differently and to their sole benefit, thereby creating uneven standards which are designed in part to ensure that "in-plan exception" denial appeals are less effective at preventing and correcting bona fide gaps in medically necessary coverage for individual patients.

III. Conclusion

Again, NJDPA greatly appreciates efforts by DOBI to provide new administrative avenues of enforcing the obligations assumed by HMOs and carriers to provide adequate provider networks for their members. NJDPA believes that the Proposed Amendments, while a significant and substantial step in the right direction, should be improved with the two following recommendations: (1) establishing specific, uniform rules and standards in appealing "in-plan exception" denials during the appeals process, such as requiring interim coverage of continuing services until full exhaustion of the appeals process; and (2) expressly defining what constitutes a "qualified, accessible, and available provider" from the individual patient's viewpoint in bringing good faith appeals of such denials.

Respectfully submitted,

Daniel B. Frier
Daniel B. Frier, Esq
Counsel for NJDPA

Respectfully submitted,

Peter H. DeNoble, M.D.
Peter H. DeNoble, M.D.
President, NJDPA