ORDER NO. E17-108

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

Proceeding by the Commissioner of Banking and Insurance, State of New Jersey, to fine, suspend and/or revoke Horizon Healthcare Services, Inc. and Horizon Healthcare of New Jersey, Inc.	)))))	CONSENT ORDER

TO: Horizon Healthcare Services, Inc.
Horizon Healthcare of New Jersey, Inc.
3 Penn Plaza East
Newark, NJ 07105

This matter, having been opened by the Commissioner of Banking and Insurance ("Commissioner"), State of New Jersey, upon information that Horizon Healthcare Services, Inc. ("Horizon HSC") and Horizon Healthcare of New Jersey, Inc. ("Horizon HMO") (collectively "Horizon"), may have violated various provisions of the insurance laws of the State of New Jersey; and

WHEREAS, Horizon HSC is a health service corporation authorized to transact business since February 4, 1986 pursuant to N.J.S.A. 17:48E-1 et seq.; and

WHEREAS, Horizon HMO is a health maintenance organization authorized to transact business since May 1, 1986 pursuant to N.J.S.A. 26:2J-1 et seq.; and

WHEREAS, N.J.S.A. 26:2S-11 established the Independent Health Care Appeals Program ("IHCAP") to provide an independent medical necessity or appropriateness of services review of final decisions of carriers to deny, reduce or terminate benefits in the event the final

decision is contested by the covered person or any health care provider acting on behalf of the covered person but only with the covered person's consent; and

WHEREAS, N.J.S.A. 26:2S-12c provides, in pertinent part, that if the IHCAP decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found to be medically necessary covered services; and

WHEREAS, N.J.A.C. 11:24-8.7(k) and 11:24A-3.6(j)2 provide that a health maintenance organization and a carrier shall provide benefits (including payment of the claim) pursuant to the IHCAP decision without delay; and

WHEREAS, N.J.S.A. 17:48E-10.1d(1) provides that a health service corporation shall remit payment for every insured claim no later than the 30th day following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. 1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th day following receipt if the claim is submitted by other than electronic means, provided the health care provider is eligible on the date of service, the person who received the health care service was covered on the date of service, the claim is for a service or supply covered under the health benefits plan, the claim is submitted with all the information requested on the claim form or in other instructions that were distributed in advance to the health care provider or covered person pursuant to N.J.S.A. 17B:30-51, and the health service corporation has no reason to believe that the claim has been submitted fraudulently ; and

WHEREAS, N.J.S.A. 26:2J-8.1d (1) provides that a health maintenance organization shall remit payment for every insured claim no later than the 30th day following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. 1395u(c)(2)(B), whichever is earlier, if the claim is submitted by

electronic means, and no later than the 40th day following receipt if the claim is submitted by other than electronic means, provided the health care provider is eligible on the date of service, the person who received the health care service was covered on the date of service, the claim is for a service or supply covered under the health benefits plan, the claim is submitted with all the information requested on the claim form or in other instructions that were distributed in advance to the health care provider or covered person pursuant to N.J.S.A. 17B:30-51, and the health maintenance organization has no reason to believe that the claim has been submitted fraudulently ; and

WHEREAS, N.J.S.A. 17:48E-10.1d(9) provides that an overdue payment of a claim by a health service corporation shall bear simple interest at the rate of 12% per annum and that interest shall be paid to the health care provider at the time the overdue payment is made; and

WHEREAS, N.J.S.A. 26:2J-8.1d(9) provides that an overdue payment of a claim by a health maintenance organization shall bear simple interest at the rate of 12% per annum and that interest shall be paid to the health care provider at the time the overdue payment is made; and

WHEREAS, N.J.S.A. 17B:30-13.1b defines an unfair claim settlement practice to include failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies; and

WHEREAS, N.J.S.A. 17B:30-13.1c defines an unfair claim settlement practice to include failing to adopt and implement reasonable standards for the prompt investigations of claims arising under insurance policies; and

WHEREAS, N.J.S.A. 17B:30-13.1d defines an unfair claim settlement practice to include refusing to pay claims without conducting a reasonable investigation based upon all available information; and

WHEREAS, N.J.S.A. 17B:30-13.1f defines an unfair claim settlement practice to include not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonable clear; and

WHEREAS, N.J.S.A. 17B:30-13.1n defines an unfair claim settlement practice to include failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and

WHEREAS, N.J.S.A. 17B:30-54 provides that a payer, or payer's agent, shall reimburse a hospital or physician according to the provider contract for all medically necessary emergency and urgent care health care services that are covered under the health benefits plan including all tests necessary to determine the nature of an illness or injury; and

WHEREAS, N.J.S.A. 17B:30-53a(1) provides, in pertinent part, that when a hospital or physician complies with the provisions of N.J.S.A. 17B:30-52, no payer, or payer's agent, shall deny reimbursement to a hospital or physician for covered services rendered to a covered person on grounds of medical necessity in the absence of fraud or misrepresentation if the hospital or physician requested authorization from the payer and received approval for the health care services delivered prior to rendering the service; and

WHEREAS, N.J.A.C. 11:24-8.5 provides that a health maintenance organization shall conclude a stage 1 appeal as soon as possible in accordance with the exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergency care, an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility and 10 calendar days in case of all other appeals; and

WHEREAS, N.J.A.C. 11:24A-3.5(k)3 provides that a carrier shall conclude a stage 2 appeal of an adverse benefit determination as soon as possible after receipt of the appeal by the carrier in accordance with the medical exigencies of the case, but in no event shall the time to conclude the stage 2 appeal exceed 72 hours in the case of appeals of determinations regarding urgent or emergent care, an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility, and which in no event shall exceed 20 business days in the case of all other appeals; and

WHEREAS, N.J.S.A. 17:48E-36a provides, in pertinent part, that the Commissioner may address inquiries to any health service corporation or its officers in relation to its condition of affairs, or any matter connected with its transactions, and it shall be the duty of the officers of the corporation to promptly reply in writing to all inquiries; and

WHEREAS, the Department received several complaints in 2016 and 2017 alleging that Horizon HSC failed to comply with decisions of the IHCAP reversing claim and/or prior authorization denials issued by Horizon HSC; and

WHEREAS, the Department's investigation revealed that in 22 instances Horizon HSC failed to promptly comply with IHCAP decisions reversing the company's claim and/or prior authorization denials ("IHCAP reversals"), with an average delay of 128 days in those instances, contrary to N.J.S.A. 26:2S-12c, N.J.S.A. 17:48E-10.1d(1), N.J.S.A. 17B:30-13.1f and N.J.A.C. 11:24A-3.6(j)2; and

WHEREAS, the cases involving failure to comply with IHCAP reversals were primarily handled by Horizon HSC's vendor for mental health and substance use disorder, Beacon Health Options, a licensed organized delivery system; and

WHEREAS, Horizon HSC failed to properly compute interest on claims paid following IHCAP reversals, contrary to N.J.S.A. 17:48E-10.1d(9); and

WHEREAS, Horizon HSC improperly paid certain claims following IURO reversals to providers, rather than covered persons, where the claims were submitted without an assignment of benefits and the covered person had already paid the provider for the services, contrary to N.J.S.A. 17:48E-10.1d(1) and N.J.S.A. 17B:30-13.1c; and

WHEREAS, during the Department's investigation of Horizon HSC's failure to comply with IHCAP reversals, the company failed to answer two Department's inquiries contrary to N.J.S.A. 17:48E-36a; and

WHEREAS, on or about April 1, 2016, Horizon HMO changed the claim platform for its Medicaid business, after which Horizon HMO made multiple claims processing errors, including improper denials, claim underpayments, delayed claim payments and erroneous interest calculations; and

WHEREAS, following the change in claim platform, the Department received multiple complaints against Horizon HMO from providers alleging improper claim denials and claim underpayments as well as claim payment delay related to the Medicaid business; and

WHEREAS, the Department performed a market conduct examination focusing on claims processed by Horizon HMO for its Medicaid business in the fourth quarter of 2016; and

WHEREAS, the market conduct examination concluded that Horizon HMO engaged in multiple improper business practices, including but not limited to,

1. untimely claim processing contrary to N.J.S.A. 26:2J-8.1d(1) and 17B:30-13.1b,
2. failure to promptly comply with stage 1 appeal decisions and IHCAP reversals contrary to N.J.A.C. 11:24-8.5a, N.J.S.A. 26:2S-12c, N.J.A.C. 11:24-8.7(k) and N.J.S.A. 17B:30-13.1b,
3. failure to properly compute interest contrary to N.J.S.A. 26:2J-8.1d(9) and 17B:30-13.1f,

4. failure to link authorization and referrals to corresponding claims contrary to N.J.S.A. 17B:30-53(1) and 17B:30-13.1d,
5. improper claim denials contrary to N.J.S.A. 17B:30-53a(1) and 17B:30-13.1d, and
6. claim payment errors contrary to N.J.S.A. 17B:30-13.1d, 17B:30-53a(1) and 17B:30-54;

and

WHEREAS, in response to another complaint, the Department discovered that Horizon HMO denied certain claims for third party liability improperly based on the Medicaid managed care contract's requirement that such claims be paid without regard to third party liability, such denials therefore being contrary to N.J.S.A. 26:2J-8.1d(1) and N.J.S.A. 17B:30-13.1d and f; and

WHEREAS, Horizon HSC and Horizon HMO have been and will continue to submit monthly reports to the Department on these issues as requested by the Department, which reports indicate progress in remedying certain of the problems described above; and

WHEREAS, Horizon HMO has remedied the payment errors cited in the market conduct examination report and made appropriate payment, including interest, to affected providers; and

WHEREAS, Horizon HMO and Horizon HSC commit to engage in a good faith effort to resolve all issues with respect to compliance with IHCAP reversals, claims processing and responsiveness to Department inquiries; and

NOW, THEREFORE, IT IS on this 15th day of NOVEMBER, 2017

ORDERED AND AGREED that, Horizon will pay a penalty of one million five hundred thousand dollars ($1,500,000), upon its execution of this Consent Order. The payment shall be made through a certified check, attorney trust account check, money order or electronic funds transfer made payable to "State of New Jersey – General Treasury" and shall be sent to Gale Simon, Assistant Commissioner, Department of Banking and Insurance, 20 West State Street, P.O. Box 329, Trenton, NJ 08625-0329; and

IT IS FURTHER ORDERED AND AGREED that the provisions of this Consent Order represent a final agency decision and constitute a full and final resolution of the matters addressed herein.

Peter L. Hartt
Director of Insurance

Consented to as to Form, Content and Entry:

Erhardt Preitauer
Senior Vice President for Government Programs
Horizon Healthcare Services, Inc.

11/9/17
Date

Erhardt Preitauer
President
Horizon Healthcare of New Jersey, Inc.

11/9/17
Date