Order No. E14-116

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

| | | |
|---|---|---|
| Proceedings by the Commissioner of Banking and Insurance, to Fine AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey | ) ) ) ) | CONSENT ORDER |

TO: AmeriHealth HMO, Inc.
Attention: Judith Roman, President
259 Prospect Plains Rd.
Building M
Cranbury, NJ 08512

AmeriHealth Insurance Company of New Jersey
Attention: Judith Roman, President And CEO
259 Prospect Plains Rd.
Building M
Cranbury, NJ 08512

This matter having been opened by the Commissioner of Banking and Insurance ("Commissioner" or "Department"), State of New Jersey, upon information that AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively "AmeriHealth"), may have violated various provisions of the laws of the State of New Jersey; and

WHEREAS, AmeriHealth HMO, Inc. is a health maintenance organization ("HMO") organized under the laws of Pennsylvania and authorized to operate in New Jersey pursuant to N.J.S.A. 26:2J-1 et seq., the Health Maintenance Organization Act ("HMO Act"), since May 9, 1991; and

WHEREAS, AmeriHealth Insurance Company of New Jersey is a domestic insurance company authorized to transact business in New Jersey pursuant to N.J.S.A. 17B:18-42 since June 16, 1995; and

WHEREAS, AmeriHealth HMO, Inc. and AmeriHealth Insurance Company are affiliates; and

WHEREAS, N.J.A.C. 11:24-9.1 (d) 1 provides that members of a HMO shall have the right to available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions; and

WHEREAS, N.J.A.C. 11:24A-2.5 (b) 2 provides that a person covered by a managed care plan shall have the right to access to services, and payment of appropriate benefits therefor, when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions, if covered; and

WHEREAS, N.J.A.C. 11:24-5.1 (a) provides that an HMO shall, at a minimum, provide for or arrange for the provision to its members of all basic comprehensive health care services and all other services enumerated therein and in N.J.S.A. 26:2J-1 et seq., as it may be amended from time to time; and

WHEREAS, N.J.S.A. 26:2S-4 provides that a carrier shall disclose in writing to a subscriber, at the time of enrollment, a description of the covered services and benefits to which the subscriber or other covered person is entitled, the restrictions or limitations on covered services and benefits, the financial responsibility of the covered person, including copayment and deductibles, prior authorization and any other review requirements with respect to accessing covered services, where and in what manner covered services may be obtained, the covered person's right to appeal and the procedure for initiating an appeal of a utilization management

decision made by or on behalf of the carrier with respect to the denial, reduction or termination of a health care benefit or the denial of payment for a health care service, and the procedure to initiate an appeal through the Independent Health Care Appeals Program; and

WHEREAS, N.J.A.C. 11:24A-2.3 provides that carriers shall provide to each subscriber within no more than 30 days following the effective date of coverage, through a handbook, certificate or other evidence of coverage, information describing, inter alia, the covered services under the policy or contract including all exclusions, limitations, restrictions on accessing covered services such as prior authorization, preadmission certification and periodic review of ongoing treatment, a full and clear description of the carrier's policies and procedures for the provision of emergency and urgent care services, all dollar, day, visit or procedure limits and the method of exchanging inpatient for outpatient services, the responsibility of the covered person to pay deductibles, coinsurance or copayment as appropriate, and when and in what manner covered services can be obtained; and

WHEREAS, N.J.A.C. 11:22-8.4 (a) 1 provides that a carrier shall provide each primary insured with an identification card containing the information set forth at N.J.A.C. 11:22-8.3 (b) 1 - 7 within 30 days of a health benefits plan becoming effective; and

WHEREAS, N.J.A.C. 11:24-3.7 (a) 4 provides that an HMO shall establish and maintain a system to provide for the presentation and resolution of complaints brought by members that includes the availability of an HMO member services representative to assist members, as requested, with compliant procedures and establishes a response time of no more than 30 days from receipt of the complaint; and

WHEREAS, N.J.A.C. 11:24A-4.6 (a) provides that a carrier establish and maintain a system for the presentation and resolution of complaints brought by covered persons that

includes availability of a service representative to assist covered persons with complaint procedures upon request and establishes a response of no more than 30 days from receipt of the complaint by the carrier; and

WHEREAS, N.J.A.C. 11:2-17.6 provides that insurers shall provide an appropriate reply within 10 working days to pertinent communications from claimants which reasonably suggest that a response is expected; and

WHEREAS, N.J.S.A. 17B:30-3 provides that no person shall make, issue, circulate or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued; and

WHEREAS, N.J.S.A. 17B:30-4 provides that no person shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of insurance, which is untrue, deceptive or misleading; and

WHEREAS, N.J.S.A. 17B:30-13.1a provides that an unfair claims settlement practice includes misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; and

WHEREAS, N.J.A.C. 11:2-11.2 provides that advertisements, defined to include material disseminated through electronic means and descriptive literature issued by an insurer for presentation to members of the public, shall be truthful and not misleading in fact or in implication; and

WHEREAS, N.J.A.C. 11:2-11.3 (b) provides that an advertisement relating to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive; and

WHEREAS, N.J.S.A. 17B:26-2.1 h and 17B:27-46.1 h mandate that individual and group health insurance policies that provide hospital and medical expense benefits and are delivered, issued, executed or renewed in New Jersey cover, for all persons 20 years of age and older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being; and

WHEREAS, N.J.S.A. 26:2J-4.6 mandates that HMOs cover, for all persons 20 years of age and older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being; and

WHEREAS, N.J.S.A. 17B:29-9.1 d (1) and 17B:27-44.2 d (1) provide, in pertinent part, that a health insurer or its agent shall remit payment for every insured claim submitted by a covered person or health care provider, no later than the 30th calendar day following receipt of a claim by a payer of the claim if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt of the claim if the claim is submitted by other than electronic means, if 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 by the payer on the claim form or in other instructions that were distributed in advance to the provider or covered person in accordance with N.J.S.A. 17B:30-51, and the payer has no reason to believe that the claim was submitted fraudulently; and

WHEREAS, N.J.S.A. 26:2J-8.1 d (1) provides, in pertinent part, that a health maintenance organization or its agent shall remit payment for every insured claim submitted by a covered person or health care provider, no later than the 30th calendar day following receipt of a claim by a payer of the claim if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt of the claim if the claim is submitted by other than electronic means, if 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 by the payer on the claim form or in other instructions that were distributed in advance to the provider or covered person in accordance with N.J.S.A. 17B:30-51, and the payer has no reason to believe that the claim was submitted fraudulently; and

WHEREAS, N.J.S.A. 17B:21-1b provides that the Commissioner may address any inquiries to an insurer or its officers in relation to its condition or affairs, or any matter connected with its transactions, and the officers of the insurer shall promptly reply in writing to all such inquiries; and

IT APPEARING that, AmeriHealth is a participant in the federally facilitated marketplace ("FFM") for individual coverage in New Jersey and has been receiving applications for individual coverage through the FFM since on or about October 1, 2013; and

IT FURTHER APPEARING that, AmeriHealth also issues individual coverage in New Jersey to person who apply to it directly, i.e. off-FFM; and

IT FURTHER APPEARING that, the Department has received a large number of consumer complaints against AmeriHealth since late 2013, with the majority of the complaints

relating to problems in enrolling for individual coverage, billing for individual coverage and terminating individual coverage, both on the FFM and off-FFM; and

IT FURTHER APPEARING that, the complaints allege that, inter alia, consumers are unable to reach AmeriHealth through its customer service telephone lines due to long wait times, dropped calls and an inability to leave a message, consumers do not get responses to emails and letters sent to AmeriHealth, consumers have not timely received identification cards and have not had coverage activated on the chosen effective date resulting in some cases in delay in receiving needed medical care, consumers have not timely received bills or have received inaccurate bills, consumers whose coverage terminated continued to be billed, consumers did not timely receive contracts, consumers relied on inaccurate summary plan descriptions posted on the AmeriHealth website, and due to a malfunction some consumers could not pay premiums electronically and received an incorrect message that coverage had been cancelled; and

IT FURTHER APPEARING that, AmeriHealth advised the Department that approximately 12,000 members did not receive identification cards within 30 days of their effective date of coverage, and explained that such delay was due, in part, to the rules of the FFM prohibiting activation of coverage until receipt of the entire first month's premium; and

IT FURTHER APPEARING that, certain members who were not shown as enrolled in the AmeriHealth system on their selected effective date were unable to timely access covered services, resulting in complaints to the Department of denial of medically necessary services and supplies; and

IT FURTHER APPEARING that, AmeriHealth acknowledged that call wait times and abandonment rates had increased in 2014 due to the tremendous influx of new members and noted that it has taken steps to address those problems; and

IT FURTHER APPEARING that, AmeriHealth advised that it had failed to timely process certain cancellation requests between March 20, 2014 and June 30, 2014, which resulted in members being billed for premium for periods following termination; and

IT FURTHER APPEARING that, all premiums paid for coverage beyond termination have been refunded; and

IF FURTHER APPEARING that, AmeriHealth processed certain cancellations using the effective date of coverage as the termination date rather than the effective date of the cancellation, resulting in premature terminations and improperly retracted claims; and

IF FURHTER APPEARING that, AmeriHealth has retroactively reinstated the affected policies and corrected the claim retractions; and

IT FURTHER APPEARING that, in response to member complaints concerning the information in the summary of benefits posted on www.ahnj4u.com, AmeriHealth admitted that from November 19, 2013 to July 13, 2014 the summary of benefits it posted for Premium Preferred Silver EPO incorrectly showed the in-network pharmacy copayment for generic, preferred brand and non-preferred brand prescription drugs as zero when the cost sharing for these drugs is not zero but rather includes deductible, coinsurance and/or copayment; and

IF FURTHER APPEARING that, AmeriHealth has agreed to provide notice to Premium Preferred Silver EPO members that the prescription drug cost sharing was incorrectly posted, that prescription drug claims with dates of service through October 31, 2014 will be reprocessed with $0 copays and that prescription drug claims with dates of service on and after November 1, 2014 will have the correct cost sharing applied; and

IT FURTHER APPEARING that, AmeriHealth admitted that the AHNJ Premium Regional Preferred Silver EPO summary of benefits posted on www.ahnj4u.com incorrectly

showed no information under the "other Covered Services" section until it was corrected on July 3, 2013; and

IT FURTHER APPEARING that, in response to another member complaint, AmeriHealth admitted that the summary of benefits for Premium Silver NTL POS+ posted on www.ahnj4u.com inaccurately showed coverage of adult routine eye exams from October 2013 through April 2013 when the plan does not cover adult eye exams by eye specialists, i.e. optometrists and ophthalmologists; and

IT FURTHER APPEARING that, AmeriHealth has agreed to covered one adult routine eye exam for Premium Silver NTL POS + members who submit a complaint about denial of a routine adult eye exam; and

IT FURTHER APPEARING that, the Department received complaints from AmeriHealth members who had claims for annual wellness exams denied because AmeriHealth contended that wellness exams for persons aged 20 to 39 are covered on a bi-annual basis, not on an annual basis; and

IT FURTHER APPEARING that, AmeriHealth has acknowledged that it improperly denied claims for annual adult wellness exams since 2009 and has reprocessed said claims; and

IT FURTHER APPEARING that, AmeriHealth did not respond timely and/or adequately to certain DOBI inquiries in 2014; and

IT FURTHER APPEARING that, AmeriHealth has admitted and corrected the errors detailed above and notes that several of the errors were due to the dramatic increase in its individual enrollment in 2014 and to the rules and operation of the FFM; and

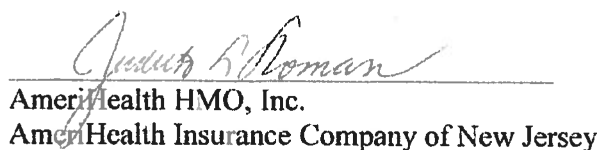
NOW, THEREFORE, IT IS on the 9th day of October, 2014

ORDERED AND AGREED, that AmeriHealth will pay a penalty of five hundred thousand dollars ($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 the "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 3329, Trenton, NJ 08625-0329; and

IT IS FURTHER ORDERED AND AGRRED, 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
Acting Director of Insurance

Consented to as to Form, Content and Entry:



AmeriHealth HMO, Inc.
AmeriHealth Insurance Company of New Jersey