Order No. E15-190

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

Proceedings by the Commissioner of Banking And Insurance to Fine Oxford Health Insurance, Inc., Oxford Health Plans (New Jersey) Inc. and UnitedHealthcare Insurance Company	)))))	CONSENT ORDER

TO: Oxford Health Insurance, Inc.
4 Research Drive, 5th floor
Shelton, CT 06484

Oxford Health Plans (New Jersey) Inc.
4 Research Drive, 5th floor
Shelton, CT 06484

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103

This matter having been opened by the Commissioner of the Department of Banking and Insurance ("Commissioner"), State of New Jersey, upon information that Oxford Health Insurance, Inc., Oxford Health Plans (New Jersey) Inc. and UnitedHealthcare Insurance Company (collectively "UHC"), may have violated provisions of the laws of the State of New Jersey; and

WHEREAS, Oxford Health Insurance, Inc. is a foreign insurance company authorized to transact business in New Jersey pursuant to N.J.S.A. 17B:23-1 et seq. since October 4, 1994; and

WHEREAS, Oxford Health Plans (New Jersey) Inc. is a health maintenance organization ("HMO") authorized to transact business in New Jersey pursuant to N.J.S.A. 26:2J-3 since October 1, 1985; and

WHEREAS, UnitedHealthcare Insurance Company is a foreign insurance company admitted to transact business in New Jersey pursuant to N.J.S.A. 17:23-1 et seq. since August 31, 1982; and

WHEREAS, N.J.A.C. 11:24-9.1(d)1 provides that HMO members 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) provides that persons covered by managed care plans issued by insurance companies 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.S.A. 17B:30-50 defines "medical necessity" or "medically necessary" as a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: (1) in accordance with the generally accepted standards of medical practice, (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease, (3) not primarily for the convenience of the covered person or the health care provider, and (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the covered person's illness, injury or disease; and

WHEREAS, N.J.S.A. 17B:30-50 defines "generally accepted standards of medical practice" as standards that are based on (1) credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, (2) physician and health care provider specialty society recommendation, (3) the views of physicians and health care providers practicing in relevant clinical areas, and (4) any other relevant factor as determined by the Commissioner by regulation; and

WHEREAS, N.J.S.A. 26:2S-11 establishes the Independent Health Care Appeals Program ("IHCAP") to provide an independent review by Independent Utilization Review Organizations ("IUROs") of the decisions of insurance companies and HMOs to deny, reduce or terminate benefits based on a lack of medical necessity or appropriateness; and

WHEREAS, N.J.S.A. 26:2S-12c provides that if the IURO determines that the denial, reduction or termination of benefits deprived the covered person of medically necessary covered services, it should convey to the covered person or the health care provider acting on behalf of the covered person and the carrier its decision regarding the appropriate, medically necessary health care services that the person should receive, which shall be binding on the carrier, and the carrier shall promptly provide coverage for the health care services found to be medically necessary services; and

WHEREAS, N.J.A.C. 11:24-8.7(k) states that the IURO's determination is binding on an HMO and further states that where the IURO's decision is adverse to an HMO, the HMO "shall provide benefits (including payment on the claim) pursuant to the IURO's determination without delay"; and

WHEREAS, N.J.S.A. 26:2S-12d provides that if the Commissioner determines that a carrier has failed to comply with the decision of an IURO or is otherwise in violation of patient

rights and other applicable regulations, the Commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the Commissioner deems appropriate; and

WHEREAS, prior to December 19, 2013, the small employer regulations at N.J.A.C. 11:21-7.3(f) allowed a small employer carrier to elect to provide retiree coverage only if the small employer's retired employees were covered under a health benefits plan issued prior to January 1, 1994, the retiree coverage was continuously maintained when the carrier converted the small employer plan to a standard small employer health benefits plan and the carrier offers retiree coverage to all such small employers without regard to which small employer plan is selected; and

WHEREAS, N.J.A.C. 11:21-7.3(f) was repealed effective December 19, 2013 and retiree coverage under small employer plans may not be offered under small employer plans issued on and after that date; and

WHEREAS, N.J.S.A. 17B:27A-19a requires that the Board of the Small Employer Health Benefits Program ("SEH") establish small employer plans which shall be the only plans offered to small employers after January 1, 1994; and

WHEREAS, N.J.A.C. 11:21-3.1(a) provides that the standard health benefits plans established by the SEH Board are Plan B, Plan C, Plan D and Plan E for carriers that are insurance companies, and the HMO Plan and the HMO-POS Plan for carriers that are health maintenance organizations and that the standard plan text of these plans is contained in the Appendix Exhibits F, G, W, Y, HH and II; and

WHEREAS, the text of the standard small employer plans allows coverage for employees and dependents only, and does not allow for coverage of retirees; and

WHEREAS, N.J.S.A. 17B:30-13.1a defines an unfair claim settlement practice to include misrepresentation of pertinent facts or insurance policy provisions relating to the coverages at issue; 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 on all available information; and

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

WHEREAS, UHC issues health benefit plans to individuals and groups in New Jersey and as of 12/31/14 covered 202,643 members in the New Jersey commercial market; and

WHEREAS, UHC implemented prior authorization/medical necessity programs for certain prescription drugs that included certain requirements ("requirements"); and

WHEREAS, the Department finds that use of the requirements resulted in the denial of medically necessary services and appropriate benefits to covered persons and unfair claims settlement practices, in violation of N.J.A.C. 11:24-9.1(d)1 and N.J.A.C. 11:24A-2.5(b), N.J.S.A. 17B:30-13.1a, -13.1d and -13.1f, and N.J.S.A. 17B:30-50; and

WHEREAS, UHC has revised the prior authorization/medical necessity programs to remove the requirements applicable to fully insured commercial business issued in New Jersey, has reconsidered all denials issued in 2015 and is reconsidering all denials issued in 2014 under the revised prior authorization/medical necessity programs; and

WHEREAS, the IURO issued decisions on April 30, 2015 and July 24, 2015 reversing denials by Oxford Health Plans (New Jersey) Inc. and UnitedHealthcare Insurance Company of

inpatient treatment for persons suffering from multiple serious mental illnesses, concluding that the denials were contrary to the American Psychiatric Association Practice Guidelines; and

WHEREAS, the Department finds that the two individualized denials of inpatient treatment constitute a denial of access to medically necessary services and appropriate benefits therefore, in violation of N.J.A.C. 11:24-9.1 (d) 1 and N.J.A.C. 11:24A-2.5(b), and a failure to apply generally accepted standards of medical practice in the determination of medical necessity in violation of N.J.S.A. 17B:30-50; and

WHEREAS, Oxford Health Insurance, Inc. and Oxford Health Plans (New Jersey) Inc. issued small employer coverage to four small employer groups covering a total of ten retirees and nineteen dependents with effective dates of March 1, 1998, January 1, 2011, February 1, 2011 and April 1, 2015 and offered retiree coverage to at least one small employer in 2015; and

WHEREAS, Oxford Health Insurance, Inc. and Oxford Health Plans (New Jersey) Inc. have indicated that as of July 14, 2015 no additional small employer plans would be offered or issued retiree coverage; and

WHEREAS, the Department finds that the issuance and offer of issuance of retiree coverage by Oxford Health Insurance, Inc. and Oxford Health Plans (New Jersey) Inc. prior to December 19, 2013 was contrary to the then in effect N.J.A.C. 11:21-7.3(f); and

WHEREAS, the Department finds that the issuance and offer of issuance of retiree coverage to small employers by Oxford Health Insurance, Inc. and Oxford Health Plans (New Jersey) Inc. after December 19, 2013 violates N.J.S.A. 17B:27A-19a and N.J.A.C. 11:21-3.1(a); and

WHEREAS, on April 30, 2015 the IURO issued a decision reversing the denial of several claims for inpatient services for a member covered by an HMO plan issued by Oxford Health Plans (New Jersey) Inc. with a total claim amount of $338,420.04; and

WHEREAS, on May 14, 2015 Oxford Health Plans (New Jersey) Inc. advised the member that it was reprocessing the claims pursuant to the IURO decision; and

WHEREAS, on June 1, 2015 Oxford Health Plans (New Jersey) Inc. issued multiple Explanation of Benefit ("EOB") forms denying the claims for services that the IURO had determined to be medically necessary for the member with the denial message: "Oxford is unable to process the claim due to missing information. All claims must include an itemized bill of services rendered, medical diagnosis codes(s), procedural code(s), place of service and any other pertinent clinical information"; and

WHEREAS, the member complained to the Department by letter dated June 9, 2015 about Oxford Health Plans (New Jersey) Inc.'s refusal to pay the claims that were the subject of the April 30, 2015 IURO decision; and

WHEREAS, the Department contacted Oxford Health Plans (New Jersey) Inc. on June 23, June 29 and July 7, 2015 concerning its failure to pay the claims; and

WHEREAS, Oxford Health Plans (New Jersey) Inc. paid the claims on July 8, 2015; and

WHEREAS, the company's 69 day delay in complying with the April 30, 2015 IURO decision and its issuance of EOB forms denying the claims following the adverse IURO decision constitute failures to provide benefits promptly and without delay following an adverse IURO decision in violation of N.J.S.A. 26:2S-12c and N.J.A.C. 11:24-8.7(k); and

WHEREAS, UHC does not agree with the Department's findings, but desires to settle the matter without resort to a formal hearing; and

WHEREAS, UHC hereby waives its right to a hearing on the aforementioned disputed findings and consents to the entry of this order memorializing this settlement; and

NOW, THEREFORE, IT IS on the 2nd day of December, 2015:

ORDERED AND AGREED that UHC shall pay a fine in the amount of eight hundred thousand dollars ($800,000) to the Department; and

IT IS FURTHER ORDERED AND AGREED that said fine shall be paid by certified check, cashier's check or wire transfer payable to "State of New Jersey – General Treasury" upon the execution of this Consent Order by UHC; and

IT IS FURTHER ORDERED AND AGREED that, within sixty days of the date of this Consent Order, UHC shall reconsider the denials it issued in 2014 based on its application of the revised medical necessity/prior authorization programs and shall submit a report to the Department detailing the results of such reconsideration; and

IT IS FURTHER ORDERED AND AGREED that medical necessity determinations are necessarily clinically individualized; and therefore nothing in this order shall be construed to mean that any other IURO overturns regarding medical necessity constitute a violation of the referenced New Jersey statutes; and

IT IS FURTHER ORDERED AND AGREED that UHC shall cease and desist from engaging in the conduct that gave rise to this Consent Order and shall hereafter comply in all respects with New Jersey insurance statutes and regulations; and

IT IS FURTHER ORDERED AND AGREED that the provisions of this Consent Order represent a final agency decision and constitute a final resolution of only the violations specified herein.

Peter L. Hartt
Director of Insurance

Consented to as to Form, Content, and Entry:

Oxford Health Insurance, Inc.
Oxford Health Plans (New Jersey) Inc.
UnitedHealthcare Insurance Company

By: _____
Name

General Counsel
Title

11-23-15
Date