Order No. E18-12

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

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

TO: Americhoice of New Jersey, Inc.
333 Thornall St., 9th floor
Edison, NJ 08837

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 Americhoice of New Jersey, Inc., 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, Americhoice of New Jersey, Inc. ("Americhoice") is a health maintenance organization ("HMO") authorized to transact business in New Jersey pursuant to N.J.S.A. 26:2J-3 since September 25, 1995; and

WHEREAS, Oxford Health Insurance, Inc. ("OHI") 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 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. 17B:23-1 et seq. since August 31, 1982; and

Use of Non-designated Hemophilia Provider

WHEREAS, N.J.S.A. 26:2S-10.1 provides that a carrier which offers a managed care plan that provides benefits or health care services, as applicable, for the home treatment of bleeding episodes associated with hemophilia, including the purchase of blood product and blood infusion equipment, shall be required to contract with, and exclusively use, providers that comply with standards adopted by regulation of the Department of Banking and

Insurance ("Department") in consultation with the Hemophilia Association of New Jersey; and

WHEREAS, N.J.A.C. 11:24C-2.1 et seq. establishes the application process and standards for designation as a hemophilia health care provider; and

WHEREAS, N.J.A.C. 11:24C-3.3(b) provides that no carrier shall arrange with any person for the provision of home treatment of bleeding episodes associated with hemophilia unless that person shall be a designated provider of such services, nor shall a carrier refer any covered person or cause a covered person to be referred to a person that is not a designated health care provider of services and supplies for the home treatment of bleeding episodes associated with hemophilia; and

WHEREAS, N.J.A.C. 11:24C-2.5(b) lists the standards required for designation, which include the ability to provide services and to maintain and provide all brands of blood product, including low, medium and high-assay range levels to execute treatment regiments as prescribed by a covered person's attending physician, without making substitutions of blood products except upon prior approval of the attending physician; the ability to maintain and provide all needed ancillary supplies for the treatment or prevention of bleeding episodes, including blood infusion equipment and cold compression packs and the ability to deliver any and all prescribed blood

products, medications, nursing services and blood infusion equipment within three hours after receipt of a prescription for a covered person's emergent situation, 24-hours per day, seven days per week; and

WHEREAS, UHC directed certain members to a non-designated provider in 2017 for provision of hemophilia supplies and services; and

WHEREAS, the Department received complaints in July and August of 2017 alleging, among other things, that UHC members were experiencing service issues when dealing with the non-designated provider; and

WHEREAS, in response to the Department's investigation of these complaints and its inquiry as to why UHC was utilizing a provider of hemophilia supplies that had not received the required designation, UHC explained that the non-designated provider was acquired by a UHC company in July 2015, that the lack of designation was the result of administrative oversight, and that since January 1, 2017 eleven members had hemophilia supplies and services provided by the non-designated provider; and

WHEREAS, as of September 1, 2017 UHC has ceased using the non-designated provider to provide hemophilia supplies to members and has retracted notices to members that stated that

they would be required to use the non-designated provider for hemophilia supplies; and

Delayed Compliance with IURO Reversals

WHEREAS, the Independent Health Care Appeals Program ("IHCAP") established by N.J.S.A. 26:2S-11 provides an independent medical necessity or appropriateness of services review of final decisions by 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 with the covered person's consent; and

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

WHEREAS, N.J.S.A. 26:2S-12c states that if all or part of the IURO's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care

services found by the IURO to be medically necessary covered services; and

WHEREAS, N.J.A.C. 11:24-8.7(k) provides that an HMO shall provide benefits pursuant to the IURO's determination without delay; and

WHEREAS, Americhoice failed to comply promptly and without undue delay with multiple IURO decisions rendered in 2016 and 2017, with delays ranging from 39 to 217 days; and

Failure to Provide UM Appeal Rights for Prescription Drug Limit Override Requests

WHEREAS, N.J.A.C. 11:24-1.2 and 11:24A-1.2 define utilization management as a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines to determine whether a service is covered and includes, among other things, application of practice guidelines and preauthorization; and

WHEREAS, N.J.A.C. 11:24-8.5 and 11:24A-3.5(j) provide that in the first stage of internal utilization management appeal a covered person and his provider must be afforded the opportunity to speak with the carrier's medical director or the medical director who rendered the utilization management denial; and

WHEREAS, N.J.S.A. 26:2S-11 and 12 provide that a covered person has the right to appeal to the IHCAP if his internal appeal is unsuccessful; and

WHEREAS, the Department received a complaint from an OHI member covered by an individual health benefits plan who was prescribed oral chemotherapy in an amount more than the OHI daily quantity limit for that medication, who requested and was denied prior authorization for the amount in excess of the quantity limit, and who was told by OHI that she could not have a peer to peer discussion with the OHI physician who made the determination because this was an administrative denial and not a utilization management denial; and

WHEREAS, in response to the complaint OHI acknowledged that the process for adjudication of appeals of quantity limit overrides was not consistent between group health benefit plans and individual health benefit plans in that appeals of quantity limit override denials were treated as administrative denials for persons covered by individual health benefits plans and as utilization management denials for persons covered by group health benefits plans, and stated that two such individual health benefits plan adjudications occurred and were overturned; and

WHEREAS, OHI agreed to change its practice to make the adjudication of quantity limit override appeals consistent

across business lines, and that going forward it would subject all quantity limit override appeals to utilization management review; and

Provision of Incorrect Information Regarding IHC Plans

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 and annuities or with respect to any person in the conduct of his insurance and annuity business which is untrue, deceptive or misleading; and

WHEREAS, OHI offered individual health benefits plans to New Jersey residents, which plans are guarantee issue (i.e. no medical underwriting) and provide comprehensive benefits; and

WHEREAS, from January 1, 2017 to September 8, 2017 OHI's website had no information with respect to the sale of individual health benefits plans in New Jersey but instead contained a message stating that persons interested in information about individual health benefits plans in New Jersey

should call a specified 800 number, which OHI claims was a result of error; and

WHEREAS, a Department employee called the 800 number and was incorrectly advised that OHI does not sell individual health benefits plans in New Jersey and that OHI only sells some medically underwritten limited benefit plans to New Jersey residents; and

WHEREAS, OHI initially advised the Department that the information provided to the Department employee was an isolated error and due to improper customer service representative training; and

WHEREAS, the Department requested and reviewed recordings of 434 calls from New Jersey residents to the OHI 800 number, which recordings included several in which OHI improperly asked medical questions of callers, provided incorrect information about individual health benefits plans offered by OHI in New Jersey, and erroneously told callers they were ineligible for individual coverage due to medical conditions; and

WHEREAS, OHI advised the Department on August 29, 2017 that the website was revised to provide correct information about the individual health benefits plans it offers in New Jersey and that the call center practices were adjusted to address the concerns raised by the Department and that the problems with the call center and website were not intentional; and

Requiring Member Consent for Provider Payment Appeals

WHEREAS, the Health Claims Authorization, Processing and Payment Act ("HCAPPA") requires that carriers establish an internal appeal mechanism to resolve any disputes raised by a health care provider regarding payment, provided that the dispute does not involve a medical necessity issue which could be submitted to the IHCAP ("payment dispute"); and

WHEREAS, HCAPPA requires a provider to submit an internal appeal of a payment dispute to a carrier within 90 days of the claims determination being challenged on a form prescribed by the Department and does not require that a provider obtain member consent in order to file an appeal of a payment dispute; and

WHEREAS, the Department received several complaints that stated that UHC is requiring physicians to complete a form captioned "Member Authorization Form for a Designated Representative to Appeal a Determination" in order to submit a payment appeal; and

WHEREAS, the Department contacted UHC regarding use of the form and was advised that it would cease requiring submission of the form as a prerequisite to a provider payment appeal; and

WHEREAS, the Department continued to receive complaints that UHC was requiring member consent in order to process provider payment appeals; and

WHEREAS, the Department was advised by UHC that the erroneous requirement to obtain member consent for a provider payment appeal was imposed from January to August 2017; and

WHEREAS, UHC reprocessed the improperly denied payment appeals in September 2017; and

WHEREAS, UHC does not agree with the Department's findings but desires to settle this matter without a formal hearing and consents to the entry of this order memorializing this settlement; and

NOW, THEREFORE, IT IS on the day of February 22, 2018

ORDERED AND AGREED that UHC shall pay a fine in the amount of two million five hundred thousand dollars ($2,500,000.00) 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 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 Americhoice shall provide the Department with monthly reports of its compliance

with IURO decisions until notified by the Department that the reports may be discontinued; 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.

Marlene Caride
Acting Commissioner

Consented to as to Form, Content, and Entry:

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

By: _____
Name Payman Pezhman