ORDER NO. A15-112

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE REQUEST OF CAPITAL HEALTH REGIONAL MEDICAL CENTER, CENTRASTATE MEDICAL CENTER, HOLY NAME MEDICAL CENTER, INC., THE COMMUNITY HOSPITAL GROUP INC., t/a JFK MEDICAL CENTER, KENNEDY HEALTH, OUR LADY OF LOURDES HEALTH CARE SERVICES, INC., ST. FRANCIS MEDICAL CENTER, INC., TRINITAS REGIONAL MEDICAL CENTER, VALLEY HEALTH SYSTEM, AND VIRTUA HEALTH, INC.'S REQUEST TO STAY THE DEPARTMENT'S APPROVAL OF HORIZON'S OMNIA NETWORK	ORDER DENYING REQUEST FOR A STAY

This matter arises out of a request by Capital Health Regional Medical Center ("Capital Health"), CentraState Medical Center ("CentraState"), Holy Name Medical Center, Inc., ("Holy Name"), The Community Hospital Group, Inc., t/a JFK Medical Center ("JFK Medical Center"), Kennedy Health ("Kennedy"), Our Lady of Lourdes Health Care Services, Inc. ("Our Lady of Lourdes"), St. Francis Medical Center, Inc. ("St. Francis"), St. Luke's Warren Hospital, Inc. ("St. Luke's"), Trinitas Regional Medical Center ("Trinitas"), Valley Health System ("Valley") and Virtua Health, Inc. ("Virtua") (collectively known as the "Hospital Group") dated November 19, 2015, for a stay of the approval by the Commissioner of Banking and Insurance ("Commissioner") of the OMNIA Network (the "OMNIA Network") filed by Horizon Healthcare Services, Inc. (d/b/a Horizon Blue Cross Blue Shield of New Jersey) ("Horizon") pending review by the Appellate Division of the Hospital Group's challenge to the Commissioner's approval. For the reasons set forth below, this stay request is denied.

STATEMENT OF FACTS

A) Advent of Tiered Network Plans in New Jersey and Nationwide

Over the past several years and coinciding with the advent of changes to health care caused by the federal Affordable Care Act and continuing upward pressure on the costs of health care and insurance, health carriers have been looking for ways to lower the costs of insured health products and to offer consumers more choice. As has been reported in the media, carriers throughout the nation have added limited or "narrow" networks and/or tiered networks to their product offerings to achieve lower costs and provide more choice to consumers. We have seen this development in New Jersey because carriers are seeking to provide lower cost options for consumers, while still ensuring the provision of quality health benefits under any given plan. Tiered network products offer consumers a comprehensive health benefits plan that provides two levels of cost-sharing (i.e. deductibles, co-insurance and/or copayments) depending on the tier of the network in which the provider falls. Two-tiered networks provide an adequate network of distinct providers in both Tier 1 and Tier 2, and if the consumer elects to use a Tier 1 provider then his or her cost-share is a lower amount - or savings - over the standard Tier 2 cost-share.

Through these offerings, health carriers are providing consumers with multiple plan options at different premium levels. Consumers who elect to purchase tiered network products are informed of the different out-of-pocket, cost-sharing levels for each tier before purchase, have the ability to review the providers in each tier before purchase, and in return they pay less in premium and save on out-of-pocket expenses if they elect to use a tier 1 provider. Tiered networks are now common in New Jersey and throughout the nation, and over 10 tiered networks have been filed with the Department over the past five years. Almost every carrier in New

Jersey has offered, or is currently offering, a tiered network product in the fully insured market[1], but consumer selection of such products has been limited.[2]

Like most carriers in the fully-insured health insurance markets in this State and nationwide, Horizon sold a tiered network plan in 2014 and 2015 with its Advance tiered network product. Horizon's Advance tiered network had 31 hospitals in Tier 1, comprised generally of smaller hospital systems, and 37 Tier 2 hospitals. All hospitals in the Hospital Group challenging the Department's approval of the OMNIA network were participating providers in Horizon's Advance tiered network. Of the eleven hospital systems in the Hospital Group, the following five systems or stand-alone hospitals were in Horizon's Advance Tier 1: Kennedy, Lourdes, St. Francis, St. Luke's and Trinitas. The remaining six systems or stand-alone hospitals were in Horizon's Advance Tier 2: Capital Health, Centrastate, Holy Name, JFK, and Virtua. The Department received no complaints from any hospitals – including the Hospital Group here - or from consumers about the hospitals participating in the Advance tiered network product that was sold for two years and for which plans are currently in effect.

B) <u>The Scope of the Department's Statutorily-Granted Regulatory Authority with regard to Health Benefits Plans and Network Adequacy</u>

Due to the nature of the assertions made in the Hospital Group's request for a stay of the Department's approval of Horizon's OMNIA Network, it is necessary and appropriate to review the statutory authority granted to the Department in regulating the issuance of health benefits plans in this State generally and specifically with regard to network adequacy.

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[1] Aetna (Savings Plus); Amerihealth (Tier 1 Advantage and Community Advantage); Horizon (Advance and OMNIA); Health Republic Insurance of New Jersey (CentraState Community Health Plan and Preferred Care Network); and Oscar.

[2] As an example of the limited enrollment in such products, Horizon's Advance tiered network products for 2015 represented less than 3 percent of Horizon's total statewide enrollment in fully-insured health benefits plans.

The Department, in conjunction with the Individual Health Coverage (IHC) and Small Employer Health (SEH) Program Boards, has been granted statutory authorities to regulate fully-insured health benefit plans sold in the commercial markets in this State. Fully-insured plans are health plans where the insurance carrier accepts risk by bearing the costs of the claims generated by the plan's members in return for payment of the insurance premium. Only about 25 percent of health plans in the State are fully-insured and regulated by the Department. Most citizens obtain their health coverage through self-funded plans offered by their employers under which the employers bear the risk and financial responsibility for payment of the health care costs of the members, and the insurance carrier only administers the operation of the plan in return for the payment of a fee.

For fully insured plans, the Department has the sole authority to license insurers to transact health insurance business in this State after determining that they meet the standards set forth in New Jersey law.[3] In conjunction with the Program Boards, the Department ensures that health insurers provide to consumers all state and federally required consumer protections and coverage for all required health benefits through issuance of standardized health benefit plans in the fully-insured individual and small employer markets.[4] Additionally, the Department conducts continuous, risk-focused monitoring and examinations of health insurers' financial conditions to ensure that the companies have sufficient funds to provide health insurance coverage to New Jersey's consumers and pay claims to health care providers.[5] The Department

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[3] See N.J.S.A. 17:48-1 (hospital service corporations); N.J.S.A. 17:48A-1 et seq. (medical service corporations); N.J.S.A. 17:48E-1 et seq. (health service corporations); N.J.S.A. 17B:17-1, 17B:18-1 et seq. and N.J.A.C. 11:2-1.1 et seq. (health insurers); N.J.S.A. 26:2J-1 et seq., Reorganization Plan No. 005-2005 at 37 N.J.R. 2737(a), and N.J.A.C. 11:24-2.1 et seq. and -11.1 et seq. (health maintenance organizations).

[4] N.J.S.A. 17B:27A-4; N.J.S.A. 17B:27A-19.

[5] See e.g. N.J.S.A. 17:23-20 et seq. and N.J.A.C. 11:1-36.1 et seq.; N.J.S.A. 17:27A-1 et seq. and N.J.A.C. 11:1-35.1 et seq.; N.J.S.A. 17:48-12.2 et seq.; N.J.S.A. 17:48A-19.2 et seq.; N.J.S.A. 17:48E-37.2 et seq.; N.J.S.A. 17B:18-70 et seq.; N.J.A.C. 11:2-39.1 et seq. and Department of Banking and Insurance Order A15-102.

reviews insurers' proposed premium rates for certain health insurance benefit plans in accordance with our statutory authority to ensure that the rates being charged are not inadequate, excessive, or unfairly discriminatory, and are in compliance with all other state and federal requirements.[6] Plus, the Department has an entire unit dedicated to consumer protection that receives and investigates complaints and inquiries from consumers, providers and others as to alleged misconduct by carriers, that takes enforcement action where warranted, and that provides assistance and guidance to consumers with insurance questions.

New Jersey's laws establish important protections for consumers and providers concerning their relationships with health insurers.[7,8] Most pertinent to this matter is the Department's role in reviewing the adequacy of provider networks, which are created by insurers and sold to New Jersey employers and residents through fully-insured health benefit plans, to ensure there is adequate access to care for consumers. New Jersey is a national leader in network

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[6] N.J.S.A. 17:48-6.5, -6.9, -6.14, and -9; N.J.S.A. 17:48A-6.9, -7.5, -7.9. and -10; N.J.S.A. 17:48E-13, -22.2 and -26; N.J.S.A. 17B:26B-2; N.J.S.A. 17B:27A-25.8; and N.J.S.A. 26:2J-4.3, -8.

[7] See e.g. for consumer protections, N.J.S.A. 26:2S-4 and -5 (requiring insurers to disclose: consumers' financial responsibilities under the health plan, where and in what manner coverage can be obtained, provider directories, pre-authorization requirements under the plan, the right to appeal medical services denied by the carrier, etc.); N.J.S.A. 26:2S-6 (requiring insurers to have licensed physicians administering and making medical necessity determinations in their utilization management (UM) systems and such systems must be available 24 hours a day to respond to emergent and urgent needs for medical services); N.J.S.A. 26:2S-9.1 (requiring continuity of care provisions for when a provider's contract is terminated by a health benefit plan); N.J.S.A. 26:2S-11 et seq. (requiring the Department to establish and administer the Independent Health Care Appeals Program to enable consumers and providers to appeal denials, reductions or terminations of benefits); and, N.J.A.C. 11:24A-3.4 and -3.5 (requiring insurers to have licensed physicians administering and making medical necessity determinations in their utilization management (UM) systems and such systems must be available 24 hours a day to respond to emergent and urgent needs for medical services).

[8] See e.g. for provider protections, N.J.S.A. 26:2S-7 to -7.2 (requiring review of applications for physician participation in a network by a committee of physicians and use of uniform credentialing and application forms); N.J.S.A. 26:2S-8 (requiring establishment and notice of the insurer's policy governing the removal of providers from a network); N.J.S.A. 26:2S-9 (requiring provisions in provider contracts with the insurers that prohibit penalizing providers for patient advocacy and bar any provisions that provide financial incentives to withholding covered health care services); and, Health Claims Authorization, Payment and Processing Act ("HCAPPA"), P.L. 2005, c.352 multiple sections (requiring carriers to pay claims within 30 days and application of mandatory 12 percent interest payments and establishing limits on the manner and timing of carriers' abilities to recoup payments from providers).

adequacy requirements. Our standards are objective, stricter and better-defined than in most other states.[9]

In recognition of the initial growth of managed care through Health Maintenance Organizations ("HMOs"), the Department of Health ("DOH"), in February 1997 and in consultation with the Department, adopted the first set of standards for network adequacy after creation of an HMO Advisory Committee that engaged in 14 months of active discussion with stakeholders. See 28 N.J.R. 2456(a); 29 N.J.R. 625(a) (codified at N.J.A.C. 8:38-6.1 et seq.). These initial network adequacy standards were only applicable to HMOs and were promulgated prior to enactment of any express statutory authority.

In August 1999, the Health Care Quality Act (HCQA), P.L. 1997, c. 192, was the first statute in New Jersey to require the establishment of network adequacy standards. The HCQA broadened the application of network adequacy requirements to all carriers and all managed care plans, not just HMOs. See N.J.S.A. 26:2S-2 (definitions of "carrier" and "managed care plan"). Specifically, the Commissioner of DOH was directed, in consultation with the Commissioner of Banking and Insurance, to promulgate regulations for "adequacy of the provider network with respect to the scope and type of health care benefits provided by the carrier, the geographic service area covered by the provider network and access to medical specialists, when appropriate." N.J.S.A. 26:2S-18. This is the only statutory provision requiring review of network adequacy.

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[9] To illustrate, the National Association of Insurance Commissioners - the preeminent standard setting body for state-based insurance regulation, at its Fall 2015 National Meeting in November 2015 approved a new national, network adequacy model law, the standards of which would be much less specific with regard to time and distance and sufficiency of provider population requirements, and therefore not as protective of consumer access, as New Jersey already has in place. See:

http://naic.org/meetings1511/committees_ex_plenary_2015_fall_nm_summary.pdf?1448489137956, and

http://naic.org/meetings1511/committees_ex_plenary_2015_fall_nm_materials.pdf?1448908514405 at 114-146.

In accordance with well-settled principles of statutory interpretation, the DOH in the first instance, and this Department thereafter, have promulgated rules in accordance with the unambiguous plain language of this statute, namely that the Department must establish standards and conduct reviews of the adequacy of consumer access to medical care and providers within a geographic service area. Department of Children and Families, Division of Child Protection and Permanency v. E.D.-O., 223 N.J. 166, 186 (2015) (citing DiProspero v. Penn, 183 N.J. 477 (2005)).

Neither this statute, nor any other statute, grants the Department the authority to review managed care networks with regard to other parameters, such as the criteria a carrier uses when deciding to contract with a particular provider and on what terms. Additionally, N.J.S.A. 26:2S-18 provides no specific standards by which the Department is to determine whether a network is "adequate."

Therefore, in 1999, the DOH adopted network adequacy rules at N.J.A.C. 8:38A-4.10 for all carriers and managed care plans that established the details of the standards in a manner that is identical to the HMO adequacy rules. See 31 N.J.R. 953(a); 32 N.J.R. 1544(a). In 2005, pursuant to Reorganization Plan No. 005-2005 at 37 N.J.R. 2737(a), the responsibility for licensing HMOs and the Office of Managed Care, which was responsible for reviewing and enforcing network adequacy standards, were moved to the Department. The rules as promulgated by DOH were recodified and have been continued by this Department with recent amendments that made changes with respect to standards for provider directories and provider contracts as required by the Health Care Quality Act and HCAPPA. See fn8 supra.

N.J.A.C. 11:24-6.1 et seq. is applicable to HMOs and N.J.A.C. 11:24A-4.10 is applicable to networks created by all other carriers, but the standards are the same. Both provisions require

all carriers offering managed care plans in this State to maintain an adequate network of primary care physicians ("PCPs"), certain specialists, and ancillary providers:

> to assure that covered persons are able to access services in-network and take full advantage of in-network benefits levels when the policy or contract specifies that there is a differential between the in-network and out-of-network benefits levels for one or more covered services, or the policy or contract is subject to a gatekeeper system.
>
> [N.J.A.C. 11:24A-4.10(a).]

For PCPs, carriers shall demonstrate a sufficient number of physicians to assure that at least two physicians eligible to function as PCPs (adult, pediatric and primary ob/gyn providers) are "within 10 miles or 30 minutes driving time or public transit (if available), whichever is less, of 90 percent of the carrier's covered persons." N.J.A.C. 11:24A-4.10(b)(1). For medical specialists, carriers are required to have a sufficient number, 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).

Carriers also shall maintain contracts or other arrangements acceptable to the Department with regard to licensed acute care hospitals with licensed medical-surgical, pediatric, obstetrical and critical care services in any county or service area that is sufficient to meet the medical needs within 20 miles or 30 minutes driving time, whichever is less, for 90 percent of covered persons within the county or service area. N.J.A.C. 11:24A-4.10(b)(3)(i). Similarly, carriers are required to have contracts or arrangements for services for its members with surgical facilities, including acute care hospitals, licensed ambulatory surgical facilities, and/or Medicare-certified physician surgical practices available in each county or service area that are no greater than 20 miles or 30

minutes driving time, whichever is less, for 90 percent of covered persons within the county or service area. N.J.A.C. 11:24A-4.10(b)(3)(ii).

Carriers are also required to "have a contract or otherwise agree to cover medically necessary trauma services at a reasonable cost with all Level I or II trauma centers designated by the Department of Health and Senior Services, with the provision of benefits at the in-network level [for consumers]." N.J.A.C. 11:24A-4.10(b)(3)(iii).

Additionally, carriers are required to have contracts for the following specialized services at in-network rates so that services will be available within 45 miles or 60 minutes driving time, whichever is less, of 90 percent of covered persons within each county or service area: a hospital providing regional perinatal services; a hospital offering tertiary pediatric services; in-patient psychiatric services; residential substance abuse treatment centers; diagnostic cardiac catheterization services in a hospital; specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies; and comprehensive rehabilitation services. N.J.A.C. 11:24A-4.10(b)(3)(iv).

With regard to licensed long-term care facilities, therapeutic radiation, magnetic resonance imaging centers, diagnostic radiology (including x-ray, ultrasound, and CAT scan), emergency mental health service (including a short-term care facility for involuntary psychiatric admissions, and outpatient therapy for mental health and substance abuse conditions), and licensed renal dialysis, carriers must have a contract or arrangement for those specialized services to be provided at in-network benefit levels (if covered by one or more of the carrier's health benefits plans in-network, and determined to be medically necessary), and to be available within 20 miles or 30 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area. N.J.A.C. 11:24A-4.10(b)(3)(v).

Additionally, N.J.A.C. 11:24A-4.10(d) provides that a carrier shall demonstrate that a network meets the time/distance standards of these rules when a member uses public transportation under certain circumstances. Specifically, the rule provides for application of public transportation travel times "[i]n any county or approved service area in which 20 percent or more of a carrier's projected or actual number of covered persons must rely upon public transportation to access health care services, as documented by U.S. Census Data."

As discussed above, the statutory language of N.J.S.A. 26:2S-18 provides that for all managed care plans the Department shall promulgate regulations to ensure the "adequacy of [a carrier's] provider network with respect to the scope and type of health care benefits provided by the carrier, the geographic service area covered by the provider network and access to medical specialists, when appropriate." The plain language makes clear that the Department's statutory mission in conducting these reviews is to protect consumers who purchase fully-insured health benefits plans because if the consumers cannot access care, then the benefits provided by the carrier's plan are illusory. Consequently, the Department conducts network adequacy reviews of every carrier network for fully-insured plans to ensure that the network meets the detailed time and distance standards in the Department's rules at N.J.A.C. 11:24A-4.10 for all provider types, ensures that physicians and facilities are available in sufficient numbers to service the volume of the projected membership in the plan, and that physicians have sufficient facility privileges to ensure that they truly can provide services to members at eligible in-network facilities.

Due to the specificity of these standards, network adequacy reviews require the Department to engage in a detailed, complex, and time-consuming analysis. It is rare that a network submission is complete or adequate upon the initial filing. The carriers' submissions of information supporting the adequacy of the network, and the Department's review of this

information for compliance with the adequacy standards, are an iterative and continual process. Furthermore, the Department continues to monitor the adequacy of networks after initial approval through regular updates, and the Department makes inquiries of carriers upon the receipt of information or complaints from consumers, interest groups, and/or providers. Where new information or a complaint indicates a failure of the carrier to maintain adequacy, the Department requires corrective action.

Tiered networks were not envisioned when these network adequacy standards were adopted. In New Jersey and nationwide, state insurance departments have had to interpret their existing rules for application to tiered network plans.[10] Pursuant to New Jersey's rules, the carriers must have contracts or "other arrangements acceptable to the Department" with providers within the applicable time/distance standards. This does not mean that a carrier has to contract with a provider in a way that specifies a certain level of tiered network cost-sharing for the consumer. The rules do not provide that this type of contracting is required, and therefore the Department does not currently have the power to hold, and has not held, any carrier with a tiered network to such an onerous standard. For the purposes of the Department's review, the key is not whether there is a contract with providers at a specific cost-sharing level in a tiered plan, but whether the consumer has legitimate access to necessary and covered medical services at the most-preferred (i.e. lowest) cost-sharing level. A carrier could have a contract with a provider that is silent with regard to consumer cost-sharing. A carrier could also assure compliance with access standards by applying Tier 1 cost-sharing in certain instances where the consumer accesses services from providers not contracted with the carrier. Simply put, the purpose of the

[10] See fn9 supra. The NAIC after months of work by state regulators throughout the U.S. and with extensive input from interested parties like medical providers, carriers and consumer representatives, recently adopted a new Network Adequacy Model Act that for the first time added provisions on reviewing the adequacy of tiered networks.

network adequacy rules is to assure consumer access to care, not provider access to specific kinds of contracts.

Similarly, to ensure maximum consumer access to needed health care at the most preferred and least expensive cost-sharing level, the Department has interpreted its rules strictly, in favor of consumers, to require each tier of the network to meet the network adequacy standards described above. Because of the "discount" in cost-share in Tier 1, carriers at times have asserted that all tiers of a network should be reviewed together for network adequacy. The Department has rejected these entreaties and has interpreted its rules as requiring separate and distinct network adequacy at all tiers of a tiered network. To implement this interpretation and ensure that consumers are able to access the preferred, i.e. lower, cost-sharing of Tier 1 of a tiered network plan, the Department reviews the network filings to verify that the smaller tier 1 subsets of a carrier's proposed tiered network independently meet the standards for network adequacy and are surrounded by a broader tier 2 containing the remainder of the networks' providers. Because of the limited number of acute care hospitals in certain areas of the State, hospital networks for tier 2 must rely upon tier 1 hospitals; however, this comports with public interest because consumers have access to the hospitals within the required time/distance standards of the rule at a lower cost-share than standard tier 2 cost-share.

Both of these interpretations of the network adequacy reviews are necessary to serve the legislative intent of N.J.S.A. 26:2S-18 to protect the interests of consumers because it ensures fulsome access to needed medical care for all consumers at the most preferred cost-sharing level. This interpretation of the Department's rules is well-within the Commissioner's repeatedly recognized authority and expertise, and it is entitled to great weight and deference. New Jersey

Healthcare Coalition, et al. v. New Jersey Department of Banking and Insurance, 440 N.J. Super. 129, 135-136 (App. Div.), certif. denied 222 N.J. 17 (2015).

Lastly, nothing in N.J.S.A. 26:2S-18 or the Department's rules enables or requires the Department to hold a public hearing on a network adequacy filing. The Department has been responsible for network adequacy reviews since 2005; not once has a hearing been requested by any interested party or provider, and no Commissioner during the past ten years has held a hearing on the adequacy of a specific carrier's network.[11]

C) Review and Approval of Horizon's OMNIA Network

On June 25, 2015, Horizon made its first submission to the Department in support of its application for approval of the OMNIA Network's adequacy pursuant to N.J.S.A. 26:2S-18 and N.J.A.C. 11:24A-4.10. Additional materials in support of the application were filed with the Department on various dates thereafter. OMNIA is Horizon's new tiered network of providers, replacing Horizon's Advance Tiered Network, which has been in place and sold to the public over the last two years. The OMNIA Network contains two tiers of in-network providers (including hospitals), with lower cost-sharing applicable to services rendered by providers in Tier 1, and higher cost-sharing applicable to services rendered by providers in Tier 2. Consumers who obtain medical services through a Tier 1 provider will save on the standard out-of-pocket expenses by paying lower co-pays, co-insurance and/or deductibles when compared to obtaining the same medical services through a Tier 2 provider. The OMNIA Network of physicians and specialists is a broader and more fulsome tiered network than its previously approved Advance tiered network. OMNIA's Tier 1 hospital network is comprised of 35

[11] This includes the three years from 2006-2009 when the Hospital Group's counsel was Commissioner.

hospitals, and there are 32 hospitals in Tier 2.[12] Horizon has projected that only approximately 250,000 New Jersey consumers will enroll in OMNIA Plans with this tiered network throughout 2016. Enrollment in OMNIA plans is therefore expected to be a small percentage of Horizon's total statewide membership, which in 2015 was approximately 3.8 million New Jersey insureds statewide.

Over the course of several months, the Department undertook a diligent review of Horizon's submissions in support of its OMNIA Network adequacy application – just as it has for all previous tiered networks approved over the past five years. The information reviewed by the Department included, but was not limited to, submission and Departmental review of multiple tables of PCPs, specialists, and hospitals, enrollment projections by geographic area, and geo-access reports for areas of concern.

Specifically, the Department's review focused on ensuring that the OMNIA Network met the detailed time and distance standards in the Department's rules at N.J.A.C. 11:24A-4.10 for all providers, to ensure that physicians and facilities are available in sufficient numbers to service the volume of the projected membership, and to ensure that network physicians have sufficient facility privileges so that the provider truly can provide services to members at in-network facilities and cost-sharing levels. As per the norm for all network adequacy reviews and as discussed above, this review was an iterative process. Department staff engaged in a number of exchanges with Horizon regarding satisfaction of the network adequacy requirements. This included an August 25, 2015, letter requesting more information, multiple phone conversations, and e-mail submissions.

[12] By comparison, Horizon's Advance tiered network sold in 2014 and 2015 had only 31 hospitals in Tier 1, comprised generally of smaller hospital systems, and 37 Tier 2 hospitals.

Based upon the Department's review of Horizon's submissions, the Department only found one major deficiency in the OMNIA Tier 1 network upon its initial review. Specifically, the Department found that the OMNIA Network, as originally filed, was inadequate for the provision of hospital-based obstetric services for projected membership in and around Burlington County. In response to Department inquiries, Horizon acknowledged that access to obstetrics in the Burlington County area only reached 88 percent of the projected membership for its OMNIA plan, rather than the required 90 percent. See, N.J.A.C. 11:24A-4.10(b)(3)(i). Other than this one deficiency, the OMNIA Network exceeded the required standards for network adequacy.

On September 15, 2015, in response to the Department's initial findings related to Burlington County, Horizon committed in writing to ensuring network adequacy for obstetrics in the Burlington County service area by having members pay Tier 1 copays, co-insurance and/or deductibles for obstetric services rendered at a Tier 2 hospital in Burlington County.[13] The Department instructed Horizon to ensure that all consumer-facing information regarding the OMNIA Network for obstetric services in Burlington County clearly informed consumers that such services would be available at Tier 1 cost-sharing, and, to date, Horizon has complied. As detailed above, this approach satisfied the requirements of the Department's rules and the public interest because: i) OMNIA members are able to access obstetrical services in the Burlington County service area at Tier 1 cost-sharing, even though all other services at the hospital are subject to Tier 2 cost-sharing; and, ii) consumers are fully informed of this ability when purchasing an applicable OMNIA plan and when seeking services as a member after January 1, 2016.

[13] Although Horizon's hospital tables reflected that obstetric services are available at two Burlington County hospitals, such services are only available at Virtua Memorial in Mount Holly. Horizon reaffirmed this commitment to require only Tier 1 cost-sharing for obstetrics at this hospital in writing on October 1, 2015.

With this cure to the Burlington County obstetrics deficiency, the Department determined that the OMNIA Network met the time and distance requirements in N.J.A.C. 11:24A-4.10 and qualified for statewide approval. With regard to the acute care hospital requirements at N.J.A.C 11:24A-4.10(b)3i, the OMNIA Network satisfied the access adequacy standard with 35 hospitals in Tier 1 and 32 additional in-network hospitals in Tier 2. This means that the OMNIA Network has at least one acute care hospital with medical-surgical, pediatric, obstetrical, and critical care services, within 20 miles or 30 minutes driving time for 90 percent or more of the OMNIA plans' projected enrollment in each county or service area.

On September 15, 2015, the Department notified the Center for Medicaid and Medicare Services ("CMS") that review of the network for Horizon's OMNIA Plans demonstrated adequacy, and changed the recommended qualified health plan status from "pending" to "yes." On September 18, 2015, the Department issued a letter to Horizon confirming this action and approval of the OMNIA Network statewide.

D) The Department's Second Adequacy Review in Response to Complaints from Capital Health, St. Francis and Others

During this timeframe, Horizon also informed the public and all of its contracted New Jersey hospitals of the new OMNIA Network. For example, on September 10, 2015, Horizon announced publicly its launch of the OMNIA Network. On this same day, Horizon also mailed letters to those hospitals designated as Tier 2 facilities advising them of the new OMNIA Network and their designation status. In a separate public announcement on September 16, 2015, Horizon rolled-out educational material about the OMNIA Network and its plans.

On or about September 17, 2015, the Department received a letter from state legislators for District 15 and elected officials from the City of Trenton raising concerns about the impact of Horizon's new OMNIA Network on two Trenton hospitals - St. Francis and Capital Health –

which are both in Tier 2.[14] In response, on September 23, 2015, the Department met with the legislators from District 15, and representatives from the City of Trenton, Capital Health and St. Francis. During this meeting, the Department listened to the concerns of the parties and advised that the OMNIA Network met the standards for adequacy in the rules and had been approved.

At this meeting, two questions were raised regarding the OMNIA Network's compliance with the Department's rules. Specifically, the interested parties queried whether the OMNIA Network met adequacy for Mercer County with regard to hospital obstetric services and whether the Department analyzed the Mercer County time and distance standards based upon times for public transportation, which is contemplated by the rules in N.J.A.C. 11:24A-4.10(d). The Department advised that the OMNIA Network met the standards and that the public transportation exception did not apply to Mercer County.

After this meeting, in furtherance of the Department's role in reviewing and responding to complaints/concerns regarding network adequacy, the Department conducted another review of the adequacy of the OMNIA Network in light of the concerns raised. Each of the issued raised by Capital Health, St. Francis, the City of Trenton and interested legislators were found to be without merit.

With regard to hospital obstetric services for residents in the Mercer County service area, the Department confirmed that the OMNIA Tier 1 network met adequacy through the provision of obstetric services at the University Medical Center of Princeton at Plainsboro.[15]

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[14] Note that Capital Health was a Tier 2 hospital in Horizon's Advance Tiered Network products in 2014 and 2015.

[15] Despite this, Horizon agreed to provide even greater access to members in the service area containing Mercer County by providing Tier 1 cost-sharing access to members that utilize Capital Health Medical Center in Hopewell for obstetric services, and Horizon clearly communicates this ability to its members on its website both before and after purchase of an OMNIA Plan.

With regard to the public transportation analysis in N.J.A.C. 11:24A-4.10(d), the Department confirmed that this exception to the standard time/distance rules did not apply because U.S. Census Data demonstrated that only approximately 7.6 percent of Mercer County residents rely on public transportation, and thus Mercer County did not meet the 20 percent or more standard in the rule. Therefore, the Department determined there was no basis under the rules to halt the approval of the OMNIA Network as had been requested by the pertinent elected officials, Capital Health and St. Francis.

E) The Detailed and Public Explanation of the OMNIA Network and Its Approval

On October 1, 2015, in anticipation of a joint Senate hearing regarding the new OMNIA Network, Horizon sent a letter to legislators explaining the parameters of the OMNIA Network. This letter detailed the goals and objectives of the OMNIA Network, including which hospitals were designated as Tier 1 hospitals and which hospitals were given Tier 2 designations, and the metrics used by Horizon to make such placement determinations.

On October 5, 2015, the Senate Commerce and Health, Human Services and Senior Citizens Committees held a joint hearing at which officers of Horizon appeared and answered questions from legislators about their concerns regarding the OMNIA Network. The Department also appeared, submitted written testimony and over 700 pages of non-confidential government records from Horizon's OMNIA Network adequacy review file, and discussed its review and approval of the adequacy of the OMNIA Network in detail.

As noted above, the Department is committed to reviewing complaints and/or concerns about the adequacy of any network, even after initial approval, because provider networks tend to be fluid. Despite multiple meetings and legislative inquiries, including another meeting with

Capital Health on October 23, 2015[16], none of the information or questions offered to date have demonstrated that the OMNIA Network does not meet the Department's adequacy requirements in N.J.A.C. 11:24A-4.10.

On November 19, 2015, the Hospital Group filed the within request for a stay with the Commissioner and a Notice of Appeal, including a motion for an extension of time within which to file, with the Superior Court of New Jersey, Appellate Division, advising of its intention to challenge the Department's approval of the OMNIA Network.

Open enrollment for consumers seeking a fully-insured health benefit plan in the individual market began on November 1, 2015, and is currently ongoing. Enrollment for small employer fully-insured plans is year-round, and therefore enrollments in small employer plans using the OMNIA Network is also occurring at this time.[17] This open enrollment period includes all carriers of fully-insured qualified health plans, and includes the Horizon OMNIA plans and all other carriers' tiered network plans.

DISCUSSION

The Hospital Group has requested that the Commissioner stay the Department's approval of the Horizon OMNIA Network, and thus effectively require a halt of sales of fully-insured OMNIA health benefits plans in this State that rely on this Network.[18] The submission by the

[16] At this meeting, the Department assured Capital Health that it would thoroughly review any information that the hospital would like to submit regarding OMNIA Network adequacy concerns. On November 4, 2015, Capital Health submitted information to the Department, and the Department initiated a detailed review; however, the Department has not yet responded to this letter and will not be able to do so now that Capital Health has joined in the appellate suit challenging the Department's approval.

[17] Pursuant to federal law, the State Health Benefits Plan (SHBP) and the School Employees Health Benefits Plan (SEHBP) as self-funded plans are not subject to Department regulation. Therefore, enrollment in the OMNIA Plans in the SHBP did not require any approval by the Department.

[18] This Order will only address the assertions raised by the Hospital Group in the stay request dated November 19, 2015, to the extent necessary to rule on this stay request. The Department reserves its full rights to present the facts and legal analysis contained in this Order and any additional facts, evidence and arguments not contained herein, as determined necessary and appropriate by the Commissioner, in any proceeding by the Hospital Group or any other parties that seeks to stay, challenge and/or overturn the Department's approval of the Horizon OMNIA Network.

Hospital Group relies on bald and unsupported assertions regarding the Department's statutory and regulatory powers to review a carrier's network for adequate access to care and concerning perceived deficiencies in the OMNIA Network under the standards in N.J.S.A. 26:2S-18 and N.J.A.C. 11:24A-4.10. In total, the Hospital Group provides no evidence in support of these attacks on the Department's review and the adequacy of the OMNIA Network and thus, there is no legally competent basis to support a stay. For all of the reasons set forth below, the Hospital Group has failed to sustain its burden of proof for a stay established by the Supreme Court in Crowe v. DeGioia, 90 N.J. 126, 132 (1982), and its progeny.

Standard of Review

It is well settled that movants have the burden of establishing by clear and convincing evidence that a stay should be granted in this matter. American Employers' Insurance Co. v. Elf Atochem N.A., Inc., 280 N.J. Super. 601, 611, fn8 (App. Div. 1995); Subcarrier Communications, Inc. v. Day, 299 N.J. Super. 634, 639 (App. Div. 1999) (citing American Employers' Ins. Co., supra). In this application, the Hospital Group has failed to recite facts or present evidence in its moving papers that meet the legal requirements entitling it to the relief requested. Indeed, the Hospital Group has done little more than reiterate the claims previously asserted by Capital Health and St. Francis, which were reviewed and deemed meritless by the Department.

A stay of a final administrative decision pending appeal is an extraordinary equitable remedy involving the most sensitive exercise of judicial discretion. Crowe v. DeGioia, 90 N.J. 126, 132 (1982); Zoning Board of Adjustment of Sparta v. Service Electric Cable Television of N.J., Inc., 198 N.J. Super. 370, 379 (App. Div. 1985). It is not a matter of right, even though irreparable injury may otherwise result. Yakus v. United States, 321 U.S. 414, 440, 64 S. Ct.

660, 674, 88 L. Ed. 834 (1944). Because it is the exception rather than the rule, GTE Corp. v. Williams, 731 F.2d 676, 678 (10th Cir. 1984), the party seeking such relief must clearly carry the burden of persuasion as to all the prerequisites in most circumstances. United States v. Lambert, 695 F.2d 536, 539 (11th Cir. 1983). Relaxation of the standard is appropriate to maintain the status quo even when a claim appears doubtful "when a balancing of the relative hardships substantially favors the movant, or the irreparable injury to be suffered by the movant in the absence of the injunction would be imminent and grave, or the subject matter of the suit would be impaired or destroyed." Waste Mgmt. of New Jersey v. Morris Cty. MUA, 433 N.J. Super. 445, 453-454 (App. Div. 2013).

Nevertheless, in most circumstances, the injunctive relief of a stay is appropriate only in instances where the party seeking this extraordinary measure demonstrates that each of the following conditions has been satisfied: (1) a reasonable probability that the moving party will prevail on the merits of the underlying appeal; (2) the public interest favors such relief; (3) on balance, the benefit of the relief to the movant will outweigh the harm such relief will cause other interested parties, including the general public; and (4) irreparable injury will result if a stay is denied. Crowe v. DeGioia, 90 N.J. 126, 132-134 (1982). The Hospital Group's request for a stay fails to meet any of these elements.

A) Reasonable Probability of Success On the Merits

The Hospital Group argues "that [the Department] has failed to meet the standards for administrative decision making" and its approval of the OMNIA Network was "arbitrary, capricious, unreasonable," a violation of its "express or implied legislative power," and "is not supported by sufficient credible evidence from the record as a whole." Specifically, the Hospital Group contends: (1) that "[the Department] improperly approved the OMNIA Plan despite the

Plan's failure to meet network adequacy requirements;" and, (2) "[the Department] improperly abdicated its responsibility to consider whether the OMNIA plan was in the public's best interest."

For the reasons stated below, the Department's approval of the OMNIA Network was not arbitrary, capricious, or unreasonable, and the Hospital Group does not have a reasonable probability of success on the merits of its appeal.

1) The Hospital Group's Contention that the Department Improperly Approved the OMNIA Network

The Hospital Group alleges that the OMNIA Network failed to meet the adequacy requirements, as specified in N.J.A.C. 11:24-6.1 et seq. and N.J.A.C. 11:24A-4.10, at the time the plan was approved. Specifically, the Hospital Group alleges that: a) Horizon did not have agreements with each Tier 1 hospital at the time of the Department's approval, which made it impossible to evaluate the OMNIA Network's compliance with the Department's regulations, and the OMNIA Network did not meet adequacy standards for obstetrical services in the Burlington and Mercer County service areas; b) the OMNIA Network fails to include in-network access to all Level I and Level II trauma centers; and c) Horizon failed to demonstrate that the Tier 1 network is adequately accessible by consumers using public transportation. For the reasons stated below, each argument fails as the OMNIA Network meets the network adequacy requirements in N.J.S.A. 26:2S-18 and N.J.A.C. 11:24A-4.10[19].

[19] Although identical in substance, the network access requirements in N.J.A.C. 11:24-6.1 et seq. are only applicable to HMOs, and therefore not applicable to Horizon as a health service corporation (N.J.S.A. 17:48E).

a) Requirement for Contracting or Arrangements Acceptable to the Department & Adequacy of Obstetric Hospital Services in Burlington and Mercer County Service Areas

The Hospital Group's assertions that the OMNIA Network failed to meet network adequacy because it did not "have agreements with each Tier 1 hospital in place at the time of approval" is inaccurate and misinterprets the Department's rules. Furthermore, the Hospital Group is mistaken in its allegations that the OMNIA Network does not meet adequacy requirements for obstetric services at hospitals in the Burlington and Mercer County service areas.

First, carriers must demonstrate a sufficient number of acute care hospitals with licensed obstetrical services, among other services, in any county or service area that is within 20 miles or 30 minutes driving time, whichever is less, for 90 percent of covered persons within the county or service area. N.J.A.C. 11:24A-4.10(b)3i. Horizon's OMNIA Network met this standard with 35 hospitals in Tier 1 and 32 hospitals in Tier 2. With respect to the OMNIA Network's adequacy for obstetrical services in Mercer County, all projected OMNIA members in Mercer County have access to a Tier 1 hospital with obstetrical services within 20 miles or 30 minutes driving time. In fact, Horizon demonstrated that if 100 percent of its managed care, female members in Mercer County, who are between the ages of 18 to 45, migrate to OMNIA Plans, the furthest average distance the members would need to travel would be 16.5 miles and the longest drive was 26.1 minutes to a Tier 1 hospital.

Additionally, although the OMNIA Network did not initially meet the network adequacy requirements as it related to Tier 1 obstetrical services in the Burlington County service area, Horizon committed to ensuring that network adequacy would be achieved by applying Tier 1 cost-sharing for consumers that obtain obstetrical services at Burlington County's Virtua

Memorial Hospital, even though its placement is in Tier 2. This commitment was given prior to the Department's approval of the OMNIA Network on September 15, 2015, and Horizon's online provider directory makes the availability of obstetric services at this hospital at Tier 1 cost-sharing known to consumers both before and after purchase of an OMNIA Plan.

It is important to note that, with regard to OMNIA, all of the Tier 1 and Tier 2 hospitals participating in the OMNIA Network were already contracted with Horizon and considered in-network. Establishment of the OMNIA Network did not require re-contracting with these hospitals. Furthermore, as discussed above, the purpose of the Department's review of networks is to ensure adequate consumer access to necessary medical care and providers so that the benefits provided under the fully-insured health benefits plan are not illusory. Here, the Department has fulfilled this role and required Horizon to take action prior to sale of the OMNIA plans in the limited area where the network was found to be deficient. The Hospital Group has failed to demonstrate any facts that Horizon has not complied with the foregoing.

Additionally, as detailed above, N.J.A.C. 11:24A-4.10 does not require carriers to have contracts with network providers that specifies a particular cost-sharing tier for consumers in order to meet network adequacy. The rules merely provide that the carrier have a contract or other arrangement acceptable to the Department.

Carriers can satisfy this requirement in a number of ways. They can contract with a provider for inclusion in a network at a specific cost-sharing tier. With regard to OMNIA, Horizon could make a business decision to contract with a particular hospital for inclusion in the OMNIA Alliance that specifies consumers will experience Tier 1 cost-sharing when utilizing that in-network facility. A carrier could also make a business decision to have a general contract that is not network or plan specific, and which does not specify the cost-sharing for consumers.

Under this option, Horizon can have a general contract that requires a hospital to participate in all of its networks without regard to tier assignment and thus require participation in the OMNIA Network at any tier. A carrier can also decide, or the Department can require a carrier, to apply Tier 1 cost-sharing for consumers at certain facilities and/or providers to expand access or meet network adequacy standards. As discussed above, both of these circumstances have occurred with regard to the OMNIA Network. Although not required for adequacy, Horizon decided to apply Tier 1 cost-sharing for consumers receiving obstetric services at Capital Health Hopewell to expand access for Mercer County area residents. Additionally, the Department required Horizon to apply Tier 1 cost-sharing for consumers receiving obstetric services at Virtua Memorial in order to meet network adequacy standards for members in the service area in and around Burlington County.

Finally, and contrary to the unsupported contentions of the Hospital Group, pursuant to the HCQA, N.J.S.A. 26:2S-18 et seq., the Department only has the authority to review the adequacy of provider networks with respect to the scope and type of health care benefits provided by a carrier, the geographic service area covered by the network, and access to specialists, when appropriate. The Department does not have the authority to exceed these parameters and regulate the criteria used by a carrier to construct a network, such as the metrics for selecting with what providers to contract or in which tier to place a provider. The Department also does not have the authority under any State law to review and/or approve the specific level of provider compensation; such agreements between carriers and providers are matters of proprietary negotiations and contracting. It is especially important to note that New Jersey does not have an "any willing provider law" for hospitals. Instead, under New Jersey law,

carriers are free to select the hospitals with whom they wish to contract, negotiate compensation levels, and determine the metrics for deciding hospital tier placement.

For these reasons, the Hospital Group's assertions that the OMNIA Network failed to meet the Department's network adequacy standards in N.J.S.A. 26:2S-18 and N.J.A.C. 11:24A-4.10 for acute care hospitals is incorrect, and therefore fails to demonstrate a reasonable probability of success on the merits of the Hospital Group's appeal.

b) Access to Level I and II Trauma Centers

N.J.A.C. 11:24A-4.10(b)(iii) requires that a carrier "have a contract or otherwise agree to cover medically necessary trauma services at a reasonable cost with all Level I or Level II trauma centers designated by the Department of Health and Senior Services, with the provision of benefits at the in-network level." (Emphasis added). Horizon satisfies both parts of the regulation. First, the rule does not require Horizon to contract with all Level I and Level II trauma centers as alleged by the Hospital Group. In accordance with the Department's statutory mission to ensure adequate access for consumers, the rule permits two options to enable such access to trauma services – either contracting or agreeing to cover trauma services at in-network cost-sharing. N.J.A.C. 11:24A-4.10(b)(iii). Nothing in the regulation requires that all trauma centers be placed in the most preferred tier, only that they be in-network.

Here, Horizon's OMNIA Network has contracts will all ten DHSS-designated trauma centers in the State to be in-network - 6 trauma centers are in Tier 1 and 4 trauma centers are in Tier 2. Second, because N.J.A.C. 11:4-37.3(b)2 provides that a member's responsibility for emergency services is limited to network cost-sharing and because trauma services are considered emergency services, as emergency is defined in N.J.A.C. 11:24A-1.2, members are

only required to pay the in-network cost-sharing for trauma services, regardless of the participation status (in-network vs. out-of-network) of the hospital which rendered services.

In light of the above, the Hospital Group's assertion that the OMNIA Network fails to meet network adequacy for Trauma Centers is incorrect, and fails to demonstrate a reasonable probability of success on the merits of an appeal.

c) Public Transportation Metric for Time/Distance Requirements

N.J.A.C. 11:24A-4.10(d) provides that:

> [i]n any county or approved service area in which 20 percent or more of a carrier's projected or actual number of covered persons must rely upon public transportation to access health care services, as documented by U.S. Census Data, the driving times . . . shall be based upon average transit time using public transportation, and the carrier shall demonstrate how it will meet the requirements in its application.

Without any evidence or specific factual arguments, the Hospital Group asserts that the Department failed to properly apply this metric to review of the OMNIA Network. This assertion is inaccurate. Based upon the U.S. Census Data, only two counties in New Jersey have populations where 20 percent or more of the carrier's projected or actual number of covered persons may rely upon public transportation - Essex and Hudson, at 20.1 percent and 40 percent, respectively. Applying the public transportation review, each of these counties met or exceeded the adequacy requirements as specified above and the Hospital Group has not presented any evidence or facts to belie this finding.

It is also important to note that none of the hospital systems or stand-alone hospitals in the Hospital Group are located in either Essex or Hudson County, and this calls into question the requestors' standing to challenge this aspect of the Department's review. Additionally, as stated above, this issue was raised by some hospitals within the challenging Hospital Group on or about

September 23, 2015, with regard to Mercer County. However, following a second review in response to these concerns, the Department confirmed that the U.S. Census data for Mercer County demonstrates at most, only 7.6 percent of Mercer residents rely on public transportation, and therefore the public transportation analysis at N.J.A.C. 11:24A-4.10(d) does not apply. For these reasons, the Hospital Group's argument with regard to the public transportation metric in N.J.A.C. 11:24A-4.10(d) is without merit and fails to demonstrate a reasonable probability of success on the merits of their appeal.

2) The Hospital Group's Contention that the Department Abdicated its Responsibility to Consider Whether the OMNIA Plan Was in the Public Interest

The Hospital Group alleges that the Department violated the agency's obligation under N.J.S.A. 17:1C-19 and 17:48e-4a to ensure that the OMNIA Network is not contrary to the public interest. Neither of these provisions are applicable to the Department's specific review of the OMNIA Network for adequacy pursuant to N.J.S.A. 26:2S-18 and N.J.A.C. 11:24A-4.10. While N.J.S.A. 17:1C-19a(1) provides that the Department "has a statutory obligation to protect the interest of New Jersey's insurance consumers and to regulate and oversee the operations of the insurance industry," the purpose of the provision was to establish a special purpose funding mechanism for the Department. N.J.S.A. 17:48E-4a relates to the documents that a health service corporation like Horizon must provide to the Department in order to obtain a Certificate of Authority and the factors that the Department must review prior to issuing same.

Under well-settled canons of statutory construction, these general provisions in acts unrelated to network adequacy do not supersede the specific statutory direction in N.J.S.A. 26:2S-18 regarding the scope of the Department's powers to review the adequacy of carriers' networks, and the detailed regulatory framework in N.J.A.C. 11:24A-4.10 for protecting the public interest with regard to network adequacy. See, Wilson v. UCJF, 109 N.J. 271, 278

(1988); Clymer v. Summit Bancorp, 171 N.J. 57, 70 (2002); and, Bergen Cty. PBA Local 134, et al. v. Donovan, 436 N.J. Super. 187, 199-200 (App. Div. 2014). The Department is not free to ignore the Legislature's express direction in N.J.S.A. 26:2S-18 that network adequacy reviews are to focus on the ability of consumers to access an adequate number of providers, facilities and specialists for the services covered under the health benefits plan within reasonable geographic parameters. Nor is the Department authorized to ignore its detailed time and distance standards in N.J.A.C. 11:24A-4.10 that were adopted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., with the full input and participation of interested parties. Indeed, these standards are some of the strictest in the nation. If the Department took any action beyond this statutorily delegated authority or its rules implementing same, then the Department would clearly be acting in an arbitrary and capricious manner.

Even assuming the Hospital Group provided a legitimate legal basis for its contention, the Department's rules and its actions in reviewing the adequacy of the OMNIA Network fully comport with protecting the public interest. As discussed above, N.J.S.A. 26:2S-18 provides that for all managed care plans the Department shall promulgate regulations to ensure the "adequacy of [a carrier's] provider network with respect to the scope and type of health care benefits provided by the carrier, the geographic service area covered by the provider network and access to medical specialists, when appropriate." The plain language of this statute clearly establishes that the Department's mission in reviewing network adequacy is to protect consumers who purchase fully-insured health benefits plans to ensure access to medically necessary covered care through a sufficient number of providers and within a reasonable geographic distance from where the member resides. The Department fulfills this mission by applying the detailed time/distance standards in N.J.A.C. 11:24A-4.10 to carriers' networks to ensure access within

those parameters for all provider types, to ensure that physicians and facilities are available in sufficient numbers to service the volume of the projected membership in the plan, and to ensure that physicians have sufficient in-network facility privileges so that members can legitimately access the covered medical services at in-network cost-sharing levels. Additionally, with the advent of tiered networks, the Department has interpreted its rules, to the consternation of some carriers, in a strict manner to further protect the stated public interest of consumer access by requiring carriers to have fully-adequate networks at both tiers of consumer cost-sharing.

The Hospital Group specifically alleges that: 1) the OMNIA Network "jeopardizes the stability and quality of the New Jersey Hospital system as a whole;" 2) Horizon's distribution into tiers lacks transparency;" 3) the OMNIA Network will "make it unnecessarily difficult for patients to receive continuity of care;" and 4) the OMNIA Network undermines the "financial viability" of Tier 2 hospitals.

First, the Hospital Group argues that the OMNIA Network jeopardizes the stability and quality of the hospital system in this State. Specifically, it argues that the OMNIA Network "encourage[s] members to choose Tier 1 hospitals over Tier 2, and is based on projections that patient volumes at Tier 1 hospitals will increase as patients migrate away from Tier 2 hospitals." It further argues that consumers may mistakenly believe that the "Tier 2" label is indicative of quality of care and the OMNIA Network may endanger the "financial viability" of Tier 2 hospitals as patients with high quality commercial health insurance may migrate to Tier 1 hospitals. Plus, the Hospital Group asserts that the OMNIA Network undermines the "financial viability" of Tier 2 hospitals contrary to the public interest and increases the Tier 2 hospitals' risk of default. These arguments are completely speculative and without merit.

Contrary to the assertions of the Hospital Group (which is represented by a former Commissioner of the Department), tiered plans have been in existence in New Jersey for many years and almost every carrier in New Jersey has offered or is currently offering a tiered network product in the fully-insured market. Further, the various members of the Hospital Group have participated in these other tiered networks as in-network providers at both Tier 1 and Tier 2 cost-sharing levels. Over 10 tiered networks have been approved by the Department over the past five years, including Horizon's previously approved tiered network known as Advance, which was sold in the individual health insurance market in 2014 and 2015. To date, none of the speculative harms alleged by the Hospital Group have come to fruition. In fact, all of the hospital systems and stand-alone hospitals in the challenging Hospital Group participated in Horizon's Advance tiered network - 6 in Tier 1 and 5 in Tier 2- without such adverse consequences. Moreover, consumers still have access to – and predominantly buy – full network plans where such tiered cost-sharing is not present; thus, even if any such "hospital migration" were to result, the financial and/or reputational impact would likely be small. Lastly, fully-insured health benefit plans subject to the Department's regulation only comprise about 25% of how consumers obtain coverage for their health care needs. Thus, the likelihood of such significant financial and reputational impacts as alleged by the Hospital Group being caused by Horizon's sale of the OMNIA Plans that are only expected to garner approximately 250,000 New Jersey consumers, is extremely remote.

Furthermore, different carriers make different decisions with regard to tiering. Thus, a hospital may not be in OMNIA's Tier 1, but it will likely be a Tier 1 hospital for another carrier. Carriers are competing for market share and this encourages differentiation between plans that enables consumer access to different providers at different levels of cost-sharing. Consumers in

New Jersey have many plan choices, and the opportunity to fully review and learn about the plans, the available in-network and tiered providers, and the applicable cost-share, all prior to purchase. This enables consumers to select a plan that meets their budget and healthcare needs. If a consumer expects to use a hospital in OMNIA's Tier 2, they are free to accept the cost-sharing level for that hospital in the OMNIA Network plan, or choose another health plan from a different carrier that includes that particular hospital in Tier 1, or to buy a non-tiered network plan offered by Horizon or another carrier that has that particular hospital as a participating, non-tiered provider.

Finally, the OMNIA Network is projected to include only 250,000 members, which is only approximately 6.5 percent of Horizon's total marketshare statewide. The Hospital Group has failed to demonstrate, despite months of time to do so, how such a small percentage of Horizon's marketshare – which is only about half of the entire market - can so adversely affect their financial positions. Indeed, the members of the Hospital Group should have far greater concerns if the potential migration of such a small number of consumers can cause the substantial financial harm they allege. Furthermore, the Hospital Group's participation in Horizon's Advance Tiered Network for the past two years as both Tier 1 and Tier 2 providers and in other carriers' tiered network products demonstrates that such dire financial consequences are hyperbole at best.

Accordingly, there is no factual basis for the Hospital Group's arguments in this regard, and the Hospital Group's prior participation in and failure to challenge similar tiered networks in years prior refutes the merits of their unsupported allegations.

Further, the Hospital Group argues that "the Tier 1 sub-network . . . excludes hospitals located in underserved communities, while many of the Tier 2 hospitals are located in such

areas." As previously discussed above, the Department, pursuant to N.J.S.A. 26:2S-18, has the authority to review network adequacy requirements as specified in N.J.A.C. 11:24-6.1 et seq. and N.J.A.C. 11:24A-4.10. The network adequacy requirements are meant to protect a consumer's access to certain benefits and services at specified cost-sharing levels, as agreed upon by the consumer and the carrier. As such, the requirements relate to the protection of consumers and not the continued financial well-being of providers. As long as the network meets the applicable adequacy standards, the Department does not have the authority to require carriers to construct their networks to include specific providers, including hospitals.

Additionally, the Hospital Group argues that Horizon's division of hospitals lacks transparency in its criteria for determining which providers are included in each tier within the OMNIA Network. As stated above, the Department has no authority to compel carriers to include specific providers, including hospitals, in its network, nor does the Department have authority to require that carriers utilize specific criteria in its determination of which the hospitals will be placed within each tier of a network. The Department also does not have any statutory authority to review the metrics used by carriers to choose with which providers to contract or on what terms.

Further, while the Hospital Group states that the Department approved the OMNIA Network within two weeks of the receipt of Horizon's submission, this assertion is not supported by the facts. Horizon first submitted the OMNIA Network to the Department on June 25, 2015, and the Department approved the OMNIA Plan more than two months later on September 15, 2015, as confirmed by the letter dated September 18, 2015.

Additionally, the Hospital Group argues that the OMNIA Plan will make it unnecessarily difficult for patients to receive continuity of care. Specifically, it argues that many physicians

were designated as Tier 1, but the hospitals that the physicians are affiliated with are designated as Tier 2 and certain services that are provided at Tier 2 hospitals are considered Tier 1. This argument is contradicted by the Department's network adequacy review which ensures that in-network physicians have privileges at in-network facilities within the same cost-sharing tier.

For all the foregoing reasons, it is clear that the Hospital Group has failed to demonstrate a reasonable probability of success on the merits and is not entitled to a stay. In total, the Hospital Group's substantive challenges to the Department's review of the OMNIA Network under the detailed standards of N.J.A.C. 11:24A-4.10 are either unsupported, contradicted by the facts and evidence of the Department's review, or misinterpretations of the applicable network adequacy standards and the regulatory role and purpose of the Department's review. Overall, the Hospital Group has failed to demonstrate a reasonable probability of success on the merits of an appeal, especially in light of the great weight and deference courts are required to afford to the Department's interpretations of its own rules. See New Jersey Healthcare Coalition, et al. v. New Jersey Department of Banking and Insurance, supra, 440 N.J. Super. at 135-136. Here, the Department interpreted and applied its detailed and existing network adequacy rules to new tiered networks in fulfillment of its paramount statutory duty to ensure meaningful consumer access to providers by requiring adequacy at both tiers of a network. This deference to the Department's expertise, and the fact that the existing statutory and regulatory requirements do not enable the Department to engage in the type of analyses that the Hospital Group seems to desire, further demonstrate that the Hospital Group has not demonstrated a reasonable probability of success on the merits of an appeal. Therefore, I find that Hospital Group has failed to carry its burden to demonstrate by clear and convincing evidence that the first Crowe factor for injunctive relief is present in this matter.

B) Public Interest

The public interest does not favor a stay. The Hospital Group argues that "OMNIA is the first of its kind in New Jersey [and] the manner in which OMNIA was created and approved by [the Department] has the potential to set a dangerous precedent." It further argues that this approval would cause harm to the healthcare field as a whole, could significantly affect New Jersey consumers and could affect the viability of the public health and welfare institutions. To the contrary, granting a stay of the Department's approval of the OMNIA Network would in fact have a deleterious effect on the public in that it would cause significant disruption in the healthcare market, especially for those who have already chosen to enroll or are considering enrolling in a plan using the OMNIA Network.

As a threshold matter, the Hospital Group is grossly inaccurate in its assertion that the OMNIA Network is the first of its kind. As stated earlier, New Jersey has had tiered networks for at least five years and the Department has reviewed and approved the adequacy of such tiered networks for virtually every major health insurance carrier in New Jersey,[20] including the Advance Network which was most recently offered by Horizon and is being replaced by the OMNIA Network. Tiered networks have been a part of the New Jersey health insurance market for five years and these tiered networks offer consumers an additional option for health coverage.

In addition, tiered network products offer consumers new and less costly options for comprehensive health benefits plans, and consumers have the ability to fully vet the participating providers (including hospitals), the tier level, and the applicable cost-sharing prior to purchase. Plus, every carrier continues to offer plans without tiered cost-sharing. Therefore, consumers in the market will have the ability to dictate through their purchase whether such tiered plans are

[20] The Department of Health was responsible for reviewing network adequacy prior to 2005. See 37 N.J.R. 2737(a).

considered a valuable market addition, and there is nothing inherent in tiered plans that on its face demonstrates that such plans are contrary to the public interest. In fact, the Hospital Group has conceded on several occasions that tiered plans provide lower cost options to consumers.

While it is unclear what, if any, harm would be experienced by the Hospital Group as they have only advanced speculative scenarios, it is clear that granting a stay and removing the Department's approval of the OMNIA Network would cause significant upheaval and disruption to the New Jersey marketplace and its consumers. Notably, OMNIA plans in the individual market are currently being sold both on the federally facilitated marketplace (FFM) and directly by Horizon off the FFM with effective dates of January 1, 2016 and later. Moreover, OMNIA plans are also being sold to small employers both on the federal SHOP and directly. Individual consumers and small employers are currently selecting OMNIA plans as the appropriate choice to service their particular healthcare needs. Staying the sale and effective date of these plans would immediately trigger chaos. Consumers who have already purchased OMNIA products would be displaced. Under our State laws, these consumers would need to be given immediate and specific written notice that the OMNIA plan is no longer available to cover them effective January 1st. Notice would have to be provided to all brokers advising that OMNIA is no longer available for sale. For plans sold on the FFM, CMS would have to emergently suppress sale of the OMNIA plans and enable selection of new plans by the consumers through a special enrollment period. And, ultimately, the consumers would actually have to select a new health plan. All of this would have to be accomplished by December 15, 2015, at the latest in order to enable a January 1, 2016 effective date. Such disruption to the market is clearly not in the public interest and does not protect New Jersey consumers.[21]

[21] Additionally, plans sold on the federally facilitated marketplace may provide consumers with a subsidy in the form of an advanced premium tax credit ("APTC"). Each plan sold on the FFM must satisfy actuarial values to fall

Overall, the public interest warrants denial of the stay. The disruption to the market and New Jersey consumers that would result from a stay is substantial and is inimical to the purpose of the State's network adequacy laws.

C) Benefits vs. Harm of Granting the Request for a Stay

A balancing of the benefits and the harms of granting the request for a stay of the Department's approval of the OMNIA Network weighs heavily against granting the stay. The Hospital Group argued that the balancing of the hardships favors a stay of the Department's approval of the OMNIA Network because OMNIA will drive consumers from Tier 2 hospitals to Tier 1 hospitals and will have a damaging effect on the Hospital Group. The Hospital Group argues that neither the Department, nor other interested parties, will suffer hardship if the stay is granted. This argument is incorrect. First, enrollment in OMNIA plans has already begun. As discussed above, staying the Department's approval of the OMNIA Network will cause disruption to those that have purchased OMNIA plans by exposing them to the risk of being without coverage on their selected effective date. Moreover, a stay will remove varied plan options for those consumers currently looking for health coverage, particularly those who are looking for less costly plans.

In addition, issuance of a stay would require burdensome and possibly impossible regulatory action by this Department and CMS. As discussed above, multiple actions would have to be taken by both State and Federal regulators to implement an immediate suppression of the OMNIA plans and adequate time for consumers to make an informed selection of a new plan, all of which must occur before December 15, 2015, at the latest for consumers that require a

within a certain "metal level" – Platinum (lowest levels of cost-share), Gold, Silver and Bronze (highest levels of cost-share). The base level of the APTC is calculated based upon the second least costly Silver metal level plan in a given market. Here in New Jersey, a Horizon OMNIA Silver Plan is the base plan for the APTC. Rescinding approval of the OMNIA Network will cause substantial disruption to the FFM in New Jersey and all consumers that qualify for the APTC because it will require recalculation of the APTC amount.

January 1, 2016 effective date. See also fn 22 supra. Such a process is fraught with the legitimate peril of disrupting necessary medical care for consumers who have purchased an OMNIA plan simply to avoid highly speculative and unknown financial harm to the Hospital Group.

Lastly, suppression of the OMNIA plans would also be inequitable to Horizon. Almost all other carriers have tiered network products for sale in the 2016 market. To suppress Horizon's tiered plans would likely put the carrier at a competitive disadvantage and clearly creates an unlevel playing field. There is simply no basis in law or fact to hold Horizon to new and unwritten standards that no other carrier has had to meet with regard to its tiered network plans.

D) Irreparable Harm

The "harm" cited by the Hospital Group is not certain, imminent or irreparable. The only harm offered is monetary in nature and therefore does not satisfy the fourth Crowe requirement. The Hospital Group argues that approval of the OMNIA Network will cause irreparable injury in that it will jeopardize the stability of the members of the Hospital Group because the network is designed to encourage members to choose Tier 1 hospitals over Tier 2 hospitals and, therefore, the Hospital Group will lose patients which will ultimately endanger the financial viability of the hospitals. The Hospital Group argues that the Tier 2 label may stigmatize such hospitals and cause consumer confusion in that consumers will see this label as a reflection on the quality of care offered by these institutions. These arguments fail on several grounds.

The Hospital Group provides no documents or evidence to support the speculative assertion that patients will ultimately fail to utilize Tier 2 facilities. Tiered plans have been in existence for over five years in New Jersey and have not had the impact on hospitals as alleged

herein. In fact, the challenging hospitals all have participated in such tiered networks as both Tier 1 and Tier 2 hospitals without such deleterious effects. Plus, this is only one tiered plan offering in this State; the hospitals are likely participants in other carriers' tiered plans as a Tier 1 provider. Common sense indicates that market forces and carrier competition will strongly counteract any speculated financial impacts.

In addition, the lack of urgency in the stay request militates in favor of denial of the requested stay. The OMNIA Network was approved on September 15, 2015, and this approval was memorialized in a letter to Horizon dated September 18, 2015. Members of the Hospital Group were aware of this approval at that time or shortly thereafter. Horizon publicly announced the OMNIA plans and informed hospitals as to their tier assignment on or about September 10, 2015. Plus, Capital Health and St. Francis took part in a meeting with the Department to express their concerns regarding the approval of the OMNIA Network on September 23, 2015. Despite this, and an October 5, 2015 public hearing on this issue, the Hospital Group waited until November 19, 2015, two months after approval and after open enrollment commenced on November 1, 2015, to seek this stay allegedly based on imminent and irreparable harm. The Hospital Group's lack of action during this time demonstrates a lack of irreparable and imminent harm.

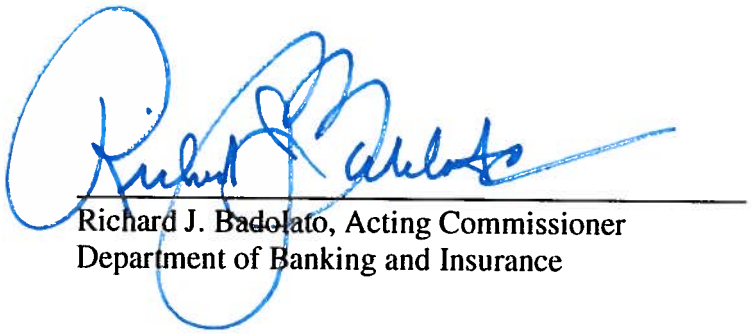
Finally, and perhaps most compelling, the harm relied upon by the Hospital Group involves their own monetary loss. It is axiomatic that the loss of income does not constitute irreparable harm for purposes of obtaining interlocutory relief. Bd. of Ed. of Union Beach v. N.J.Ed. Ass'n, et al, 96 N.J. Super. 371, 391 (Ch. Div. 1967), aff'd 53 N.J. 29 (1968).

Based upon the foregoing, the Hospital Group has failed to carry its burden of establishing, by clear and convincing evidence, that irreparable harm will befall any parties under the OMNIA Network.

CONCLUSION

The Hospital Group failed to satisfy its burden of proof to demonstrate by clear and convincing evidence that any of the four Crowe prerequisites for a stay are present here. For all the foregoing reasons, the Hospital Group's request for a stay is hereby DENIED.

11/30/15
Date



Richard J. Badolato, Acting Commissioner
Department of Banking and Insurance