Recodify proposed N.J.A.C. 11:22-1.8 and 1.9 as ***1.7 and 1.8*** (No change in text.)

11:22-*[1.10]* ***1.9*** Reporting requirements

(a)-(e) (No change.)

(f) After the Commissioner has reviewed the annual report and the request for exemption, the Commissioner shall either grant or disapprove the request. Any request meeting the conditions of (e) above shall be deemed granted 30 days after its receipt by the Commissioner unless disapproved. The Commissioner may disapprove a request for one or more of the following reasons:

1.-2. (No change.)

3. The Commissioner finds that an audit is necessary to verify the accuracy of the report or to otherwise meet the purposes of this section and N.J.S.A. 17B:30-12 et seq.

(g) (No change.)

11:22-*[1.11]* ***1.10*** Remediation/penalty

(a) Upon review of the reports required by N.J.A.C. 11:22-*[1.10]* ***1.9***, the Commissioner may require that the carrier or ODS, at its own expense:

1.-2. (No change.)

(b) The Commissioner may impose a civil penalty of not more than $10,000 upon the carrier, to be collected pursuant to "the penalty enforcement law," N.J.S.A. 2A:58-1 et seq., if, following the remediation measures in (a) above, the Commissioner determines that:

1. An unreasonably large or disproportionate number of eligible claims continue to be disputed, denied or not paid in accordance with the time frames in N.J.A.C. 11:22-*[1.6]* ***1.5***; or

2. A carrier, ODS or the agent of a carrier or ODS has failed to pay interest as required pursuant to N.J.A.C. 11:22-*[1.8]* ***1.7***.

11:22-1.11 — 1.15 (Reserved)

11:22-*[1.5]*** 1.16*** Explanation of benefits

(a) Every carrier shall provide an explanation of benefits, within 30 days if the claim is filed electronically or 40 days if a claim is submitted in writing, to covered persons in response to the filing of a claim by a provider or a covered person under a health benefits plan.

(b) The explanation of benefits shall include at least the following information:

1. Name of the covered person;
2. Name of the provider;
3. Date of service;
4. Clear description of the service;
5. Billed charge;
6. Allowed charge;
7. Non-covered amount;
8. A specific explanation of why a charge is not covered by the health benefits plan, for example, person not covered on date of service, provider not in network, other coverage is primary, the service is not medically necessary, no prior authorization, no referral, experimental or investigational service, or service is excluded by contract. Use of denial reasons with multiple grounds shall only be used if each denial ground applies to the specific claim, including when the reasons are separated by an "and," similar text, symbol, or punctuation;
9. The amount that is the covered person's responsibility due to deductible, coinsurance, and copayment;
10. The accumulation toward the covered person's deductible, or family deductible, if applicable;
11. The accumulation toward the covered person's maximum out-of-pocket, or family maximum out-of-pocket, if applicable;
12. Amount paid by plan, interest should be shown separately if interest is paid;
13. An explanation of the process to appeal the determination on the claim; and
14. A telephone number that the covered person can call to get additional information on the processing of the claim.

(c) If review of the claim is still pending upon issuance of the EOB, the EOB shall so state and (b)6 through 10 above can be omitted.

(a)

DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH
Health Maintenance Organizations
Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations
Adopted Amendments: N.J.A.C. 11:24-1.2 and 11:24A-1.2 and 2.3

Proposed: September 5, 2017, at 49 N.J.R. 2880(a).
Adopted: December 20, 2017, by Richard J. Badolato, Commissioner, Department of Banking and Insurance.
Filed: December 20, 2017, as R. 2018 d.065, **without change**.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, and 26:2S-1 et seq.

Effective Date: January 16, 2018.
Expiration Dates: January 14, 2022, N.J.A.C. 11:24;
March 1, 2018, N.J.A.C. 11:24A.

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received timely written comments from the Home Care and Hospice Association of New Jersey; the Medical Society of New Jersey; the New Jersey Association of Ambulatory Surgery Centers; the New Jersey Doctor-Patient Alliance; the New Jersey Hospital Association; the New Jersey Obstetrical and Gynecological Society; the New Jersey Orthopaedic Society; the New Jersey State Society of Anesthesiologists; and the New Jersey Association of Health Plans.

COMMENT: Several commenters expressed support for the Department's proposed amendments.

RESPONSE: The Department appreciates the commenters' support of its proposal.

COMMENT: Several commenters expressed concern with the phrase "qualified, accessible, and available provider" found in N.J.A.C. 11:24A-1.2 (definition of in-plan exceptions), 11:24A-2.3(a)1v and (a)3ii. One commenter questioned if these characteristics are defined solely by the carrier or can a provider's other contracts further restrict the definitions. The commenter cited an example, where a Medicaid Managed Care beneficiary residing in a nursing home (and thus has his/her room and board paid by an HMO) is denied access to the hospice program of his/her choice because the beneficiary seeks services from a hospice that is in-network for the beneficiary, but the nursing home has an exclusive contract with only one hospice, which is an out-of-network provider for that beneficiary. The commenter questioned if the hospice of the beneficiary's choice can be considered inaccessible or unavailable merely because the nursing home has a contract with a different hospice (which is an out-of-network provider for that beneficiary).

A second commenter believes that the definition sets forth a vague threshold for determining whether a consumer has access to a network provider. The commenter stated that a denial of an in-plan exception is subject to appeal. Thus, a vague standard could increase the number of appeals and complaints carriers see related to the provider network. The commenter contends that guidance on what standards the IURO would use if an appeal were made would be helpful. The commenter stated that it does not believe that the terms used in the proposed rule ("who are qualified, accessible, and available") provide any clarity and suggest the deletion of these terms. Additionally, the commenter believes that "qualified" is addressed simply by the carrier's credentialing process and the licensure requirements of the state. The commenter also stated that it would like guidance from the Department as to whether the applicable Department geo-access standards may also serve as a standard for determining access if the request for a waiver is based on a time and/or distance concern raised by the member. The commenter requested that the Department consider the following amendment or alternatively provide greater clarity around the standards to which carriers will be held:

N.J.A.C. 11:24-1.2 and 11:24A-1.2

"In-plan exception" means a request by a member or provider to obtain medically necessary covered services from an out-of-network provider, with the member's liability limited to network level cost sharing, because the carrier's network does not have providers [who are qualified, accessible, and available] to perform the medically necessary covered service the member requires.

A third commenter requested that the Department clarifies or defines what constitutes a "qualified, accessible, and available" provider. The commenter recommended that the Department employ a mixed objective-subjective standard that focuses on the individual patient's point of view in appealing adverse benefit determinations for denials of "in-plan exceptions." The commenter fears that in the absence of definitions, HMOs and carriers will define such terms differently to their benefit, thereby creating uneven standards which are designed in part to ensure that "in-plan exception" denial appeals are less effective at preventing and correcting bona fide gaps in medically necessary coverage for individual patients.

A fourth commenter stated that most patients are not aware that they may apply for an in-plan exception if an in-network physician is not "qualified, accessible and available." Additionally, the commenter contends that most patients do not know the circumstances that will give rise to the approval of an out-of-network physician at in-network costs. The commenter suggested that the Department require that plain language examples, giving rise to the right, be provided in the plan documents.

RESPONSE: The Department believes that a definition of "qualified, accessible, and available" is not needed because these terms have either a plain meaning or are defined elsewhere in the Department's regulations. With respect to who is a qualified provider to render a particular service to a specific patient, not every provider who is credentialed by a carrier and licensed by the State is qualified to perform certain procedures in specific circumstances. Procedures that are complex or involve high-risk patients are properly performed only by providers with specialized training and extensive experience in the particular procedures and/or patient type. Accessible refers to the network adequacy standards at N.J.A.C. 11:24-6.1 to 6.3 and 11:24A-4.10. Available means that the provider can render the medically necessary service to the covered person within a time period appropriate to the medical exigencies of the case. These terms have plain meaning or are otherwise defined in the regulations, have been the basis upon which in-plan exceptions have been granted for years, and therefore additional definitions are not necessary. As to the explicit example of a covered person seeking hospice care from a network provider, the Department notes that since the requested care is from a network provider, the in-plan exception is not applicable. The HMO would make necessary arrangements with the facility for the covered person to receive hospice services.

COMMENT: Three commenters stated that the proposed amendments do not sufficiently address the rights of out-of-network providers in situations where an in-network exception applies. For example, the commenters stated that N.J.A.C. 11:22-5.8(c), which applies when covered persons obtain services from out-of-network providers, specifically provides that carriers shall not calculate benefits for services provided by out-of-network providers by using negotiated fees agreed to by network providers. The commenters believe that to avoid unnecessary ambiguity, the proposed rules should contain a similar restriction. The commenters contend that since the Department's proposed amendments require a carrier to hold a covered person harmless beyond the covered person's network level cost sharing responsibility, a carrier must either pay an out-of-network provider the full charges billed by the provider, less any network level cost sharing amount, or negotiate a different fee directly with the provider. The commenters stated that to keep covered persons from being drawn into disputes between the carriers and the providers, the proposed amendments should include the following prohibition and make it clear that a carrier has only two choices: (1) pay the full charges billed by the provider, less any network level cost sharing amount; or (2) negotiate a different fee directly with the provider.

RESPONSE: These rules expand the definition of "adverse benefit determination" to afford covered persons and providers the right to an internal and external appeal to challenge a carrier's denial of a request for an in-plan exception. These rules do not address payment. Provisions addressing payment are neither appropriate nor necessary.

COMMENT: Two commenters expressed concern with improving access to documentation regarding network adequacy. One commenter suggested that the Department amend N.J.A.C. 11:24-8.4(c) and 11:24A-3.5(f) to require carriers and HMOs to maintain the status quo by providing interim coverage of treatment when faced with good faith appeals of "in-plan exception" denials unless and until such appeals are fully exhausted. The commenter believes that it is important that the Department establish specific, uniform rules and standards in appealing "in-plan exception" denials during the appeal process, such as requiring interim coverage of continuing services until full exhaustion of the appeals process.

A second commenter stated that the language is not sufficient to ensure that the beneficiary is provided with appropriate documentation reflecting the carrier's or HMO's methodology for determining network adequacy and as a result the beneficiary is unable to properly respond during an adverse benefit determination appeal. The commenter suggested that the Department propose rules that ensure disclosure of relevant network adequacy documentation during appeals.

A third commenter recommended that the Department's proposed amendment specify the type of documentation that must be reasonably produced to patients and their providers as to network adequacy. The commenter stated that the documentation should include the type of documentation relied upon by the Department in approving the carriers' or HMO's plan pursuant to N.J.S.A. 26:2S-18, including such documentation relied on by the Department in evaluating the carrier or HMO's compliance with N.J.A.C. 11:24-6.2 and/or 11:24A-4.10.

RESPONSE: The existing rules address continued care during internal and external appeals of adverse benefit determinations, and those rules are now expressly applicable to in-plan exceptions by the addition to the definition. See N.J.A.C. 11:24-8.4(f) and 11:24A-3.5(i). With respect to the comment regarding network adequacy methodology, the current rules address the information that must be provided by a carrier in an initial adverse benefit determination and an adverse benefit determination following internal appeal. These rules specify that the carrier provide the reason for the adverse benefit determination and a description of the standard used by the carrier in the denial. N.J.A.C. 11:24-8.4(e)2 and 11:24A-3.5(h)2. With respect to the comment regarding documentation, the Department sees no reason to require carriers to submit detailed geo-access for all of its membership to all provider types in response to an in-plan exception request. Current rules require disclosure of the reason and standard used by the carrier in making the adverse benefit determination. Additionally, in-plan exceptions will pre-date the rendering of care by the out-of-network provider, and therefore continuation of care pending the outcome of the appeal is not an issue.

COMMENT: One commenter suggested an expedited appeal process in the event of a denial of an "in-plan exception" request from a patient or health care provider. The commenter stated that a beneficiary's good faith request for treatment from an out-of-network provider should not be delayed while avenues of appeal are exhausted. The commenter contends that under existing regulations, the HMO or carrier is fully responsible for payment to an out-of-network provider if it makes an out-of-network referral. The commenter believes that with an expedited appeal process the HMO or carrier would be able to limit costs and quickly resolve questions of network adequacy. The commenter stated that patients should not be required to pay out-of-network cost sharing amounts while appeal proceedings are pending, and as such, an expedited appeals process for a denial of an "in-plan exception" would result in reduced costs to HMOs or carriers and the patient having access to care more quickly.

Finally, the commenter stated that if a patient is successful on an appeal and can demonstrate that the HMO's or carrier's network is inadequate, the patient's expenses should be limited to the in-network cost share. The commenter contends that the health care provider should not be penalized when there is network inadequacy and the health care

provider performing the services should receive reimbursement from the HMO or carrier based upon that provider's usual and customary charges. Reimbursing the provider at a rate lesser than unusual and customary charges could seemingly create a disincentive for an HMO or carrier to create an adequate network.

RESPONSE: The current rules provide for an expedited appeals process in urgent care situations. Such situations occur when application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or that, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the covered person to severe pain that cannot be managed without the care or treatment that is the subject of the claim. N.J.A.C. 11:24-8.5, and 8.6(d) and 11:24A-3.5(j)1 and (k)3.

Moreover, the limitation of the covered person's liability to network cost sharing when an in-plan exception is granted is clear from the definition of that phrase at N.J.A.C. 11:24-1.1 and 11:24A-1.2.

COMMENT: One commenter suggested that the notice of the right to apply for an in-plan exception should be required to be prominent on the carrier's website, on directory pages, and patient portal. The commenter believes that plain language FAQs should be developed. Additionally, the commenter stated that there should be a dedicated line for consumers to call with questions about the process for applying for the in-plan exception. The plan document, website, and FAQ should include examples of situations where an in-plan exception would be granted.

RESPONSE: The Department sees no reason to treat adverse benefit determination that deny in-plan exceptions differently than other types of adverse benefit determinations, such as those that deny claims or authorization based on a lack of medical necessity. The right to appeal is set forth in the adverse benefit determination and at each level of the internal appeal process. The proposed rules require that policies and certificates describe the process by which a covered person or provider can seek an in-plan exception. The Department believes the existing and proposed rules provide sufficient information on the in-plan exception and appeals processes, and notes the Department's Appeal and Complaint Guide for New Jersey Consumer is available at: http://www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf.

COMMENT: One commenter stated that physicians should be promptly paid the agreed upon amount. The commenter contends that physicians are granted permission to treat a patient under an in-plan exception and then the carrier does not process the claim or pay the agreed upon amount. The commenter believes that this violates the current requirement. The commenter stated that the carrier will often pay the provider at the in-network rate and ignore communications from the provider requesting the fee agreed to in the pre-service single case agreement. The commenter avers that: payment should be made promptly under the prompt pay rules as soon as the out-of-network provider submits a clean claim and interest should accrue for claims that are not paid in a timely manner. The commenter recommends that they propose rule contain language requiring the carrier to pay the negotiated fee under the prompt pay rules. Alternatively, the Department should make the provider whole by requiring payment of the billed charges minus the patient's network level cost sharing.

RESPONSE: The comment is beyond the scope of the proposal because the proposed rules do not concern payment issues.

Federal Standards Statement

The Federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152, and rules promulgated and guidance issued thereunder (collectively, the Federal law), among a myriad of other things, addresses adverse benefit determinations and the right to appeal such determinations. This rulemaking specified that a denied in-plan exception is included in the definition of adverse benefit determination. The Department believes this specificity is supported by the Federal definition and, thus, the rulemaking does not exceed the requirements of Federal law.

Full text of the adoption follows:

CHAPTER 24
HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER 1. SCOPE AND DEFINITIONS

11:24-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Adverse benefit determination" means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, denial of a request for an in-plan exception, as well as a failure to cover an item or service for which benefits are otherwise provided because the HMO determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the HMO has rescinded the coverage.

. . .

"In-plan exception" means a request by a member or provider to obtain medically necessary covered services from an out-of-network provider, with the member's liability limited to network level cost sharing, because the carrier's network does not have providers who are qualified, accessible, and available to perform the medically necessary covered service the member requires.

. . .

CHAPTER 24A
HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, AND MEDICAL SERVICE CORPORATIONS

SUBCHAPTER 1. GENERAL PROVISIONS

11:24A-1.2 Definitions

For the purposes of this chapter, the words and terms set forth below shall have the following meanings, unless the word or term is further defined within a subchapter of this chapter, or the context clearly indicates otherwise:

. . .

"Adverse benefit determination" means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, denial of a request for an in-plan exception, as well as a failure to cover an item or service for which benefits are otherwise provided because the carrier determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the carrier has rescinded the coverage.

. . .

"In-plan exception" means a request by a covered person or provider to obtain medically necessary covered services from an out-of-network provider, with the covered person's liability limited to network level cost sharing, because the carrier's network does not have providers who are qualified, accessible, and available to perform the medically necessary covered service the covered person requires.

. . .

SUBCHAPTER 2. PROVISIONS APPLICABLE TO ALL CARRIERS

11:24A-2.3 Disclosure requirements

(a) Carriers shall provide to each subscriber within no more than 30 days following the effective date of coverage, and upon request thereafter, through a handbook, certificate, or other evidence of coverage designed for covered persons, information describing the following:

1. The services or benefits therefor to which a covered person is entitled under the policy or contract, including:

i.-ii. (No change.)

iii. A full and clear description of the carrier's policies and procedures governing the provision of emergency and urgent care services or the payment of benefits therefor, including a statement that emergency or urgent care services are not covered, if that is the case;

iv. All dollar, day, visit, or procedure limitations applicable to at least those services set forth at (a)1i above, and the method for exchanging inpatient for outpatient services or vice versa, when such exchanges are permitted under the policy or contract; and

v. The right to request to use an out-of-network provider at network level cost sharing where the network does not contain a qualified, accessible, and available provider to perform a service.

2. (No change.)

3. Where and in what manner covered services may be obtained.

i. Even in the instance in which the contract or policy is not subject to any network requirements or differentials, carriers shall specify if benefits are payable for certain services only when rendered by a specified class or classes of provider(s); and

ii. The process a covered person or provider must follow to request to use an out-of-network provider and be responsible only for network level cost sharing where the network does not contain a qualified, accessible, and available provider to perform the service.

4.-7. (No change.)

(b)-(c) (No change.)

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS

Limitations on and Obligations Associated with Acceptance of Compensation from Pharmaceutical Manufacturers by Prescribers

Adopted New Rules: N.J.A.C. 13:45J

Proposed: October 2, 2017, at 49 N.J.R. 3330(a).

Adopted: December 20, 2017, by Christopher S. Porrino, Attorney General of New Jersey.

Filed: December 20, 2017, as R.2018 d.054, with **non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 45:1-17.b.

Effective Date: January 16, 2018.

Expiration Date: January 16, 2025.

The notice of proposed new rules was published in the New Jersey Register on October 2, 2017 at 49 N.J.R. 3330(a), which included a public hearing held on October 19, 2017. Notice of the proposal was posted on the Division of Consumer Affair website, was sent to the Statehouse Press, and was emailed to interested parties and attorneys as listed with the State Board of Medical Examiners, New Jersey State Board of Dentistry, New Jersey Board of Nursing, and New Jersey State Board of Optometrists under N.J.A.C. 1:30-5.2(a)3. Notice of the public hearing also appeared in newspapers around the State. Written comments were accepted through December 1, 2017.

Summary of Hearing Officer's Recommendation and Agency's Response:

The public hearing was held on October 19, 2017, at the Offices of the Division of Consumer Affairs in Newark, New Jersey. The following persons or entities offered testimony at the public hearing: Dr. Andy Kaufman, New Jersey Society of Interventional Pain Physicians; Kristina M. Moorhead, MPAff, Senior Director, State Advocacy, Pharmaceutical Research and Manufacturers of America (PhRMA); Andrew N. de Torre MD, FACS, Liver, Pancreas and Biliary Surgery, St. Joseph's Medical Center; Dr. Otto Sabando, New Jersey Association of Osteopathic Physicians and Surgeons; Dean Paranicas, President and CEO, HealthCare Institute of New Jersey (HINJ); Patrick Plues, Vice President, State Government Affairs, the Biotechnology Innovation Organization (BIO); Howard Fienberg, Director of Government Affairs, The Insights Association; Debbie Hart, President and CEO, BioNJ; Larry Downs, Esq., Chief Executive Officer, Medical Society of New Jersey; John Kamp, Executive Director, Coalition for Healthcare Communication; Steven Andreassen, Esq., Chief of Staff, Rutgers Biomedical & Health Sciences; Douglas Peddicord, Ph.D., Executive Director, Association of Clinical Research Organizations (ACRO); and Beverly Wong, MD Candidate, Class of 2018, Rutgers Robert Wood Johnson Medical School. Maryann Sheehan, Director, Legislative and Regulatory Affairs, Division of Consumer Affairs presided at the hearing. A record of the public hearing and hearing report are available for inspection in accordance with applicable law by contacting:

Division of Consumer Affairs
Office of the Director
Legislative & Regulatory Affairs
PO Box 45027
Newark, NJ 07101
Phone: 973-504-6534 Fax: 973-648-3538

Summary of Public Comments and Agency Reponses:

In addition to the comments received at the public hearing (as noted above), the Attorney General received comments from:

1. Jim Kremidas, Executive Director, Association of Clinical Research Professionals (ACRP);
2. Christine Pierre, President, Society for Clinical Research Sites (SCRS);
3. Jean Publiee;
4. Dawn Handschuh;
5. Jeff Boatman, Sr., SME, Quality & Compliance, QPharma;
6. Andrew M. Rosenberg, Senior Advisor, CME Coalition;
7. Adrian O. Mapp, Mayor, City of Plainfield, New Jersey;
8. Arthur C. Santora II, MD, Ph.D.;
9. Tracy Doyle, Chief Executive Officer, Phoenix Marketing Solutions;
10. Amanda Kaczerski, Director, Educational Strategy & Design, The Academy for Continued Healthcare Learning;
11. Michael V. Kerwin, Somerset County Business Partnership;
12. Mary Kathryn Roberts, Riker Danzig Scherer Hyland Perretti, LLP, on behalf of the Pharmaceutical Research and Manufacturers of America (PhRMA);
13. Steve Borrus, MD, Lawrence Medical Associates;
14. Kathleen A. Arntsen, President & CEO, Lupus and Allied Diseases Association, Inc.;
15. Brian Shott, NJ Government Relations Director, American Cancer Society Cancer Action Network;
16. Stephen A. Fegard, JD, MPH;
17. Angelica Davis, MPPA, President, Fight Colorectal Cancer;
18. Ken M. Farber, President and Chief Executive Officer, Lupus Research Alliance;
19. Richard H. Bagger, Executive Vice President, Corporate Affairs & Market Access, Celgene Corporation;
20. Bryan Lowe, Director, State Government Affairs, Healthcare Distribution Alliance;
21. Timothy J. Fournier, Senior Vice President and Chief Enterprise Risk Management, Ethics, and Compliance Officer, Rutgers, The State University of New Jersey;
22. Gail Andlik, Deborah Heart & Lung Center;
23. Thomas A. Leach, Executive Director, New Jersey Association for Biomedical Research;
24. Neil Eicher, Vice President, Government Relations and Policy, New Jersey Hospital Association (NJHA);
25. Dean J. Paranicas, President and Chief Executive Officer, HealthCare Institute of New Jersey (HINJ);
26. Thomas Sullivan, President, Rockpointe Corporation;
27. David Knowlton, Former Deputy Commissioner of Health for the State of New Jersey and Former President and CEO of the NJ Health Care Quality Institute;
28. George Coutros, Director, State Government Relations, Sanofi U.S.;