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IN THE MATTER OF REQUEST FOR A DECLARATORY RULING FROM THE STATE HEALTH BENEFITS COMMISSION MONTVALE SURGICAL CENTER, Appellant	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION DOCKET NUMBER A-003402-12T2 Appeal from Final Administrative Decision of the New Jersey State Health Benefits Commission CIVIL ACTION

BRIEF ON BEHALF OF *AMICI CURIAE* MEDICAL SOCIETY OF NEW JERSEY AND AMERICAN MEDICAL ASSOCIATION

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This matter challenges the methodology used by the State Health Benefits Program (SHBP) to calculate "usual, customary, and reasonable" (UCR) rates for payment of out-of-network medical services from physicians and health care provider entities such as ambulatory surgical centers. The questions revolve initially around the entitlement of medical providers to seek declaratory relief and then a review of administrative decisions made by the State Health Benefits Commission (SHBC or Commission) and whether the decisions and calculations made are reflective not only of New Jersey statutory law but also fair policies and practices. The systematic under-calculation of payments threatens and impedes patient access to services, including their physicians of choice, and deprives them of important benefits guaranteed by law. New Jersey citizens in entering public sector employment face increasing frustration regarding their expectations for the scope and security of their employment as well as unfairly enhanced financial exposure to medical expenses as a result of shifts in the scope of the SHBP and the lack of transparency in the payment methodology used by the Plan.

This Brief is submitted in connection with the application by the Medical Society of New Jersey (MNSJ) and the American Medical Association (AMA) to appear as *amici*

curiae in this matter. Participation by MSNJ and the AMA on behalf of their physician memberships will sharpen the focus on physician-related issues presented on this appeal.

The MSNJ is a non-profit professional society organized under the laws of the State of New Jersey and is located in Lawrenceville. It was founded in 1766 and was the first state society of physicians in the nation. It is the primary and largest organization of physicians in New Jersey.

The AMA, an Illinois non-profit corporation with its principal location in Chicago, is the largest professional association of physicians and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policy making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these still remain its core purposes. Its members practice in every state, including New Jersey, and in every specialty. MSNJ is an affiliate and constituent of the AMA.

The AMA and MSNJ join in this Brief on their own behalves and as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each

state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

The MSNJ and the AMA have played important roles in advocating on behalf of their members over the years. For over 240 years, the MSNJ has been an advocate of quality health care and health services for all citizens of this State, and has offered leadership and assistance to its physician members. The MSNJ regularly participates in important issues in the judicial, legislative and regulatory arenas.

The MSNJ, frequently joined by the AMA, has participated in the judicial arena either as a party, as an *amicus* or in a representational capacity, on behalf of the medical profession and the physicians of New Jersey as a whole, in a number of cases before the Supreme Court of New Jersey, the Appellate Division and in the federal courts.[1] These were all cases involving issues of importance to the medical profession or to the patients who the members of that profession are privileged

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[1] *See, e.g., Nicholas v. Mynster*, 213 N.J. 463 (2013); *Ryan v. Renny*, 203 N.J. 37(2010); *Liguori v. Elmann*, 191 N.J. 527(2007); *In re License Issued to Zahl*, 186 N.J. 341 (2006); *Johnson v. Braddy*, 186 N.J. 40 (2006); *New Jersey Ass'n of Nurse Anesthetists, Inc. v. New Jersey State Bd. of Med. Exam'rs*, 183 N.J. 605 (2005); *Cmty. Hosp. v. More*, 183 N.J. 36 (2005); *Macedo v. Dello Russo*, 178 N.J. 340 (2003); *Howard v. UMDNJ*, 172 N.J. 537 (2002); *Morlino v. Med. Ctr.*, 152 N.J. 563 (1997); *Hirsch v. New Jersey State Bd. of Med. Exam'rs*, 128 N.J. Super. 160 (1992); *MSNJ v. New Jersey Dep't of Law & Pub. Safety, Div. of Consumer Affairs*, 120 N.J. 18 (1990); *Betancourt v. Trinitas*, 415 N.J. Super. 301 (App. Div. 2010); *Webb v. Witt*, 379 N.J. Super. 18 (App. Div. 2005); *New Jersey Ass'n of Health Plans v. Farmer*, 342 N.J. Super. 536 (App. Div. 2000), *Petrocco v. Dover Gen. Hosp.*, 273 N.J. Super. 501 (App. Div. 1994); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.2d 266 (3d Cir. 2001); and *Vacco v. Quill*, 521 U.S. 793 (1997).

to serve. The issues have included the process for adjudicating questions of quality of care provided to patients and also the economics of and access to medical care.

Through participation in state and federal lawsuits and testimony before legislative bodies such as United States Senate committees, the AMA and MSNJ have been involved in challenging the flaws in the methodology used to determine payment for physician services. Because of the importance of the issue of out-of-network benefits to State employees participating in the SHBP, the likelihood of its repetition, and the involvement generally of these professional associations in developing the law and public policy in cases affecting the practice of medicine, the MSNJ together with the AMA wish to participate and be heard as *amici curiae* in the issues in the present appeal.

PROCEDURAL HISTORY

Following inaction by the SHBC on requests by Montvale Surgical Center (MSC) for a declaratory ruling by the Commission regarding out-of-network ambulatory surgical center payments in connection with the SHBP, MSC filed an appeal with the Appellate Division.[2] The initial MSC request of November 9, 2011 had included a demand that Horizon Blue Cross Blue Shield of New Jersey (Horizon or Administrator) be required to reprocess claims at an appropriate level of reimbursement. [MSNJ/AMA App at 1A-6A][3] The SHBC did not respond to this request.

MSC made a second request for a declaratory ruling on January 17, 2012, which also did not result in any action by the Commission. [MSNJ/AMA App at 7A-8A] A Notice of Appeal followed on February 14, 2012 under Docket No. A-002811-11.

On August 7, 2012, the Commission moved in the Appellate Division to consolidate MSC's appeal with an appeal filed by

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[2] References to the record for this appeal will be done using the MSC Appendix with the legend of MSC App at 00A.

References to materials included in the Appendix on behalf of the *amici curiae* will be done using the legend MSNJ/AMA App at 00A.

[3] This letter and the follow-up correspondence of January 17, 2012 discussed in the next paragraph are not included in the MSC Appendix but were listed in the Statement of Items Comprising the Record on Appeal dated May 29, 2013 that was filed by the Attorney General. See Items 14 and 15. These letters had been included in the Appendix to the Attorney General's Letter Brief in support of its motion to consolidate and remand the matter to the SHBC that was filed in the prior appeal under Docket No. A-2811-11T3. As such they are properly before this court and properly the subject of judicial notice pursuant to NJRE 201(b)(2) and NJRE 202(b).

Hackensack Surgery Center, and to remand both matters so the Commission could consider whether out-of-network providers have standing to appeal before it. The application was granted on August 31, 2012 and the consolidated matters were remanded for a determination pertaining to standing. [MSC App at 12A]

A hearing was held on November 14, 2012, with the only issue to be considered being standing to appear before the Commission.[4] [MSC App at 14A] As a result of the hearing the Commission ruled that MSC lacked standing. [MSC App at 038A] David Perry, Horizon's Director of Account Management, appeared at the November 2012 hearing and "discuss[ed] a little bit about the networks." [MSC App at 40A] Perry was allowed to testify as to the substance of the matter (even though the issue was limited to standing), specifically whether the policy to pay ASCs 160% of the CMS Medicare allowance violates New Jersey law and contradicts the terms of the SHBP.[5] Nonetheless, the matter was subsequently placed on the Commission's February 13, 2013 agenda to allow the "record to be re-opened for amplification to allow [Horizon] to

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[4] Since no one appeared for Hackensack Surgical Center despite having been noticed of the hearing, the Commission separated the consolidated matters.

[5] The Commission manifestly treated the parties in a disparate manner. While Horizon was permitted to testify directly as to the substance of the allowance methodology, the Commission quickly reminded MSC's counsel that the issue was limited to standing when he began to discuss the methodology as the backdrop for his argument. [MSC App at 18A] MSC's counsel has never been permitted to put before the Commission a full substantive position on the methodology issue, which impacts the record for this appeal.

provide additional information as well as for approval of the Final Administrative Determination." [MSC App at 38A] Once again, Perry was the only one addressing the substantive issue.

The Commission thereafter issued a Final Administrative Determination (FAD) on March 5, 2013, ruling that "Montvale is not an interested party under the APA and, therefore lacks standing to pursue its request for a declaratory ruling." [MSC App at 65A] The Commission further determined that even if MSC were an interested party under the APA, its declaratory ruling application was denied on the merits. [*Ibid.*]

STATEMENT OF FACTS

MSC is a licensed ambulatory surgery center where physicians have provided medical services to patients who are present or retired employees of the State of New Jersey or the dependents of such employees. As part of their government employment, these State employees are entitled to health benefits under the SHBP.

Currently and indeed for an extended period of time, the health benefits coverage available to State employees has included several different plans. There have been HMO-type plans which require the participating State employee to choose a Primary Care Physician who has contracted to participate in the plan and in seeking care from a specialist to stay within

a network of other physicians who have contracted to accept discounted payments in exchange for a volume of patients in the network and the SHBP. At the same time, State employees are led to believe that they have the opportunity to choose a health plan - at some cost to them in the form of increased payroll deductions - that provides a combination of in-network care and out-of-network care with the ability to choose the out-of-network provider. These options with out-of-network benefits have the additional cost of imposing a portion of the charges for medical services on the employee above and beyond routine co-pay or co-insurance amounts. The availability of out-of-network benefits to the employees appears repeatedly in the information provided to employees.

Pursuant to an assignment of benefits from the patient-employee, MSC submitted claims for medical services to be paid by Horizon Blue Cross Blue Shield of New Jersey on behalf of the SHBP in accordance with MSC's status as a non-participating provider in its network and thus had not contracted with Horizon for particular rates. MSC's expectation was that the claims would be paid in accordance with the applicable statutory provisions for the program setting reimbursement for out-of network charges on the basis of usual, customary, and reasonable charges. The statute - *N.J.S.A.* 52:14-17.29, discussed at length below - declared

that "'reasonable and customary charges' means charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges." Member Handbooks distributed to State Employees, at least in Plan Year 2009 and 2011, were the same. [MSC App at 70A and 73A]

While accepting MSC's reimbursement claim, instead of using a statutorily required database to determine the range of usual, customary, and reasonable charges, Horizon paid MSC using a percentage of the amount allowed by the Centers for Medicare and Medicaid (CMS) made under the Medicare program. [MSC App at 2A-3A] This resulted in significantly lower reimbursement with a higher obligation imposed on the patient for the uncovered balance. With regard to the sample 2011 claim payment in the MSC Appendix, the total charge, the allowed and paid amounts, and the resulting total patient's liability are as follows:

Total charge	$11,110.00
Allowed amount	$650.00
Amount paid to MSC	$650.00
Total Patient's Liability	$10,460.00

This practice of making payments based on the CMS Medicare allowance had apparently begun in 2009. [MSC App at 17A-18A]

At the August 10, 2011 meeting of the SHBC, Horizon had submitted its proposed Ambulatory Surgery Center payment policy under which it would pay 160% of the CMS Medicare amount. [*Id.* at 18A-19A] This was approved at that meeting. Since that meeting, Horizon has based its response to challenges to benefit determinations on this approval by the SHBC. [*Id.* at 19A]

While the Act concerning public employee pension and health care benefits was amended in June 2011, that amendment did not alter the section referencing the Health Insurance Association of America's database or other similarly nationally recognized database. In this same time period, there were no regulations promulgated and passed by the SHBC revising the methodology used to determine out-of-network reimbursement.

LEGAL ARGUMENT

I. BECAUSE MSC IS AN INTERESTED PERSON WITHIN THE MEANING OF THE ADMINISTRATIVE PROCEDURE ACT, THE SHBC INCORRECTLY CONCLUDED THAT MSC DOES NOT HAVE STANDING TO CHALLENGE THE LEVEL OF REIMBURSEMENT MADE TO IT BY THE PLAN.

MSC has standing to seek a declaratory ruling that the rates paid by the SHBP's Administrator were unlawful or otherwise improper because MSC is an interested person for the purposes of *N.J.S.A.* 52:14-17.29 and the Member Handbook. The Administrative Procedure Act (APA) states that an "agency upon the request of an ***interested person*** may in its discretion make a declaratory ruling with respect to the applicability to any person, property or state of facts of any statute or rule enforced or administered by that agency." *N.J.S.A.* 52:14B-8 (emphasis added). MSC is an "interested person" because members of the SHBP assigned to it the right to reimbursement and to enforce the right to reimbursement by the SHBP and, in any event, by regularly making payments to MSC, the SHBP has relinquished any claim that these rights are not assignable. Therefore, the SHBC incorrectly concluded that MSC is not an "interested person" and thus lacks standing to request the declaratory ruling. [MSC App at 65A]

MSC's standing to seek this declaratory ruling is fully supported by *Karasina v. State*, 2010 WL 3517041 (N.J. App.

Div. 2010).[6] The plaintiffs were Registered Nurse First Assistants who acted as surgical assistants during operations instead of assistant surgeons who were physicians. The plaintiffs sought payment for services that had been provided. They filed a lawsuit against the SHBP and the SHBC seeking a declaratory judgment that they were entitled to payment under the SHBP. Defendants filed a motion to dismiss for failure to state a claim based on the failure of plaintiffs to have exhausted administrative remedies. Speaking directly to the issue presented here, the Appellate Division stated:

> On appeal, plaintiffs argue the trial court erroneously granted the motion to dismiss their complaint because no viable administrative remedy is available to them, asserting that the administrative appeal procedure established by *N.J.A.C.* 17:9-1.3 only applies to members of the SHBP and plaintiffs are not members, but medical providers. We disagree. [*Id.* at *1.]

After citing *N.J.S.A* 52:14B-8 entitling "any interested person" to seek a declaratory ruling from an agency, the Appellate Division held that "[b]ecause plaintiffs have a financial interest in receiving payment for their services, they are interested persons under the statute." *Id.* It premised its conclusion in a holding of the New Jersey Supreme Court that found standing on the part of someone with a "financial interest" affected by the agency action along with

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[6] In compliance with R. 1:36-3, a copy of any opinion cited in this Brief that has not been approved for publication is in the Appendix to this Brief. Unless otherwise noted, counsel is not aware of any contrary authority that has not been published.

the broader principle of a liberal application of standing criteria to matters under the Administrative Procedure Act. *Id.* (citing *In re Camden County*, 170 N.J. 439, 448 (2002) and *Ridgewood Educ. Ass'n v. Ridgewood Bd. of Educ.*, 284 N.J. Super. 427, 431 (App. Div. 1995)). The analysis and conclusion in this opinion, although not approved for publication, is virtually on all fours with the matter on this appeal and is well-supported by fundamental principles of the law of standing repeatedly recognized in case law.

The federal courts in New Jersey have acknowledged that derivative standing, also known as standing-by-assignment, allows an out-of-network provider, to stand in the shoes of a member of or participant in a health benefit plan to challenge actions (or inactions) of the payor or administrator of health benefits under the SHBP. *See North Jersey Ctr. for Surgery, P.A. v. HBCBS of New Jersey, Inc.*, 2008 WL 4371754, at *5 (D.N.J. Sept. 17, 2008) (holding that an assignment of rights under a health benefit plan by a plan participant upon a provider may provide that provider with derivative standing to sue the administrator of the plan). *See also Gregory Surgical Servs., LLC v. Horizon Blue Cross Blue Shield of New Jersey, Inc.*, 2009 WL 749795, at *3-*4 (D.N.J. Mar. 19, 2009), where the court held that an out-of-network provider, to whom the member patient had assigned rights under the plan, must meet

the requirement of exhaustion of administrative remedies before instituting litigation. As perceived by the Federal District Court, in asserting "the rights of beneficiaries under the SHBP," this included the requirement that the provider pursue "recourse to appeal claim decisions by Defendant [Horizon, which] is to file an appeal with the SHBC." *Id.* at *4.

More to the point, an assignment of benefits may confer upon its recipient the right not only to receive reimbursement pursuant to a contract between a participant and carrier but also to enforce that contract. The concept that an assignment of benefits included enforcement of the benefits was recognized in *Wayne Surgical Ctr., LLC v. Concentra Preferred Systems, Inc.*, 2007 WL 2416428 (D.N.J. Aug. 20, 2007). There, the provider was a surgical center that provided out-of-network services to subscribers in a number of health insurance plans on a non-contractual basis. *Id.* at *1. Under the health care plans, the carriers were "obligated to reimburse [the out-of-network provider] on usual, customary, and reasonable charges." *Ibid.* The defendant provided to carriers "health care management services, including re-pricing of claims submitted . . . by medical services providers." *Ibid.* It is the defendant who determined what the usual, customary, and reasonable charges were for services

rendered. *Ibid.* The carrier then would pay the provider based on that assessment. *Ibid.* The allegation in *Wayne Surgical Center* was that the re-pricing practice had "systematically reduced payments to medical service providers . . . using flawed and inaccurate computer software data." *Ibid.*

The *Wayne Surgical* court concluded that the plaintiff provider had standing as an assignee to sue the defendant management service for wrongfully determining the amounts of usual, customary, and reasonable charges. *Id.* at *3. The court further found that "it is illogical to recognize that the [out-of-network provider] as a valid assignee has a right to receive the benefit of direct reimbursement from its patients' insurers but cannot enforce this right." *Ibid.* The court also agreed that "granting derivative standing to the assignees of health care providers helps participants and beneficiaries by encouraging providers to accept participants who are unable to pay up front." *Ibid.* (quoting *Tango Transport v. Healthcare Financial Servcs.*, 322 F.3d 888, 894 (5th Cir. 2003)). *See also MHA, LLC v. Aetna Health, Inc.*, 2013 WL 705612, at *6 (D.N.J. Feb. 25, 2013) (acknowledging that providers may sue where a beneficiary or participant has assigned to the provider that individual's right to benefits and legal right to enforce the benefits under the plan).

The concept of derivative standing is not confined to federal jurisprudence. It is found in and supported by state case law that holds an insurance carrier may waive a non-assignment provision in an insurance agreement by reimbursing directly an out-of-network provider for providing services to a participant in the policy. In a per curiam decision, the appellate division determined in *Prospect Med. Ctr v. HBCBS of New Jersey, Inc.*, 2011 WL 3629180, at *5 (N.J. App. Div. Aug. 19, 2011), that the plaintiff providers had standing to "assert claims consistent with the rights obtained from the assignments executed by their patients, no more or less" if they were able to demonstrate that the carrier waived the non-assignment provision in the insurance agreements with the patients by paying the providers directly. This case did not involve the SHBP. But the court referred to a companion appeal in *Advanced Rehab of Jersey City v. Horizon Healthcare of N.J., Inc.*, 2011 WL 3629176 (N.J. Super. Ct. App. Div. Aug. 19, 2011) issued that same day and stated:

> [There] we concluded that the statutory and regulatory framework of the State Health Benefits Plan (the Plan) requires all Horizon subscribers in that plan, and **any providers seeking payments**, to **submit disputes through the internal appeals process and ultimately to the State Health Benefits Commission**. [*Prospect Medical, supra*, 2011 WL 3629180, at *5, n. 4 (emphasis added).]

In *Advanced Rehab*, the panel concluded that providers who wish to dispute a payment determination first had to exhaust

the internal remedies, with an appeal to the SHBC. In other words, the appellate panel recognized a provider's standing before the SHBC, in the face of the SHBC's determination, as here, that only a plan member or legal representative may appeal to the SHBC. *Id.* at *5.

Here, as an assignee of benefits and the right to enforce claims, MSC has derivative standing and thus the SHBC's conclusion that MSC is not an interested person must be overturned. With regard to *N.J.S.A.* 52:14-17.29(C), MSC steps in the shoes of the Plan "participant" and is entitled to interested person status with regard to reimbursement. The SHBC incorrectly held that the statute provides reimbursement only to participants in the plan and it is only the participants who have a financial interest (and are interested persons) in the application of the statute. [MSC App at 65A] The Commission failed to recognize that through the application of the doctrine of derivative standing, MSC is functionally a "participant" as an interested person with a financial interest in the application of *N.J.S.A.* 52:14-17.29(C).

The same analysis applies to the reference to "member" in *N.J.A.C.* 17:9-1.3(a), which addresses appeals from commission decisions. This is the **only** regulation referring to appeals to the Commission. *See generally Burley v. Prudential Ins. Co.*,

251 N.J. Super. 493, 499 (App. Div. 1991). It states: "Any member of the SHBP who disagrees with the decision of the claims administrator and has exhausted all appeals within the plan, may request that the matter be considered by the Commission." By virtue of the members' assignments, MSC stands in the shoes of members for purposes of this provision. Further, contrary to the SHBC's written opinion [MSC App at 65A], the regulation is not limited to "only members" and thus without any such exclusionary language it allows assignees of rights to step into the shoes of members to request review by the SHBC.

The same analysis also applies to MSC's status as an interested person for the purposes of enforcing provisions of the Member Handbook. Through the application of the derivative standing doctrine, MSC may stand in the shoes of "member" for purposes of provision of the Handbook. Further, even if the Handbook's language regarding "only the member" is construed as a non-assignment provision, the prohibition was waived or otherwise equitably relinquished because Horizon's practice was to reimburse MSC directly for services provided to its members. *See Prospect Med. Ctr.*, *supra*, at *4-5.

In setting up a public policy argument, the SHBC noted that "NJ Direct . . . allows members the option of using out-of-network providers subject to the member's payment of co-

insurance and limited to reimbursement of reasonable and customary costs." MSC App at 63A (citing to page 20 of the Handbook which states, "NJ Direct includes an option for using out-of-network providers. When you exercise this out-of-network option, you will be responsible for deductibles and a percentage of coinsurance based on a reasonable and customary fee schedule, and any amount exceeding the reasonable and customary allowances for all services"). The SHBC found further support that members are responsible for any amounts exceeding the reimbursement provided by NJ Direct on page 17 of the Handbook, particularly under a section entitled Reasonable and Customary Allowance (for Out-of-Network Services):

> NJ Direct covers only reasonable and customary allowances, which are determined by the Prevailing Healthcare Charges System fee schedule or a similar nationally recognized database. This schedule is based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay.
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> In some instances the out-of-network allowance is derived from an alternate nationally recognized source. One example is Ambulatory Surgery Centers (ASC's). The out-of-Network plan allowance used for ASC's is based on a percentage of the Centers for Medicare and Medicaid (CMS) allowance. [*Ibid.*]

As will be discussed in the next section of this Brief, the above-quoted language from the Handbook is **not** the

language of the Handbook as it existed at the time of the claims giving rise to the issue presented to the Commission by MSC. **The reference to "an alternate nationally recognized source" was only added as of the 2012 version of the Handbook**.

But the asserted conclusion by the SHBC that the SHBP has a significant policy interest in ensuring that the SHBP design and coverage provisions for out-of-network providers is enforced and that members pay co-insurance to their out-of-network providers should be rejected because it speaks to the substance of the issue and not to standing. Moreover, MSC is plainly not arguing that members are not or should not be required to pay a portion of the out-of-network charges. Instead, MSC is challenging the amount of reimbursement that is considered the reasonable and customary base benefit, which will obviously impact on the amount which a member will have to pay out of their own funds. In any event, the more important public policy is that SHBP members should be able to visit a provider of their choice, in this case MSC, even if they cannot pay the provider up front and must wait for reimbursement by Horizon for the service. *See Wayne Surgical Center, supra*, 2007 WL 2416428 at *3.

It should be clear that MSC has standing as an interested person to seek a declaratory ruling as to Horizon's policy to pay 160% of the CMS Medicare allowance for a given service.

Thus, the SHBC's conclusion that the medical provider MSC does not have standing to challenge the UCR methodology determination should be overturned.

II. USE OF 160% OF THE MEDICARE ALLOWANCES TO CALCULATE THE PAYMENT TO OUT-OF-NETWORK PROVIDERS VIOLATES *N.J.S.A.* 52:14-17.29. FURTHER IT VIOLATES THE MEMBER HANDBOOK AND MISLEADS STATE EMPLOYEES PARTICIPATING IN THE STATE HEALTH BENEFITS PROGRAM.

The dispute in this matter arises any time a State employee chooses to receive care at an ambulatory surgery center (ASC) that is not part of the contractual network of health care providers that have agreed to participate in the SHBP and to accept the contracted fee amount. Such fees encompass the so-called professional component for the physician performing a procedure or surgery as well as anesthesia where applicable. Such fees also encompass so-called facility fees. These are similar to the circumstance of patients receiving treatment at a hospital where in addition to the treating physician's fees, there are charges for the use of the facility, its personnel, and equipment.[7] The passage from the 2012 Handbook regarding ASC treatment quoted above and relied upon by the SHBC does not make any distinction between professional fees and facility fees. The trigger for the use of this "alternate" is simply the fact

[7] The regulations of the State Board of Medical Examiners specifically allow physicians to charge and receive "facility fees." *N.J.A.C.* 13:35-6.17.

that the State employee had received the treatment at the outpatient ASC.

It is important, if not essential, to the appropriate disposition of this matter to distinguish between the fee that a physician **charges** (the "**billed**" fee amount) and the actual payment made (the "**paid**" fee amount), whether by an insurance company or health plan. The "paid" fee may be considerably less than the "charged" or "billed" fee. This distinction is acknowledged in New Jersey case law. *See, e.g., Coalition for Quality Health Care v. Dept. of Banking & Ins.*, 358 N.J. Super. 123, 126 (App. Div. 2003). The distinction, however, can be a source of confusion.

The out-of-network allowance to MSC for services performed at issue on this appeal was calculated at 160% of the amount that Medicare pays for those services. [MSC App at 17A-19A] The Medicare allowance is a fee schedule. There is a significant difference between "paid fees" and "charges" or "billed fees." The amount of the allowance, therefore, is contrary to New Jersey law as well as the SHBP's own Handbook before it was rewritten during the pendency of this litigation. It results in a serious under-calculation of the amount to be paid by the SHBP for the supposedly permitted out-of-network medical services, exposing State employees to

unanticipated financial burdens. That result should be rejected by this court.

The State Health Benefits Act was codified at *N.J.S.A.* 52:14-17.25 *et seq.* The Act is administered by the State Health Benefits Commission with the purpose of providing comprehensive health care benefits for eligible public employees, retirees, and their dependents at reasonable cost. The Commission is composed of the State Treasurer, the Commissioner of Insurance and the Commissioner of Personnel. *N.J.S.A.* 52:14-17.27. The Commission contracted with Horizon Blue Cross Blue Shield to administer the traditional plan. Blue Cross Blue Shield does not act as an insurer; rather, the State self-insures the cost of the traditional plan, and the plan administrator reviews and pays claims according to the plan. The Commission pays an administrative fee and reimburses the administrator for paid claims. The Commission retains final authority and financial responsibility for the State Program.

The Commission is statutorily required to have contracts providing certain basic benefits and major medical services. It has authority to establish "such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, duplication of services or benefits otherwise available. . .

." *N.J.S.A.* 52:14-17.29(B). Such authority and discretion, however is subject to the requirements in *N.J.S.A.* 52:17-14.29(C) that such contracts for the two statutorily required types of plans "shall include the following provisions regarding reimbursements and payments":

> (1) [For the first plan]. . . . the participant shall receive ***reimbursement for out-of-network charges at the rate of 80% of reasonable and customary charges*** . . . .
>
> (2) [For the second option, consisting of managed care plans]. . . . the participant shall ***receive reimbursement for out-of-network charges at the rate of 70% of reasonable and customary charges***. . . . [Emphasis added.]

The statute goes on to define "reasonable and customary charges" as "charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges." *Id.* at (3).

The reference to the database used by the Health Insurance Association of America to determine UCR fees is more accurately a reference to the Prevailing Healthcare Charges System (PHCS). The PHCS is explicitly identified in the Member Handbooks included at MSC App at 70A and 73A. It also is identified in the minutes of the SHBC August 10, 2011 meeting [*Id.* at 5A-6A] which considered a handout by Horizon regarding its proposed Ambulatory Surgery Centers Payment Policy. In its

written FAD for the matter on appeal, the SHBC recognized and identified the use of the PHCS database. [MSC App at 63A (citing to page 17 of the Handbook, noting that reasonable and customary allowances are determined by the Handbook)]

The PHCS was established in 1973 by the Health Insurance Association of America, but was transferred in 1998 to Ingenix. This change was recognized in amendments to some but not all pertinent regulations in the New Jersey Administrative Code.[8]

Ingenix became a wholly-owned subsidiary of the health insurance company UnitedHealthcare. In time the manifest conflict of interest led to extensive litigation and administrative investigation of the validity of the databases maintained by Ingenix. Although Ingenix is still in business in a different structure,[9] the Ingenix database has generally been replaced by a non-profit entity named FAIR Health that was formed in 2009 following the investigation by then New

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[8] *See, e.g., N.J.A.C.* 11:21-7.13(a) deleting the Health Insurance Association of America and substituting Ingenix as the provider of the PHCS database proposed in 35 N.J.R. 5011(a) (Nov. 3, 2003); *N.J.A.C.* 11:20-24.5 with the same type of change as proposed in 37 N.J.R. 2994(a) (Aug. 15, 2005). A further change so as to discontinue reference to Ingenix and replace it with FAIR Health can be found in 2013 NJ DIRECT Handbook, discussed further below. Inclusion of the FAIR Health database has been implemented by DOBI in connection with automobile-related insurance payments. See *N.J.A.C.* 11:3-29.4. This amendment was proposed on August 1, 2011 and ultimately was adopted November 5, 2012 with substantial changes to become effective as of January 4, 2013. See 43 *N.J.R.* 1640(a); 44 *N.J.R.* 383(a); 44 *N.J.R.* 2652(a).

[9] Ingenix is now Optuminsight, which is still part of the UnitedHealthcare group of companies. See generally www.optmuminsight.com.

York Attorney General Andrew Cuomo.[10] FAIR Health has been compiling its own databases on health care costs. It is now included in some of the regulations contained in the New Jersey Administrative Code that had referenced Ingenix. In short, FAIR Health ***is*** "a similar nationally recognized database of prevailing health care charges" comparable to the PHCS of the Health Insurance Association of American/Ingenix.

The fundamental tools of statutory construction help provide both the issue and the approach to the necessary analysis for this appeal. In *Wilson ex rel. Manzano v. City of Jersey City*, 209 N.J. 558 (2012), the Supreme Court provided a succinct review of these principles. The paramount goal is to give effect to the Legislature's intent. "When that intent is revealed by a statute's plain language - ascribing to the words used 'their ordinary meaning and significance' - we need look no further." It is only where the language is

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[10] The investigation by Mr. Cuomo's office revealed that the Ingenix database had faulty data collection and poor pooling procedures and lacked audits. The investigation also made the finding that having a health insurer determine the usual and customary rate, a large portion of which the insurer then reimburses, creates an incentive for the insurer to manipulate the rate downward. *In the Matter of UnitedHealth Group Incorporated*, Investigation No. 2008-161, Assurance of Discontinuance Under Executive Law §63(15) dated January 13, 2009 available at http://www.oag.state.ny.us/sites/default/files/pdfs/bureaus/health_care/United%20Health.pdf.

Problems with the Ingenix database had previously been noted in *McCoy v. Health Net, Inc.*, 569 F.Supp. 2d 448 (D.N.J. 2008). The Appellate Division generally accepted the identified deficiencies and flaws of the Ingenix database in *In re Adoption of N.J.A.C. 11:3-29 ex rel. State Dept. of Banking & Ins.*, 410 N.J. Super. 6,28-30 (App. Div.), *certif. denied*, 200 N.J. 506 (2009).

sufficiently ambiguous that it might be susceptible to more than one and conflicting interpretation(s) that the court may turn to extrinsic evidence. *Id.* at 572. *Accord, Nicholas v. Mynster,* 213 N.J. 463, 480 (2013). Or as Chief Justice Rabner recently put it in very simple terms: "Words make a difference." *In re Plan for the Abolition of the Council on Affordable Housing,* 214 N.J. 444, 470 (2013).

The words chosen here by the Legislature were "database of prevailing health care charges." Those words together with the manifest legislative intent should guide the court's disposition of this matter.

In *Heaton v. State Health Benefits Commission,* 264 N.J. Super. 141 (App. Div. 1993), this court had stated:

> The goal of the State Health Benefits Program Act is to provide comprehensive health benefits for eligible public employees and their families at tolerable cost. It establishes a plan for state funding and private administration of a health benefits program which will protect public employees from catastrophic health expenses, and which encourages public employees to rely on the Program instead of seeking protection in the commercial insurance market.
>
> By undertaking that very consequential role in the financial security of public employees and their families, the State also undertakes to play fair with them. Hidden or unfair reservations in insurance policies are ignored because they do not reflect the reasonable expectations of the parties. … Because of the significance of health insurance to public employees and their families, and the Legislature's undertaking to furnish insurance and determine its scope, one of the goals of the Legislature must have been to assure the

> fair and even-handed application of Program provisions, and the avoidance of crabbed interpretations of ambiguous terms. [*Id.* at 151-52.]

The important role that health benefits through the SHBP plays in public employment was stressed by the Appellate Division in *Micheletti v. Health Benefits Comm'n*, 389 N.J. Super. 510 (App. Div. 2007), where this court stated:

> There can be little doubt that the Program is an inducement to public service. It is the sole source of medical benefits coverage for tens of thousands of State employees and their only protection from catastrophic medical expenses. While the SHBC has wide discretion to define benefit limits and exclusions from coverage, its statutory authority is circumscribed by the goals of the Program and the reasonable expectation of its participants. [*Id.* at 522.]

There are well-established tools to interpret the statutory authority of the SHBC. The doctrine of *ejusdem generis* so that "'where general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words'" is a leading tool of statutory construction *Gallenthin Realty Dev., Inc. v. Borough of Paulsboro*, 191 N.J. 344, 367 (2007)(quoting 2A Norman J. Singer, Sutherland Statutory Construction § 47:17 (6th ed. 2000)). Thus, as noted in *Wilson*, unless the use of the doctrine will subvert the legislative intent, the words "charges … determined by the Health Insurance Association of America **or a similar nationally recognized database of**

prevailing health care charges" provide the touchstone for analysis here. The issue to be addressed by the court on this appeal is whether the Commission was using "a similar nationally recognized database of prevailing health care charges" when it approved of Horizon's use of the Medicare fee schedule instead of a health care charges database.

Use of fees paid by Medicare in contrast to physician charges is discussed more extensively below. But there is an additional point regarding statutory construction.

As with the phrase "other conditions" used in the statute at issue in *Gallenthin Realty*, the phrase "or a similar nationally recognized database" in *N.J.S.A.* 52:14-17.29 is not a universal catch-all that refers to any database. Rather it refers to a collection of information involving the same or like sources of data on prevailing health care charges.

As noted by the Administrative Law Judge in *Seiglie v. State Health Benefits Commissions*, 2011 WL 4802634 (N.J. Admin 2011) at *2, the PHCS was a database of physician charges maintained by Ingenix. Ingenix collected charge data from insurance companies and providers nationwide, based upon zip-code ranges. Ingenix provided a range of percentiles from the 50th percentile through the 95th percentile based upon the charges collected. The SHBP utilizes the 90th percentile as reasonable and customary.

As noted in *Heaton*, the Commission has statutory authority to create Plan Handbooks. Such Handbooks are "understood to embody the terms of the Program as communicated to the employees." *Heaton, supra*, 264 N.J. Super. at 144. In *N.J.A.C.* 17:9-2.14, the Commission specifically "adopts by reference all of the policy provisions contained in the contracts between the health, prescription drug and dental plans and the [State Health Benefits] Commission, as well as any subsequent amendments thereto, to the exclusion of all other possible coverages".

The Plan's Handbook supplements the master contracts and contains the specific provisions for services to be covered and those which are excluded. As set out in the 2011 Handbook, the PHCS data "is **based on actual charges** by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay." [MSC App at 73A (Emphasis added)]

A more detailed description of the PHCS database was developed by the Administrative Law Judge in *A.J.H. v. State Health Benefits Commission*, 1998 WL 656496 (N.J. Admin. 1998). The PHCS collects provider charge data from more than 150

major contributors, including commercial insurance companies, third party administrators, Blue Cross and Blue Shield plans, and self-insured groups. Data are gathered from all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. The ALJ stated: "**The PHCS data bases [sic] do not include charges from government sponsored programs such as Medicare** and Medicaid." *Id.* at *3 (emphasis added). While Horizon had at its disposal charge information for the disputed fees from its commercial business, the record does not reflect whether that information was even considered.

In contrast, the "database" advanced by Horizon here and eventually approved by the SHBC is premised solely on the use of Medicare data. It is not "a similar nationally recognized database of prevailing healthcare charges." While it certainly may be "nationally recognized" and have its information in a "database," the information does not represent "prevailing health care charges."

Essential to the correct analysis of this matter is the awareness and recognition that the Legislature repeatedly refers to "charges." While "charges" may be synonymous with "billed fees," it is not the same or equivalent to "paid fees." This distinction was well established in the context of the fee schedule adopted by the Department of Banking and Insurance (DOBI) in connection with payment of PIP claims

pursuant to the No Fault Act. *Coalition for Quality Health Care v. Dept. of Banking & Ins.*, 358 N.J. Super. 123, 126 (App. Div. 2003)("The charged-fee versus paid-fee issue must be resolved at some point. It is better resolved now than later.") In resolving the issue, the court commented that DOBI acknowledged that the historical practice has been to use "billed fees" or "charges" rather than "paid fees" to determine the amount of a payment. *Id.* at 127. And in this regard, the court emphasized that the legislative standard for evaluating the PIP fee schedule as found in *N.J.S.A.* 39:6A-4.6 was not "charges" but rather "reasonable and prevailing fees." *Id.* at 129. As emphasized in this Brief, that is **not** the legislative standard for this matter involving the SHBP, which is based on "charges."

Third-party payers, whether insurers or government programs, pay medical bills in one of two ways, either through fee schedules, or through a repricing concept of the submitted charges that has come to be known as usual, customary and reasonable, or simply as UCR.

Fee schedules can either be voluntary through contract or governmentally mandated. When a medical service provider joins a health care plan such as a PPO (preferred provider organization) or HMO (health maintenance organization) that

provider agrees to accept the fee schedule set by the PPO or HMO. Medical service providers who participate in Medicare-Medicaid for example receive a fixed fee for the services they provide that is set by the federal government. These are sometimes referred to as "participating providers."

In contrast to participating providers whose fees are limited by contract and fully paid by third-parties (subject to any co-pay requirement) are physicians who have not contracted to join a network and are referred to either as non-participating ("non-par") or out-of-network providers. Typically when health plan beneficiaries use out-of-network providers, they receive reduced levels of coverage because the plan does not cover the entire fee charged by the providers. The plan pays a percentage of the allowable charges for a particular treatment or procedure with the beneficiary paying the remaining percentage and being responsible for the rest of the medical bill to the extent it exceeds the covered charge. *See generally Wachtel v. Health Net, Inc.*, 239 F.R.D. 81, 85 (D.N.J. 2006). The method used for determining the amount a health plan will pay for out-of-network services is referred to as UCR. In their simplest form, UCR payment schedules are determined from statistical analysis of prevailing charges among all providers within a given geographical area for a given service or procedure. When a physician submitted a bill,

it was checked to determine (a) whether it was above or below the median charge for the same service by that physician during the prior year, (b) whether it was comparable to the 75th percentile of charges by all doctors in that area, and (c) whether or not it was justifiably higher because of some complicating factor in the particular patient's circumstance. The coalescence of these (a), (b), and (c) factors results in the phrase Usual, Customary, and Reasonable. T.E. GETZEN, HEALTH ECONOMICS AND FINANCING at 124-25 (5th ed. 2013).

Medicare adopted the UCR pricing system for a number of years and it became the standard method used by the insurance industry for repricing medical bills. In the early 1990's Medicare began reimbursing physicians using what is called a resource-based relative value scale (RBRVS). RBRVS was developed by a Harvard research group and basically relates the value of medical procedures to each other (based on time, skills required and other factors), assigns a dollar conversion factor along with a geographic factor to derive a formula which computes payments for specific services and procedures. The Medicare system is not based on UCR charges regardless of the database being used. It is a fee schedule. T.E. GETZEN, *supra*, at 125-26.

Until discredited, Ingenix was the primary database for UCR information.[11] The replacement nonprofit organization called FAIR Health Inc. has developed new UCR databases to replace the UnitedHealthcare/Ingenix databases. FAIR Health was established in October 2009 to serve as an independent, objective, and transparent source of healthcare reimbursement data for consumers, insurers, healthcare providers, researchers and policymakers.

It has established two websites that can readily be accessed. The first is available at www.fairhealth.org and provides for the purchase of licenses to obtain "actual charge data reported by healthcare professionals." The other is more consumer-oriented and can be found at http://www.fairhealthconsumer.org. That website allows a consumer to develop estimates of out-of-pocket costs for out-of-network care. This includes the ability to compare UCR reimbursement and reimbursement based on a percentage of the Medicare fee schedule. The website states that "FAIR Health data reflect benchmark market rates, which are what providers typically charge for a procedure or service in a particular geographic area."

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[11] Another nationally recognized database is the Wasserman Physician Fee Reference. http://www.medfees.com. Both the Wasserman and Ingenix data are considered proprietary.

http://www.fairhealthconsumer.org/medicalcostlookup/compare.aspx.

These websites are intended to address many of the shortcomings that the New York Attorney General's investigation had identified in the use of the Ingenix database and the setting of UCR. These included being conflict-laden, potentially flawed, and opaque to patients seeking cost information.

The FAIR Health website includes an online tool allowing consumers to better understand their out-of-pocket medical costs if their health plans base out-of-network reimbursement on the "Medicare fee schedule." After noting that Medicare pays only a "fixed amount," it refers to its online tool for comparing Medicare fees with a UCR determination for procedures. Such comparison repeatedly demonstrates the lower level of reimbursement from Medicare.

A *New York Times* article in April 2012 reviewed the emerging shift away from UCR determination to Medicare multiples by many health plans. Nina Bernstein, "Insurers Alter Cost Formula, and Patients Pay More, available at http://www.nytimes.com/2012/04/24/nyregion/health-insurers-switch-baseline-for-out-of-network-charges.html?pagewanted+all& r+0.

The news report noted that there were variable levels of reimbursement. "The traditional benchmark was 80 percent of

the U.C.R., while newer ones mostly range from 140 percent to 250 percent of Medicare rates. **That sounds like more, but typically amounts to less**, and is drastically below charges in large, emergency out-of-network bills." (Emphasis added.) The article discusses an example using the FAIR Health website with a comparison to Medicare multiples:

> When [Chad Glaser's] son, Ethan, was a baby, doctors said he had a rare liver disease. The family, which was in a health maintenance organization, had to appeal three times to get approval for the out-of-network surgery that saved the boy, now 10. So Mr. Glaser was overjoyed two years ago when his employer switched to a preferred provider organization that promised out-of-network coverage. Including premiums and deductibles, he and his employer pay about $14,600 a year for family coverage.
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> But he discovered that at 150 percent of Medicare rates, it fell far short. In the case of a $275 liver checkup, for example, the balance due was $175, almost three times the patient share under Fair Health's customary rate, and three and a half times what it was five years ago under Ingenix.
>
> If Ethan had to repeat the $200,000 transplant, which used some of his father's liver in 2003, the plan would pay little of the cost under the Medicare formula. [*Id.*]

As a "similar nationally recognized database" FAIR Health does have information on physician charges for procedures performed at ASCs. It does not currently have the data for facility fees at ASCs that may be charged in addition to the professional fee but expects overtime to expand its online tool to include such charges. See http://www.fairhealthconsumer.org/medicalcostlookup/. Based on the

language of the 2012 Member Handbook and Horizon's stance, this approach is not limited to facility fees but encompasses any service at an ASC, which would clearly violate the statute.

The reduction of out-of-network benefits is a cost-containment strategy that can frequently have unintended consequences. When insurers or health plans contract with health care providers to specify the rates they will pay for their insured's or members' medical services and procedures, the costs are controlled. Given the disparity in bargaining power, those contract rates are frequently inadequate. Not all medical practices can sustain the decision to not participate in these plans. That is an issue for another day. But in any event, without a contract, when the provider is considered "out-of-network" the insurer will typically reimburse an out-of-network provider only a percentage of the billed charge. The health care provider then bills the patient directly to collect the remaining balance. This puts patients and physicians in an awkward and unfair position. Both rightfully expected more payment from the health plan. The payment issue may have a negative impact on the physician-patient relationship. It may even affect continuity of care if the patient believes that the physician is overcharging rather

than there being an underpayment by the health plan or insurer.

The SHBP disclosure documents refer to the out-of-network reimbursement methodology. However, these documents do not enable enrolled members to estimate the amount their plan will reimburse for a specific out-of-network service, or the amount that the member in turn will be responsible for paying. The MSC Appendix for this appeal provides the Members Handbook for 2009 and 2011. The pertinent portions of the equivalent 2012 and the current 2013 document are included in the Appendix at MSNJ/AMA App at 9A-23A. The 2013 document is available in full at the Division of Pensions webpage:

www.state.nj.us/treasury/pension/pdf/handbook/njdirectbk.pdf

The section entitled "Reasonable and Customary Allowances (for Out-of-Network Services)" was quoted by the SHBC in its written FAD decision regarding the MSC request for declaratory ruling. Significantly, inclusion of the references to the FAIR Health database and the CMS ASC fee schedule were not present until the 2012 Handbook and thus are not truly germane to the issue presented by MSC.

Nonetheless, as demonstrated above, the use of the CMS fee schedule or a multiple thereof does not comply with the legislative standard set forth in *N.J.S.A.* 52:14-17.29 of a

"database of prevailing health care charges." In the times of financial and budgetary stress faced by State Government, the attempt to base out-of-network allowance on what Medicare pays - a low reimbursement rate the Federal Government provides to keep the tax burden for senior citizen health care low - may be understandable. Indeed, case law has recognized the Commission's fiduciary obligation to balance the obligation to meet the health care needs of its members with the need to make the program cost effective. *Murray v. State Health Benefits Commission*, 337 N.J. Super. 435, 440 (App. Div. 2001).

But notwithstanding this objective and the broad authority of the SHBC as a state administrative agency that ordinarily is to be accorded the benefit of the presumption afforded to administrative regulations, the action must be reasonable and consistent with the legislative intent and statutory standard. *Pascucci v. Vagot*, 71 N.J. 40, 50 (1976). In *Pascucci*, Chief Justice Hughes writing for a unanimous Court invalidated a regulation of the Division of Public Welfare, New Jersey Department of Institutions and Agencies, setting lower levels of financial assistance to persons classified as "employable" than to those classified as "unemployable." The court evaluated the regulatory action in the context of the statute which provided for assistance to

persons "willing to work but [who] are unable to secure employment due either to physical disability or inability to find employment." The regulation distinguished between persons who had physical or mental handicaps or impairments and needy persons for whom there simply was no work. Finding the regulation improperly broke down the single category into two, the Chief Justice stated: "it is plainly discordant on its face with the statutory purpose." *Id.*

There is the same improper breaking of a single category into two here with the continued use of "charges" in the invocation of the FAIR Health database for some services but then "paid fees" as set by a multiple of Medicare when the medical services are provided at an ASC. Unless there is legislative action changing the language *of N.J.S.A.* 52:14-17.29, this court must correct the overreaching at the regulatory level.

This point was recognized in *Murray v. State Health Benefits Comm'n, supra,* where the pertinent language in the SHBP required an administrator to determine whether a treatment was experimental by evaluating published reports in authoritative medical literature. The Appellate Division stated: "if the Commission does not wish the administrator to be so limited, then the State Plan's language must be modified." 337 N.J. Super. at 445.

The Commission's practice limits the ability of member patients to choose among health care providers and have the SHBP pay the statutorily mandated portion of charges for the resulting care. Since the patients have specifically paid for that right, the Commission's action has a chilling effect on the patients' choice that must be overturned.

III. THE SHBP ADMINISTRATOR'S USE OF 160% OF THE MEDICARE ALLOWANCES TO CALCULATE THE OUT-OF-NETWORK PAYMENTS IN 2009 AND THE SHBC'S APPROVAL OF THIS PRACTICE IN 2011 CONSTITUTE DE FACTO RULEMAKING WHICH MUST BE VOIDED FOR FAILURE TO COMPLY WITH THE APA.

Even if the SHBC could interpret the statutory term "charges" to mean "paid fees," the SHBC has violated the Administrative Procedure Act (APA), *N.J.S.A.* 52:14B-1 *et seq.* by reimbursing out-of-network providers based on 160% of the CMS Medicare allowance without first satisfying the rulemaking process. It is well established that agency action akin to rulemaking which fails to comply with the APA is voidable as a matter of law. *See Besler & Co., Inc. v. Bradley*, 361 N.J. Super. 168, 171 (2003) (stating "[i]nformal agency action that is de facto rulemaking will be voided for failing to comply with the APA rulemaking procedures"). The APA requires that prior to adopting or amending any rule, agencies give notice of their intended action and afford interested parties a

"reasonable opportunity to submit data, views or arguments, orally or in writing." *N.J.S.A.* 52:14B-4(a)(1), -(3).

In *Metromedia, Inc. v. Director Div. of Taxation*, 97 N.J. 313 (1984), the New Jersey Supreme Court defined when rulemaking rather than *ad hoc* adjudication was required, *i.e.*, when the agency determination:

> (1) is intended to have wide coverage encompassing a large segment of the regulated or general public, rather than an individual or a narrow select group; (2) is intended to be applied generally and uniformly to all similarly situated persons; (3) is designed to operate only in future cases, that is, prospectively; (4) prescribes a legal standard or directive that is not otherwise expressly provided by or clearly and obviously inferable from the enabling statutory authorization; (5) reflects an administrative policy that (i) was not previously expressed in any official and explicit agency determination, adjudication or rule, or (ii) constitutes a material and significant change from a clear, past agency position on the identical subject matter; and (6) reflects a decision on administrative regulatory policy in the nature of the interpretation of law or general policy. [*Id.* at 331-32.]

It is not necessary that all six factors be present. *In re Solid Waste Util. Customer Lists*, 106 N.J. 508, 518 (1987). But most are here. Moreover, under *Metromedia*, an agency "may not use its power to interpret its own regulations as a means of amending those regulations or adopting new regulations." *Besler, supra,* 361 N.J. Super. at 173 (quotation omitted). Nor may an agency change its interpretation of a regulation or

other requirement without proper notice and formal rulemaking. As stated in *Metromedia:*

> Similarly, an agency determination can be regarded as a "rule" when it effects a material change in existing law. This feature relates not only to fairness to the individual party actually before the agency but to other persons as well. When an agency's determination alters the *status quo,* persons who are intended to be reached by the finding, and those who will be affected by its future application, should have the opportunity to be heard and to participate in the formulation of the ultimate determination. [97 N.J. at 330.]

Accord, Northwest Covenant Med. Ctr. v. Fishman, 167 N.J. 123, 136 (2011)(holding Department of Health and Senior Services acted arbitrarily and engaged in quasi-legislative activity of rule-making with regard to basis for reallocation of charity care subsidy).

When analyzed under *N.J.S.A.* 52:14B-2(e) and *Metromedia,* the SHBP Administrator's unilateral and unreviewed application of 160% of the CMS Medicare allowance to the claims submitted by out-of-network surgical centers, where prior to 2009 the reimbursement was calculated based on the 90th percentile of the PHCS, combined with the 2011 acquiescence in that change by the SHBC itself, constitutes administrative rulemaking that failed to afford MSC, and other New Jersey out-of-network surgical centers, notice and comment as required under the APA.

The deficiency in satisfying the retroactive rulemaking prohibition arises with the SHBC's unilateral change in interpretation and application of *N.J.S.A.* 52:14-17.29 in 2009 and only made explicit in 2011, particularly with regard to the requirement in *N.J.S.A.* 52:17-14.29(C) concerning "charges."

The status quo was to pay out-of-network providers in accordance with the directives in the statute. This is reflected in language found in the Member Handbooks and in the usual course of dealing. The 2009 Member Handbook states that "reasonable and customary allowances" for out-of-network "[s]urgical [s]ervices" are "determined by the [PHCS] fee schedule or a similar nationally recognized database." [MSC App at 068A] The same directive is found in the 2011 Member Handbook. [MSC App at 072A-073A] MSC was indeed paid pursuant to these directives until 2009.

It is undisputed that in or about May 2009, without providing notice and a comment period, Horizon abruptly and dramatically decreased payment to MSC submitted on behalf of plan participants. [MSC App at 17A-18A] The payments appeared to represent 160% of the CMS Medicare allowance for each CPT code. [*Id.* at 18A] In response to a challenge to this apparent new methodology, Horizon represented that the claims were processed according to an "allowance" developed by a

nationally recognized consulting firm but without characterizing it as a "database … of prevailing health care charges." [*Ibid.*; MSC App at 2A] But the record in this case demonstrates that that process was done without any transparency of the methodology being used or the data being considered. In August 2011, the SHBC explicitly approved the Administrator's policy to pay based on 160% of the CMS Medicare allowance, again without allowing for the requisite notice and comment period. [*Id.* at 22A-23A] Horizon's Director of Account Management, David Perry testified that this policy, which was approved in 2011, had gone into effect in late 2009. [*Id.* at 31A] Further, a report prepared by Horizon, which was disclosed in response to an Open Public Records Act (OPRA) request by MSC for documents pertaining to the new payment methodology, plainly confirms that at a previous point in time, the SHBP used the 90th percentile of the PHCS to determine reasonable and customary allowance for claims from an out-of-network provider, including an ASC. [MSC App at 93A]

Horizon has attempted to justify the shift with an explanation that the PHCS database did not provide rates for all ASC services and the charge data was commingled with hospital outpatient charges for similar procedures and care. Indeed, a similar rationale was offered in connection with adoption of a new PIP fee schedule. The Appellate Division

noted this in *In re Adoption of N.J.A.C. 11:3-29 by the State of New Jersey, Dep't of Banking and Ins.*, 410 N.J. Super. 6 (App. Div.), *certif. denied*, 200 N.J. 506 (2009). But that is neither a reason nor a justification to skip the rulemaking process and unilaterally and arbitrarily determine that an allowance based on CMS rates may be used.

Indeed, in the different but still germane context of the regulation of PIP benefits, DOBI took the appropriate steps by engaging in the administrative rulemaking process when seeking to adopt and amend payment methodology to providers who do PIP work. *In re Adoption of N.J.A.C. 11:3-29 by the State of New Jersey, Dep't of Banking and Ins., supra*, 410 N.J. Super. at 13. The Department proposed amendments to *N.J.A.C.* 39:6A-4.6, which would modify reimbursement to medical providers using a new physician's fee schedule and establishing a schedule for ASC fees. Prior to publishing notice of the rule, DOBI also solicited pre-proposal comments. *Id.* at 13-14. Given the Appellate Division's conclusion as to the questions concerning the "reliability" of use of the Ingenix database, the court enjoined its further use and remanded the matter to the Commissioner to assess any use of that data in arriving at the fee schedule. *Id.* at 41. Despite opposition and subject to review on remand, DOBI's final rule which set a fee schedule based on various percentages of Medicare rates was upheld by

the Appellate Division. But importantly, notice and an opportunity to comment had been extended to the public. *Id.* at 12-13.

It is also of interest that with regard to the use of Medicare multiples, these generally ranged from 130% to 800% *Id.* at 33-35. In sharp contrast to the action taken by the SHBC in adopting the 160% of Medicare multiple without any input from the affected community, **the rate for procedures done at an ASC** set by DOBI for PIP benefits and upheld by the Appellate Division was **300% whether physician fee or facility fee**. *Id.* at 35-36.[12]

If one accepts for purposes of argument that 300% of Medicare is reasonable reimbursement for a procedure done at an ASC (and the *amici* do not accept or concede this point), then in the setting of a member of the SHBP consider the consequence. In comparison to the determination made by one State agency in New Jersey for the same type of service provided to a State employee there will only be a payment of 160%. That leaves a 140% component of the Medicare multiple to reach the "prevailing fee" as determined by the Commissioner of Insurance for the same services if needed in a car accident. That is to say, the member State employee in

[12] Litigation challenging the DOBI PIP fee schedule, including its 300% Medicare multiplier, is still pending. *See New Jersey Healthcare Coalition v. New Jersey Department of Banking and Insurance*, Docket No. A-001038-12T2, consolidated with A-1445-12, A-1636-12, and A-1792-12.

exercising the purported right to have out-of-network benefits now faces the potential burden of non-reimbursement of nearly 50% of the out-of-network benefit. When measured against the clear statutory standard that a SHBP participant "shall receive reimbursement … at the rate of 80%/70%" depending on the plan chosen, this fails miserably.

Amici reject the notion that any multiplier of the Medicare fee schedule can or should be used to determine UCR charges for physicians. But even if the Administrator and SHBC are convinced that 160% or some other multiplier of the CMS Medicare allowance is an appropriate methodology to calculate reimbursements, MSC and others were entitled to notice and a comment period on this action. At present the data used to arrive at the selected Medicare multiplier is not identified and transparent. Moreover, it is apparent from the testimony of the Horizon representative that there is data that was collected by Ingenix on the charges of outpatient surgical facilities but that such data was not neatly separated into the charges by free-standing ambulatory surgery centers and those facilities that were affiliated with a hospital. This is precisely the type of circumstance where input and comment from the affected industry has a role to play in developing an appropriate regulatory scheme.

There is no doubt that this informal agency action was intended to have wide coverage encompassing a large segment of the regulated public: out-of-network physicians and healthcare provider entities such as ambulatory surgical centers. Indeed, Horizon's Account Manager has testified that ASCs have grown dramatically in popularity since the 1980's and that not all ASCs choose to participate in the SHBP network. [MSC App at 42A-43A] Thus, applying the 160% of the CMS Medicare allowance to claims for reimbursement by out-of-network surgical centers is akin to rulemaking and must comply with the APA.

Here, however, the SHBC has failed to comply with the APA. Instead the Administrator has unilaterally changed the way claims are repriced and then received support for the unlawful practice from the SHBC. However, the public and interested parties were never given the opportunity to provide commentary regarding the Administrator's payment of 160% of the CMS Medicare allowance or the SHBC's approval of that.

Thus, when the Administrator, acting on behalf of the SHBC, implemented its reimbursement calculation and paid out-of-network ambulatory surgery centers 160% of the CMS Medicare allowance for a given service, it engaged in retroactive rulemaking contrary to the mandate found in the APA. Under the newly implemented payment scheme, the amount of reimbursement was no longer based on a percentage of charges in the PHCS

database but rather a percentage of the fee amount set by CMS. Reimbursement was based solely on a schedule of fee paid by Medicare. The use of "paid fees" rather than "billed fees" or as set out explicitly as "charges" is contrary to the language of the controlling statute.

This application of 160% of the CMS Medicare allowance to the claims for reimbursement constituted a material substantive change in the way out-of-network ambulatory surgical centers were being paid. This constituted administrative rulemaking requiring notice and an opportunity to comment to interested parties such as MSC. Unfortunately, neither MSC, nor any other interested party, was provided with that opportunity. The SHBC's failure to provide a notice and comment period on this newly amended rule constitutes retroactive rulemaking, rendering its application of 160% of the CMS Medicare allowance to the claims submitted by MSC on behalf of SHBP members invalid.

CONCLUSION

For all the foregoing reasons, the determination that appellant Montvale Surgical Center lacked standing to pursue an appeal to the State Health Benefits Commission was in error and should be reversed. Similarly, with regard to the merits of its request for a declaratory ruling, this court should hold that use of a multiple of the CMS Medicare fee schedule did not comply with the statutory mandate and that any change in methodology for determining payment of benefits is subject to the notice and comment requirements of the Administrative Procedure Act.

Respectfully,

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Dated: October 21, 2013