May 16, 2016

Honorable Gary S. Schaefer

c/o Frank Haines
Legislative Budget and Finance Officer
Office of Legislative Services
State House Annex
P.O. Box 068
Trenton, New Jersey 08625-0068

Dear Chairman Schaefer:

Please accept the following response to your letter of April 19, 2016 which contained questions raised at the Department of Banking and Insurance budget hearing on April 13, 2016. In order to respond to your inquiries as quickly as possible, please find the response to your question that was asked at the hearing. We are working to prepare additional answers for the remainder of your questions.

Assemblyman Schaefer:

- New Jersey's Health Maintenance Organizations (HMO) Act (N.J.S.A.26:2J-1 et seq.) and Health Care Quality Act (HCQA) (N.J.S.A.26:2S-1 et seq.) provide protections to patients covered under health benefits plans by requiring carriers' health plans and HMOs to meet minimum standards, including network access and adequacy standards. Network access and adequacy standards ensure that a health plan can provide health care services to all of its subscribers. The Department of Banking and Insurance enforces the network access and adequacy provisions provided for in N.J.S.A.26:2S-18, N.J.A.C.11:24-6.1 et seq., and N.J.A.C.11:24A-4.10. This includes the review of new networks and the review of county service area data on primary care physicians, specialty care physicians, acute care hospitals, and ancillary and specialty providers, as well as information on provider turnover throughout the year. Since March 2015, please provide the number of proactive inquiries that the department initiated versus the number of reactive inquiries that the department responded to in regard to healthcare network compliance with access and adequacy standards.

Response: In response to the Chairman's request, the Department has reviewed its files since March, 2015 and identified 15 instances of proactive inquiries initiated by the Department regarding the adequacy of health carrier networks.

In five of those instances, the Department initiated the inquiries because of concerns arising from the Department's review of consumer complaints or decisions of the Independent Utilization Review Organization (IURO). In 10 of those instances, the Department initiated the inquiries as a result of other concerns, such as changes in
market conditions (e.g. changes in the availability of healthcare services) that raised questions about the ongoing adequacy of existing networks.

As the Department has noted on other occasions, the Department reviews network adequacy, pursuant to specified regulatory standards, at the time of filing of the network plan by the carrier, annually thereafter, and on an ongoing basis as conditions change and concerns arise.

I trust that the foregoing is responsive to the first question in your letter. The responses to the additional questions requested will be forthcoming in a separate response.

Very truly yours,

[Signature]

Richard J. Scolato
Acting Commissioner
June 24, 2016

Honorable Gary S. Schaer
C/O Frank Haines
Legislative Budget and Finance Officer
Office of Legislative Services
State House Annex
P.O. Box 068
Trenton, New Jersey 08625-0068

Dear Chairman Schaer:

Please accept the following responses to the additional questions raised at the Department of Banking and Insurance budget hearing.

- Some hospitals have begun to offer same day scheduling, on-line, for emergency room visits. What steps is the department taking to protect consumers who might mistakenly believe that all care rendered in an emergency room is considered responsive to a true medical emergency and therefore subject to DOBI’s regulations requiring an insurance company to limit the insureds financial exposure for the visit, even if occurring at an out-of-network facility, the same as it would had the visit occurred at an in-network event?

  RESPONSE:

  As the practice of “scheduling emergency care” appears to be a relatively new phenomena, the Department is reviewing its consumer guides and considering whether enhancements to those guides are warranted.

- It’s been reported that New York’s legislation on surprise billing is working and protecting consumers (Modern Healthcare: “New York law to curb surprise billing shows promising results”) and other states are moving to address the problem of price gouging and surprise billing (Modern Healthcare: “Florida and California move to shield consumers from surprise medical bills”). Does the administration believe that moving to these arbitration models would protect consumers and result in a more efficient expenditure of state tax dollars under the State Health Benefits Program as a means to achieving the $250 million in savings that were booked in the proposed budget?

  RESPONSE: As a general matter the Department does not comment on pending legislation and has not taken a formal position on these matters. It is important to note that the Department does not have jurisdiction over the State Health Benefits Program.
• Horizon BCBS, contracted with CareCentrix to manage commercial home health authorization and claims effective July 1st 2015. When they went live several codes never worked, thus home health providers have not been reimbursed for care under those codes since that time. What will be done to ensure this never occurs again if another payer looks to contract out their claims management?

RESPONSE: As a general matter the Department does not comment on or confirm the existence of specific investigations or enforcement actions while they are in progress. However, we are aware of this issue and remedial action has been taken to ensure all providers are reimbursed. We note that we have a dedicated unit for investigating complaints from providers regarding matters such as the timeliness of reimbursements by health carriers and the Department has the ability to take certain enforcement action in such instances, if necessary.

• The Department has made a significant increase in investment by hiring and training new fraud investigators. Please elaborate on what this means for consumers and the Bureau of Fraud Deterrence’s ability to curtail fraudulent activity.

RESPONSE: The Department is increasing its focus on the deterrence value of large civil enforcement actions against fraudulent behavior, so is stepping up its activity in identifying and prosecuting fraud rings and cases involving large dollar amounts. This will increase our ability to achieve restitution for insurance companies victimized by fraud, and thus reduce the impact of fraud on the prices consumers pay for insurance products.

• During the budget hearing, you had indicated that the Department was planning to hire additional staff to better monitor network adequacy. Do you currently have enough staff to properly monitor network adequacy? Could you please describe how you currently measure a plan’s network adequacy? What are the factors upon which that determination is based? How often do you follow up to ensure a network is still adequate after the initial determination? Have you ever found a network to not be adequate thereby leading to its rejection? If so, when and in what specific instance(s) did this occur?

RESPONSE: As stated during our testimony, and as subsequently affirmed by the Appellate Division in its OMNIA decision, the Department has been fully and properly enforcing network adequacy requirements pursuant to the relevant statutes and rules. Thus, current staffing levels have not been inadequate. However, as the Department has also indicated, we believe that additional staff will allow us to fulfill this function more quickly.

As has been described during Department testimony before the legislature, in our Order A15-112 (http://www.state.nj.us/dobi/orders/a15_112.pdf), and in the Appellate Division decision, the Department applies specific time and distance standards to proposed networks, as those standards are specified in our rules.

Network adequacy review is necessarily a continual and ongoing process, as networks and plans change, and as providers enter or exit the marketplace.

In the past, on numerous occasions the Department has found proposed networks to be inadequate, and has thus required cures to any deficiencies under the rules. For instance, there have been occasions where a carrier has sought approval of a statewide
network, the Department has found the network deficient in certain counties, and therefore approved the network only in those counties in which adequacy was demonstrated. Moreover, there have been instances in which the Department has required carriers to grant in-plan exceptions (i.e. allow members to access out-of-network providers and pay only network cost sharing) based on lack of available and geographically accessible providers in particular sub-specialties in the carrier’s network, such as breast reconstructive surgery and thoracic surgery.

- Please provide details on the department’s on-going response to Hurricane Sandy, including the outreach efforts and the number of consumers assisted to date. Last year the department testified that it assisted 3,103 consumers through March 2015. Have any more complaints been reported since that time? If so, what have the nature of those complaints been? What type of outreach is used to make people aware of the support that the Department offers?

RESPONSE: As of June 7, 2016, the Department has assisted 4,560 consumers with issues related to Sandy. The majority of the concerns related to claim denials and disputed claim settlement amounts. The Department continues to participate in on-site events, maintains a special phone line for Sandy inquiries and posts information on our website to assist Sandy victims.

- Last year the Department testified that as a part of their Sandy recovery support it was staffing mobile cabinets and attending community events. Is this still the case? What is the department currently doing to support victims of Hurricane Sandy? How much staff continues to be dedicated to Hurricane Sandy related issues? What issues continue to linger?

RESPONSE: Dozens of Department staff members continue to have potential roles, in conjunction with their other regular duties, in assisting consumers with Sandy related matters. For example, Consumer Assistance staff field inquiries from time to time regarding Sandy-related matters, and Enforcement staff are ready to investigate new complaints as necessary. We are also pleased to attend community events as requested. However, it is important to note that more than 90% of regulated Sandy claims were satisfied within several months of the storm, and 99.9% of Sandy claims under the jurisdiction of the Department are currently settled. Thus, the volume of activity in this area is quite low. The remaining cases appear predominately to be in litigation, taking those matters outside of the scope of the Department.

The significant lingering issues for consumers involve claims under the federal, National Flood Insurance Program, over which the Department has no jurisdiction.

- Is there an end date scheduled after which the department will no longer allocate resources for providing assistance to New Jersey residents impacted by Sandy?

RESPONSE: No. The Sandy mediation program will accept requests for mediations through August 1, 2016 and the Department will continue to field consumer requests and investigate complaints after that date, and for as long as such requests and complaints continue to be made.

- As of last year’s budget hearings, meetings of the Financial Sector Working Group were still ongoing. Have the meetings been completed? If so, please provide an update on what was accomplished. What recommendations were made regarding the action plan
offered by the Office of Homeland Security? If the meetings have not been completed please provide an update on the work that has been done thus far and an anticipated date of completion of the meetings.

RESPONSE: This activity is necessarily ongoing. It does not have an end date. Emergency Management, Homeland Security and industry representatives continue to share information on threats, and to coordinate and plan their responses to events.

• Last year media outlets such as the New York Times and Bloomberg published reports indicating complaints that engineer’s reports relating to flood damage were altered for the purpose of either rejecting or underpaying claims. As a result of these reports FEMA agreed to reopen claims related to flood damage. Please report on the status of reopened National Flood Insurance Programs flood claims in the State. How many claims have been reopened, and what is the status of those claims? How much additional money have Hurricane Sandy victims received?

RESPONSE: The Department regrets to report that, despite numerous requests, FEMA has yet to provide this information to the Department.

• Last year the department testified that it assists New Jersey residents with referrals to NFIP when it is contacted with questions or concerns about federal flood insurance rates. To date how many referrals has the department made? Does the department keep track of the amount of calls that come in regarding increased insurance rates? If so, is there any follow up with the callers to ensure that their concerns were adequately addressed? If not, do you believe that this is something the department should begin doing?

RESPONSE: The Department has made 803 referrals to NFIP. NFIP does not advise the Department of the resolution of these referrals.

Very truly yours,

Richard J. Badolato
Commissioner