SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1064-16T1

E.W.,

Appellant,

v.

STATE OF NEW JERSEY,
DEPARTMENT OF THE TREASURY,
DIVISION OF PENSIONS AND
BENEFITS,

Respondent.

Submitted February 13, 2018 – Decided April 20, 2018

Before Judges Yannotti and Carroll.

On appeal from the State of New Jersey, Department of the Treasury, Division of Pensions and Benefits.

The Killian Firm, PC, attorneys for appellant (Ryan Milun, on the briefs).

Gurbir S. Grewal, Attorney General, attorney for respondent (Melissa H. Raksa, Assistant Attorney General, of counsel; Danielle P. Schimmel, Deputy Attorney General, on the brief).

PER CURIAM

E.W. appeals from a final determination of the School Employees' Benefits Commission (Commission), which found that she was not entitled to coverage for certain treatments she received for an eating disorder and psychological problems. We affirm.

I.

This appeal arises from the following facts. E.W. has health coverage through the School Employees' Health Benefits Program (SEHBP). Accordingly, E.W. is enrolled in NJ DIRECT10, a Preferred Provider Organization. Horizon Blue Cross Blue Shield of New Jersey (Horizon) administers the program for the SEHBP, and it has contracted with Magellan Behavioral Health (Magellan) to provide mental health services for persons entitled to coverage under the program.

In April 2012, E.W. began treatment at Oliver-Pyatt Centers (OPC) for an eating disorder, major depressive disorder, and social phobia. The SEHBP covered the treatment until July 11, 2012. Thereafter, E.W. continued her treatment at OPC from July 12 to July 31, 2012, and from October 16 through November 19, 2012. She challenged the denial of coverage after July 11, 2012.

On July 4, 2012, OPC initiated a first-level appeal on E.W.'s behalf. On July 11, 2012, Horizon denied the appeal. On that same date, a second-level appeal was requested. Three Horizon employees

reviewed the appeal: a medical director, who is a board certified medical doctor; another medical director, who is board certified in internal medicine, and a registered nurse. On July 13, 2012, the appeal was denied and Horizon sent E.W. a letter explaining the decision.

In its letter, Horizon informed E.W. that she had the right to an external review of her appeal by an Independent Review Organization (IRO). The letter explained the procedure for taking an external appeal and noted that she must make her request for external review within four months after her receipt of the letter, or November 13, 2012. E.W. did not, however, request an external appeal.

It appears that on August 22, 2013, E.W. submitted an appeal request to Magellan. On August 30, 2013, Magellan wrote to E.W. and stated that she had exhausted all appeals "available to you through our organization." Magellan stated, however, that external review by an IRO was still available. Magellan provided E.W. with the instructions for filing such an appeal. E.W. did not request external review.

On November 19, 2013, Magellan again wrote to E.W., noting that it had received a request from an attorney for a response to the appeal request E.W. had submitted on August 22, 2013. Magellan noted that E.W. had not authorized the release of any privileged

health information to the attorney. Magellan also stated that all appeal levels through its organization had been exhausted, but "[a]n external appeal is still available."

On January 21, 2015, E.W.'s counsel submitted an appeal to the Commission from the second-level denial of coverage for E.W.'s treatment at OPC from July 12 to July 31, 2012, and from October 16 to November 19, 2012. On April 17, 2015, the Commission acknowledged receipt of the appeal and asked Horizon to conduct a review of its denial of coverage.

On May 13, 2015, Horizon responded, noting that "[a]lthough [E.W.] was eligible for an external appeal through an [IRO], [the] request was not received within the required four month timeframe." On July 8, 2015, the Commission "voted to deny [E.W.'s] appeal . . . . because Horizon did not receive a request for an [e]xternal [a]ppeal with an [IRO] within four months of [E.W.'s] receipt of Horizon's final adverse benefit determination."

In a letter dated July 27, 2015, the Commission set forth the reasons for its decision. The Commission noted that its regulations require all available appeals within the SEHBP to be exhausted before the Commission may consider an appeal. The Commission determined that E.W. could not appeal the denial of benefits because she had not exhausted all available appeals.

On August 28, 2015, E.W. sought administrative review of the Commission's determination and requested a hearing in the Office of Administrative Law. On September 23, 2015, the Commission considered and denied E.W.'s hearing request, finding "no material facts in dispute." On September 28, 2016, the Commission issued its final agency decision.

The Commission reviewed the relevant facts, and noted that when E.W.'s counsel appeared on her behalf, counsel did not dispute the fact that E.W. had not sought external review by an IPO. Counsel argued there may have been some confusion because the appeal decision stated that E.W. could pursue an external appeal, not that she must pursue such an appeal.

In its decision, the Commission noted that in March 2010, the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act (HCERA), P.L. 111-152, 124 Stat. 1029 (2010), were enacted, and amended the Public Health Services Act (PHSA), 42 U.S.C. § 300gg-19(b), to require that all health insurance plans, including self-insured plans, incorporate external review into their programs. The United States Department of Health and Human Services then issued technical guidelines to non-federal, self-insured plans such as the SEHBP on how to comply with federal law.

The Commission noted that SEHBP decided to have external reviews conducted by nationally-accredited IROs, through the administrators of the SEHBP, including Horizon. This change to the appeal process was incorporated into the Plan Year 2012 NJ Direct Member Handbook (the Handbook) in the section entitled "Appeal Procedures." The Handbook states:

> If you are dissatisfied with the results of Horizon BCBSNJ's internal appeals process, and you wish to pursue an [e]xternal [a]ppeal with an [IRO], you must submit a written request within four (4) months from your receipt of Horizon BCBSNJ's final adverse benefit determination of your Appeal.

The Handbook also provided detailed information as to where the written request for external review should be sent, and the factual information required for the IRO to properly evaluate the merits of the final adverse benefit determination.

The Commission further explained that N.J.A.C. 17:9-1.3 then provided E.W. with the requirements for appealing an adverse benefit determination to the Commission. The regulation stated that "[a]ny 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." Ibid.

The Commission addressed E.W.'s concern that there may have been confusion based on the permissive language of the appeal

rights. In its decision, the Commission explained that "the appeals process is an option for the member, and is never required. Members have the option to accept the [p]lan's decision and not pursue an appeal." The Commission noted, however, that "[t]he Handbook language clearly states that the third level of appeal available through the Plan is the [e]xternal [r]eview" and the "Handbook also clearly states that the deadline for an [e]xternal [a]ppeal request is four (4) months following the receipt of the adverse determination."

The Commission added that there was no dispute that E.W. had not requested external review within four months after the July 13, 2012, letter. Moreover, E.W. did not seek external review within four months after such review was offered in August 2013 and November 2013, which was long after the time for external review had expired.

The Commission concluded that because E.W. had not exhausted all levels of appeal available to her through the plan, she could not appeal the benefits determination. The Commission also determined that because the essential facts were not in dispute, there was no need for an administrative hearing. This appeal followed.

II.

On appeal, appellant argues that the changes to the external review process were not adopted as part of the Administrative Code until November 2016, which was after E.W. sought review of the benefits denial by the Commission. She argues that when she submitted her administrative appeal to the Commission, there was no requirement that she seek external review. E.W. therefore argues that the Commission should have considered the merits of her appeal.

We note that the scope of our review of an administrative agency's decision is limited. Circus Liquors, Inc. v. Governing Body of Middletown Twp., 199 N.J. 1, 9 (2009). In an appeal from a final decision of an administrative agency, our inquiry is limited to the following:

> (1) whether the agency's action violates express or implied legislative policies, that is, did the agency follow the law; (2) whether the record contains substantial evidence to support the findings on which the agency based its action; and (3) whether in applying the legislative policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors.
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> [In re Proposed Quest Acad. Charter Sch. of Montclair Founders Grp., 216 N.J. 370, 385 (2013) (quoting Mazza v. Bd. of Trs., 143 N.J. 22, 25 (1995)).]

Although we are not bound by an agency's legal conclusions, we generally defer to the agency's interpretation of its own

regulations and enabling statutes. Utley v. Bd. of Review, 194 N.J. 534, 551 (2008). We give considerable deference to the agency's interpretation of its own rules "because the agency that drafted and promulgated the rule should know [its] meaning." N.J. Healthcare Coal. v. N.J. Dept. of Banking & Ins., 440 N.J. Super. 129, 135 (App. Div. 2015) (quoting In re Freshwater Wetlands Gen. Permit No. 16, 379 N.J. Super. 331, 341-42 (App. Div. 2005)).

When interpreting an administrative regulation, we apply the same rules of construction that apply to the interpretation of statutes. US Bank, N.A. v. Hough, 210 N.J. 187, 199 (2012). Thus, our "goal is to divine and effectuate" the intent of the regulation. State v. Shelley, 205 N.J. 320, 323 (2011) (citing DiProspero v. Penn, 183 N.J. 477, 492 (2005)). In furtherance of that goal, we begin each such inquiry with the language of the rule, giving the terms used therein their ordinary and accepted meaning. Ibid.

When the chosen words lead to one clear and unambiguous result, the interpretive process is at an end, and we do not need to consider extrinsic evidence. State v. D.A., 191 N.J. 158, 164 (2007) (citation omitted). However, we may consider extrinsic evidence, such as the rulemaking history, for assistance when statutory language yields "more than one plausible

interpretation." Shelly, 205 N.J. 323-24 (quoting DiProspero, 183 N.J. at 492-93).

III.

Under the School Employees' Health Benefits Program Act, N.J.S.A. 52:14-17.46.1 to -.11, the Commission is responsible for the operation of the SEHBP, which is a health benefits program for various school employees and their dependents. N.J.S.A. 52:14-17.46.4 to -.5. The Commission has the authority to "establish and change rules and regulations as may be deemed reasonable and necessary for the administration of this act." N.J.S.A. 52:14-17.46.4.

The health benefits offered to SEHBP members are provided under contracts authorized by the Commission with carriers that administer the terms of the plan. N.J.S.A. 52:14-17.46.5. The plan's terms and conditions are set forth in the governing statutes, regulations, and the policies of the carriers. N.J.S.A. 52:14-17.46.6 to -.7; N.J.A.C. 17:9-1.1 to -13.6. These terms and conditions are included in the SEHBP Handbook, which sets forth the procedure for appeals from the denial of benefits by the administrator, which, in this case, was Horizon.

As indicated in the Handbook, a member is entitled to first-level and second-level internal appeals. The member must file a first-level appeal within one year of receipt of the initial

adverse benefit determination. If the member disagrees with that decision, the member must file the second-level appeal within one year of the original determination letter.

The Handbook also states that if a member is "dissatisfied with the results of Horizon BCBSNJ's internal appeals process, and [wishes] to pursue an External Appeal with an [IRO], [the member] may submit a written request within four (4) months from [his] receipt of Horizon BCBSNJ's final adverse benefit determination of [his] appeal." The Handbook further provides that "[o]nce all appeal options have been exhausted through Horizon . . . , the member may appeal to the [Commission]." The appeal must be submitted within one year following the initial adverse benefit determination.

In January 2015, when E.W. submitted her request for appeal to the Commission, N.J.A.C. 17:9-1.3(a) then provided that:

> 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. Requests for consideration must be directed to the Secretary of the Commission, and must contain the reason for the disagreement and all available supporting documentation.
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> [N.J.A.C. 17:9-1.3(a) (emphasis added).]

On appeal, E.W. argues that based on the language of N.J.A.C. 17:9-1.3(a), she was only required to exhaust "all appeals within

the plan" before seeking Commission review. She interprets the phrase "all appeals within the plan" to mean first- and second-level internal appeals.

In support of her argument, E.W. notes that in November 2016, N.J.A.C. 17:9-1.3(a) was amended to require an individual seeking Commission review to exhaust "all appeals within the plan, as well as any external review required by the PPACA, if applicable." We are not persuaded by E.W.'s contentions.

As noted previously, in March 2010, the PHSA was amended to require all health insurance plans, including self-insured plans, to provide external review of adverse health benefits decisions, and the SEHBP decided to have such review conducted by IROs. The change in the appeal procedure was incorporated in the Handbook for Plan Year 2012.

The Handbook expressly stated that a SEHBP member who is dissatisfied with a decision after second-level internal review, could seek external review by an IRO. The Handbook also stated that an appeal to the Commission may only be requested after "all appeal options have been exhausted" through Horizon. We are therefore convinced that the phrase "all appeals within the plan" that appears in the version of N.J.A.C. 17:9-1.3(a) before its amendment in November 2016, encompassed both first- and second-

level internal appeals, as well as an internal appeal through an IRO.

We note that the pre-amendment regulation did not refer to internal or external review by Horizon. It referred to "appeals within the plan," a phrase that can reasonably be interpreted to include external appeals to an IRO. As indicated in the Handbook, external appeals are permitted in the plan, and requests for such review must be submitted to Horizon, the plan administrator.

We are also convinced that the November 2016 amendment to N.J.A.C. 17:9-1.3(a) does not require a contrary interpretation of the pre-amendment version of the regulation. As noted, the amendment states that a member may only request a Commission appeal if the member has exhausted "all appeals within the plan, as well as any external review required by the PPACA, if applicable." The amendment clarifies the prior regulation by requiring members to exhaust all appeal options, including internal first- and second-level appeals, as well as any external review by an IRO.

We note that when the regulation was amended, the Commission explained that "[s]ubsection (a) will also be proposed for amendment to include the external review process, which is now required under the Federal Patient Protection and Affordable Care Act (PPACA)." 44 N.J.R. 784(a) (May 16, 2016) (emphasis added).

This statement indicates that the regulation would be amended to "include" a specific reference to the external review process.

The amendment was a clarification of the existing regulation because the external review process, which was mandated by federal law after March 2010, had already been incorporated in the plan, as explained in the Handbook. The amendment to the regulation clarified the regulation to reflect that before seeking a Commission appeal, the member must exhaust all appeals allowed under the plan, which include both internal appeals through the plan administrator and external appeals through an IRO.

We note that on several occasions, E.W. was provided with copies of the relevant sections of the appeal procedures, which provide internal first- and second-level appeals, and the right to seek an external appeal through an IRO. The appeal procedures provided to E.W. made clear that she could not seek Commission review unless she had exhausted all appeal options, which included external appeals through an IRO. It is undisputed that she never made a request for external review.

We therefore conclude that because E.W. failed to exhaust all appeals options within the SEHBP as required by N.J.A.C. 17:9-1.3(a), the Commission did not err by refusing to entertain her appeal.

Affirmed.