SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-5653-14T1

ASSOCIATION OF NEW JERSEY CHIROPRACTORS, INC., and STEVEN CLARKE, DC,

Appellants,

v.

STATE HEALTH BENEFITS COMMISSION, STATE HEALTH COMMISSION, STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE, SCHOOL EMPLOYEE HEALTH BENEFITS COMMISSION, SCHOOL EMPLOYEE HEALTH BENEFITS PROGRAM DESIGN COMMITTEE, and STATE OF NEW JERSEY, DIVISION OF PENSIONS & BENEFITS,

Respondents.

Argued May 9, 2017 – Decided April 25, 2018

Before Judges Fisher, Leone, and Moynihan.

On appeal from the State Health Benefits Plan Design Committee, Division of Pensions and Benefits.

Jeffrey B. Randolph argued the cause for appellants.

Amy Chung, Deputy Attorney General, argued the cause for respondents (Christopher S. Porrino, Attorney General, attorney; Jean P. Reilly, Assistant Attorney General, of counsel and on the brief; Eileen S. Den Bleyker, Senior Deputy Attorney General, on the brief).

Budd Larner, PC, attorneys for amicus curiae National Guild of Acupuncture & Oriental Medicine — New Jersey Chapter (Donald P. Jacobs, on the brief).

The opinion of the court was delivered by

LEONE, J.A.D.

The Association of New Jersey Chiropractors and Steven Clarke, D.C. (collectively "appellants"), appeal from a July 6, 2015 Resolution by the State Health Benefits Plan Design Committee (Committee). We affirm.

I.

On July 6, 2015, the Committee considered a resolution "limiting out of network coverage for [chiropractic and acupuncture] services." The resolution provided that, "to maintain adequate access to certain services for its members through in-network provided care," "out-of-network coverage for chiropractic and acupuncture services effective for Plan Year 2016 will be no more than $35 a visit for chiropractic and $60 a visit for acupuncture or 75% of the in-network cost per visit, whichever is less." The resolution also requested that its vendors/carriers "implement an increase in the in-network rates for these same

services in order to help grow the network to adequate levels." The resolution stated "[t]he success of the vendor/carriers to increase network size may determine whether or not the PDC will expand, at some later date, the elimination of out-of-network coverage to other therapies and services."

In a Q&A sheet for the Committee, the plan administrator, Horizon Blue Cross Blue Shield of New Jersey (Horizon), "highlight[ed] Chiropractic, Physical Therapy, and Behavioral Health as categories experiencing year over year declines in overall in-network participation. These categories provide the best opportunity for savings." Horizon supplied the Committee with a PowerPoint presentation noting "several benefit categories that qualify as outliers relative to the overall network participation rate": Physical Therapy, Acupuncture, Chiropractic, and Behavioral Health. In its July 2015 recommendations for Plan Year 2016, the plan actuary, Aon Hewitt, estimated the reduction in plan payments for out-of-network chiropractic and acupuncture services would result in "[a] 0.2% reduction ($3 million) in projected Plan Year 2016 medical claims."

At the July 6 meeting, the Committee adopted the resolution without discussion or dissent. The Committee later explained the resolution would "[r]estrict plan payments for out-of-network

chiropractic and acupuncture services to drive in-network utilization which produces projected savings of $2 million."

Appellants appealed the Committee's resolution directly to the Appellate Division. We denied appellants' motion for a stay. We permitted participation as amicus curiae by the National Guild of Acupuncture & Oriental Medicine — NJ Chapter (Guild).

II.

We must hew to our standard of review. "Our review of agency determinations is quite limited." Murray v. State Health Benefits Comm'n, 337 N.J. Super. 435, 442 (App. Div. 2001). "We will ordinarily defer to the decision of a State administrative agency unless the appellant establishes that the agency's decision was arbitrary, capricious, or unreasonable, or that it was unsupported by sufficient credible, competent evidence in the record." Green v. State Health Benefits Comm'n, 373 N.J. Super. 408, 414 (App. Div. 2004). To make that determination, we must examine

> "(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 Stallworth, 208 N.J. 182, 194 (2011) (citations omitted); see Markiewicz v. State

Health Benefits Comm'n, 390 N.J. Super. 289, 296 (App. Div. 2007).]

"Courts afford an agency 'great deference' in reviewing its 'interpretation of statutes within its scope of authority[.]'" N.J. Ass'n of Sch. Adm'rs v. Schundler, 211 N.J. 535, 549 (2012) (citations omitted). Nonetheless, "when an agency's decision is based on the 'agency's interpretation of a statute or its determination of a strictly legal issue,' we are not bound by the agency's interpretation. Statutory interpretation involves the examination of legal issues and is, therefore, a question of law subject to de novo review." Saccone v. Bd. of Trs. of Police & Firemen's Ret. Sys., 219 N.J. 369, 380 (2014) (citation omitted).

III.

Appellants argue the cap on chiropractic reimbursement violates N.J.S.A. 52:14-17.29(C). That section governs the conduct of the State Health Benefits Commission ("Commission" or "SHBC") and provides that "[t]he contract or contracts purchased by the commission pursuant to [N.J.S.A. 52:14-17.28(c)] shall include the following provisions regarding reimbursements and payments" for the "successor plan." N.J.S.A. 52:14-17.29(C).[1] Since 2007, that section has provided:

[1] The "successor plan" is "a State managed care plan that shall replace the traditional plan and that shall provide benefits as

> In the successor plan, the co-payment for doctor's office visits shall be $10 per visit with a maximum out-of-pocket of $400 per individual and $1,000 per family for in-network services for each calendar year. The out-of-network deductible shall be $100 per individual and $250 per family for each calendar year, and the participant shall receive reimbursement for out-of-network charges at the rate of 80% of reasonable and customary charges, provided that the out-of-pocket maximum shall not exceed $2,000 per individual and $5,000 per family for each calendar year."
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> [N.J.S.A. 52:14-17.29(C)(1).]

"'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." N.J.S.A. 52:14-17.29(C)(3).

However, "[i]n 2011, the Legislature enacted Chapter 78, making numerous and significant changes to public employee pension and health care benefits." Rosenstein v. State, Dep't of Treasury, 438 N.J. Super. 491, 494 (App. Div. 2014). "As part of this overhaul, the Legislature provided the State Health Benefits Plan Design Committee . . . with the exclusive authority to design

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set forth in [N.J.S.A. 52:14-17.29(B)] with provisions regarding reimbursements and payments as set forth in [N.J.S.A. 52:14-17.29(C)(1)]." N.J.S.A. 52:14-17.26(j).

state health benefits plans — a power previously possessed by the State Health Benefits Commission[.]" Ibid.

> The committee shall have the responsibility for and authority over the various plans and components of those plans, including for medical benefits, prescription benefits, dental, vision, and any other health care benefits, offered and administered by the program. The committee shall have the authority to create, modify, or terminate any plan or component, at its sole discretion. Any reference in law to the State Health Benefits Commission in the context of the creation, modification, or termination of a plan or plan component shall be deemed to apply to the committee.
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> [L. 2011, c. 78 § 45(b) (emphasis added) (codified at N.J.S.A. 52:14-17.27).]

Thus, "the Legislature eliminated the SHBC's former authority in this regard," and "transferred the authority to design all aspects of the state health plan to the [Committee]." Rosenstein, 438 N.J. Super. at 500-01. The Legislature similarly created a School Employees' Health Benefits Plan Design Committee (SEHBPDC) and transferred to it the authority to design plans for school employees which had previously been exercised by the School Employees' Health Benefits Commission (SEHBC). L. 2011, c. 78, § 46(e) (codified at N.J.S.A. 52:14-17.46.3(e)). "With the enactment of Chapter 78, the Legislature has vested the Design Committees with the 'sole discretion' to create, modify, or terminate any plan or component, as well as to set amounts for

maximums, co-pays, deductibles, and other participant costs for all plans offered." Teamsters Local 97 v. State, 434 N.J. Super. 393, 416 (App. Div. 2014).

The Legislature also amended N.J.S.A. 52:14-17.29 to make clear the Committee had this exclusive discretion notwithstanding any other provision of law.

> Beginning January 1, 2012, the State Health Benefits Plan Design Committee shall provide to employees the option to select one of at least three levels of coverage each for family, individual, individual and spouse, and individual and dependent, or equivalent categories, for each plan offered by the program differentiated by out of pocket costs to employees including co-payments and deductibles. Notwithstanding any other provision of law to the contrary, the committee shall have the sole discretion to set the amounts for maximums, co-pays, deductibles, and other such participant costs for all plans in the program.
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> [L. 2012, c. 78, § 47(j) (emphasis added) (codified at N.J.S.A. 52:14-17.29(J)).]

When construing a statute, our primary goal is to discern the meaning and intent of the Legislature. "In most instances, the best indicator of that intent is the plain language chosen by the Legislature." State v. Gandhi, 201 N.J. 161, 176 (2010). "The inquiry thus begins with the language of the statute, and the words chosen by the Legislature should be accorded their ordinary and accustomed meaning. If the language leads to a clearly

understood result, the judicial inquiry ends without any need to resort to extrinsic sources." State v. Hudson, 209 N.J. 513, 529 (2012) (citation omitted).

The plain language of N.J.S.A. 52:14-17.29(J) dictates that the Committee's exercise of discretion under N.J.S.A. 52:14-17.29(J) cannot be defeated by claiming it conflicts with N.J.S.A. 52:14-17.29(C). "[I]n construing statutes, the use of such a 'notwithstanding' clause clearly signals the drafter's intention that the provisions of the 'notwithstanding' section override conflicting provisions of any other section." Cisneros v. Alpine Ridge Grp., 508 U.S. 10, 18 (1993); see 3B N. Singer & S. Singer, Statutes and Statutory Construction § 77:6 at 315-16 (7th ed. 2011). Thus, the "notwithstanding" clause expresses the Legislature's intention to override any potential limitation N.J.S.A. 52:14-17.29(C)(3) or any other section might otherwise have on the Committee's discretion to set participant costs. Courts "generally have 'interpreted similar "notwithstanding" language . . . to supersede all other laws, stating that "'[a] clearer statement is difficult to imagine.'"'" Cisneros, 508 U.S. at 18 (citations omitted). A "notwithstanding" clause "is a fail-safe way of ensuring that the clause it introduces will absolutely, positively prevail." A. Scalia & B. Garner, Reading Law: The Interpretation of Legal Texts 127 (2012).

Here, there is a conflict between the two sections. N.J.S.A. 52:14-17.29(C) sets fixed amounts for maximums, co-pays, deductibles, and reimbursement level for "the participant."[2] However, the Legislature more recently enacted N.J.S.A. 52:14-17.29(J) giving the Committee "sole discretion to set the amounts for maximums, co-pays, deductibles, and other such participant costs for all plans in the program." The Legislature included a "notwithstanding" clause to allow the Committee to carry out that command and exercise that discretion to modify the co-pays, maximums, deductibles, and other "participant costs" fixed in earlier legislation. N.J.S.A. 52:14-17.29(J). To read the "notwithstanding" clause otherwise would nullify the Legislature's grant of discretion.

The Committee's resolution modified participant costs by limiting the amount of reimbursement for out-of-network visits to "no more than $35 a visit for chiropractic . . . or 75% of the in network cost per visit, whichever is less." Thus, the resolution represented the Committee's exercise of its discretion under N.J.S.A. 52:14-17.29(J). The Committee may exercise that discretion "[n]otwithstanding any other provision of law to the

[2] "Participant" refers to the employee participating in the plan and receiving services from providers. See, e.g., N.J.S.A. 52:14-17.26(g), (i).

contrary," ibid., including N.J.S.A. 52:14-17.29(C)(1)'s provision that "the participant shall receive reimbursement for out-of-network charges at the rate of 80% of reasonable and customary charges[.]" Thus, N.J.S.A. 52:14-17.29(J) allows the Committee to supersede the participant cost provision in N.J.S.A. 52:14-17.29(C)(1). See Teamsters Local 97, 434 N.J. Super. at 417 (holding N.J.S.A. 52:14-17.29(J) superseded N.J.S.A. 52:14-17.36(b)).

"When we review separate legislative enactments, we have '"an affirmative duty to reconcile them, so as to give effect to both expressions of the lawmakers' will."'" Redd v. Bowman, 223 N.J. 87, 118 (2015) (citations omitted). Our reading reconciles the two separately-enacted subsections (C) and (J) of N.J.S.A. 52:14-17.29. Subsection (C)'s maximums, co-pays, deductibles, and participant costs enacted in 2007 continue to govern unless the Committee exercises its discretion to modify them given by the Legislature's 2011 enactment of subsection (J). The latter does not repeal the former in full but simply allows it to be modified by the Committee.

The legislative history confirms that Chapter 78 "confers on the committees the responsibility for plan design. . . . The bill requires the committees for both programs to set the amounts for maximums, co-pays, deductibles, and other such participant

costs[.]" S. 2937, 214th Legis., Sponsors' Statement 5 (June 13, 2011); accord Senate Budget & Appropriations Comm. Statement to S. 2937, 214th Legis., at 5 (June 16, 2011); Assembly Budget Comm. Statement to A. 4133, 214th Legis., at 5 (June 20, 2011). Granting an administrative agency the discretion to modify the monetary details of the health benefit coverage is a rational legislative choice that we must respect. The Legislature could conclude that, to control spiraling health benefits costs and negotiate more cost-effective health care plans with carriers and providers, such specific monetary amounts should be set by administrative action rather than by legislation.

Our reading also serves the "legitimate public policy goal" of Chapter 78 to address "the serious fiscal issues that confront the State[.]" DePascale v. State, 211 N.J. 40, 63-64 (2012). Like prior legislation, Chapter 78 reflects the State's "legitimate interest[s] in controlling the cost of health care benefits," "ensuring that the programs that make health care coverage available to public employees remain viable for both current and future employees," and "minimizing taxpayer burdens." Teamsters Local 97, 434 N.J. Super. at 423.

Appellants do not address the effect of N.J.S.A. 52:14-17.29(J) on N.J.S.A. 52:14-17.29(C)(1). Instead, they rely on an unpublished decision interpreting the latter's equivalent for

school employees, N.J.S.A. 52:14-17.46.7, which required the SEHBC to offer a plan "paying for 80% of reasonable and customary charges as defined herein," and used the same definition of "reasonable and customary charges" as appears in N.J.S.A. 52:14-17.29(C)(3). However, that unpublished decision reviewed an SEHBC decision issued in 2009. In enacting Chapter 78 in 2011, the Legislature transferred the authority to design plans from the SEHBC to the SEHBPDC, and gave the SEHBPDC "the sole discretion to set the amounts for maximums, co-pays, deductibles, and other such participant costs," "[n]otwithstanding any other provision of law to the contrary." L. 2011, c. 78, § 48(g) (codified at N.J.S.A. 52:14-17.46.6(g)); see L. 2011, c. 78, § 49 (codified at N.J.S.A. 52:14-17.46.7). The unpublished decision did not involve a modification under Chapter 78's amended provisions, did not consider the Chapter 78's amendments, and is neither persuasive here nor binding precedent. R. 1:36-3.

Therefore, appellants cannot use N.J.S.A. 52:14-17.29(C) to prevent the Committee's exercise of its discretion under N.J.S.A. 52:14-17.29(J) to reduce the rate of reimbursement. Because the Committee merely reduced, but did not eliminate, reimbursement for chiropractic services, we need not address the Guild's concern that out-of-network reimbursements may ultimately be eliminated.

IV.

Appellants also argue the resolution discriminates against chiropractors in violation of N.J.S.A. 17B:27-51.1. That statute provides:

> Notwithstanding any provision of a policy or contract of group health insurance, hereafter delivered or issued for delivery in this State, whenever such a policy or contract provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor, a person covered under such group health policy or contract or the chiropractor rendering such service shall be entitled to reimbursement for such service when the said service is performed by a chiropractor. The foregoing provision shall be liberally construed in favor of reimbursement of chiropractors.
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> [N.J.S.A. 17B:27-51.1 (emphasis added).]

However, N.J.S.A. 17B:27-51.1 cannot trump N.J.S.A. 52:14-17.29(J), which applies "[n]otwithstanding any other provision of law[.]" By contrast, N.J.S.A. 17B:27-51.1 only trumps provisions of a "policy or contract," not a statute like N.J.S.A. 52:14-17.29(J).

Additionally, N.J.S.A. 17B:27-51.1 would not bar the Committee's resolution even in the absence of N.J.S.A. 52:14-17.29(J). First, N.J.S.A. 17B:27-51.1 only addresses a "policy or contract of group health insurance[.]" Its legislative history indicated "[t]he purpose of this bill is to provide the health

care consumer who is insured by a group health policy with payment by the company issuing the health insurance policy[.]" A. 23, 196th Legis., Sponsors' Statement at 1 (pre-filed for 1974) (emphasis added). Another bill similarly addressed individual "policy of health insurance," N.J.S.A. 17B:26-2(f), with the purpose of providing the insured "with payment by the company issuing the health insurance policy," A. 22, 196th Legis., Sponsors' Statement at 3 (pre-filed for 1974). The State Health Benefits Program (SHBP) was not mentioned in either statute, their sponsors' statements, or the discussion of the bills in the lengthy public hearing. Public Hearing on Assembly Nos. 21, 22, and 23 Before Senate Comm. on Labor, Indus. & Professions, 196th Leg. (1975).[3]

When the Legislature wishes to bind both private insurers and the SHBC to provide the same coverage, it amends the statutes governing both. E.g., L. 2011, c. 188, §§ 5, 9; L. 2008, c. 126, §§ 6, 10. Thus, when the Legislature passed a law requiring privately-issued health insurance contracts and policies to provide coverage for biologically-based mental illness (BBMIs), it passed a "companion statute," N.J.S.A. 52:14-17.29e, "with the

[3] The only mention of State-paid health benefits, id. at 69, concerned a third bill which would have required medical service corporations to pay chiropractors. A. 21, 196th Legis., Sponsors' Statement at 4 (pre-filed for 1974). That bill was not enacted.

stated purpose of requiring that the Commission provide the same coverage for BBMIs to persons covered under the State Health Benefits Program," and we founded our ruling on the statute addressed to the Commission, using the private insurance law only as part of the legislative history. Micheletti v. State Health Benefits Comm'n, 389 N.J. Super. 510, 516-17, 520-22 (App. Div. 2007). Here, there is no such statute addressed to the SHBP. Nor was there a statute in Micheletti giving the agency discretion "[n]otwithstanding any other provision of law to the contrary." N.J.S.A. 52:14-17.29(J).

Second, N.J.S.A. 17B:27-51.1 only provides that a person "shall be entitled to reimbursement" if a service is provided by a chiropractor. It does not dictate the level of reimbursement, or require the reimbursement be the same as it would be if the service was performed by another type of provider. The Committee's resolution provides reimbursement for such services when performed by chiropractors, but at a reduced rate if they are out-of-network. We note the Commissioner of Banking and Insurance has issued an order that "Horizon is not required under N.J.S.A. 17B:27-51.1 to pay Doctors of Chiropractic in the same amounts it reimburses other health care providers" for similar services. Am. Chiropractic Ass'n v. Horizon Blue Cross Blue Shield of N.J., NJODBI Order No. A09-113, Docket No. BKI 6230-04 at 15 (Oct. 7,

2009). We reject appellants' claim that the Committee's resolution violated N.J.S.A. 17B:27-51.1 or that order.

Respondents contend N.J.S.A. 17B:27-51.1 does not grant a private cause of action, but that issue is not presented in this case. "A private cause of action is essential when the plaintiff seeks damages for injury or loss suffered as a consequence of another's violation of a statute or to compel another private party to comply with a statute." N.J. Dental Ass'n v. Metro. Life Ins. Co., 424 N.J. Super. 160, 165 (App. Div. 2012). Here, appellants do not sue a private party or seek damages; instead, they appeal the Committee's resolution. "A statutory cause of action is not needed to challenge governmental action; one aggrieved by improper official action has a constitutional right to seek judicial review." Id. at 166. Thus, appellants' "ability to challenge the legality of the Commi[ttee]'s action does not turn on whether the Legislature expressly granted or implied a private cause of action." Id. at 164-65.[4]

[4] By contrast, respondents rely on an unpublished opinion where the plaintiffs sued Horizon, a private entity, as part of a complaint seeking damages; we transferred for agency review the claim that Horizon violated N.J.S.A. 17B:27-51.1.

V.

Appellants also claim a violation of Section 2706(a) of the Patient Protection and Affordable Care Act (ACA), P.L. 111-148. Section 2706(a), codified at 42 U.S.C. 300gg-5(a), provides:

> A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

We assume without deciding that Section 2706(a) applies to the SHBP.[5] We also assume without deciding that appellants do not

[5] See 42 U.S.C. § 300gg-91(a)(1) (defining "group health plan" by incorporating ERISA's definition in 29 U.S.C. § 1002(1)); see also 42 USCS § 300gg-21(a) (stating when "[t]he requirements of subparts 1 and 2 [42 USCS §§ 300gg et seq. and 300gg-11 et seq.] shall apply with respect to group health plans" that are either a "governmental plan" or a "nonfederal governmental plan"); 42 U.S.C. § 300gg-91(d)(8) (defining "governmental plan" by incorporating ERISA's definition in 29 U.S.C. § 1002(32)); cf. 29 U.S.C. § 1003(b)(1) (excluding a "governmental plan" from ERISA's coverage); see generally Ohio v. United States, 849 F.3d 313, 319-20 (6th Cir. 2017).

need a private cause of action to appeal the Committee's resolution on the grounds that it violates Section 2706(a).[6]

However, "the definition of 'discrimination' under § 2706 of the ACA is a contested issue[.]" Dominion Pathology Labs., 111 F. Supp. 3d at 738. The United States Departments of Labor, Treasury, and Health & Human Services have stated that, after a Senate report questioned their original interpretation of Section 2706(a), and after 1,500 public comments, the Departments revoked their prior interpretation and announced

> their current enforcement approach to PHS Act section 2706(a)[:] Until further guidance is issued, the Departments will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision[.]
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> [FAQs About Affordable Care Act Implementation (Part XXVII) at 3-4 (May 26, 2015).[7]]

[6] See Dominion Pathology Labs., P.C. v. Anthem Health Plans of Va., Inc., 111 F. Supp. 3d 731, 736, 739 (E.D. Va. 2015) (stating that "[t]he parties, and the court, agree that § 2706 of the ACA does not create a private cause of action" against a private insurer and that "Congress did not create a private right of action to enforce § 2706 of the ACA and reserved its enforcement to the states"); cf. Ohio, 849 F.3d at 319 ("the Federal Government exercises enforcement authority over 'group health plans that are non-Federal governmental plans'" (quoting 42 U.S.C. § 300gg-22(b)(1)(B))).

[7] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part-XXVII-MOOP-2706-FINAL.pdf.

As the federal Departments responsible for implementing the ACA are still uncertain of the meaning of Section 2706(a), and further guidance has not yet issued, we will not attempt to divine its meaning. Following the Departments' current approach, we simply rule that the Committee's resolution, which permits chiropractic providers to participate in the SHBP but caps their out-of-network reimbursement, does not appear to be a bad faith or unreasonable interpretation of Section 2706(a).

Appellants complain that the Committee only capped the out-of-network reimbursements for chiropractors even though Horizon "highlight[ed] Chiropractic, Physical Therapy, and Behavioral Health as categories" with waning "in-network participation" which provided "the best opportunity for savings," and Horizon stated the differential between out-of-network and in-network allowances is much higher for surgeries than for chiropractic services. However, these comparisons with specialties providing different services do not clearly evidence discrimination. Appellants argue doctors of osteopathy perform similar procedures to chiropractors, but concede they bill using different CPT codes.

In any event, we cannot say the Committee's exercise of discretion to address reimbursement for out-of-network chiropractors constituted discrimination. Appellants provide

"SHBP Claims Paid Data By Provider Specialty" showing that the number of claims paid to chiropractors dwarfs the number of claims by other specialists, and that the $24 million the SHBP paid to chiropractors is the third highest amount, after only "outpatient hospital" and "orthopedic surgery." An administrative agency is not barred from addressing a prominent problem area because it has not yet addressed all problem areas.

VI.

Finally, appellants argue that, in issuing the resolution, the Committee violated the Open Public Meetings Act ("OPMA" or "the Sunshine Act"), N.J.S.A. 10:4-6 to -21. They cite the OPMA's preamble:

> The Legislature finds and declares that the right of the public to be present at all meetings of public bodies, and to witness in full detail all phases of the deliberation, policy formulation, and decision making of public bodies, is vital to the enhancement and proper functioning of the democratic process; . . . and hereby declares it to be the public policy of this State to insure the right of its citizens to have adequate advance notice of and the right to attend all meetings of public bodies at which any business affecting the public is discussed or acted upon in any way except only in those circumstances where otherwise the public interest would be clearly endangered or the personal privacy or guaranteed rights of individuals would be clearly in danger of unwarranted invasion.
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> [N.J.S.A. 10:4-7.]

However, "the aforesaid rights are implemented pursuant to the provisions of this act." Ibid. The operative provisions of the OPMA generally require a public body to give adequate notice of its meetings, N.J.S.A. 10:4-9(b)(3), make its meetings open to the public, N.J.S.A. 10:4-12(a), and keep minutes available to the public, N.J.S.A. 10:4-14. Here, the Committee gave notice of the July 6, 2015 public meeting, issued an agenda attaching the proposed resolutions, held the public meeting, and issued minutes. The minutes and the transcript of the public meeting show the Committee briefly discussed two resolutions, voted on all the resolutions, and made closing comments. The chiropractic resolution was voted on without further discussion.

The agenda contained a "Sunshine Act Statement," which stated that adequate notice had been given and added:

> RESOLUTION TO GO INTO EXECUTIVE SESSION TO REQUEST/RECEIVE ATTORNEY/CLIENT ADVICE FROM THE DEPUTY ATTORNEY GENERAL
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> "In accordance with the provisions of the Open Public Meeting Act, N.J.S.A. 10:4-13, be it resolved that the SHBP Plan Design Committee go into closed (executive) session to discuss matters falling within the attorney-client privilege, and/or matters in which litigation is pending or anticipated, pursuant to N.J.S.A. 10:4-12[(b)](7). . . ."

At the beginning of the public meeting, at which two Deputy Attorney Generals were present, a staff member read the "Sunshine Act Statement" into the record. See N.J.S.A. 10:4-10.

There was no evidence such a closed session was held. To the contrary, one of the Deputy Attorneys General certified as follows: The Committee's regular practice is to read such a resolution into the record. If the Committee wishes to go into a closed session to receive legal advice, members make a motion, second it, and vote to pass the resolution. See N.J.S.A. 10:4-13. No such actions were taken on July 6 and there was no closed meeting.

In any event, it would not violate the OPMA to have a closed part of the meeting to discuss "pending or anticipated litigation . . . in which the public body is, or may become, a party, or matters falling within the attorney-client privilege, to the extent that confidentiality is required in order for the attorney to exercise his ethical duties as a lawyer[.]" N.J.S.A. 10:4-12(b)(7). Moreover, there was no indication the chiropractic resolution was discussed in a closed session.

Appellants claim the administrative record reveals that "presentation, discussion, and deliberation" was done in a closed session. However, they cite only the documents and PowerPoint printouts Horizon allegedly submitted to the Committee before the meeting, and Aon Hewitt's post-meeting report on the changes

adopted. Nothing in OPMA bars members of public bodies from receiving and reviewing documents prior to a public meeting. Indeed, OPMA does not cover discussions by "a public official with subordinates or advisors." N.J.S.A. 10:4-7.

There could be no violation of OPMA absent a closed meeting "attended by, or open to, all of the members of a public body . . . to discuss or act as a unit upon the specific public business of that body." N.J.S.A. 10:4-8(b). See In re Consider Distribution of Casino Simulcasting Special Fund, 398 N.J. Super. 7, 16-17 (App. Div. 2008) (finding an OPMA violation where "[b]y the Chairman's admission, [a commission] made its decision based on a discussion that did not take place at the public meeting," and then voted in public). Here, "the record does not support the allegation that action taken at a prior meeting led to the predetermined adoption of the [July 6] resolutions," and "we reject the conjecture of [appellants] that those resolutions were the product of a private meeting." See Witt v. Gloucester Cty. Bd. of Chosen Freeholders, 94 N.J. 422, 431-32 (1983).

The OPMA was not violated merely because the documents were not presented and discussed during the public meeting before the chiropractic resolution was passed. Nothing in the OPMA requires any particular level of deliberation; it simply prohibits private

meetings except in specified circumstances. Absent evidence of such a meeting, appellants' OPMA claim fails.

Affirmed.