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SEMI-ANNUAL LEGISLATIVE REPORT
INDEPENDENT HEALTH CARE APPEALS PROGRAM
DEPARTMENT OF BANKING AND INSURANCE

This is the semi-annual report to the Legislature on activities related to the Independent Health Care Appeals Program from July 1, 2025 through December 31, 2025.

The Health Care Quality Act established the Independent Health Care Appeals Program to provide covered persons with the right to appeal to an independent utilization review organization (IURO) a carrier's denial, limitation or termination of a covered service on the grounds that it is not medically necessary. The overturn of a carrier's denial signifies that the IURO determined, after a review of all medical information submitted by the carrier and the covered person, that the services requested for the covered person were medically necessary and appropriate and should therefore be covered by the carrier. If all or part of the IURO's decision is in favor of the covered person, the carrier is required to provide coverage for the healthcare services found to be medically necessary within ten business days. The IURO's decision is binding on the carrier and the covered person, except if other remedies are available under state or federal law. The New Jersey Department of Banking and Insurance (Department) provides administration for the Independent Health Care Appeals Program, currently contracting with one IURO that conducts the appeal reviews. In this process, the Department's role is limited to administration; it has no authority to influence the decisions or outcomes of IURO deliberations.

Two thousand two hundred thirty-nine (2,239) external appeals were filed with the IURO during the period of this report. Of the 2,239 appeals, 1,337 were accepted for review by the IURO. Appeals determined to be ineligible for the Independent Health Care Appeals Program were rejected for the following reasons: failure to exhaust the carrier's internal appeal process; not a utilization management (UM) issue; member is covered by self-funded plan; fair hearing request; failure to provide signed consent to appeal; issue already resolved; out of state coverage; appeal untimely; and the appeal involves a non-covered benefit.

The IURO rendered decisions on 1,337 appeals during this period. Of the 1,337 appeals, the IURO upheld the carrier's denial 706 times (53%) and overturned or modified the carrier's denial 631 times (47%). In the previous 6-month period, January 1, 2025, through July 1, 2025 the IURO rendered decisions on 1,160 appeals. The carrier's denial was upheld in 56% of the cases and overturned or modified in 44% of the cases.

The appeals involved various types of medical service denials as shown below:

July 1, 2025 – December 31, 2025

Category	Number of Appeals
Covered Medication	0
Hospital Admission, Days, Reduction of Acuity	274
Outpatient Medical Treatment/Diagnostic Testing	191
Skilled Nursing Facility	37
Dental - Medicaid	103
Medical Daycare	10
Home Health Care	163
Medical Equipment (DME) and/or Supplies	61
Surgical Procedure	49
Service Experimental/Investigational	0
Outpatient Rehab Therapy (PT, OT, Cardio, etc.)	22
Behavioral Health – Inpatient	32
Behavioral Health – Residential	0
Behavioral Health – Outpatient	3
Substance Abuse - Detox	1
Substance Abuse – Inpatient	2
Substance Abuse - Residential	2
In-Network Exception	73
Medication	307
Emergency Admission	0
Other	7
Totals	1337

The medical specialties that are most frequently represented in the appeals are as follows:

Specialty	Number of Appeals
Infectious Disease	7
Gastroenterology	65
Pediatrics	0
Internal Medicine	33
Cardiology	59
Dental	63
Physical Medicine and Rehabilitation	36
Neurology	5
Psychiatry	5
Endocrinology	4
Pulmonary	6
Orthopedics	108
Oncology	40
Neonatology	0
Pediatric Endocrinology	8
Urology	13
Pain Management	0
General Surgery	13
Radiation Oncology	10

Nephrology	59
Pediatric Pulmonary	0
Plastic Surgery	10
OB/GYN	23
Hematology Oncology	1
Geriatrics	0
Oral Maxillofacial	3
Dermatology	26
Ophthalmology	5
ENT (Eye, Nose, Throat)	0
Anesthesiology	32
Allergy Immunology	2
Neurosurgery	14
Addiction Medicine	25
Child and Adolescent Psychiatry	19
Clinical Genetics and Genomics	0
Endocrinology, Diabetes, and Metabolism	39
Emergency Medicine	3
Critical Care Medicine	47
Family Medicine	4
Geriatric Psychiatry	60
Interventional Radiology and Diagnostic Radiology	0
Neurodevelopmental Disabilities; Neurology with Special Qualification in Child Neurology	0
Neurology with Special Qualification in Child Neurology	42
Neurology; Neuromuscular Medicine	0
Neuromuscular Medicine	12
Orthodontics	40
Otolaryngology; Neurotology	7
Pediatric Critical Care Medicine	35
Pediatric Gastroenterology	152
Optometry	1
Acupuncture	0
Pediatric Rehabilitation Medicine	34
Pediatric Cardiology	0
Podiatric Surgery	0
Reproductive Endocrinology and Infertility	0
Rheumatology	17
Sleep Medicine	27
Pediatric Surgery	0
Vascular Neurology	97
Vascular Surgery	11
Hospice and Palliative Care Medicine	13
Pediatric Hematology-Oncology	0
Chiropractic	2
Totals	1337

The number and disposition of appeals filed for each carrier is shown on the table below.

July 1, 2025 – December 31, 2025

Carrier	Market Share	Total Appeals Completed	IURO Determination			
			Disagree with Plan	% Disagree with Plan	Agree with Plan	% Agree With Plan
Aetna Better	4.06%	100	53	53%	47	47%
Aetna	6.51%	18	10	56%	8	44%
AmeriChoice/UHCCP**	11.77%	144	63	44%	81	56%
Amerigroup	5.80%	133	54	41%	79	59%
AmeriHealth	5.68%	55	32	58%	23	42%
Cigna	2.10%	6	2	33%	4	67%
Horizon	53.48%	794	377	47%	417	53%
Oscar	1.09%	17	7	41%	10	59%
Oxford**	4.14%	15	7	47%	8	53%
United**	2.40%	3	1	33%	2	67%
Nippon Life Insurance	0.15%	2	1	50%	1	50%
WellCare/Fidelis	2.82%	50	24	48%	26	52%
Total	100%	1337	631	47%	706	53%

** AmeriChoice (now d/b/a United Healthcare Community Plan), Oxford and United are all owned by UnitedHealth Group. The combined market share is 18.31%.

The table below shows the number of appeals received and the number reviewed by the IUROs since establishment of the IHCAP in 1997:

Year	Appeals Received	Appeals Accepted by IURO
CY 1997	27	25
CY 1998	122	104
CY 1999	174	144
CY 2000	174	133
CY 2001	303	273
CY 2002	260	233
CY 2003	342	318
CY 2004	337	314
CY 2005	358	343
CY 2006	354	340
CY 2007	306	299
CY 2008	359	355
CY 2009	477	477
CY 2010	424	422
CY 2011	712	702
CY 2012	672	665
CY 2013	548	521
CY 2014	454	446
CY2015	602	581

CY2016	1027	984
CY2017	1574	1166
CY2018	2472	2390
CY2019	2478	2398
CY2020	2127	1882
CY2021	2212	1996
CY2022	2814	1360
CY2023	3803	1835
CY2024	3861	2066
CY2025	4318	2580

As the table demonstrates, the annual number of appeals filed by covered persons remains low considering the number of residents enrolled in HMOs and other managed care plans (over 3.1 million). However, there has been a continuous increase in appeals, with a marked upturn in appeals starting in 2011. The number of appeals shown on the chart as received, represents the appeals determined to meet the criteria for review. The number of actual appeals reviewed by the IURO is often lower because of the carrier's decision to cover the service before the IURO initiates its review.

How the Appeal System Works

It is important to remember that covered persons are required to exhaust the carrier's internal appeals process before submitting an appeal for review by an IURO, except in urgent or emergency cases.

During the period covered by this report, all external appeal case reviews were conducted by one IURO under contract with the Department – Maximus Federal Services. The reviews are performed by medical professionals, including specialty physicians appropriate to the area under review. The physician reviewers examine cases on the basis of medical records and other documents, generally accepted practice guidelines and applicable clinical protocols. The cost of the review is paid by the carrier and the fees ranged from $900 to $920 for this reporting period. Consumers pay a $25 filing fee for an external appeal, which is waived in cases of financial hardship and for Medicaid enrollees. The carrier is required to refund the $25 filing fee to the covered person if the carrier's denial is overturned.

Consumers are allowed up to four months and up to sixty days for Medicaid enrollees from the date of a carrier's final adverse benefit determination to file an external appeal. Under routine circumstances, a decision must be rendered by the IURO within 45 calendar days from receiving the appeal request; however, the IURO can act within a matter of hours in urgent or emergency cases.

Consumer Education

New Jersey law requires that covered persons who are denied coverage based on lack of medical necessity for an otherwise covered medical procedure or service must be given an appeal form that includes instructions on how to file an appeal. On the few occasions when the Department has learned that a carrier failed to notify its member of the right to appeal, the Department has taken prompt corrective action.

An Appeal and Complaint Guide for New Jersey Consumers is available on the Department's website at www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf.

This Guide explains the utilization management appeal process and provides instructions for filing complaints against carriers with the Department. The Department also produces an annual HMO Report Card which includes information on the appeal process.