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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, 2018 through December 31, 2018.

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 promptly provide coverage for the healthcare services found by the IURO to be medically necessary covered services. 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) administers the Independent Health Care Appeals Program and currently contracts with two IUROs to conduct the appeal reviews.

One thousand six hundred seventy-six (1,676) external appeals were filed with the Department's Office of Managed Care during the time period of this report. Of the 1,676 appeals, 1,239 were accepted for review by the IUROs. 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 IUROs rendered decisions on 1,239 appeals during this period. Of the 1,239 appeals, the IURO upheld the carrier's denial 784 times (63.2%) and overturned or modified the carrier's denial 455 times (36.7%). In the previous 6-month period, January 1, 2018 through June 30, 2018, the IURO rendered decisions on 1,151 appeals. The carrier's denial was upheld in 46.4% of the cases and overturned or modified in 53.6% of the cases.

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

July 1, 2018 - December 31, 2018

Category	Total
Covered Medication	131
Hospital Admission, Days, Reduction of Acuity	671
Outpatient Medical Treatment/Diagnostic Testing	50
Skilled Nursing Facility	7
Dental - Medicaid	98
Home Health Care	66
Medical Equipment (DME) and/or Supplies	34
Surgical Procedure	19
Service Experimental/Investigational	37
Outpatient Rehab Therapy (PT, OT, Cardio, etc.)	23
Inpatient Behavioral Health Treatment	65
In-Network Exception	9
Outpatient Behavioral Treatment	0
Miscellaneous	25
Emergency Room Treatment	4
Total	1239

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

Medical Specialty	Total Cases
Allergy Immunology	10
Anesthesiology	7
Cardiology	58
Dental	98
Dermatology	21
Endocrinology	10
ENT (Eye, Nose, Throat)	2
Gastroenterology	95
General Surgery	32
Geriatrics	10
Hematology Oncology	12
Infectious Disease	71
Internal Medicine	362
Neonatology	9
Nephrology	3
Neurology	83
Neurosurgery	4

OB/GYN	36
Oncology	4
Ophthalmology	2
Oral Maxillofacial	17
Orthopedics	21
Pain Management	10
Pediatric Endocrinology	5
Pediatric Otolaryngology	10
Pediatric Pulmonary	7
Pediatrics	75
Plastic Surgery	18
Psychiatry	43
Pulmonary	38
Radiation Oncology	6
Rehabilitation	39
Urology	21
Total	1239

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

July 1, 2018 – December 31, 2018

Carrier	Market Share	Total Appeals Completed	IURO Determination			
			Disagree with Plan	% Disagree with Plan	Agree with Plan	% agree With Plan
Aetna Better	1.8%	5	0	0%	5	100%
Aetna	10.7%	16	8	50%	8	50%
AmeriChoice**	15.3%	349	139	40%	210	60%
Amerigroup	5.5%	72	32	44%	40	56%
AmeriHealth	5.8%	42	13	31%	29	69%
Cigna	1.1%	7	2	29%	5	71%
Horizon	50.4%	698	249	36%	449	64%
Nippon	0.2%	2	0	0%	2	100%
Oscar	0%	3	0	0%	3	100%
Oxford**	4.1%	19	4	21%	15	79%
United**	2.3%	1	0	0%	1	100%
WellCare	2.2%	25	8	32%	17	68%
Total		1239	455	37%	784	63%

** AmeriChoice (now d/b/a United Healthcare Community Plan), Oxford and United are all owned by UnitedHealth Group. The combined market share is 21.7%.

The table below shows the number of appeals received by the Office of Managed Care (OMC) and the number reviewed by the IURO since establishment of the IHCAP in 1997:

Year	Appeals Accepted by OMC	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

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 3.15 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 accepted by OMC, represents the appeals determined to meet the criteria and forwarded to the IURO 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 the two IUROs under contract with the Department --Island Peer Review Organization and Permedion, Inc. 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.