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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 January 1, 2026 through June 30, 2026.

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.

Three thousand six hundred forty (3,640) external appeals were filed with the IURO during the period of this report. Of the 3,640 appeals, 1,293 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 1,293 appeals during this period. Of the 1,293 appeals, the IURO upheld the carrier's denial 562 times (43%) and overturned or modified the carrier's denial 731 times (57%). In the previous 6-month period, July 1, 2025 through December 31, 2025 the IURO rendered decisions on 1,337 appeals. The carrier's denial was upheld in 53% of the cases and overturned or modified in 47% of the cases.

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

January 1, 2026 – June 30, 2026

Category	Number of Appeals
Covered Medication	0
Hospital Admission, Days, Reduction of Acuity	247
Outpatient Medical Treatment/Diagnostic Testing	152
Skilled Nursing Facility	36
Dental - Medicaid	58
Medical Daycare	6
Home Health Care	167
Medical Equipment (DME) and/or Supplies	38
Surgical Procedure	47
Service Experimental/Investigational	0
Outpatient Rehab Therapy (PT, OT, Cardio, etc.)	34
Behavioral Health – Inpatient	25
Behavioral Health – Residential	0
Behavioral Health – Outpatient	39
Substance Abuse - Detox	0
Substance Abuse – Inpatient	3
Substance Abuse - Residential	0
In-Network Exception	79
Medication	340
Emergency Admission	1
Other	21
Totals	1293

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

Specialty	Number of Appeals
Infectious Disease	2
Gastroenterology	52
Pediatrics	12
Internal Medicine	37
Cardiology	49
Dental	29
Physical Medicine and Rehabilitation	26
Neurology	1
Psychiatry	39
Endocrinology	0
Pulmonary	81
Orthopedics	41
Oncology	47
Neonatology	0
Pediatric Endocrinology	7
Urology	12
Pain Management	10
General Surgery	15
Radiation Oncology	25

Nephrology	36
Pediatric Pulmonary	0
Plastic Surgery	6
OB/GYN	23
Hematology Oncology	2
Geriatrics	0
Oral Maxillofacial	3
Dermatology	29
Ophthalmology	4
ENT (Eye, Nose, Throat)	0
Anesthesiology	12
Allergy Immunology	1
Neurosurgery	20
Addiction Medicine	57
Child and Adolescent Psychiatry	57
Clinical Genetics and Genomics	3
Endocrinology, Diabetes, and Metabolism	45
Emergency Medicine	15
Critical Care Medicine	46
Family Medicine	1
Geriatric Psychiatry	51
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	5
Orthodontics	26
Otolaryngology; Neurotology	3
Pediatric Critical Care Medicine	87
Pediatric Gastroenterology	95
Optometry	0
Acupuncture	0
Pediatric Rehabilitation Medicine	23
Pediatric Cardiology	0
Podiatric Surgery	0
Reproductive Endocrinology and Infertility	1
Rheumatology	10
Sleep Medicine	14
Pediatric Surgery	0
Vascular Neurology	81
Vascular Surgery	2
Hospice and Palliative Care Medicine	8
Pediatric Hematology-Oncology	0
Chiropractic	0
Totals	1293

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

January 1, 2026 – June 30, 2026

Carrier	Market Share	IURO Determination				
		Total Appeals Completed	Disagree with Plan	% Disagree with Plan	Agree with Plan	% Agree With Plan
Aetna Better	4.36%	85	44	52%	41	48%
Aetna	2.59%	5	2	40%	3	60%
AmeriChoice/UHCCP**	12.23%	123	66	54%	57	46%
Amerigroup/Wellpoint	5.93%	91	58	64%	33	36%
AmeriHealth	5.71%	74	49	66%	25	34%
Cigna	2.05%	14	5	36%	9	64%
Horizon	52.96%	769	427	56%	342	44%
Oscar	5.14%	56	35	63%	21	37%
Oxford**	4.04%	21	13	62%	8	38%
United**	2.07%	7	4	57%	3	43%
WellCare/Fidelis	2.78%	48	28	58%	20	42%
Total	99.85%	1293	731	57%	562	43%

** AmeriChoice (now d/b/a United Healthcare Community Plan), Oxford and United are all owned by UnitedHealth Group. The combined market share is 18.34%.

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.