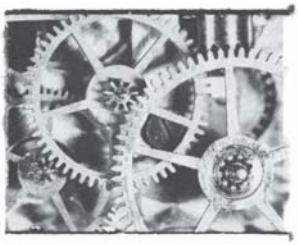

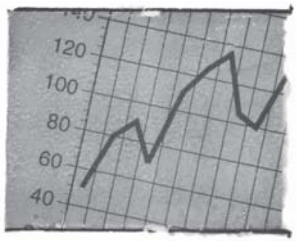

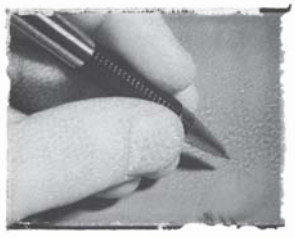

ANALYSIS OF THE NEW JERSEY BUDGET

DEPARTMENT OF BANKING AND INSURANCE

FISCAL YEAR 2018-2019

PREPARED BY OFFICE OF LEGISLATIVE SERVICES
NEW JERSEY LEGISLATURE • APRIL 2018

NEW JERSEY STATE LEGISLATURE

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

Paul A. Sarlo (D), 36th District (Parts of Bergen and Passaic), *Chair*
Brian P. Stack (D), 33rd District (Part of Hudson), *Vice-Chair*
Dawn Marie Addiego (R), 8th District (Parts of Atlantic, Burlington and Camden)
Anthony R. Bucco (R), 25th District (Parts of Morris and Somerset)
Nilsa Cruz-Perez (D), 5th District (Parts of Camden and Gloucester)
Sandra B. Cunningham (D), 31st District (Part of Hudson)
Patrick J. Diegnan Jr. (D), 18th District (Part of Middlesex)
Linda R. Greenstein (D), 14th District (Parts of Mercer and Middlesex)
Declan O'Scanlon, Jr. (R), 13th District (Part of Monmouth)
Steven V. Oroho (R), 24th District (All of Sussex, and parts of Morris and Warren)
M. Teresa Ruiz (D), 29th District (Part of Essex)
Troy Singleton (D), 7th District (Part of Burlington)
Samuel D. Thompson (R), 12th District (Parts of Burlington, Middlesex, Monmouth and Ocean)

GENERAL ASSEMBLY BUDGET COMMITTEE

Eliana Pintor Marin (D), 29th District (Part of Essex), *Chair*
John J. Burzichelli (D), 3rd District (All of Salem, parts of Cumberland and Gloucester), *Vice-Chair*
Daniel R. Benson (D), 14th District (Parts of Mercer and Middlesex)
Robert D. Clifton (R), 12th District (Parts of Burlington, Middlesex, Monmouth and Ocean)
John DiMaio (R), 23rd District (Parts of Hunterdon, Somerset and Warren)
Gordon M. Johnson (D), 37th District (Part of Bergen)
Patricia Egan Jones (D), 5th District (Parts of Camden and Gloucester)
John F. McKeon (D), 27th District (Parts of Essex and Morris)
Raj Mukherji (D), 33rd District (Part of Hudson)
Nancy F. Munoz (R), 21st District (Parts of Morris, Somerset and Union)
Carol A. Murphy (D), 7th District (Part of Burlington)
Edward H. Thomson (R), 30th District (Parts of Monmouth and Ocean)
Benjie E. Wimberly (D), 35th District (Parts of Bergen and Passaic)

OFFICE OF LEGISLATIVE SERVICES

Frank W. Haines III, *Legislative Budget and Finance Officer*
Thomas Koenig, *Assistant Legislative Budget and Finance Officer*

Marvin W. Jiggetts, *Director, Central Staff*
Thomas K. Musick, *Section Chief, Commerce, Labor and Industry Section*

This report was prepared by the Commerce, Labor and Industry Section of the Office of Legislative Services under the direction of the Legislative Budget and Finance Officer. The primary author was Juan C. Rodriguez. The background paper "Utilization Management Review for Medical Necessity by New Jersey Health Insurance Plans" was authored by Richard T. Corbett.

Questions or comments may be directed to the OLS Commerce, Labor and Industry Section (Tel. 609-847-3845) or the Legislative Budget and Finance Office (Tel. 609-847-3105).

DEPARTMENT OF BANKING AND INSURANCE

Budget Pages..... C-3, C-9, C-16, D-23 to D-29

Fiscal Summary ($000)

	Expended FY 2017	Adjusted Appropriation FY 2018	Recommended FY 2019	Percent Change 2018-19
State Budgeted	$56,090	$64,013	$64,013	0.0%
Federal Funds	292	0	0	0.0%
Other	423	448	454	1.3%
Grand Total	$56,805	$64,461	$64,467	0.0%

Personnel Summary - Positions By Funding Source

	Actual FY 2017	Revised FY 2018	Funded FY 2019	Percent Change 2018-19
State	0	0	0	0.0%
Federal	2	1	5	400.0%
Other	457	452	510	12.8%
Total Positions	459	453	515	13.7%

FY 2017 (as of December) and revised FY 2018 (as of January) personnel data reflect actual payroll counts. FY 2019 data reflect the number of positions funded.

Link to Website: http://www.njleg.state.nj.us/legislativepub/finance.asp

Highlights

- The Department of Banking and Insurance's activities are entirely funded through revenue collected from fees and assessments imposed on the industries it regulates, and in certain years, federal funding.

- The Governor's FY 2019 Budget recommends $64.5 million in State and dedicated funds be appropriated for the department in FY 2019, an increase of $6,000 above the current year's adjusted appropriations.

- The funding increase of $6,000 reflects growth in dedicated Small Employer Health Insurance assessment revenue which can be attributed to an increase in operating costs by the Small Employer Health Program board of directors.

- The Governor's FY 2019 Budget funds 515 positions in the department in FY 2019, which is unchanged from the count of funded positions in FY 2018. Of the 515 funded FY 2018 positions, 453 were filled in January 2018. Of the 62-count difference between FY 2018 filled and funded positions, 48 unfilled but funded positions are located in the Consumer Protection Services and Solvency Regulation and the Bureau of Fraud Deterrence program classes.

- Although the department does not anticipate receiving any federal funds in FY 2019, it intends to fund five positions with unexpended federal grant moneys received prior to FY 2017 for activities related to the federal Patient Protection and Affordable Care Act.

Background Paper:

Fiscal and Personnel Summary

AGENCY FUNDING BY SOURCE OF FUNDS ($000)

	Expended FY 2017	Adj. Approp. FY 2018	Recom. FY 2019	Percent Change 2017-19	Percent Change 2018-19
General Fund					
Direct State Services	$56,090	$64,013	$64,013	14.1%	0.0%
Grants-In-Aid	0	0	0	0.0%	0.0%
State Aid	0	0	0	0.0%	0.0%
Capital Construction	0	0	0	0.0%	0.0%
Debt Service	0	0	0	0.0%	0.0%
Sub-Total	**$56,090**	**$64,013**	**$64,013**	**14.1%**	**0.0%**
Property Tax Relief Fund					
Direct State Services	$0	$0	$0	0.0%	0.0%
Grants-In-Aid	0	0	0	0.0%	0.0%
State Aid	0	0	0	0.0%	0.0%
Sub-Total	**$0**	**$0**	**$0**	**0.0%**	**0.0%**
Casino Revenue Fund	$0	$0	$0	0.0%	0.0%
Casino Control Fund	$0	$0	$0	0.0%	0.0%
State Total	**$56,090**	**$64,013**	**$64,013**	**14.1%**	**0.0%**
Federal Funds	$292	$0	$0	(100.0%)	0.0%
Other Funds	$423	$448	$454	7.3%	1.3%
Grand Total	**$56,805**	**$64,461**	**$64,467**	**13.5%**	**0.0%**

PERSONNEL SUMMARY - POSITIONS BY FUNDING SOURCE

	Actual FY 2017	Revised FY 2018	Funded FY 2019	Percent Change 2017-19	Percent Change 2018-19
State	0	0	0	0.0%	0.0%
Federal	2	1	5	150.0%	400.0%
All Other	457	452	510	11.6%	12.8%
Total Positions	**459**	**453**	**515**	**12.2%**	**13.7%**

FY 2017 (as of December) and revised FY 2018 (as of January) personnel data reflect actual payroll counts. FY 2019 data reflect the number of positions funded.

AFFIRMATIVE ACTION DATA

Total Minority Percentage	32.0%	32.0%	N/A	----	----

Significant Changes/New Programs ($000)

Budget Item	Adj. Approp. FY 2018	Recomm. FY 2019	Dollar Change	Percent Change	Budget Page
DEDICATED REVENUE					
Small Employer Health Benefits	**$448**	**$454**	**$6**	**1.3%**	**C-9**
ALL OTHER FUNDS APPROPRIATIONS					
Consumer Protection Services and Solvency Regulation	**$448**	**$454**	**$6**	**1.3%**	**D-28**

The Small Employer Health Benefits Program, enacted pursuant to P.L.1992, c.162 (N.J.S.A. 17B:27A-17 et seq.), was established to provide employers with two to 50 employees with the option to purchase standardized health benefits plans. The department charges an assessment on all Small Employer Health Insurance carriers for the reasonable and necessary organizational and operating expenses of the Small Employer Health Benefits Program board of directors.

Accordingly, the anticipated $6,000 increase in dedicated revenue collected from the Small Employer Health Insurance assessment can be attributed to an anticipated equal increase in operating costs by the board of directors. The anticipated appropriation for the Small Employer Health Benefits Program board of directors is shown in the Consumer Protection Services and Solvency Regulation program class under "All Other Funds."

Significant Language Changes

The Governor's FY 2019 Budget recommendation for the Department of Banking and Insurance does not contain any changes in language provisions when compared to the FY 2018 Appropriations Act.

EXPLANATION: FY 2018 language not recommended for FY 2019 denoted by strikethrough.
Recommended FY 2019 language that did not appear in FY 2018 denoted by underlining.

Background Paper: Utilization Management Review for Medical Necessity by New Jersey Health Insurance Plans

INTRODUCTION

Utilization management review for medical necessity or, more simply, "utilization management," is a technique used by health insurance carriers to evaluate the appropriateness, efficiency, and costs of health care services used by persons covered under health benefits policies. Under utilization management, a carrier reviews the treatment proposed by the health care provider and determines whether the treatment is medically necessary according to specific guidelines. If the proposed treatment is determined to be not medically necessary, the carrier can deny, reduce, or terminate coverage for the treatment.

In New Jersey, the use of utilization management is governed by the "Health Care Quality Act" and the "Health Care Carrier Accountability Act." These acts require carriers that use utilization management to adhere to certain processes that are designed to protect consumers of health care services, including a requirement to allow covered persons and their health care providers to appeal adverse benefit determinations through a system administered by the Department of Banking and Insurance (DOBI).

In addition to the appeals process, the "Health Care Carrier Accountability Act" provides consumer protections by allowing a covered person to sue for damages caused by a carrier's negligence in making a utilization management decision, under certain circumstances.

UTILIZATION MANAGEMENT - OVERVIEW

The "Health Care Quality Act" and regulations adopted and implemented by DOBI (hereinafter referred to collectively as "HCQA") authorize health insurance carriers in New Jersey to use a utilization management program to make decisions to deny, reduce, or terminate a health benefit for a covered person if the carrier determines that the benefit is not medically necessary.[1]

The HCQA requires a carrier's utilization management program to be administered under the direction of a physician licensed to practice in this State and utilization management decisions to be made by medical professionals. Medical necessity determinations often distinguish medical treatment that is necessary from treatment that is cosmetic, experimental, or elective.

If the treatment proposed by the health care provider satisfies the carrier's criteria for medical necessity, the coverage will be approved. If the carrier determines the treatment to be unnecessary, coverage could be denied, reduced, or terminated, in which case a covered person or a health care provider can appeal this adverse benefit determination through the utilization review appeals process described below.

[1] N.J.S.A.26:2S-1 et al. The implementing regulations for the "Health Care Quality Act" relating to utilization review are at: N.J.A.C.11:24-8.1 et seq. (applicable to health maintenance organizations); and N.J.A.C.11:24A-3.1 et seq. (applicable to health insurance carriers). For all practical purposes, the regulations provide identical processes for appealing utilization management decisions made by both types of entities.

Background Paper: Utilization Management Review for Medical Necessity by New Jersey Health Insurance Plans (Cont'd)

A carrier's utilization management system may include prospective (known as prior authorization), concurrent, and retrospective reviews of benefits. Carriers must have staff available during normal working hours to respond to utilization management inquiries and available on a 24-hour basis to respond to requests for authorization for emergency and urgent services.

There are certain circumstances under which utilization management is limited. By its express terms, the HCQA only applies to carriers that offer insured health benefits plans, but not to self-funded health benefits plans governed by the federal "Employee Retirement Income Security Act of 1974" (ERISA). Further, notwithstanding the HCQA, some New Jersey "mandated benefits" laws require that carriers cover certain health care services without applying utilization management review for medical necessity by placing medical necessity decisions solely within the judgment of the treating health care provider.[2]

A carrier is also required to adhere to certain provisions of the "Health Claims Authorization, Processing and Payment Act" (HCAPPA) that relate to utilization management. Most notably, the HCAPPA requires carriers to post on their websites the clinical guidelines that they use to determine medical necessity and to respond to requests by health care providers for authorization of health care services within certain time periods.[3]

UTILIZATION REVIEW APPEALS PROCESS

The HCQA establishes a three-part process - Stage 1, Stage 2, and Stage 3 - to appeal adverse benefit determinations for a person covered by a group health benefits plan, or a health care provider acting with the consent of the covered person. For a person covered by an individual health benefits plan, the appeals process is a two-part process, consisting of Stage 1 and Stage 3 appeals.[4]

- Stage 1 Informal Internal Appeal: A covered person or health care provider has the right to speak to the carrier's medical director concerning an adverse benefit determination. The carrier is required to conclude the appeal within 72 hours or 10 calendar days, depending on the urgency of the situation.

[2] See, for example: P.L.2017, c.28 (N.J.S.A.17:48-6nn et al.) (Requires coverage for outpatient prescription drugs to treat substance abuse disorder when determined medically necessary by the covered person's physician, psychologist or psychiatrist); and P.L.2007, c.345 (N.J.S.A.17:48-6ff et al.) (Requires coverage for orthotic or prosthetic appliances as determined by the covered person's physician).

[3] N.J.S.A.17B:30-48 et seq. The HCAPPA provides for another type of appeals process – the Program for Independent Claims Payment Arbitration (PICPA). PICPA provides an independent external review for issues that do not involve medical necessity but instead involve questions of whether claim payment amounts were appropriate under contract terms and applicable fee schedules. The HCAPPA also requires payments of health insurance claims within certain time periods and accordingly is commonly known as New Jersey's "prompt pay law."

[4] N.J.A.C.11:24-8.4 through 11:24-8.7 (applicable to health maintenance organizations) and N.J.A.C.11:24A-3.5 through 11:24A-3.7 (applicable to health insurance carriers).

Background Paper: Utilization Management Review for Medical Necessity by New Jersey Health Insurance Plans (Cont'd)

- Stage 2 Formal Internal Appeal: An unfavorable Stage 1 determination can be appealed to a panel of physicians and experts who have been selected by the carrier but who were not involved in the adverse benefit determination. The carrier is required to conclude the appeal within 72 hours for emergency or urgent care determinations, and otherwise within 20 business days.

- Stage 3 Independent External Appeal: An unfavorable Stage 2 determination can be appealed to the Independent Health Care Appeals Program (IHCAP). The HCQA requires DOBI to contract with one or more independent utilization review organizations (IUROs) to manage the IHCAP. IUROs are independent organizations of health care professionals who determine if adverse benefit determinations are justified.

  The IURO is required to conclude the appeal within 45 days, except for urgent and emergency care, in which case the IURO is required to conclude the appeal within 48 hours. If the IURO decides that the carrier's adverse benefit determination deprived the covered person of a medically necessary covered service, the carrier is required to provide benefits without delay. The IURO's decision is binding on the carrier and the covered person, except to the extent that other remedies are available under State or federal law.

An Appeal and Complaint Guide for New Jersey Consumers, which explains the utilization review appeals process, is available on the department's website at www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf. A set of Questions and Answers about the IHCAP is available on the department's website at http://www.state.nj.us/dobi/chap352/352umappealsqanda.html.

INDEPENDENT HEALTH CARE APPEALS PROGRAM - BIANNUAL REPORT

Pursuant to the HCQA, since 1997, the department has been required to submit a biannual report concerning the IHCAP to the Senate and General Assembly standing reference committees on health insurance, and to the Governor. All of the reports are available at: http://www.state.nj.us/dobi/division_insurance/managedcare/ihcapreports.htm. For an analysis by the Office of Legislative Services of two key features of cumulative data from the five most recent IHCAP reports, see the Appendix to this background report.

THE "HEALTH CARE CARRIER ACCOUNTABILITY ACT"

The "Health Care Carrier Accountability Act" (HCCAA) allows a covered person to sue for damages caused by a carrier's negligence in making a utilization management decision, under certain circumstances.[5] The HCCAA provides that a carrier is liable to a covered person for

[5] N.J.S.A.2A:53A-30 et seq. The HCCAA applies to carriers offering insured health benefits plans, but not to self-funded health benefits plans governed by ERISA. N.J.S.A.2A:53A-33c.(2). See also: Yodzis v. Tilak, No. A-0737-12T2, 2009 N.J. Super. Unpub. LEXIS 490 (App. Div. February 26, 2009), certif. den., 199 N.J. 134 (2009) (HCCAA held not to apply to ERISA plans).

Background Paper: Utilization Management Review for Medical Necessity by New Jersey Health Insurance Plans (Cont'd)

economic and non-economic (pain and suffering) losses that occur as a result of negligence with respect to the denial of, or delay in, approving or providing medically necessary covered services, which is the proximate cause of certain serious conditions, as listed in the HCCAA.

Before bringing suit pursuant to the HCCAA, a covered person is required to: (1) first exhaust an appeal through the IHCAP, unless serious or significant harm has occurred or will immediately occur; and (2) provide an affidavit from a physician or other appropriate licensed person that there is a reasonable probability that the loss occurred as a result of the carrier's negligence in denying or delaying coverage.

APPENDIX

Pursuant to the HCQA, the department provides semi-annual reports to the Legislature related to certain aspects of decisions made by IUROs under the IHCAP on appeals of carrier denials of coverage for services.

Among other data, the IHCAP reports provide for the six-month period covered by each report:

- the number of appeals completed, the percentage of instances in which the IURO upheld the carrier's denial, and the percentage of instances in which the IURO overturned or modified the carrier's denial; and
- the categories of health services that were subject to completed appeals and the number of appeals in each category.

According to the five reports for the two-and-one-half-year period from July 16, 2014 to January 15, 2017, IUROs completed 1,741 appeals. Certain aspects of the reports for this time period are analyzed below.

RESULTS OF IHCAP APPEALS

Out of the 1,741 completed appeals, the IUROs upheld the carrier's denial of coverage for services 49.9 percent of the time and overturned or modified the carrier's denial 50.1 percent of the time. As the table on the following page indicates, there were two general trends in the examined two-and-a-half-year period, notably steady increases in the number of appeals adjudicated by the IUROs and in the percentage of denials of coverage that the IUROs overturned or modified.

Background Paper: Utilization Management Review for Medical Necessity by New Jersey Health Insurance Plans (Cont'd)

IURO DECISIONS AS TO BENEFIT DENIALS: JULY 16, 2014 TO JANUARY 15, 2017

Report period	Appeals completed	Percentage upheld	Percentage overturned/modified
7/16/16 – 1/15/17	605	44.6	55.4
1/16/16 – 7/15/16	379	49.6	50.4
7/16/15 – 1/15/16	315	53.7	46.3
1/16/15 – 7/15/15	266	52.3	47.7
7/16/14 – 1/15/15	176	58.5	41.5
TOTAL	**1,741**	**49.9%**	**50.1%**

CATEGORIES OF IHCAP APPEALS BY HEALTH CARE SERVICES

Out of the 1,741 completed appeals, the five categories of health care services with the highest numbers of completed appeals, and their percentage shares of the total number of completed appeals are as follows:

TOP FIVE CATEGORIES OF APPEALS: JULY 16, 2014 TO JANUARY 15, 2017

Categories of health care services	Appeals completed	Percentage of all completed appeals
1. Covered Medication	343	20
2. Inpatient Admission	270	16
3. Inpatient Hospital Days	160	9
4. Reduction of Acuity Level (Inpatient)	152	9
5. Home Health Care	127	7
TOTAL	**1,052**	**61**

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services provides nonpartisan assistance to the State Legislature in the areas of legal, fiscal, research, bill drafting, committee staffing and administrative services. It operates under the jurisdiction of the Legislative Services Commission, a bipartisan body consisting of eight members of each House. The Executive Director supervises and directs the Office of Legislative Services.

The Legislative Budget and Finance Officer is the chief fiscal officer for the Legislature. The Legislative Budget and Finance Officer collects and presents fiscal information for the Legislature; serves as Secretary to the Joint Budget Oversight Committee; attends upon the Appropriations Committees during review of the Governor's Budget recommendations; reports on such matters as the committees or Legislature may direct; administers the fiscal note process and has statutory responsibilities for the review of appropriations transfers and other State fiscal transactions.

The Office of Legislative Services Central Staff provides a variety of legal, fiscal, research and administrative services to individual legislators, legislative officers, legislative committees and commissions, and partisan staff. The central staff is organized under the Central Management Unit into ten subject area sections. Each section, under a section chief, includes legal, fiscal, and research staff for the standing reference committees of the Legislature and, upon request, to special commissions created by the Legislature. The central staff assists the Legislative Budget and Finance Officer in providing services to the Appropriations Committees during the budget review process.

Individuals wishing information and committee schedules on the FY 2019 budget are encouraged to contact:

Legislative Budget and Finance Office
State House Annex
Room 140 PO Box 068
Trenton, NJ 08625
(609) 847-3105 • Fax (609) 777-2442