FISCAL NOTE TO

ASSEMBLY, No. 491

STATE OF NEW JERSEY

DATED: JANUARY 31, 1997

Bill Summary:

Assembly Bill No. 491 of 1996 establishes a Statewide Independent Health Benefits Appeals Program in the Department of Health and Senior Services (DHSS) to provide an independent medical necessity or appropriateness of services review of final decisions by health benefits plans to deny, reduce or terminate covered benefits in the event the final decision is contested by the covered person. The Commissioner of Health and Senior Services would contract with one or more regional independent utilization review organizations (UROs) to conduct the patient reviews. The costs of such review would be supported by:

- A $25 application fee (which may be waived in cases of financial hardship) would be charged to each person requesting an independent review.
- An assessment against each health benefits plan based on the number of appeals filed against each plan.

The health benefits plan would be required to comply with the URO's recommendation. In addition, a managed care plan or indemnity carrier would be required to file a registration form with DHSS and pay a biennial registration fee of $200.

Agency Comments:

DHSS and the Office of Management and Budget are unable to estimate the cost of the legislation as the number of appeals that may be filed is not known.

DHSS and OMB estimate that the $200 biennial registration fee would generate $11,600, based on 58 managed care plans and indemnity carriers.

Office of Legislative Services Comments:

There is no cost to the State to implement a Statewide Independent Health Benefits Appeals Program as the program's cost is to be supported by the $25 application fees charged to individuals filing an appeal and by assessments against health benefit plans as discussed in greater detail below.

The Statewide Independent Health Benefits Appeals Program to be established by the legislation largely mirrors proposed DHSS regulations, 28 N.J.R. 2456 et seq., that would establish an external appeals process for "any HMO member, and any provider acting on behalf of a member, with the member's consent, who is dissatisfied with the results of the internal appeal process" the regulations would establish. Both the legislation and proposed regulations require a $25 application fee. However, the legislation

would waive the fee in cases of financial hardship while the proposed regulations would reduce the fee to $2.00 for HMO members who are on Medicaid, SSI, General Assistance, PAAD or receive unemployment assistance.

To implement a Statewide Independent Health Benefits Appeal Program, DHSS will likely issue a Request for Proposal from UROs who would like to conduct such independent reviews. Until bids are received from UROs, the cost to conduct such independent reviews will not be known. The cost of such reviews would be supported by revenues available to UROs -- the $25 application processing fee and assessments imposed on health benefit claims.

It is further noted that the federal Medicare and Medicaid programs may not be covered by this legislation as these programs have their own procedures to conduct impartial utilization reviews. If these two programs are exempt from the legislation's provisions the number of appeals the Statewide Independent Health Benefits Appeals Program would have to conduct would be significantly reduced which would, in turn, increase the unit cost to conduct such reviews.

Finally, DHSS' estimate that the $200 biennial registration fee would generate $11,600 appears reasonable.

This fiscal note has been prepared pursuant to P.L.1980, c.67.