

## CHAPTER 75

**AN ACT** eliminating fees to appeal certain decisions by health insurance carriers and amending P.L.1997, c.192.

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. Section 11 of P.L.1997, c.192 (C.26:2S-11) is amended to read as follows:

C.26:2S-11 Independent Health Care Appeals Program.

11. There is established the Independent Health Care Appeals Program in the department.

The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce, or terminate benefits in the event the final decision is contested by the covered person or any health care provider acting on behalf of the covered person, but only with the covered person's consent. The appeal review shall not include any decisions regarding benefits not covered by the covered person's health benefits plan.

a. A covered person or health care provider may apply to the Independent Health Care Appeals Program for a review of a decision to deny, reduce, or terminate a benefit if the person or health care provider has already completed the carrier's appeals process, if any, and the person or health care provider contests the final decision by the carrier. The person or health care provider shall apply to the department within 60 days of the date the final decision was issued by the carrier in a manner determined by the commissioner.

b. As part of the application, the covered person or health care provider shall provide the department with:

- (1) The name and business address of the carrier;
- (2) A brief description of the covered person's medical condition for which benefits were denied, reduced, or terminated;
- (3) A copy of any information provided by the carrier regarding its decision to deny, reduce, or terminate the benefit; and
- (4) A written consent to obtain any necessary medical records from the carrier and, in the case of a carrier which offers a managed care plan, any other out-of-network physician the person may have consulted on the matter.

c. (Deleted by amendment, P.L.2025, c.75)

d. Prior to receiving hospital services, a covered person or a person designated by the covered person may sign a consent form authorizing a health care provider acting on the covered person's behalf to appeal a determination by the carrier to deny, reduce, or terminate benefits. The consent is valid for all stages of the carrier's informal and formal appeals process and the Independent Health Care Appeals Program established pursuant to this section. A covered person shall retain the right to revoke his consent at any time.

e. A health care provider shall provide notice to the covered person whenever the health care provider initiates an appeal of a carrier's determination to deny, reduce, or terminate a benefit or deny payment for a health care service based on a medical necessity determination made by the carrier. The health care provider shall provide additional notice to the covered person each time the health care provider continues the appeal to the next stage of an appeals process, including any appeal to an independent utilization review organization pursuant to this section.

2. This act shall take effect immediately.

Approved June 30, 2025.