LEGISLATIVE REPORT
AUGUST 2000
INDEPENDENT HEALTH CARE APPEALS PROGRAM

The Health Care Quality Act, signed by former Governor Whitman on August 7, 1997, gave New Jersey residents many new and important consumer rights. Among the most significant is the right to appeal to an independent organization for a non-binding determination when an HMO or other managed care plan denies, limits or terminates a covered service on the grounds that it is not medically necessary. The right of appeal is offered through the Independent Health Care Appeals Program (IHCAP) and is administered by the New Jersey Department of Health and Senior Services (Department).

This is the fifth semiannual report to the Legislature on the appeal process. This report covers the period from January 16, 2000 through July 15, 2000.

One hundred and sixty nine (169) requests for an external appeal were filed with the Department's Office of Managed Care during the time period of this report. Of the 169 requests filed, 92 met the requirements for processing under the HMO regulations and the Health Care Quality Act and were forwarded to an independent utilization review organization (IURO) for preliminary review, where 70 were accepted by the IUROs for full review. Reasons for rejection and subsequent return of the appeal to the appellant included the following: failure to exhaust the plan's internal appeal process; internal resolution of the denial after filing; resolution of the denial through the Department's Office of Managed Care's complaint unit; non eligibility of the member due to ERISA; out of state coverage; or enrollment in a federal health benefits plan.

Of the 70 appeals accepted by the IUROs for full review, 58 appeals have been completed and 12 are pending. Of the 58 appeals completed, the independent panel supported the health plan's decision 31 times (53%) and disagreed with the health plan's decision 27 times (47%). This represents a increase in the number of cases in which the panel supported the plan's decision. In the previous report, the review panel agreed with the plan in 48% of cases. Of the 27 recommendations disagreeing with the health plan's decision during this reporting period, health plans rejected the independent panel's recommendation only once. Most appeal cases continue to fall into three categories: denial of level of care, denial of inpatient hospital days, and denial of surgical procedures.

Two tables are attached demonstrating the number of appeals filed for each health plan. The first table indicates the number of appeals and outcomes from March 1997, when the HMO regulations went into effect, through July 15, 2000.

The second table represents the number of appeals and outcomes during the period of this report, January 16, 2000 through July 15, 2000. Plans with no appeals and/or very small enrollment have been omitted. The first column indicates the market share for each HMO; however, the market share for non-HMO plans is not recorded by the Department, and thus not shown. The second column provides the total number of appeals accepted for full review by the independent panel. Appeals categorized as completed are those for which the panel has made its recommendation to the plan. Appeals that are still in the process of being reviewed by the panel are considered pending. The third column shows the independent panel's recommendation. If the panel determines that the plan's medical treatment was appropriate, the panel upholds the plan’s decision. However, if the panel determines that the consumer is being denied medically appropriate care, the panel disagrees with the plan's decision and decides in favor of the consumer. Once the panel has made its determination, the plan has 10 business days to either accept or reject the recommendation. The last column shows the plan’s decision to accept or reject the panel’s recommendation, or whether the plan is still within the 10-day time frame to make its final decision.

As evidenced by this report, and the four prior reports, although the number of appeals filed by consumers in New Jersey is increasing, it remains low when considering the large number of HMO and other managed care plan members who have access to the appeal process. Please see the table below:

	External Appeal Requests Filed with DHSS that Met Processing Requirements	**External Appeals Accepted by IUROs for Full Reviews**
1997	27	25
1998	122	104
1999	174	144

How the Appeal System Works

It is important to remember that consumers are required to exhaust their plan's internal appeal process before applying for an appeal to the independent panel. Under New Jersey law, all managed care plans must have an internal appeal process that meets standards set by the Department. This system was established as an incentive for HMOs and other managed care plans to resolve most disputes internally, with only unresolved issues rising to the level of the external appeal stage.

During the period covered by this report, all external appeals were conducted by the Peer Review Organization (PRO) of New Jersey or the IPRO (Island Peer Review Organization). These panels, consisting of medical professionals including physicians whose specialty covers the area under review, 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 health plan and ranges from $330 to $350. Consumers pay a $25 filing fee for an external appeal, which can be reduced to $2 in cases of financial hardship. During the time period of this report, there were no hardship cases.

Consumers are given up to 60 days from the date of a plan's denial to file an external appeal. Under routine circumstances, a decision must be rendered by the external appeals panel within 30 days after receiving all documents, but the panel can act within a matter of hours, if necessary.

Consumer Education

By New Jersey law, patients who are turned down for a 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 an HMO or other managed care plan has failed to notify its member of the right to appeal, the Department has taken prompt action.

The Department also informs consumers about their rights, including the right to appeal, by publishing the annual HMO report card. Our third report card was made available to the public in December 1999. Consumers can access it through the Department's website at www.state.nj.us/health, through their workplace or in mailings from the Department.

In addition to the appeals system, the Department operates a hotline (1-888-393-1062) for consumers to register complaints about their managed care plan. During the period of this report, January 16, 2000 through July 15, 2000, the Department handled more than 1,700 telephone inquiries and complaints and more than 650 written complaints. These complaints involve issues such as access to care, quality of care, denial of coverage, and payment issues.

Table 1

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
March 15, 1997 - July 15, 2000

Name of Plan	HMO Market Share*	Total Appeals		Panel Recommendation		Did Plan Accept Recommendation?		
		Pending	Completed	Agree With Plan	Disagree With Plan	Yes	No	Pending
HMOs								
Aetna/US Healthcare	38.2%	5	49	17	32	49	0	0
Amerigroup	2.1%	0	2	0	2	2	0	0
AmeriHealth	6.9%	0	16	10	6	15	1	0
CIGNA	5.1%	1	17	12	5	15	2	0
First Option		0	27	18	9	26	1	0
HIP		0	4	1	3	4	0	0
Horizon (HMO Blue)	16.9%	1	28	13	15	17	11	0
NYLCare		0	24	15	9	24	0	0
Oxford	7.1%	1	59	30	29	58	1	0
Physicians Health Services	10.3%	2	32	22	10	32	0	0
Prudential HealthCare	4.2%	1	22	13	9	20	2	0
United	3.3%	0	4	4	0	4	0	0
Non HMO Managed Care Plans								
Aetna/US Healthcare		0	3	0	3	3	0	0
AmeriHealth		0	5	4	1	5	0	0
CIGNA		1	2	1	1	2	0	0
First Option		0	1	1	0	1	0	0
Horizon (BCBS)		0	8	5	3	8	0	0
NYLCare		0	1	0	1	1	0	0
Oxford		0	3	3	0	3	0	0
Physicians Health Services		0	5	3	2	5	0	0
Prudential		0	6	6	0	6	0	0
United		0	2	2	0	2	0	0
Totals		**12**	**320**	**180**	**140**	**302**	**18**	**0**

*Source: Department of Banking and Insurance (1st Quarter 2000)

Table 2

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
January 16, 2000 - July 15, 2000

Name of Plan	HMO Market Share*	Total Appeals		Panel Recommendation		Did Plan Accept Recommendation?		
		Pending	Completed	Agree With Plan	Disagree With Plan	Yes	No	Pending
HMOs								
Aetna/US Healthcare	38.2%	5	17	4	13	17	0	0
Amerigroup	2.1%	0	1	0	1	1	0	0
AmeriHealth	6.9%	0	6	3	3	6	0	0
CIGNA	5.1%	1	1	1	0	1	0	0
Horizon	16.9%	1	3	2	1	2	1	0
Oxford	7.1%	1	10	7	3	10	0	0
Physicians Health Services	10.3%	2	9	7	2	9	0	0
Prudential HealthCare	4.2%	1	4	3	1	4	0	0
United	3.3%	0	1	0	1	1	0	0
Non HMO Managed Care Plans								
Aetna/US Healthcare		0	1	0	1	1	0	0
AmeriHealth		0	1	1	0	1	0	0
CIGNA		1	1	0	1	1	0	0
Horizon (BCBS)		0	2	2	0	2	0	0
Oxford		0	1	1	0	1	0	0
Totals		**12**	**58**	**31**	**27**	**57**	**1**	**0**

*Source: Department of Banking and Insurance (1st Quarter 2000)