LEGISLATIVE REPORT
AUGUST 2001
INDEPENDENT HEALTH CARE APPEALS PROGRAM

This is the seventh semiannual report to the Legislature on the managed care coverage denial appeal process. This report covers the period from January 16, 2001 through July 15, 2001.

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).

On January 16, 2001 former Governor Whitman signed P.L. 2001, c.1, amending the Health Care Quality Act by making determinations rendered under the Independent Health Care Appeals Program binding on carriers. The current reporting period coincided precisely with the effective date of this legislation causing this report to be fully reflective of the change from non-binding to binding determinations. As a result, the sections in previous reports referring to the plan's acceptance or rejection of the independent utilization review organization's (IURO) recommendation are no longer relevant and have been removed from the current report.

Two hundred and thirty (230) requests for an external appeal were filed with the Department's Office of Managed Care during the time period of this report. Of the 230 requests filed, 162 met the requirements for processing under the Health Care Quality Act and regulations and were forwarded to an IURO for preliminary review, where 133 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 federal law preemption under ERISA; out of state coverage; or enrollment in a federal employee health benefits plan.

Of the 133 appeals accepted by the IUROs for full review, 89 appeals have been completed and 44 are pending. Of the 89 appeals completed, the independent panel supported the health plan's decision 43 times (48%) and disagreed with the health plan's decision 46 times (52%). This represents a one percent decrease 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 49% of cases. However, it should be noted that the overall numbers are small, and that caution should be used in observing changes from one reporting period to the next. Most appeal cases fell into four categories: denial of level of care for hospital inpatients, denial of inpatient hospital days, denial of surgical procedures, and denial of utilization of out-of-network providers.

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, 2001.

The second table represents the number of appeals and outcomes during the period of this report, January 16, 2001 through July 15, 2001. 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 communicated its determination 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 determination. 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. If all or part of the panel's decision is in favor of the consumer, the plan shall promptly provide coverage for the health care services found by the panel to be medically necessary covered services.

While the first five reports indicated a steady increase with the sixth evidencing a leveling off, this report shows a 47% increase in the number of appeals filed by consumers. Whether this increase is due to the passage of P.L. 2001, c.1, or an increased awareness of the program is unknown. The total number of appeals filed, however, continues to remain low considering the large number of residents enrolled in HMOs and other managed care plans in New Jersey. Please see the table below:

	External Appeal Requests Filed with DHSS that Met Processing Requirements	External Appeals Accepted by IUROs for Full Reviews
CY 1997	27	25
CY 1998	122	104
CY 1999	174	144
CY 2000	174	133
CY 2001 (as of 7/15/01)	169	139

How the Appeal System Works

It is important to remember that consumers are required to exhaust their plan's internal appeal process before submitting an appeal for consideration by an independent panel. Under New Jersey law, all managed care plans must have an internal appeal process that meets standards set by the Department. This requirement was established to provide 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 process.

During the period covered by this report, all external appeal case reviews were conducted by panels convened by the Peer Review Organization of New Jersey (PRONJ) or the Island Peer Review Organization (IPRO). These panels, consisting of medical professionals, including specialty physicians appropriate to 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 approximately $350 to $375. Consumers pay a $25 filing fee for an external appeal, which can be reduced to $2 in cases of financial hardship. During the period of this report, there were no hardship cases.

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

Patients' Right to Sue Carriers

On July 30, 2001, the "Health Care Carrier Accountability Act" was enacted by Acting Governor Donald DiFrancesco, and it becomes effective 90 days after enactment. This new law makes carriers liable for the losses of their covered persons resulting from negligence related to the denial or delay in approval of medically necessary covered services by the carrier, if the denial or delay is the proximate cause of the covered person's death or serious injury. Generally, the law requires that covered persons exhaust their appeal rights through the Independent Health Care Appeals Program before bringing court action against a carrier alleging liability. However, the law specifies that the Independent Health Care Appeals Program can be bypassed if serious or significant harm to the member has occurred or is imminent.

Consumer Education

By New Jersey law, consumers who are denied coverage 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 corrective action.

The Department also informs consumers about their rights, including the right to appeal, by publishing the annual HMO report card. Our fourth report card was made available to the public in October 2000. The fifth report card will be available to the public in the fall of 2001. 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 plans. During the period of this report, January 16, 2001 through July 15, 2001, the Department handled 2,176 telephone inquiries and complaints and 683 written complaints. These complaints involve issues such as access to care, quality of care, and denial of coverage issues.

On January 29, 2001 former Governor Whitman signed P.L. 2001, c.14 appropriating $500,000 for the establishment of the Managed Health Care Consumer Assistance Program (MHCCAP) in the Department. The law directs the Department, in consultation with the Departments of Human Services and Banking and Insurance, to educate and assist health care consumers regarding their rights in a managed health care system. The Department was directed to work with the Community Health Law Project and New Jersey Protection and Advocacy, Inc. to operate the program on a one-year, interim basis until a permanent program is developed. The MHCCAP became operational on July 5, 2001 with consumer access to the program provided through a toll free number (1-888-838-3180). On line access will also be available through a website (www.managedcarehelpline.org) which is currently under construction.

Table 1

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
March 15, 1997 - July 15, 2001

HMO Name	HMO Market Share*	Total Appeals		Panel Determination	
		Pending	Completed	Disagree With Plan	Agree With Plan
HMO					
Aetna/US Healthcare	38.9%	9	109	58	51
Americaid	--	0	1	1	0
Amerigroup New Jersey	2.9%	0	1	1	0
Amerihealth HMO	7.2%	3	30	15	15
Cigna Healthcare of N.J.	3.8%	2	29	14	15
First Option	--	0	27	9	18
HIP	--	0	4	3	1
Horizon Healthcare of N.J.	18.4%	8	55	29	26
NYLCare	--	0	26	11	15
Oxford Health Plans	7.4%	2	66	33	33
Physicians Health Service of N.J.	10.8%	10	68	29	39
Prudential Health Care Plan	0.3%	1	31	13	18
United Healthcare of N.J.	3.6%	1	5	1	4
Non HMO Managed Care Plan					
Aetna/US Healthcare		0	4	3	1
Amerigroup New Jersey		1	0	0	0
Amerihealth HMO		2	6	2	4
Cigna Healthcare of N.J.		0	3	2	1
First Option		0	1	0	1
The Guardian		1	0	0	0
Horizon Healthcare of N.J.		5	18	9	9
Managed Health Care Systems		0	1	0	1
NYLCare		0	1	1	0
Oxford Health Plans		0	3	0	3
Physicians Health Service of N.J.		0	6	3	3
Prudential Health Care Plan		0	7	1	6
United Healthcare of N.J.		0	2	0	2
Total		**45**	**504**	**238**	**266**

*Source: Department of Banking and Insurance (2nd Quarter 2001)

Table 2

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
January 16, 2001 - July 15, 2001

HMO Name	HMO Market Share*	Total Appeals		Panel Determination	
		Pending	Completed	Disagree With Plan	Agree With Plan
HMO					
Aetna/US Healthcare	38.9%	9	30	13	17
Amerihealth HMO	7.2%	3	3	1	2
Cigna Healthcare of N.J.	3.8%	2	4	1	3
Horizon Healthcare of N.J.	18.4%	8	16	8	8
Oxford Health Plans	7.4%	2	3	3	0
Physicians Health Service of N.J.	10.8%	10	22	13	9
Prudential Health Care Plan	0.3%	1	1	0	1
Non HMO Managed Care Plan					
Aetna/US Healthcare		0	1	0	1
Amerigroup New Jersey		1	0	0	0
Amerihealth HMO		2	1	1	0
The Guardian		1	0	0	0
Horizon Healthcare of N.J.		5	7	5	2
Prudential Health Care Plan		0	1	1	0
Total		**44**	**89**	**46**	**43**

*Source: Department of Banking and Insurance (2nd Quarter 2001)