LEGISLATIVE REPORT
FEBRUARY 1999
INDEPENDENT HEALTH CARE APPEALS PROGRAM

The Health Care Quality Act, signed by 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 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 second semiannual report to the Legislature on the results of the appeals process. The first report covered a 16-month period from March 15, 1997, when New Jersey's new HMO regulations first created an external appeals process, through July 31, 1998. This report provides information on the program's operations from August 1, 1998, until January 15, 1999.

There were 57 appeals filed during this time period. Of these, 50 appeals have been reviewed in full and 7 appeals are pending. Of the 50 appeals completed, the independent panel supported the HMO's decision 33 times and recommended in favor of consumers 17 times. Most appeal cases fall into two categories: denials of inpatient hospital days or denial of a surgical procedure.

Attached are two tables that show the number of appeals filed for each health plan. The first table presents the number of appeals during the time period covered by this report. The second table shows the number of appeals and outcomes since March 1997, when the HMO regulations went into effect. Plans with no appeals and very small enrollment have been omitted. The first column shows the market share for each HMO; the market share for non HMO plans is not recorded by the Department. The second column provides the total number of appeals filed for review by the independent panel. Appeals categorized as completed are those for which the panel 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 proposed medical treatment is appropriate, the panel upholds the plan. However, if the panel determines that the consumer is being denied medically appropriate care, the panel decides in favor of the consumer. Once the panel has made its determination, the plan has 10 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.

A recent report prepared for the Kaiser Family Foundation on external review programs established by a state or federal agency, shows that New Jersey is one of 18 states to establish a process for an independent review of health plan decisions that deny coverage for enrollee health services. This report, External Review of Health Plan Decisions: *An Overview of Key Program Features in the States and Medicare* and prepared by the Institute for Health Care Research and Policy at the Georgetown University, focused on 13 state programs that were similar in design and operational during 1998. New Jersey is one of the states featured in the report. The report's findings reflect New Jersey's experience: consumers seek external reviews infrequently and independent panels uphold decisions by health plans in nearly half the cases. However, New Jersey is one of only two states in which external review decisions are not binding.

The report found that, as in New Jersey, the number of cases brought to external review is quite low in all state programs. The number of appeals filed by consumers in New Jersey is steadily increasing; however, the total number of appeals completed so far - 119 - remains low. As expected, the Medicare external appeal process, by far, has the largest caseload. This can largely be attributed to Medicare's requirement for health plans to automatically send all denials upheld by the health plan's internal review process for external review.

The experience in New Jersey is also consistent with the finding that independent panels uphold the health plans decision about as frequently as it overturns them. Table 2 shows of the 119 completed appeals, the independent panel supported the plan's decision 73 times and upheld the consumer 46 times. The survey of state programs found that health plan decisions were overturned between one-third and two-thirds of the time.

How the Appeal System Works

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

During the period covered by this report, all external appeals were conducted by the Peer Review Organization of New Jersey (PRONJ) or the Island Peer Review Organization (IPRO). The panel, which consists of medical professionals including physicians whose specialty covers the area under review, examine cases on the basis of medical records and other materials, generally accepted practice guidelines and applicable clinical protocols. The fee for the panel's review is paid

by the plan whose decision is being appealed 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 denial to file an appeal. Under routine circumstances, a decision must be rendered by the external panel within 30 days after receiving all documents, but the panel can act within a matter of hours, if necessary.

Consumer Education

By law, patients who are turned down for a medical procedure must be given an appeal form with instructions on how to appeal. Nevertheless, we take every opportunity to publicize this appeal right. On the few occasions when we have learned that an HMO has failed to notify its member of the right to appeal, we have taken prompt action.

We also inform consumers about their rights, including the right to appeal, by publishing an HMO report card. Our second report card, published in December 1998, continues to be in demand by consumers, who access it through our website www.state.nj.us/health, through their workplace or in mailings from the Department. We will publish the 1999 report card for HMOs and some other managed care plans later this year.

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. Staff handled more than 3,000 complaints and inquiries through the hotline and 700 written complaints during 1998. These complaints involve issues such as quality of care, access and the provider network.

Table 1

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
August 1, 1998 - January 15, 1999

Name of Plan	*Market Share*	Total Appeals		Panel Recommendation		Did Plan Accept Recommendation?		
		Pending	Completed	Uphold Plan	Uphold Consumer	Yes	No	Pending
HMOs								
Aetna/US Healthcare	31.9%	1	0	0	0	0	0	0
AmeriHealth	6.1%	1	5	4	1	2	0	3
CIGNA	4.7%	0	0	0	0	0	0	0
First Option	7.2%	1	10	8	2	9	0	1
HIP	8.1%	0	0	0	0	0	0	0
Horizon (HMO Blue)	13.4%	0	7	4	3	6	0	1
NYLCare	1.4%	0	10	6	4	8	0	2
Oxford	10.2%	0	2	1	1	1	0	0
Physicians Health Services	3.7%	1	4	2	2	4	0	0
PruCare	4.8%	1	2	0	2	1	0	1
United	2.7%	0	0	0	0	0	0	0
Other Managed Care Plans								
AmeriHealth - HCQA	N.A.	0	1	1	0	1	0	0
Horizon - HCQA (BC/BS)	N.A.	0	3	2	1	3	0	0
NYLCare - HCQA	N.A.	0	1	0	1	1	0	0
Prudential - HCQA	N.A.	2	3	3	0	3	0	0
United - HCQA	N.A.	0	2	2	0	2	0	0
Totals		**7**	**50**	**33**	**17**	**42**	**0**	**8**

*Source: Department of Banking and Insurance

Table 2

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
March 15, 1997 - January 15, 1999

Name of Plan	*Market Share*	Total Appeals		Panel Recommendation		Did Plan Accept Recommendation?		
		Pending	Completed	Uphold Plan	Uphold Consumer	Yes	No	Pending
HMOs								
Aetna/US Healthcare	31.9%	1	6	5	1	6	0	0
AmeriHealth	6.1%	1	5	4	1	2	0	3
CIGNA	4.7%	0	6	3	3	6	0	0
First Option	7.2%	4	22	14	8	21	0	1
HIP	8.1%	0	3	1	2	3	0	0
Horizon (HMO Blue)	13.4%	1	11	5	6	8	2	1
NYLCare	1.4%	0	26	15	11	24	0	2
Oxford	10.2%	0	8	4	4	8	0	0
Physician Health Services	3.7%	1	7	4	3	7	0	0
PruCare	4.8%	2	14	9	5	11	2	1
United	2.7%	0	1	1	0	1	0	0
Other Managed Care Plans								
AmeriHealth - HCQA	N.A.	0	1	1	0	1	0	0
Horizon - HCQA (BCBS)	N.A.	0	3	2	1	3	0	0
NYLCare - HCQA	N.A.	0	1	0	1	1	0	0
Prudential - HCQA	N.A.	2	3	3	0	3	0	0
United - HCQA	N.A.	0	2	2	0	2	0	0
Totals		**12**	**119**	**73**	**46**	**107**	**4**	**8**

*Source: Department of Banking and Insurance