LEGISLATIVE REPORT
FEBRUARY 2002
INDEPENDENT HEALTH CARE APPEALS PROGRAM

This is the eighth semiannual report to the Legislature on the managed care coverage denial appeal process. This report covers the period from July 16, 2001 through January 15, 2002.

The Health Care Quality Act, enacted on August 7, 1997, and amended on January 16, 2001, gives New Jersey residents many new and important consumer rights. Among the most significant is the right to appeal to an independent organization for a 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).

Two hundred and two (202) requests for an external appeal were filed with the Department's Office of Managed Care during the time period of this report. Of the 202 requests filed, 147 met the requirements for processing and were forwarded to an independent utilization review organization (IURO) for preliminary review, where 137 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 137 appeals accepted by the IUROs for full review, 109 appeals have been completed and 28 are pending. Of the 109 appeals completed, the independent panel supported the health plan's decision 61 times (56%) and disagreed with the health plan's decision 48 times (44%). This represents an eight percent 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. However, it should be noted that the overall numbers remain 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 based on cosmetic procedure versus medical necessity.

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 January 15, 2002.

The second table represents the number of appeals and outcomes during the period of this report, July 16, 2001 through January 15, 2002. Plans with no appeals 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 determination of medical necessity 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 this report indicates a 12% decrease in the number of appeals filed by consumers over the previous report (202 compared to 230), the number of requests that ultimately went forward to a full review increased slightly (137 compared to 133). This may be indicative of increased consumer sophistication with the process, resulting in fewer inappropriate requests. The overall increase in volume reflected in the previous report remained consistent in this reporting period and is reflected in the calendar year table below. The total number of appeals filed, however, continues to remain small considering the large number of residents - over 4.5 million - enrolled in HMOs and other managed care plans in New Jersey.

	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	303	273

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 was only one case of financial hardship.

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.

Consumer Education

By New Jersey law, consumers who are denied coverage based on lack of medical necessity for an otherwise covered 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 fifth report card was made available to the public in October 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 plan. During the period of this report, July 16, 2001 through January 15, 2002, the Department handled 2,405 telephone inquiries and complaints and 705 written complaints. These complaints involve issues such as access to care, quality of care, and denial of coverage issues.

On January 29, 2001 P.L. 2001, c.14 was enacted, establishing the Managed Health Care Consumer Assistance Program. 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. The program became operational on July 5, 2001 with consumer access to the program provided through a toll free number (1-888-838-3180) and on-line through a website at www.managedcarehelpline.org.

Table 1

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
March 15, 1997 - January 15, 2002

HMO Name	HMO Market Share*	Total Appeals		Panel Determination	
		Pending	Completed	Disagree With Plan	Agree With Plan
HMO					
Aetna/US Healthcare	32.0%	7	149	73	76
Americaid	--	0	1	1	0
Americhoice	8.4%	0	2	2	0
Amerigroup New Jersey	3.4%	0	1	1	0
Amerihealth HMO	6.6%	0	35	16	19
Cigna Healthcare of N.J.	3.5%	3	44	18	26
First Option	--	0	27	9	18
Health Net	12.7%	4	91	41	50
HIP	--	0	4	3	1
Horizon Healthcare of N.J.	19.2%	2	97	44	53
NYLCare	--	0	26	11	15
Oxford Health Plans	7.2%	0	76	35	41
Prudential Health Care Plan	--	0	32	14	18
United Healthcare of N.J.	3.5%	1	6	1	5
University Health Plans	2.2%	1	0	0	0
Non HMO Managed Care Plan					
Aetna/US Healthcare		2	4	3	1
Amerigroup New Jersey		0	1	1	0
Amerihealth HMO		0	10	6	4
Atlanticare Health Plan		0	1	0	1
Cigna Healthcare of N.J.		0	5	3	2
First Option		0	1	0	1
Health Net		0	7	3	4
Horizon Healthcare of N.J.		5	28	14	14
NYLCare		0	1	1	0
Oxford Health Plans		3	6	2	4
Prudential Health Care Plan		0	8	2	6
The Guardian		0	3	2	1
United Healthcare of N.J.		0	2	0	2
Total		**28**	**668**	**306**	**362**

*Source: Department of Banking and Insurance (3rd Quarter 2001)

Table 2

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
July 16, 2001 - January 15, 2002

HMO Name	HMO Market Share*	Total Appeals		Panel Determination	
		Pending	Completed	Disagree With Plan	Agree With Plan
HMO					
Aetna/US Healthcare	32.0%	7	29	13	16
Americhoice	8.4%	0	2	2	0
Amerihealth HMO	6.6%	0	1	0	1
Cigna Healthcare of N.J.	3.5%	3	13	4	9
Health Net	12.7%	4	11	6	5
Horizon Healthcare of N.J.	19.2%	2	35	15	20
Oxford Health Plans	7.2%	0	7	0	7
United Healthcare of N.J.	3.5%	1	0	0	0
University Health Plans	2.2%	1	0	0	0
Non HMO Managed Care Plan					
Aetna/US Healthcare		2	0	0	0
Amerihealth HMO		0	2	2	0
Cigna Healthcare of N.J.		0	1	1	0
Health Net		0	1	0	1
Horizon Healthcare of N.J.		5	4	3	1
Oxford Health Plans		3	1	0	1
Prudential Health Care Plan		0	1	1	0
The Guardian		0	1	1	0
Total		**28**	**109**	**48**	**61**

*Source: Department of Banking and Insurance (3rd Quarter 2001)