LEGISLATIVE REPORT
AUGUST 1998
INDEPENDENT HEALTH CARE APPEALS PROGRAM

The Health Care Quality Act 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 under the Independent Health Care Appeals Program (IHCAP) and is administered by the New Jersey Department of Health and Senior Services (Department).

This is the first semiannual report to the Legislature on the results of the appeals process. The report covers 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. Consumer rights were established under the state's HMO regulations, long considered the most consumer focused package of rules in the country. Those rights were extended to other managed care plans under the Health Care Quality Act, which took effect in February.

There have been 82 appeals filed during this time period. Of these, 69 appeals have been reviewed in full and 13 appeals are pending. These figures appear very small compared to the estimated 3.5 million New Jersey residents covered by managed care plans. But they are consistent with the number of appeals in states with comparable programs. Connecticut had 18 appeals in 7 months, Rhode Island had 50 over 12 years and Texas had 196 since implementation of its program in November 1997.

Attached is a table displaying the number of appeals filed during this time period for each health plan. 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 next column provides the total number of appeals. Appeals categorized as completed are those which the panel made its recommendation to the plan and the plan, in turn, acted on the panel's recommendation. Appeals that are still in the process of being reviewed by the panel or the plan is reviewing the panel's recommendation are considered pending. The next 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 upholds the consumer. The last column shows the action of the plan after being advised of the panel's recommendation.

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. We expect the number of appeals to increase in the coming year, mainly because the right to appeal was extended in February to consumers in other forms of managed care plans under the Health Care Quality Act.

How the Appeal System Works

During the period covered by this report, all external appeals were conducted by the Peer Review Organization of New Jersey (PRONJ). Recently, another organization, the Island Peer Review Organization (IPRO) contracted with the state. The panel, which consists of medical professionals including physicians whose specialty covers the area under review, examines 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 three 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 appeals panel within 30 days after receiving all documents, but the panel can act within a matter of hours if necessary.

The Nature of Appeals and Results

Most appeal cases fall into two categories: denials of inpatient hospital days or denial of a surgical procedure. There were individual cases involving denials of equipment, skilled nursing care, speech or physical therapy, mental health care, home health, and the use of an out of network provider. In more than half the cases, the appeal was filed after the service was provided.

Of the 69 appeals completed during this time period, the independent panel supported the HMO's decision 40 times and recommended in favor of consumers 29 times.

The appeal panel's recommendations in favor of consumers were accepted by the managed care plan 25 times and rejected in 4 cases. Each of the 4 cases was unique and the carriers' reasons for rejecting the recommendation included: 1) the service might be medically necessary but was related to a pre-existing condition not covered by the plan; or 2) the service requested was experimental or investigational and therefore not a covered service; or 3) the member could be adequately treated in an outpatient setting and therefore did not require hospitalization. At this time, the Department has not identified a pattern of non-compliance with the findings and recommendations of the review panel.
New Jersey is one of only two states with a non-binding appeals process. A total of 13 states (and Medicare) have some form of an external appeals program. Only some five states had an external appeals system when New Jersey began its program in 1997. Since then, we have been active in assisting other states, as well as the federal government as they considered legislation to establish an appeals process.

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. We are currently working on a booklet about how to appeal a decision by managed care organizations and plan to distribute it to doctors' offices and other locations around the state. 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. First published in November 1997, this report card 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 1998 report card for HMOs and some other managed care plans later this year.

Consumer Complaints

In addition to establishing an appeals system, the Department operates a hotline (1-888- 393-1062) for consumers to register complaints about their managed care plans. Staff handled about 1,500 complaints and inquiries through the hotline in 1997. We also responded to 291 written complaints from consumers in 1996 and 480 written complaints in 1997. These complaints involve issues such as quality of care, access and the provider network.

What We have Learned

We have learned a great deal about how to improve the appeals process since it began in March 1997. We have worked to strengthen the quality of the program by requiring more detailed justification letters from the review panel and the managed care plan and giving health plans feedback on their overall performance compared to the rest of the industry.

Some denials of service by a health plan involve gray areas such as experimental/investigational procedures and cosmetic versus medically necessary procedures. Even though carriers generally want to exclude these procedures as coverage issues under the contract, we have allowed these to go forward to an independent appeals panel for an unbiased third party review.

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
March 15, 1997 - July 31, 1998

Name of Plan	Market Share*	Total Appeals		Panel Recommendation		Did Plan Accept Recommendation?	
		Pending	Completed	Uphold Plan	Uphold Consumer	Yes	No
HMOs							
Aetna/US Healthcare	37.1%	0	6	5	1	6	
AmeriHealth	5.0%	2	0				
CIGNA	5.8%	0	6	3	3	6	
First Option	8.2%	3	12	6	6	12	
HIP	8.1%	0	3	1	2	3	
HMO Blue	10.3%	1	4	1	3	2	2
NYLCare	1.8%	2	16	9	7	16	
Oxford	10.2%	0	6	3	3	6	
Physicians Health Services	4.7%	0	3	2	1	3	
PruCare	5.5%	1	12	9	3	10	2
United	2.7%	0	1	1		1	
Prudential - HCQA	N.A.	3	0				
United - HCQA	N.A.	1	0				
Totals		**13**	**69**	**40**	**29**	**65**	**4**