LEGISLATIVE REPORT
AUGUST 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 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 third 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. The second report provided information on the program's operations from August 1, 1998, until January 15, 1999. This report covers the period from January 16, 1999 through July 31, 1999.

There were 71 appeals filed during the time period of this report, indicating a 20% increase from the last report. Of these, 47 appeals have been reviewed in full and 24 appeals are pending. Of the 47 appeals completed, the independent panel supported the health plan's decision 25 times (53%) and disagreed with the health plan's decision 22 times (47%). This represents a reduction 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 66% of cases. Of the 22 recommendations disagreeing with the health plan's decision during this reporting period, health plans rejected the independent panel's recommendation 4 times. Most appeal cases continue to fall into two categories: denials of inpatient hospital days or denials of surgical procedures.

Attached are two tables that show the number of appeals filed for each health plan. The first table shows the number of appeals and outcomes from March 1997, when the HMO regulations went into effect, through July 31, 1999. The second table represents the number of appeals and outcomes during the period of this report, January 16, 1999 through July 31, 1999. Plans with no appeals and/or 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 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 two 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.

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, plans must have an internal appeal 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 (PRO) of New Jersey or the IPRO (Island Peer Review Organization). These panels, which consist 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 fee for the panels' 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 2 hardship cases.

Consumers are given up to 60 days from the date of a plan's denial to file an 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 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. Nevertheless, the Department takes every opportunity to publicize this appeal right. On the few occasions when we have 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 is scheduled for publication in November 1999. The report card continues to be in demand by consumers, who access it through our 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. Staff handled more than 3,000 complaints and inquiries through the hotline and more than 800 written complaints during 1998. From January 1, 1999 through July 31, 1999 the Department has handled more than 2,500 telephone inquiries and complaints and more than 900 written complaints. These complaints involve issues such as quality of care, access and the provider network, denial of coverage, and payment for medical services.

Recommendation

From observing the process over a period of two years, it is evident that the numbers of appeals filed are increasing; however, the numbers remain very low when compared to the total population for whom the process is available. The Department has concluded that the number remains low, in part, because of the non-binding status. Filing an appeal is, for the consumer, a process that requires time and expense. It is possible that the consumer, having already been denied the service twice by the managed care plan, may hesitate to expend the effort, time and money to file an external appeal, knowing that the plan has no obligation to honor the decision should the external appeal panel rule in favor of the consumer.

During the past 6 month period that this report covers, the number of refusals by the health plans to accept the recommendations of the external panel has increased. For the 28 months that this process has been in effect, there have been a total of 11 refusals. Of these, 4 refusals have been in the past 6 months alone,

averaging 1 refusal every 6 weeks. The other 7 refusals were distributed over the first 22 month period of the process, averaging 1 refusal every 3 months. It is the Department's observation that the plans are increasingly refusing to accept the non-binding recommendations of the external panel. If New Jersey initiates a binding process, the health plans will have to accept and implement the recommendation of the external panel. It is most disheartening for a consumer, who has taken the time to comply with the rules and regulations, to have the external panel rule in his/her favor only to have the health plan still refuse to provide the service.

Also, in two recent instances where the health plans refused to accept the recommendations of the external panel, the health plans stated that their basis for rejection was because the benefit and/or service under review was *not* a covered benefit. However, it should be noted that this factor was never even considered by the plans during the internal Stage 1 and Stage 2 appeal processes. Review of the plans' denial letters indicated that the Stage 1 and Stage 2 denials were made on the basis that the service was "not medically necessary." It was only after the external review panel decision disagreed with the plans and called the services "medically necessary" that the plans determined the services were not covered benefits. Both plans rejected the external review decision.

The Department also notes that New Jersey is now the only state with a non-binding process. The District of Columbia also has a non-binding process. All other states that have established an independent review process have either established a binding decision, or have converted their non-binding process to a binding process. Both New York and Pennsylvania have a binding process.

Therefore, for the reasons cited above, the Department of Health and Senior Services is recommending that the **IHCAP** appeal process be changed by law from a non-binding process to a binding process.

Table 1

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
March 15, 1997 - July 31, 1999

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	35.7%	1	9	6	3	9	0	0
Americaid	1.8%	0	1	0	1	0	0	1
AmeriHealth	5.5%	0	6	4	2	5	1	0
CIGNA	4.6%	1	11	5	6	9	1	1
First Option	-	0	28	19	9	27	1	0
HIP	5.1%	0	4	1	3	3	0	1
Horizon (HMO Blue)	16.9%	3	15	6	9	10	5	0
NYLCare	-	0	25	15	10	25	0	0
Oxford	7.8%	14	21	11	10	20	1	0
Physicians Health Services	11.2%	0	11	8	3	11	0	0
PruCare	4.7%	0	18	10	8	15	2	1
United	2.7%	0	2	2	0	2	0	0
Non HMO Managed Care Plans								
AmeriHealth		1	2	2	0	2	0	0
CIGNA		1	0	0	0	0	0	0
First Option		0	1	1	0	1	0	0
Horizon (BCBS)		1	6	4	2	6	0	0
NYLCare		0	1	0	1	1	0	0
Oxford		0	1	1	0	1	0	0
Physicians Health Services		2	3	1	2	3	0	0
Prudential		0	6	6	0	6	0	0
United		0	2	2	0	2	0	0
Totals		**24**	**173**	**104**	**69**	**158**	**11**	**4**

*Source: Department of Banking and Insurance

Table 2

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
January 16, 1999 - July 31, 1999

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	35.7%	1	3	1	2	3	0	0
Americaid	1.8%	0	1	0	1	0	0	1
AmeriHealth	5.5%	0	2	1	1	1	1	0
CIGNA	4.6%	1	5	2	3	3	1	1
First Option		0	1	1	0	1	0	0
HIP	5.1%	0	1	0	1	0	0	1
Horizon (HMO Blue)	16.9%	3	6	2	4	4	2	0
Oxford	7.8%	14	12	7	5	12	0	0
Physicians Health Services	11.2%	0	3	3	0	3	0	0
PruCare	4.7%	0	3	1	2	2	0	1
United	2.7%	0	1	1	0	1	0	0
Non HMO Managed Care Plans								
AmeriHealth - HCQA		1	0	0	0	0	0	0
CIGNA - HCQA		1	0	0	0	0	0	0
First Option - HCQA		0	1	1	0	1	0	0
Horizon - HCQA (BCBS)		1	3	2	1	3	0	0
Oxford - HCQA		0	1	1	0	1	0	0
Physicians Health Services - HCQA		2	3	1	2	3	0	0
Prudential - HCQA		0	1	1	0	1	0	0
Totals		**24**	**47**	**25**	**22**	**39**	**4**	**4**

*Source: Department of Banking and Insurance