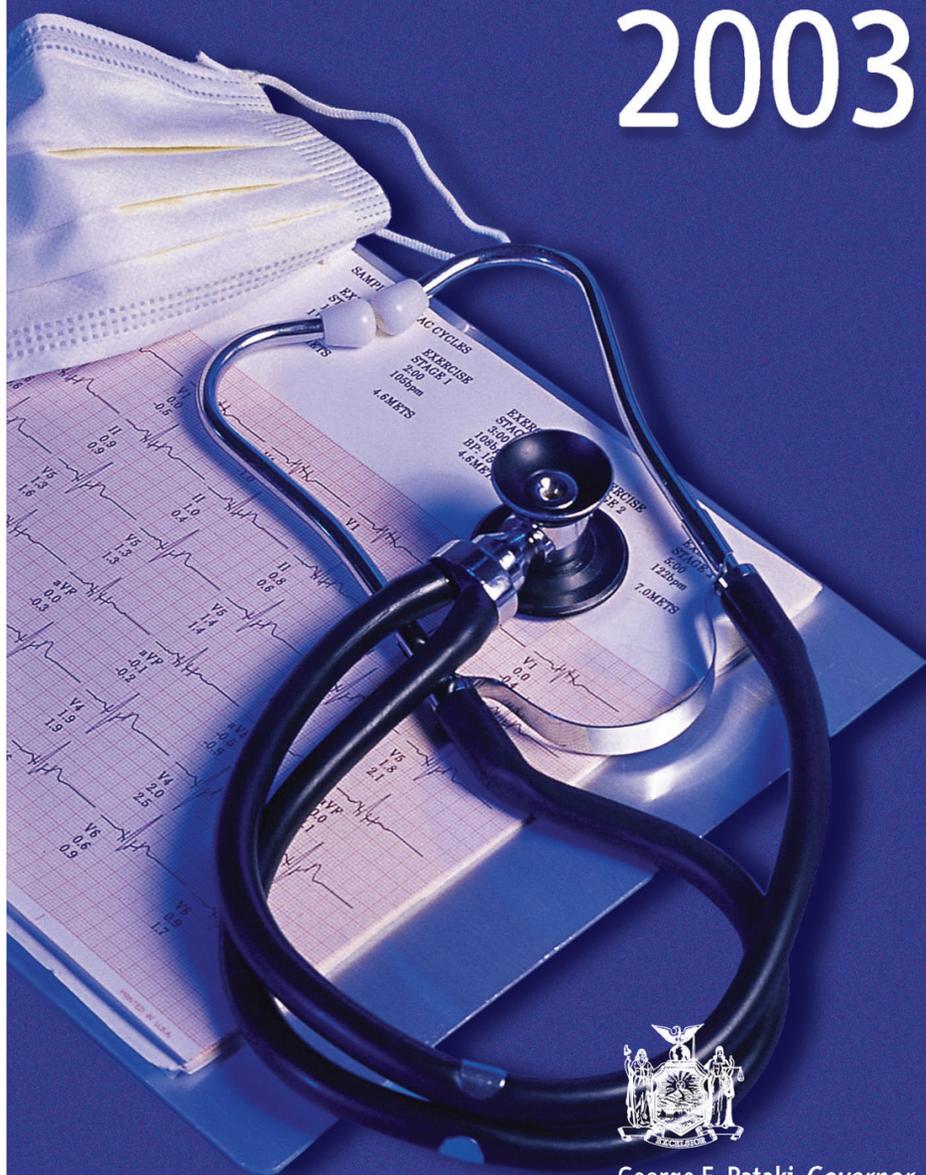


New York State Department of Insurance
New York State Department of Health

NEW YORK STATE
External Appeal Program
2003



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A REPORT ON EXTERNAL APPEALS IN NEW YORK

January 1, 2003 through December 31, 2003

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External appeal information is also available on the Insurance Department's Web site at www.ins.state.ny.us or by calling 1-800-400-8882.

With thanks and appreciation to health plans and external appeal agents for providing requested information and for participating in our surveys.

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Introduction

Recently completing its fourth year of operation, New York's External Appeal Program continues to provide New Yorkers with the right to obtain a review by independent medical experts when their health plan denies health care services as not medically necessary or because the plan considers the services to be experimental or investigational. The Program is the result of New York's landmark External Appeal Legislation which has proven to be an effective means of assisting consumers in gaining access to, and reimbursement for, health care services.

In order to be eligible for an external appeal, an insured, an insured's designee, or in certain cases, an insured's health care provider, must submit an external appeal request to the New York State Insurance Department within 45 days of receipt of a final adverse determination from a first level of appeal with a health plan, or upon waiver of the internal appeal process. The Insurance Department reviews applications for eligibility and completeness and randomly assigns appeals to one of three certified external appeal agents that have networks of medical experts available to review the appeal.

External appeal agents customarily assign one clinical peer reviewer to medical necessity appeals and three clinical peers to review appeals of treatments considered to be experimental or investigational. Decisions are rendered within thirty days for standard appeals, or within three days for expedited appeals if an attending physician attests that a delay would pose an imminent or serious threat to the health of the patient.

The New York State Insurance Department and the New York State Department of Health are responsible for oversight of the External Appeal Program and are statutorily required to review the activities of health plans and external appeal agents, investigate consumer complaints, and determine compliance with requirements. The law further provides that the Departments must annually report External Appeal Program results to the Legislature and Governor.

This year's report provides a comprehensive overview of the 2003 external appeal results, categorized by health plan, agent, and types of denials. As in previous years, the report also includes information about utilization review agents and federal developments impacting state external appeal programs. New this year, the report includes a discussion of the external appeal process from the perspective of New York's health plans and certified external appeal agents.

A brief overview of the report reveals that the number of external appeal requests submitted in 2003 increased 12%, as 1,803 external appeal applications were submitted to the Insurance Department in 2003, while 1,391 applications were submitted in 2002. In addition, the 2003 External Appeal Program results also show a decrease in the percentage of medical necessity determinations overturned by external appeal agents from previous years, while the percentage of experimental or investigational treatment decisions overturned by the agents remained the same. Also in 2003, and as discussed further in the report, the Insurance Department finalized improvements to its computerized tracking system which enabled external appeal requests to be processed more efficiently.

Managed Care Reform in New York: Utilization Review and Grievance

In 1996, Governor Pataki signed landmark managed care legislation into law. This Managed Care Reform Act afforded new protections to health care consumers, including; the right to obtain a description of health care services covered by a health plan, the right to an explanation of financial responsibility for health care services, a prudent layperson standard for accessing emergency care, the right to receive care through a comprehensive network of doctors and medical specialists, and the right to appeal coverage denials.

In providing consumers with the right to appeal coverage denials, the Managed Care Reform Act required health maintenance organizations (HMOs) and insurers to establish two separate internal appeal procedures, a utilization review procedure and a grievance procedure. All HMOs and insurers that make determinations as to whether services are medically necessary, experimental, or investigational must provide consumers with the right to appeal these utilization review determinations with the insurer or HMO. In addition, HMOs and insurers offering managed care coverage are also required to have an internal grievance procedure that provides consumers with the right to appeal all other types of adverse determinations, such as requests for referrals to non-participating providers and denials because a benefit is not covered under the health insurance contract.

The Managed Care Reform Act establishes timeframes in which utilization review and grievance determinations must be rendered by health plans and timeframes in which consumers must appeal adverse determinations. The Act specifies the information that health plans must include in these determinations, and mandates that only health care professionals render adverse determinations regarding clinical matters.

Health plans conducting utilization review must have a medical director that oversees the utilization review process, written policies and procedures that govern all aspects of the utilization review process, written clinical review criteria, procedures to ensure patient confidentiality, procedures to ensure that reviews and determinations are conducted within the requisite timeframes, and written procedures to ensure that adverse determinations include a clinical rationale and a description of appeal rights. The law further provides that health plans may conduct utilization review themselves, or in conjunction with a utilization review agent.

Given the importance of utilization review and its relation to the external appeal process, the Insurance Department surveyed all health plans that had external appeals in 2003 and asked plans whether they contract with a utilization review agent and if so, to identify the name of the agent and the types of services the agent reviews. The following chart identifies the health plans that contract with utilization review agents, grouping plans into categories based on the type of health insurance coverage provided. In reviewing the chart, it is important to keep the following distinctions in mind.

- HMOs may be for-profit or not-for-profit and offer health insurance coverage through a network of contracted providers. Typically, a primary care physician (PCP) will coordinate the member’s care and a referral must be obtained from the PCP before accessing specialty care.
- Non-profit indemnity insurers and commercial insurers are insurers that provide fee-for-service coverage so that the member and the insurer each pay a portion of costs. The cost to the member may be reduced if the insurer contracts with a network of providers and the member obtains services from one of the participating providers. The primary difference between these insurers is that commercial insurers are for-profit.
- Prepaid Health Service Plans provide coverage to Medicaid recipients through a network of contracted providers.
- Municipal Cooperative Health Benefit Plans are public entities, such as municipal corporations and school districts, that have joined together to share in the cost of health insurance coverage.

Utilization Review Agents

| Health Maintenance Organizations | Name of Utilization Review Agent | Type of Service Reviewed |
|---|--|---|
| Aetna Health Inc. | <ul style="list-style-type: none"> • Care One National • Magellan Behavioral Health • ACN Group (American Chiropractic Network) | <ul style="list-style-type: none"> • Radiology • Behavioral Health • Chiropractic |
| Atlantis Health Plan, Inc. | <ul style="list-style-type: none"> • CSC (formerly Nichols Txen Corp.) • Health Integrated | <ul style="list-style-type: none"> • Concurrent Reviews • Behavioral Health |
| Capital District Physicians Health Plan (CDPHP) | <ul style="list-style-type: none"> • St. Peters Addiction Recovery Center • ValueOptions | <ul style="list-style-type: none"> • Substance Abuse • Behavioral Health |
| CIGNA Healthcare of New York | <ul style="list-style-type: none"> • CIGNA Behavioral Health • Intracorp | <ul style="list-style-type: none"> • Behavioral Health • Medical/Surgical Benefits |
| Empire Healthchoice HMO, Inc. | <ul style="list-style-type: none"> • Doral Dental Services (CHP Only) • Empire Contracted MD Consultants • Magellan Behavioral Health • Medical Care Management Corp. (MCMC) | <ul style="list-style-type: none"> • Dental • Specialty Reviews • Behavioral Health and Substance Abuse • Outside Specialty Reviews |

| Health Maintenance Organizations | Name of Utilization Review Agent | Type of Service Reviewed |
|--|--|--|
| Excellus Health Plan, Inc. (HMO) | <ul style="list-style-type: none"> • NorthEast Imaging | <ul style="list-style-type: none"> • Radiology |
| Excellus Health Plan, Inc. (HMO Blue) (BCBS Utica Watertown) | <ul style="list-style-type: none"> • NorthEast Imaging | <ul style="list-style-type: none"> • Radiology |
| Excellus Health Plan, Inc. (Univera-CNY) | <ul style="list-style-type: none"> • Landmark Healthcare Services, Inc. | <ul style="list-style-type: none"> • Chiropractic |
| GHI HMO Select, Inc. | <ul style="list-style-type: none"> • Alignis • CareCore National • Doral Dental • Express Scripts • Magellan Behavioral Health • ValueOptions | <ul style="list-style-type: none"> • Chiropractic and Physical Therapy • Radiology • Dental • Pharmacy • Behavioral Health • Mental Health and Substance Abuse |
| Health Net of New York, Inc. (formerly Physicians Health Services, Inc.) | <ul style="list-style-type: none"> • Coordinated Care Solutions (CCS) • Landmark Healthcare Services, Inc. • Managed Health Network (MHN) • National Imaging Associates (NIA) | <ul style="list-style-type: none"> • Home Care and Skilled Nursing Facilities • Chiropractic, Occupational Therapy and Physical Therapy • Behavioral Health • Radiology |
| HealthNow New York Inc. (Community Blue) (HMO of BCBS NENY) | <ul style="list-style-type: none"> • APS Healthcare • National Imaging Associates (NIA) • Prism Health Networks | <ul style="list-style-type: none"> • Behavioral Health and Substance Abuse • Radiology • Chiropractic |
| Health Insurance Plan of Greater New York, Inc. (HIP) | <ul style="list-style-type: none"> • Care Core • National Care Continuum • Geriatrix • Lenox Hill • Monefiore CMO • Health Care Partners • Partners in Health • Prism Health Network • Urban Dental Mgmt. | <ul style="list-style-type: none"> • Medical /Surgical Benefits • Medical/Surgical Benefits • Dental |
| MDNY Healthcare, Inc. | <ul style="list-style-type: none"> • HAYES Plus, Inc. | <ul style="list-style-type: none"> • Outside Specialty Reviews |
| MVP Health Plan, Inc. | <ul style="list-style-type: none"> • CORE • Medical Care Management Corp. (MCMC) | <ul style="list-style-type: none"> • Outside Specialty Reviews • Outside Specialty Reviews |

| Health Maintenance Organizations | Name of Utilization Review Agent | Type of Service Reviewed |
|---|---|---|
| Oxford Health Plans of New York, Inc. | <ul style="list-style-type: none"> • CareCore National • Orthonet • TRIAD Healthcare | <ul style="list-style-type: none"> • Radiology • Physical Therapy • Chiropractic |
| United Healthcare of New York, Inc. | <ul style="list-style-type: none"> • Medical Care Management Corp. (MCMC) • Medical Review Institute • National Medical Review | <ul style="list-style-type: none"> • Outside Specialty Reviews • Medical/Surgical Benefits • Medical/Surgical Benefits |
| Vytra Health Plans Long Island, Inc. | <ul style="list-style-type: none"> • ACCESS Managed Health | <ul style="list-style-type: none"> • Chiropractic |
| Wellcare of New York, Inc. | <ul style="list-style-type: none"> • Health Integrated • Urban Dental Mgmt. | <ul style="list-style-type: none"> • Behavioral Health • Dental |

| Non-Profit Indemnity Insurers | Name of Utilization Review Agent | Type of Service Reviewed |
|--|--|--|
| Excellus Health Plan, Inc. (BCBS CNY) | <ul style="list-style-type: none"> • NorthEast Imaging | <ul style="list-style-type: none"> • Radiology |
| Excellus Health Plan, Inc. (BCBS Utica Watertown) | <ul style="list-style-type: none"> • NorthEast Imaging | <ul style="list-style-type: none"> • Radiology |
| Group Health Incorporated (GHI) | <ul style="list-style-type: none"> • Alignis • CareCore National • HAYES Plus, Inc. • Medical Care Management Corp. (MCMC) • ValueOptions | <ul style="list-style-type: none"> • Chiropractic • Radiology • Outside Specialty Reviews • Outside Specialty Reviews • Behavioral Health |
| HealthNow New York Inc. (Traditional Blue Indemnity) | <ul style="list-style-type: none"> • APS Healthcare • National Imaging Associates (NIA) • Prism Health Networks | <ul style="list-style-type: none"> • Behavioral Health and Substance Abuse • Radiology • Chiropractic |
| Vytra Health Services, Inc. | <ul style="list-style-type: none"> • ACCESS Managed Health | <ul style="list-style-type: none"> • Chiropractic |

| Commercial Insurers | Name of Utilization Review Agent | Type of Service Reviewed |
|--|--|--|
| Aetna Life Insurance Company | <ul style="list-style-type: none"> • ACN Group (American Chiropractic Network) • CareCore National • Magellan Behavioral Health | <ul style="list-style-type: none"> • Chiropractic • Radiology • Behavioral Health |
| Connecticut General Life Insurance Company | <ul style="list-style-type: none"> • Intracorp • CIGNA Behavioral Health | <ul style="list-style-type: none"> • Appeals • Behavioral Health |

| Commercial Insurers | Name of Utilization Review Agent | Type of Service Reviewed |
|---|---|--|
| Empire Healthchoice Inc. | <ul style="list-style-type: none"> • Magellan Behavioral Health • Medical Care Management Corp. (MCMC) • Empire Contracted MD Consultants | <ul style="list-style-type: none"> • Behavioral Health and Substance Abuse • Outside Specialty Reviews • Medical Management |
| Health Net Insurance of New York, Inc. | <ul style="list-style-type: none"> • Coordinated Care Solutions (CCS) • Landmark Healthcare Services, Inc. • Managed Health Network (MHN) • National Imaging Associates (NIA) | <ul style="list-style-type: none"> • Home Care and Skilled Nursing Facilities • Chiropractic • Behavioral Health • Radiology |
| Oxford Health Plans of New York, Inc. | <ul style="list-style-type: none"> • CareCore National • Orthonet • TRIAD Healthcare | <ul style="list-style-type: none"> • Radiology • Physical Therapy • Chiropractic |
| UniCARE Life & Health Insurance Company | <ul style="list-style-type: none"> • Cost Care, Inc. d/b/a Unicare Cost Care | <ul style="list-style-type: none"> • Pre-hospital, Concurrent, and Transplant Review |
| United Healthcare Insurance Company | <ul style="list-style-type: none"> • Medical Care Management Corp. (MCMC) • Medical Review Institute • National Medical Reviews | <ul style="list-style-type: none"> • Outside Specialty Reviews • Medical/Surgical Benefits • Medical/Surgical Benefits |

| Prepaid Health Service Plans | Name of Utilization Review Agent | Type of Service Reviewed |
|-------------------------------------|--|---|
| Affinity Health Plan | <ul style="list-style-type: none"> • Block Vision • Healthplex • Landmark Healthcare Services, Inc. • ValueOptions | <ul style="list-style-type: none"> • Vision • Dental • Chiropractic • Behavioral Health |

| Municipal Cooperative Health Benefit Plans | Name of Utilization Review Agent | Type of Service Reviewed |
|--|--|---|
| Catskill Area Schools Employees Benefit Plan | <ul style="list-style-type: none"> • Corporate Care Management | <ul style="list-style-type: none"> • All Utilization Review |
| Cayuga-Onondaga Area School Employees' Healthcare Plan | <ul style="list-style-type: none"> • Corporate Care Management | <ul style="list-style-type: none"> • All Utilization Reviews |
| State-Wide Schools Cooperative Health Plan (SWSCHP) | <ul style="list-style-type: none"> • Empire Contracted MD Consultants • Magellan Behavioral Health • Medical Care Management Corp. (MCMC) | <ul style="list-style-type: none"> • Specialty Reviews • Behavioral Health and Substance Abuse • Outside Specialty Reviews |

Federal Utilization Review and Grievance Requirements

Several years after New York's utilization review and grievance requirements became effective, the federal government promulgated a regulation establishing claim processing standards for self-insured plans and for state regulated HMOs and insurers that provide fully-insured group health insurance coverage. This regulation, 29 CFR §2560.503-1, was promulgated by the United States Department of Labor, Employee Benefits Security Administration (DOL) and preempts state law to the extent that state utilization review, grievance, and prompt payment requirements prevent the application of a federal requirement.

In order to determine whether state law prevents the application of a federal requirement, each standard and timeframe must be compared since some New York requirements are more stringent than the DOL requirements while others are not as stringent. In 2003, the Insurance Department continued to receive questions as to how certain New York and DOL standards should be applied, as well as submissions from health plans for compliance with the combined requirements. Questions also arose because the DOL regulation contemplates one claim processing procedure, while New York has two separate procedures, a grievance procedure and a utilization review procedure.

The following issues arose in 2003 with respect to the integration of state and federal requirements:

Denials for lack of information: Under New York law, a health plan is not required to render a medical necessity determination until all necessary information is received. However, the DOL regulation requires a health plan to make a determination regardless of whether the information is received, but does not identify what type of denial it should be since the DOL regulation does not separate claims into grievances and utilization review determinations. Given that New York State law distinguishes between claims for services that are covered if determined to be medically necessary and other types of claims, the Insurance Department and Health Department have advised plans that if a service would otherwise be covered under a contract and medical necessity cannot be established due to a lack of information, the denial must be considered a medical necessity denial, with the attendant Article 49 internal utilization review and external appeal rights.

Combining a request for information with a denial: Health plans have questioned whether they may combine a written request for additional clinical information with a notice of adverse determination, so that if the information is not received, the services are automatically denied without further notice. The Department of Labor has taken the position that such a practice is permissible under the DOL regulation, however the Insurance Department and Health Department have advised plans that such is not permissible under New York State law.

Reversals of denials: New York State law provides that failure by a health plan to make a utilization review appeal determination within the requisite timeframe is considered to be a reversal of the health plan's adverse determination. The DOL regulation does not include a similar requirement. Issues have been raised as to how this New York requirement is applied if a health plan does not comply with a DOL timeframe but is in compliance with a less stringent New York timeframe, or in the alternative, if a health plan does not comply with a New York timeframe but is in compliance with a less stringent DOL timeframe. The Insurance Department and the Health Department have advised plans that the New York requirement only applies with respect to compliance with New York timeframes.

The Insurance Department and the Health Department will continue to work with health plans on the integration of state and federal requirements. In addition, the Departments are currently evaluating whether regulations are needed to clarify state and federal utilization review and grievance requirements.

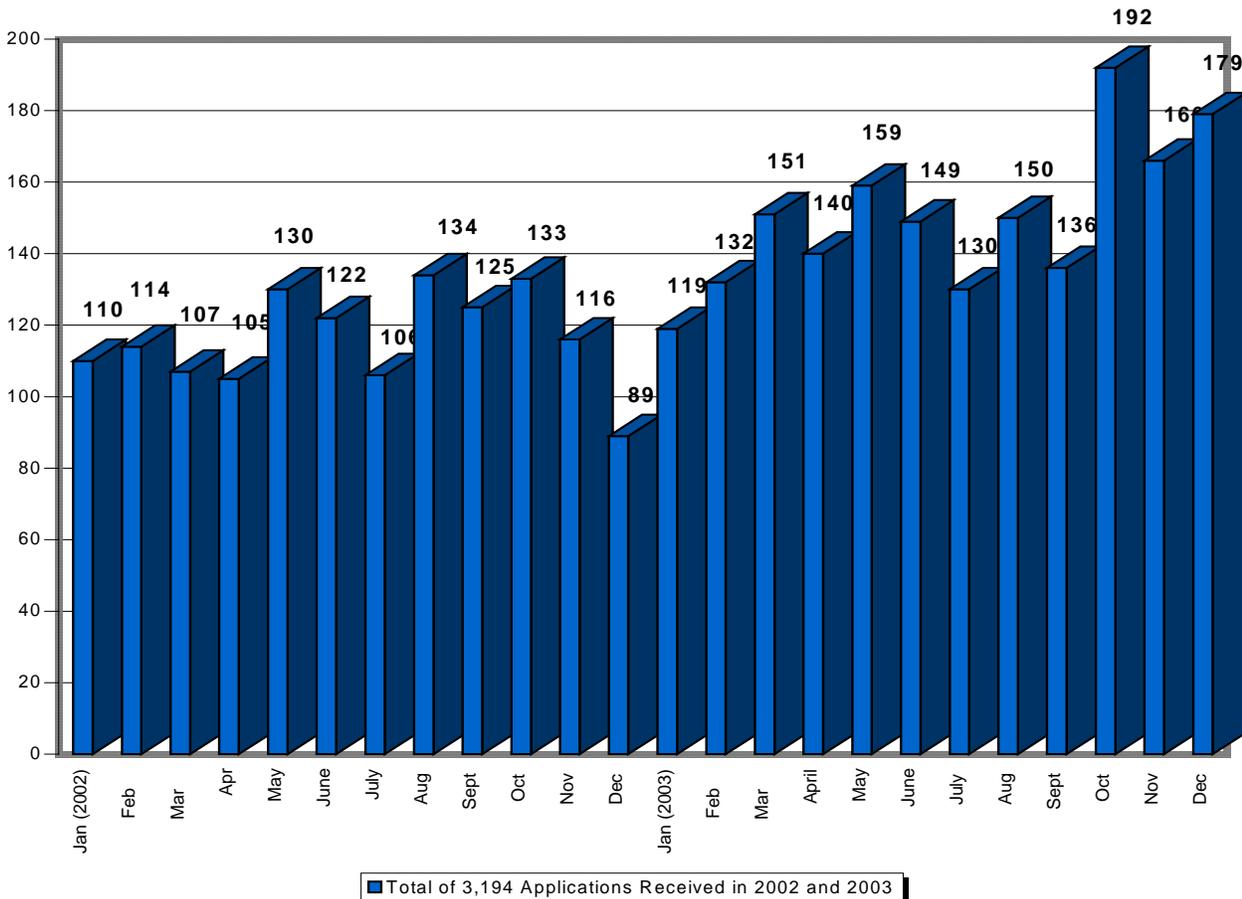
Volume of External Appeal Requests Received by the Insurance Department

When a health plan makes a utilization review determination that services are not medically necessary or are experimental or investigational, the External Appeal Law gives health care consumers the right to obtain an independent review of the determination. Consumers may request an external review by submitting an application to the Insurance Department.

In 2003 the Insurance Department received 1,803 external appeal applications, the largest number of requests since the program's inception. The second highest volume of requests, 1,703 was received in year 2000, and in 2001 and 2002, the number of requests were slightly lower, as 1,546 requests were submitted in 2001 and 1,391 requests were submitted in 2002.

The following chart identifies the number of external appeal requests submitted to the Insurance Department each month in 2002 and 2003.

External Appeal Applications Received by the Insurance Department in 2002 and 2003

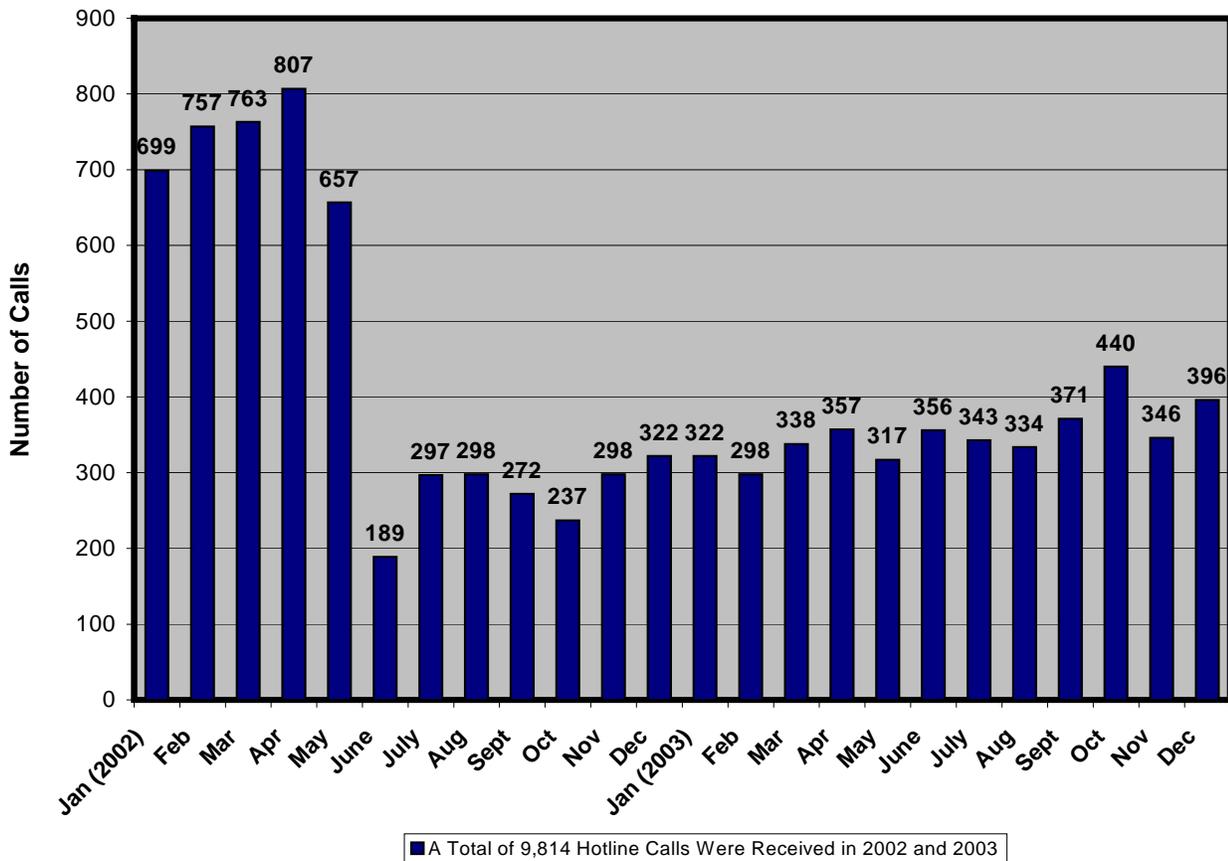


Volume of External Appeal Hotline Calls

The Insurance Department operates an external appeal hotline (1-800-400-8882) to assist consumers in utilizing their external appeal rights. Hotline operators answer any external appeal questions consumers may have and assist consumers in submitting external appeal requests. The hotline is operated by trained and experienced staff from the Insurance Department's Consumer Services Bureau, with back-up assistance provided by attorneys in the Health Bureau. The hotline is staffed Monday through Friday from 9:00 a.m. – 5:00 p.m. If a consumer calls after hours, a message can be left with the answering service that will be responded to the next business day.

The Insurance Department has received and responded to over 20,000 hotline calls since the hotline became operational. The following chart identifies the number of external appeal calls received by the Insurance Department on a monthly basis from January 2002 through December 2003.

**Incoming Calls to the Toll-Free External Appeal Hotline
in 2002 and 2003**



Insurance Department Outreach

In addition to the hotline, the Insurance Department uses several other mechanisms to ensure that consumers are made aware of their external appeal rights. The Department posts external appeal information and external appeal applications on its Web site at www.ins.state.ny.us. This Web site was recently updated to make external appeal information easier to access. The Insurance Department also operates a dedicated mailbox and external appeal questions can be submitted by e-mail to health@ins.state.ny.us.

Along with Department outreach efforts that help make consumers aware of their external appeal rights, there are also requirements in law to ensure that consumers are able to exercise their right to an appeal. The Insurance Department and the Health Department monitor health plan compliance and enforce the following external appeal requirements:

- The External Appeal Law requires health plans to provide external appeal information to prospective subscribers upon request. (Ins. Law §3217-a, §4324, and PHL §4408.)
- The External Appeal Law requires health plan member handbooks and subscriber contracts to include a description of external appeal rights, including the timeframes in which an external appeal must be requested. (Ins. Law §3217-a, §3216, §3221, §4303, §4324 and PHL §4408.)
- The External Appeal Law requires health plans to notify subscribers of their external appeal rights, in writing, at the time any adverse medical necessity, experimental, or investigational determination is rendered. (Ins. Law §4903, §4904, PHL §4903 and §4904.)
- The external appeal regulations require health plans to send external appeal applications to consumers with a final adverse medical necessity, experimental, or investigational treatment determination. (11 NYCRR 410 and 10 NYCRR 98-2.)
- When handling consumer complaints, both the Insurance Department and the Health Department advise complainants of their external appeal rights if the complaint appears to raise issues addressed by the External Appeal Law. In addition, both Departments provide assistance to complainants who would like to file an external appeal request.

Insurance Department Review of External Appeal Requests

External appeal applications are submitted to the Insurance Department using either a dedicated external appeal fax number (1-800-332-2729) or a dedicated Insurance Department Post Office Box. Once an external appeal application is received by the Insurance Department, it is date stamped and the documents are immediately scanned into the Department's computerized tracking system.

Updates to the External Appeal Computer Tracking System:

The most significant external appeal programmatic change in 2003 was to the Insurance Department's computerized tracking system. The computer system used for the external appeal program was originally developed in 1999 to track the status of external appeal applications. After using this system for several years, the Department determined that processes could be improved if the functionality of the system was expanded to allow letters to be automatically generated and applications to be scanned. These improvements were intended to increase efficiency and eliminate the need for paper files.

The first stage of the project began in 2002 when staff developed sample letters that could commonly be used when screening, assigning and closing external appeal files. The letters were integrated into the tracking system and additional information fields were added so that certain information, such as the patient's name, health plan member identification number, and health care provider's name and address, would automatically populate the standard letters. The standard letter generation feature became operational in March 2003, and Department staff can now send requests for information, follow-up letters, appeal assignment letters and closure letters more quickly and efficiently.

The next stage of the project was to establish a paperless system with the ability to scan and store all incoming applications and supporting documentation electronically. This feature was implemented in August 2003 and as a result, each applicant's external appeal file is in one location, accessible only to designated staff, which ensures both confidentiality and the integrity of the file. In addition, the designated staff members are now able to review external appeal requests, supporting documentation, and responses to requests for additional information electronically which facilitates review and promotes efficiency.

The implementation of the automatic letter generation feature and the electronic file storage system has been immensely successful. These improvements have simplified the handling of external appeals and the Department's oversight of the external appeal program.

Disaster Planning and Preparation

The Department's ability to receive and assign external appeal requests is an essential and vital operation. After the widespread blackout that occurred in August of 2003, the Insurance Department further developed and refined its emergency protocols to be utilized in the event of an emergency or disaster situation, to ensure that the External Appeal Program will not be disrupted.

Access to Stored Information: Incoming external appeal applications and supporting documentation are scanned into a computer database. This database allows designated members of the Insurance Department to view a consumer's application or supporting documentation at any time. On a daily basis, the Insurance Department's Systems Bureau backs up all stored information in the Albany external appeal database to a database in the Department's New York City office. In the event of an emergency situation at one location, the information will still be available through back-up at the second location. Designated Insurance Department staff members are also able to access the database off-site through laptops, which would still be operational in the event of an emergency situation such as a power outage.

Accepting External Appeal Applications: An emergency situation, such as a power failure or a systems failure, may impact the Department's ability to receive a faxed external appeal application under the normal procedure. The Insurance Department has therefore made arrangements to ensure that fax machines at alternate locations will be available. In addition, the external appeal application advises applicants to call the Department when an expedited appeal is submitted, so the Insurance Department can provide the applicant with any necessary instructions, including where to send the materials. The Insurance Department also has an arrangement with an answering service with live operators to answer any incoming telephone calls on weekends and holidays or when telephone service is unavailable in the Albany office. The answering service has a list of designated Department staff members to contact when calls are received, who are accessible by cellular telephone and pager.

Assigning Expedited Appeals: When an expedited external appeal is received in an emergency situation, a designated Insurance Department staff member will contact the randomly assigned external appeal agent by telephone to ensure that the agent is capable of receiving the external appeal application and assigning the appeal to a clinical peer for review. If the Insurance Department is unable to transmit the application to the agent by facsimile from the Albany office, the application will be faxed to the agent either by a designated New York City Insurance Department staff member or by using an off-site fax machine. If neither New York City or Albany Insurance Department staff are able to transmit external appeal requests to an agent via facsimile, the Insurance Department has an arrangement in place to have the application hand delivered to one of the certified external appeal agents.

In the event another emergency situation were to occur, the Insurance Department is confident that these emergency protocols will ensure that the External Appeal Program will remain operational and accessible.

External Appeal Eligibility

The Insurance Department is responsible for reviewing external appeal applications for eligibility and completeness and for assigning eligible requests to external appeal agents. The Department's review must be conducted within 24 hours of receipt if the appeal is expedited or within five business days of receipt if the appeal is standard. The Insurance Department considers an external appeal request to be eligible if the following conditions are met:

- **Applicability:**

- ✓ Services must have been denied as not medically necessary or as experimental or investigational. Other types of coverage determinations, such as a denial because the patient has a pre-existing condition, the benefit is not covered under the insurance policy, or the patient is requesting a referral to a non-participating provider, are not eligible for external appeal.
- ✓ The patient must be covered under a fully insured health insurance contract. The External Appeal Law is not applicable to self-insured coverage, Medicaid fee-for-service coverage, and Medicare coverage, including coverage provided by Medicare managed care plans.

- **Timeliness:**

- ✓ An external appeal application must be submitted to the Insurance Department within 45 days of receipt of the final adverse determination from the first level of internal appeal with the health plan or receipt of notice that the health plan agreed to waive the internal appeal process.
- ✓ The Insurance Department presumes that the final adverse determination was received within 8 days of the date on the determination, unless otherwise demonstrated, so that the applicant has 53 days (45 plus an additional 8 days) to initiate an external appeal.

- **Completeness:**

- ✓ The application must be signed. The patient, a parent if the patient is a minor, a guardian, or if the patient is deceased, the administrator or executor of a patient's estate, must sign the application.
- ✓ A copy of the final adverse determination must be included with the external appeal request.
- ✓ If services were denied as experimental or investigational, the patient's attending physician must complete the attestation portion of the external appeal application and attach two articles of medical and scientific evidence. If the appeal is for a clinical trial, it is also recommended that the physician submit the clinical trial protocols.

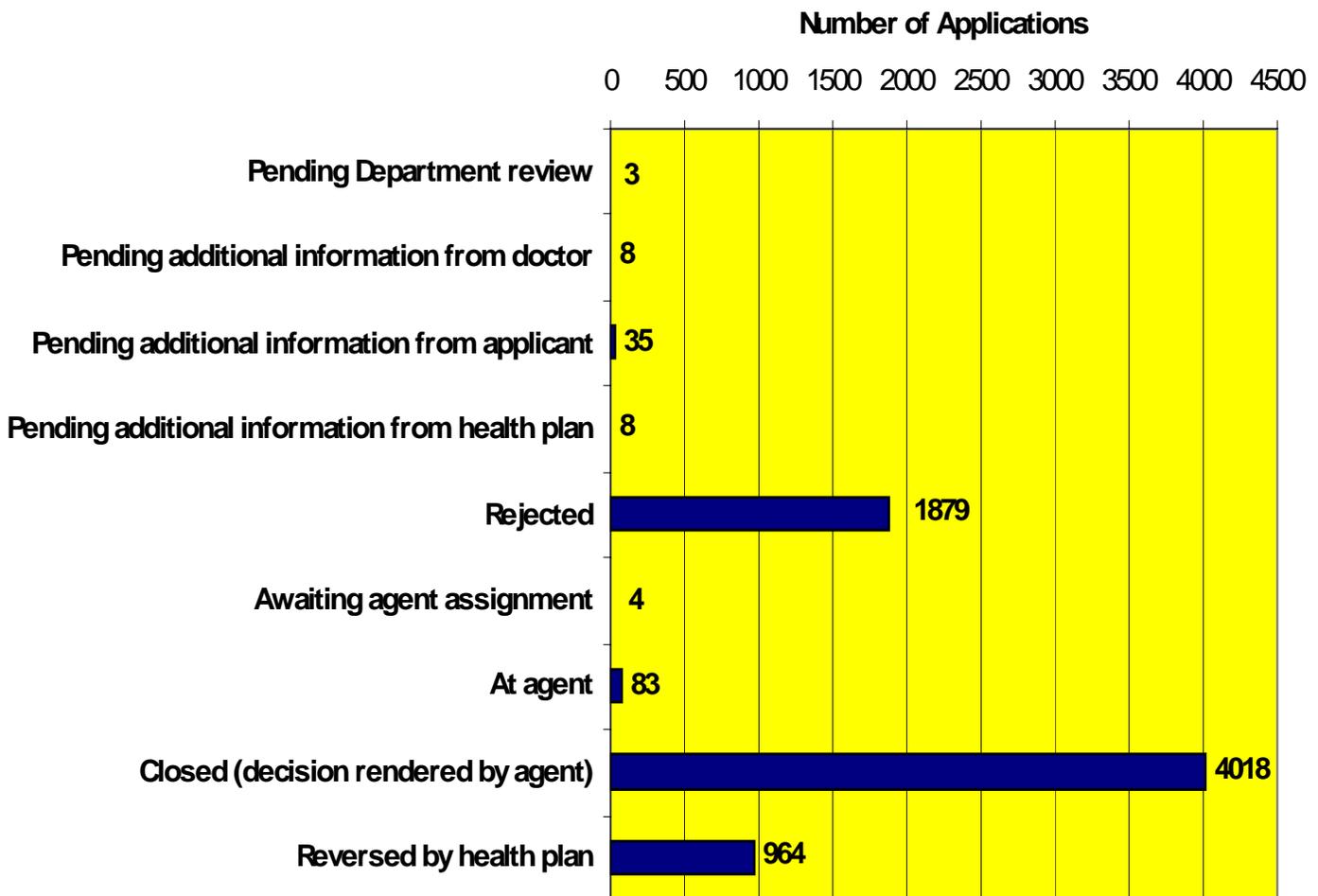
- ✓ If an expedited appeal is requested, the patient's attending physician must complete the attestation portion of the external appeal application and affirm that the patient has not received the requested service and that a delay would pose an imminent or serious threat to the health of the patient.

- ✓ The \$50.00 external appeal fee must be submitted, if required by the health plan. The fee is automatically waived for patients covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee would pose a hardship. The fee is returned to the applicant if the external appeal agent overturns the health plan's denial in whole or in part, or forwarded to the health plan if the denial is upheld.

Status of External Appeal Requests Submitted to the Insurance Department

Since July 1, 1999 the Insurance Department has been tracking all external appeal requests that it receives. External appeal requests are assigned an identification number and a status code. The identification number remains the same, however, the status code is automatically updated as the status of the request changes. Status codes identify whether the application is pending Insurance Department review, pending receipt of additional information, awaiting agent assignment, under review by an external appeal agent, rejected, reversed by a health plan, or closed because an external appeal agent rendered a decision. The following chart identifies the status of all external appeal requests submitted to the Insurance Department as of December 31, 2003.

Status of External Appeal Applications Received by the Insurance Department as of December 31, 2003



Rejection of External Appeal Requests

External appeal requests that are statutorily ineligible for external appeal are rejected by the Insurance Department and returned to the applicant. An external appeal request will be rejected for the following reasons:

- If services were not denied on the basis of medical necessity or because the services were considered experimental or investigational.
- If the patient has coverage that is exempt from the New York external appeal requirements, such as self-insured coverage, Medicaid fee-for-service coverage, or Medicare coverage.
- If the applicant does not submit an application within the 45 day time frame for requesting an external appeal.
- If an external appeal application is incomplete and the missing information is not provided to the Insurance Department after two requests are made for the information.
 - ✓ An external appeal request is considered to be incomplete if the application is not signed, if the final adverse determination is not provided, if a fee is required and not submitted, or if the appeal is for experimental or investigational services and the attending physician attestation has not been completed.
 - ✓ If an application is incomplete, the Insurance Department will request the missing information from the applicant and, as appropriate, from the applicant's attending physician, and allow two weeks for a response.
 - ✓ If a response is not provided, the Insurance Department will make a second request for the information. If a response is not provided to the second request, the application will be rejected.
- When an application is rejected, the applicant is advised that although the request is ineligible for external appeal, the Insurance Department's Consumer Services Bureau is available to investigate the health plan's denial, and will do so upon the applicant's request. If federal law applies to the applicant's coverage, instead of New York State law, the Insurance Department will also provide information on Medicare appeal rights or rights under self-insured plans, as applicable.

Since the beginning of the external appeal program in July of 1999, 1,879 external appeal requests have been rejected as ineligible for external appeal. During the past two years, 392 external appeal requests were rejected in 2002 and 452 requests were rejected in 2003. The most frequent reason for rejection of external appeal requests had been that the application was incomplete and the applicant did not provide the missing information after two requests were made by the Insurance Department. However, this year there was a significant increase in the number of requests rejected because the application was not submitted within the 45 day timeframe. In fact, almost half of the rejected applications in 2003 were rejected because they were incomplete or untimely.

The following chart identifies the number of external appeal requests that have been rejected in New York in calendar years 2002 and 2003 and lists the reasons for rejection.

| Reasons for Rejection of External Appeal Requests in New York | | |
|---|-------------|-------------|
| | 2003 | 2002 |
| Applicant did not provide missing information: | 101 | 91 |
| • Physician attestation for experimental/investigational appeal. | 18 | 12 |
| • Health plan denial letter. | 11 | 9 |
| • Check or money order. | 2 | 6 |
| • Patient did not submit external appeal request and did not confirm interest in pursuing an external appeal. | 4 | 6 |
| • Consent form. | 1 | 5 |
| • An application. | 5 | 2 |
| • More than one of the above items missing. | 60 | 51 |
| Application was not submitted within the 45 day time frame. | 101 | 65 |
| Self-insured coverage. | 70 | 35 |
| Applicant did not first appeal the denial with the health plan. | 44 | 40 |
| Denial was for a benefit that was not covered under the contract. | 36 | 47 |
| Provider ineligible to request an external appeal. | 20 | 22 |
| CPT code, UCR, or level of reimbursement dispute. | 14 | 14 |
| Denial for a referral to a non-participating provider. | 14 | 7 |
| Attending physician attestation for experimental/investigational appeal did not meet the requirements of law. | 10 | 24 |
| Applicant withdrew external appeal request. | 10 | 25 |
| Out-of-state insurance policy. | 8 | 2 |
| Medicare managed care coverage. | 7 | 3 |
| Federal employee coverage or United States military coverage. | 5 | 6 |
| Denial for a failure to request pre-authorization. | 3 | 6 |
| Complaints relating to eligibility, termination, premiums, and administration of contract. | 6 | 3 |
| Duplicate applications submitted. | 2 | 2 |
| Worker's compensation claim. | 0 | 0 |
| Member pursued a Medicaid Fair Hearing instead of an external appeal. | 1 | 0 |
| Total | 452 | 392 |

Reversals by Health Plans

An appeal may also be closed during the external appeal process because a health plan reverses its adverse determination before a decision is rendered by an external appeal agent. Some denials are reversed by a health plan when an external appeal is initially requested, while others are reversed because new information is submitted with the external appeal request.

From the program's inception in July, 1999 through December 31, 2003, 961 appeals were closed during the appeal process because a health plan reversed its adverse determination before the external appeal agent rendered a determination. In the past two years, 239 appeals were reversed in 2003 and 159 were reversed in 2002.

| Health Maintenance Organizations | Health Plan Reversals in 2003 | Health Plan Reversals in 2002 |
|--|-------------------------------|-------------------------------|
| Aetna Health Inc. | 0 | 2 |
| Atlantis Health Plan, Inc. | 11 | 0 |
| Capital District Physicians' Health Plan, Inc. (CDPHP) | 9 | 5 |
| CIGNA Healthcare of New York, Inc. | 1 | 1 |
| Empire Healthchoice HMO, Inc. | 6 | 2 |
| Excellus Health Plan, Inc. (BlueChoice HMO of BCBS Rochester) | 0 | 1 |
| Excellus Health Plan, Inc. (HMO-CNY) | 0 | 2 |
| Excellus Health Plan, Inc. (Univera-CNY) | 1 | 0 |
| Excellus Health Plan, Inc. (Univera-WNY) | 5 | 8 |
| GHI HMO Select, Inc. | 4 | 2 |
| HealthNow New York, Inc. (HMO of BCBS of NENY) (Community Blue) | 7 | 4 |
| Health Net of New York, Inc. (formerly Physicians Health Services, Inc.) | 21 | 7 |
| Health Insurance Plan of Greater NY, Inc. (HIP) | 3 | 4 |
| Independent Health Association, Inc. | 0 | 0 |
| MDNY Healthcare, Inc. | 1 | 0 |
| MVP Health Plan, Inc. | 6 | 0 |
| Oxford Health Plans of New York, Inc. | 59 | 46 |
| Rochester Area HMO, Inc. (Preferred Care) | 1 | 1 |

| Health Maintenance Organizations | Health Plan Reversals in 2003 | Health Plan Reversals in 2002 |
|--|--------------------------------------|--------------------------------------|
| United Healthcare Plan of New York, Inc. | 5 | 1 |
| Vytra Health Plans Long Island, Inc. | 0 | 1 |
| Total | 140 | 87 |

| Non-Profit Indemnity Insurers | Health Plan Reversals in 2003 | Health Plan Reversals in 2002 |
|---|--------------------------------------|--------------------------------------|
| Excellus Health Plan, Inc. (BCBS CNY) | 3 | 4 |
| Excellus Health Plan, Inc. (BCBS Rochester) | 5 | 2 |
| Excellus Health Plan, Inc. (BCBS Utica Watertown) | 1 | 1 |
| Group Health Incorporated (GHI) | 44 | 34 |
| HealthNow New York Inc. (Traditional Blue) | 2 | 3 |
| Total | 55 | 44 |

| Commercial Insurers | Health Plan Reversals in 2003 | Health Plan Reversals in 2002 |
|--|--------------------------------------|--------------------------------------|
| Aetna U.S. Healthcare (Prudential HealthCare) | 0 | 1 |
| Aetna Life Insurance Company | 0 | 1 |
| Connecticut General Life Insurance Company | 1 | 1 |
| Empire Healthchoice Inc. | 19 | 16 |
| GE Financial Assurance | 1 | 0 |
| Gerber Life Insurance Company | 1 | 0 |
| Guardian Life Insurance Company of America | 0 | 1 |
| Horizon Healthcare Insurance Company of New York | 0 | 0 |
| Metropolitan Life | 1 | 0 |
| Mutual of Omaha | 0 | 0 |
| Oxford Health Plan | 6 | 0 |
| UniCARE Life & Health Insurance Company | 0 | 1 |
| United HealthCare Life Insurance Company of New York | 13 | 4 |
| Total | 42 | 25 |

| Medicaid Managed Care Plans | Health Plan Reversals in 2003 | Health Plan Reversals in 2002 |
|------------------------------------|--------------------------------------|--------------------------------------|
| Affinity Health Plan | 0 | 0 |
| Americhoice of New York, Inc. | 0 | 0 |
| Buffalo Community Health Inc. | 0 | 1 |
| Centercare Inc. | 1 | 0 |
| HealthPlus PHSP | 0 | 0 |
| Metroplus Health Plan | 1 | 0 |
| New York-Presbyterian CHP | 0 | 1 |
| Total | 2 | 2 |

| Municipal Cooperative Health Benefit Plans | Health Plan Reversals in 2003 | Health Plan Reversals in 2002 |
|--|--------------------------------------|--------------------------------------|
| Catskill-Area School Employee Benefit Plan | 0 | 0 |
| Cayuga-Onondaga Area School Employees' Healthcare Plan | 0 | 0 |
| State Wide Schools Cooperative Health Plan | 0 | 1 |
| Total | 0 | 1 |

Certification of External Appeal Agents

External appeal agents are certified by the Insurance Department and the Health Department for two-year periods and must meet the following certification standards:

- External appeal agents must have a comprehensive network of clinical peer reviewers available to review a health plan's denial of services.
- Clinical peer reviewers must be appropriately licensed and trained in New York external appeal standards.
- External appeal agents must assign appeals to a clinical peer in the same or similar specialty as the health care provider that typically manages the medical condition or provides the treatment that is the subject of the appeal, so that cases will be reviewed by a qualified and impartial provider in the appropriate specialty.
- External appeal agents must appoint a medical director who is responsible for oversight of the external appeal process.
- External appeal agents must have policies and procedures in place to protect confidentiality and must have a quality assurance program.
- External appeal agents must have mechanisms in place to ensure that appeal decisions are made within the required time frames.
- External appeal agents and clinical peer reviewers must be independent from the health plan and any party involved in the appeal so that there is no conflict of interest. External appeal agents and their clinical peer reviewers are prohibited from having a material professional affiliation, a material financial affiliation, or a material familial affiliation with the health plan, patient, provider, or facility involved in the external appeal. External appeal agents are also prohibited from accepting an appeal if they previously reviewed the case in connection with the health plan's internal appeal procedure.

Currently there are three certified external appeal agents that review external appeals in New York. The agents are Medical Care Management Corporation (MCMC), certified on July 2, 1999, recertified on July 1, 2001, and recertified again on July 1, 2003; Island Peer Review Organization (IPRO), certified on June 30, 1999, recertified on July 1, 2001, and recertified again on July 1, 2003; and Hayes Plus, certified on June 21, 2001, and recertified on July 1, 2003. As part of the recertification process, each of the agents provided a description of any policies and procedures that have changed since the previous certification, along with a description of any changes in the agent's network of clinical peer reviewers. The agents also provided a plan of correction for any deficiencies the Departments identified during the recertification process.

External Appeal Agent Review

The standard of review that an external appeal agent utilizes when assigned to a particular case is established by law and varies depending on whether services have been denied as not medically necessary, experimental, investigational, or because the services are provided in a clinical trial. When reviewing a medical necessity denial, an external appeal agent must make a determination as to whether the health plan acted reasonably, with sound medical judgement and in the best interest of the patient. An external appeal agent must consider the clinical standards of the plan, the information provided concerning the patient, the attending physician's recommendation, and applicable and generally accepted practice guidelines.

When reviewing an appeal of experimental or investigational services, an external appeal agent must consider the medical and scientific evidence, the patient's medical record and any other pertinent information and determine whether the proposed service is likely to be more beneficial than any standard treatment. If the appeal involves a clinical trial, an external appeal agent must review the patient's medical record and any other pertinent information and determine whether the clinical trial is likely to benefit the patient. Typically, external appeal agents assign one clinical peer to review medical necessity denials and three clinical peers to review appeals of experimental or investigational treatments.

If a patient's attending physician attests that a delay would pose an imminent or serious threat to the health of the patient, the appeal will be expedited, and the agent must issue a decision in three days. If the appeal is not expedited, the external appeal agent must issue a decision within 30 days, unless the agent needs additional information, and then the agent will have five additional business days to render a determination.

An external appeal agent must notify the health plan, the patient, and as appropriate, the patient's provider of the determination by telephone or facsimile if the appeal is expedited, with written notification to follow. If the appeal is not expedited, notification must be provided in writing within two days from when the decision is rendered. The decision of the external appeal agent is subject to the terms and conditions of the patient's coverage with the health plan, such as cost sharing requirements or maximum visit limits. The decision of the external appeal agent is also binding on the parties, but admissible in court proceedings.

The Insurance Department has received complaints from patients and health plans in relation to external appeal agent determinations. The Department investigates all complaints to ensure the appeal was conducted in compliance with statutory and regulatory requirements. The Department received 20 complaints in 2001, 31 complaints in 2002 and 46 complaints in 2003. The types of complaints most frequently received related to an applicant's disagreement with either the external appeal agent's decision or with the specialty of the clinical peer assigned by the agent to review the appeal.

Perspective of New York's External Appeal Agents

This year when preparing the 2003 external appeal annual report, the Insurance Department sought input from New York's three certified external appeal agents. The Insurance Department requested that each agent respond to questions regarding external appeal trends, differences in state programs, and suggested improvements for the New York State External Appeal Program. The following is a discussion of our questions and agent responses.

We asked agents to identify the types of health care services they are most frequently asked to review in New York and in other states and the agents identified the following:

- Inpatient hospital stays.
- Mental health treatment.
- Surgery.
- Physical therapy.

We asked agents whether they noticed any increases in types of external appeal cases or in unique types of cases in New York and in other states. The agents noted increases in the following:

- Gastric surgery procedures for morbid obesity.
- Expanded requests for MRI, particularly in cancer diagnoses.
- Dynamic Orthotic Cranioplasty (DOC band).
- Extracorporeal shock wave therapy for the treatment of plantar fasciitis.
- Kyphoplasty for compression fractures of extended duration with failure of non-invasive modalities.
- Prescription drug treatments.
- Treatment for varicose veins, including surgery.
- Uses for the tinnitus restraining helmet.
- C-leg prostheses.
- Home anticoagulation therapy monitoring devices.
- Surgery to remove excess skin after weight loss.
- Pediatric speech therapy.
- Emergency room denials.
- Assistant surgeon use.
- Private duty and skilled nursing.
- Alternative type services, especially in states other than New York.

We asked agents whether they noticed any decreases in types of external appeal cases in New York and in other states. The agents responded that they have noticed decreases in appeals for the following treatments:

- Aggressive surgical, transplant, and chemotherapy procedures for the treatment of cancer, with one agent suggesting that health plans were resolving those cases in their internal appeals process.
- Appeals for Intradiscal Electrothermal Therapy (IDET).
- Cases involving long-term antibiotic therapy for Lyme disease.

We asked agents whether the medical records received for NY appeals are thorough and complete.

- One agent indicated that patient medical records frequently lack sufficient clinical information, particularly with regard to the length of inpatient hospital stays.
- Another agent noted increases in cases in which patient medical information is submitted with the patient's external appeal application that was never provided to the health plan, during the health plan's internal appeal process. In these cases, the agent must forward the medical records to the health plan and the health plan is provided three days to consider whether to overturn its denial. The agent also noted that there is only one other state in which it conducts reviews that has a similar requirement.

We asked agents to describe what makes the New York External Appeal Program unique from the external appeal programs of other states and we received the following responses:

- Unlike other states in which one agent conducts reviews, New York is the only state in which medical necessity governs decisions, as opposed to an insurer's review criteria.
- Patients and providers have more involvement in the New York appeals process than in other states, and the New York State Insurance Department is proactive in assisting consumers with external appeal requests.
- The New York external appeal process is highly structured, as compared to other states; for example, deadlines are outlined for most phases of the process.
- The New York Insurance Department is very responsive to any problems or issues regarding cases, as compared to other states.
- Two external appeal agents noted that in New York they are instructed to request medical records from health plans, patients, and providers. However, most other states only require that agents request information from the patient's health plan.
- Unlike other states, New York law requires that clinical peers must practice in their area of specialty for at least five years.
- Two agents advised that New York's standard of review for experimental or investigational treatments is different from most other states. In New York, agents must consider whether the proposed experimental or investigational service is likely to be more beneficial than any standard treatment. These agents advised that in other states they are only asked to make a determination as to whether the services are in fact experimental or investigational. One agent also mentioned that New York is the only state in which it conducts reviews that has a separate standard of review for clinical trial cases, which is whether the trial is likely to benefit the patient. In addition, one agent noted that most other states do not require the use of three clinical peers for experimental, investigational, or clinical trial cases.

- One agent noted a higher number of expedited cases in New York than in other states.

We asked the agents to provide suggestions for improvement of the New York External Appeal Program for our consideration and we received the following responses:

- Strengthen the attending physician attestation requirements and the Insurance Department's ability to enforce standards for expedited reviews. The agents advised that expedited appeals are requested in cases when processing the appeal within the standard timeframes would not present an imminent threat to the patient's health. One agent also suggested the addition of an "urgent" or "rush" category for case reviews for those patients who do not fit the expedited category where a decision is needed in three days, yet due to the clinical circumstances do not want to wait 30 days for a standard review to be performed.
- Increase education efforts to facilities and providers regarding the necessity of providing medical record documentation to health plans and external appeal agents.
- Revise the external appeal application to include the patient's age and diagnosis.
- Ensure that health plan final adverse determination letters are not confusing. Agents mentioned that some letters do not clearly explain what is being denied, especially in length of hospital stay cases and in cases when services are described by CPT code.

We asked agents what challenges they have encountered in performing external reviews in New York. The overwhelming response we received from agents was that they have been experiencing difficulties in obtaining patient medical records.

- In New York, health plans are statutorily required to provide patient medical records to external appeal agents. The Insurance Department has also instructed external appeal agents to request patient medical records from the patient's provider.
- External appeal agents have noted an increase in the number of cases in which health plans were unable to provide the patient's medical records to the external appeal agent, citing a failure by the patient's provider to forward the records to the health plan during the plan's internal appeal process, coupled with the new federal requirements for health plans to make determinations regardless of whether necessary information is submitted.
- One agent noted difficulty in obtaining medical documentation from health care providers and facilities within the three day timeframe for expedited reviews.

- The agents indicated that some hospitals have not been accepting a patient's consent to the release of medical information form from the external appeal application and are requiring that patients sign a facility-specific form. Given this added requirement, some patient medical records have not been submitted to the external appeal agent within the requisite timeframe for the agent to be able to consider the information.
- Another agent noted that when it obtains information that a health plan has not had an opportunity to review, the agent must forward this new information to the health plan and allow the health plan three business days to determine whether to uphold or overturn its denial. This agent expressed concern that this requirement diminishes the time the agent's clinical peers have to review the appeal.
- In addition to concerns relating to patient medical records, one agent also indicated that appropriately documenting the review determination is a different mindset for many clinical peers and requires a great deal of training to ensure that its clinical peers are aware of what must be addressed to comply with requirements for New York appeals.

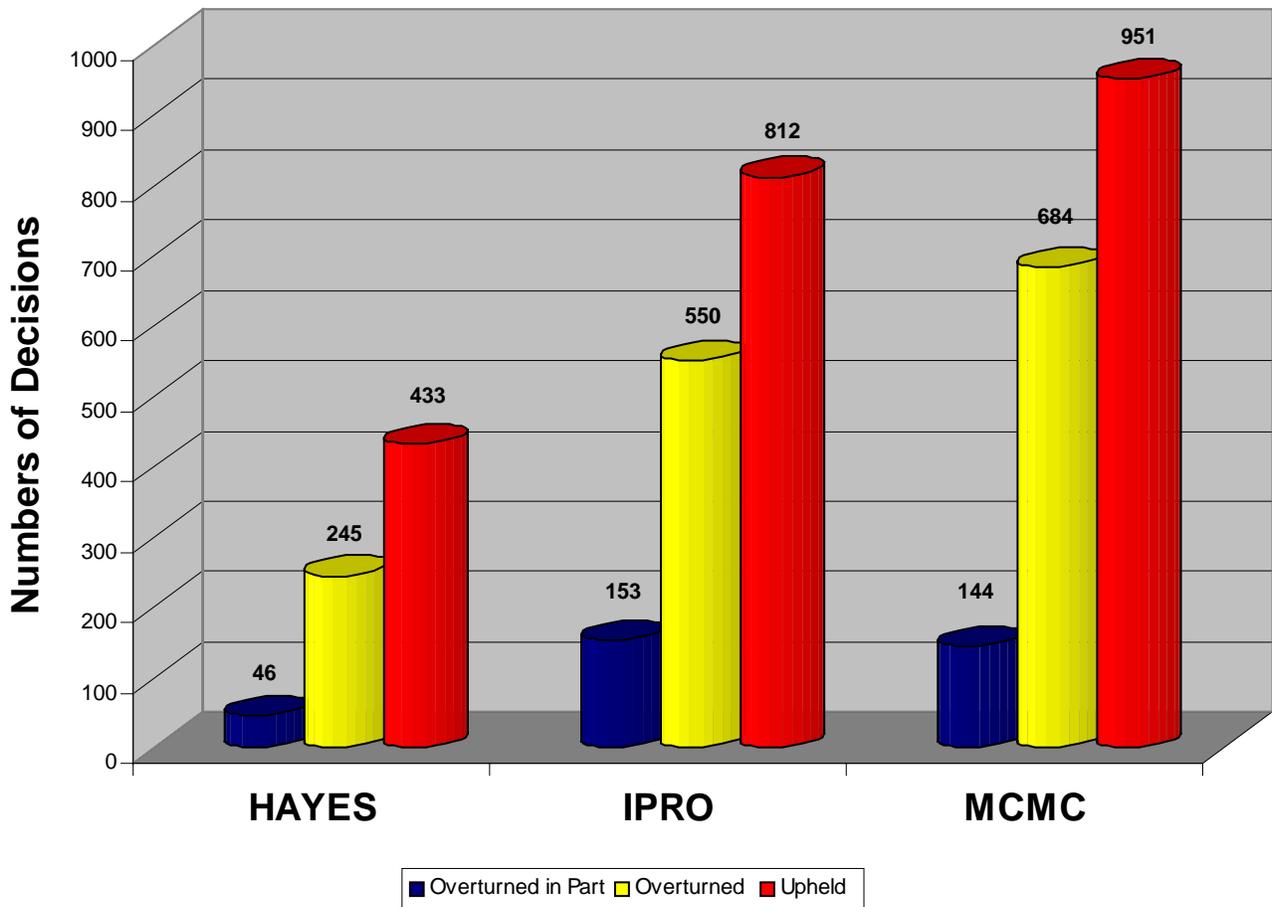
External Appeal Agent Decisions

The Insurance Department randomly assigns appeals to external appeal agents and provides all information submitted with the application to the agent once the Department verifies that the agent does not have a conflict of interest with respect to the appeal.

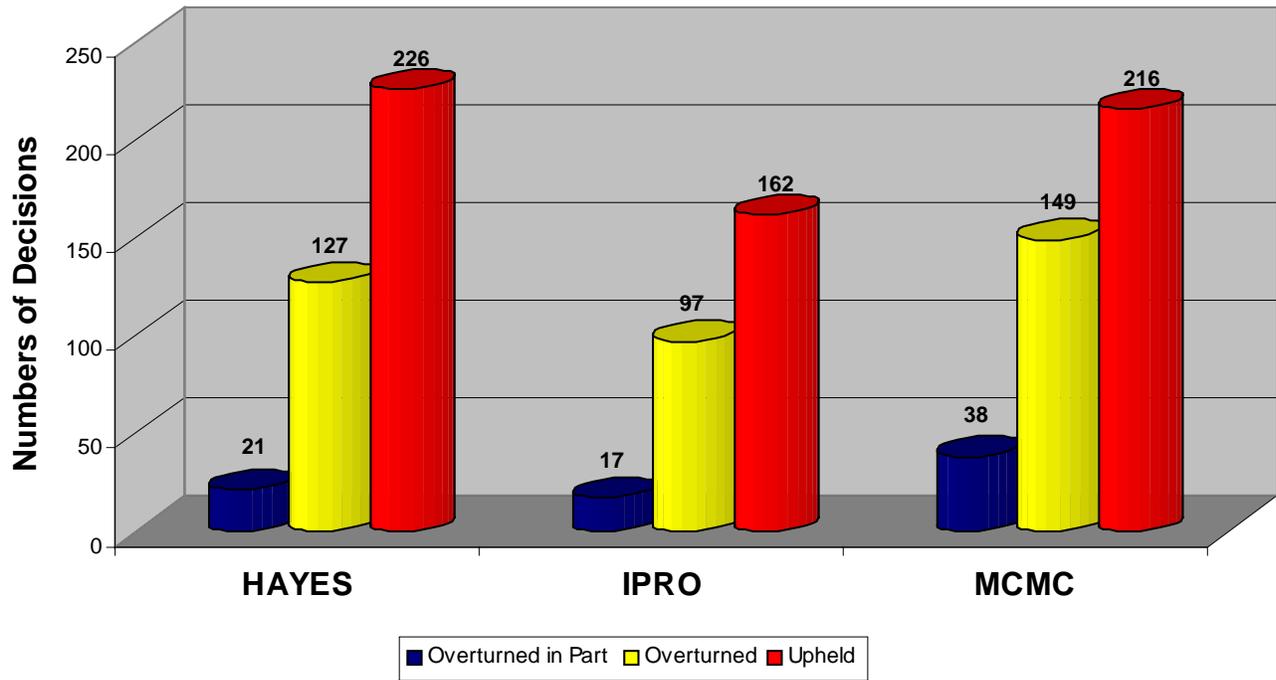
- In 2003, 374 cases were assigned to Hayes, 276 were assigned to IPRO, and 403 were assigned to MCMC. The differences in case assignments can be attributed to the random assignment process and to reassignments due to conflicts of interest.
- In 2003, health plan denials were overturned in whole or in part by Hayes in 40% of cases, by IPRO in 40% of cases, and by MCMC in 50% of cases.
- In 2002, health plan denials were overturned in whole or in part by Hayes in 42% of cases, by IPRO in 48% of cases. and by MCMC in 44% of cases.

The following charts identify external appeal results by agent from July 1999 through December 2003:

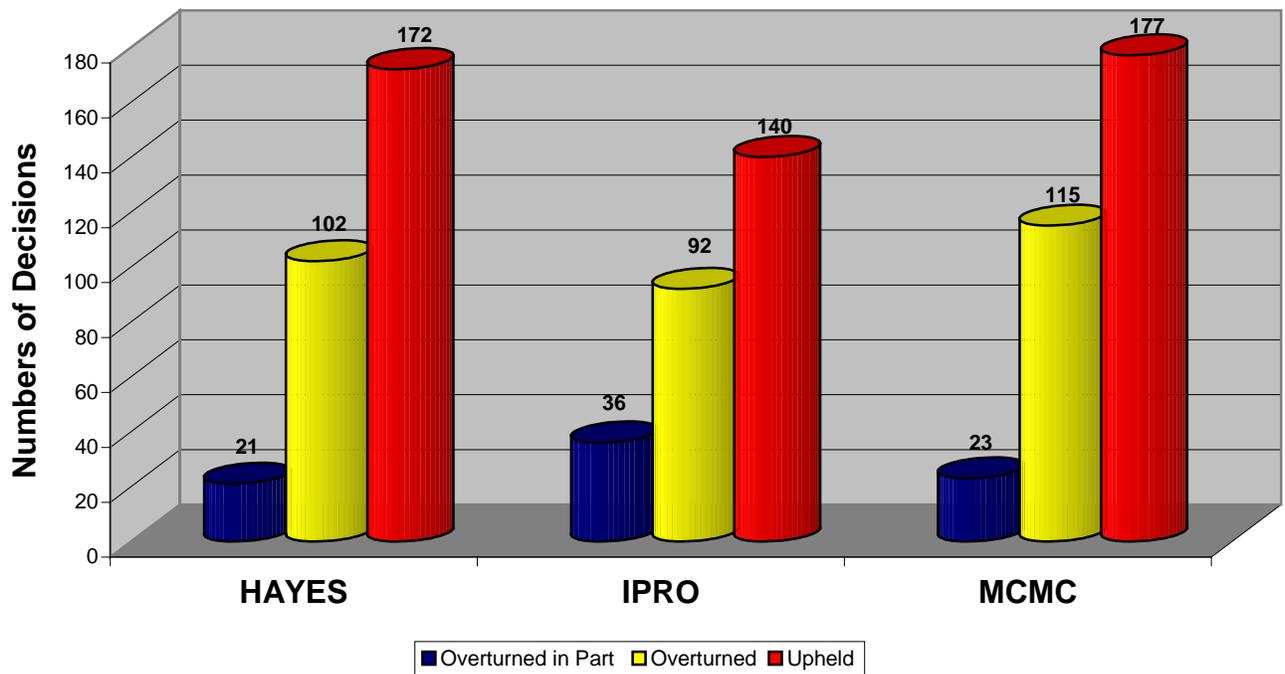
**External Appeal Decisions by Agent
July 1, 1999 - December 31, 2003**



External Appeal Decisions by Agent 2003



External Appeal Decisions by Agent 2002



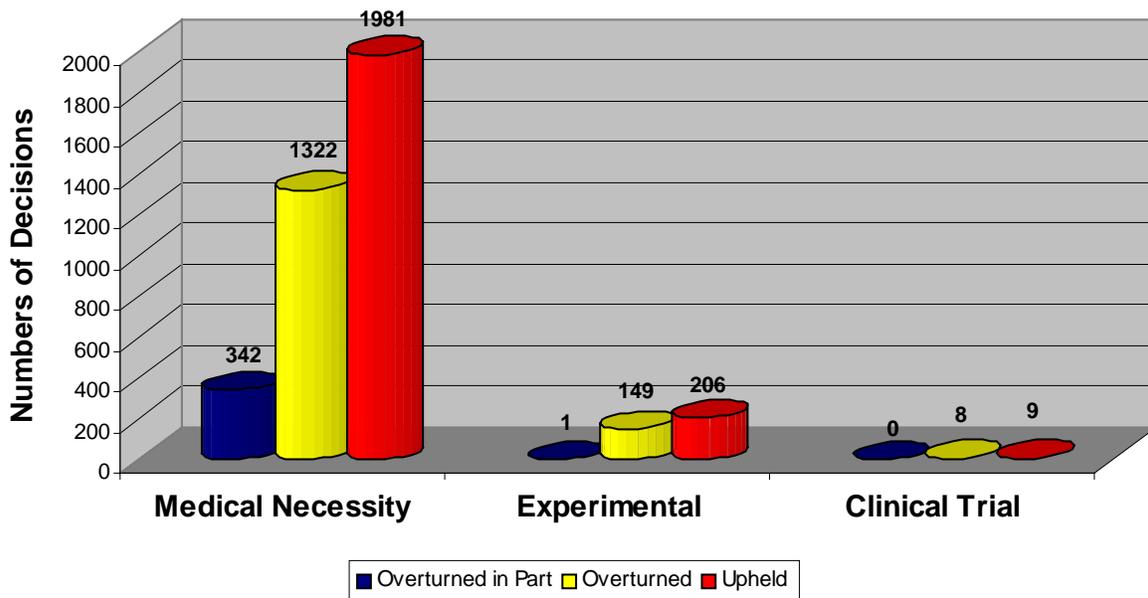
External Appeal Results by Type of Health Plan Denial

External appeal results can also be viewed by type of health plan denial. Since the beginning of the External Appeal Program, through the most recent year, the majority of external appeal requests have related to denials based on medical necessity, as opposed to denials because services were considered experimental or investigational. Of the medical necessity denials, the most frequent types of services appealed in 2003 included substance abuse treatment, surgical services, inpatient hospital services, diagnostic testing, mental health services, physical therapy, prescription drug coverage, and chiropractic services.

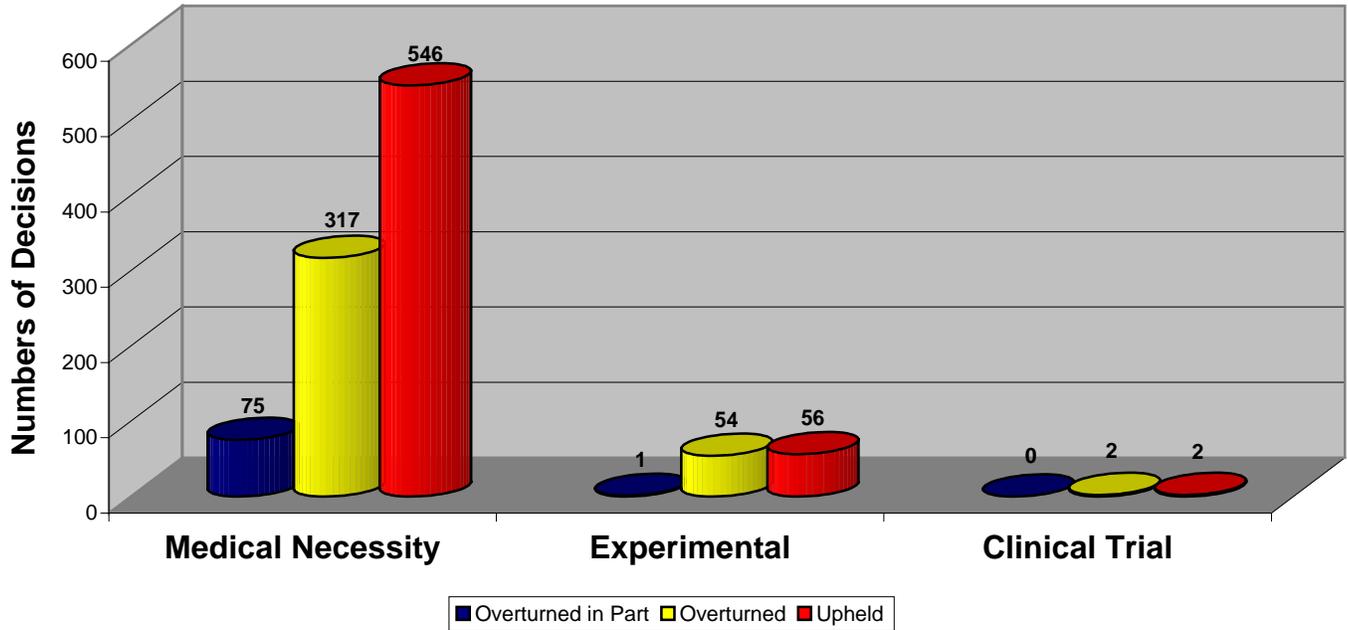
During the first two years of operation of the External Appeal Program, external appeal agents overturned medical necessity denials in whole or in part in approximately half of all cases, but only overturned experimental or investigational treatment denials in approximately one out of every three cases. In the past two years, the percentage of medical necessity denials overturned in whole or in part has decreased, while the percentage of experimental or investigational treatment denials overturned in whole or in part has increased. The following charts identify external appeal results based on whether services were denied as not medically necessary or as experimental or investigational:

- In 2001, 46% of medical necessity denials were overturned in whole or in part, while 37% of experimental or investigational treatment denials were overturned.
- In 2002, 44% of medical necessity denials were overturned in whole or in part, while 50% of experimental or investigational treatment denials were overturned.
- In 2003, 42% of medical necessity denials were overturned in whole or in part, while 50% of experimental or investigational treatment denials were overturned.

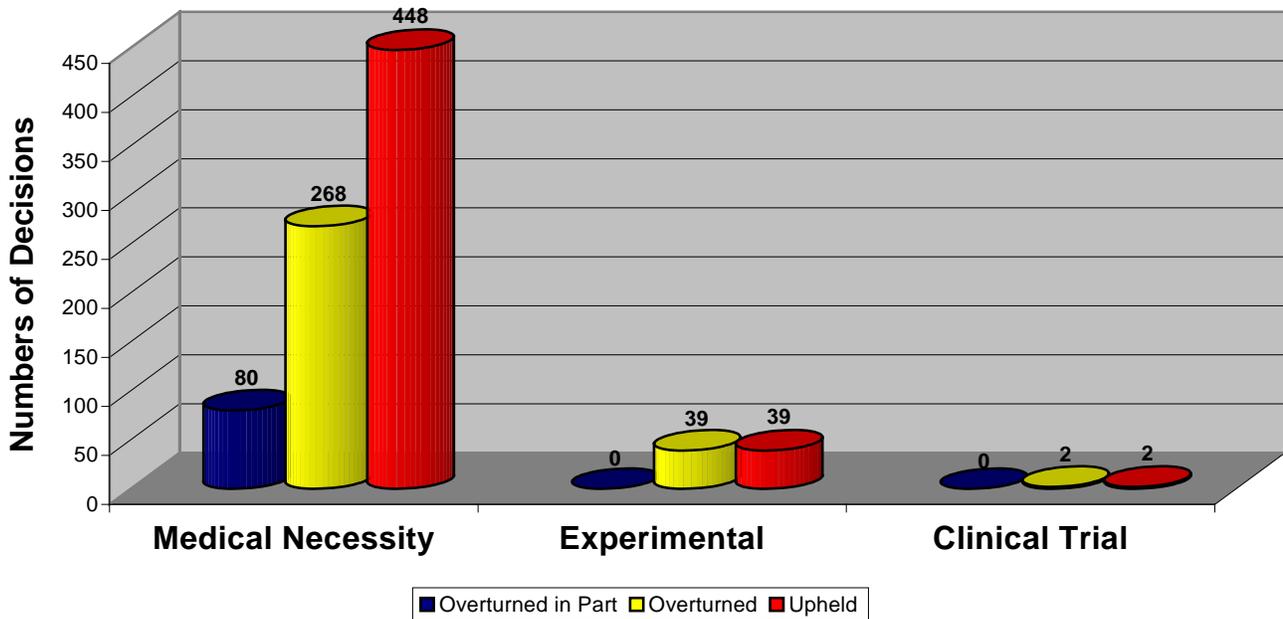
External Appeal Decisions by Type of Health Plan Denial July 1, 1999 - December 31, 2003



External Appeal Decisions by Type of Health Plan Denial 2003



External Appeal Decisions by Type of Health Plan Denial 2002



Expedited External Appeals

An external appeal must be expedited if the patient's attending physician attests that a delay in providing the health care service would pose an imminent or serious threat to the health of the patient. If an appeal is expedited, the law requires the external appeal agent to make a decision in three days instead of the standard 30 days.

Expedited external appeals can be problematic because the three day timeframe only allows the patient and the patient's health care provider a limited opportunity to submit additional information, and it can be difficult for the external appeal agent to obtain this information in the short timeframe, especially if the appeal is submitted over the weekend. The Insurance Department has also noted an increase in cases in which the health plan, to comply with new federal requirements, makes a determination in its internal appeal process regardless of whether it has obtained medical records from the patient's provider. In such cases, it is essential for the patient's provider to forward the patient's medical records to the external appeal agent, as the law requires the external appeal agent to issue a decision in three days, regardless of whether the agent has all the necessary information.

There have also been cases when expedited appeals have been requested by patients and attested to by physicians when a delay would not appear to present an imminent or serious threat to the health of the patient, for example when the external appeal is requested more than a month after the health plan's denial or after the services have been provided. Two of New York's certified external appeal agents also mentioned that they have been assigned expedited appeals that their clinical peers believed did not need to be expedited, and suggested strengthening attestation requirements and enforcement standards.

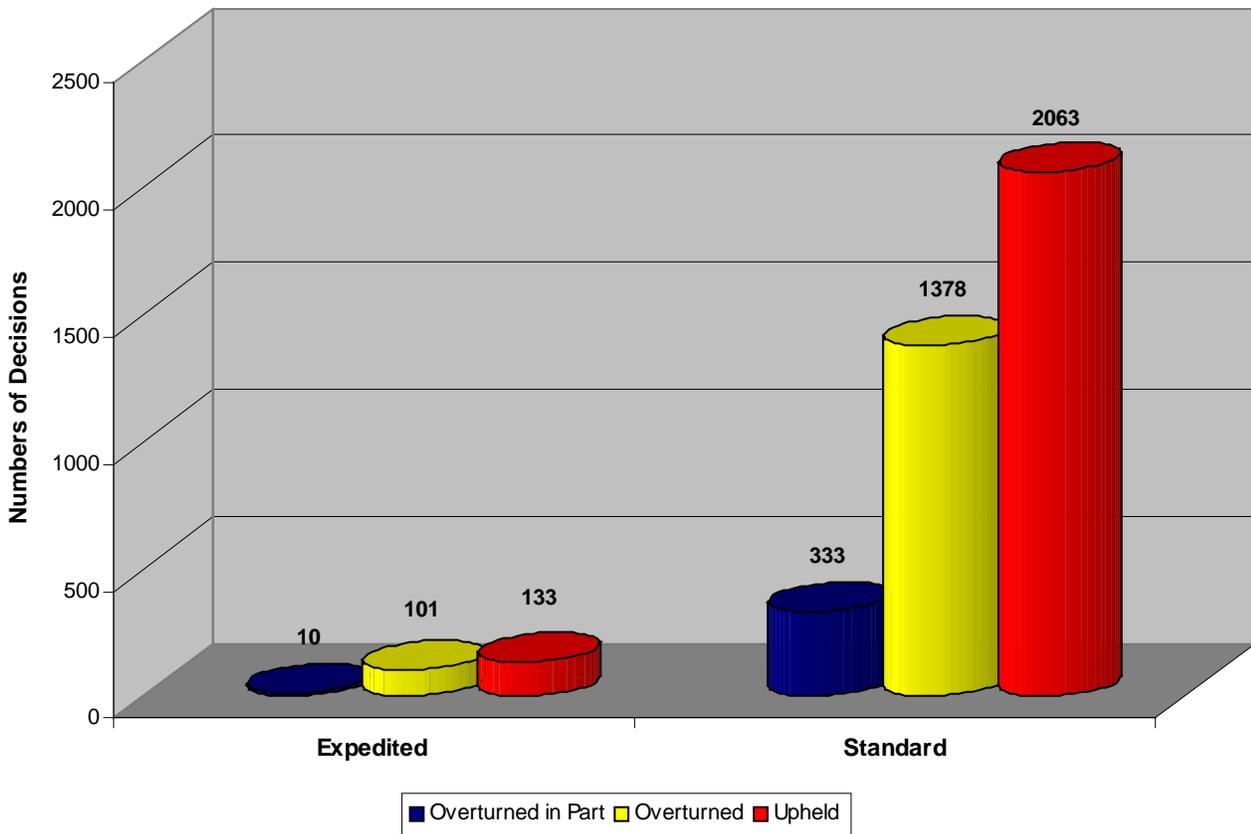
To address these expedited appeal issues, in certain cases, the Insurance Department will contact the patient's attending physician and the patient to explain that any information must be submitted immediately and discuss the option of processing the appeal as standard. If the patient's attending physician states that the appeal should remain expedited, it is assigned as such, unless the services have already been provided. In addition, the Department added a detailed explanation about expedited appeals to the standardized external appeal applications and to the Department's Web site so that consumers and providers would be better informed about the three day review timeframe and the need to submit information immediately in order for it to be considered by the agent. The revised applications also request that the patient's attending physician provide weekend contact information to ensure that an external appeal agent will be able to reach the physician if additional information is needed.

Insurance Department staff is available to handle expedited appeals submitted during business hours and after the close of business. Two Insurance Department staff members are on call each weekend to handle expedited appeals. Applicants requesting an expedited appeal are asked to call the Department to provide notice that an expedited appeal is being submitted.

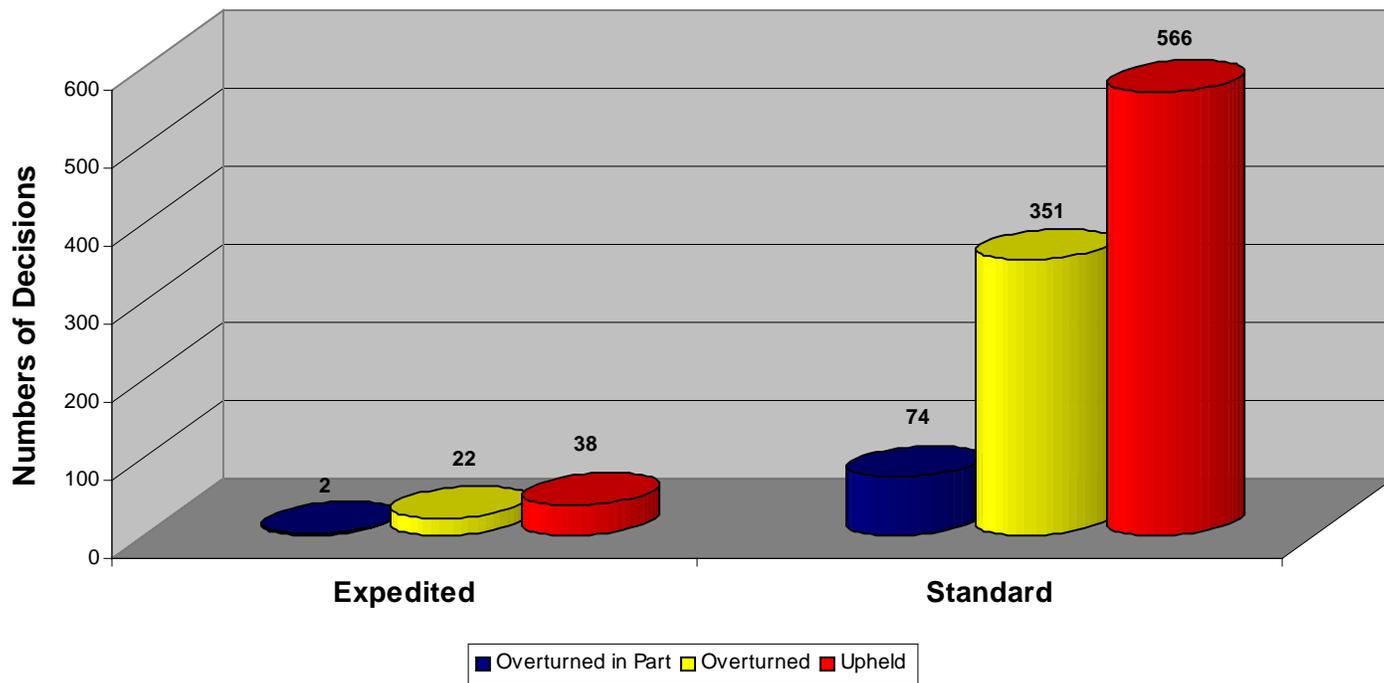
The Department has noted a slight decrease in the number of expedited external appeals requested, along with a significant decrease in the number of applicants that have called either during the week or on a weekend or holiday to advise the Department that an expedited appeal will be submitted.

In previous years external appeal agents overturned health plan denials in whole or in part at a slightly higher percentage in expedited cases than in non-expedited cases. Noteworthy, in 2003, external appeal agents overturned health plan denials in whole or in part in expedited cases at the same rate as in standard cases. The following charts compare standard and expedited appeal results.

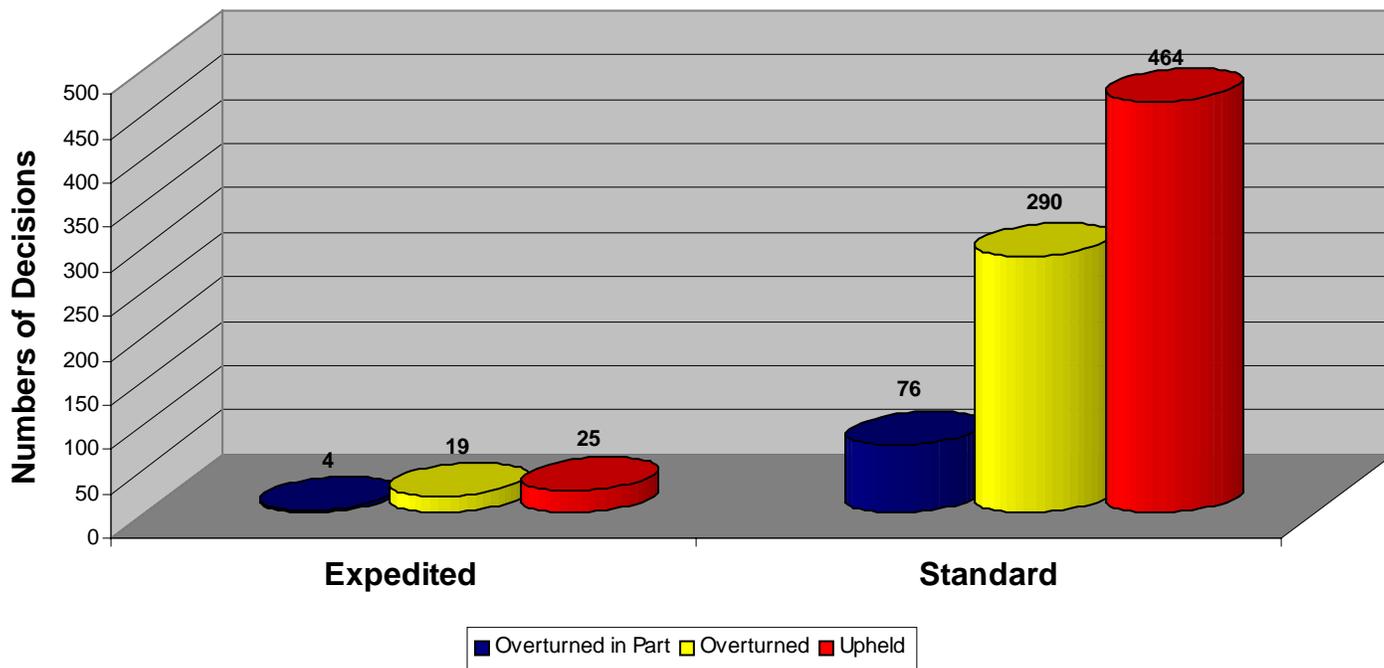
**External Appeal Decisions by Type of Appeal
July 1, 1999 - December 31, 2003**



External Appeal Decisions by Type of Appeal 2003



External Appeal Decisions by Type of Appeal 2002



External Appeal Results and Costs

In addition to viewing external appeal results by agent, by type of health plan denial, and by type of appeal, external appeal results can also be viewed on a calendar year basis. As seen in the chart below, there have been a total of 4,018 decisions rendered by external appeal agents since the beginning of the External Appeal Program in July 1999. The overall percentage of health plan denials overturned in whole or in part by external appeal agents has slightly declined in the past three years of operation of the Program.

| Timeframe | Total | Health Plan Denial Overturned | Health Plan Denial Overturned in Part | Health Plan Denial Upheld | Percentage Overturned in Whole or in Part |
|--------------|-------------|-------------------------------|---------------------------------------|---------------------------|---|
| 1999 | 205 | 79 | 20 | 106 | 48.3% |
| 2000 | 936 | 371 | 91 | 474 | 49.4% |
| 2001 | 946 | 347 | 76 | 523 | 44.7% |
| 2002 | 878 | 309 | 80 | 489 | 44.3% |
| 2003 | 1053 | 373 | 76 | 604 | 42.6% |
| Total | 4018 | 1479 | 343 | 2196 | 45.3% |

Health plans are responsible for paying the external appeal agent for the appeal regardless of whether the health plan's determination is upheld or overturned. The fees charged by external appeal agents are approved by the Insurance Department and the Health Department for two year periods. The fees must be reasonable, and must be inclusive of indirect costs, administrative fees and incidental expenses. A health plan must pay the external appeal agent's fee within 45 days from the date the appeal determination is received by the health plan. If payment is not made within the 45 days, the plan is required to pay the agent interest at a statutorily prescribed rate. Below is a table of the costs to all health plans for external appeal determinations rendered from January 1, 2002 through December 31, 2003:

| | Medical Necessity Standard | Medical Necessity Expedited | Experimental/ Investigational Standard | Experimental/ Investigational Expedited | Total |
|--------------|----------------------------|-----------------------------|--|---|--------------------|
| 2002 | \$398,485 | \$23,130 | \$144,550 | \$48,600 | \$614,765 |
| 2003 | \$485,375 | \$36,610 | \$219,475 | \$48,700 | \$790,160 |
| Total | \$883,860 | \$59,740 | \$364,025 | \$97,300 | \$1,404,925 |

External Appeal Decisions by Health Plan

The following charts identify external appeal results by health plan for 2003, and in total for all years that the external appeal law has been in effect. The charts categorize health plans based on whether the coverage is HMO, non-profit indemnity insurance, commercial insurance, Medicaid managed care, or Municipal Cooperative Health Benefit Plan coverage. When reviewing the charts, it is important to keep in mind that some health plans provide coverage to greater numbers of New Yorkers than others. Larger plans may have more external appeals than smaller plans because more people are covered under the plans.

| Health Maintenance Organizations | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|---|-------|-----------|-------------------|--------|---|
| Aetna Health Inc. | | | | | |
| 2003 | 36 | 15 | 1 | 20 | 44.4% |
| All ¹ | 160 | 61 | 15 | 84 | 47.5% |
| Atlantis Health Plan, Inc. | | | | | |
| 2003 | 13 | 6 | 0 | 7 | 46.2% |
| All | 15 | 8 | 0 | 7 | 53.3% |
| Capital District Physicians' Health Plan, Inc. (CDPHP) | | | | | |
| 2003 | 6 | 3 | 0 | 3 | 50% |
| All | 43 | 19 | 3 | 21 | 51.2% |
| CIGNA Healthcare of New York, Inc. | | | | | |
| 2003 | 4 | 2 | 0 | 2 | 50% |
| All | 62 | 21 | 11 | 30 | 51.6% |
| Empire Healthchoice HMO, Inc. | | | | | |
| 2003 | 75 | 28 | 4 | 43 | 42.7% |
| All | 222 | 98 | 12 | 112 | 49.5% |
| Excellus Health Plan, Inc. (Blue Choice) (BCBS of Rochester) | | | | | |
| 2003 | 20 | 4 | 1 | 15 | 25% |
| All | 80 | 33 | 1 | 46 | 42.5% |

¹ The "All" category includes appeal results from July 1999 – December 2003.

| Health Maintenance Organizations | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|--|-------|-----------|-------------------|--------|---|
| Excellus Health Plan, Inc. (HMO Blue) (BCBS of Utica Watertown) | | | | | |
| 2003 | 3 | 0 | 0 | 3 | 0% |
| All | 18 | 6 | 2 | 10 | 44.4% |
| Excellus Health Plan, Inc. (HMO CNY) (BCBS of Central NY) | | | | | |
| 2003 | 4 | 1 | 1 | 2 | 50% |
| All | 39 | 14 | 4 | 21 | 46.2% |
| Excellus Health Plan, Inc. (Univera CNY) | | | | | |
| 2003 | 2 | 1 | 1 | 0 | 100% |
| All | 25 | 9 | 2 | 14 | 44% |
| Excellus Health Plan, Inc. (Univera Southern Tier) | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 2 | 1 | 0 | 1 | 50% |
| Excellus Health Plan, Inc. (Univera WNY) | | | | | |
| 2003 | 21 | 8 | 0 | 13 | 38.1% |
| All | 102 | 42 | 0 | 60 | 41.2% |
| GHI HMO Select, Inc. | | | | | |
| 2003 | 2 | 2 | 0 | 0 | 100% |
| All | 9 | 4 | 0 | 5 | 44.4% |
| Health Net of New York, Inc. | | | | | |
| 2003 | 58 | 24 | 3 | 31 | 46.6% |
| All | 207 | 89 | 21 | 97 | 53.1% |
| HealthNow New York, Inc. (Community Blue HMO) (BCBS of Western NY – Buffalo / BS of Northeastern NY) | | | | | |
| 2003 | 73 | 31 | 7 | 35 | 52.1% |
| All | 157 | 47 | 14 | 96 | 38.9% |
| Health Insurance Plan of Greater NY, Inc. (HIP) | | | | | |
| 2003 | 29 | 9 | 1 | 19 | 34.5% |
| All | 102 | 44 | 6 | 52 | 49% |

| Health Maintenance Organizations | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|---|-------------|------------|-------------------|-------------|---|
| Independent Health Association, Inc. | | | | | |
| 2003 | 3 | 0 | 0 | 3 | 0% |
| All | 15 | 4 | 1 | 10 | 33.3% |
| MDNY Healthcare, Inc. | | | | | |
| 2003 | 5 | 2 | 0 | 3 | 40% |
| All | 19 | 12 | 1 | 6 | 68.4% |
| MVP Health Plan, Inc. | | | | | |
| 2003 | 17 | 8 | 0 | 9 | 47.1% |
| All | 65 | 30 | 2 | 33 | 49.2% |
| Oxford Health Plans of New York, Inc. | | | | | |
| 2003 | 238 | 65 | 23 | 150 | 37% |
| All | 790 | 232 | 64 | 494 | 37.5% |
| Rochester Area HMO, Inc. (Preferred Care) | | | | | |
| 2003 | 4 | 3 | 0 | 1 | 75% |
| All | 18 | 11 | 0 | 7 | 61.1% |
| United Healthcare of New York, Inc. | | | | | |
| 2003 | 5 | 2 | 0 | 3 | 40% |
| All | 27 | 13 | 0 | 14 | 48.1% |
| Vytra Health Plans Long Island, Inc. | | | | | |
| 2003 | 4 | 2 | 1 | 1 | 75% |
| All | 68 | 30 | 10 | 28 | 58.8% |
| Totals | | | | | |
| 2003 | 622 | 216 | 43 | 363 | 41.6% |
| All | 2245 | 828 | 169 | 1248 | 44.4% |

| Non-Profit Indemnity Insurers | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|---|--------------|------------------|------------------------------|---------------|--|
| Excellus Health Plan, Inc. (BCBS of Central NY) | | | | | |
| 2003 | 30 | 13 | 1 | 16 | 46.7% |
| All | 172 | 61 | 14 | 97 | 43.6% |
| Excellus Health Plan, Inc. (BCBS of Rochester) | | | | | |
| 2003 | 5 | 3 | 1 | 1 | 80% |
| All | 32 | 13 | 1 | 18 | 43.8% |
| Excellus Health Plan, Inc. (BCBS of Utica-Watertown) | | | | | |
| 2003 | 12 | 3 | 0 | 9 | 25% |
| All | 52 | 16 | 1 | 35 | 32.7% |
| Group Health Incorporated (GHI) | | | | | |
| 2003 | 55 | 11 | 9 | 35 | 36.4% |
| All | 298 | 89 | 55 | 154 | 48.3% |
| HealthNow New York Inc. (Traditional Blue Indemnity) | | | | | |
| 2003 | 27 | 6 | 2 | 19 | 29.6% |
| All | 72 | 27 | 6 | 39 | 45.8% |
| Vytra Health Services, Inc. | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 9 | 5 | 0 | 4 | 55.6% |
| Totals | | | | | |
| 2003 | 129 | 36 | 13 | 80 | 38% |
| All | 635 | 211 | 77 | 347 | 46.1% |

| Commercial Insurers | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|--|-------|-----------|-------------------|--------|---|
| Aetna Life Insurance Company | | | | | |
| 2003 | 11 | 1 | 1 | 9 | 18.2% |
| All | 16 | 1 | 4 | 11 | 31.3% |
| Anthem Health & Life Insurance Company of New York | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 5 | 2 | 0 | 3 | 40% |
| Connecticut General Life Insurance Company | | | | | |
| 2003 | 27 | 12 | 1 | 14 | 48.1% |
| All | 67 | 35 | 2 | 30 | 55.2% |
| Continental Assurance Company | | | | | |
| 2003 | 1 | 1 | 0 | 0 | 100% |
| All | 1 | 1 | 0 | 0 | 100% |
| Empire Healthchoice, Inc. ² | | | | | |
| 2003 | 151 | 61 | 12 | 78 | 48.3% |
| All | 604 | 231 | 56 | 317 | 47.5% |
| Equitable Life Assurance Company of America | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 2 | 0 | 0 | 2 | 0% |
| Guardian Life Insurance Company of America | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 13 | 2 | 3 | 8 | 38.5% |
| Health Net Insurance Company of New York, Inc. (formerly Physicians Health Services, Inc.) | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 18 | 5 | 4 | 9 | 50% |

² Empire Healthchoice, Inc. converted to a for-profit commercial insurer in October 2002. The "All" appeal numbers include appeals conducted while the insurer was a non-profit insurer and while the insurer was a commercial insurer.

| Commercial Insurers | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|--|--------------|------------------|------------------------------|---------------|--|
| Horizon Healthcare Insurance Company of New York | | | | | |
| 2003 | 8 | 5 | 1 | 2 | 75% |
| All | 22 | 12 | 2 | 8 | 63.6% |
| Metropolitan Life | | | | | |
| 2003 | 4 | 2 | 0 | 2 | 50% |
| All | 4 | 2 | 0 | 2 | 50% |
| Mutual of Omaha Insurance Company | | | | | |
| 2003 | 4 | 3 | 0 | 1 | 75% |
| All | 5 | 4 | 0 | 1 | 80% |
| Oxford Health Insurance Company | | | | | |
| 2003 | 18 | 3 | 1 | 14 | 22.2% |
| All | 18 | 3 | 1 | 14 | 22.2% |
| UniCARE Life & Health Insurance Company | | | | | |
| 2003 | 2 | 0 | 0 | 2 | 0% |
| All | 18 | 4 | 6 | 8 | 55.6% |
| United HealthCare Insurance Company of New York | | | | | |
| 2003 | 56 | 27 | 3 | 26 | 53.6% |
| All | 211 | 92 | 10 | 109 | 48.3% |
| Totals | | | | | |
| 2003 | 282 | 115 | 19 | 148 | 47.5% |
| All | 1004 | 394 | 88 | 522 | 48% |

| Medicaid Managed Care Coverage | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|---|-------|-----------|-------------------|--------|---|
| Affinity Health Plan | | | | | |
| 2003 | 2 | 0 | 0 | 2 | 0% |
| All | 2 | 0 | 0 | 2 | 0% |
| Americhoice of New York, Inc. | | | | | |
| 2003 | 1 | 1 | 0 | 0 | 100% |
| All | 3 | 2 | 0 | 1 | 66.7% |
| Capital District Physicians Health Plan, Inc. (CDPHP) | | | | | |
| 2003 | 1 | 0 | 0 | 1 | 0% |
| All | 2 | 0 | 0 | 2 | 0% |
| CenterCare Health Plan | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 1 | 0 | 1 | 0 | 100% |
| Excellus Health Plan Inc. (Blue Choice)(BCBS of Rochester) | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 1 | 0 | 0 | 1 | 0% |
| Excellus Health Plan Inc. (HMO-CNY) (BCBS of Central NY) | | | | | |
| 2003 | 1 | 0 | 0 | 1 | 0% |
| All | 1 | 0 | 0 | 1 | 0% |
| Health Insurance Plan of Greater NY, Inc. (HIP) | | | | | |
| 2003 | 1 | 1 | 0 | 0 | 100% |
| All | 6 | 2 | 1 | 3 | 50% |
| HealthNow New York, Inc. (Community Blue) (BCBS of Western NY- Buffalo) | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 2 | 0 | 0 | 2 | 0% |
| HealthNow New York, Inc. (BS of Northeastern NY HMO) | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 2 | 0 | 2 | 0 | 50% |

| Medicaid Managed Care Coverage | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|--|-----------|-----------|-------------------|-----------|---|
| Health Plus PHSP Inc. | | | | | |
| 2003 | 1 | 0 | 0 | 1 | 0% |
| All | 1 | 0 | 0 | 1 | 0% |
| Healthsource/HHP (Westchester Prepaid Health Services Plan) | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 2 | 1 | 0 | 1 | 50% |
| Independent Health Association, Inc. | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 1 | 1 | 0 | 0 | 100% |
| NYS Catholic Health Plan (Fidelis Care) | | | | | |
| 2003 | 4 | 1 | 0 | 3 | 25% |
| All | 10 | 2 | 0 | 8 | 20% |
| United Healthcare of New York, Inc. | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 2 | 2 | 0 | 0 | 100% |
| Vytra Health Plans Long Island, Inc. | | | | | |
| 2003 | 1 | 0 | 0 | 1 | 0% |
| All | 3 | 0 | 0 | 3 | 0% |
| Wellcare of New York, Inc. | | | | | |
| 2003 | 1 | 0 | 0 | 1 | 0% |
| All | 2 | 0 | 0 | 2 | 0% |
| Totals | | | | | |
| 2003 | 13 | 3 | 0 | 10 | 23.1% |
| All | 41 | 10 | 4 | 27 | 34.1% |

| Municipal Cooperative Health Benefit Plans | Total | Overtured | Overtured in Part | Upheld | Percentage Overtured or Overtured in Part |
|--|--------------|------------------|--------------------------|---------------|--|
| Catskill Area Schools Employees Benefit Plan | | | | | |
| 2003 | 1 | 1 | 0 | 0 | 0 |
| All | 4 | 2 | 0 | 2 | 50% |
| Cayuga-Onondaga Area School Employees' Healthcare Plan | | | | | |
| 2003 | 1 | 0 | 0 | 1 | 0% |
| All | 1 | 0 | 0 | 1 | 0% |
| Jefferson-Lewis et al. School Employees Healthcare Plan | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 2 | 0 | 1 | 1 | 50% |
| Putnam/Northern Westchester Health Benefits Consortium | | | | | |
| 2003 | 0 | 0 | 0 | 0 | 0% |
| All | 3 | 1 | 0 | 2 | 33.3% |
| State-Wide Schools Cooperative Health Plan (SWSCHP) | | | | | |
| 2003 | 5 | 2 | 1 | 2 | 60% |
| All | 5 | 2 | 1 | 2 | 60% |
| Totals | | | | | |
| 2003 | 7 | 3 | 1 | 3 | 57.1% |
| All | 15 | 5 | 2 | 8 | 46.7% |

| | | | | | |
|--------------------------------------|-------------|-------------|------------|-------------|--------------|
| Totals For All Coverage Types | | | | | |
| 2003 | 1053 | 373 | 76 | 604 | 42.6% |
| All | 3940 | 1448 | 340 | 2152 | 45.4% |

Health Plan Surveys

In addition to requesting input from New York's external appeal agents for inclusion in the report, the Insurance Department also sought input from New York health plans that have had decisions reviewed in the external appeal process. The Department forwarded plans the following questions and received the responses discussed below.

We asked health plans whether they have made any changes to their medical necessity determinations or clinical review criteria as a result of external appeal decisions.

- Some health plans responded that they have made changes to their medical necessity coverage determinations based on external appeal decisions for laparoscopic gastric banding for obesity, ingestible telemetric gastrointestinal capsule imaging system for diagnosing disorders of the digestive tract, and stereotactic radiosurgery for trigeminal neuralgia (nerve disorders).

We asked health plans whether they have made any changes in determinations as to what services are experimental or investigational as a result of external appeal decisions.

- As a whole, health plans noted very little change to their policies or determinations due to external appeal decisions. The only treatments for which health plans noted making policy changes were prostheses (C-leg) and obesity surgery.

We asked health plans whether they have received any requests or claims for new or unique types of health care services or treatments in the past year and health plans identified the following:

- Biological drugs
- Botox injections for back pain
- Brachytherapy in treating breast cancer
- Capsule endoscopy
- Cardiac defibrillator vests
- Ceramic prosthesis for hip replacement
- Computerized artificial legs
- C-Reactive protein testing as a risk factor for coronary artery disease
- End of life expedited appeals
- Endovascular repair of aortic aneurysms and drug-eluting stents
- Enteryx™ system for treatment of gastroesophageal reflux disease
- Essure system (fallopian tube occlusion for permanent contraception)
- Flu Mist use (intranasal influenza vaccine)
- Intradiscal electrothermal therapy (IDET)
- Implantation of intraocular lens
- Intensity modulated radiation therapy (IMRT) for treatment of prostate cancer

- Thermal balloon and hydrothermal endometrial ablation
- Implantable beta-emitting microspheres for treatment of malignant tumors
- Lap band in the surgical treatment of obesity
- Laparoscopic radical prostatectomy
- MRI of brain with spectroscopy
- Nebulized antibiotic therapy for chronic sinusitis
- Position emission tomography (PET) scans in patients with dementia
- Post transplant gastric electrical stimulation system
- Prolotherapy
- Scarless reduction mammoplasty
- Vertebral axial decompression (Vax-D) for lower back pain
- Virtual colonoscopy
- Viscoanalostomy for the Treatment of Glaucoma
- Wireless capsule endoscopy

We asked health plans whether they had any questions or suggested improvements for the New York External Appeal Program. We received the following input from health plans and provided health plans with the following clarifications and explanations:

- Health plans requested clarification as to the timeframe in which a health plan may reverse their adverse determination.
 - ✓ Health plans may reverse their adverse determination at any time during the external appeal process and should notify the Insurance Department and the external appeal agent.
 - ✓ There are also certain times during the external appeal process when a health plan is specifically provided an opportunity to reconsider its denial. If the external appeal request is not expedited, Department staff will contact the health plan prior to assigning the appeal to an agent and discuss whether the health plan will reverse its denial, providing the health plan 24 hours to consider this option. In some cases the health plan overturns its own denial through this option and review by an external appeal agent is not necessary.
 - ✓ Health plans may also reverse their adverse determination when new information is submitted with an external appeal application. If the appeal is not expedited, the agent must consider whether documentation submitted by the patient or the patient's provider represents a material change from the documentation upon which the health plan based its denial. If the information is material, the agent is statutorily required to forward the information to the health plan and the external appeal is tolled for three business days while the health plan considers the documentation and decides whether to overturn or uphold its adverse determination.

- Health plans requested clarification as to whether cosmetic surgery denials are eligible for external appeal.
 - ✓ In New York, surgery is a mandated benefit that must be covered under most health insurance contracts, however, cosmetic surgery may be excluded. A determination as to whether surgical services are covered by the health plan as a mandated benefit, or denied as cosmetic, is a medical necessity determination that must be subject to external review. The Insurance Department is considering a clarification to the cosmetic surgery exclusion in Regulation 62 (11 N.Y.C.R.R. 52.16).

- Health plans requested that external appeal agents incorporate nationally recognized criteria, such as InterQual or Milliman & Robertson standards into their decision-making.
 - ✓ The Insurance Law and Public Health Law require external appeal agents to consider the clinical standards of the health plan, the information provided concerning the patient, the attending physician's recommendation, and applicable and generally acceptable practice guidelines developed by the federal government, national or professional medical societies, boards and associations when making a medical necessity determination. The Insurance Department monitors compliance and if a health plan believes an external appeal agent is not adhering to these requirements, the Insurance Department should be contacted.

- Health plans requested that external appeal agents include detailed clinical rationale when the external appeal agent overturns a health plan's adverse determination.
 - ✓ The Insurance Department and Health Department have been working with external appeal agents to ensure that detailed clinical rationale is included.

- Health plans requested that external appeal agents be permitted to consider the plan's coverage provisions.
 - ✓ Health plans are required to transmit their clinical standards used to determine medical necessity to external appeal agents. External appeal agents will consider these standards but are not statutorily bound by them.

ERISA Update

In each annual report, the Department provides an update as to developments on the federal level that could impact the New York State External Appeal Program. Last year's report included a discussion of *Moran v. Rush Prudential HMO, Inc.*, a case in which the United States Supreme Court held in a 5 to 4 decision that state external appeal programs are not preempted by the Employee Retirement Income Security Act (ERISA).

In 2003, the United States Supreme Court granted certiorari to *Aetna Health Inc. et al. v. Davila* (02-1845) and *CIGNA Healthcare of Texas, Inc. et al. v. Calad* (03-83), cases that questioned whether state law liability claims can be brought against a health plan for failure to authorize health care treatment, or whether such claims are preempted by ERISA. In *CIGNA Healthcare of Texas, Inc. et al. v. Calad*, the insured suffered a relapse when continued hospital coverage was denied by her HMO. In *Aetna Health Inc. et al. v. Davila* the insured suffered complications after his HMO denied coverage of medication because the insured had not tried other less expensive generic drugs. Both insureds sued their HMOs in state court under the Texas Health Care Liability Act, a patient protection law, alleging that the HMOs failed to use ordinary care in making their medical necessity decisions. The HMOs removed the cases to federal district court arguing that the claims were preempted by ERISA. The insureds moved to remand the cases back to Texas state court. However, the federal district court denied the remand motions in both cases concluding that the insureds were challenging plan benefit determinations and that relief was available exclusively under ERISA so that the cases must be heard in federal court.

- ERISA § 502(a)(2) authorizes relief under ERISA §1109(a) and provides that a fiduciary who breaches any responsibility or obligation is personally liable and must make good to the plan for losses to the plan resulting from the breach.
- ERISA § 502(a)(1) allows a plan participant or beneficiary to sue for relief if a plan fiduciary breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries.
- ERISA § 502(a)(1)(B) allows a plan participant or beneficiary to bring a civil action to recover benefits under a plan, to enforce rights under the plan, or to clarify rights to future benefits under the plan.
- ERISA § 514(a) provides that ERISA supersedes any and all State laws insofar as they relate to any employee benefit plan described in § 1003(a) of ERISA.

Neither insured was willing to amend their pleadings to bring an ERISA claim and as a result, the federal district court dismissed each insured's complaint for failure to state a cause of action. When the insureds appealed, the Fifth Circuit Court of Appeals concluded that § 502(a)(1)(B) of ERISA did not completely preempt the Texas state law claims because the insureds were not suing their plan administrators, nor were they challenging the interpretation of the plan. As for ERISA § 502(a)(2) preemption, the Fifth Circuit Court of Appeals held that mixed eligibility and treatment decisions are not fiduciary in nature and, therefore, § 502(a) of ERISA does not completely preempt the insureds' claims under Texas state law. As a result, the Fifth Circuit Court of Appeals concluded that the insureds' claims did not arise under federal law, as is required for federal jurisdiction, and remanded the matters to the federal district court for further remand to state court.

These cases attracted widespread interest because the decision would not only impact Texas insureds, but would also impact insureds in any other state who may want to sue their health plan. At the time of publication of this report, the United States Supreme Court did issue a decision, finding that the insureds claims fall within ERISA §502(a)(1)(B) and are therefore completely preempted by ERISA.

As for New York in particular, a certiorari petition for a similar case, *Vytra Healthcare et. al. v. Cicio*, was granted and the United States Supreme Court remanded the case back to the United States Second Circuit Court of Appeals for reconsideration in view of *Davila* and *Calad*. In *Cicio*, the insured's health plan denied coverage of a stem cell transplant and the United States Court of Appeals for the Second Circuit originally determined that the case was not preempted by ERISA §502 or §514 so that the insured could bring a claim against Vytra Healthcare in state court. On September 23, 2004, the United States Court of Appeals for the Second Circuit vacated their previous decision and affirmed the judgement of the district court, finding that the insured's state law claims were preempted by ERISA.

Closing Remarks

Since the external appeal program's inception four years ago, it continues to provide consumers with an effective means to gain access to, and reimbursement for, medically necessary health care services, experimental or investigational treatments that are more beneficial than standard treatments, and clinical trials that are likely to benefit the patient. It is also the mutual cooperation of the Health Department, the Insurance Department, providers, health plans and consumer groups that has contributed to the success of this program. In addition, the New York External Appeal Program continues to be used as a model for other state programs. The Insurance Department is committed to the External Appeal Program and will continue to work with consumers, providers and health plans to maintain standards of excellence and to ensure that consumers are able to access the critical protections that this independent appeals process provides.