

**NEW YORK STATE INSURANCE DEPARTMENT
AND
NEW YORK STATE DEPARTMENT OF HEALTH**



**New York State External Appeal Program Annual Report
July 1, 2000 - June 29, 2001**

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A REPORT ON EXTERNAL APPEALS IN NEW YORK

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Introduction:

New York's External Appeal Program recently completed its second year of operation. During the program's second year, there were over 1,600 requests for external appeals. Of all 41 states and the District of Columbia with external appeal programs currently in place, New York has received the highest number of external appeal requests.

New York's External Appeal Law became effective on July 1, 1999. The Law provides health care consumers with the right to obtain an independent review of a health plan's denial of coverage on the basis that the services are not medically necessary or that the services are experimental or investigational. The Law also enables health care providers to request an external appeal in limited circumstances, when there has been a retrospective adverse determination relating to medical necessity or regarding experimental/investigational services.

To be eligible for an external review, a denial must first be appealed through the health plan's internal appeal process or the patient and the health plan must jointly agree to waive the internal appeal process. External appeal requests must then be submitted to the New York State Insurance Department within 45 days of receipt of the notice of final adverse determination from the first level of appeal with the health plan or confirmation that the internal appeal process has been waived.

Health plans may charge a fee of up to \$50.00 for an external appeal. If a patient has coverage under Medicaid, Child Health Plus, or the health plan determines the fee will pose a hardship, the fee is automatically waived for that patient. If the external agent overturns the health plan's denial, the fee is returned to the patient. If the external appeal agent finds in favor of the health plan then the fee is forwarded to the plan.

The Insurance Department is responsible for screening external appeal requests for eligibility and completeness. The Insurance Department is required to review external appeal requests within 24 hours for expedited appeals or within five days for standard appeals. Once appeals are determined to be eligible and complete, the Insurance Department will randomly assign the appeal to one of the state's certified external appeal agents.

New York currently has three certified external appeal agents with extensive panels of clinical peers available to review appeals. Typically, external appeal agents assign one clinical peer to review medical necessity appeals and three clinical peers to review appeals of experimental or investigational treatments. Decisions must be rendered by external appeal agents within 30 days for standard appeals, or within three days for expedited appeals if an attending physician has attested that a delay would pose an imminent or serious threat to the health of the patient.

Notwithstanding the success of New York's External Appeal Program, there have been developments on the federal level that could impact the external appeal programs of all states, including New York's. The U.S. Supreme Court is currently considering whether state external appeal laws are preempted by The Employee Retirement Income Security Act (ERISA), a federal law regulating employer provided benefit plans. Legislation is also pending in Congress that would establish federal standards for external appeals and could preempt New York's External Appeal Program.

This year's annual report provides a comprehensive overview of New York's External Appeal Program for its second year of operation and includes a description of external appeal results on a calendar year basis along with a summary of all external appeal results from the effective date of the program. New this year, because of the developments on the federal level, the report also includes information about the pending U.S. Supreme Court case and the pending federal legislation. Also new this year is a comparison of external appeal programs in other states, the results from a survey conducted by the Insurance Department.

Background of the External Appeal Law:

The External Appeal Law expands the protections of the 1996 Managed Care Reform Act which added a Title I to Article 49 of the Insurance Law and the Public Health Law. The Managed Care Reform Act included many consumer protections such as requiring access to specialists and continuity of care when a provider is no longer participating in a network; a prudent layperson standard for coverage of emergency services; mandatory disclosure of coverage information to subscribers; prohibitions on gag clauses in provider contracts and requirements for health plans to have a grievance procedure and a utilization review appeal process.

Under the Managed Care Reform Act, managed care plans are required to have a grievance process for review of all determinations other than medical necessity determinations. The types of determinations that are subject to the grievance process include access to referral disputes or determinations that a benefit is not covered under the terms of a contract.

Along with a grievance process, the Managed Care Reform Act also requires health plans to have a utilization review process if medical necessity determinations are rendered. Utilization review is defined as the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. The Act establishes standards and timeframes for health plan initial utilization review determinations and also requires plans to have an internal appeal process. The Act permits patients, a patient's designee or, in connection with a retrospective adverse determination, the patient's health care provider to appeal an adverse medical necessity determination with the health plan.

The External Appeal Law builds on the utilization review provisions of the Managed Care Reform Act by adding a Title II to Article 49 of the Insurance Law and the Public Health Law, providing additional protections for health care consumers. The External Appeal Law enables consumers to obtain an independent review if a health plan upholds an adverse medical necessity determination or an experimental/investigational treatment determination on appeal. Specifically, the Law permits patients, a patient's designee or, in connection with a retrospective adverse determination, the patient's health care provider, to appeal a denial upheld by the health plan to an external appeal agent.

Implementation of the External Appeal Law:

Once the external appeal legislation was signed into law, staff from the Insurance Department and the Health Department began meeting regularly to ensure that the External Review Program would be operational by the July 1, 1999 effective date imposed by statute. During these meetings, the Departments identified the following tasks that had to be completed prior to July 1, 1999 in order for the program to be operational.

- Regulations implementing the legislation had to be promulgated.
- An application for certification of external appeal agents had to be developed.
- External appeal agents had to be certified.
- Lists of health plan staff members responsible for handling external appeal requests had to be compiled.
- A process for Insurance Department receipt and review of external appeal requests had to be established.
- A computer system capable of handling and tracking external appeal requests had to be developed.
- Insurance Department staff availability on weekends had to be arranged in order to handle expedited appeals.
- A standard description of the external appeal process and an external appeal application had to be developed and disseminated.
- Outreach had to be conducted so that consumers would be made aware of their new external appeal rights.
 - ✓ A toll-free hotline was launched to assist consumers in filing external appeal requests.
 - ✓ External appeal information and applications were posted on the Web sites of the Insurance Department and the Health Department.
 - ✓ Brochures describing the new external appeal rights were developed and disseminated.
 - ✓ The Insurance Department and the Health Department participated in external appeal informational meetings with health plans, providers and consumer groups.

All tasks were completed prior to July 1, 1999 so that the External Appeal Program was fully operational on the statutory effective date. Once the External Appeal Program became operational, the Insurance Department and the Health Department transitioned their focus from implementation to the day-to-day operation and administration of the program. Both Departments continue to meet bi-monthly to discuss the operations of the program and continue to maintain a dialogue with interested parties to discuss questions and concerns in relation to the External Appeal Program.

During the second year of operation of the External Appeal Program, the Insurance Department and the Health Department certified a new external appeal agent and began the task of re-certifying the external appeal agents who were initially certified in 1999. In addition, the Departments are in the process of revising the standard description of the External Appeal Program and the external appeal application to incorporate changes suggested by interested parties. The Insurance Department is also reviewing an Insurance Department regulation governing permissible benefit exclusions, promulgated prior to the passage of the External Appeal Law, in order to ascertain what changes may need to be made to the regulation due to the requirements of the External Appeal Law.

The External Appeal Regulations:

The External Appeal Law requires the Insurance Department and the Health Department to promulgate regulations to implement an external appeal program. The Law identifies three areas in which regulations have to be promulgated governing conflict of interest, random assignment of external appeal agents and a standard description of the external appeal process. The Law does not limit the regulations to these three areas though, and permits the Superintendent of Insurance and the Commissioner of the Department of Health to promulgate regulations covering other areas as well.

When drafting and promulgating the regulations, staff from the Insurance Department and the Health Department met with interested parties, including representatives of health plans, providers and consumer groups, to discuss the content of the regulations. The Departments also received and responded to over 40 public comments submitted by interested parties during the first formal public comment period and later responded to additional comments in subsequent comment periods. The regulations were revised twice in order to incorporate the revisions requested by interested parties in their public comments.

Regulations were first filed by the Insurance Department with the Secretary of State on June 18, 1999 and by the Health Department on June 21, 1999 on an emergency basis so that the regulations would be in effect by July 1, 1999. The Departments made additional filings as follows:

- The Insurance Department re-filed its regulation as an emergency measure on September 15, 1999, December 13, 1999, February 10, 2000, April 7, 2000, June 6, 2000, August 4, 2000, October 2, 2000, December 1, 2000 and January 29, 2001.
- The Health Department re-filed its regulation as an emergency measure on September 17, 1999, December 17, 1999, February 10, 2000, April 10, 2000, June 9, 2000, August 9, 2000, October 6, 2000 and December 5, 2000.
- The Insurance Department filed proposed and revised notices of rule-making with the Secretary of State for publication in the State Register on November 24, 1999, May 31, 2000 and December 6, 2000.
- The Health Department filed proposed and revised notices of rule-making with the Secretary of State for publication in the State Register on November 17, 1999, May 31, 2000 and December 6, 2000.
- The Insurance Department's external appeal regulation was adopted on February 14, 2001 and the Health Department's external appeal regulation was adopted on January 31, 2001.
- The Insurance Department's regulation is codified as a new Part 410 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation 166) while the Health Department's regulation is codified as a new Subpart 98-2 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York.

Staffing for the External Appeal Program:

The Insurance Law and the Public Health Law provide that the Insurance Department and the Health Department shall be jointly responsible for implementation of the external appeal legislation, certification and oversight of external appeal agents, and oversight and monitoring of the external appeal process. The regulations of both Departments provide that the Insurance Department shall be responsible for screening external appeal requests for eligibility and completeness and for assigning requests to external appeal agents.

Due to the volume of external appeal requests, eight staff members in the Insurance Department's Consumer Services Bureau and three Insurance Department attorneys in the Health Bureau are responsible for screening external appeal requests for eligibility and completeness, assigning appeals to external appeal agents and responding to calls on the external appeal hotline, in addition to other job responsibilities.

Insurance Department attorneys in the Health Bureau and the Health Department staff in the Office of Managed Care are also responsible for certification and oversight of external appeal agents and for monitoring health plan compliance with external review requirements.

Types of Determinations Eligible for External Review and Standards Used for Review:

To be eligible for external review, services must be denied on the basis of medical necessity or as experimental or investigational. In addition, the denial must first be appealed internally with the health plan, unless the patient and the health plan jointly agree to waive the internal appeal process.

Medical Necessity External Appeals:

- Patients do not need an attestation from their attending physician in order to request an external appeal of a medical necessity determination unless they believe their appeal should be expedited.
- The standards that an external appeal agent must apply when reviewing a medical necessity determination are imposed by statute and the health plan's definition of medical necessity is not determinative.
- When reviewing a medical necessity determination, an external appeal agent must determine 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.

Experimental/Investigational External Appeals:

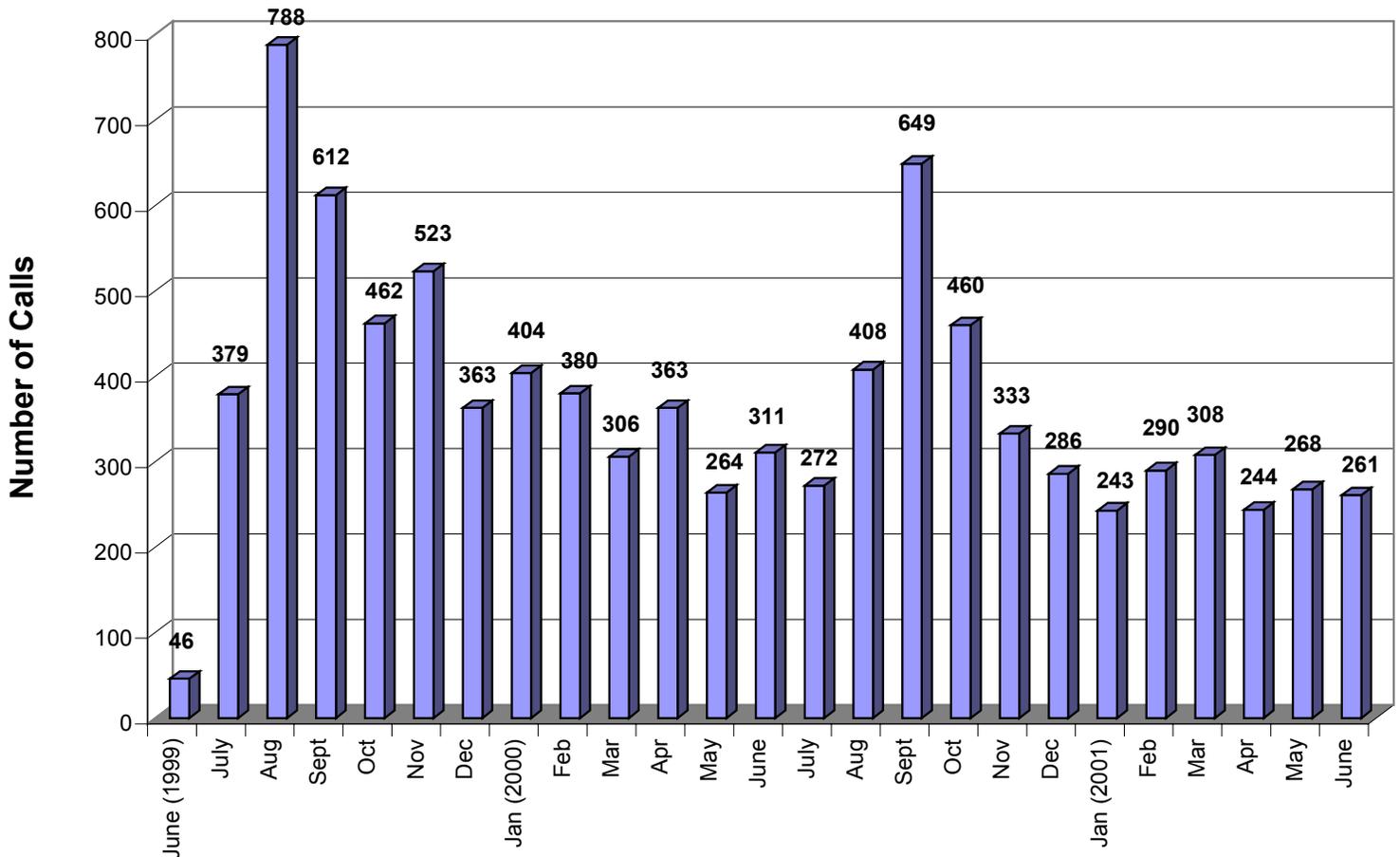
- In order for a patient to be eligible for an external review of an experimental or investigational determination, a patient's attending physician must attest that the patient has a life-threatening or disabling condition or disease for which a more beneficial standard procedure does not exist, would be ineffective, or for which there exists a clinical trial.
- The patient's attending physician must also either have recommended a health service that, based upon two documents from the available medical and scientific evidence, is likely to be more beneficial than a standard treatment or, the attending physician must have recommended a clinical trial for which the patient is eligible.
- The off-label use of prescription drugs is also included within the scope of experimental or investigational denials eligible for external review.
- When reviewing an experimental/investigational treatment appeal, an external appeal agent must determine whether the services are likely to be more beneficial than any standard treatment.
- When reviewing an appeal involving a clinical trial, an external appeal agent must determine whether the trial is likely to benefit the patient.

Volume of External Appeal Hotline Calls:

The Insurance Department operates an external appeal hotline so that consumers will be able to effectively utilize their external appeal rights. Calls to the hotline are answered by trained and experienced staff from the Consumer Services Bureau. Attorneys from the Insurance Department's Health Bureau are also available to respond to calls. Hotline operators provide external appeal information and assist consumers in filing external appeal requests.

During the first two years of operation, over 9,000 calls came in on the external appeal hotline and were responded to by Insurance Department staff. The hotline has, and continues to provide a valuable service to consumers. The following chart identifies the number of calls received each month on the external appeal hotline from June 10, 1999 through June 29, 2001.

Incoming Calls to the Toll-Free External Appeal Hotline 1-800-400-8882

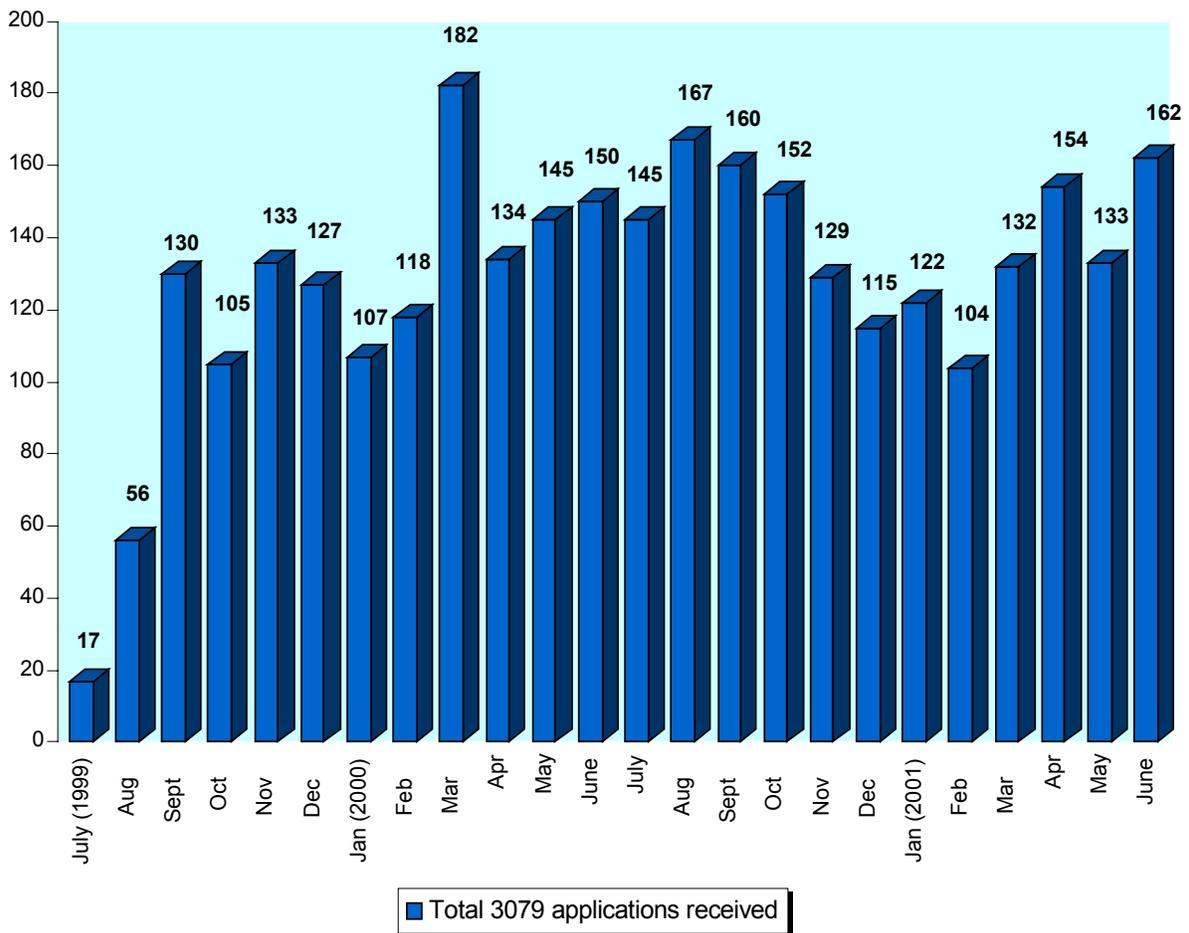


Volume of External Appeal Requests:

The Insurance Department has received over 3,000 external appeal requests during the first two years that the External Appeal Law has been in effect. This extraordinary volume of external appeal requests was not anticipated when the Law was first implemented. Before New York's External Appeal Law became effective, the Insurance Department and the Health Department reached out to numerous other states with external appeal programs already in place. All states contacted by the Departments reported a low volume of external appeal requests. The initial volume of external appeal requests in New York was unexpected since it was significantly higher than the volume reported by other states.

The following chart identifies the number of external appeal requests received by the Insurance Department for each month the program has been operational.

**External Appeal Applications Received by the Insurance Department
between July 1, 1999 and June 29, 2001**



Volume of External Appeal Requests in Other States:

The Insurance Department and the Health Department were aware the initial volume of external appeal requests in New York was higher than that experienced by other states due to information provided by other states two years ago. Since two years have elapsed, the Insurance Department and the Health Department decided to again contact other states to obtain information about their external appeal programs and determine how New York's External Appeal Program compares to the programs in other states.

Over the past several months, the Insurance Department conducted a survey of the 37 other states and the District of Columbia that have external appeal programs in place.¹ Staff from the Insurance Department contacted the various state agencies responsible for oversight of state external appeal programs and forwarded a questionnaire for completion. Of the states contacted, 35 responded to the questionnaire and provided survey results to the Insurance Department between May 2001 and July 2001. All the information contained in the following charts is based upon the written responses received from state agencies.

¹ Subsequent to the survey, legislation establishing an external appeal program passed in North Carolina, Oregon and West Virginia.

Number of External Appeal Requests Each State Received in the Last Four Years.

	Effective Date of Law	2001 (to mid-year)	2000	1999	1998
AK	7/1/01	N/A	N/A	N/A	N/A
AZ	7/1/98	139	282	265	61
CA	1/1/01	538	N/A	N/A	N/A
CO	6/1/00	27	28	N/A	N/A
CT	1/1/98	26	42	34	39
D.C.	1/14/00	14	12	N/A	N/A
DE	7/1/00	0	0	N/A	N/A
FL	1985	182	415	650	215
GA	7/1/99	16	76	29	N/A
HI	7/15/98	13	15	0	0
IA	1/1/00	14	16	N/A	N/A
IL	1/1/00	Not Available	Not Available	N/A	N/A
IN	7/1/99	Not Available	20	Not Available	N/A
KS	1/1/00	20	24	N/A	N/A
KY	7/14/00	44	26	N/A	N/A
LA	1/1/01	Not Available	N/A	N/A	N/A
MA	1/1/01	56	N/A	N/A	N/A
MD	1/1/99	636	1526	1063	N/A
ME	8/11/00	18(approx.)	6(approx.)	N/A	N/A
MI	10/1/00	153	47	N/A	N/A
MN	4/1/00	8	20	N/A	N/A
MO	DNR	DNR	DNR	DNR	DNR
MT	10/1/99	4	2	0	N/A
NH	9/3/00	18	15	N/A	N/A
NJ*	HMO regulations – 3/97 Health Care Quality Act – 2/98	169	174	174	122
NM	3/1/97	11	31	20	13
NY	7/1/99	1679 (7/1/00 - 6/30/01)	1400 (7/1/99 - 6/30/00)	See 2000 #s	N/A
OH	5/1/00	Not Available	Not Available	N/A	N/A
OK	1/1/00	11	8	N/A	N/A
PA	DNR	DNR	DNR	DNR	DNR
RI	1992	Not Available	48	14	26
SC	1/1/02	N/A	N/A	N/A	N/A
TN	1/1/98	23	102	77	41
TX	9/1/97	156	404	381	371
UT	1/1/01	Not Available	N/A	N/A	N/A
VA	5/17/00	65 (5/17/00 - 5/1/01)	See 2001 #s	N/A	N/A
VT	DNR	DNR	DNR	DNR	DNR
WA	7/1/01	N/A	N/A	N/A	N/A
WI	Not Yet Implemented	N/A	N/A	N/A	N/A

DNR - indicates states for which we did not receive survey responses.

N/A - indicates dates during which a state's law was not effective.

*** New Jersey indicated this is the number of appeals processed, not received.**

Frequent Use of the External Appeal Program:

New York has received a significantly higher volume of external appeal requests than the majority of other states. Efforts of the Insurance Department and the Health Department to facilitate consumer access to the New York external appeal process may have contributed to this high volume.

The Kaiser Family Foundation identified a lack of public awareness, the length of the internal and external appeal process, filing fees, external appeal filing deadlines, claims thresholds, and limits on types of cases eligible for external review as possible barriers to external appeal access.² Many of these potential barriers, such as the length of the internal and external appeal process, filing fees, external appeal filing deadlines, and claims thresholds are fairly standard and comparable among states.

Where states tend to differ, as we discovered in our survey, is with public outreach and efforts for public awareness. The Insurance Department and the Health Department have committed resources to ensure that consumers are made aware of their external appeal rights, to assist consumers in the filing of appeals and to ensure that the external appeal process is easily accessible.

- Both Departments have participated in informational seminars throughout the state with providers, health plans and consumers in order to disseminate information on the external appeal process.
- The Insurance Department established an external appeal hotline to assist New Yorkers in filing external appeal requests and to answer any questions applicants may have.
- Insurance Department staff is available on weekends and holidays to handle expedited external appeal requests and to assist patients with the filing of expedited requests.
- Information about the external appeal process and applications for consumers and providers to request an external appeal are available on the Web sites of the Insurance Department at www.ins.state.ny.us and the Health Department at www.health.state.ny.us.

²See Karen Pollitz, Geraldine Dallek, and Nicole Tapay, “External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare,” prepared for the Kaiser Family Foundation, November 1998. See also, Geraldine Dallek and Karen Pollitz, “External Review of Health Plan Decisions: An Update,” prepared for the Kaiser Family Foundation, May 2000.

In addition to outreach efforts, both the Insurance Department and the Health Department monitor compliance and promote enforcement of the External Appeal Law, including the requirements for health plan disclosure of external appeal information to consumers.

- The External Appeal Law requires health plans to provide external appeal information to prospective subscribers upon request.
- The External Appeal Law requires health plan member handbooks and subscriber contracts to include external appeal information.
- The External Appeal Law requires health plans to notify subscribers, in writing, of their external appeal rights at the time any adverse medical necessity or experimental/investigational determination is rendered.
- The external appeal regulations require health plans to enclose an external appeal application with a final adverse medical necessity or experimental/investigational treatment determination.
- 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.

New York is not the only state that has implemented measures for public awareness of the external appeal process. In our survey we asked other states how their consumers are made aware of external appeal rights. We also specifically inquired how consumers obtain applications to request an external appeal. Only nine states responded that health plans are required to provide an external appeal application with a final denial.

The following chart describes what other states do to make consumers aware of their external appeal programs.

How Do Consumers Find Out About External Appeals Rights in Other States?	
AK	<ul style="list-style-type: none"> Plans are responsible for informing subscribers of their rights.
AZ	<ul style="list-style-type: none"> An "Information packet" describing external appeal rights must be mailed to all new members and must be provided to members and their physicians upon request. At time of renewal health plans must send a statement reminding members of their external appeal rights. EOBs must provide information regarding external appeal rights. Press releases were issued by the state agency responsible for external appeals.
CA	<ul style="list-style-type: none"> External appeal information must be included in member handbooks. Denial letters must provide information regarding external appeal rights. Outreach programs have been conducted.
CO	<ul style="list-style-type: none"> Final denial letters must provide information regarding external appeal rights.
CT	<ul style="list-style-type: none"> All denial letters must provide information regarding external appeal rights, including timeframes for filing, Ins. Dept. address & telephone number. External appeal applications and instructions may be obtained from the Ins. Dept. and plans may, but are not required to include a copy with their denials.
DC	<ul style="list-style-type: none"> Denial letters must provide information regarding external appeal rights. External appeal applications may be obtained from the Grievance & Appeals Office. A member letter can trigger an external appeal. Outreach programs have been conducted.
DE	<ul style="list-style-type: none"> Plans will be required to publish external appeal information.
FL	<ul style="list-style-type: none"> External appeals are directed by HMOs, however, a state agency phone number and address are referenced in the HMO denial letter. HMOs file quarterly reports of unresolved grievances along with names and addresses of subscribers. A letter is sent to each subscriber informing them of their external appeal rights.
GA*	<ul style="list-style-type: none"> Denial letters must provide information regarding external appeal rights. External appeal applications must be sent with final denial letters.
HI	<ul style="list-style-type: none"> Final denial letters must provide information regarding external appeal rights.
IA	<ul style="list-style-type: none"> Denial letters must provide information regarding external appeal rights and must include the Ins. Dept. address and telephone number.
IL	<ul style="list-style-type: none"> EOBs must provide information regarding external appeal rights. Physicians and physicians' offices, the Illinois Department's HMO Unit and Office of Consumer Health Insurance also provide external appeal information.
IN	<ul style="list-style-type: none"> Plans are required to inform subscribers of external appeal rights. Denial letters must provide information regarding external appeal rights. Providers are required to have rights posted in full view for patients.
KS	<ul style="list-style-type: none"> Final denial letters must provide information regarding external appeal rights.
KY	<ul style="list-style-type: none"> External appeal information must be included in subscriber contracts. Denial letters must provide information regarding external appeal rights.
LA	<ul style="list-style-type: none"> Plans are required to advise subscribers of external appeal rights.
MA	<ul style="list-style-type: none"> External appeal information must be included in subscriber contracts. Disclosure notices were mailed in January 2001. Denial letters must provide information regarding external appeal rights. Information is provided on the State Health Department Web site.
MD	<ul style="list-style-type: none"> Plans must provide notice to subscribers of their rights to appeal to the State Insurance Administration.
ME	<ul style="list-style-type: none"> Plans must inform subscribers of external appeal rights and include information on how to contact the Bureau of Insurance to request an external appeal application.
MI*	<ul style="list-style-type: none"> Plans must inform subscribers of their external appeal rights. External appeal applications must be sent with final denial letters. External appeal applications are also posted on the state agency's Web site.

How Do Consumers Find Out About External Appeals Rights in Other States?	
MN	<ul style="list-style-type: none"> External appeal information must be included in subscriber contracts. Denial letters must provide information regarding external appeal rights and include information on how to contact the state agency responsible for external appeals to request an external appeal application.
MO	<ul style="list-style-type: none"> DNR
MT*	<ul style="list-style-type: none"> Plans must inform subscribers of their external appeal rights. External appeal applications must be sent with final denial letters.
NH*	<ul style="list-style-type: none"> Plans must inform subscribers of their external appeal rights. External appeal applications must be sent with final denial letters. External appeal information can also be obtained from the Insurance Department.
NJ*	<ul style="list-style-type: none"> External appeal information must be included in member handbooks. Plans must inform consumers of their external appeal rights. External appeal applications must be sent with final denial letters. External Appeal information is available on the State agency's Web site and through the State's Managed Health Care Consumer Assistance Program.
NM*	<ul style="list-style-type: none"> Plans must inform consumers of external appeal rights in enrollment packets. External appeal applications must be sent with final denial letters.
NY*	<ul style="list-style-type: none"> Plans must inform members of external appeal rights in member handbooks/subscriber contracts. Denial letters must provide information regarding external appeal rights. External appeal applications must be sent with final denial letters. External appeal information is available on the Insurance Department and Health Department Web sites and outreach has been conducted.
OH	<ul style="list-style-type: none"> External appeal information must be included in subscriber contracts. Denial letters must provide information regarding external appeal rights. Annual mailings describing external appeal rights are required.
OK*	<ul style="list-style-type: none"> Plans must inform subscribers of their external appeal rights. External appeal applications must be sent with denial letters.
PA	<ul style="list-style-type: none"> DNR
RI	<ul style="list-style-type: none"> Plans are required to provide written notification of the external appeal process with contact information.
SC	<ul style="list-style-type: none"> N/A
TN	<ul style="list-style-type: none"> External appeal information must be included in subscriber contracts.
TX*	<ul style="list-style-type: none"> Plans must inform subscribers and providers of external appeal rights. External appeal applications must be sent with denial letters.
UT	<ul style="list-style-type: none"> External appeal information must be included in subscriber contracts. Plans must inform consumers of external appeal rights if they call in relation to a denial or a problem.
VA*	<ul style="list-style-type: none"> External appeal information must be included in subscriber contracts. External appeal applications must be sent with final denial letters. There is an outreach program.
VT	<ul style="list-style-type: none"> DNR
WA	<ul style="list-style-type: none"> N/A
WI	<ul style="list-style-type: none"> Plans will be required to notify consumers of their rights and provide an explanation of procedures whenever a plan makes a determination subject to external review.

*** Indicates states that require plans to include an application or request form for an external appeal with denial letters.**

DNR – indicates states for which we did not receive survey responses.

N/A – indicates states that did not have that information available at the time of the survey.

Eligibility for an External Appeal:

The New York External Appeal Law is broad in application and limits on eligibility are minimal. Disputes concerning medical necessity, experimental and investigational services, clinical trials and the off-label use of prescription drugs are eligible for external review in New York. There is no requirement that the claim have a minimum dollar value.

Access to a referral to a non-participating provider or review of the appropriateness of a particular coding to a patient, including the assignment of diagnosis and procedure are not subject to the external review process. Disputes concerning benefit or coverage limitations are also not eligible for external review.

Questions have arisen as to the distinction between medical necessity determinations and disputes concerning coverage or benefit limitations. Denials because a contractual visit limit has been exceeded or denials because a benefit itself is not covered under the contract are not eligible for external review. Determinations that services are cosmetic or custodial are considered medical necessity determinations, subject to the external appeal process. Some health plans have questioned the applicability of the external appeal process to determinations that surgical services are cosmetic or that care is custodial because Insurance Department Regulation 62, promulgated many years prior to the passage of the External Appeal Law, permits plans to exclude coverage for cosmetic surgery and custodial care.³

Custodial Care:

Regulation 62 permits plans to exclude coverage for custodial care which is defined as “help in transferring, eating, dressing, bathing, toileting, and other such related activities”. This definition of custodial care is very narrow. If services other than those specifically referenced in the Regulation 62 custodial care definition are provided, the care cannot be considered custodial and the denial must be one of medical necessity. Custodial care determinations have been subject to external review when services other than “help in transferring, eating, dressing, bathing, toileting” were provided, yet the plan still considered the care to be custodial.

Cosmetic Surgery:

The Insurance Law and corresponding regulations require most plans to provide coverage for surgical services. Regulation 62 does permit plans to exclude coverage for cosmetic surgery but provides an automatic exception to the cosmetic surgery exclusion for reconstructive surgery. Reconstructive surgery is one exception to the cosmetic surgery exclusion but is not the only type of surgery that is considered medically necessary. If the reconstructive surgery exception is not met, the plan must still consider whether the surgery is medically necessary or cosmetic. It is the Insurance Department’s position that whenever surgery itself is a covered benefit under a policy, a determination that the surgery is cosmetic is a medical necessity determination. The Insurance Department is working on an amendment to Regulation 62 to clarify this position.

³ 11 N.Y.C.R.R. 52.16.

In our survey we questioned other states as to which types of denials are eligible for external review. The following information was provided by the states surveyed.

Which Determinations Are Eligible For External Review?

State	Medical Necessity	Experimental/ Investigational Treatment	Denials for a Referral to a Non-Participating Provider	Other
AK	X	X		Denial based on a failure to meet a deadline for internal appeal or a decision to cover a benefit that involves medical judgment.
AZ	X	X	X	Issues of coverage and contract interpretation.
CA	X	X		Urgent care/emergency care reimbursement.
CO	X		X (for medical necessity)	
CT	X	X		
DC	X	X		
DE	X	X		Cosmetic surgery.
FL	X	X	X	Excluded benefits, non-authorization of services, denial of enrollment, termination of policy, emergency room coverage, contract interpretation and claims payment.
GA	X	X	X (for medical necessity)	
HI	X	X	X	The law allows enrollees to request an external review of any final determination of a managed care plan.
IA	X			
IL	X	X (with physician attestation)	X (for medical necessity)	
IN	X	X	X	
KS	X	X		
KY	X	X		
LA	X			
MA	X	X	X (If member states that expertise is not available within network or is in the middle of treatment.)	
MD	X	X	X	
ME	X	X	X	Pre-existing conditions, clinical issues related to diagnosis, care and treatment.
MI	X	X	X	

DNR – indicates states for which we did not receive survey responses.

N/A – indicates states that did not have the information available at the time of the survey.

State	Medical Necessity	Experimental/ Investigational Treatment	Denials for a Referral to a Non-Participating Provider	Other
MN	X	X	X	Any claims except allegations of misrepresentation by agents.
MO	DNR			
MT	X			Medically appropriate and medically necessary care.
NH	X	X	X	
NJ	X	X	X (for medical necessity)	
NM	X	X	X	Consumers can ask for a hearing concerning any adverse determination made by a plan.
NY	X	X (with physician attestation)		
OH	X	X	X (for medical necessity)	
OK	X			Medically appropriate and medically effective care.
PA	DNR			
RI	X			
SC	N/A			
TN	X	X	X	
TX	X			
UT	X	X	X	Any disagreement with an insurance related decision of an insurer as long as the external review does not expand, extend or modify the terms of the contract with respect to covered benefits.
VA	X	X		
VT	DNR			
WA	X	X	X	For covered benefits.
WI	X	X	X (for medical necessity)	

DNR – indicates states for which we did not receive survey responses.

N/A – indicates states that did not have the information available at the time of the survey.

How External Appeal Requests are Submitted and Reviewed:

External appeal applications are submitted to the Insurance Department which is responsible for screening applications for eligibility and completeness. When screening an external appeal request, Insurance Department staff reviews the application to ensure that:

- The application has been completed and is signed.
 - ✓ The application must be signed by the patient, a parent if the patient is not 18 years of age, a guardian, or an executor/administrator of the patient's estate if the patient is deceased.
- A final adverse determination from the first level of appeal with the health plan is included.
 - ✓ If a final adverse determination has not yet been rendered, the patient is advised to appeal internally with the health plan within the requisite timeframe and then, if necessary, request an external appeal.
- Services have been denied on the basis of medical necessity or as experimental or investigational.
 - ✓ The denial letter from the health plan is used to determine the basis of the denial.
 - ✓ If external appeal rights are not provided in the denial letter, staff from the Insurance Department reviews the denial to ensure that it is not one that falls within the scope of what should be considered a medical necessity or experimental/investigational denial. If it appears that a decision involving medical necessity or experimental/investigational services has been made, the Insurance Department will contact the health plan and request that external appeal rights be provided.
 - ✓ Denials based solely upon a request for a referral to a non-participating provider, failure to obtain health services from a designated provider, reimbursement amounts, or the appropriateness of a particular procedure coding are not considered medical necessity determinations subject to external review.
- An attending physician attestation has been fully completed if the appeal is expedited or if the services are experimental or investigational. If services are denied as experimental or investigational, an attending physician must:
 - ✓ Attest that the patient has a life-threatening or disabling condition or disease.
 - ✓ Attest that standard health services have been ineffective, would not be more beneficial than the proposed treatment, or that there exists a clinical trial.
 - ✓ Submit two articles in support of the recommended procedure that meet the statutory definition of medical and scientific evidence or attest that the patient is eligible for a clinical trial.
 - ✓ If the attending physician attestation does not meet all of these requirements, the request will not be eligible for external review.

- The 45 day timeframe has not been exceeded.
 - ✓ An application is considered timely if 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.
 - ✓ It is presumed that the final adverse determination was received within eight days of the date on the determination.
- The type of coverage falls within the scope of the Law.
 - ✓ The External Appeal Law is not applicable to self-insured plans, out-of-state insurance policies, workers compensation coverage, no-fault automobile coverage, Medicaid fee-for-service coverage and Medicare coverage, including coverage under Medicare managed care plans.
- The fee has been submitted or waived.
 - ✓ The applicant must enclose a check or money order for the application fee made payable to the health plan, or the applicant must indicate the fee does not apply or a fee waiver has been requested.

If the application is determined to be incomplete:

- A letter identifying and requesting the missing information is sent to the patient, and the attending physician, as appropriate. An Insurance Department address for the submission of the information is provided and a timeframe for submitting the information is included. The name and telephone number of the Insurance Department staff member reviewing the appeal is also provided so that the patient may readily contact the Insurance Department with any questions. If the appeal is expedited, the request for the missing information is made by telephone, followed by written notice.

If the application is determined to be ineligible:

- Supervisory approval is required before an external appeal request may be rejected by Insurance Department staff. If an application is rejected, the application and the fee are returned to the applicant and an explanation of why the application has been rejected is provided. Applicants are also advised that even though the request is not eligible for external review, they may still request that the matter be reviewed and handled by staff from the Office of Managed Care in the Health Department or the Consumer Services Bureau in the Insurance Department.

Rejection of External Appeal Requests:

During the past two years, from July 1, 1999 through June 29, 2001, a total of 859 external appeal applications were rejected. On a calendar year basis, 149 external appeal requests were rejected in 1999, 536 external appeal applications were rejected in 2000 and 174 external appeal applications were rejected from January 1, 2001 through June 29, 2001.

When all External Appeal Program year results are considered, the most frequent reason for rejection of external appeal requests has been and continues to be because an application is incomplete and the applicant does not provide the missing information after two requests for the information are made by Insurance Department staff. In order to minimize the possibility of rejection because an application is incomplete, the Insurance Department has implemented several procedures for handling incomplete applications.

When an incomplete application is submitted, Insurance Department staff sends the applicant and the applicant's attending physician, as appropriate, a letter requesting the missing information and identifying a timeframe for the submission of the information. The applicant is also encouraged to contact the Department if the applicant requires assistance or has any questions in relation to the information requested. If the information is not received within the timeframe, a second letter is sent identifying a date that the appeal will be rejected if the information is not received. If the information missing is the final adverse determination from the health plan, Insurance Department staff may also contact the health plan and request the health plan forward a copy of the final denial letter. If the information missing is the physician attestation, Insurance Department staff will send written requests to the patient's attending physician and may also call the attending physician to request the information. If the missing information is not received after the two written requests have been sent to the applicant, and the applicant has not contacted the Department to request assistance or to explain that additional time is needed, only then is the application is rejected.

The following chart lists the numbers of appeals that have been rejected and the reasons for rejection of external appeal requests for the two years of operation of the External Appeal Program. The chart also specifies the type of information that was missing from applications that were rejected as incomplete.

Reasons for Rejections from July 1, 1999 through June 29, 2001	
Applicant did not provide missing information:	218
• Denial letters, including FAD.	41
• Physician attestation for experimental/investigational appeal.	25
• An application.	16
• Patient did not submit external appeal request and failed to confirm they wanted an external appeal.	14
• Signed consent form.	8
• Check or money order.	3
• More than one of the above items missing.	111
Application was not submitted within 45 day timeframe.	141
Provider ineligible to request external appeal.	127
Dispute involved benefit that was not covered under the contract.	74
Self-insured coverage.	55
Applicant did not first appeal internally with the health plan.	50
Final adverse determination rendered prior to 7/1/99.	32
Medicare managed care coverage.	31
CPT code, UCR and level of reimbursement dispute.	27
Access to non-participating provider.	26
Applicant withdrew external appeal request.	20
Duplicate application submitted.	16
Failure to request pre-authorization as basis for denial.	11
Attending physician attestation for experimental/investigational appeal did not meet requirements of Law.	8
Out-of-state insurance policy.	8
Loss of coverage / not covered at time of treatment.	7
Federal employee coverage.	4
No-fault automobile coverage.	3
Worker's compensation claim	1
Total	859

Reversals by Health Plans:

A health plan may reverse its adverse determination during the external appeal process, at any time, until the external appeal agent renders a determination. Some denials are reversed by the health plan prior to assignment of an external appeal agent, while others are reversed by the health plan because new information is forwarded to the plan as a result of the external appeal.

Insurance Department staff contacts the health plan prior to assigning an external appeal to an agent in order to provide the plan with early notice that an appeal is eligible for external review. The initial contact also provides an opportunity for staff from the Insurance Department and the health plan to discuss whether the plan would like to reverse its adverse determination. In some cases the dispute is resolved through the Insurance Department's early intervention and review by an external appeal agent is not necessary.

A health plan may also decide to reverse its adverse determination when the case is pending with an external appeal agent. The Law requires agents to provide health plans with a copy of any material information submitted with an external appeal that had not previously been reviewed by the health plan. The health plan then has three days to consider the information and must decide whether to reverse its denial or to proceed with the external appeal.

From July 1, 1999 through June 29, 2001, 454 appeals were closed because of health plan reversal of an adverse determination during the external appeal process. On a calendar year basis, 64 external appeals were reversed by health plans in 1999, 259 were reversed in 2000 and 131 were reversed between January 1, 2001 and June 29, 2001.

Assignment of External Appeal Requests to Agents:

If an external appeal request is determined to be eligible and complete, staff at the Insurance Department will notify the health plan, the applicant and the external appeal agent in writing. The Insurance Department provides the health plan, the applicant and the external appeal agent with the contact information for all parties involved in the appeal and advises parties as to whether the appeal will be processed as standard or expedited and whether the denial is based on medical necessity, experimental/investigational services or a clinical trial. The Insurance Department also provides specific information to each of the parties, in order to assist the parties with the appeal.

In notices to health plans, the Insurance Department reminds plans that they must send medical records to the external appeal agent within three business days from when the agent contacts the plan for standard appeals, or 24 hours from when the agent contacts the plan for expedited appeals. The Department also provides health plans with a copy of the plan's own final adverse determination, along with the patient's signed consent to the release of medical records, so that the plan is made aware of the services being appealed and has the appropriate authorization to release the patient's medical records to the external appeal agent.

In notices to external appeal applicants, the Insurance Department identifies the agent that has been assigned to review the appeal and explains that all materials included with the application will be sent to the agent. The Insurance Department also advises applicants that any additional information the applicant would like to submit must be sent immediately to the agent.

In notices to external appeal agents the Insurance Department reminds agents of the timeframes for rendering a determination. The Insurance Department also forwards all information submitted with the appeal to the external appeal agent by either facsimile or overnight mail, depending upon the type and length of information submitted.

External appeal agents must render a decision in three days for expedited appeals and 30 days (plus five business days when additional information is requested) for standard appeals. Pursuant to the Law, medical necessity decisions must include the reasons for the determination and, if the plan's denial is upheld on appeal, the clinical rationale, if any, for such determination. The Law provides that decisions involving experimental or investigational treatments must include a written statement as to whether the proposed treatment is likely to be more beneficial than any standard treatment for a patient's life-threatening or disabling condition or disease. Decisions involving a clinical trial must include a written statement as to whether the clinical trial is likely to benefit the patient in the treatment of the patient's life-threatening or disabling condition or disease.

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 binding, but admissible in court proceedings.

External Appeal Agents:

The Law and regulations impose standards for the certification and re-certification of external appeal agents. Both are designed to ensure that agents provide an independent review of a health plan's determination through a comprehensive network of qualified providers.

Operational Requirements:

External appeal agents must demonstrate that they have a panel of clinical peer reviewers qualified to review both medical necessity and experimental and investigational treatment determinations. Clinical peers must be appropriately licensed, trained in New York external appeal standards, and knowledgeable about the health care service under appeal. External appeal agents must assign appeals to a clinical peer in the same or similar specialty as the provider that typically manages the medical condition that is the subject of the appeal to ensure that the case will be reviewed by a provider of the appropriate specialty.

There are also requirements in the Law for external appeal agents to have a medical director who is responsible for supervision and oversight of the external appeal process. External appeal agents must have a quality assurance program and must also have policies and procedures in place to protect confidentiality.

Conflict of interest standards are included in the Law and regulations so that external appeal agents and their clinical peers will be independent from the health plan and any party involved in the external appeal. External appeal agents and their clinical peers are prohibited from having a material professional affiliation, material financial affiliation or material familial affiliation with the health plan, patient, provider or facility involved in the external appeal and/or proposing to provide services. External appeal agents are also prohibited from accepting an appeal if they have reviewed the case for the health plan during the plan's internal appeal process.

The Insurance Department and external appeal agents are both responsible for reviewing cases to make sure that a conflict of interest does not exist with respect to the agent at the time an appeal is assigned. The agent is also responsible for ensuring that a conflict of interest does not exist with respect to its clinical peers assigned to the appeal and must attest that no conflict of interest exists.

Certification:

The Insurance Department and the Health Department are jointly responsible for reviewing applications for external appeal agent certification and re-certification. To date eleven applications requesting certification have been submitted and reviewed:

- Two applicants withdrew their applications after receiving comment letters from the Departments.
- Five applicants were rejected because they were unable to meet the standards imposed by law and regulation.
- One application is pending, awaiting a response from the applicant to comment letters sent by the Departments.
- Three applicants, IPRO, MCMC and HAYES Plus were certified.

HAYES Plus, Inc (HAYES Plus), located in Lansdale, Pennsylvania, was certified on June 21, 2001 as an external appeal agent to conduct external reviews in New York State. HAYES Plus is an affiliate of HAYES, Inc., a national medical technology assessment organization founded in 1989. HAYES Plus is also certified to conduct external reviews in Arizona, California, Colorado, District of Columbia, Georgia, Michigan, New Hampshire, Nevada, Ohio, Oklahoma, Pennsylvania, Tennessee and Washington. You may visit the HAYES Plus, Inc. web site at www.hayesinc.com.

Island Peer Review Organization (IPRO), located in Lake Success, New York, was certified on June 30, 1999 as an external appeal agent to conduct external reviews in New York State. IPRO has over 15 years experience as a health care quality evaluation organization. IPRO is also certified to conduct external reviews in Colorado, Connecticut, District of Columbia, Massachusetts, Maryland, New Hampshire, New Jersey, Oklahoma and Pennsylvania. You may visit IPRO's web site at www.ipro.org.

Medical Care Management Corporation (MCMC), located in Bethesda, Maryland, was certified on July 2, 1999 as an external appeal agent to conduct external reviews in New York State. MCMC has been providing external reviews to patients, providers, health plans and employers nationwide, for the past seven years, and has reviewed over 8,000 cases in all areas of medicine. MCMC is also certified to conduct external reviews in California, Colorado, Indiana, New Hampshire, Ohio and Oklahoma. You may visit MCMC's web site at www.mcman.com.

Recertification:

Once certified, external appeal agents must be re-certified every two years. IPRO and MCMC are currently in the re-certification process. As part of the re-certification, the Insurance Department and the Health Department have requested that agents provide a description of any policies and procedures that have changed since initial certification along with a description of any changes in the agent's clinical peer review network. The Departments also requested agents provide a plan of correction for any deficiencies the Departments identified during on-going monitoring and oversight.

Cost of External Appeals:

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.

Health plans are responsible for paying the costs of the external appeal regardless of whether the health plan's determination is upheld or overturned by the agent. Payment must be made by the health plan to the external appeal agent 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.

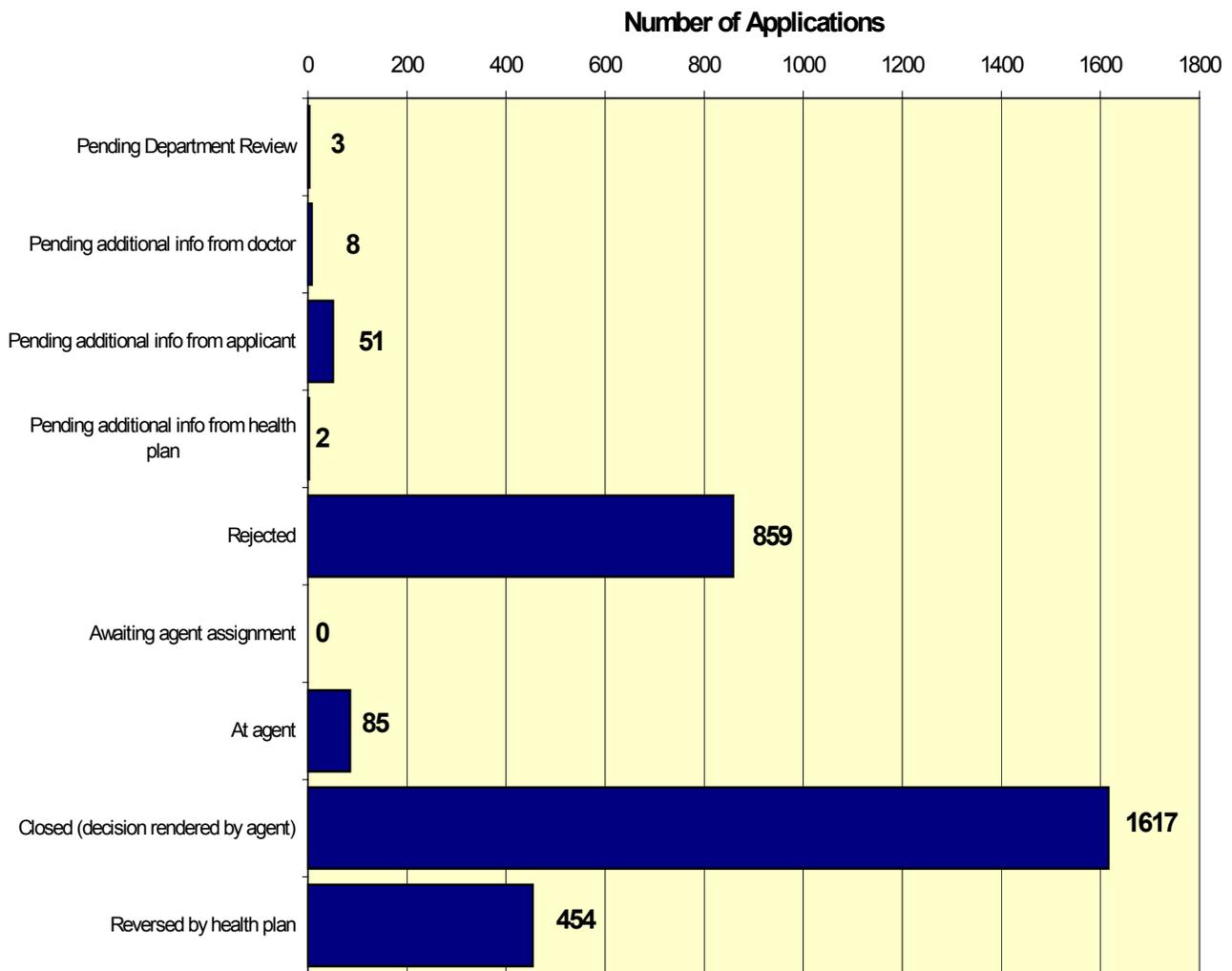
Below is a table of the costs to all health plans for external appeal determinations rendered from July 1, 1999 through June 29, 2001:

	Medical Necessity	Experimental/ Investigational	Total
1999	\$105,460	\$31,580	\$137,040
2000	\$474,665	\$149,840	\$624,505
2001	\$226,530	\$113,260	\$339,790
Total	\$806,655	\$294,680	\$1,101,335

Status of External Appeal Requests as of June 29, 2001:

External appeal requests submitted to the Insurance Department are assigned a status code which 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, under review by an external appeal agent, rejected, reversed by a health plan, or closed because an external appeal agent has rendered a determination. The following chart identifies the status of all external appeal requests submitted to the Insurance Department as of June 29, 2001:

Status of Applications Received by the Insurance Department as of June 29, 2001



External Appeal Results By Health Plan:

There were a total of 1,617 decisions rendered by external appeal agents from July 1, 1999 through June 29, 2001. Chart 1 identifies the total number of decisions overturned in whole, overturned in part and upheld by external appeal agents for each calendar year of operation of the External Appeal Program. Chart 2 lists external appeal results for each health plan for each calendar year of operation of the External Appeal Program. Chart 3 lists external appeal results for health plans by the type of coverage provided, HMO, non-profit indemnity insurance, commercial insurance, Medicaid managed care coverage and 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 plan.

A comparison of the charts reveals that external appeal results do not vary significantly depending on the type of coverage provided. From July 1, 1999 through June 29, 2001, HMO denials were overturned by external appeal agents in whole or in part in 48% of cases. Non-profit indemnity insurer denials were overturned in whole or in part in 49% of cases and commercial insurer denials were overturned in whole or in part in 50% of cases.

Chart 1:

Timeframe	Total	Health Plan Denial Overturned	Health Plan Denial Overturned in Part	Health Plan Denial Upheld
January 1, 2001 – June 29, 2001	474	189	39	246
January 1, 2000 – December 31, 2000	937	371	91	475
July 1, 1999 – December 31, 1999	206	80	20	106
Total	1617	640	150	827

External Appeal Decisions by Health Care Plan
(listed alphabetically)
July 1, 1999 – June 29, 2001

Chart 2:

Health Plan	Total	Overturned	Overturned in Part	Upheld
Americhoice	1	1	0	0
• 2001	0	0	0	0
• 2000	1	1	0	0
• 1999	0	0	0	0
Aetna Life Insurance Company	3	0	2	1
• 2001	3	0	2	1
• 2000	0	0	0	0
• 1999	0	0	0	0
Aetna U.S. Healthcare, Inc.	66	29	8	29
• 2001	15	10	0	5
• 2000	44	16	7	21
• 1999	7	3	1	3
Anthem Health and Life Ins. Co. of NY	3	2	0	1
• 2001	1	0	0	1
• 2000	2	2	0	0
• 1999	0	0	0	0
Blue Choice (Excellus BC/BS of Rochester HMO)	23	13	0	10
• 2001	14	7	0	7
• 2000	7	4	0	3
• 1999	2	2	0	0
Buffalo Community Health, Inc.	1	0	0	1
• 2001	0	0	0	0
• 2000	0	0	0	0
• 1999	1	0	0	1
CDPHP (Capital District Physicians Health Plan)	28	13	2	13
• 2001	9	4	0	5
• 2000	17	8	2	7
• 1999	2	1	0	1
Catskill Area Schools Employee Benefit Plan	2	0	0	2
• 2001	2	0	0	2
• 2000	0	0	0	0
• 1999	0	0	0	0

Health Plan	Total	Overturned	Overturned in Part	Upheld
CIGNA HealthCare of New York	29	11	6	12
• 2001	5	2	2	1
• 2000	24	9	4	11
• 1999	0	0	0	0
Community Blue (Health Now BC/BS of Western NY-Buffalo HMO)	27	5	3	19
• 2001	8	1	1	6
• 2000	15	4	1	10
• 1999	4	0	1	3
Connecticut General Life Ins. Co.	21	13	0	8
• 2001	6	4	0	2
• 2000	14	8	0	6
• 1999	1	1	0	0
Empire Healthchoice HMO, Inc.	69	32	4	33
• 2001	21	11	0	10
• 2000	38	16	3	19
• 1999	10	5	1	4
Empire Healthchoice, Inc.	260	100	20	140
• 2001	100	40	11	49
• 2000	150	57	7	86
• 1999	10	3	2	5
Excellus (BC/BS of Central NY Indemnity)	77	26	7	44
• 2001	26	10	0	16
• 2000	45	15	6	24
• 1999	6	1	1	4
Excellus (BC/BS of Rochester Indemnity)	16	8	0	8
• 2001	6	4	0	2
• 2000	9	3	0	6
• 1999	1	1	0	0
Excellus (BC/BS of Utica-Watertown Indemnity)	16	5	0	11
• 2001	6	2	0	4
• 2000	8	1	0	7
• 1999	2	2	0	0

Health Plan	Total	Overturned	Overturned in Part	Upheld
Fidelis Care New York (NYS Catholic Health Plan)	3	0	0	3
• 2001	0	0	0	0
• 2000	2	0	0	2
• 1999	1	0	0	1
GHI	139	49	35	55
• 2001	29	5	8	16
• 2000	96	40	25	31
• 1999	14	4	2	8
GHI HMO Select Inc.	2	0	0	2
• 2001	1	0	0	1
• 2000	1	0	0	1
• 1999	0	0	0	0
Guardian Life Ins. Co.	5	0	2	3
• 2001	4	0	2	2
• 2000	1	0	0	1
• 1999	0	0	0	0
Health Now (BC/BS of Western NY – Indemnity)	16	6	3	7
• 2001	6	3	1	2
• 2000	8	1	2	5
• 1999	2	2	0	0
Health Now (BS of Northeastern NY – HMO)	11	4	0	7
• 2001	1	0	0	1
• 2000	6	3	0	3
• 1999	4	1	0	3
Health Now (BS of Northeastern NY – Indemnity)	19	11	0	8
• 2001	6	2	0	4
• 2000	5	3	0	2
• 1999	8	6	0	2
Health Plus	5	1	0	4
• 2001	0	0	0	0
• 2000	4	1	0	3
• 1999	1	0	0	1

Health Plan	Total	Overtured	Overtured in Part	Upheld
Healthsource HMO of NY, Inc. (no longer operational)	1	0	0	1
• 2001	0	0	0	0
• 2000	0	0	0	0
• 1999	1	0	0	1
HIP (Health Insurance Plan of Greater NY)	44	20	3	21
• 2001	17	7	0	10
• 2000	25	12	3	10
• 1999	2	1	0	1
HMO Blue (Excellus BC/BS of Utica-Watertown HMO)	8	2	1	5
• 2001	4	1	0	3
• 2000	3	1	1	1
• 1999	1	0	0	1
HMO-CNY (Excellus BC/BS of Central NY HMO)	20	9	3	8
• 2001	4	3	0	1
• 2000	16	6	3	7
• 1999	0	0	0	0
Horizon Healthcare Ins. Co. of NY	3	2	0	1
• 2001	1	1	0	0
• 2000	2	1	0	1
• 1999	0	0	0	0
Independent Health Association (IHA)	9	2	1	6
• 2001	2	0	0	2
• 2000	6	2	1	3
• 1999	1	0	0	1
Jefferson-Lewis Healthcare Plan	1	0	0	1
• 2001	1	0	0	1
• 2000	0	0	0	0
• 1999	0	0	0	0
Kaiser Permanente (no longer operational)	4	2	0	2
• 2001	0	0	0	0
• 2000	2	1	0	1
• 1999	2	1	0	1

Health Plan	Total	Overtured	Overtured in Part	Upheld
MDNY Healthcare Inc.	12	9	1	2
• 2001	4	2	1	1
• 2000	7	6	0	1
• 1999	1	1	0	0
Metropolitan Life Ins. Co.	50	23	2	25
• 2001	0	0	0	0
• 2000	23	11	1	11
• 1999	27	12	1	14
MVP (Mohawk Valley PHP)	21	6	1	14
• 2001	7	2	0	5
• 2000	13	4	1	8
• 1999	1	0	0	1
New England Life Ins. Co.	1	1	0	0
• 2001	0	0	0	0
• 2000	1	1	0	0
• 1999	0	0	0	0
Nippon Life Ins. Co. of America	1	0	0	1
• 2001	1	0	0	1
• 2000	0	0	0	0
• 1999	0	0	0	0
Oxford Health Plan	243	81	16	146
• 2001	70	26	4	40
• 2000	112	33	7	72
• 1999	61	22	5	34
Partner's Health Plans (HUM) (no longer operational)	2	1	0	1
• 2001	0	0	0	0
• 2000	1	0	0	1
• 1999	1	1	0	0
Phoenix Home Life Mutual Ins. Co.	1	0	0	1
• 2001	0	0	0	0
• 2000	0	0	0	0
• 1999	1	0	0	1

Health Plan	Total	Overtured	Overtured in Part	Upheld
Physicians Health Services (Health Net)	72	31	13	28
• 2001	16	5	3	8
• 2000	45	22	7	16
• 1999	11	4	3	4
Preferred Care (Rochester Area HMO)	5	3	0	2
• 2001	0	0	0	0
• 2000	5	3	0	2
• 1999	0	0	0	0
Prudential Health Care Plan of New York (no longer operational)	12	4	1	7
• 2001	2	1	0	1
• 2000	7	3	0	4
• 1999	3	0	1	2
Putnam/Northern Westchester Health Benefits Consortium	1	0	0	1
• 2001	0	0	0	0
• 2000	1	0	0	1
• 1999	0	0	0	0
UniCARE Life and Health Ins. Co.	8	2	4	2
• 2001	3	0	1	2
• 2000	5	2	3	0
• 1999	0	0	0	0
Union Labor Life Ins. Co.	1	0	0	1
• 2001	0	0	0	0
• 2000	1	0	0	1
• 1999	0	0	0	0
United HealthCare Ins. Co. of NY	120	52	5	63
• 2001	37	18	2	17
• 2000	81	33	2	46
• 1999	2	1	1	0
United HealthCare of New York, Inc.	11	7	0	4
• 2001	2	1	0	1
• 2000	9	6	0	3
• 1999	0	0	0	0

Health Plan	Total	Overtured	Overtured in Part	Upheld
United States Life Ins. Co. of NY	1	0	0	1
• 2001	0	0	0	0
• 2000	0	0	0	0
• 1999	1	0	0	1
Univera Healthcare CNY	10	5	0	5
• 2001	4	2	0	2
• 2000	5	2	0	3
• 1999	1	1	0	0
Univera Healthcare Southern Tier	4	2	0	2
• 2001	0	0	0	0
• 2000	3	1	0	2
• 1999	1	1	0	0
Univera Healthcare WNY (Health Care Plan)	46	15	0	31
• 2001	16	6	0	10
• 2000	22	7	0	15
• 1999	8	2	0	6
Vytra Healthcare of Long Island	63	32	7	24
• 2001	14	9	1	4
• 2000	45	22	5	18
• 1999	4	1	1	2
Total	1617	640	150	827

External Appeal Decisions by Health Care Plan
(listed by type of coverage)

July 1, 1999 – June 29, 2001

Chart 3:

Health Maintenance Organizations	Total	Overturned	Overturned in Part	Upheld
Aetna U.S. Healthcare	66	29	8	29
• 2001	15	10	0	5
• 2000	44	16	7	21
• 1999	7	3	1	3
Blue Choice (Excellus BC/BS of Rochester HMO)	21	11	0	10
• 2001	12	5	0	7
• 2000	7	4	0	3
• 1999	2	2	0	0
CDPHP (Capital District Physicians Health Plan)	27	13	2	12
• 2001	8	4	0	4
• 2000	17	8	2	7
• 1999	2	1	0	1
CIGNA HealthCare of New York	29	11	6	12
• 2001	5	2	2	1
• 2000	24	9	4	11
• 1999	0	0	0	0
Community Blue (Health Now BC/BS of Western NY-Buffalo HMO)	27	5	3	19
• 2001	8	1	1	6
• 2000	15	4	1	10
• 1999	4	0	1	3
Empire Healthchoice HMO, Inc.	69	32	4	33
• 2001	21	11	0	10
• 2000	38	16	3	19
• 1999	10	5	1	4
GHI HMO Select, Inc.	2	0	0	2
• 2001	1	0	0	1
• 2000	1	0	0	1
• 1999	0	0	0	0

Health Maintenance Organizations	Total	Overtured	Overtured in Part	Upheld
Health Now (BS of Northeastern NY HMO)	11	4	0	7
• 2001	1	0	0	1
• 2000	6	3	0	3
• 1999	4	1	0	3
Healthsource HMO of NY, Inc. (no longer operational)	1	0	0	1
• 2001	0	0	0	0
• 2000	0	0	0	0
• 1999	1	0	0	1
HIP (Health Insurance Plan of Greater NY)	42	19	3	20
• 2001	17	7	0	10
• 2000	23	11	3	9
• 1999	2	1	0	1
HMO Blue (Excellus BC/BS of Utica-Watertown HMO)	7	1	1	5
• 2001	3	0	0	3
• 2000	3	1	1	1
• 1999	1	0	0	1
HMO-CNY (Excellus BC/BS of Central NY HMO)	20	9	3	8
• 2001	4	3	0	1
• 2000	16	6	3	7
• 1999	0	0	0	0
Independent Health Association (IHA)	9	2	1	6
• 2001	2	0	0	2
• 2000	6	2	1	3
• 1999	1	0	0	1
Kaiser Permanente (no longer operational)	4	2	0	2
• 2001	0	0	0	0
• 2000	2	1	0	1
• 1999	2	1	0	1
MDNY	12	9	1	2
• 2001	4	2	1	1
• 2000	7	6	0	1
• 1999	1	1	0	0

Health Maintenance Organizations	Total	Overtured	Overtured in Part	Upheld
MVP (Mohawk Valley PHP)	21	6	1	14
• 2001	7	2	0	5
• 2000	13	4	1	8
• 1999	1	0	0	1
Oxford Health Plan	243	81	16	146
• 2001	70	26	4	40
• 2000	112	33	7	72
• 1999	61	22	5	34
Partner's Health Plans (HUM) (no longer operational)	2	1	0	1
• 2001	0	0	0	0
• 2000	1	0	0	1
• 1999	1	1	0	0
Physicians Health Services (Health Net)	55	27	9	19
• 2001	12	5	2	5
• 2000	33	18	4	11
• 1999	10	4	3	3
Preferred Care (Rochester Area HMO)	5	3	0	2
• 2001	0	0	0	0
• 2000	5	3	0	2
• 1999	0	0	0	0
Prudential Health Care Plan of New York (no longer operational)	12	4	1	7
• 2001	2	1	0	1
• 2000	7	3	0	4
• 1999	3	0	1	2
United HealthCare of New York, Inc.	10	6	0	4
• 2001	2	1	0	1
• 2000	8	5	0	3
• 1999	0	0	0	0
Univera Healthcare CNY	10	5	0	5
• 2001	4	2	0	2
• 2000	5	2	0	3
• 1999	1	1	0	0
Univera Healthcare Southern Tier	4	2	0	2
• 2001	0	0	0	0
• 2000	3	1	0	2
• 1999	1	1	0	0

Health Maintenance Organizations	Total	Overtured	Overtured in Part	Upheld
Univera Healthcare WNY (Health Care Plan)	46	15	0	31
• 2001	16	6	0	10
• 2000	22	7	0	15
• 1999	8	2	0	6
Vytra Healthcare of Long Island	52	26	7	19
• 2001	12	8	1	3
• 2000	36	17	5	14
• 1999	4	1	1	2
Totals	807	323	66	418

Non-Profit Indemnity Insurers	Total	Overtured	Overtured in Part	Upheld
Empire Healthchoice, Inc.	260	100	20	140
• 2001	100	40	11	49
• 2000	150	57	7	86
• 1999	10	3	2	5
Excellus (BC/BS of Central NY Indemnity)	77	26	7	44
• 2001	26	10	0	16
• 2000	45	15	6	24
• 1999	6	1	1	4
Excellus (BC/BS of Rochester Indemnity)	16	8	0	8
• 2001	6	4	0	2
• 2000	9	3	0	6
• 1999	1	1	0	0
Excellus (BC/BS of Utica-Watertown Indemnity)	16	5	0	11
• 2001	6	2	0	4
• 2000	8	1	0	7
• 1999	2	2	0	0
GHI	139	49	35	55
• 2001	29	5	8	16
• 2000	96	40	25	31
• 1999	14	4	2	8

Non-Profit Indemnity Insurers	Total	Overtured	Overtured in Part	Upheld
Health Now (BC/BS of Western NY – Indemnity)	16	6	3	7
• 2001	6	3	1	2
• 2000	8	1	2	5
• 1999	2	2	0	0
Health Now (BS of Northeastern NY – Indemnity)	19	11	0	8
• 2001	6	2	0	4
• 2000	5	3	0	2
• 1999	8	6	0	2
Physicians Health Services (Health Net)	17	4	4	9
• 2001	4	0	1	3
• 2000	12	4	3	5
• 1999	1	0	0	1
Vytra Healthcare of Long Island	9	6	0	3
• 2001	1	1	0	0
• 2000	8	5	0	3
• 1999	0	0	0	0
Totals	569	215	69	285

Commercial Insurers	Total	Overtured	Overtured in Part	Upheld
Aetna Life Ins. Co.	3	0	2	1
• 2001	3	0	2	1
• 2000	0	0	0	0
• 1999	0	0	0	0
Anthem Health and Life Ins. Co. of NY	3	2	0	1
• 2001	1	0	0	1
• 2000	2	2	0	0
• 1999	0	0	0	0
Connecticut General Life Ins. Co.	21	13	0	8
• 2001	6	4	0	2
• 2000	14	8	0	6
• 1999	1	1	0	0
Guardian Life Ins. Co.	5	0	2	3
• 2001	4	0	2	2
• 2000	1	0	0	1
• 1999	0	0	0	0

Commercial Insurers	Total	Overturned	Overturned in Part	Upheld
Horizon Healthcare Ins. Co. of NY	3	2	0	1
• 2001	1	1	0	0
• 2000	2	1	0	1
• 1999	0	0	0	0
Metropolitan Life Ins. Co.	50	23	2	25
• 2001	0	0	0	0
• 2000	23	11	1	11
• 1999	27	12	1	14
New England Life	1	1	0	0
• 2001	0	0	0	0
• 2000	1	1	0	0
• 1999	0	0	0	0
Nippon Life Ins. Co. of America	1	0	0	1
• 2001	1	0	0	1
• 2000	0	0	0	0
• 1999	0	0	0	0
Phoenix Home Life Mutual Ins. Co.	1	0	0	1
• 2001	0	0	0	0
• 2000	0	0	0	0
• 1999	1	0	0	1
UniCARE Life and Health Ins. Co.	8	2	4	2
• 2001	3	0	1	2
• 2000	5	2	3	0
• 1999	0	0	0	0
Union Labor Life Ins. Co.	1	0	0	1
• 2001	0	0	0	0
• 2000	1	0	0	1
• 1999	0	0	0	0
United HealthCare Ins. Co. of NY	120	52	5	63
• 2001	37	18	2	17
• 2000	81	33	2	46
• 1999	2	1	1	0
United States Life Ins. Co. of NY	1	0	0	1
• 2001	0	0	0	0
• 2000	0	0	0	0
• 1999	1	0	0	1
Totals	218	95	15	108

Medicaid Managed Care Coverage	Total	Overturned	Overturned in Part	Upheld
Americhoice	1	1	0	0
• 2001	0	0	0	0
• 2000	1	1	0	0
• 1999	0	0	0	0
Blue Choice (Excellus BC/BS of Rochester HMO)	2	2	0	0
• 2001	2	2	0	0
• 2000	0	0	0	0
• 1999	0	0	0	0
Buffalo Community Health, Inc.	1	0	0	1
• 2001	0	0	0	0
• 2000	0	0	0	0
• 1999	1	0	0	1
CDPHP (Capital District Physicians Health Plan)	1	0	0	1
• 2001	1	0	0	1
• 2000	0	0	0	0
• 1999	0	0	0	0
Fidelis Care New York (NYS State Catholic Health Plan)	3	0	0	3
• 2001	0	0	0	0
• 2000	2	0	0	2
• 1999	1	0	0	1
Health Plus	5	1	0	4
• 2001	0	0	0	0
• 2000	4	1	0	3
• 1999	1	0	0	1
HIP (Health Insurance Plan of Greater NY)	2	1	0	1
• 2001	0	0	0	0
• 2000	2	1	0	1
• 1999	0	0	0	0
HMO Blue (Excellus BC/BS of Utica-Watertown HMO)	1	1	0	0
• 2001	1	1	0	0
• 2000	0	0	0	0
• 1999	0	0	0	0

Medicaid Managed Care Coverage	Total	Overturned	Overturned in Part	Upheld
United HealthCare of New York, Inc.	1	1	0	0
• 2001	0	0	0	0
• 2000	1	1	0	0
• 1999	0	0	0	0
Vytra Healthcare of Long Island	2	0	0	2
• 2001	1	0	0	1
• 2000	1	0	0	1
• 1999	0	0	0	0
Totals	19	7	0	12

Municipal Cooperative Health Benefit Plans	Total	Overturned	Overturned in Part	Upheld
Catskill Area Schools Employee Benefit Plan	2	0	0	2
• 2001	2	0	0	2
• 2000	0	0	0	0
• 1999	0	0	0	0
Jefferson Lewis Healthcare Plan	1	0	0	1
• 2001	1	0	0	1
• 2000	0	0	0	0
• 1999	0	0	0	0
Putnam/Northern Westchester Health Benefits Consortium	1	0	0	1
• 2001	0	0	0	0
• 2000	1	0	0	1
• 1999	0	0	0	0
Totals	4	0	0	4

Totals for all decisions	1617	640	150	827
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External Appeal Results by Type of Denial:

The overwhelming majority of external appeal requests involved denials based on medical necessity rather than denials because the service was considered experimental or investigational. From July 1, 1999 through June 29, 2001, 91.7% of external appeal determinations related to medical necessity denials, 7.9% of external appeal determinations involved experimental or investigational treatments and .4% of determinations involved clinical trials.

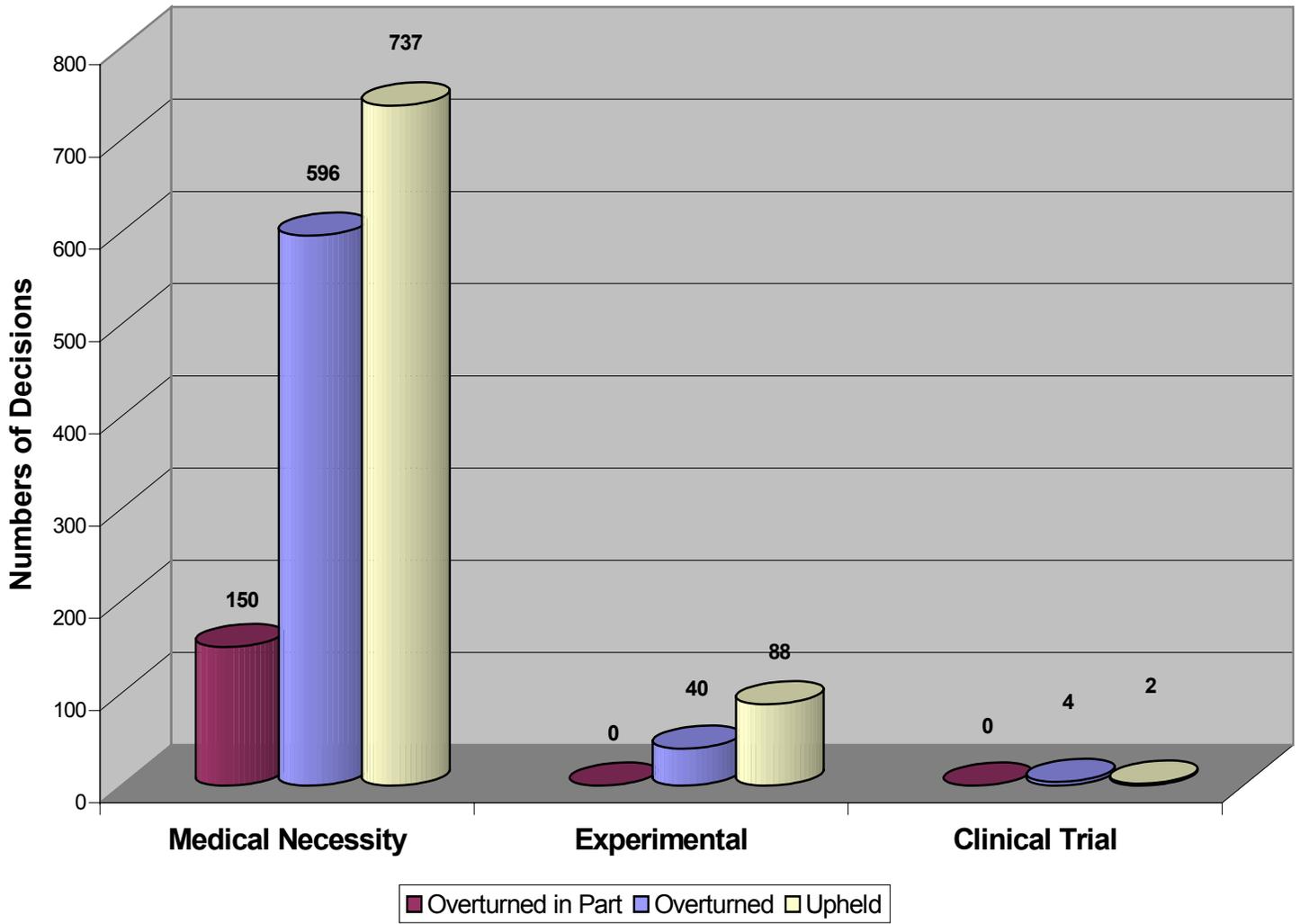
Of the medical necessity cases reviewed during the first External Appeal Program year, the majority involved requests for coverage of surgical services, inpatient and outpatient mental health care and inpatient hospital lengths of stays. During the most recent External Appeal Program year, cases involving surgical services, inpatient and outpatient mental health care and inpatient hospital lengths of stays were again most prevalent, however, increases were seen in medical necessity cases involving pharmaceuticals and in cases involving therapy services including chiropractic care.

The following charts identify external appeal results based upon whether the denial related to medical necessity, experimental or investigational services or a clinical trial. The results from July 1, 1999 through June 29, 2001 indicate that health plan denials were overturned in whole or in part in 50% of cases involving medical necessity denials and in 31% of cases involving experimental/investigational treatment determinations.

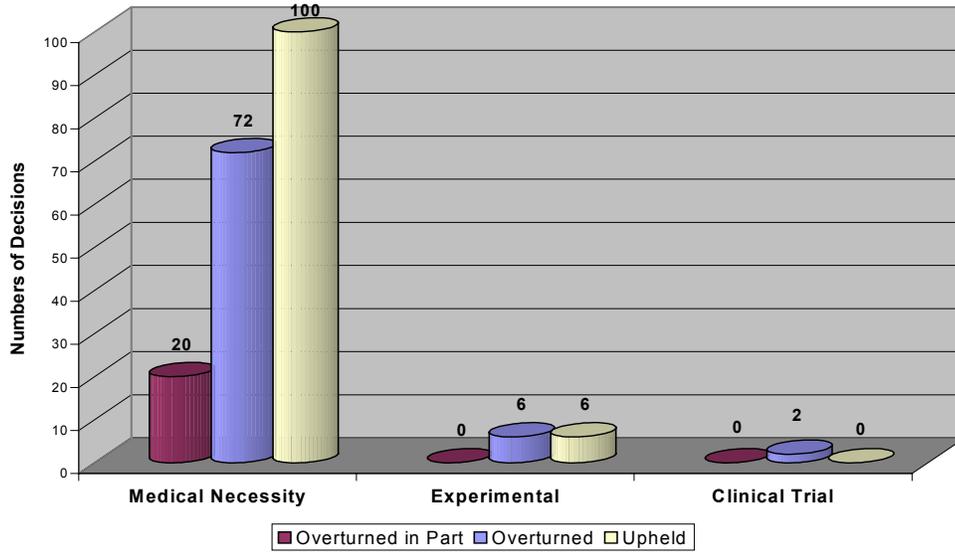
The percentage of medical necessity determinations overturned by external appeal agents in New York is consistent with overturn rates reported by other states. In our survey other states did not report experimental/investigational treatment determinations separately so we were unable to determine how New York's results compare to other states as far as experimental/investigational treatment determinations are concerned.

Within New York, the difference in the overturn rate between medical necessity cases and cases involving experimental/investigational treatments may be attributable in part to the statutorily prescribed review criteria external appeal agents must use for the cases. In medical necessity cases, an external appeal agent must determine whether the health plan acted reasonably, with sound medical judgement, in the best interest of the patient. In cases involving experimental/investigational services, external appeal agents must find that the proposed service is likely to be more beneficial than any standard treatment. In addition, many health plans now consult outside experts when rendering experimental/investigational treatment determinations. After such consultation, health plans may be less likely to deny services as experimental or investigational and their determinations may be better able to withstand independent review by an external appeal agent.

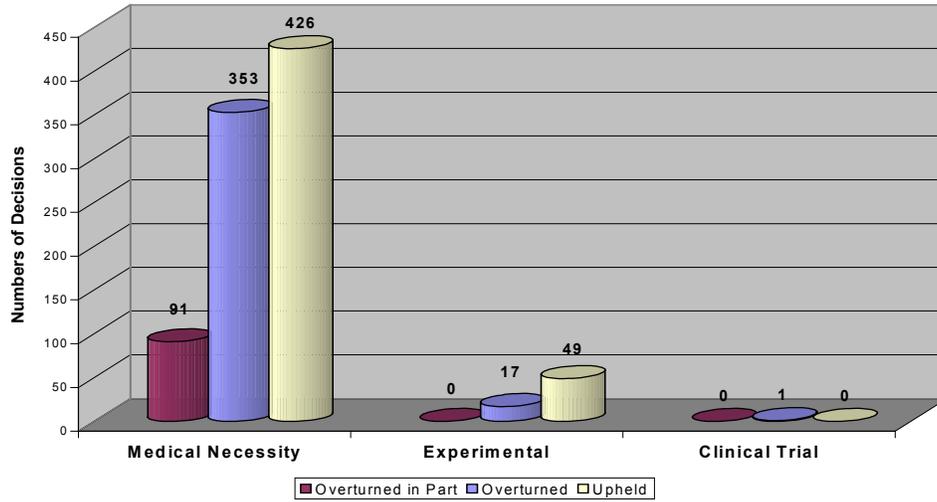
External Appeal Decisions by Type of Denial July 1, 1999 - June 29, 2001



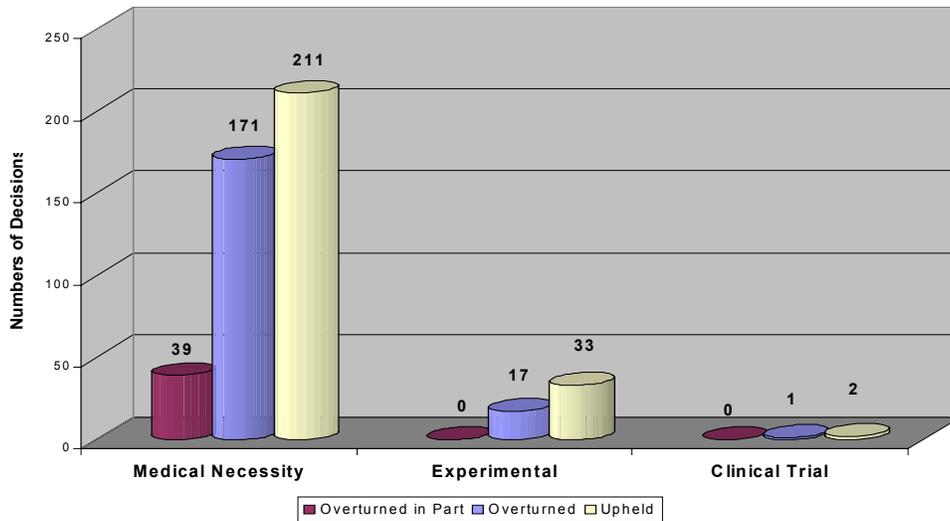
**External Appeal Decisions by Type of Denial
1999**



**External Appeal Decisions by Type of Denial
2000**



**External Appeal Decisions by Type of Denial
2001**

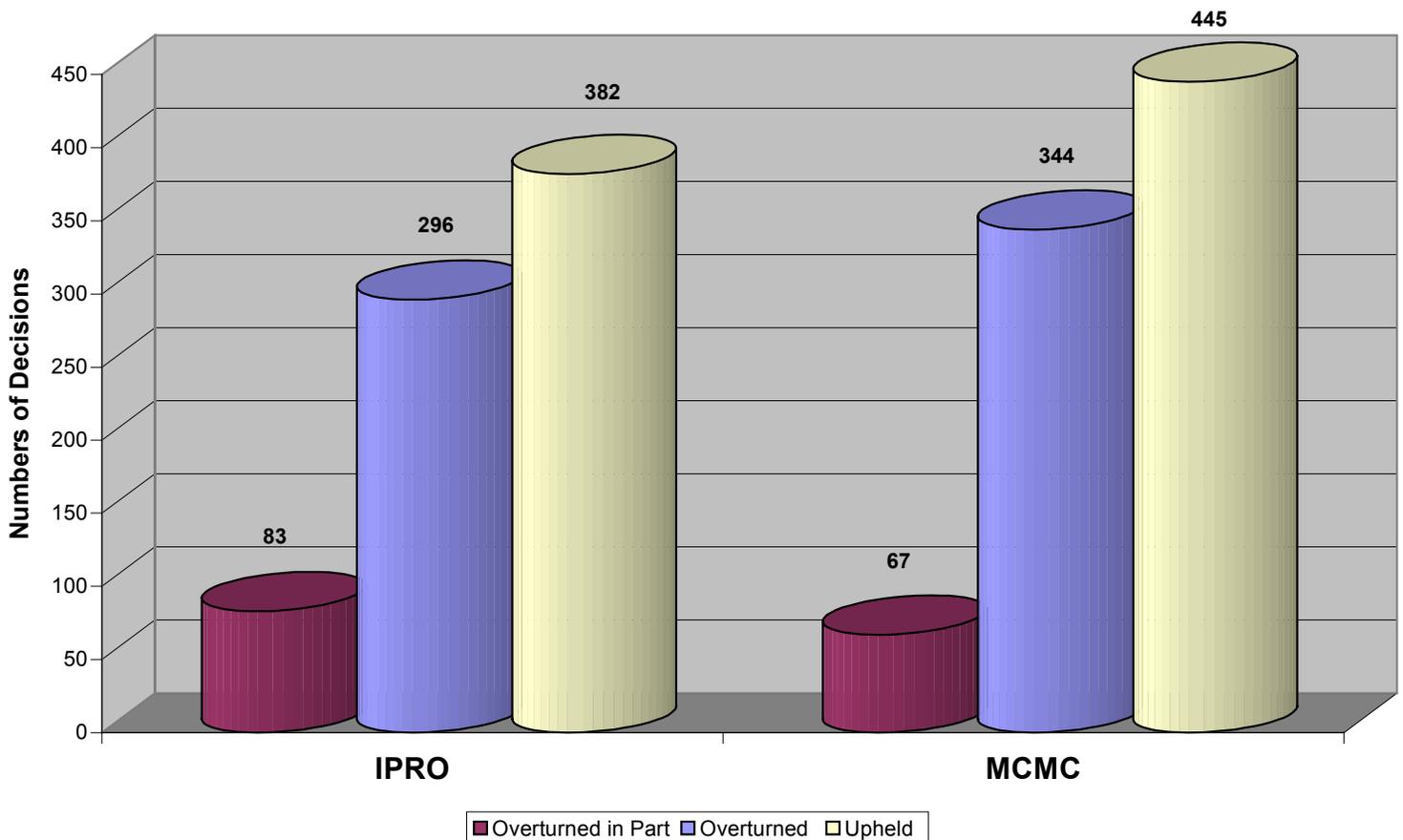


External Appeal Results by Agent:

External appeal requests are randomly assigned to agents. If the assigned agent has a conflict of interest, the appeal is assigned to another agent. The difference in the number of appeals assigned to external appeal agents can be attributed to the random assignment process and to re-assignments due to conflict of interest.⁴

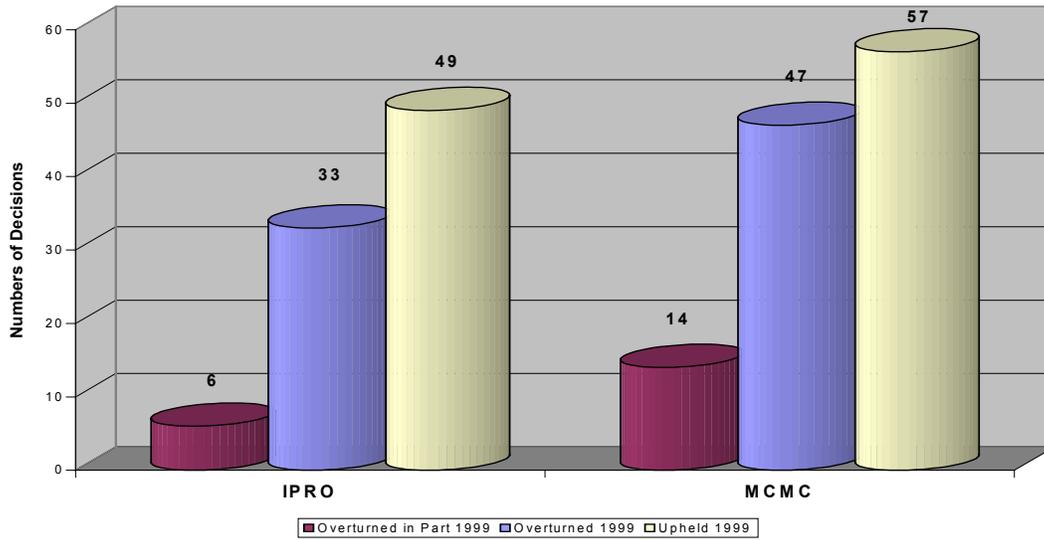
The overall external appeal results indicate that approximately half of the external appeal agent determinations upheld the denials of health plans while the other half overturned the denials of health plans in whole or in part. These results remain the same even when the determinations of each external appeal agent are considered independently. As evidenced in the following charts, from July 1, 1999 through June 29, 2001, IPRO overturned the denials of health plans in whole or in part in 50% of cases while MCMC overturned the denials of health plans in whole or in part in 48% of cases.

External Appeal Decisions by Agent July 1, 1999 - June 29, 2001

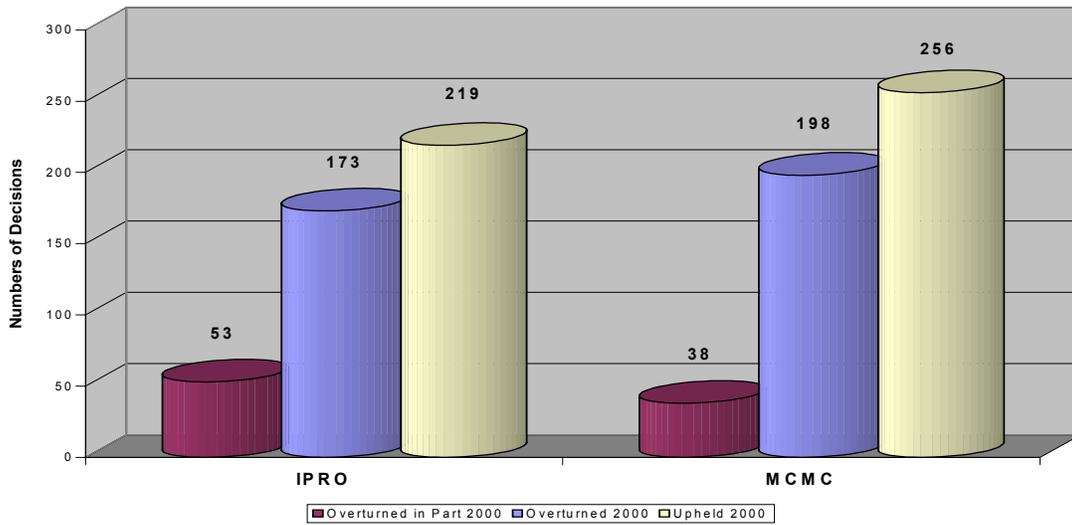


⁴ At the time the results were compiled, HAYES Plus, Inc. had not yet been assigned any appeals.

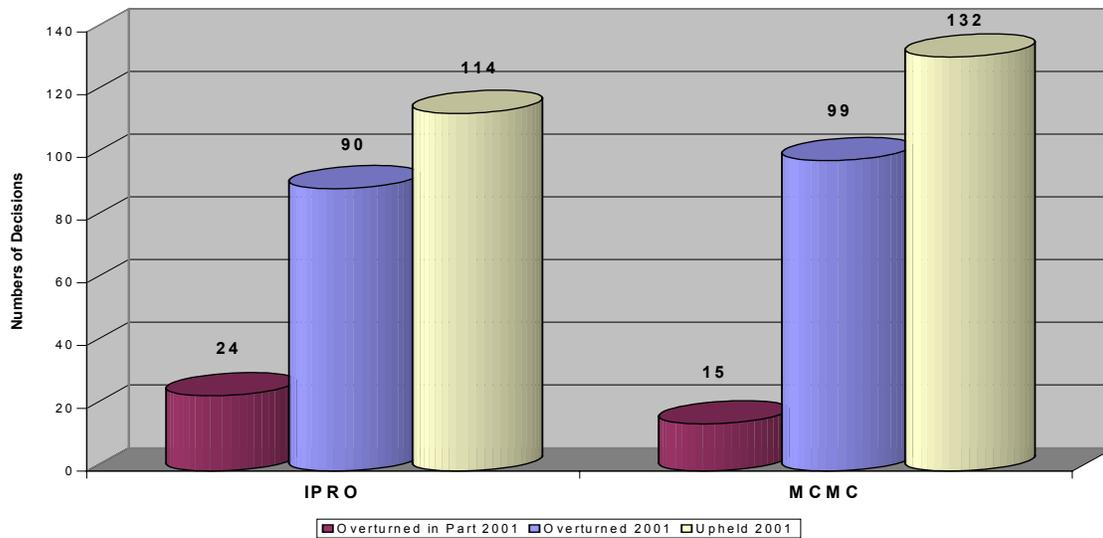
**External Appeal Decisions by Agent
1999**



**External Appeal Decision by Agent
2000**



**External Appeal Decisions by Agent
2001**



Expedited External Appeals:

The External Appeal Law provides that an appeal must be expedited if the patient's attending physician attests that a delay in providing the health care services would pose an imminent or serious threat to the health of the patient. When an appeal is expedited, a decision must be rendered by the external appeal agent within three days.

Insurance Department staff is on-call on weekends and holidays to handle expedited appeals submitted after close of business. Staff received and responded to 40 calls during non-business hours relating to expedited appeals from July 1, 1999 through June 29, 2001.

Month / Year	Number of Calls	Month / Year	Number of Calls
July, 1999	1	July, 2000	0
August, 1999	0	August, 2000	2
September, 1999	1	September, 2000	4
October, 1999	2	October, 2000	6
November, 1999	2	November, 2000	3
December, 1999	0	December, 2000	1
January, 2000	2	January, 2001	2
February, 2000	0	February, 2001	1
March, 2000	2	March, 2001	1
April, 2000	0	April, 2001	1
May, 2000	2	May, 2001	2
June, 2000	1	June, 2001	4

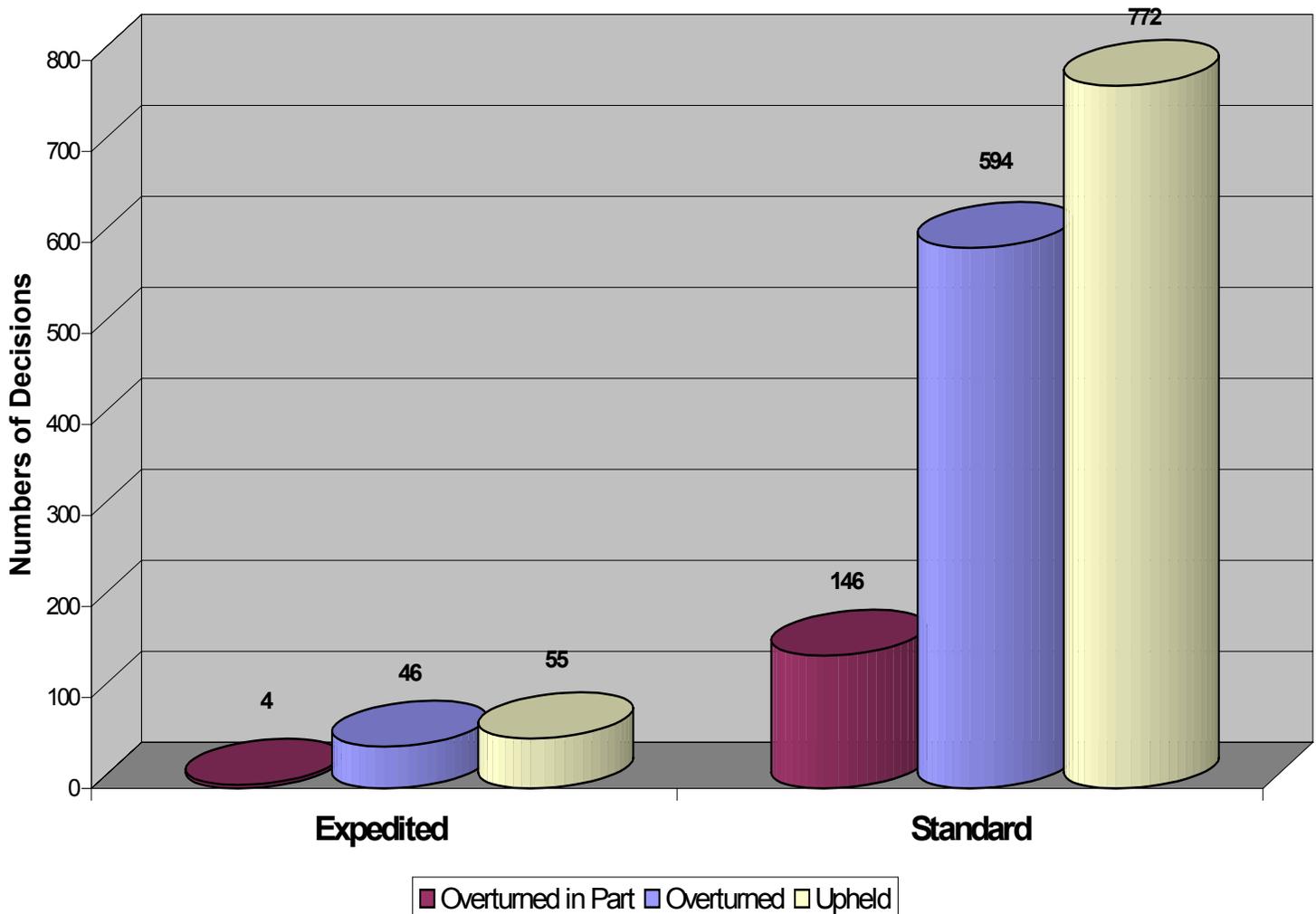
The submission and handling of expedited appeals continues to present unique issues that were unanticipated when the Law was implemented. Expedited appeals continue to be requested by patients and attested to by attending physicians in cases where a delay would not appear to pose an imminent or serious threat to the health of the patient. Some appeals that fall into this category are submitted a month after the patient receives notice of the final adverse determination from the health plan. In other cases, expedited appeals are requested when health care services have already been provided.

Processing an appeal as expedited is not always in the best interest of the patient since a decision must be rendered in three days and there is only a limited opportunity for the patient and the patient's provider to submit additional information. Moreover, the three day timeframe cannot be waived so if the information is not submitted in time, it is not considered by the external appeal agent.

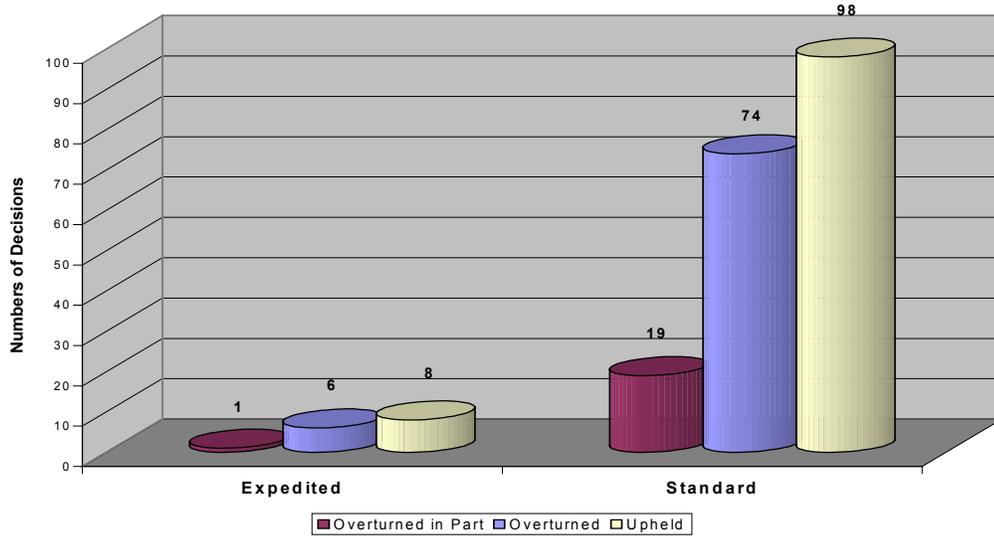
To address the situation of appeals being expedited when a three day review timeframe may not necessarily be in the best interest of the patient, Insurance Department staff will contact the attending physician to ascertain why the physician attested that the appeal should be expedited and discuss the option of processing the appeal as standard. If the attending physician indicates that the appeal should remain expedited, it is processed as such, since the Law is specific in requiring an appeal to be expedited if an attending physician attests that it should be. The Law does not, however, require an external appeal to be expedited if health care services have already been provided. In such cases the request is treated as a standard appeal.

The following charts identify external appeal results based upon whether the appeal was standard or expedited for each calendar year of operation of the External Appeal Program. From July 1, 1999 through June 29, 2001 external appeal agents overturned the denials of health plans in whole or in part in 48% of cases involving expedited appeals and in 49% of cases involving standard appeals.

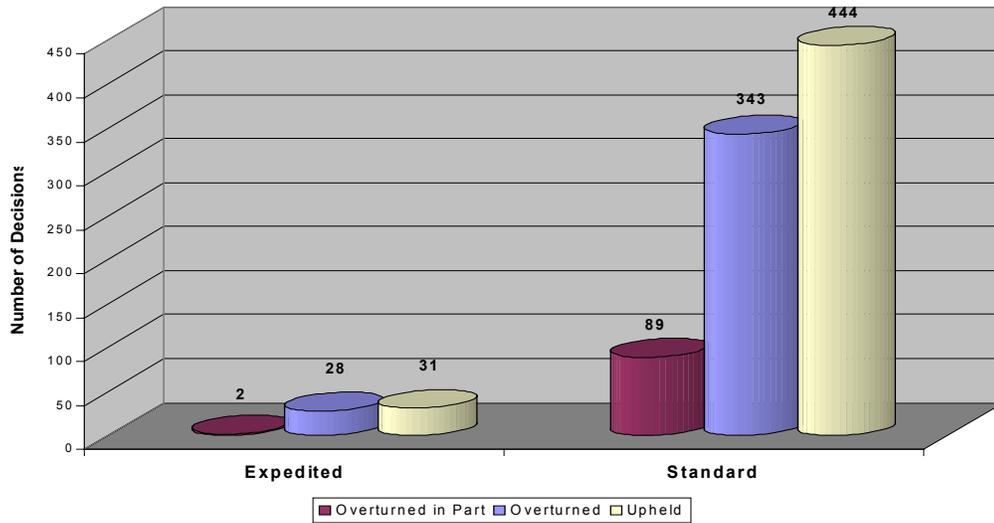
External Appeal Decisions by Type of Appeal July 1, 1999 - June 29, 2001



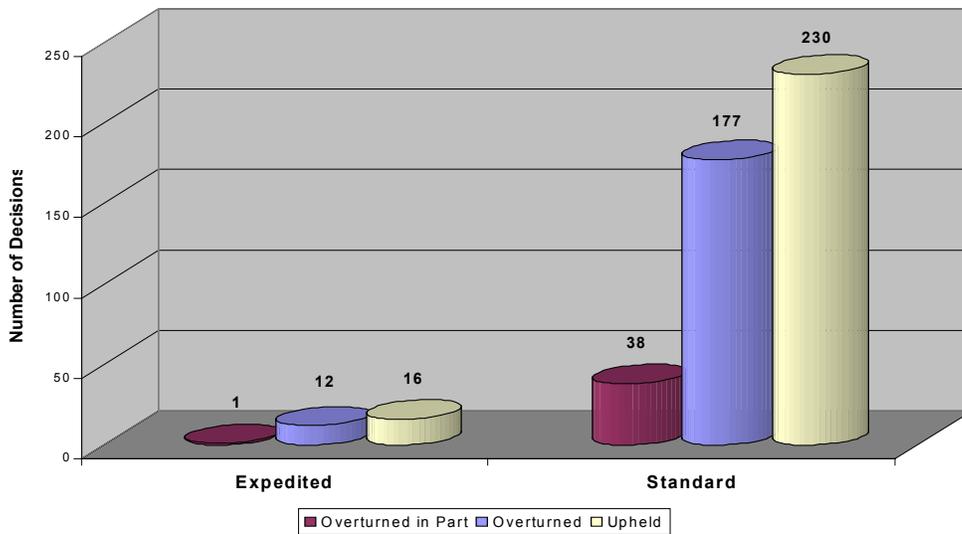
**External Appeal Decisions by Type of Appeal
1999**



**External Appeal Decisions by Type of Appeal
2000**



**External Appeal Decisions by Type of Appeal
2001**



ERISA Preemption of State External Appeal Laws:

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law regulating employee pension and benefit plans. ERISA establishes comprehensive minimum standards for pension plans and some standards for health benefit plans. ERISA affects state laws as follows:

1. ERISA preempts state laws that “relate to” employee health plans.
2. ERISA “saves” from preemption state laws that regulate insurance.
3. However, even state laws that are “saved” from preemption because they regulate insurance can be preempted if they conflict with a substantive portion of ERISA.

Federal courts have differed in their interpretations of the extent of ERISA’s preemption of state laws and conflicting decisions have been rendered. There have been two recent U.S. Court of Appeals decisions relating to whether external appeal statutes in Illinois and Texas are preempted by ERISA.

The U.S. Court of Appeals for the 5th Circuit found that the Texas external appeal statute is preempted, while the U.S. Court of Appeals for the 7th Circuit subsequently found that the Illinois external appeal statute is not preempted. There are no significant distinguishing characteristics between the Texas and the Illinois external appeal statutes, nor between both statutes and the New York External Appeal Law. Moreover, the statutes in all three states only impose external appeal requirements on fully-insured health plan coverage and do not attempt to regulate self-insured plans. The following is a summary of the Texas and the Illinois cases:

Corporate Health Ins. Plans, et al. v. Texas Dept of Ins., 215 F.3d 526 (5th Cir. 2000).

The Texas legislature established procedures for the independent review of health plan medical necessity determinations. The Law was challenged on the basis that it was preempted by ERISA and the U.S. Court of Appeals for the 5th Circuit held that the state independent review program would in fact fall under the ERISA preemption.

The 5th Circuit held that although the Texas External Review Law would otherwise be saved from ERISA preemption because it regulates insurance, the Law is preempted because it conflicts with a substantive portion of ERISA. The court held that the external review provisions are an alternative mechanism through which plan members may seek benefits. The court found that the state external review procedure conflicted with §502(a)(1)(B) of ERISA which enables ERISA beneficiaries to enforce rights to obtain benefits.

Moran v. Rush Prudential HMO, Inc., 230 F.3d. 959 (7th Cir. Oct. 19, 2000).

In this case, the U.S. Court of Appeals for the 7th Circuit was asked to consider whether Section 4-10 of the Illinois Health Maintenance Organization Act, providing for external review of health plan medical necessity determinations, was preempted by ERISA. The court held that the Illinois Law was not preempted by ERISA because it fell within the “saving clause” of ERISA. The court concluded that the Illinois Law did not conflict with a substantive portion of ERISA because external review does not provide the same relief as Section 502(a)(1)(B) of ERISA. The court reasoned that the Illinois statute simply establishes an additional internal mechanism for making medical necessity decisions and resolving disputes regarding such determinations.

U.S. Supreme Court Consideration:

A petition for a writ of certiorari for U.S. Supreme Court consideration was filed for both decisions and on June 29, 2001, the Court granted certiorari for the 7th Circuit case. If the U.S. Supreme Court overturns the decision of the United States Court of Appeals for the 7th Circuit and holds that state external appeal laws are preempted by ERISA, New York consumers will be directly affected.

In the event of such a ruling by the U.S. Supreme Court, New York consumers covered under HMO and insurance policies through their employer groups will lose the right to obtain an independent review of a health plan’s denial of coverage through the New York State External Appeal Program. New York consumers covered under individual direct payment policies, Medicaid managed care coverage and Child Health Plus would, however, still be able to obtain an independent review of a health plan’s denial of coverage through the New York State External Appeal Program.

A U.S. Supreme Court ruling that ERISA preempts state external appeal laws could deprive a significant number of consumers in New York and throughout the United States of an important external appeal remedy. This case should be watched closely because of its potential impact on external appeal rights.

Federal Legislation:

The Senate and the House have each passed their own version of a Patients' Bill of Rights, Senate bill S.1052 and House bill H.R. 2563. The bills include protections similar to those mandated by New York's Managed Care Reform Act and New York's External Appeal Law such as requirements for a grievance procedure, a utilization review procedure, a prudent layperson standard for emergency care, access to specialty care and external appeal of health plan determinations. Both bills have provisions providing that state standards will not be preempted if the standards are substantially similar to federal requirements, however, the House bill states that state provisions regarding utilization review, grievance, and external review will be preempted by the federal law.

The bills have been referred to a conference committee to reconcile inconsistent provisions. To date the committee has not been appointed and no further action has been taken. If no action is taken, the bills will expire when the 107th Congress adjourns at the end of the year, 2002.

The following is a comparison of the House and Senate bills and the New York External Appeal Law:

	House Bill	Senate Bill	New York
Decisions eligible for external review.	Medical necessity. Experimental/ Investigational treatment. Denials based on an evaluation of medical facts.	Medical necessity. Experimental/ Investigational treatment. Denials based on an evaluation of medical facts.	Medical necessity. Experimental/ Investigational treatment.
Timeframe for requesting an external appeal.	180 days from receipt of denial or waiver of internal appeal process.	180 days from receipt of denial or waiver of internal appeal process.	45 days from receipt of denial or waiver of internal appeal process.
How external appeal requests are made.	External appeal requests may be made orally.	External appeal requests may be made orally.	External appeal requests must be in writing.
Permissible fee	\$25.00, which must be waived if the applicant is indigent and returned if the denial is overturned.	\$25.00, which must be waived if the applicant is indigent and returned if the denial is overturned.	\$50.00, which must be waived if the applicant is covered under Medicaid, Child Health Plus or if the fee would pose a hardship and returned if the denial is overturned in whole or in part.

	House Bill	Senate Bill	New York
Selection of external appeal agents.	Health plans contract with external appeal agents and assign appeals to external appeal agents.	Health plans contract with external appeal agents and assign appeals to external appeal agents.	The Insurance Department randomly assigns appeals to state certified external appeal agents.
Screening of external appeal requests for eligibility.	External appeal agents are responsible for screening requests.	External appeal agents are responsible for screening requests.	The Insurance Department is responsible for screening requests.
Number of clinical peers that must be assigned to appeals.	Three clinical peers.	One or more clinical peers.	One or a greater odd number of clinical peers for medical necessity appeals and three or a greater odd number of clinical peers for experimental/ investigational treatment appeals.
Timeframe for external appeal agents to render a determination.	<p>14 business days after receipt of information up to 21 days for prior authorization determinations.</p> <p>30 business days after receipt of information up to 60 days for retrospective determinations.</p> <p>72 hours for expedited appeals (24 hours for on-going care.)</p>	<p>14 business days after receipt of information up to 21 days for prior authorization determinations.</p> <p>30 business days after receipt of information up to 60 days for retrospective determinations.</p> <p>72 hours for expedited appeals (24 hours for on-going care.)</p>	<p>30 days (+ 5 business days if additional information is requested) for standard appeals.</p> <p>3 days for expedited appeals.</p>
Determinations that may be rendered by external appeal agents	External appeal agents may uphold or overturn a health plan's denial.	External appeal agents may uphold or overturn a health plan's denial in whole or in part.	External appeal agents may uphold or overturn a health plan's denial in whole or in part.
Binding review.	Yes.	Yes.	Yes.

Closing Remarks:

The external appeal legislation is truly remarkable in that it provides New Yorkers with critical protections that they are utilizing. The goal of the legislation, to provide patients access to an independent review process for appealing health plan determinations, has been fully operationalized through the Insurance Department's and the Health Department's implementation of the Law.

Through the efforts of the Insurance Department and the Health Department, the New York external appeal process is accessible to consumers as evident by the volume of external appeal requests in New York, especially as compared to other states.

In addition, the Insurance Department and the Health Department have worked with providers, health plans and consumer groups to ensure that the External Appeal Program continues to meet the needs of New Yorkers. The External Appeal Program has been working effectively and it is the dedicated efforts of the Departments and the mutual cooperation of all parties that has enabled the program to be successful.

The Departments will continue to track external appeal results and will continue to monitor developments on the federal level which could have a significant impact on all states, including New York. And starting next year, the Insurance Department and the Health Department will begin publishing the external appeal annual report in the beginning of each calendar year in order to include current results on a calendar year basis and to facilitate comparison with other states.