

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

**New York State  
External Appeal Program**

**2002**



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## **A REPORT ON EXTERNAL APPEALS IN NEW YORK**

January 1, 2002 – December 31, 2002

New York State  
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External appeal information is also available on the Insurance Department's Web site at [www.ins.state.ny.us](http://www.ins.state.ny.us) or by calling 1-800-400-8882.

\*With thanks and appreciation to all the states that participated in our survey and to health maintenance organizations and insurers for providing requested information.

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## Introduction

New York's landmark External Appeal Law, effective July 1, 1999, provides health care consumers with the right to obtain an independent review when a health plan denies services as not medically necessary or as experimental or investigational. External appeal requests must be submitted to the New York State Insurance Department within 45 days of a consumer's receipt of the final adverse determination from a first level of appeal with a health plan or receipt of a letter from a health plan waiving the internal appeal process.

External appeal requests are reviewed by the Insurance Department for eligibility and completeness and assigned to a state certified external appeal agent that has a network of medical experts available to review a health plan's denial of services. 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 a patient's attending physician attests that a delay in providing the services would pose a threat to the health of the patient.

The Insurance Department and the New York State Department of Health publish an annual report on the number of external appeals requested and the outcomes of such appeals. This year's annual report not only includes New York external appeal information, but also includes information on the external appeal programs of other states, obtained from a survey the Insurance Department conducted of states with external appeal programs in place. New this year, the report includes information on the utilization review procedures of health plans as well as the agents that contract with health plans to perform utilization review. Also new this year, the report discusses the changes on both the federal and state level that impacted the New York external appeal program during its third year of operation.

In reviewing program results from 2002, the number of external appeals requested in New York decreased slightly from previous years. The types of services appealed remained consistent, with surgical services, inpatient hospital services, and mental health treatment once again being the most frequently appealed. The percentage of medical necessity denials overturned in whole or in part by external appeal agents decreased slightly, while the percentage of experimental or investigational treatment denials overturned by external appeal agents increased significantly. Also in 2002, the standardized external appeal applications were revised so that the applications would be even easier for patients and providers to complete and to ensure that the consent to the release of medical information would be in compliance with federal privacy requirements.

The following report is organized into five sections - utilization review, the New York External Appeal Program and recent results, the external appeal programs of other states, federal developments impacting state external appeal programs, and state developments that impacted the New York External Appeal Program.

## **Background Of The New York External Appeal Law**

The New York External Appeal Law had been proposed in successive legislative sessions until it passed and was signed into law in 1998. 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 access to specialists and continuity of care when a provider no longer participates in a network, a prudent layperson standard for coverage of emergency services, mandatory disclosure of coverage information, prohibitions on gag clauses in subscriber contracts, and requirements that health plans have procedures in place for consumers to appeal coverage denials.

### **Utilization Review And Grievance Requirements**

The Managed Care Reform Act established two different procedures, a grievance procedure and a utilization review procedure, for the appeal of coverage denials. The grievance procedure is used for the review and appeal of all coverage determinations, other than utilization review determinations. Denials, typically subject to the grievance procedure, include requests for referrals to non-participating providers and denials because a benefit is not covered under a contract. Only managed care plans are required to have a grievance procedure.

The utilization review procedure is used to determine whether services that have been provided, are being provided, or are proposed to be provided are medically necessary, experimental, or investigational. Any health plan that conducts utilization review must have a utilization review procedure that complies with the standards and time frames in the Managed Care Reform Act. The Managed Care Reform Act requires health plans to make pre-authorization of service determinations in three business days, concurrent utilization review determinations in one business day, and retrospective utilization review determinations in 30 days, after the necessary information has been provided. The Act further requires health plans to have both a standard and an expedited appeals process for a member to appeal a utilization review denial.

A member has 45 days from receipt of an initial utilization review denial to request an appeal and the health plan must make an appeal determination in two business days if the appeal is expedited or 60 days if the appeal is standard, again once the necessary information has been provided. The appeal determination must be in writing and must include the reasons for the determination, the clinical rationale, and information describing internal and external appeal rights.

The Managed Care Reform Act permits health plans to contract with utilization review agents to perform utilization review. The Act requires health plans and their utilization review agents to report or register with the Insurance Department or the Health Department every two years. Health plans and utilization review agents must provide the Departments with a utilization review plan which must include procedures to ensure decisions will be made within required time frames. Health plans and agents must have confidentiality protections in place and are required to appoint a medical

director to oversee the utilization review process. Health plans and agents must also provide a description of the personnel that will be conducting utilization review and must ensure that health care professionals conducting utilization review are appropriately licensed or certified.

## **Utilization Review Agents That Contract With Health Plans**

The Insurance Department surveyed the 49 health plans that had external appeals in 2001 and 2002 to determine if the plans contract with utilization review agents and, if so, which services the agents review. Thirty-three plans responded that they contract with one or more utilization review agents. Some utilization review agents such as National Imaging Associates, CareCore National, Magellan, Orthonet, Landmark, ACCESS and Intracorp contract with more than one New York health plan. In addition, 14 health plans, including Anthem Health & Life Insurance Company of New York, Capital District Physicians' Health Plan, Inc. (CDPHP), Excellus Health Plan, Inc. (BCBS Rochester), Excellus Health Plan, Inc. (Blue Choice) (HMO of Excellus Rochester), Health Insurance Plan of Greater NY, Inc., Horizon Healthcare Insurance Company of New York, Independent Health Association, Inc., MDNY Healthcare, Inc., Mutual of Omaha Insurance Company, MVP Health Plan, Inc., Rochester Area HMO (Preferred Care), United HealthCare Insurance Company of New York., Excellus Health Plan, Inc. (Univera WNY) and Excellus Health Plan, Inc. (Univera Southern Tier) responded that they do not contract with a utilization review agent.<sup>1</sup>

The following chart lists health plans that contract with utilization review agents and identifies the types of services reviewed. The chart groups health plans into categories based on the type of health insurance coverage provided:

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

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<sup>1</sup> Two plans did not provide utilization review information in time for inclusion in the report.

Health Maintenance Organizations	Name of Utilization Review Agent	Type of Service Reviewed
Aetna Health Inc.	<ul style="list-style-type: none"> <li>• CareCore National</li> <li>• Magellan Behavioral Health</li> <li>• ACN Group (American Chiropractic Network)</li> </ul>	<ul style="list-style-type: none"> <li>• Radiology</li> <li>• Behavioral Health</li> <li>• Chiropractic</li> </ul>
Atlantis Health Plan, Inc.	<ul style="list-style-type: none"> <li>• CSC (formerly Nichols Txen Corp.)</li> <li>• American Case Management</li> </ul>	<ul style="list-style-type: none"> <li>• Concurrent Reviews</li> <li>• Mental Health</li> </ul>
Empire Healthchoice HMO, Inc.	<ul style="list-style-type: none"> <li>• Magellan Behavioral Health</li> <li>• MCOP Medical Care Management Corp.</li> <li>• National Imaging Associates (NIA)</li> <li>• Orthonet</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral Health and Substance Abuse</li> <li>• Outside Specialty Reviews</li> <li>• Radiology</li> <li>• Physical Therapy</li> </ul>
Excellus Health Plan, Inc. (HMO-CNY) (BCBS CNY)	<ul style="list-style-type: none"> <li>• NorthEast Imaging</li> </ul>	<ul style="list-style-type: none"> <li>• Radiology</li> </ul>
Excellus Health Plan, Inc. (HMO Blue) (BCBS Utica Watertown)	<ul style="list-style-type: none"> <li>• NorthEast Imaging</li> </ul>	<ul style="list-style-type: none"> <li>• Radiology</li> </ul>
Excellus Health Plan, Inc. (Univera-CNY)	<ul style="list-style-type: none"> <li>• Landmark Healthcare</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic</li> </ul>
GHI HMO Select, Inc.	<ul style="list-style-type: none"> <li>• Alignis</li> <li>• CareCore National</li> <li>• Magellan Behavioral Health</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic and Physical Therapy</li> <li>• Radiology</li> <li>• Behavioral Health</li> </ul>
Health Net of New York, Inc. (formerly Physicians Health Services, Inc.)	<ul style="list-style-type: none"> <li>• Coordinated Care Solutions (CCS)</li> <li>• Landmark Healthcare</li> <li>• Managed Health Network (MHN)</li> <li>• National Imaging Associates (NIA)</li> </ul>	<ul style="list-style-type: none"> <li>• Home Care and Skilled Nursing Facilities</li> <li>• Chiropractic</li> <li>• Behavioral Health</li> <li>• Radiology</li> </ul>
HealthNow New York Inc. (Community Blue) (HMO of BCBS WNY)	<ul style="list-style-type: none"> <li>• APS Healthcare</li> <li>• National Imaging Associates (NIA)</li> <li>• Prism Health Networks</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral Health and Substance Abuse</li> <li>• Radiology</li> <li>• Chiropractic</li> </ul>
Health Now New York, Inc. (HMO of BS NENY)	<ul style="list-style-type: none"> <li>• APS Healthcare</li> <li>• National Imaging Associates (NIA)</li> <li>• Prism Health Networks</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral Health and Substance Abuse</li> <li>• Radiology</li> <li>• Chiropractic</li> </ul>
Oxford Health Plans of New York, Inc.	<ul style="list-style-type: none"> <li>• CareCore National</li> <li>• Orthonet</li> <li>• TRIAD Healthcare</li> </ul>	<ul style="list-style-type: none"> <li>• Radiology</li> <li>• Physical Therapy</li> <li>• Chiropractic</li> </ul>

<b>Health Maintenance Organizations</b>	<b>Name of Utilization Review Agent</b>	<b>Type of Service Reviewed</b>
United Healthcare of New York, Inc.	<ul style="list-style-type: none"> <li>• Medical Care Management Corp.</li> <li>• Medical Review Institute</li> <li>• National Medical Review</li> </ul>	<ul style="list-style-type: none"> <li>• Medical/Surgical Benefits</li> <li>• Medical/Surgical Benefits</li> <li>• Medical/Surgical Benefits</li> </ul>
Vytra Health Plans Long Island, Inc.	<ul style="list-style-type: none"> <li>• ACCESS Managed Health</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic</li> </ul>

<b>Non-Profit Indemnity Insurers</b>	<b>Name of Utilization Review Agent</b>	<b>Type of Service Reviewed</b>
Empire Healthchoice Inc.	<ul style="list-style-type: none"> <li>• Intracorp</li> <li>• Magellan Behavioral Health</li> <li>• MCOP Medical Care Management Corp.</li> <li>• National Imaging Associates (NIA)</li> <li>• New York County Health Services Review Organization (NYCHSRO)</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Management</li> <li>• Behavioral Health and Substance Abuse</li> <li>• Outside Specialty Reviews</li> <li>• Radiology</li> <li>• Medical Management</li> </ul>
Excellus Health Plan, Inc. (BCBS CNY)	<ul style="list-style-type: none"> <li>• NorthEast Imaging</li> </ul>	<ul style="list-style-type: none"> <li>• Radiology</li> </ul>
Excellus Health Plan, Inc. (BCBS Utica Watertown)	<ul style="list-style-type: none"> <li>• NorthEast Imaging</li> </ul>	<ul style="list-style-type: none"> <li>• Radiology</li> </ul>
Group Health Incorporated (GHI)	<ul style="list-style-type: none"> <li>• Alignis</li> <li>• CareCore National</li> <li>• GHI-Behavioral Management Program</li> <li>• ValueOptions</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic</li> <li>• Radiology</li> <li>• Behavioral Health</li> <li>• Behavioral Health</li> </ul>
HealthNow New York Inc. (BCBS WNY)	<ul style="list-style-type: none"> <li>• APS Healthcare</li> <li>• National Imaging Associates (NIA)</li> <li>• Prism Health Networks</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral Health and Substance Abuse</li> <li>• Radiology</li> <li>• Chiropractic</li> </ul>
HealthNow New York Inc. (BCBS NENY)	<ul style="list-style-type: none"> <li>• APS Healthcare</li> <li>• National Imaging Associates (NIA)</li> <li>• Prism Health Networks</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral Health and Substance Abuse</li> <li>• Radiology</li> <li>• Chiropractic</li> </ul>
Vytra Health Services, Inc.	<ul style="list-style-type: none"> <li>• ACCESS Managed Health</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic</li> </ul>

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

<b>Commercial Insurers</b>	<b>Name of Utilization Review Agent</b>	<b>Type of Service Reviewed</b>
Equitable Life Assurance Society of the United States	<ul style="list-style-type: none"> <li>• Elite Physicians</li> </ul>	<ul style="list-style-type: none"> <li>• Retrospective Reviews and Appeals</li> </ul>
Guardian Life Insurance Company of America	<ul style="list-style-type: none"> <li>• Private Health Care Systems (PHCS)</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital and Medical</li> </ul>
Health Net Insurance of New York, Inc.	<ul style="list-style-type: none"> <li>• Coordinated Care Solutions (CCS)</li> <li>• Landmark Healthcare</li> <li>• Managed Health Network (MHN)</li> <li>• National Imaging Associates (NIA)</li> </ul>	<ul style="list-style-type: none"> <li>• Home Care and Skilled Nursing Facilities</li> <li>• Chiropractic</li> <li>• Behavioral Health</li> <li>• Radiology</li> </ul>
UniCARE Life & Health Insurance Company	<ul style="list-style-type: none"> <li>• Unicare Cost Care</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-hospital, Concurrent, and Transplant Review</li> </ul>

<b>Medicaid Managed Care Plans</b>	<b>Name of Utilization Review Agent</b>	<b>Type of Service Reviewed</b>
Americhoice of New York, Inc.	<ul style="list-style-type: none"> <li>• Med Net Healthcare Group</li> </ul>	<ul style="list-style-type: none"> <li>• Precertification and Concurrent Reviews</li> </ul>
CenterCare Health Plan	<ul style="list-style-type: none"> <li>• Ryan Community Health Network</li> </ul>	<ul style="list-style-type: none"> <li>• All Utilization Review</li> </ul>
HealthSource/HHP (Westchester Prepaid Health Services Plan)	<ul style="list-style-type: none"> <li>• Beacon Health Strategies</li> <li>• Urban Dental Mgmt.</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral Health</li> <li>• Dental</li> </ul>
NYS Catholic Health Plan (Fidelis Care)	<ul style="list-style-type: none"> <li>• Doral Dental Services</li> </ul>	<ul style="list-style-type: none"> <li>• Dental</li> </ul>
Wellcare of New York, Inc.	<ul style="list-style-type: none"> <li>• ACCESS Managed Health</li> <li>• CareCore National</li> <li>• Comprehensive Health Management</li> <li>• CMS Care of NY</li> <li>• Urban Dental Mgmt.</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic</li> <li>• Radiology</li> <li>• Medical</li> <li>• Behavioral Health</li> <li>• Dental</li> </ul>

<b>Municipal Cooperative Health Benefit Plans</b>	<b>Name of Utilization Review Agent</b>	<b>Type of Service Reviewed</b>
Catskill Area Schools Employees Benefit Plan	<ul style="list-style-type: none"> <li>• Corporate Care Management</li> </ul>	<ul style="list-style-type: none"> <li>• All Utilization Review</li> </ul>
Putnam/Northern Westchester Health Benefits Consortium	<ul style="list-style-type: none"> <li>• Aetna Health</li> </ul>	<ul style="list-style-type: none"> <li>• All Utilization Review</li> </ul>

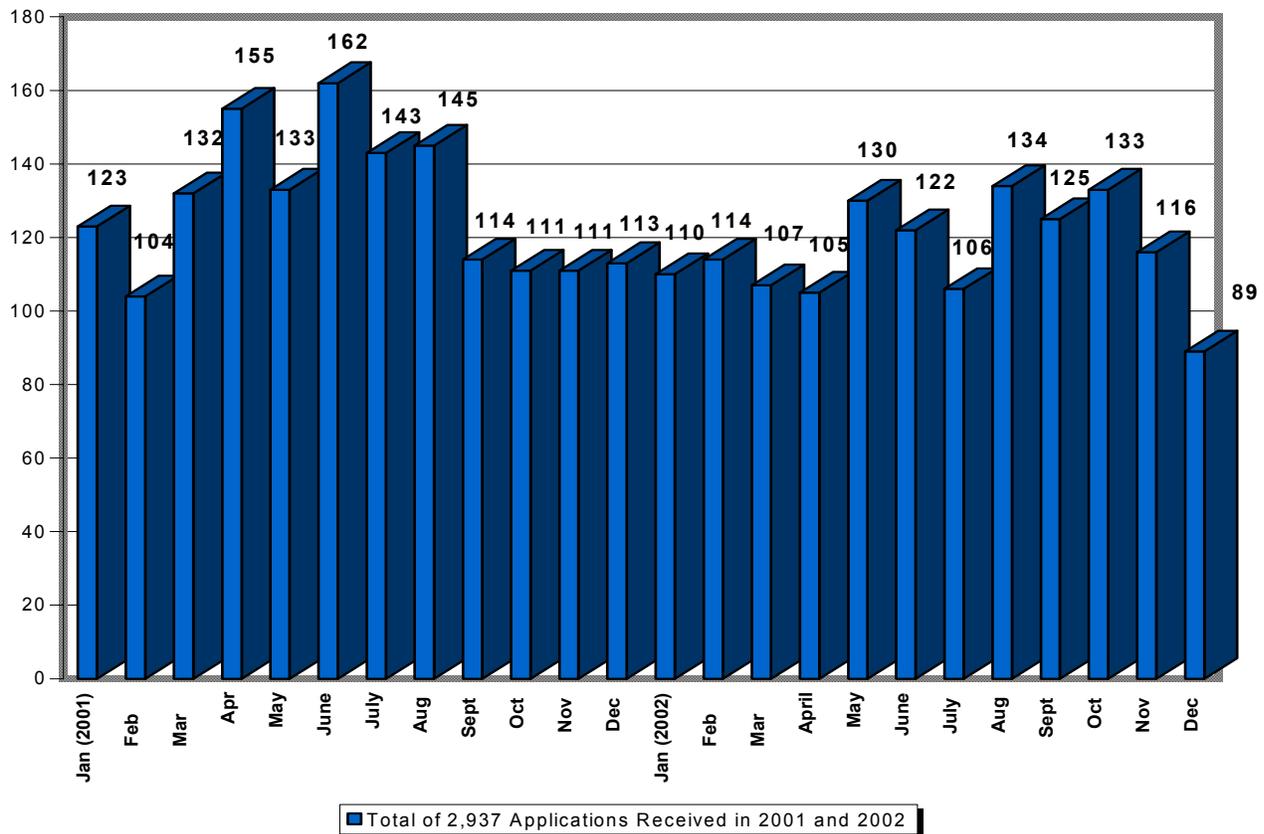
## Submission And Volume Of External Appeal Requests

The External Appeal Law builds on the protections of the Managed Care Reform Act and adds a Title II to Article 49 of the Insurance Law and Public Health Law. The External Appeal Law enables consumers to obtain an independent review if a health plan upholds an adverse utilization review determination that services are not medically necessary or are experimental or investigational. A consumer may request an external appeal by sending an external appeal application to the Insurance Department.

The Insurance Department has received 5,208 external appeal requests since the external appeal program became operational in July of 1999. The highest volume of requests, 1,703, was submitted in year 2000. The number of requests submitted in 2001 and 2002 were slightly lower, as 1,546 requests were submitted in 2001 and 1,391 requests were submitted in 2002. On average, 124 external appeal requests are submitted to the Department each month.

The following chart identifies the number of external appeal requests submitted to the Insurance Department each month in 2001 and 2002.

**External Appeal Applications Received by the  
Insurance Department in  
2001 and 2002**

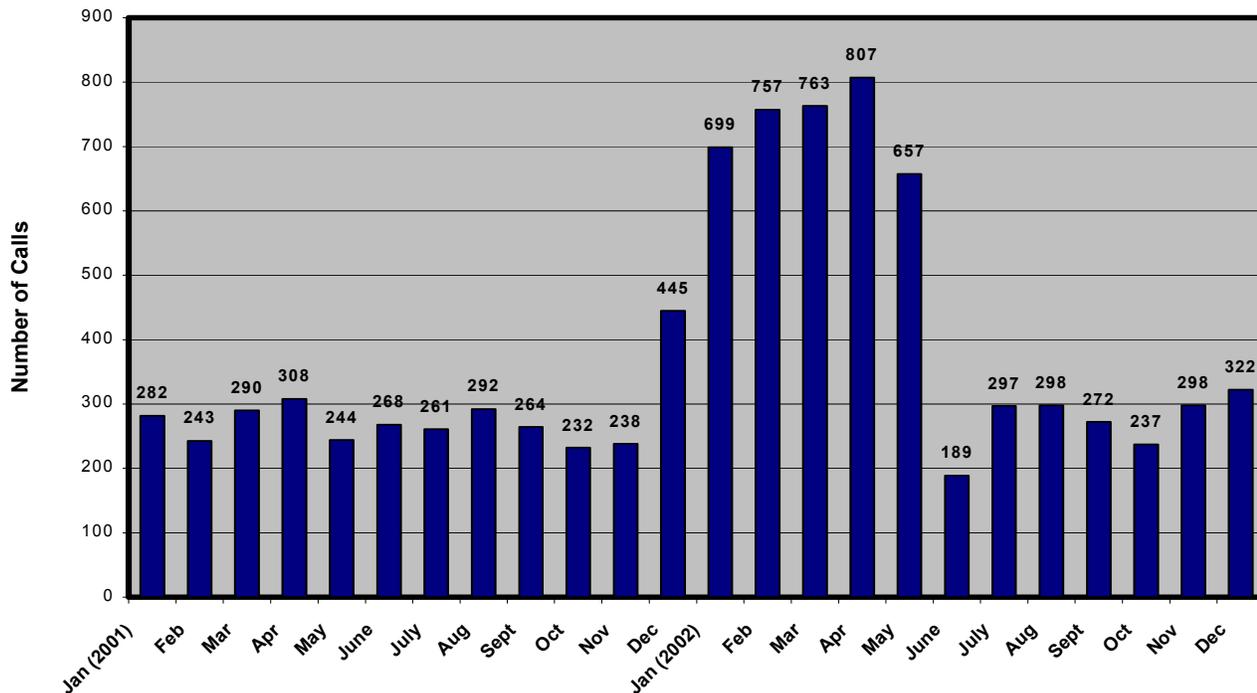


## Insurance Department Outreach

The Insurance Department operates an external appeal hotline (1-800-400-8882) to assist consumers in filing external appeal requests and to answer any external appeal questions consumers may have. Hotline calls are answered by trained and experienced staff from the Insurance Department's Consumer Services Bureau, with back-up assistance provided by attorneys in the Health Bureau. The hotline is staffed Monday through Friday from 9:00 a.m. – 5:00 p.m.

The Insurance Department has responded to over 16,000 hotline calls since the inception of the external appeal program in July 1999. The following chart identifies the number of external appeal calls the Insurance Department received and responded to each month in 2001 and 2002.

**Incoming Calls to the Toll-Free External Appeal Hotline  
in 2001 and 2002**



The hotline is just one of the mechanisms the Department uses to ensure that consumers are able to effectively utilize their external appeal rights. In addition to the hotline, the Insurance Department and the Health Department post external appeal information and the external appeal applications on their Web sites at [www.ins.state.ny.us](http://www.ins.state.ny.us) and [www.health.state.ny.us](http://www.health.state.ny.us). The Insurance Department's Web site was recently updated so that external appeal information is even easier to access. The Insurance Department also operates a dedicated mailbox and external appeal questions can be submitted by e-mail to [health@ins.state.ny.us](mailto:health@ins.state.ny.us).

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

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

## **Insurance Department Review Of External Appeal Requests**

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

### **A request is eligible for external appeal if the following conditions are met:**

- Services must have been denied as not medically necessary or as experimental or investigational.
  - ✓ Other types of denials, such as a denial because the patient has a pre-existing condition, the benefit is not covered under the contract, or the patient is requesting a referral to a non-participating provider, are not eligible for external appeal.
- The coverage falls within the scope of the External Appeal Law.
  - ✓ The External Appeal Law is not applicable to self-insured coverage, Medicaid fee-for-service coverage, and Medicare coverage, including coverage provided by Medicare managed care plans.
- The appeal has been submitted within the 45 day time frame.
  - ✓ An application must be submitted to the Insurance Department within 45 days of a patient's or provider's receipt of either the final adverse determination from a first level of appeal with a health plan or the letter from the health plan waiving the internal appeal. It is presumed that the final adverse determination or waiver letter was received within eight days of the date on the determination or letter.

### **An application is complete when the following information is included:**

- The application must be signed.
  - ✓ The patient, a parent if the patient is a minor, a guardian, or if the patient is deceased, the administrator or executor of the patient's estate, must sign the application.
- The final adverse determination from the first level of appeal with a health plan or a letter from the health plan waiving the internal appeal process must be included.
- If services were denied as experimental or investigational, an attending physician attestation must be completed.
  - ✓ The 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 include two articles of medical and scientific evidence for an appeal of experimental and investigational services, other than a clinical trial.

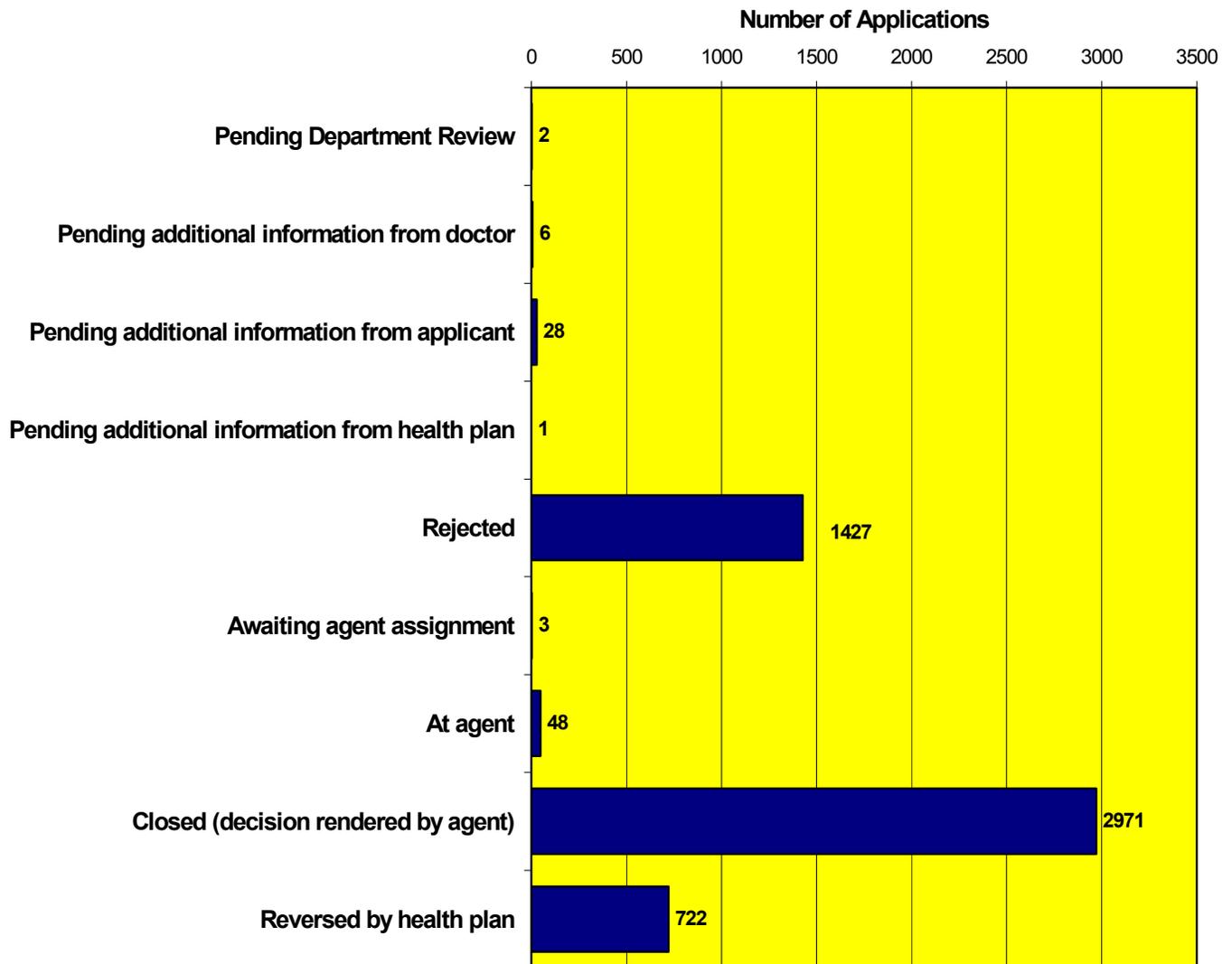
- If the patient requests an expedited appeal, the patient's attending physician must attest that the patient has not yet received the service and that a delay in providing the service would pose an imminent or serious threat to the health of the patient.
- The fee must be submitted, if required by the health plan.
  - ✓ Health plans may charge a fee up to \$50.00 for an external appeal. The fee is automatically waived for patients covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee would pose a hardship. The fee is returned to the applicant if the external appeal agent overturns the health plan's denial in whole or in part and forwarded to the health plan if the denial is upheld.

Applications that are eligible and complete are assigned by the Insurance Department to an external appeal agent. If an application is incomplete and the missing information is not provided after the Insurance Department makes two attempts to obtain the information, or if a request is determined to be ineligible for external appeal, the application will be rejected.

## Status Of All External Appeal Requests Submitted To The Insurance Department

Since July 1, 1999 the Insurance Department has been tracking all external appeal requests that it receives. External appeal requests are assigned an identification number and a status code. The identification number remains the same, however, the status code is automatically updated as the status of the request changes. Status codes identify whether the application is pending Insurance Department review, pending receipt of additional information, under review by an external appeal agent, rejected, reversed by a health plan, or closed because an external appeal agent rendered a decision. The following chart identifies the status of all external appeal requests submitted to the Insurance Department as of December 31, 2002.

**Status of External Appeal Applications Received by the Insurance Department as of December 31, 2002**



## Rejection Of External Appeal Requests

External appeal requests which the Insurance Department determines to be ineligible for external appeal are rejected and returned to the applicant. An external appeal request will be rejected if the denial does not fall within the scope of the External Appeal Law, if the External Appeal Law is not applicable to the applicant's health insurance coverage, or if the applicant does not submit an application within the 45 day time frame for requesting an external appeal.

An external appeal request will also be rejected if the application is incomplete and the missing information is not provided to the Insurance Department after two requests are made. An external appeal request is considered to be incomplete if the application is not signed, if the final adverse determination is not provided, if a fee is required and not submitted, or if the appeal is for experimental or investigational services and the attending physician attestation has not been completed.

If an application is incomplete, the Insurance Department will request the missing information from the applicant and, as appropriate, the applicant's attending physician and allow two weeks for a response. If a response is not provided, the Insurance Department will make a second request for the information. If a response is not provided to the second request, the application will be rejected.

When an application is rejected, the applicant is advised that although the request is not eligible for external appeal, the Insurance Department's Consumer Services Bureau is available to investigate the health plan's denial and will do so upon request by the applicant. If federal law applies to the applicant's coverage, instead of New York Law, the Insurance Department will also provide information on Medicare appeal rights or rights under self-insured plans, as applicable.

Since the beginning of the external appeal program in July of 1999, 1,427 external appeal requests have been rejected as ineligible for external appeal. During the past two years of operation, 746 requests were rejected as ineligible for external appeal, with 354 external appeal requests rejected in 2001 and 392 requests rejected in 2002.

In our 2002 survey of states with external appeal programs, the Insurance Department asked states to identify their most frequent reasons for rejection of external appeal requests. While a few states did not maintain the information because the health plan or the external appeal agent determines external appeal eligibility, the majority of states did make eligibility determinations and were able to provide the information. The most common reasons for rejection of external appeal requests in other states with external appeal programs were, in order of frequency, the applicant was covered under a self-insured plan, the dispute involved a benefit that was not covered under the contract, the applicant failed to complete the necessary internal appeal, and the application was not submitted within the time frame.

The most common reasons for rejection of external appeal requests in New York varied slightly from other states. In New York, the most frequent reason for rejection of external appeal requests has been and continues to be that the application is incomplete and the applicant has not provided the missing information after two requests are made by the Insurance Department.

The following chart identifies the number of external appeal requests that have been rejected in New York in calendar years 2001 and 2002 and lists the reasons for rejection.

<b>Reasons for Rejection of External Appeal Requests in New York</b>		
	<b>2002</b>	<b>2001</b>
Applicant did not provide missing information:	91	80
• Physician attestation for experimental/investigational appeal.	12	7
• Health plan denial letter.	9	11
• Check or money order.	6	1
• Patient did not submit external appeal request and did not confirm interest in pursuing an external appeal.	6	5
• Consent form signed by patient or patient's legal representative.	5	8
• An application.	2	2
• More than one of the above items missing.	51	46
Application was not submitted within the 45 day time frame.	65	79
Denial was for a benefit that was not covered under the contract.	47	34
Applicant did not first appeal the denial with the health plan.	40	21
Self-insured coverage.	35	31
Applicant withdrew external appeal request.	25	22
Provider ineligible to request external appeal.	22	29
Attending physician attestation for experimental/investigational appeal did not meet the requirements of law.	24	6
CPT code, UCR or level of reimbursement dispute.	14	15
Denial for a referral to a non-participating provider.	7	4
Denial for a failure to request pre-authorization.	6	7
Federal employee coverage or United States military coverage.	6	3
Medicare managed care coverage.	3	6
Out-of-state insurance policy.	2	7
Complaints relating to eligibility, premiums, and administration of contract.	2	2
Duplicate applications submitted.	2	2
Member did not have coverage with the health plan at the time of treatment.	1	5
Member pursued a Medicaid Fair Hearing instead of an external appeal.	0	1
<b>Total</b>	<b>392</b>	<b>354</b>

## Reversals By Health Plans

In addition to appeals that are closed because they are ineligible, an appeal may also be closed during the external appeal process because a health plan reverses its adverse determination before a decision is rendered by an external appeal agent. Some denials are reversed by a health plan when an external appeal is initially requested, while others are reversed because new information is submitted during the course of an external appeal.

When the Insurance Department receives an external appeal request, Department staff contacts the health plan. Staff from the Insurance Department and the health plan discuss the denial and determine whether the health plan would like to reverse its denial. In some cases, the dispute is resolved in this manner and review by an external appeal agent is not necessary.

A denial may also be reversed by a health plan when the case has been assigned to an external appeal agent and new information is submitted. If the health plan was not previously given an opportunity to review the information, an external appeal agent must forward the information to the health plan and the health plan is allowed three days to decide whether to reverse its denial.

Other denials are reversed because a consumer requests both a second level appeal with the health plan and an external appeal. In these cases a health plan may overturn its denial in the second level appeal process, and if that occurs before the external appeal agent renders a determination, the denial will be considered reversed and the appeal will be closed.

From July 1, 1999 through December 31, 2002, 722 appeals were closed because a health plan reversed an adverse determination during the external appeal process. On a calendar year basis, 247 external appeals were reversed by health plans in 2001 and 159 were reversed in 2002. The following charts identify the denials that were reversed by health plans before a decision was rendered by an external appeal agent. When reviewing the charts, it is important to keep in mind that some health plans provide coverage to a greater number of New Yorkers than others. Larger plans may have more reversals than smaller plans because more people are covered under the plans.

Health Maintenance Organizations	Health Plan Reversals in 2002	Health Plan Reversals in 2001
Aetna Health Inc.	2	1
Capital District Physicians' Health Plan, Inc. (CDPHP)	5	3
CIGNA Healthcare of New York, Inc.	1	3
Empire Healthchoice HMO, Inc.	2	5
Excellus Health Plan, Inc. (Blue Choice) (BCBS Rochester)	1	6

<b>Health Maintenance Organizations</b>	<b>Health Plan Reversals in 2002</b>	<b>Health Plan Reversals in 2001</b>
Excellus Health Plan, Inc. (HMO-CNY) (BCBS CNY)	2	0
Excellus Health Plan, Inc. (Univera-CNY)	0	2
Excellus Health Plan, Inc. (Univera-Southern Tier)	0	1
Excellus Health Plan, Inc. (Univera-WNY)	8	1
GHI HMO Select, Inc.	2	2
HealthNow New York, Inc. (Community Blue) (BCBS WNY)	2	5
HealthNow New York, Inc. (HMO of BS NENY)	2	0
Health Net of New York, Inc. (formerly Physicians Health Services, Inc.)	7	1
Health Insurance Plan of Greater NY, Inc. (HIP)	4	2
MDNY Healthcare, Inc.	0	2
MVP Health Plan, Inc.	0	2
Oxford Health Plans of New York, Inc.	46	31
Rochester Area HMO, Inc. (Preferred Care)	1	0
United Healthcare of New York, Inc.	1	0
Vytra Health Plans Long Island, Inc.	1	4
<b>Total</b>	<b>87</b>	<b>71</b>

<b>Non-Profit Indemnity Insurers</b>	<b>Health Plan Reversals in 2002</b>	<b>Health Plan Reversals in 2001</b>
Empire Healthchoice Inc.	16	118
Excellus Health Plan, Inc. (BCBS CNY)	4	3
Excellus Health Plan, Inc. (BCBS Rochester)	2	0
Excellus Health Plan, Inc. (BCBS Utica Watertown)	1	0
Group Health Incorporated (GHI)	34	31
HealthNow New York Inc. (BCBS WNY)	2	1
HealthNow New York Inc. (BCBS NENY)	1	7
<b>Total</b>	<b>60</b>	<b>160</b>

<b>Commercial Insurers</b>	<b>Health Plan Reversals in 2002</b>	<b>Health Plan Reversals in 2001</b>
Aetna U.S. Healthcare (Prudential HealthCare)	1	0
Aetna Life Insurance Company	1	0
Anthem Health & Life Insurance Company of New York	0	1
Connecticut General Life Insurance Company	1	1
Guardian Life Insurance Company of America	1	1
Horizon Healthcare Insurance Company of New York	0	1
UniCARE Life & Health Insurance Company	1	0
United HealthCare Life Insurance Company of New York	4	10
<b>Total</b>	<b>9</b>	<b>14</b>

<b>Medicaid Managed Care Plans</b>	<b>Health Plan Reversals in 2002</b>	<b>Health Plan Reversals in 2001</b>
Americhoice of New York, Inc.	0	1
Buffalo Community Health Inc.	1	0
New York-Presbyterian CHP	1	0
Suffolk Health Plan	0	1
<b>Total</b>	<b>2</b>	<b>2</b>

<b>Municipal Cooperative Health Benefit Plans</b>	<b>Health Plan Reversals in 2002</b>	<b>Health Plan Reversals in 2001</b>
State Wide Schools Cooperative Health Plan	1	0
<b>Total</b>	<b>1</b>	<b>0</b>

## **External Appeal Agents**

If an external appeal request is determined to be eligible and complete, and the denial is not reversed, the Insurance Department will randomly assign the appeal to an external appeal agent. External appeal agents are certified by the Insurance Department and the Health Department for two year periods and must meet the certification standards in Title II of Article 49 of the Insurance Law and Public Health Law.

The law requires external appeal agents to have a comprehensive network of clinical peer reviewers available to review a health plan's denial of services. Clinical peer reviewers must be appropriately licensed and trained in New York external appeal standards. External appeal agents must assign appeals to a clinical peer in the same or similar specialty as the provider that typically manages the medical condition or provides the treatment that is the subject of the appeal so that cases will be reviewed by a qualified and impartial provider in the appropriate specialty. External appeal agents must appoint a medical director who is responsible for oversight of the external appeal process. External appeal agents must have policies and procedures in place to protect confidentiality and must have a quality assurance program. External appeal agents must also have mechanisms in place to ensure that appeal decisions are made within the required time frames.

The law includes conflict of interest protections to ensure that external appeal agents and clinical peers are independent from the health plan and any party involved in the appeal. External appeal agents and their clinical peer reviewers are prohibited from having a material professional affiliation, a material financial affiliation, or a material familial affiliation with the health plan, patient, provider, or facility involved in the external appeal. External appeal agents are also prohibited from accepting an appeal if they previously reviewed the case in connection with the health plan's internal appeal procedure.

Currently there are three certified external appeal agents that review external appeals in New York. The agents are Medical Care Management Corporation (MCMC), certified on July 2, 1999 and recertified on July 1, 2001; Island Peer Review Organization (IPRO), certified on June 30, 1999 and recertified on July 1, 2001; and Hayes Plus, certified on June 21, 2001.

All three external appeal agents will need to be recertified in the summer of 2003. As part of the recertification process, agents must provide a description of any policies and procedures that have changed since the previous recertification and a description of any changes in the agent's network of clinical peer reviewers. Agents must also provide a plan of correction for any deficiencies the Departments identify. The Insurance Department and the Health Department are currently working on the recertification of the agents.

## Assigning External Appeals To Agents

The Insurance Department randomly assigns appeals to external appeal agents. After an agent is selected, but before case materials are sent to the agent, the Insurance Department will confirm that the agent does not have a conflict of interest with respect to the appeal. If there is no conflict, the Insurance Department will forward all information submitted with the appeal to the external appeal agent. The Department will also advise the agent whether the appeal is standard or expedited, what the basis of the denial is, and the time frame in which a determination must be rendered.

When an appeal is assigned, the Insurance Department will send a letter to the applicant and, as appropriate, the applicant's attending physician identifying the name of the agent that will be reviewing the case and explain that any additional information must be submitted to the agent immediately. The Department further advises the applicant that once an agent renders a determination, additional information will not be considered.

The Insurance Department also notifies health plans when an agent has been assigned. The Department advises health plans that they must send the patient's medical records to the external appeal agent within three business days for standard appeals or 24 hours for expedited appeals. The Department forwards a copy of the plan's own final adverse determination along with the patient's signed consent to the release of medical records so 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.

Within three business days of receiving a standard appeal or 24 hours of receipt of an expedited appeal, an external appeal agent will request information from the health plan, the patient, and the patient's providers. An external appeal agent may also request additional information if the clinical peer reviewing the appeal determines that more information is needed to make a determination.

External appeal agents use the patient's signed consent to the release of medical information in the external appeal application to obtain the patient's medical records. The external appeal applications were recently revised so that the consent would be in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) privacy requirements. HIPAA is a comprehensive enactment by the United State Congress relating to health insurance. Section 264 of HIPAA, codified as a Note to 42 U.S.C.A. §1320d-2 (West 1999), required the Secretary of Health and Human Services to promulgate a regulation governing the disclosure of individually identifiable health information. In accordance with the directive, the Secretary promulgated a final privacy regulation in 2002 which included requirements for a patient's signed consent to the release of health information.<sup>1</sup> The regulation identifies the following core elements and statements that must be included an authorization in order for a health plan or provider to release a patient's medical information:

(1) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.

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<sup>1</sup> See 45 C.F.R. § 164.508(c).

- (2) The name or other specific identification of the person(s) authorized to make the requested use or disclosure.
- (3) The name or other specific identification of the person(s) to whom the disclosure will be made.
- (4) A description of each purpose of the requested use or disclosure.
- (5) An expiration date or an expiration event for the use or disclosure.
- (6) The patient's signature and date.
- (7) If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient.
- (8) Notification of the patient's right to revoke the authorization in writing.
- (9) Notification of the ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either: (A) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations applies; or (B) The consequences to the patient of a refusal to sign the authorization when the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.
- (10) Notification of the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected by federal regulation.

The revised external appeal applications include all the above elements so that health plans and providers will be able to release medical information to the external appeal agents. The Insurance Department is also available to intervene in the event an external appeal agent is unable to obtain the patient's medical records.

## **External Appeal Agent Review And Decisions**

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

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

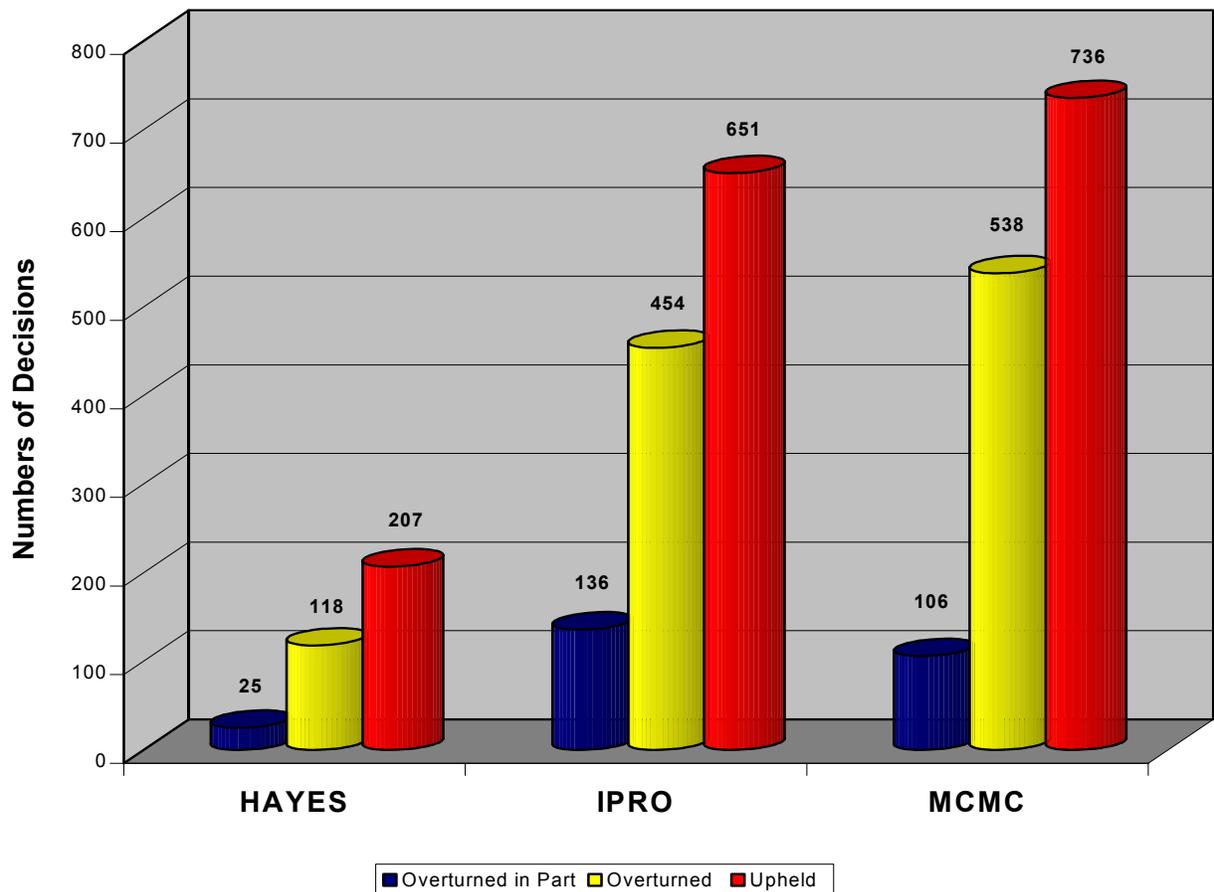
Typically, external appeal agents assign one clinical peer to review medical necessity denials and three clinical peers to review appeals of experimental or investigational treatments. If a patient's attending physician attests that a delay would pose an imminent or serious threat to the health of the patient, the appeal will be expedited, and an agent must render a decision in three days. If the appeal is not expedited, an external appeal agent must render a decision within 30 days, unless the agent needs additional information, and then the agent will have five additional business days to render a determination.

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

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

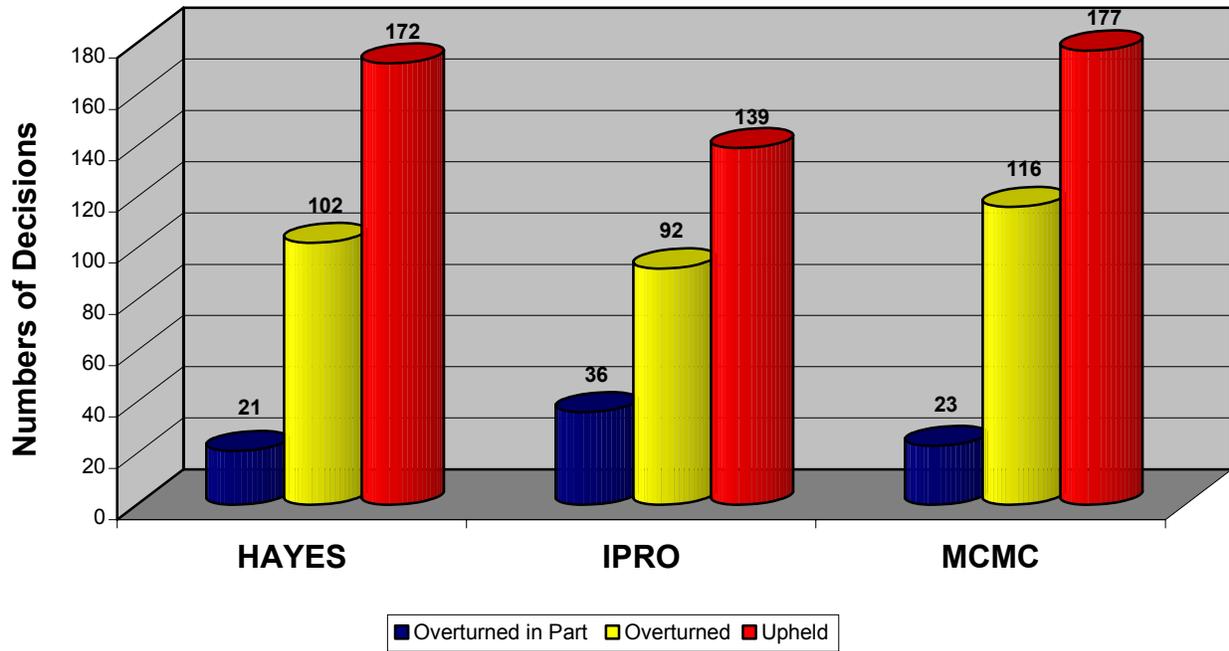
The Insurance Department tracks the cases that are assigned to external appeal agents. In 2002, 295 cases were assigned to Hayes, 267 were assigned to IPRO, and 316 were assigned to MCMC. The differences in case assignments can be attributed to the random assignment process and to reassignments due to conflicts of interest. The Insurance Department also tracks the decisions of external appeal agents. In 2002, health plan denials were overturned in whole or in part by Hayes in 42% of cases, by IPRO in 48% of cases and by MCMC in 44% of cases. In 2001, 45% of health plan denials were overturned in whole or in part by IPRO and 46% were overturned in whole or in part by MCMC.\* The following charts identify external appeals results by agents from July 1999 through December 2002.

### External Appeal Decisions by Agent July 1, 1999 - December 31, 2002

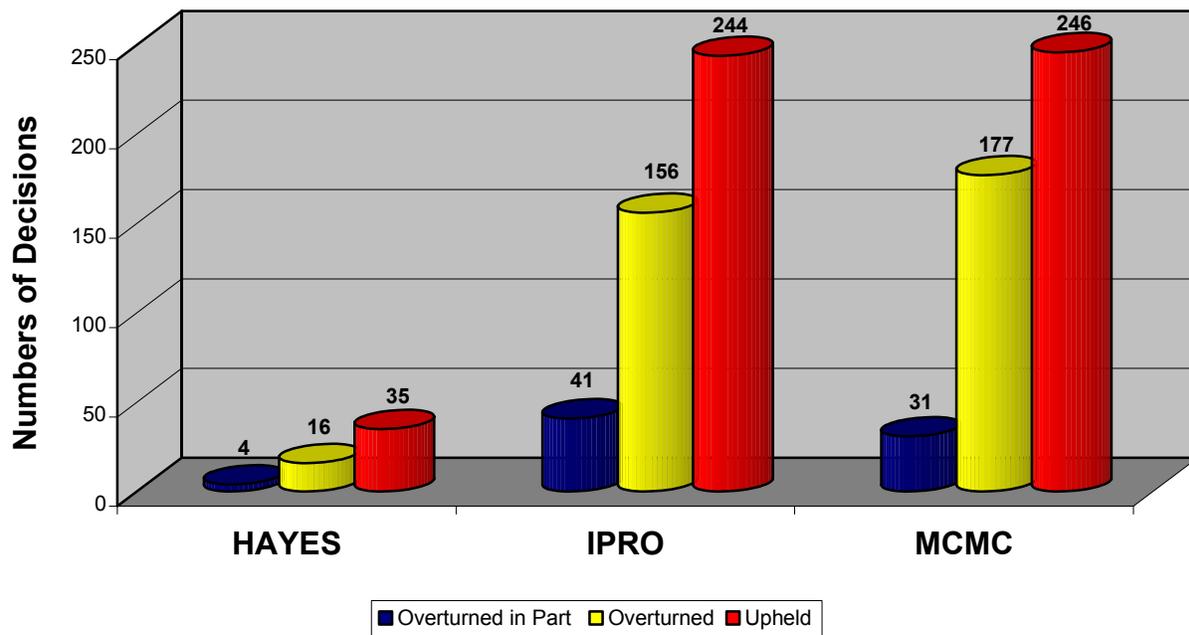


\* Hayes was certified mid-year and did not have appeals assigned during the same time period for comparison.

## External Appeal Decisions by Agent 2002



## External Appeal Decisions by Agent 2001



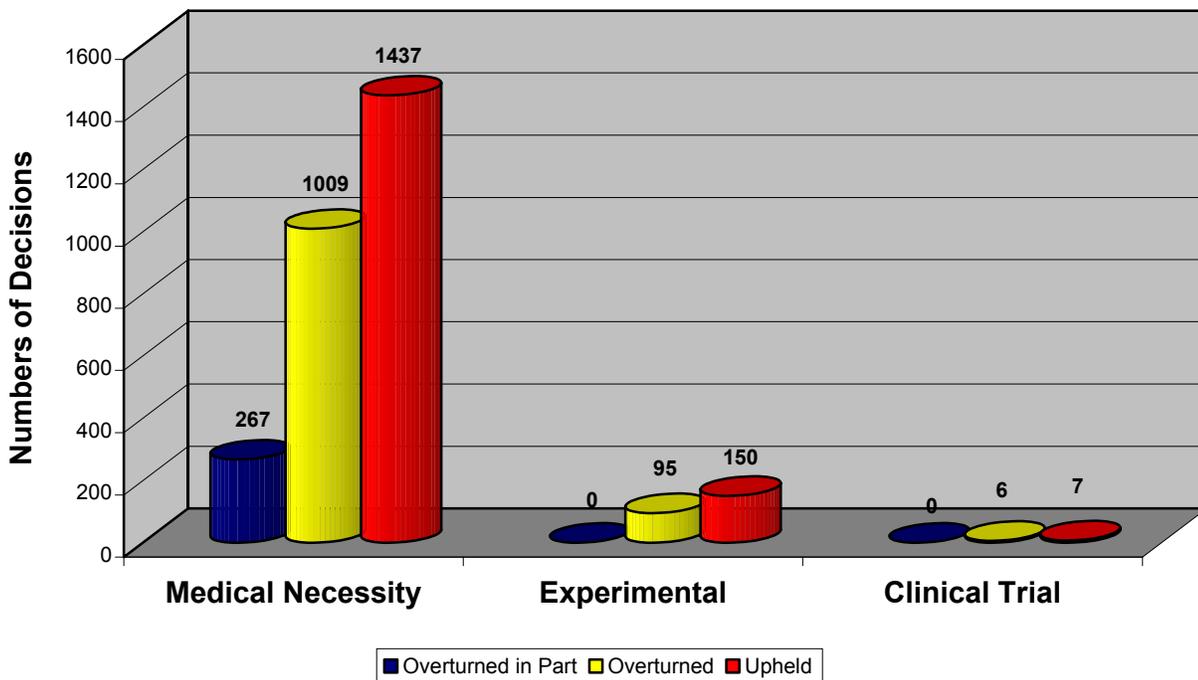
## External Appeal Results By Type Of Health Plan Denial

In addition to viewing external appeal results by agent, results can also be viewed by type of health plan denial. Since the beginning of the program through the most recent program year, the majority of external appeal requests have related to denials based on medical necessity and not denials because services were considered experimental or investigational. Of the medical necessity denials, the most frequent types of services appealed in 2002 included surgical services, inpatient hospital services, mental health services, physical therapy, prescription drug coverage, and chiropractic services.

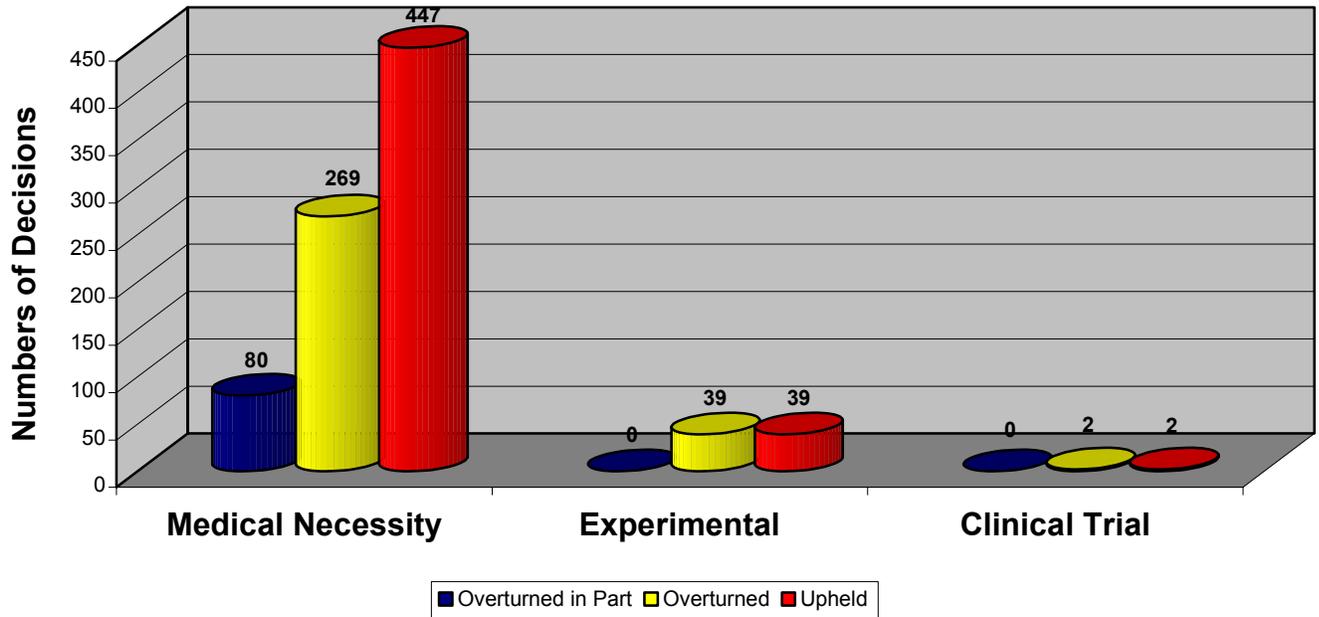
In previous years, external appeal agents overturned medical necessity denials in whole or in part in approximately half of all cases, but only overturned experimental or investigational treatment denials in approximately one out of every three cases. In calendar years 2001 and 2002, the percentage of medical necessity denials overturned in whole or in part by external appeal agents decreased while the percentage of experimental or investigational denials overturned by external appeal agents increased.

In 2001, 46% of medical necessity denials were overturned in whole or in part, while 37% of experimental or investigational treatment denials were overturned. In 2002, 44% of medical necessity denials were overturned in whole or in part, while 50% of experimental or investigational treatment denials were overturned. The following charts identify external appeal results based on whether services were denied as not medically necessary or as experimental or investigational.

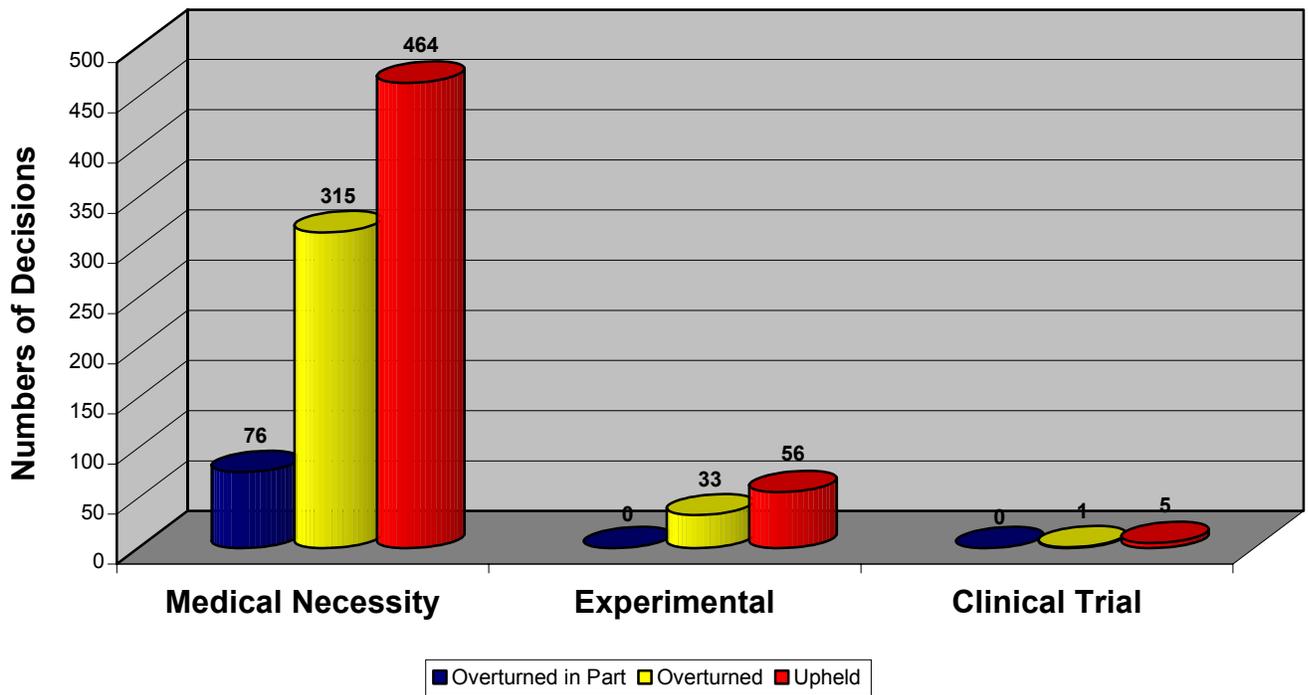
### External Appeal Decisions by Type of Health Plan Denial July 1, 1999 - December 31, 2002



## External Appeal Decisions by Type of Health Plan Denial 2002



## External Appeal Decisions by Type of Health Plan Denial 2001



## **Expedited External Appeals**

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

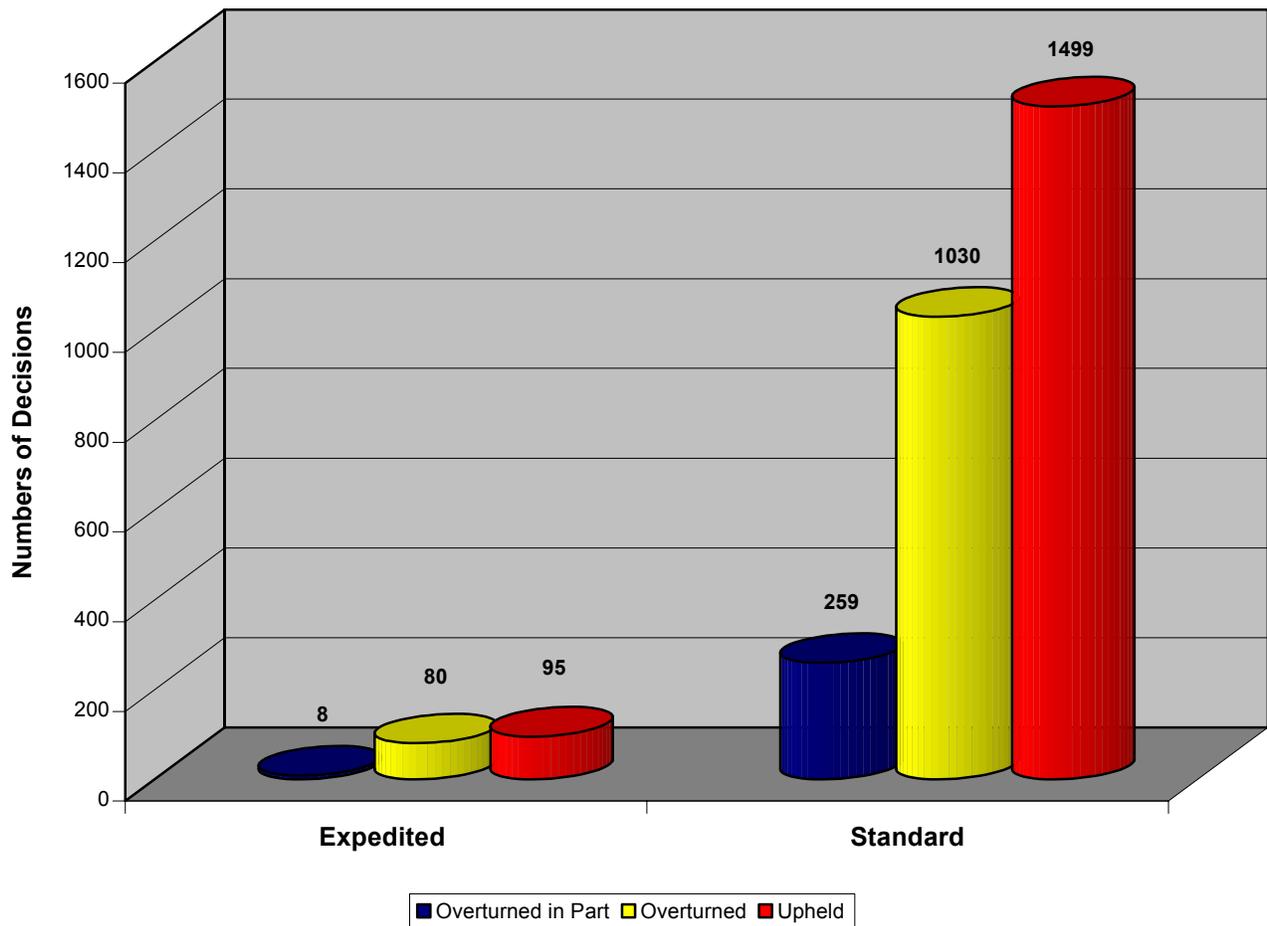
Expedited external appeals can be problematic because the three day time frame only allows the patient and the patient's provider a limited opportunity to submit additional information. Depending on the services that have been denied, and when the external appeal is requested, processing an appeal as expedited is not always in the best interest of the patient. For example, if additional information is needed it can be difficult for the external appeal agent to obtain information from the patient's health care provider in the short time frame, especially if the appeal is submitted over the weekend. Moreover, the law requires a decision to be made in three days, regardless of whether the agent has all the necessary information. There have also been cases when expedited appeals have been requested by patients and attested to by physicians when a delay would not appear to impose an imminent or serious threat to the health of the patient, for example when the external appeal is requested more than a month after the health plan's denial or after the services have been provided.

To remedy these issues, the Insurance Department may contact the patient's attending physician and the patient to explain that any information must be submitted immediately and discuss the option of processing the appeal as standard. If the patient's attending physician states that the appeal should remain expedited, it is assigned as such, unless the services have already been provided. In addition, to better inform consumers, the Department added a detailed explanation about expedited appeals when revising the standardized external appeal applications. The applications now reference the three day expedited appeal decision time frame, the need to submit any information immediately, and that agents are required by law to make a determination regardless of whether the necessary information is provided. The revised applications also request the patient's attending physician to provide weekend contact information so an external appeal agent will be able to reach the physician if additional information is needed.

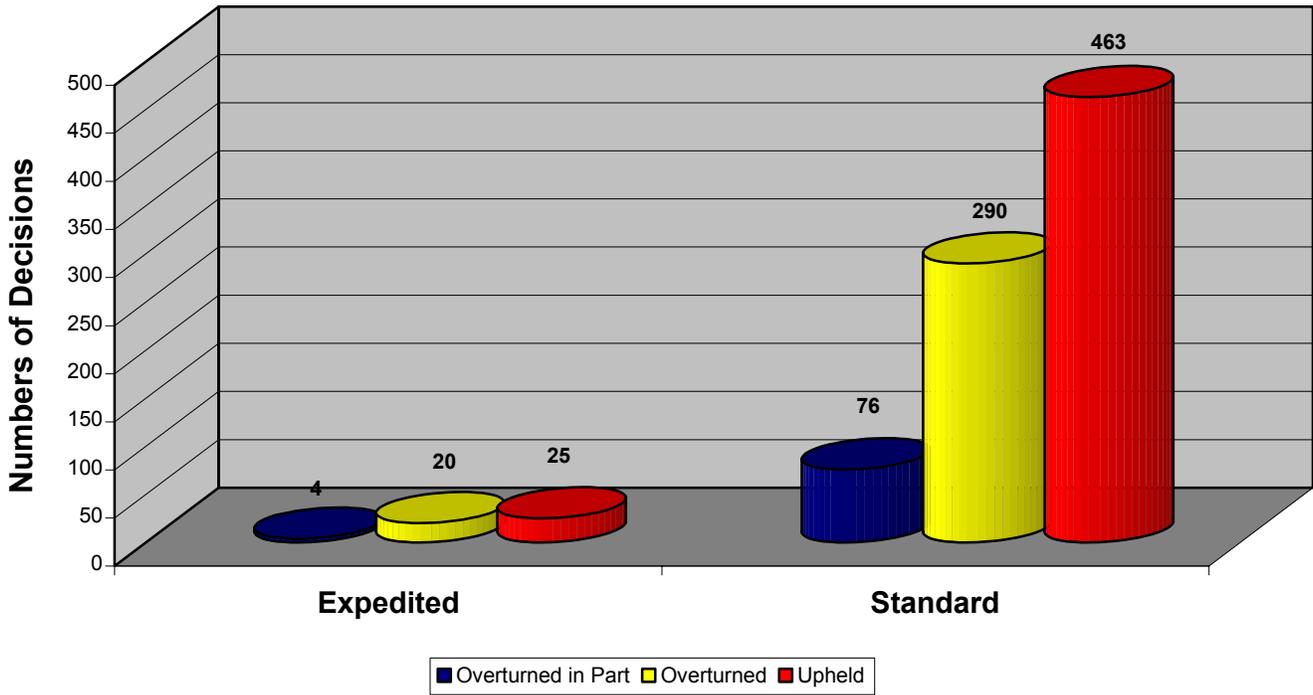
Insurance Department staff is available to handle expedited appeals submitted during business hours and after the close of business. Two Insurance Department staff members are on call each weekend to handle expedited appeals. Applicants requesting an expedited appeal are asked to call the Department to provide notice that an expedited appeal is being submitted. While there has only been a slight decrease in the number of expedited external appeals requested, there has been a significant decrease in the number of applicants that have called either during the week or on a weekend or holiday to advise the Department that an expedited appeal will be submitted. The Insurance Department received and responded to 18 expedited appeal calls and questions on weekends and holidays in 2001 and 4 calls in 2002.

Along with tracking expedited appeal calls, the Insurance Department also tracks expedited appeal decisions. External appeal agents have overturned health plan denials in whole or in part in expedited cases at a slightly higher percentage than in standard appeals. In 2002, external appeal agents overturned health plan denials in whole or in part in 49% of expedited cases and in 44% of standard appeal cases. In 2001, external appeal agents overturned health plan denials in whole or in part in 46% of expedited cases and in 45% of standard cases. The following charts compare standard and expedited appeal results.

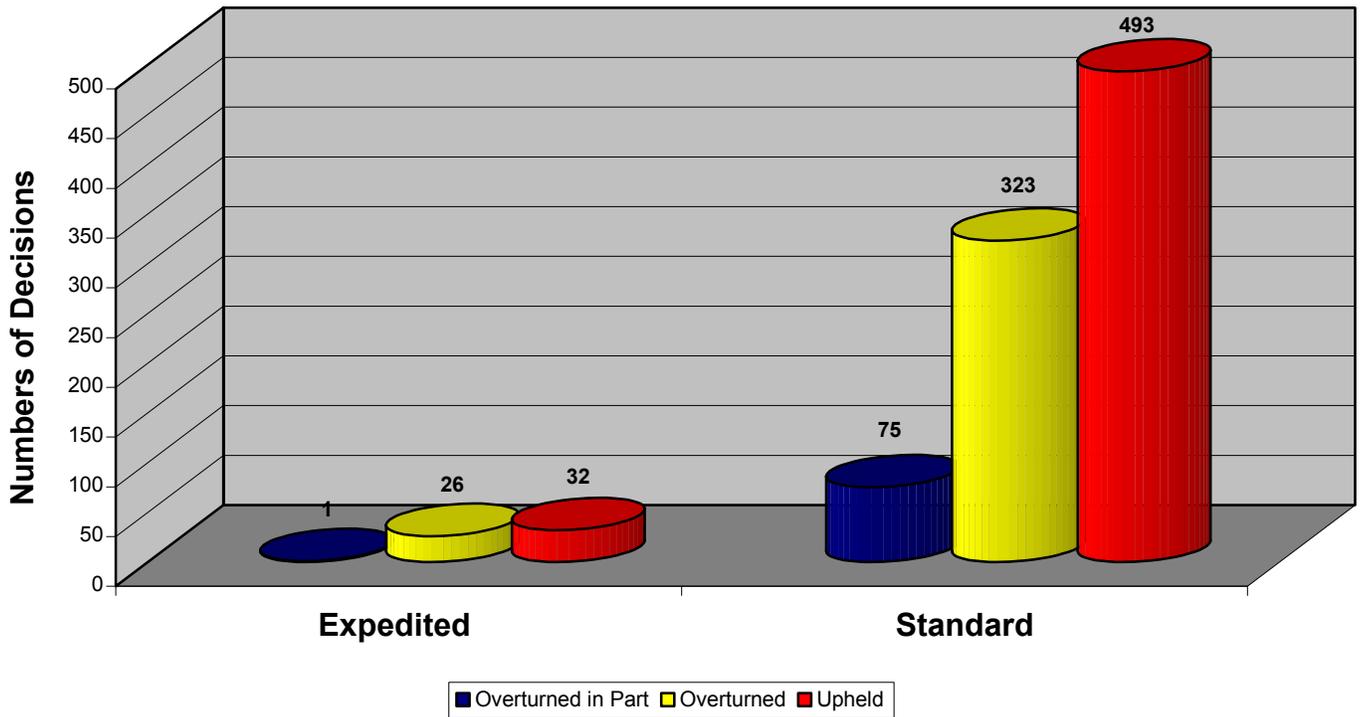
### External Appeal Decisions by Type of Appeal July 1, 1999 - December 31, 2002



### External Appeal Decisions by Type of Appeal 2002



### External Appeal Decisions by Type of Appeal 2001



## External Appeal Results By Calendar Year

In addition to viewing external appeal results by agent, by type of health plan denial, and by type of appeal, external appeal results can also be viewed on a calendar year basis. As seen in the chart below, there have been a total of 2,971 decisions rendered by external appeal agents since the beginning of the external appeal program in July 1, 1999. The percentage of health plan denials overturned in whole or in part by external appeal agents has decreased slightly in the past two years of operation of the Program.

Timeframe	Total	Health Plan Denial Overturned	Health Plan Denial Overturned in Part	Health Plan Denial Upheld	Percentage Overturned in Whole or in Part
2002	878	310	80	488	44%
2001	950	349	76	525	45%
2000	937	371	91	475	49%
July – December 1999	206	80	20	106	49%
<b>Total</b>	<b>2971</b>	<b>1110</b>	<b>267</b>	<b>1594</b>	<b>46%</b>

## External Appeal Decisions By Health Plan

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

Health Maintenance Organizations	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
<b>Aetna Health Inc.</b>					
2002	37	12	2	23	37.8%
All*	124	46	14	64	48.4%
<b>Atlantis Health Plan, Inc.</b>					
2002	2	2	0	0	100%
All	2	2	0	0	100%
<b>Capital District Physicians' Health Plan, Inc. (CDPHP)</b>					
2002	2	0	1	1	50%
All	37	16	3	18	51.4%
<b>CIGNA Healthcare of New York, Inc.</b>					
2002	21	5	4	12	42.9%
All	58	19	11	28	51.7%
<b>Empire Healthchoice HMO, Inc.</b>					
2002	42	21	1	20	52.4%
All	147	70	8	69	53.1%
<b>Excellus Health Plan, Inc. (Blue Choice) (BCBS of Rochester)</b>					
2002	23	11	0	12	47.8%
All	60	29	0	31	48.3%
<b>Excellus Health Plan, Inc. (HMO Blue) (BCBS of Utica Watertown)</b>					
2002	5	2	1	2	60%
All	15	6	2	7	53.3%

\* The "All" category includes appeal results from July 1999 – December 2002.

Health Maintenance Organizations	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Excellus Health Plan, Inc. (HMO CNY) (BCBS of Central NY)					
2002	10	4	0	6	40%
All	35	13	3	19	45.7%
Excellus Health Plan, Inc. (Univera CNY)					
2002	5	1	0	4	20%
All	23	8	1	14	39.1%
Excellus Health Plan, Inc. (Univera Southern Tier)					
2002	1	0	0	1	0%
All	2	1	0	1	50%
Excellus Health Plan, Inc. (Univera WNY)					
2002	24	14	0	10	58.3%
All	81	34	0	47	42%
GHI HMO Select, Inc.					
2002	3	2	0	1	66.7%
All	7	2	0	5	28.6%
Health Net of New York, Inc. (formerly Physicians Health Services, Inc.)					
2002	59	28	4	27	54.2%
All	149	65	18	66	55.7%
HealthNow New York, Inc. (Community Blue) (BCBS of Western NY – Buffalo)					
2002	21	1	3	17	19%
All	57	7	7	43	24.6%
HealthNow New York, Inc. (BS of Northeastern NY)					
2002	4	1	0	3	25%
All	27	9	0	18	33.3%
Health Insurance Plan of Greater NY, Inc. (HIP)					
2002	25	12	2	11	56%
All	73	35	5	33	54.8%

Health Maintenance Organizations	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Independent Health Association, Inc.					
2002	2	1	0	1	50%
All	12	4	1	7	41.7%
MDNY Healthcare, Inc.					
2002	1	1	0	0	100%
All	14	10	1	3	78.6%
MVP Health Plan, Inc.					
2002	18	9	0	9	50%
All	48	22	2	24	50%
Oxford Health Plans of New York, Inc.					
2002	220	63	14	143	35%
All	552	167	41	344	37.7%
Rochester Area HMO, Inc. (Preferred Care)					
2002					
All	7 14	5 8	0 0	2 6	71.4% 57.1%
United Healthcare of New York, Inc.					
2002	6	3	0	3	50%
All	22	11	0	11	50%
Vytra Health Plans Long Island, Inc.					
2002	5	1	1	3	40%
All	64	28	9	27	57.8%
<b>Totals</b>					
<b>2002</b>	<b>543</b>	<b>199</b>	<b>33</b>	<b>311</b>	<b>42.7%</b>
<b>All</b>	<b>1623</b>	<b>612</b>	<b>126</b>	<b>885</b>	<b>45.5%</b>

Non-Profit Indemnity Insurers	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Empire Healthchoice, Inc. <sup>1</sup>					
2002	125	43	20	62	50.4%
All	453	170	44	239	47.2%
Excelsus Health Plan, Inc. (BCBS of Central NY)					
2002	39	15	5	19	51.3%
All	142	48	13	81	43%
Excelsus Health Plan, Inc. (BCBS of Rochester)					
2002	7	2	0	5	28.6%
All	27	10	0	17	37%
Excelsus Health Plan, Inc. (BCBS of Utica-Watertown)					
2002	17	5	1	11	35.3%
All	40	13	1	26	35%
Group Health Incorporated (GHI)					
2002	70	19	10	41	41.4%
All	243	78	46	119	51%
HealthNow New York Inc. (BCBS of Western NY)					
2002	3	1	1	1	66.7%
All	22	8	4	10	54.5%
HealthNow New York Inc. (BS of Northeastern NY)					
2002	2	0	0	2	0%
All	23	13	0	10	56.5%
Vytra Health Services, Inc.					
2002	0	0	0	0	
All	9	5	0	4	55.6%
<b>Totals</b>					
<b>2002</b>	<b>263</b>	<b>85</b>	<b>37</b>	<b>141</b>	<b>46.4%</b>
<b>All</b>	<b>959</b>	<b>345</b>	<b>108</b>	<b>506</b>	<b>47.2%</b>

<sup>1</sup> Empire Healthchoice, Inc. converted to a for-profit commercial insurer in October 2002.

Commercial Insurers	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Aetna Life Insurance Company					
2002	2	0	1	1	50%
All	5	0	3	2	60%
Anthem Health & Life Insurance Company of New York					
2002	2	0	0	2	0%
All	5	2	0	3	40%
Connecticut General Life Insurance Company					
2002	12	5	1	6	50%
All	40	23	1	16	60%
Equitable Life Assurance Society of the United States					
2002	2	0	0	2	0%
All	2	0	0	2	0%
Guardian Life Insurance Company of America					
2002	5	2	1	2	60%
All	13	2	3	8	38.5%
Health Net Insurance Company of New York, Inc. (formerly Physicians Health Services, Inc.)					
2002	1	1	0	0	100%
All	18	5	4	9	50%
Horizon Healthcare Insurance Company of New York					
2002	10	5	1	4	60%
All	14	7	1	6	57.1%
Mutual of Omaha Insurance Company					
2002	0	0	0	0	
All	1	1	0	0	100%
UniCARE Life & Health Insurance Company					
2002	4	1	1	2	50%
All	16	4	6	6	62.5%

Commercial Insurers	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
United HealthCare Insurance Company of New York					
2002	22	8	1	13	40.9%
All	155	65	7	83	46.5%
<b>Totals</b>					
<b>2002</b>	<b>60</b>	<b>22</b>	<b>6</b>	<b>32</b>	<b>46.7%</b>
<b>All</b>	<b>269</b>	<b>109</b>	<b>25</b>	<b>135</b>	<b>49.8%</b>

Medicaid Managed Care Coverage	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Americhoice of New York, Inc.					
2002	0	0	0	0	
All	2	1	0	1	50%
Capital District Physicians Health Plan, Inc. (CDPHP)					
2002	0	0	0	0	
All	1	0	0	1	0%
CenterCare Health Plan					
2002	1	0	1	0	100%
All	1	0	1	0	100%
Excellus Health Plan Inc. (Blue Choice) (BCBS of Rochester)					
2002	0	0	0	0	
All	1	0	0	1	0%
HealthNow New York Inc. (Community Blue) (BCBS of Western NY – Buffalo)					
2002	2	0	0	2	0%
All	2	0	0	2	0%
HealthNow New York Inc. (BS of Northeastern NY HMO)					
2002	1	0	1	0	50%
All	2	0	2	0	50%

Medicaid Managed Care Coverage	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Health Insurance Plan of Greater NY, Inc. (HIP)					
2002	2	0	1	1	50%
All	5	1	1	3	40%
HealthSource/HHP (Westchester Prepaid Health Services Plan)					
2002	1	1	0	0	100%
All	1	1	0	0	100%
Independent Health Association, Inc.					
2002	1	1	0	0	100%
All	1	1	0	0	100%
NYS Catholic Health Plan (Fidelis Care)					
2002	1	0	0	1	0%
All	6	1	0	5	16.7%
United Healthcare of New York, Inc.					
2002	0	0	0	0	
All	2	2	0	0	100%
Vytra Health Plans Long Island, Inc.					
2002	0	0	0	0	
All	2	0	0	2	0%
Wellcare of New York, Inc.					
2002	0	0	0	0	
All	1	0	0	1	0%
<b>Totals</b>					
<b>2002</b>	<b>9</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>55.6%</b>
<b>All</b>	<b>25</b>	<b>5</b>	<b>4</b>	<b>15</b>	<b>36%</b>

<b>Municipal Cooperative Health Benefit Plans</b>	<b>Total</b>	<b>Overtured</b>	<b>Overtured in Part</b>	<b>Upheld</b>	<b>Percentage Overtured or Overtured in Part</b>
Catskill Area Schools Employees Benefit Plan					
2002	0	0	0	0	
All	3	1	0	2	33.3%
Jefferson-Lewis et.al. School Employees Healthcare Plan					
2002	1	0	1	0	100%
All	2	0	1	1	50%
Putnam/Northern Westchester Health Benefits Consortium					
2002	2	1	0	1	50%
All	3	1	0	2	33.3%
<b>Totals</b>					
<b>2002</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>66.7%</b>
<b>All</b>	<b>10</b>	<b>3</b>	<b>1</b>	<b>6</b>	<b>40%</b>
<b>Totals For All Coverage Types<sup>1</sup></b>					
<b>2002</b>	<b>878</b>	<b>309</b>	<b>80</b>	<b>489</b>	<b>44.3%</b>
<b>All</b>	<b>2,886</b>	<b>1,075</b>	<b>264</b>	<b>1,547</b>	<b>46.4%</b>

<sup>1</sup> Health plans that did not have external appeals in 2001 or 2002 were not included in this chart.

## External Appeal Programs Of Other States

Along with New York, there are 42 other states and the District of Columbia that have external appeal programs in place. Again this year, the Insurance Department surveyed all states with external appeal programs so that the similarities and differences of state external appeal programs could be compared. 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, 38 responded to the questionnaire and provided survey responses to the Insurance Department between December 2002 and January 2003. All the information contained in the charts relating to the state programs is based upon the written responses received from state agencies.

This year the Department's survey focused on the outreach states conduct to promote external appeals and what states do to facilitate access to their external appeal programs. We asked states how their consumers are made aware of external appeal rights and questioned how consumers obtain an external appeal application. This year, 19 states responded that health plans are required to provide an external appeal application with a final denial, which is an increase from 2001, when only nine states required health plans to provide an external appeal application with a final denial. This year also saw an increase in the number of states, nine in total, that use the media to advertise their external appeal programs.

The following chart describes what states do to make consumers aware of their external appeal programs. In reviewing what states reported, California is the only state that utilized all mechanisms in the chart to make consumers aware of their external appeal rights. California is also the state that had the highest volume of external appeal requests in 2002. The state with the second highest volume of external appeal requests, New York, was one of three states that utilized eight of the identified mechanisms for making consumers aware of external appeal rights. These results may suggest that accessibility of information about a state's external appeal program may promote utilization of the program.

## How Do Consumers Find Out About External Appeal Rights?

State	Health plans must provide external appeal information to new members	Health plans must provide external appeal information upon request	Health plan denial letters must include external appeal information	Health plan denial letters must include an external appeal application	External appeal information must be included in member handbooks or other plan documents	Outreach programs have been conducted by either the plan or the State regulatory agency	Advertising (television, radio, newspaper)	External appeal information may be obtained from the State regulatory agency	External appeal information is available on the State regulatory agency's web site
AK					X				
AR			X	X	X				
AZ	X	X	X		X	X		X	X
CA	X	X	X	X	X	X	X	X	X
CO	X		X	X	X			X	X
CT			X		X	X	X	X	X
D.C.	X		X	X	X	X		X	X
DE	X	X	X		X			X	
FL	X		X		X		X	X	X
GA*		X	X	X				X	
HI		X	X	X				X	
IA			X	X				X	X
IL	X	X	X		X	X		X	X
IN	X	X	X		X			X	X
KS			X					X	
KY	X	X	X	X	X			X	X
LA	X		X	X	X	X		X	X
MA	X		X	X	X	X		X	X
MD	X		X		X	X	X	X	X
ME	X	X	X		X			X	X
MI*	X		X	X					X
MN	X	X	X		X			X	X
MO	Did Not Respond								
MT**		X						X	
NC	X		X		X	X	X	X	X
NH		X	X	X	X		X	X	X
NJ			X	X	X			X	X
NM	X		X	X	X	X	X	X	X
NY	X	X	X	X	X	X		X	X
OH	X	X	X		X		X	X	X
OK	X	X	X	X	X			X	X
OR	X	X			X			X	X
PA	X	X	X		X			X	X
RI			X						
SC			X		X			X	X
TN	X				X				
TX			X	X	X			X	X
UT	X		X		X			X	X
VA	X		X	X	X	X	X	X	X
VT			X		X			X	
WA	X	X			X				
WV	X		X	X	X			X	
WI		X	X		X	X		X	X

\* The information is based on the state's response to our 2001 external appeal survey.

\*\*Montana indicated that health plans must notify enrollees within 10 calendar days (or 48 hrs if eligible for an expedited review) of their right to seek an independent review of an adverse determination.

## External Appeal Program Requirements

Consumers become aware of their external appeal rights through outreach, however, use of these rights may be impacted by eligibility requirements which can either promote or impede access to a state's external appeal program. We asked states the following questions: What level of internal appeal must an applicant exhaust before requesting an external appeal, when must an external appeal be requested, must there be a minimum dollar amount at issue, who may request an external appeal, must the applicant be financially liable for the health care services, and what is the maximum allowable external appeal fee.

The majority of states reported that either a consumer or a designee acting on behalf of a consumer has a right to request an external appeal. Only six states grant providers a right to pursue an external appeal on their own behalf to obtain payment from a health plan. The majority of states, 25 in total, do not require payment of a fee as a condition precedent to requesting an external appeal. For states that permit a fee to be charged, many require waiver of the fee in cases of hardship and return of the fee if the health plan denial is overturned. Only 12 states require the disputed health care service to exceed a minimum dollar amount and even fewer, 5 in total, require that the applicant be financially liable for services in order to request an external appeal.

Thirteen states require consumers to exhaust only one level of internal appeal before requesting an external appeal, while 15 states require consumers to exhaust two levels of internal appeal before requesting an external appeal. In the remaining 13 states it is left to health plans to determine how many internal appeals a member must exhaust before requesting an external appeal. Some reports have suggested that the more levels of internal health plan appeals a member is required to exhaust, the less likely it is that the member will pursue an external appeal. We note the results from our survey reveal that states with the highest number of external appeal requests, California, New York, Maryland, and Texas do not require members to exhaust more than one level of internal health plan appeal before requesting an external appeal.

### State External Appeal Program Requirements

State	What level of internal appeal must an applicant exhaust?	What is the external appeal filing deadline?	Is there a minimum dollar amount that must be in dispute?	Who may request an external appeal?	Must the applicant be financially liable for services?	What is the external appeal fee that may be charged?
<b>AK</b>	Varies by plan	Varies by plan	NO	Consumer or insurer	NO	No fee
<b>AR</b>	Initial denial or 1 <sup>st</sup> level appeal*	60 days after initial or final denial	\$500	Consumer or designee	NO	\$25
<b>AZ</b>	2 <sup>nd</sup> level appeal	30 days	NO	Consumer or designee	NO	No fee

\*A member may request a waiver of internal plan appeals.

State	What level of internal appeal must an applicant exhaust?	What is the external appeal filing deadline?	Is there a minimum dollar amount that must be in dispute?	Who may request an external appeal?	Must the applicant be financially liable for services?	What is the external appeal fee that may be charged?
CA	Initial denial or 1 <sup>st</sup> level appeal *	6 months of qualifying event	NO	Consumer or designee	NO	No fee
CO	2 <sup>nd</sup> level appeal	60 days	NO	Consumer or designee	Not addressed in law	No fee
CT	Must exhaust all health plan internal appeals <sup>1</sup>	30 days after receipt of final denial	NO	Consumer or designee	NO	\$25 Waived in cases of financial hardship
D.C.	2 <sup>nd</sup> level appeal *	30 days	NO	Consumer or designee	NO	No fee
DE	1 <sup>st</sup> level appeal	6 months	NO	Consumer or designee	Not addressed in law	No fee
FL	2 <sup>nd</sup> level appeal *	365 days after final denial letter	Did not respond	Consumer or designee	NO	No fee
GA	Must exhaust all health plan internal appeals	NONE	\$500	Consumer or designee	Not addressed in law	No fee
HI	2 <sup>nd</sup> level appeal	60 days	NO	Consumer or designee	NO	No fee
IA	Must exhaust all health plan internal appeals	60 days from the date of final denial	NO	Consumer or designee	NO	\$25
IL	1 <sup>st</sup> level appeal	30 days	NO	Consumer or designee	NO	No fee
IN	1 <sup>st</sup> level appeal	The plan may set reasonable guidelines	NO	Consumer, designee, or provider may appeal on own behalf to obtain payment from the plan	NO	Up to \$25
KS	Must exhaust all health plan internal appeals*	90 days	NO	Consumer or designee	YES For retrospective appeals	No fee
KY	2 <sup>nd</sup> level appeal *	60 days after receipt of final appeal determination	\$100	Consumer or designee	NO	\$25 Waived in cases of financial hardship

<sup>1</sup> States identified in the chart as requiring exhaustion of all health plan internal appeals advised that it is within the discretion of health plans to determine how many levels of internal appeal a member must exhaust before requesting an external appeal. Also, in CT an enrollee who has been diagnosed with a condition that creates a life expectancy of less than two years and has a treatment denied as experimental may request an external appeal after the 1<sup>st</sup> level appeal determination.

State	What level of internal appeal must an applicant exhaust?	What is the external appeal filing deadline?	Is there a minimum dollar amount that must be in dispute?	Who may request an external appeal?	Must the applicant be financially liable for services?	What is the external appeal fee that may be charged?
LA	1 <sup>st</sup> level appeal *	60 days after receipt of a 1st level adverse determination	NO	Consumer, designee, or provider may appeal on own behalf to obtain payment from the plan	NO	No fee
MA	Must exhaust all health plan internal appeals, not to exceed 30 business days	45 days after receipt of final adverse determination	NO	Consumer or designee	NO	\$25 Waived in cases of financial hardship
MD	1 <sup>st</sup> level appeal *	30 business days after 1 <sup>st</sup> level appeal determination	NO	Consumer or designee	NO	No fee
ME	2 <sup>nd</sup> level appeal *	12 months after second level appeal denial	NO	Consumer or designee	NO	No fee
MI	Did not respond					
MN	1 <sup>st</sup> level appeal	NONE	NO	Consumer or designee	NO	\$25
MO	Did not respond					
MT	Must exhaust all health plan internal appeals, not to exceed 60 days*	NONE	NO	Consumer or designee	NO	No fee
NC	Must exhaust all health plan internal appeals	60 days from the date of the determination that is the subject of the external review, usually the final determination	NO	Consumer or designee	NO	No fee
NH	2 <sup>nd</sup> level appeal *	180 days from the date of the 2 <sup>nd</sup> level denial letter	\$400 in a calendar year	Consumer, designee, or provider may appeal on own behalf to obtain payment from the plan	NO	No fee
NJ	2 <sup>nd</sup> level appeal *	60 days after receipt of the final denial	NO	Consumer or designee	NO	\$25 Reduced to \$2 in cases of financial hardship

State	What level of internal appeal must an applicant exhaust?	What is the external appeal filing deadline?	Is there a minimum dollar amount that must be in dispute?	Who may request an external appeal?	Must the applicant be financially liable for services?	What is the external appeal fee that may be charged?
NM	2 <sup>nd</sup> level appeal	20 business days after receipt of the 2 <sup>nd</sup> level appeal determination	NO	Consumer, designee, or provider may appeal on own behalf to obtain payment from the plan	NO	No fee
NY	1 <sup>st</sup> level appeal *	45 days from receipt of the 1 <sup>st</sup> level appeal determination	NO	Consumer, designee, or provider may appeal a retrospective adverse determination on own behalf to obtain payment from the plan	NO	\$50 Waived in cases of financial hardship
OH	Must exhaust all health plan internal appeals, not to exceed 60 days*	60 days	\$500	Consumer or designee	YES	No fee
OK	Must exhaust all health plan internal appeals*	30 days	\$1,000	Consumer or designee	NO	\$50
OR	2 <sup>nd</sup> level appeal *	NONE	NO	Consumer or designee	NO	No fee
PA	2 <sup>nd</sup> level appeal	15 days	NO	Consumer or designee	NO	\$25
RI	2 <sup>nd</sup> level appeal	60 days	NO	Consumer, designee, or provider may appeal on own behalf to obtain payment from the plan	NO	Fee varies by independent review organization (May be up to half the cost of the review)
SC	Must exhaust all health plan internal appeals*	60 days for standard appeals, 15 days for expedited	\$500	Consumer or designee	YES	No fee
TN	1 <sup>st</sup> level appeal	NONE	\$500	Consumer or designee	NO	\$50
TX	1 <sup>st</sup> level appeal <sup>1</sup>	NONE	NO	Consumer or designee	NO	No fee

<sup>1</sup> A member with a life-threatening condition cannot be required to participate in the plan's internal appeal process.

State	What level of internal appeal must an applicant exhaust?	What is the external appeal filing deadline?	Is there a minimum dollar amount that must be in dispute?	Who may request an external appeal?	Must the applicant be financially liable for services?	What is the external appeal fee that may be charged?
UT	Must exhaust all health plan internal appeals*	180 days	NO	Consumer or designee	NO	No fee
VA	Must exhaust all health plan internal appeals	30 days but extension permitted	\$300	Consumer or designee	YES	\$50 Waived in cases of financial hardship
VT	1 <sup>st</sup> level appeal	90 days from final denial	\$100	Consumer or designee	NO	\$25
WA	2 <sup>nd</sup> level appeal	180 days	NO	Consumer or designee	NO	No fee
WV	2 <sup>nd</sup> level appeal	60 days	\$1,000	Consumer or designee	NO	No fee
WI	Initial denial or 1 <sup>st</sup> level appeal *	4 months from initial denial or appeal determination	\$250	Consumer or designee	YES	\$25

## Volume Of External Appeal Requests Received By States

The following chart identifies the number of external appeal requests received by states in 2001 and 2002. Since several states responded to our survey at the beginning of December 2002, the number of requests for 2002 may not reflect all external appeal requests received by states through the end of the year. When reviewing the chart it is also important to keep in mind that the number of consumers eligible for an external appeal varies among states.

### Number of External Appeal Requests Each State Received in the 2001 and 2002

	2001 or equivalent program year	2002 or equivalent program year		2001 or equivalent program year	2002 or equivalent program year
Alaska	*	*		Minnesota	28
Arizona	282 (7/1/00- 6/30/01)	270 (7/1/01- 6/30/02)		Missouri	DNR
Arkansas	*	*		Montana	6
California	1,821	2,821		New Hampshire	29 (9/30/00- 9/30/01)
Colorado	56	71		New Jersey**	303
Connecticut	67	89		New Mexico	28
Delaware	0	2		New York	1,546
District of Columbia	30 (10/1/00- 9/30/01)	60 (10/1/01- 9/30/02)		North Carolina	NA
Florida	458	503		Ohio	112
Georgia	39	55		Oklahoma	31
Hawaii	22	42		Oregon	NA
Illinois	116	*		Pennsylvania	165
Indiana	20	*		Rhode Island	52
Iowa	29	32		South Carolina	NA
Kansas	33	28		Tennessee	48
Kentucky	129	211		Texas	587
Louisiana	9	*		Utah	*
Maine	31	25		Vermont	31
Maryland	1,312	*		Virginia	113
Massachusetts	137	306		Washington	22 (Law effective 7/01)
Michigan	DNR	DNR		West Virginia	NA
				Wisconsin	NA
					185 (Law effective 6/15/02)

DNR – States that did not respond to the survey

NA – The state law was not in effect.

\* States that were unable to provide the data at the time of the survey.

\*\* The number of appeal requests processed, not received.

## Determinations That Are Eligible For External Review

All states that responded to our survey provide external appeal rights for medical necessity denials and all but five states permit external review when a health plan denies services as experimental or investigational. Twenty-one states allow for external review when a health plan denies a referral to a non-participating provider and 27 states permit external review when services are denied as cosmetic.

Denials because a health plan considers the services to be cosmetic have raised issues for the New York external appeal program. In New York, surgery is a mandated benefit that must be covered under a health insurance contract, however, cosmetic surgery may be excluded. Some New York health plans have argued that a cosmetic surgery denial is a covered benefit determination that should not be eligible for external review. The New York State Insurance Department and Health Department have advised health plans that a determination as to whether surgical services are covered by the plan as a mandated benefit or denied as cosmetic is a medical necessity determination that must be subject to external review.

The following chart identifies the types of health plan denials that are eligible for external review as reported by states in our survey.

### Which Determinations Are Eligible For External Review?

State	Medical Necessity	Experimental/ Investigational Treatment	Referral to a Non-Participating Provider	Cosmetic Surgery or Treatment	OTHER
AK	X	X			Denials based on medical judgement or a plan failure to meet internal appeal deadline.
AR	X	X			
AZ	X	X	X	X	Coverage issues (contractual interpretation of denials).
CA	X	X		X	
CO	X	X	X (for medical necessity)	X	
CT	X	X		X	
DC	X	X		X	Benefit issues (coverage or non-coverage).
DE	X	X		X	
FL	X	X	X	X	Excluded benefits, non-authorization of services, denial of enrollment, termination of policy, emergency care, reimbursement issues, contract interpretation, claims payment.
GA	X	X	X (for medical necessity)		

State	Medical Necessity	Experimental/ Investigational Treatment	Referral to a Non-Participating Provider	Cosmetic Surgery or Treatment	OTHER
HI	X	X		X	All unreasonable denials of coverage.
IA	X				
IL	X	X (with physician attestation)	X (for medical necessity)		
IN	X	X	X	X	Claims payment, availability of participating providers, contractual relationship with an insurer, delivery, appropriateness or quality of health care services.
KS	X	X		X (for medical necessity)	
KY	X	X			Services denied as excluded or limited by the contract where a medical issue is involved.
LA	X	X		X	
MA	X	X	X (for medical necessity)	X	
MD	X	X	X	X	
ME	X	X	X	X	Pre-existing conditions.
MI*	X	X	X		
MN	X	X	X	X	All issues other than fraudulent marketing or agent misrepresentation.
MO	<b>Did Not Respond</b>				
MT	X				Medical appropriateness denials.
NC	X	X		X	
NH	X	X	X	X	
NJ	X	X	X (for medical necessity)	X	
NM	X	X	X	X	Non-utilization management issues.
NY	X	X (with physician attestation)		X (for medical necessity)	
OH	X	X	X (for medical necessity)	X	
OK	X	X			
OR	X	X	X	X	
PA	X	X	X (for medical necessity)	X	
RI	X				

State	Medical Necessity	Experimental/ Investigational Treatment	Referral to a Non-Participating Provider	Cosmetic Surgery or Treatment	OTHER
SC	X	X			
TN	X	X	X	X	
TX	X				Medical appropriateness denials.
UT	X				
VA	X	X			
VT	X	X	X	X	Pre-existing conditions.
WA	X	X	X	X	
WI	X	X	X (for medical necessity)	X	
WV	X	X			

\* Information based on a response to the survey we conducted in the summer of 2001

## External Review And Types of Insurance Coverage

The Insurance Department questioned states as to whether their external appeal laws are applicable to all types of health insurance coverage or only to certain types of coverage. Most states responded that their external appeal laws apply to HMO coverage and a majority of states responded that their external appeal laws apply to indemnity coverage as well. The following chart identifies survey results.

### Types of Insurance and Managed Care Products That Are Subject to Each State's External Appeal Program

State	Indemnity	HMO	Non-HMO Managed Care	Medicaid Managed Care	Medicare + Choice	Self-Insured (ERISA)	Gov't. Sponsor (Title 21)	Other
AK								Any group product that provides a defined set of benefits and requires the member to comply with utilization review guidelines
AR	X	X	X					
AZ	X	X	X					Dental, optometric
CA	X	X	X	X			X	
CO	X	X	X	X				Any insured plan that can deny benefits based on medical necessity
CT		X	X				X	
D.C.	X	X						
DE	X	X	X					
FL		X		X				Florida KidCare Program, POS riders, EPO plans
GA								Managed Care Plans
HI	X	X	X					
IA	X	X	X					Individual and Group Plans
IL		X						
IN	X	X	X	X	X			
KS	X	X	X					
KY		X	X					
LA	X	X	X				X	
MA		X	X					
MD	X	X	X					
ME	X	X	X					
MI	Did Not Respond							
MN	X	X	X					External appeal is available as an optional part of the state Medicaid fair hearing process
MO	Did Not Respond							
MT	X	X	X					State of Montana's self-insured plan

State	Indemnity	HMO	Non-HMO Managed Care	Medicaid Managed Care	Medicare + Choice	Self-Insured (ERISA)	Gov't Sponsor (Title 21)	Other
NC	X	X	X				X	NC Teachers & Employees Comprehensive Major Medical Plan (Self-funded)
NH								Managed Care
NJ	X	X	X	X			X	
NM		X						POS Plans
NY	X	X	X	X			X	
OH	X	X						Public Employee Benefit Plans
OK	X	X	X			X		
OR	X	X	X					
PA		X	X	X			X	
RI								Any plans that make medical necessity determinations
SC	X	X						
TN		X						
TX	X	X	X				X	
UT	X	X	X					
VA		X	X					
VT	X	X	X					
WA		X	X	X				
WV		X						
WI	X	X	X					Medicare supplement policies, hospital, or other indemnity policies

## External Appeal Results By State

Our survey requested that states provide information on cases that had been overturned or upheld by external appeal agents in 2001 and 2002. Eleven states saw an increase in the number of determinations that had either been overturned in whole or in part by external appeal agents between 2001 and 2002, while eleven states also saw a decrease. Four states saw their overturn rates remain consistent. On average, health plan denials were overturned in whole or in part in all states in 43% of cases in 2002 and 45% of cases in 2001.

This year in addition to the state survey, the Insurance Department also surveyed New York health plans that had members who requested external appeals in 2001. The Department asked plans to provide information on their internal appeal processes so the overturn rates in a plan's internal appeal process could be compared to overturn rates in the external appeal process. In 2001, New York health plans reported that 39% of denials appealed with a health plan were overturned in the plan's first level appeal process. For plans that offered a second level appeal, 33% of denials initially upheld and appealed again were overturned at the second level. Then, as previously noted in this report, 45% of health plan denials were overturned by external appeal agents. These results reveal that approximately one out of every three denials was overturned at each level in a plan's internal appeal process and an even greater number were overturned in the external appeal process, suggesting that members willing to appeal a denial had a likelihood of success.

Unfortunately in New York, as in other states, consumers do not always request an external appeal even though they may be eligible for one. In some cases the consumer may not be financially liable for the health services so that the consumer does not have an interest in pursuing an external appeal. In others, a health plan may recommend an alternate treatment during its internal appeal process and the consumer may decide to obtain the alternate treatment. Still, there are cases in which a consumer would benefit from an external appeal but does not request one. The New York health plans we surveyed upheld 11,856 denials on internal appeal in 2001. That same year the Department received 1,546 external appeals, indicating that an external appeal was filed for approximately 1 out of every 8 denials upheld in a plan's internal appeal process.

The following chart identifies external appeal results for states that responded to our survey in 2001 and 2002.

### External Appeal Results by State

State	Overtured 2002	Overtured in Part 2002	Upheld 2002	Percentage Overtured or Overtured in Part 2002	Overtured 2001	Overtured in Part 2001	Upheld 2001	Percentage Overtured or Overtured in Part 2001
AK	Not Available							
AR	Not Available							
AZ	48	*	208	18.8%	59	*	216	21.5%
CA	243	1	458	34.8%	233	0	390	37.4%
CO	25	*	34	42.4%	23	*	29	44.2%
CT	28	*	40	41.2%	17	*	27	38.6%
D.C.	4	0	4	50%	5	0	4	55.6%
DE	1	0	0	100%	0	0	0	0%
FL	97 (includes settled cases)	4	92	52.3%	106 (includes settled cases)	4	133	45.3%
GA	6	0	17	26.1%	5	1	17	26.1%
HI	1	*	4	20%	1	*	3	25%
IA	10	2	19	38.7%	9	0	20	31%
IL	Not Available	Not Available	Not Available	Not Available	41	6	69	40.5%
IN	Not Available	Not Available	Not Available	Not Available	10	1	9	55%
KS	9	1	9	52.6%	11	0	18	37.9%
KY	84	*	127	39.8%	52	*	77	40.3%
LA	Not Available	Not Available	Not Available	Not Available	4	*	5	44.4%
MA	50	23	111	39.7%	18	4	70	23.9%
MD	Not Available	Not Available	Not Available	Not Available	215	7	168	56.9%
ME	4	*	12	25%	2	*	19	9.5%
MI	Did Not Respond							
MN 4/1/01 – 3/31/02	6	1	41	14.6%				
MO	Did Not Respond							
MT	7	*	5	58.3%	2	*	4	33.3%
NC	7	*	5	58.3%	Not Applicable	Not Applicable	Not Applicable	Not Applicable
NH	4	*	6	40%	13	*	15	46.4%
NJ	97	*	89	52.2%	124	*	148	45.6%
NM	10	*	21	32.3%	10	1	16	40.7%
NY	310	80	488	44.4%	349	76	525	44.7%
OH	39	11	89	36%	43	12	57	49.1%
OK	2	1	5	37.5%	11	1	19	38.7%
OR	3	6	5	64.3%	Not Applicable	Not Applicable	Not Applicable	Not Applicable
PA	82	*	121	40.4%	66	*	99	40%
RI	48	*	Not Available	Not Available	36	*	Not Available	Not Available
SC	Not Available							
TN	1	0	13	7.1%	0	0	2	0%
TX	377	63	279	61.2%	311	52	224	61.8%
UT	Not Available							
VA	29	*	24	54.7%	32	*	10	76.2%
VT	6	*	8	42.9%	5	*	8	38.5%
WA	Not Available							
WV	Not Available							
WI	Not Available							

\* Overtured in part numbers are combined with overtured.

## Federal Developments

During the past year there were developments on the federal level in both the courts and in the government that impacted all state external appeal programs. In 2002, the United States Supreme Court reviewed whether federal law precludes states from requiring insurers and HMOs to offer external appeal rights when providing coverage to employer groups. Also in 2002, a federal Department of Labor (DOL) regulation went into effect that established standards for health plans when making claim determinations under employer group coverage. Further, a Court of Appeals case provided an interpretation of the DOL regulation.

### U.S. Supreme Court Review Of State External Appeal Programs

In 2002, the United States Supreme Court considered whether state external appeal programs are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), a federal law that regulates employee benefit plans, including employer-provided health coverage, and preempts state laws relating to such plans unless the state law regulates insurance and does not conflict with an ERISA provision. The external appeal preemption issue was brought before the U.S. Supreme Court because the U.S. Court of Appeals for the 5<sup>th</sup> Circuit held that the Texas external appeal law was preempted by ERISA, while the U.S. Court of Appeals for the 7<sup>th</sup> Circuit found that the Illinois external appeal law was not preempted.

The U.S. Supreme Court granted certiorari for the 7<sup>th</sup> Circuit case, *Moran v. Rush Prudential HMO, Inc.*, and heard oral arguments on January 16, 2002. The petitioner, Rush Prudential HMO, argued that state external appeal laws which enable consumers to seek an independent review of health plan coverage denials conflict with ERISA because ERISA requires plans to provide a mechanism for internal review of benefit denials and a right to subsequent judicial relief. The respondent, Ms. Moran, argued that the option for external review, although potentially impacting a coverage denial, would not interfere with any remedy available under ERISA.

The case attracted widespread interest because the decision would not only impact the Illinois law, but also any other state with an external appeal program. If the Court found in favor of Rush Prudential, over 40 states would have to dismantle their external appeal programs. Given the potential widespread implications of the decision, several interested parties submitted briefs to the Court. The American Association of Health Plans and the Health Insurance Association of America submitted briefs in support of ERISA preemption, while other interested parties such as the American Medical Association, representatives of consumer groups, and the National Association of Insurance Commissioners submitted briefs in support of state external appeal programs. The New York State Insurance Department closely monitored the case and worked with the National Association of Insurance Commissioners in providing information on New York's external appeal program to the Court.

On June 20, 2002, a closely divided Supreme Court held in a 5-4 decision that state external appeal programs are not preempted by ERISA. Justice David Souter, writing for the majority, expressed frustration with the ambiguity of ERISA stating “the language seems simultaneously preempt everything and hardly anything” but concluded that it would be an exaggeration to hold that the objectives of ERISA are undermined by state external appeal laws, comparing external appeal to a benefit mandate, historically held by the Court to be a permissible state regulation of insurance. In a dissenting opinion, Justice Clarence Thomas criticized the decision stating that, “allowing disparate state laws that provide inconsistent external review requirements to govern a participant’s or beneficiary’s claim to benefits under an employee benefit plan is wholly destructive of Congress’ expressly stated goal of uniformity in this area.” Justice Thomas also suggested that standards for state external review programs would be most appropriately addressed by Congress through federal legislation, instead of by each individual state.

The decision marked an important victory for consumers by enabling consumers to continue to appeal health plan denials through state external appeal programs instead of having to solely rely on the more costly judicial remedies available under ERISA. The decision was also notable because state external appeal rights were upheld by such a narrow margin and because the dissent laid the groundwork for federal standards for state external appeal programs which had previously been proposed in Congress, but not passed in both Houses and signed into law.

## **United States Department Of Labor Claims Procedure Regulation**

The United States Department of Labor, Pension and Welfare Benefits Administration (DOL) promulgated a regulation, 29 CFR §2560.503-1, to establish minimum requirements for health plan claim procedures in relation to a claim for benefits by an insured. The DOL regulation, effective on and after July 1, 2002, applies to employee benefit plans subject to the Employee Retirement Income Security Act (ERISA) and to insurers and health maintenance organizations (HMOs) that provide fully-insured group health or disability coverage to such plans. The DOL regulation preempts state law to the extent that state law prevents the application of a federal requirement.

New York State has requirements in place for claims procedures, primarily through its utilization review, grievance, explanation of benefits, and prompt payment requirements. Some New York requirements are more stringent than the DOL requirements while others are not as stringent. The Insurance Department and the Health Department have been working with health plans to determine how health plans can best integrate the New York and DOL requirements so that plans will be in compliance with both.

The Insurance Department issued Circular Letter No. 15 (July 1, 2002) to advise health plans of the effective date and potential impact of the DOL regulation, and to provide guidance on compliance. The Department also reminded health plans that any modifications to policy forms to add the DOL standards must still be reviewed and approved by the Insurance Department since New York is a prior approval state.

In 2002, the Insurance Department began receiving submissions from health plans for compliance with the DOL requirements. The Department found that some plans did not agree with the Department's interpretation as to the integration of certain New York and DOL standards. The Department also found that the majority of plans extended the DOL requirements to coverage that was exempt from the DOL regulation, such as individual direct payment coverage and association group coverage. The Insurance Department and the Health Department are currently evaluating whether it is necessary for the Departments to promulgate a regulation to formally integrate and codify the New York and DOL requirements so there will be consistency and uniformity among health plans.

The DOL regulation does not impose requirements for external review. However, because of the standards it establishes for a health plan's internal appeal process, the regulation will impact New York's external appeal program. The DOL regulation establishes new time frames for a health plan's internal appeal process so that in certain cases a denial will be eligible for external review sooner than it would have been under New York law. In addition, the DOL regulation requires plans to make an appeal determination regardless of whether any or all necessary information is provided, whereas New York law did not require an appeal determination to be made until the plan is in receipt of all necessary information.

The possible impact of the DOL regulation is that plans will make appeal determinations without all necessary information and, if the case is subject to external appeal, the health plan will be unable to provide the patient's medical records to the external appeal agent. Consequently, the external appeal agent will have to rely on the patient's provider for the information, which could be problematic because unlike the health plan, the patient's provider does not have a statutory obligation to forward information within the agent's time frame for making a determination.

The Insurance Department has already received external appeals when the agent has been unable to obtain a patient's medical records from the health plan or the patient's provider. The Department has implemented a strategy for handling these cases by relying on requirements currently in regulation and by working with the parties involved in the appeal. Pursuant to New York regulations, external appeal agents must request information within 24 hours of receipt of the appeal. The Insurance Department has advised agents that if the information is not received, they must make a second request and also contact both the patient and the Insurance Department. If necessary, the Department will intervene in the case and work with the patient and the patient's provider to obtain the information. The Insurance Department has also sought the assistance of provider trade organizations and has found the organizations not only willing to work with the Department in obtaining the information, but also effective in educating their members as to the necessity of providing information for a patient's external appeal in a timely manner.

## **Court Of Appeals Review Of The Claims Procedure Regulation**

A case argued in 2002 and decided in 2003, *Cicio v. Vytra Healthcare*, referenced the Department of Labor Claims Procedure Regulation and will have to be monitored to determine what the impact will be on state utilization review and external review requirements. The case began when the plaintiff brought action in state court because Vytra Healthcare determined that chemotherapy in conjunction with a stem cell transplant was experimental and investigational, not a covered benefit, and suggested an alternate treatment. The plaintiff's complaint included causes of actions as to the timeliness of Vytra's decision relating to the treatment, the allegedly misleading nature of Vytra's representation about plan benefits, and a medical malpractice claim regarding the quality of the medical decisions made by Vytra, if any.

Vytra removed the case to the federal district court arguing that the plaintiff's claims were essentially federal in nature and should have been brought in federal court. The district court granted Vytra's motion to dismiss, finding the plaintiff's claims related to an ERISA plan and as such were preempted. The U.S. Court of Appeals for the Second Circuit affirmed the district court's disposition of the timeliness and misrepresentation claims, but remanded the malpractice claim back to the district court to determine whether the complaint constitutes a mixed eligibility and treatment determination. If the district court finds the complaint constitutes a mixed eligibility and treatment determination, the claim will not be preempted by federal law and there will be a further possibility for consideration by a state court to determine whether the medical malpractice claim states a cause of action under New York law.

The most publicized aspect of the case was in relation to the potential for a medical malpractice claim against an HMO. The lesser publicized aspect, but one that could also have a significant impact, was the decision of the Court of Appeals to affirm the district court's dismissal of the timeliness and misrepresentation claims. In affirming the district court's determination, the Court of Appeals stated that New York utilization review requirements, including those that are more stringent than required by federal regulation, are preempted by the Department of Labor Claims Procedure Regulation.

## **State Developments**

There were also developments on the state level that impacted the New York External Appeal Program. In 2002, the Albany County Supreme Court considered whether the external appeal regulations were promulgated by the Insurance Department and the Health Department in violation of statutory authority. In addition, legislation potentially impacting the External Appeal Program was proposed in the New York State Legislature and recently passed legislation governing end of life care went into effect.

### **Albany County Supreme Court Review Of The External Appeal Regulations**

Aspects of the New York external appeal program were challenged in an Article 78 proceeding. The Healthcare Association of New York State, an organization that primarily represents hospitals, and Citizen Action of New York, a consumer organization, brought an action seeking to have the external appeal regulations declared null and void. The parties challenged the regulatory definitions of designee, retrospective adverse determination and attending physician. The parties also challenged the regulatory requirement that patients consent to the release of their medical records and that an attending physician attest to a patient's eligibility for a clinical trial when the patient appeals a clinical trial denial.

#### **Definition of designee:**

The parties objected to a definition of designee that would limit an insured's selection of a designee if health care services had already been provided. The Departments responded that a definition of designee is necessary because there had been cases when a provider whose own application was rejected as ineligible because the utilization review determination was not retrospective, resubmitted the appeal as the patient's designee. In such cases, the Departments wanted to ensure that the provider was in fact acting on behalf of the patient and not requesting an appeal on their own behalf to obtain payment from the health plan.

#### **Definition of retrospective adverse determination:**

The parties objected to the inclusion of a definition of retrospective adverse determination in regulation and to the categorization of appeals as retrospective depending on the type of utilization review conducted. The Departments responded that the definition of retrospective adverse determination is consistent with the distinction between preauthorization, concurrent, and retrospective determinations currently in law, and was added in regulation because interested parties commenting on the proposed regulation requested a definition be included.

### **Definition of attending physician**

The parties objected to any requirement for a patient's attending physician to be board certified or board eligible in order to request an expedited medical necessity appeal. The Departments acknowledged that while the regulatory definition of attending physician was consistent with the requirements in law, the definition of attending physician in the external appeal application should be revised to clarify that board certification or eligibility is only required for an attestation for experimental or investigational treatment appeals and not for expedited appeals. The Departments also provided an assurance that board certification or eligibility had never been required for an expedited medical necessity appeal attestation.

### **Consent to release of medical information**

The parties objected to the portion of the provider external appeal application that requires a patient's signed consent for the release of the patient's medical records to an external appeal agent. The Departments advised that the consent to the release of medical records is required under both state and federal law. The Departments also advised that providers are permitted to obtain this consent at the time of treatment so that the provider does not have to locate the patient after treatment has been rendered, which had been a concern of the parties.

### **Attestation for clinical trial appeals**

The parties objected to the portion of the external appeal application that requires the patient's attending physician to attest that the patient meets the eligibility criteria for a clinical trial, the clinical trial is open, and the patient has been or will likely be accepted in the trial, when appealing a clinical trial denial. The Departments advised that the law requires the patient's attending physician attest that there exists a clinical trial for which the patient is eligible and that these factors determine eligibility.

### **Determination**

The Albany County Supreme Court issued a decision on February 8, 2002. The Court upheld the definition of retrospective adverse determination, the requirement for a patient's consent to the release of medical records and the requirement for a physician attestation of clinical trial eligibility, and overturned the definition of designee. After receiving the decision, the Departments revised the external appeal applications to correct the definition of attending physician. In addition, the Departments do not consider whether or not services have been provided when an external appeal application is submitted by a patient's designee.

## Access To End Of Life Care

There was a law passed in 1999 and amended in 2000 governing end of life care that impacted the external appeal program in 2002. Chapter 559 of the Laws of 1999 and Chapter 572 of the Laws of 2000 amended the Insurance Law and Public Health Law to require health plans that provide coverage for acute care services to provide coverage for an insured diagnosed with advanced cancer (with no hope of reversal of the primary disease and fewer than 60 days to live, as certified by the patient's attending physician) for services at an acute care facility specializing in the treatment of terminally ill patients. If the patient's health plan disagrees with the admission or continuation of care, the plan must initiate an expedited external appeal. The plan must continue to provide coverage for services until an external appeal determination is rendered. If the plan chooses not to initiate an expedited external appeal, the plan must reimburse the facility subject to the terms of the contract.

The law is unique in that it places the responsibility of initiating an external appeal on the health plan as opposed to the patient and requires a waiver of the health plan's internal appeal process. The Insurance Department received its first appeals under this law in 2002 and although the cases were resolved before external appeal agents were assigned, the Department had to determine how the appeals should be handled. The Department advised health plans of the following:

- The standardized "New York State External Appeal Application for Health Care Consumers" must still be submitted but plans can leave the inapplicable items blank. For example, since the law requires the external appeal to be expedited, it is not necessary for the plan to obtain the attending physician's attestation for an expedited appeal.
- Plans must obtain the signed consent of either the patient or the patient's legally authorized representative on the application since the patient's medical records cannot be released without this consent.
- If a health plan is unable to obtain the signed consent after making a good faith attempt, the Insurance Department will work with the plan, the patient or the patient's representative, and the acute care facility to obtain the consent and thereby ensure that both the patient's and the plan's rights are protected and that the appeal is processed.

## Proposed New York State External Appeal Legislation

Legislation was proposed in 2002 that could have impacted the New York State External Appeal Program by expanding the denials eligible for external review and modifying the standards external appeal agents use in reviewing appeals. Some of the proposed legislative changes to the New York External Appeal Program in 2002 included the following:

- Repeal of the provision in law that permits health plans to charge applicants a fee for an external appeal. Currently, the law permits health plans to charge applicants a \$50 fee. However, the fee must be waived for persons covered under government programs or in cases of hardship and must be returned if the health plan's denial is overturned in whole or in part by an external appeal agent.
- Amending the law to state that the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination by the insured, the insured's designee, if any, and the insured's health care provider. Currently, the law only references the 45-day time frame in relation to an insured's receipt of the final adverse determination. However, state regulations reference the insured, the insured's designee, and the insured's provider in relation to the 45 day time frame.
- Requiring external appeal agents to provide a copy of the external appeal decision to the insured, the insured's designee, and the insured's health care provider. Currently, the law requires the decision be sent to the insured. However, state regulations require agents to provide a copy of the decision to the insured's provider, as appropriate.
- Amending the law so that a referral to an out-of-network health care provider would no longer be reviewed as a grievance, but would be considered a determination subject to the utilization review and external appeal requirements of Article 49. At present the law only requires utilization review and external review be provided for medical necessity determinations and determinations as to whether a treatment is experimental or investigational.
- Expanding the types of denials providers may externally appeal by redefining "retrospective adverse determination" in law. Currently, providers only have an independent right to request and external appeal when there is a retrospective adverse determination. The term is defined in regulation and distinguishes between preauthorization, concurrent, and retrospective determinations based on the type of utilization review conducted.
- Amending the Public Health Law to establish an independent system for the resolution of disputed claims between health plans and health care providers and requiring the party that does not prevail to pay the costs of the independent review.

Although these proposals were not passed and signed into law in 2002, many have been proposed again in 2003. The Insurance Department and the Health Department will be monitoring these state legislative proposals to determine what impact the bills could have on New York utilization review and external appeal processes if passed and signed into law.

## **Closing Remarks**

Since its inception, the New York State External Appeal Program has become one of the most successful statutory and administrative patient protections in New York State. In addition, the New York External Appeal Program has been used as a model for other states to follow. The Insurance Department and the Health Department are continuing their efforts to ensure that all consumers are made aware of their external appeal rights, that the external appeal process is easily accessible, and that the External Appeal Program leads to the provision of high quality health care in New York State.

The Insurance Department and the Health Department also continue to work 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 process has shown to be an effective means of assisting health care consumers gain access to and reimbursement for medically necessary health care services, experimental or investigational treatments that are more beneficial than standard treatments, and clinical trials that are likely to benefit the patient. It is the dedicated efforts of the Departments and the cooperation of all involved parties that enables the program to be successful.

The Insurance Department will continue to track external appeal results and trends. Both the Insurance Department and Health Department will also continue to monitor developments on the state and federal level which could significantly impact patient protections in New York State and throughout the country.