

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

NEW YORK STATE  
External  
Appeal  
Program

**ANNUAL REPORT**

January 1, 2004 – December 31, 2004



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

January 1, 2004 through December 31, 2004

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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.

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## Chapter 1: Introduction

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

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

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

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

This year's report provides a comprehensive overview of the 2004 external appeal results, categorized by health plan, agent, and types of denials. As in previous years, the report also includes information about utilization review agents and federal developments impacting state external appeal programs.

- A brief overview of the report reveals that the number of external appeal requests submitted in 2004 increased 29% from the previous year, as 2,321 external appeal applications were submitted to the Insurance Department in 2004, while 1,803 applications were submitted in 2003.
- The 2004 External Appeal Program results also show a slight increase in the percentage of medical necessity and experimental/investigational determinations overturned by external appeal agents, as 45.4% of denials were overturned in whole or in part in 2004, while 42.6% of denials were overturned in whole or in part in 2003.

## **Chapter 2(A): Utilization Review Requirements**

In order to be eligible for an external appeal, an insured must first appeal the denial through their health plan's internal utilization review appeal process. The utilization review process is used by health plans to determine whether services that have been provided, or are proposed to be provided, are medically necessary, experimental, or investigational. Common examples of utilization review determinations include the medical necessity of hospital admissions, the continuation of physical therapy visits or chiropractic care and the provision of certain surgical services.

Any health plan that conducts utilization review must have a utilization review procedure that complies with the requirements of Article 49 of the New York State Insurance Law and Public Health Law. In addition, health plans that provide coverage to employer groups and conduct utilization review are also required to comply with the U.S. Department of Labor Claims Payment Regulation (29 CFR Part 2560) which became effective July 1, 2002 and establishes minimum requirements for health plan claim procedures. The Department of Labor Claims Payment Regulation preempts state law to the extent that state law prevents the application of a federal requirement. 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 federal requirements so that the plans will be in compliance with both.

New York law and the federal regulation require health plans to make utilization review determinations within prescribed timeframes depending on whether the health care services have been provided or whether urgent care is needed. The following timeframes apply to utilization review determinations and insured appeals when New York and federal requirements are integrated.

### **NON-URGENT PRE-AUTHORIZATION DETERMINATIONS**

#### **Initial decisions:**

- If a health plan has the necessary information to make a decision upon receipt of the request, the health plan must make a decision in 3 business days.
- If a health plan does not have the necessary information, the health plan must request the information within 15 days, and the insured has 45 days to provide the information.
- If a health plan receives the information by day 46, the health plan has 3 business days from receipt of the information to make a decision.
- If a health plan does not receive any information or receives incomplete information, the health plan must make a decision within 15 days of the end of the 45 days.

#### **Appeals:**

- If a health plan has one level of internal appeal, the health plan must make a decision within 30 days of receipt of the appeal.
- If a health plan has two levels of internal appeal, the health plan must make a decision within 15 days of receipt of the appeal.

## **CONCURRENT UTILIZATION REVIEW DETERMINATIONS**

### **Initial decisions:**

- If a health plan is reducing or terminating previously approved coverage, the plan must notify the insured and allow the insured to appeal before the benefit is reduced.
- If an insured requests a non-urgent continuation of treatment, a health plan must make a concurrent review determination within 1 business day of receipt of all necessary information, but no later than 15 days of receipt of the claim.

### **Appeals:**

- A health plan must make an expedited appeal decision within the lesser of 2 business days of receipt of the necessary information or 72 hours of receipt of the appeal.

## **URGENT-CARE UTILIZATION REVIEW DETERMINATIONS**

### **Initial decisions:**

- If an insured is requesting coverage for urgent care that has not been initiated, and the health plan has all necessary information, the health plan must make a decision within 72 hours of receipt of the request.
- If an insured is requesting coverage for urgent care that has not been initiated, and the health plan does not have all necessary information to make a determination, the health plan must notify the insured within 24 hours and then provide the insured 48 hours to provide the missing information. The health plan must then make a determination within the earlier of 48 hours of receipt of the missing information or the end of the period afforded the insured to provide the information.
- If an insured is requesting an extension of urgent care, and the insured made the request at least 24 hours prior to the expiration of the previously approved treatment, the health plan must render a determination within 24 hours of receipt of the request.
- If an insured is requesting an extension of urgent care, and the insured did not make the request at least 24 hours prior to the expiration of the previously approved treatment, the health plan must make a decision within the lesser of 1 business day of receipt of all necessary information or within 72 hours of receipt of the request.

### **Appeals:**

- A health plan must make an expedited appeal decision within the lesser of 2 business days of receipt of the necessary information or 72 hours of receipt of the appeal.

## **RETROSPECTIVE UTILIZATION REVIEW DETERMINATIONS**

### **Initial decisions:**

- If a health plan has all necessary information to make a decision upon receipt of the claim, the health plan must make a decision in 30 days.

- If a health plan does not have all necessary information to make a decision, the health plan must request the information within 30 days, and the insured has 45 days to provide the information.
- If the health plan receives the information by day 46, the health plan has 15 days from receipt of the information to make a decision.
- If the health plan does not receive any information or receives incomplete information, the health plan must make a decision within 15 days of the end of the 45 days.

**Appeals:**

- If a health plan has one level of internal appeal, the health plan must make a decision within 60 days of receipt of the appeal.
- If a health plan has two levels of internal appeal, the health plan must make a decision within 30 days of receipt of the appeal.

**Along with timeframe requirements, there are also the following New York and federal requirements as to what must be included in a final utilization review determination:**

- The reasons for the determination, including the clinical rationale.
- A clear statement that the notice constitutes the final adverse determination.
- The health plan's contact person and his or her telephone number.
- The insured's coverage type (HMO, indemnity, Medicaid managed care).
- The name and address of the health plan's utilization review agent.
- The utilization review agent's contact person and his or her telephone number.
- A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility, the physician proposed to provide the treatment and the developer/manufacture of the health care service.
- A statement that the insured may be eligible for an external appeal and the timeframes for requesting an appeal.
- For health plans that offer two levels of internal appeals, a clear statement in bolded text that the 45 day timeframe for requesting an external appeal begins upon receipt of the final adverse determination from the first level of appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal.
- A notice of the insured's right to an external appeal together with the "Standard Description, Instructions & an Application for Health Care Consumers to Request an External Appeal."

## Chapter 2(B): Utilization Review Agents That Contract with Health Plans

The Insurance Law and Public Health Law require every health plan and utilization review agent performing utilization review on behalf of a health plan to file a report with the Insurance Department or Health Department containing their utilization review plan and procedures every two years. Utilization review must be conducted by administrative personnel trained in the principles and procedures of intake screening and data collection, provided, however, that administrative personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed health care professional. Adverse utilization review determinations may only be made by a clinical peer reviewer who must either be a physician, or a health care professional other than a physician who is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the treatment under review.

The Insurance Department surveyed the health plans that had external appeals in 2004 to determine if the plans contract with utilization review agents and if so, which services the agents review. The following chart lists health plans that contract with utilization review agents and identifies the types of services reviewed by utilization review agents. The chart groups health plans into categories based on the type of health insurance coverage provided:

- ✓ Health maintenance organizations (HMOs) contract with a variety of health care providers to deliver a range of services to consumers. HMOs use primary care physicians as the coordinator of patient care needs and typically a referral must be obtained from the primary care physician before accessing specialty care.
- ✓ Non-profit indemnity insurers and commercial insurers are insurers that provide fee-for-service coverage so that the insured and the insurer pay a portion of the costs, which may be reduced if the insurer contracts with providers and the insured 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 provide coverage 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 below.
- ✓ 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.

| Health Maintenance Organizations | Name of Utilization Review Agent   | Type of Service Reviewed   |
|----------------------------------|--|--|
| Aetna Health                     | <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             | <ul style="list-style-type: none"> <li>• ValueOptions</li> </ul>   | <ul style="list-style-type: none"> <li>• Behavioral Health</li> </ul>  |

|  |  |  |
|--|--|--|
| Capital District Physicians' Health Plan (CDPHP) | <ul style="list-style-type: none"> <li>• St. Peter's Addiction Recovery Center</li> <li>• ValueOptions</li> </ul>  | <ul style="list-style-type: none"> <li>• Substance Abuse</li> <li>• Behavioral Health</li> </ul>   |
| Empire HealthChoice                              | <ul style="list-style-type: none"> <li>• Doral</li> <li>• Empire Contracted MD Consultants</li> <li>• Magellan Behavioral Health</li> <li>• MCMC Medical Care Management Corp.</li> <li>• National Imaging Associates (NIA)</li> <li>• Orthonet</li> </ul>                                       | <ul style="list-style-type: none"> <li>• Dental</li> <li>• Outside Specialty Reviews</li> <li>• Behavioral Health and Substance Abuse</li> <li>• Outside Specialty Reviews</li> <li>• Radiology</li> <li>• Physical Therapy and Speech Therapy</li> </ul>  |
| GHI HMO Select                                   | <ul style="list-style-type: none"> <li>• Alignis</li> <li>• CareCore National</li> <li>• Coordinated Care Solutions (CCS)</li> <li>• Davis Vision</li> <li>• Doral Dental</li> <li>• Express Scripts</li> <li>• Magellan Behavioral Health</li> <li>• TRANSPO</li> <li>• ValueOptions</li> </ul> | <ul style="list-style-type: none"> <li>• Physical and Occupational Therapy</li> <li>• Radiology</li> <li>• Skilled Nursing Care, Hospital and Home Care</li> <li>• Vision</li> <li>• Dental</li> <li>• Prescription Drugs</li> <li>• Behavioral Health and Substance Abuse</li> <li>• Non-Emergency Transportation</li> <li>• Behavioral Health and Substance Abuse</li> </ul> |
| Health Net of New York                           | <ul style="list-style-type: none"> <li>• CareCore National</li> <li>• Coordinated Care Solutions (CCS)</li> <li>• Landmark Healthcare</li> <li>• Managed Health Network (MHN)</li> </ul>   | <ul style="list-style-type: none"> <li>• Radiology</li> <li>• Home Care and Skilled Nursing Facilities</li> <li>• Chiropractic</li> <li>• Behavioral Health</li> </ul>   |
| HealthNow New York, Inc.                         | <ul style="list-style-type: none"> <li>• CMS Care of New York, LLC</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>   |
| MVP Health Plan                                  | <ul style="list-style-type: none"> <li>• MCMC Medical Care Management Corp.</li> </ul>   | <ul style="list-style-type: none"> <li>• Outside Specialty Reviews</li> </ul>  |
| Oxford   | <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>  |
| United Healthcare of New York                    | <ul style="list-style-type: none"> <li>• MCMC 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>  |
| WellCare   | <ul style="list-style-type: none"> <li>• Health Integrated</li> </ul>  | <ul style="list-style-type: none"> <li>• Behavioral Health</li> </ul>  |

| <b>Non-Profit Indemnity Insurers</b> | <b>Name of Utilization Review Agent</b>   | <b>Type of Service Reviewed</b>  |
|--------------------------------------|---|--|
| Group Health, Inc.                   | <ul style="list-style-type: none"> <li>Alignis</li> <li>CareCore National</li> <li>Express Scripts</li> <li>HAYES Plus, Inc.</li> <li>MCMC Medical Care Management Corp.</li> <li>ValueOptions</li> </ul> | <ul style="list-style-type: none"> <li>Chiropractic</li> <li>Radiology</li> <li>Prescription Drugs</li> <li>Medical, Surgical and Behavioral Health and Substance Abuse</li> <li>Medical, Surgical and Behavioral Health and Substance Abuse</li> <li>Behavioral Health and Substance Abuse</li> </ul> |
| HealthNow New York, Inc.             | <ul style="list-style-type: none"> <li>CMS Care of New York, LLC</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                | <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 Group                                      | <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>   |
| CIGNA Health Group                               | <ul style="list-style-type: none"> <li>CIGNA Behavioral Health</li> <li>Intracorp</li> </ul>   | <ul style="list-style-type: none"> <li>Behavioral Health and Substance Abuse</li> <li>Appeals</li> </ul>   |
| GE Global Group                                  | <ul style="list-style-type: none"> <li>Medical Review Institute (MRI)</li> <li>Private Health Care Systems (PHCS)</li> </ul>   | <ul style="list-style-type: none"> <li>Chiropractic and Physical Therapy</li> <li>Hospital and Managed Care</li> </ul>   |
| Guardian Life Group                              | <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                 | <ul style="list-style-type: none"> <li>CareCore National</li> <li>Coordinated Care Solutions (CCS)</li> <li>Landmark Healthcare</li> <li>Managed Health Network (MHN)</li> </ul> | <ul style="list-style-type: none"> <li>Radiology</li> <li>Home Care and Skilled Nursing Facilities</li> <li>Chiropractic</li> <li>Behavioral Health</li> </ul> |
| Horizon Healthcare Insurance Company of New York | <ul style="list-style-type: none"> <li>Greenspring Healthcare Services</li> <li>National Imaging Associates (NIA)</li> </ul>   | <ul style="list-style-type: none"> <li>Behavioral Health</li> <li>Radiology</li> </ul>   |
| Nippon Life Insurance Company                    | <ul style="list-style-type: none"> <li>Principal Life Insurance Company</li> </ul>   | <ul style="list-style-type: none"> <li>All Utilization Review</li> </ul>   |
| Oxford Health Insurance                          | <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>  |

|                                    |   |  |
|------------------------------------|---|--|
| Trustmark Insurance Company        | <ul style="list-style-type: none"> <li>Private Health Care Services (PHCS)</li> </ul> | <ul style="list-style-type: none"> <li>All Utilization Review</li> </ul> |
| Union Labor Life Insurance Company | <ul style="list-style-type: none"> <li>Alicare Medical Management</li> </ul>          | <ul style="list-style-type: none"> <li>All Utilization Review</li> </ul> |

| <b>Medicaid Managed Care Plans</b> | <b>Name of Utilization Review Agent</b>  | <b>Type of Service Reviewed</b>  |
|------------------------------------|--|--|
| Affinity Health Plan               | <ul style="list-style-type: none"> <li>Block Vision</li> <li>HealthPlex</li> <li>ValueOptions</li> </ul>                                 | <ul style="list-style-type: none"> <li>Vision</li> <li>Dental</li> <li>Behavioral Health</li> </ul>                    |
| CenterCare                         | <ul style="list-style-type: none"> <li>ACM</li> <li>Healthplex</li> <li>NMH CRx</li> <li>Ryan Community Health Network (RCHN)</li> </ul> | <ul style="list-style-type: none"> <li>Behavioral Health</li> <li>Dental</li> <li>Pharmacy</li> <li>Medical</li> </ul> |
| Health Plus                        | <ul style="list-style-type: none"> <li>Envision Care</li> </ul>  | <ul style="list-style-type: none"> <li>High Risk Maternity and HIV/AIDS</li> </ul>                                     |
| WellCare                           | <ul style="list-style-type: none"> <li>Health Integrated</li> </ul>  | <ul style="list-style-type: none"> <li>Behavioral Health</li> </ul>  |

| <b>Municipal Cooperative Health Benefit Plans</b>      | <b>Name of Utilization Review Agent</b>  | <b>Type of Service Reviewed</b>   |
|--|--|---|
| Cayuga-Onondaga Area Schools Employees Health 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>  |
| State-Wide Schools Cooperative Health Plan             | <ul style="list-style-type: none"> <li>Empire Contracted MD Consultants</li> <li>Magellan Behavioral Health</li> <li>MCMC Medical Care Management Corp.</li> </ul> | <ul style="list-style-type: none"> <li>Specialty Reviews</li> <li>Behavioral Health and Substance Abuse</li> <li>Outside Specialty Reviews</li> </ul> |

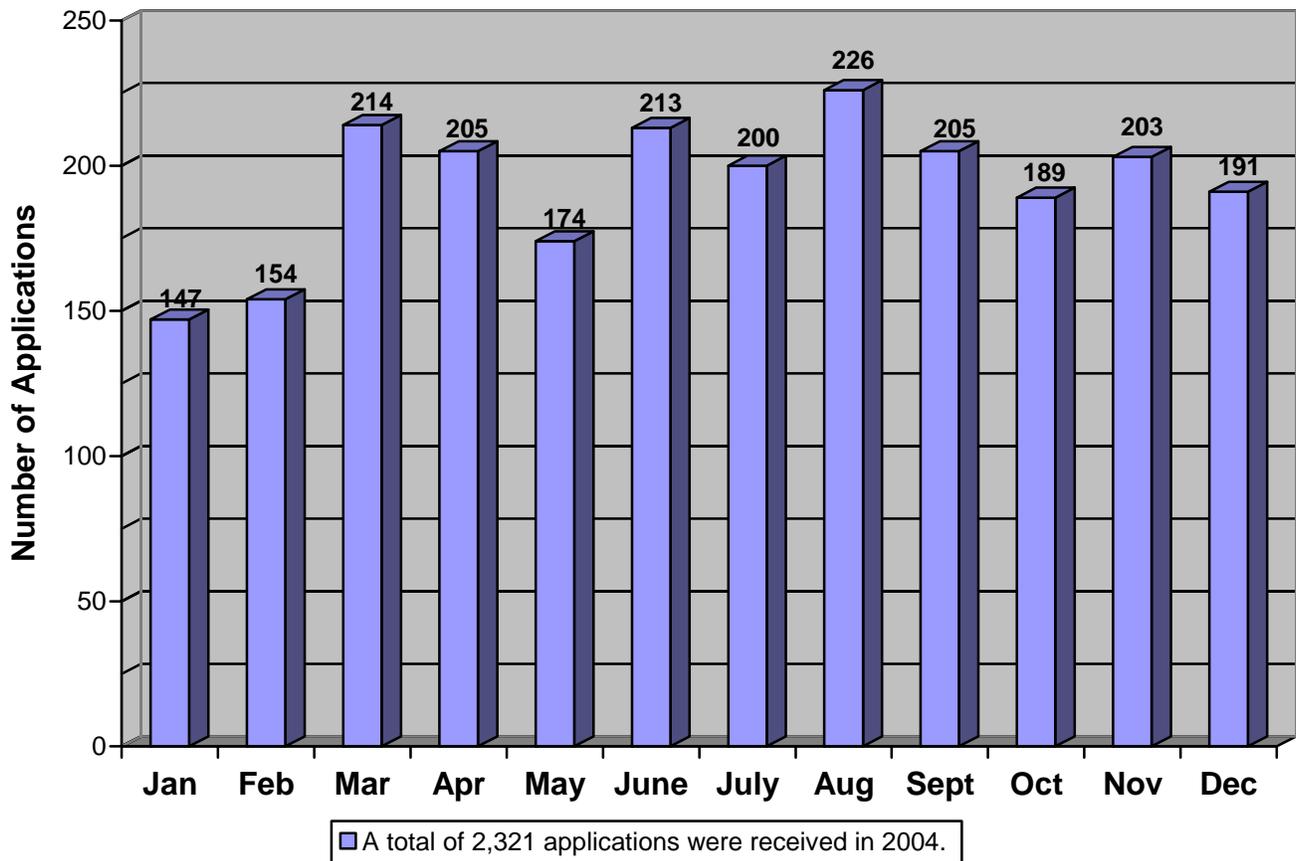
### Chapter 3(A):Volume of External Appeal Requests Received by the Insurance Department

When a health plan makes a utilization review determination that services are not medically necessary or are experimental or investigational, the External Appeal Law gives health care consumers the right to request an independent review of the determination. Consumers may request an external review by submitting an application to the Insurance Department. The Department has received over 9,000 applications from 1999 through 2004.

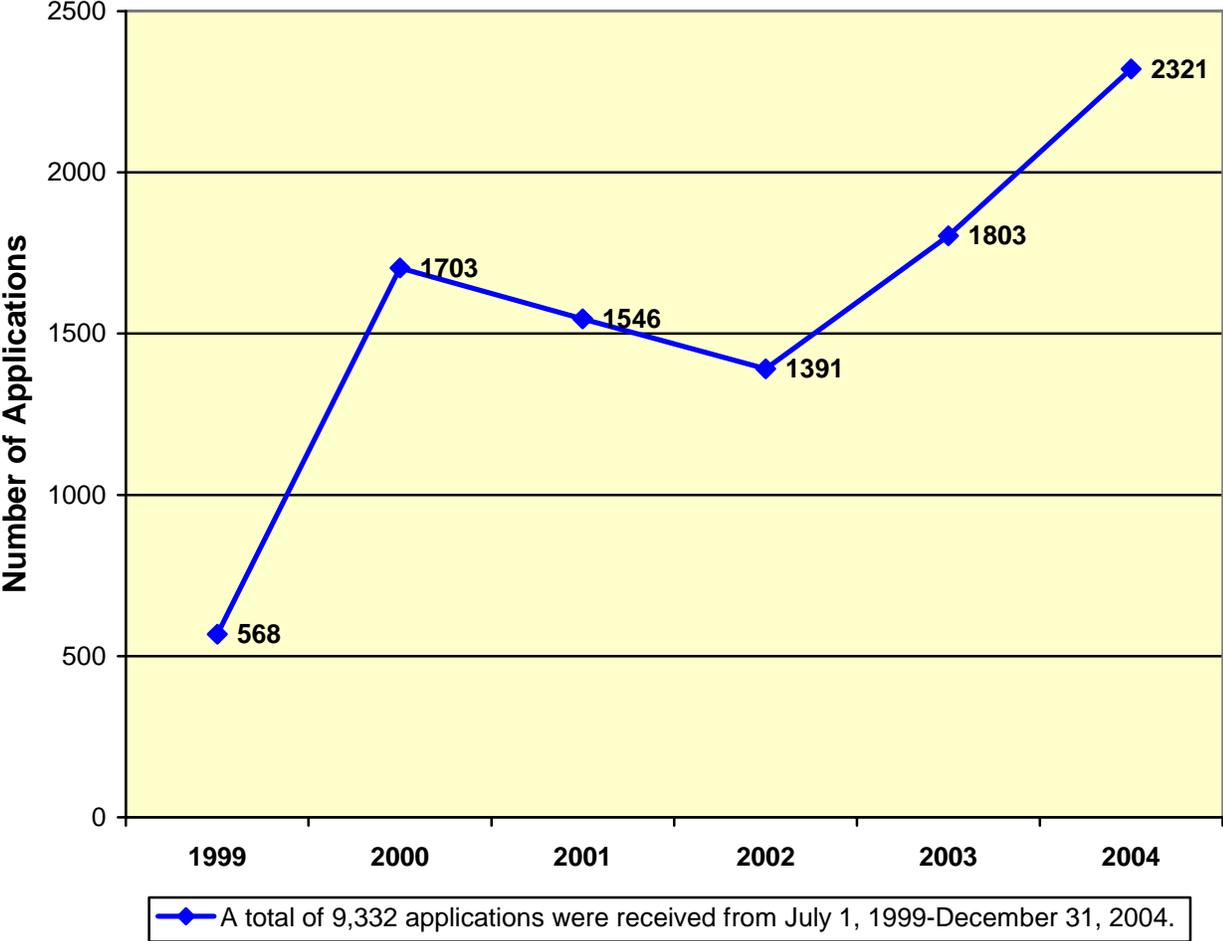
- In 2004, the Department received 2,321 external appeal applications, the largest number of requests in one year, and a 29% increase over 2003.
- In 2003, the Department received 1,803 applications, a 30% increase over 2002.
- In 2002, the Department received 1,391 external appeal applications, a 10% decrease from 2001.
- In 2001, the Department received 1,546 external appeal applications, a 10% decrease from 2000.
- In 2000, the first full year of operation of the External Appeal Program, the Department received 1,703 applications.

The following charts identify the number of external appeal requests submitted to the Insurance Department each month in 2004 and the number submitted since the program's inception.

**External Appeal Applications Received by the Insurance Department in 2004**



**External Appeal Applications Received  
July 1, 1999 - December 31, 2004**

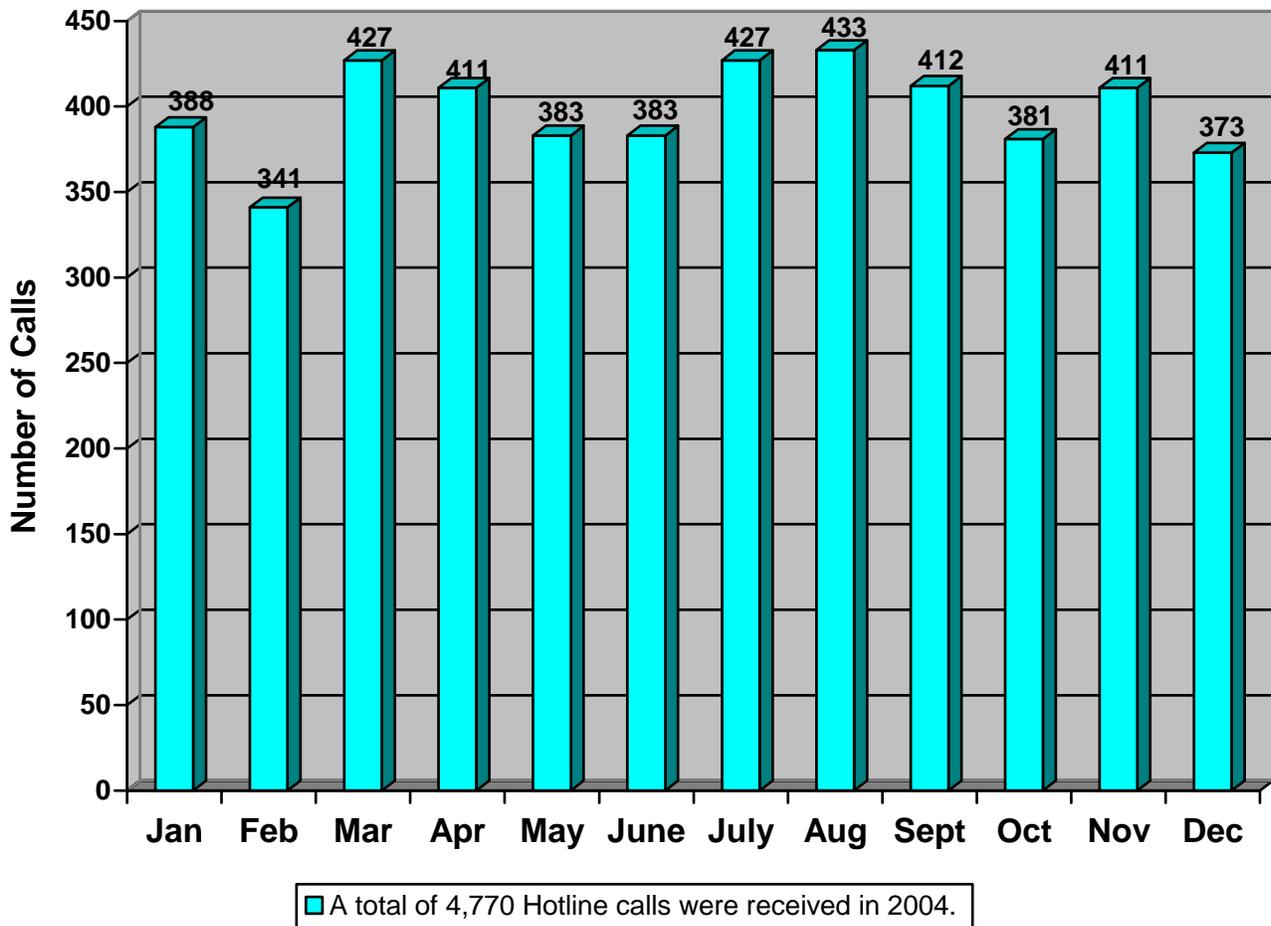


### Chapter 3(B): Volume of External Appeal Hotline Calls

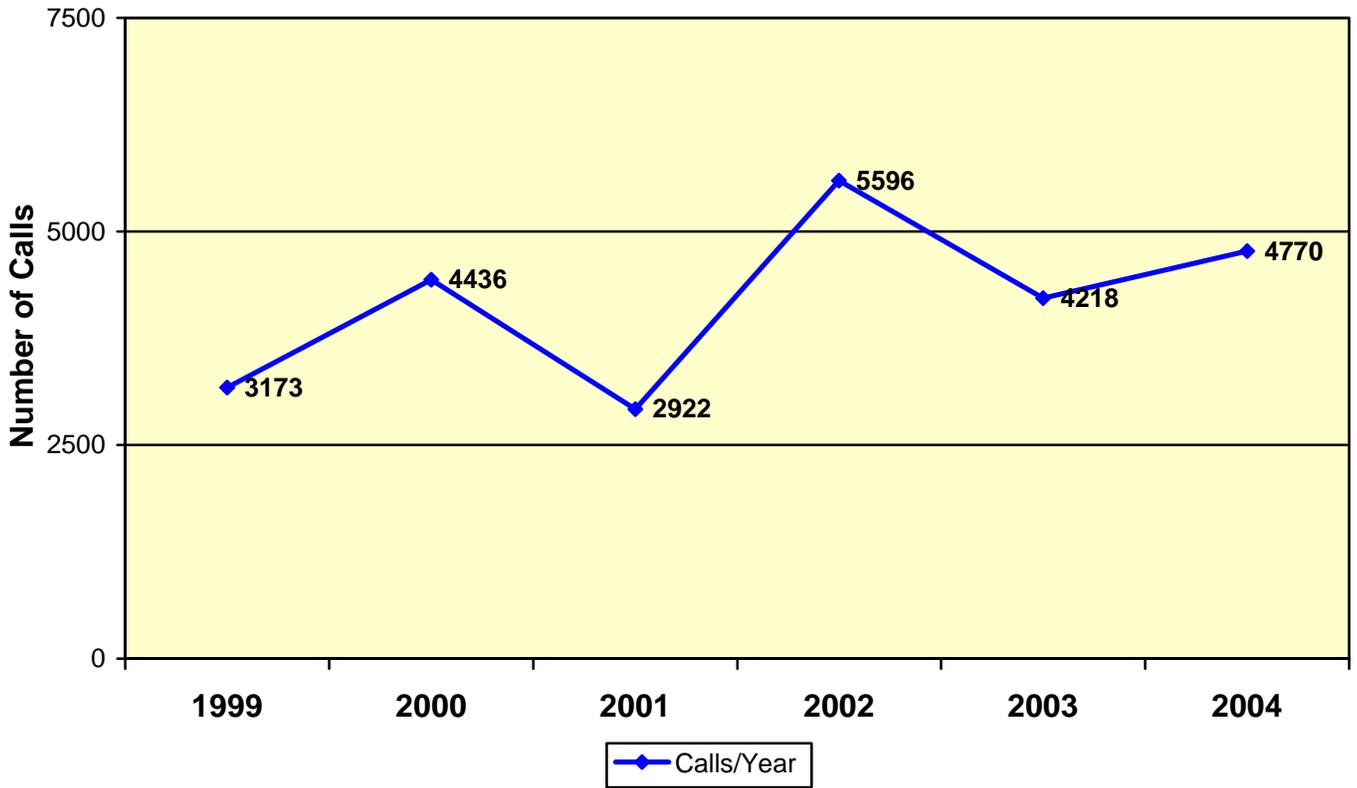
The Insurance Department operates an external appeal hotline (1-800-400-8882) to assist consumers in utilizing their external appeal rights. Hotline operators answer any external appeal questions consumers may have and assist consumers in submitting external appeal requests. The hotline is operated by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

The Insurance Department has received and responded to over 25,000 hotline calls since the hotline became operational. The following chart identifies the number of external appeal calls received by the Insurance Department on a monthly basis from January 2004 through December 2004.

**Incoming Calls to the Toll-Free External Appeal Hotline in 2004**



**Incoming Calls to the Toll-Free Hotline by Year  
July 1, 1999 - December 31, 2004**



## Chapter 3(C): External Appeal Eligibility

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

- **Applicability:**
  - ✓ Services must have been denied as not medically necessary or as experimental or investigational. Other types of coverage determinations, such as a denial because the insured has a pre-existing condition, the benefit is not covered under the insurance policy, or the insured is requesting a referral to a non-participating provider, are not eligible for external appeal.
  - ✓ The insured must be covered under a fully insured health insurance contract. The External Appeal Law is not applicable to self-insured coverage, Medicaid fee-for-service coverage, and Medicare coverage, including coverage provided by Medicare managed care plans, as persons covered under Medicaid are eligible for the Fair Hearing Process and persons covered under Medicare are eligible for a Medicare appeals process.
- **Timeliness:**
  - ✓ An external appeal application must be submitted to the Insurance Department within 45 days of receipt of the final adverse determination from the first level of internal appeal with the health plan or receipt of notice that the health plan agreed to waive the internal appeal process.
  - ✓ The Insurance Department presumes that the final adverse determination was received within 8 days of the date on the determination, unless otherwise demonstrated, so that the applicant has 53 days (45 plus an additional 8 days) to initiate an external appeal.
- **Completeness:**
  - ✓ The application must be signed. The patient, a parent if the patient is a minor, a guardian, or if the patient is deceased, the administrator or executor of a patient's estate, must sign the application.
  - ✓ A copy of the final adverse determination must be included with the external appeal request.
  - ✓ If services were denied as experimental or investigational, the patient's attending physician must complete the attestation portion of the external appeal application and attach two articles of medical and scientific evidence. If the appeal is for a clinical trial, it is also recommended that the physician submit the clinical trial protocols.

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

### Chapter 3(D): Rejection of External Appeal Requests

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

- If services were not denied on the basis of medical necessity or because the services were considered experimental or investigational.
- If the insured has coverage that is exempt from the New York external appeal requirements, such as self-insured coverage, Medicaid fee-for-service coverage, or Medicare coverage.
- If the insured does not submit an application within the 45 day time frame for requesting an external appeal.
- If an external appeal application is incomplete and the missing information is not provided to the Insurance Department after two requests are made for the information.
  - ✓ An external appeal application is considered to be incomplete if:
    - ◆ the application is not signed;
    - ◆ the final adverse determination is not provided;
    - ◆ a fee is required and not submitted; or,
    - ◆ the appeal is for experimental or investigational services and the attending physician attestation has not been completed.
  - ✓ If an application is incomplete, the Insurance Department will request the missing information from the applicant and, as appropriate, from the applicant's attending physician, and allow two weeks for a response.
  - ✓ If a response is not provided, the Insurance Department will make a second request for the information. If a response is not provided to the second request, the application will be rejected.

When an application is rejected, the applicant is advised that although the request is ineligible for external appeal, the Insurance Department's Consumer Services Bureau is available to investigate the health plan's denial, and will do so upon the applicant's request. If federal law applies to the applicant's coverage instead of New York 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 1999, 2,557 external appeal requests have been rejected as ineligible for external appeal. During the past two years, 452 external appeal requests were rejected in 2003 and 678 requests were rejected in 2004. This increase in rejections for 2004 reflects the increase in applications received in 2004. The most frequent reason for rejection of external appeal requests is that the application was incomplete and the applicant did not provide the missing information after two requests were made by the Insurance Department. However, in 2004, there was also a significant increase in the number of requests rejected because the application was not submitted within the 45 day timeframe. In fact, over half of the rejected applications in 2004 were rejected because they were incomplete or untimely.

The following chart identifies the number of external appeal requests that have been rejected in New York in 2003 and 2004 and lists the reasons for rejection.

| <b>Reasons for Rejection of External Appeal Requests in New York</b>  |             |             |
|---|-------------|-------------|
|   | <b>2004</b> | <b>2003</b> |
| Applicant did not provide missing information:  | 192         | 101         |
| • Physician attestation for experimental/investigational appeal.  | 32          | 18          |
| • Health plan denial letter.  | 28          | 11          |
| • Check or money order.   | 9           | 2           |
| • Patient did not submit external appeal request and did not confirm interest in pursuing an external appeal. | 3           | 4           |
| • Consent form.   | 13          | 1           |
| • An application.   | 5           | 5           |
| • More than one of the above items missing.   | 102         | 60          |
| Application was not submitted within the 45 day time frame.   | 158         | 101         |
| Applicant did not first appeal the denial with the health plan.   | 62          | 44          |
| Self-insured coverage.  | 58          | 70          |
| Provider ineligible to request an external appeal.  | 53          | 20          |
| Denial was for a benefit that was not covered under the contract.   | 49          | 36          |
| CPT code, UCR, or level of reimbursement dispute.   | 26          | 14          |
| Denial for a referral to a non-participating provider.  | 24          | 14          |
| Applicant withdrew external appeal request.   | 18          | 10          |
| Out-of-state insurance policy.  | 12          | 8           |
| Duplicate applications submitted.   | 6           | 2           |
| Attending physician attestation for experimental/investigational appeal did not meet the requirements of law. | 5           | 10          |
| Complaints relating to eligibility, termination, premiums, and administration of contract.                    | 5           | 6           |
| Medicare managed care coverage.   | 5           | 7           |
| Federal employee coverage or United States military coverage.   | 3           | 5           |
| Denial for a failure to request pre-authorization.  | 1           | 3           |
| Worker's compensation claim.  | 0           | 0           |
| Member pursued a Medicaid Fair Hearing instead of an external appeal.   | 0           | 1           |
| <b>Total</b>  | <b>677</b>  | <b>452</b>  |

### Chapter 3(E): Reversals by Health Plans

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

From the program's inception in July 1999 through December 31, 2004, 1,255 appeals were closed during the appeal process because a health plan reversed its adverse determination before the external appeal agent rendered a determination. In the past two years, 291 appeals were reversed in 2004 and 239 appeals were reversed in 2003.

| Health Maintenance Organizations                 | Health Plan Reversals in 2004 | Health Plan Reversals in 2003 |
|--|-------------------------------|-------------------------------|
| Aetna Health                                     | 3                             | 0                             |
| Atlantis Health Plan                             | 6                             | 11                            |
| Capital District Physicians' Health Plan (CDPHP) | 6                             | 9                             |
| CIGNA  | 6                             | 1                             |
| Empire HealthChoice                              | 12                            | 6                             |
| Excellus (Rochester)                             | 2                             | 0                             |
| Excellus (Utica Watertown)                       | 3                             | 0                             |
| Excellus (Univera)                               | 2                             | 6                             |
| GHI HMO Select                                   | 1                             | 4                             |
| Health Insurance Plan of Greater NY (HIP)        | 6                             | 3                             |
| Health Net of New York                           | 3                             | 21                            |
| HealthNow New York, Inc.                         | 21                            | 7                             |
| MDNY   | 0                             | 1                             |
| MVP Health Plan                                  | 3                             | 6                             |
| Oxford   | 100                           | 59                            |
| Rochester Area HMO (Preferred Care)              | 1                             | 1                             |
| United Healthcare of New York                    | 0                             | 5                             |
| <b>Total</b>                                     | <b>175</b>                    | <b>140</b>                    |

| <b>Non-Profit Indemnity Insurers</b>         | <b>Health Plan Reversals in 2004</b> | <b>Health Plan Reversals in 2003</b> |
|--|--------------------------------------|--------------------------------------|
| Excellus Health Plan, Inc. (CNY)             | 6                                    | 3                                    |
| Excellus Health Plan, Inc. (Rochester)       | 0                                    | 5                                    |
| Excellus Health Plan, Inc. (Utica Watertown) | 0                                    | 1                                    |
| Group Health, Inc.                           | 58                                   | 44                                   |
| HealthNow New York, Inc.                     | 8                                    | 2                                    |
| <b>Total</b>                                 | <b>72</b>                            | <b>55</b>                            |

| <b>Commercial Insurers</b>                       | <b>Health Plan Reversals in 2004</b> | <b>Health Plan Reversals in 2003</b> |
|--|--------------------------------------|--------------------------------------|
| Aetna Group                                      | 1                                    | 0                                    |
| CIGNA Health Group                               | 1                                    | 1                                    |
| Empire HealthChoice Assurance                    | 22                                   | 19                                   |
| GE Global Group                                  | 0                                    | 1                                    |
| Gerber Life Insurance Company                    | 0                                    | 1                                    |
| Guardian Life Group                              | 1                                    | 0                                    |
| Horizon Healthcare Insurance Company of New York | 4                                    | 0                                    |
| Metropolitan Group                               | 2                                    | 1                                    |
| Mutual of Omaha Group                            | 1                                    | 0                                    |
| Oxford Health Insurance                          | 0                                    | 6                                    |
| UniCare Life & Health Insurance Company          | 0                                    | 0                                    |
| United HealthCare Insurance Company of New York  | 4                                    | 13                                   |
| <b>Total</b>                                     | <b>36</b>                            | <b>42</b>                            |

| <b>Medicaid Managed Care Plans</b> | <b>Health Plan Reversals in 2004</b> | <b>Health Plan Reversals in 2003</b> |
|------------------------------------|--------------------------------------|--------------------------------------|
| CenterCare                         | 0                                    | 1                                    |
| Fidelis Care New York              | 1                                    | 0                                    |
| Health Plus                        | 0                                    | 0                                    |
| MetroPlus Health                   | 4                                    | 1                                    |
| Neighborhood Health Providers      | 1                                    | 0                                    |
| <b>Total</b>                       | <b>6</b>                             | <b>2</b>                             |

| <b>Municipal Cooperative Health Benefit Plans</b> | <b>Health Plan Reversals in 2004</b> | <b>Health Plan Reversals in 2003</b> |
|---|--------------------------------------|--------------------------------------|
| Jefferson-Lewis School Employees Health Care Plan | 1                                    | 0                                    |
| Orange-Ulster School District Health Plan         | 1                                    | 0                                    |
| <b>Total</b>                                      | <b>2</b>                             | <b>0</b>                             |

### **Chapter 3(F): Certification of External Appeal Agents**

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

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

Currently there are three certified external appeal agents that review external appeals in New York. The agents are Medical Care Management Corporation (MCMC), certified on July 2, 1999, recertified on July 1, 2001, and recertified again on July 1, 2003; Island Peer Review Organization (IPRO), certified on June 30, 1999, recertified on July 1, 2001, and recertified again on July 1, 2003; and Hayes Plus, certified on June 21, 2001, and recertified on July 1, 2003. All three external appeal agents will be recertified in 2005. As part of the recertification process, each of the agents must provide a description of any policies and procedures that have changed since the previous certification, along with a description of any changes in the agent's network of clinical peer reviewers. The agents must also provide a plan of correction for any deficiencies the Departments identify during the recertification process.

### **Chapter 3(G): External Appeal Agent Review**

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

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

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

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

The Insurance Department has received complaints from patients and health plans in relation to external appeal agent determinations. The Department investigates all complaints to ensure the appeal was conducted in compliance with statutory and regulatory requirements. The Department received 20 complaints in 2001, 31 complaints in 2002, 46 complaints in 2003, and 75 complaints in 2004. The types of complaints most frequently received related to an applicant's disagreement with either the external appeal agent's decision or with the Department's rejection of an external appeal application.

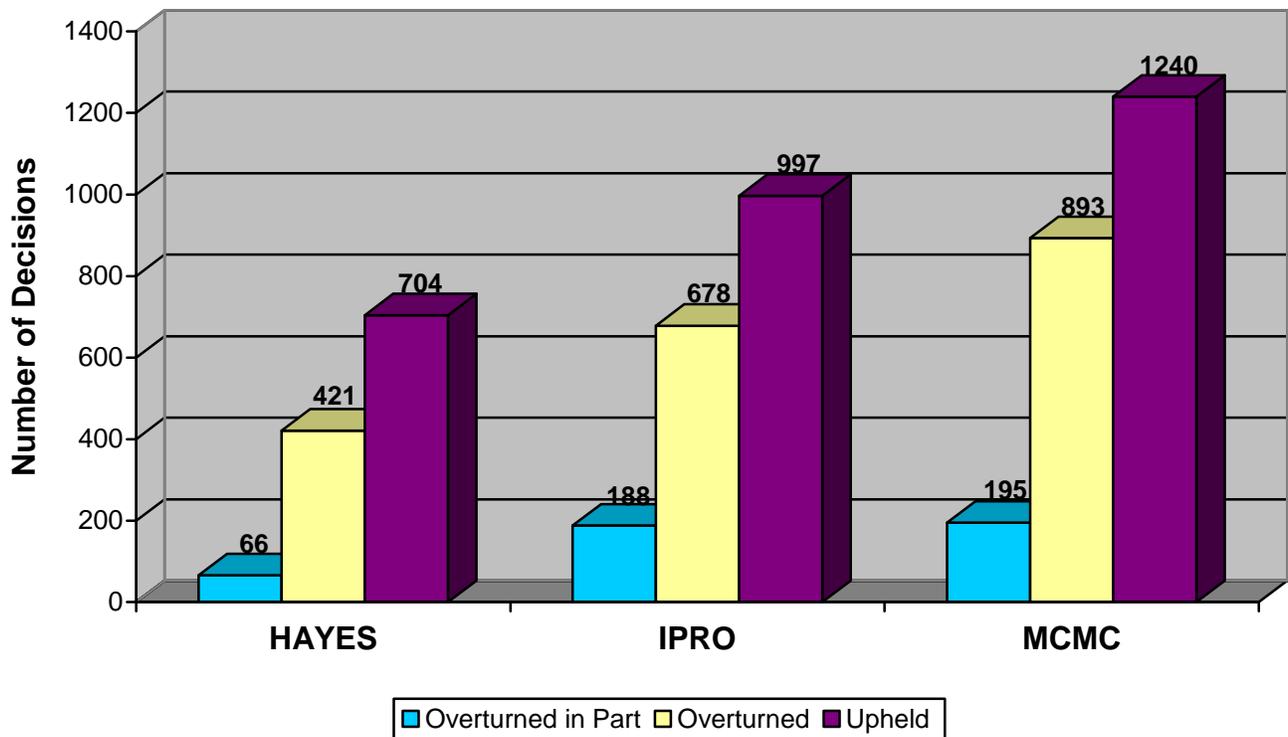
### Chapter 3(H): External Appeal Agent Decisions

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

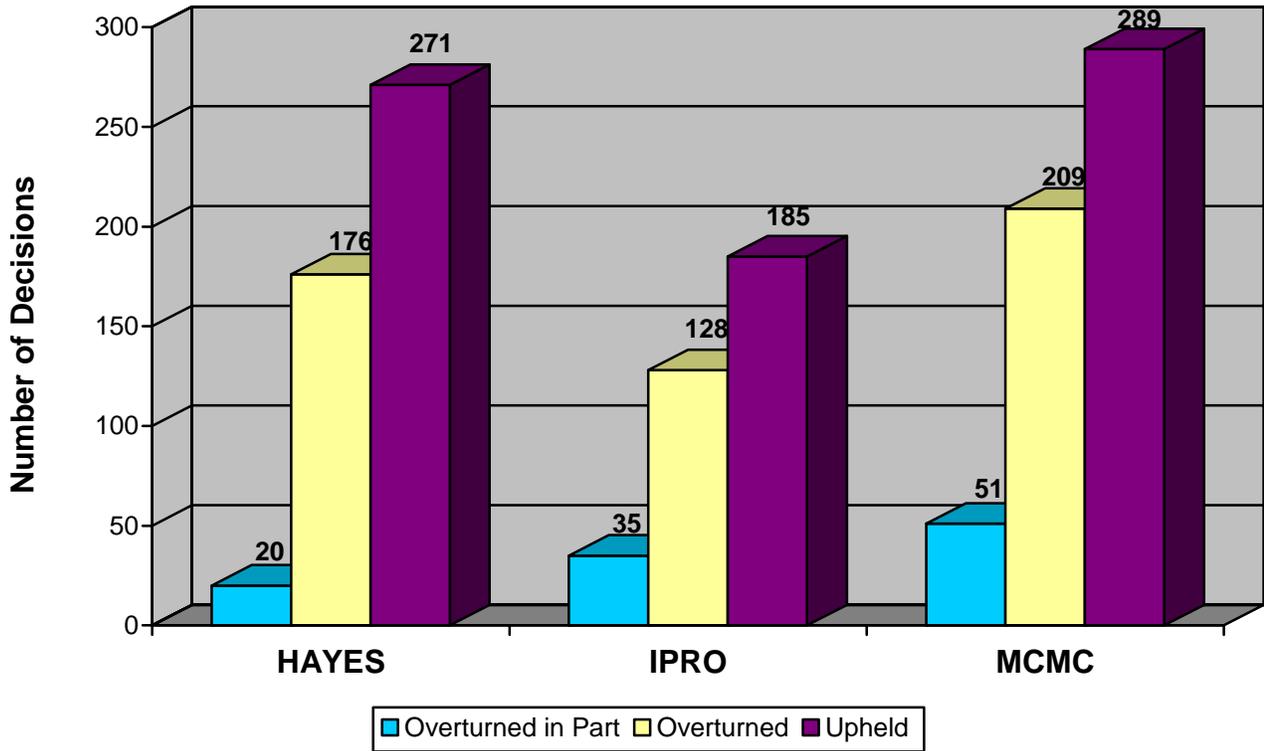
- In 2004, 467 cases were assigned to Hayes, 348 were assigned to IPRO, and 549 were assigned to MCMC. The differences in case assignments can be attributed to the random assignment process and to reassignments due to conflicts of interest.
- In 2004, health plan denials were overturned in whole or in part by Hayes in 42% of cases, by IPRO in 47% of cases, and by MCMC in 47% of cases.
- In 2003, health plan denials were overturned in whole or in part by Hayes in 40% of cases, by IPRO in 40% of cases and by MCMC in 50% of cases.

The first chart identifies external appeal results by agent from July 1999 through December 2004. The second chart identifies external appeal results by agent for 2004.

**External Appeal Decisions by Agent  
July 1, 1999 - December 31, 2004**



### External Appeal Decisions by Agent 2004



### Chapter 3(I): External Appeal Results by Type of Health Plan Denial

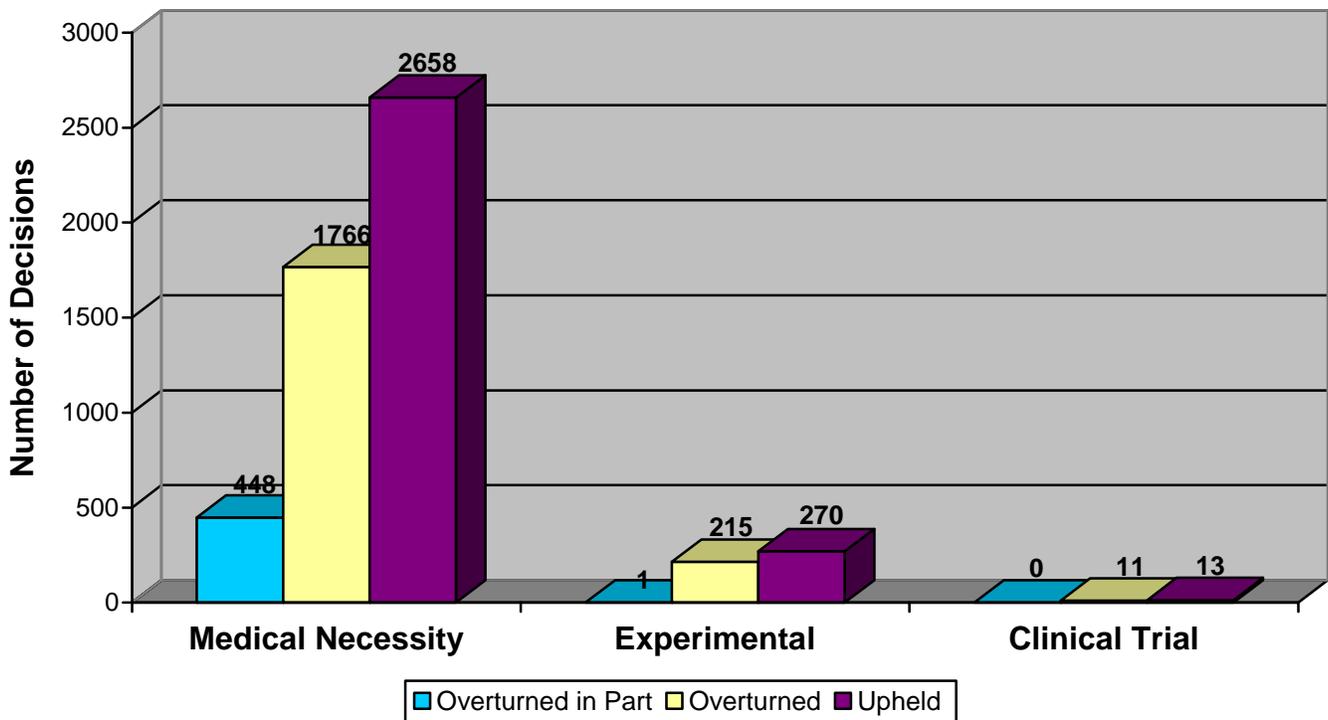
Since the beginning of the External Appeal Program, through the most recent year, the majority of external appeal requests have related to denials based on medical necessity, as opposed to denials because services were considered experimental or investigational. Of the medical necessity denials, the most frequent types of services appealed in 2004 included substance abuse treatment, surgical services, inpatient hospital services, diagnostic testing, coverage of durable medical equipment, mental health services, physical therapy, prescription drug coverage, and chiropractic services.

In 2004, the percentage of medical necessity denials overturned slightly increased, as did the percentage of overturned experimental or investigational treatment denials.

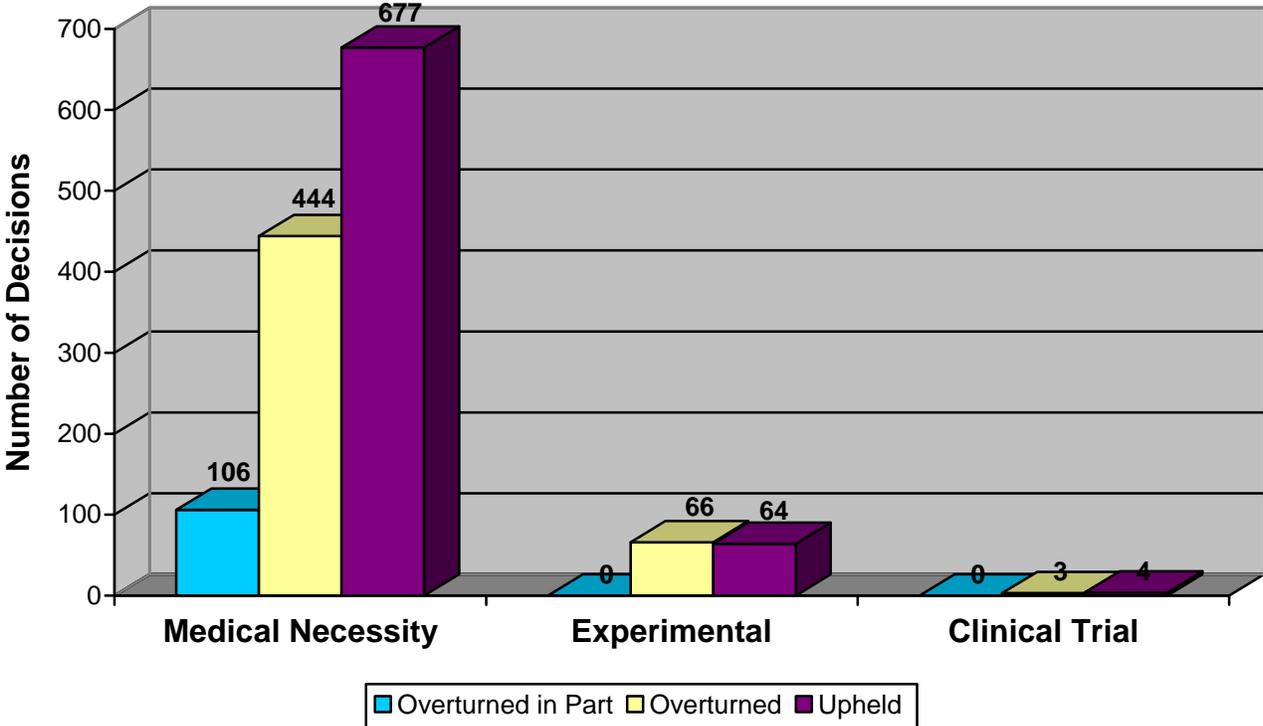
- In 2004, 45% of medical necessity denials were overturned in whole or in part, while 51% of experimental or investigational treatment denials were overturned.
- In 2003, 42% of medical necessity denials were overturned in whole or in part, while 50% of experimental or investigational treatment denials were overturned.

The following charts identify external appeal results based on whether services were denied as not medically necessary or as experimental or investigational:

**External Appeal Decision by Type of Health Plan Denial 1999-2004**



### External Appeal Decisions by Type of Health Plan Denial 2004



## Chapter 3(J): Expedited External Appeals

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

Expedited external appeals can be problematic because the three day timeframe only allows the patient and the patient's health care provider a limited opportunity to submit additional information. Due to this time constraint, the external appeal agent can have difficulty obtaining this information in the short timeframe, especially if the appeal is submitted over the weekend. Thus, it is essential for the patient's provider to immediately forward the patient's medical records to the external appeal agent, as the law requires the external appeal agent to issue a decision in three days, regardless of whether the agent has all the necessary information.

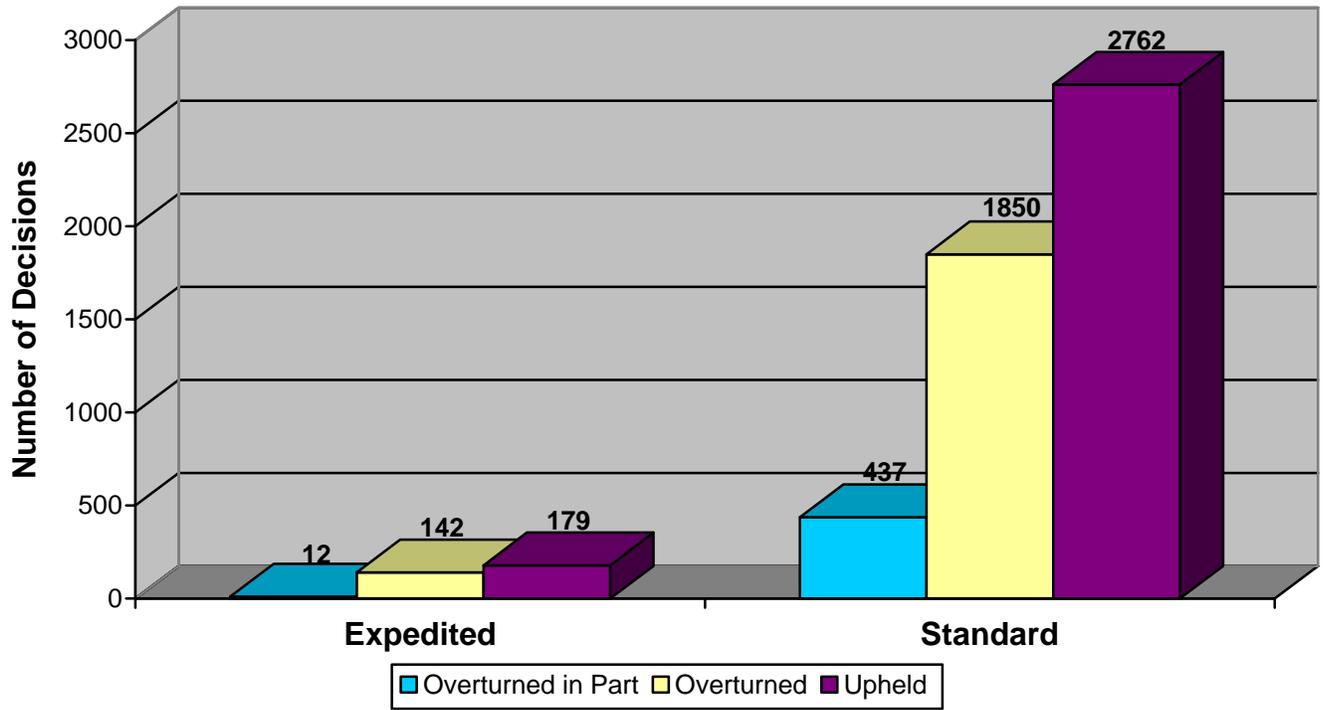
Insurance Department staff is available to handle expedited appeals submitted during business hours and after the close of business. Two Insurance Department staff members are on call each weekend to handle expedited appeals. Applicants requesting an expedited appeal are asked to call the Department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

Since the beginning of the external appeal program, 333 expedited external appeals have been reviewed by external appeal agents, or 6.2% of the total external appeals. The Department has noted a slight increase in the number of expedited external appeals requested in 2004.

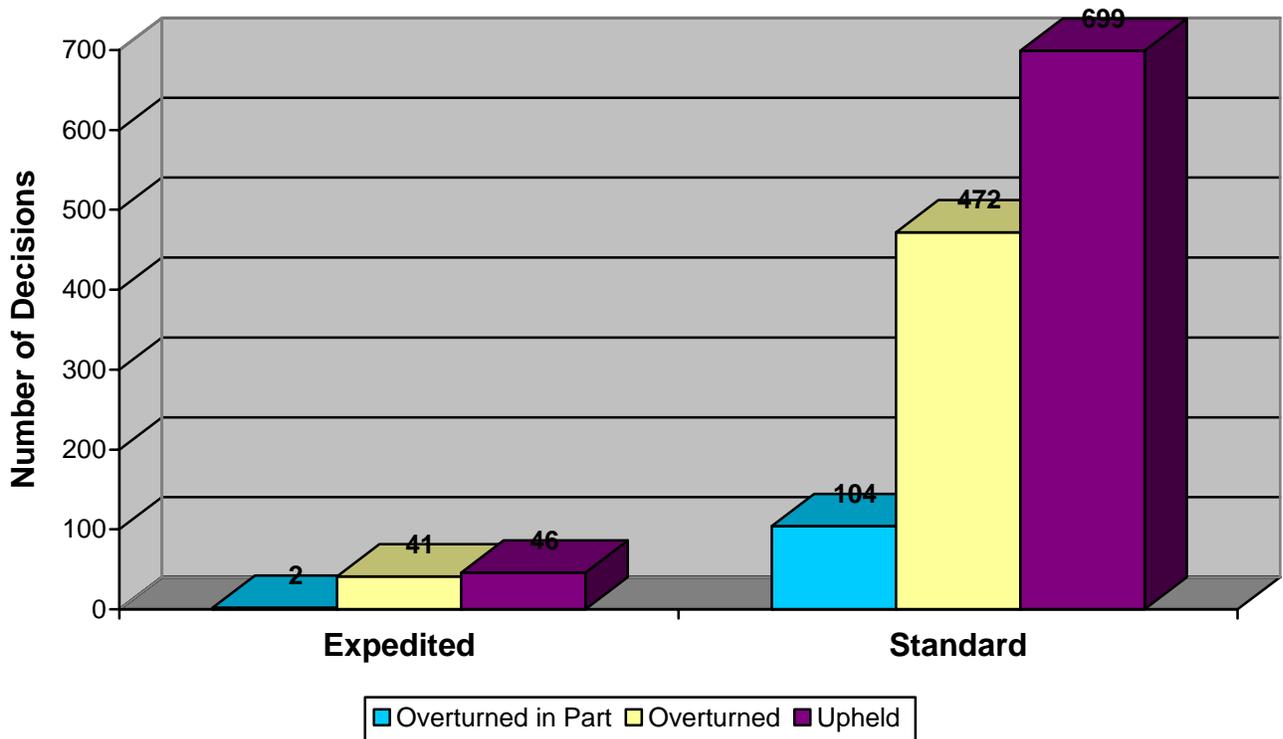
- In 2004, 89 expedited external appeals were reviewed by the external review agents, or 6.5% of the total external appeals reviewed.
- In 2003, 62 expedited external appeals were reviewed by the external review agents, or 5.9% of the total external appeals reviewed.
- In 2002, 48 expedited external appeals were reviewed by the external review agents, or 5.5% of the total external appeals reviewed.

The first chart compares standard and expedited appeal results for 1999 - 2004 and the second chart compares standard and expedited appeal results for 2004.

**External Appeal Decision by Type of Appeal  
July 1, 1999 - December 31, 2004**



**External Appeal Decisions by Type of Appeal 2004**



### Chapter 3(K): External Appeal Results and Costs

In addition to viewing external appeal results by agent, by type of health plan denial, and by type of appeal, external appeal results can also be viewed on a calendar year basis. As seen in the chart below, there have been a total of 5,382 decisions rendered by external appeal agents since the beginning of the External Appeal Program in July 1999 through 2004. The overall percentage of health plan denials overturned in whole or in part by external appeal agents declined slightly in 2001-2003 and began to increase in 2004.

| Timeframe    | Total       | Health Plan Denial Overturned | Health Plan Denial Overturned in Part | Health Plan Denial Upheld | Percentage Overturned in Whole or in Part |
|--------------|-------------|-------------------------------|---------------------------------------|---------------------------|---|
| 1999         | 205         | 79                            | 20                                    | 106                       | 48.3%                                     |
| 2000         | 936         | 371                           | 91                                    | 474                       | 49.4%                                     |
| 2001         | 946         | 347                           | 76                                    | 523                       | 44.7%                                     |
| 2002         | 878         | 309                           | 80                                    | 489                       | 44.3%                                     |
| 2003         | 1053        | 373                           | 76                                    | 604                       | 42.6%                                     |
| 2004         | 1364        | 513                           | 106                                   | 745                       | 45.4%                                     |
| <b>Total</b> | <b>5382</b> | <b>1992</b>                   | <b>449</b>                            | <b>2941</b>               | <b>45.4%</b>                              |

Health plans are responsible for paying the external appeal agent for the appeal regardless of whether the health plan's determination is upheld or overturned. The fees charged by external appeal agents are approved by the Insurance Department and the Health Department for two year periods. The fees must be reasonable, and must be inclusive of indirect costs, administrative fees and incidental expenses. A health plan must pay the external appeal agent's fee within 45 days from the date the appeal determination is received by the health plan. If payment is not made within the 45 days, the plan is required to pay the agent interest at a statutorily prescribed rate. Below is a table of the costs to all health plans for external appeal determinations rendered in 2004:

|      | Medical Necessity Standard | Medical Necessity Expedited | Experimental/ Investigational Standard | Experimental/ Investigational Expedited | Total       |
|------|----------------------------|-----------------------------|--|---|-------------|
| 2004 | \$701,075                  | \$60,230                    | \$274,350                              | \$55,400                                | \$1,091,055 |

### Chapter 3(L): External Appeal Decisions by Health Plan in 2004

The following charts identify external appeal results by health plan for 2004. The charts categorize health plans based on whether the coverage is HMO, non-profit indemnity insurance, commercial insurance, Medicaid managed care, or Municipal Cooperative Health Benefit Plan coverage. When reviewing the charts, it is important to keep in mind that some health plans provide coverage to greater numbers of New Yorkers than others. Larger plans may have more external appeals than smaller plans because more people are covered under the plans.

| Health Maintenance Organizations                 | Total      | Overtured  | Overtured in Part | Upheld     | Percentage Overtured or Overtured in Part |
|--|------------|------------|-------------------|------------|---|
| Aetna Health                                     | 30         | 12         | 2                 | 16         | 46.7%                                     |
| Atlantis Health Plan                             | 17         | 10         | 2                 | 5          | 70.6%                                     |
| Capital District Physicians' Health Plan (CDPHP) | 13         | 4          | 0                 | 9          | 30.8%                                     |
| CIGNA  | 16         | 12         | 0                 | 4          | 75%                                       |
| Empire HealthChoice                              | 112        | 49         | 5                 | 58         | 48.2%                                     |
| Excellus (Rochester)                             | 20         | 7          | 0                 | 13         | 35%                                       |
| Excellus (Utica Watertown)                       | 8          | 5          | 0                 | 3          | 62.5%                                     |
| Excellus (Central NY)                            | 10         | 4          | 2                 | 4          | 60%                                       |
| Excellus (Univera)                               | 21         | 5          | 2                 | 14         | 33.3%                                     |
| GHI HMO Select                                   | 2          | 1          | 1                 | 0          | 100%                                      |
| Health Insurance Plan of Greater NY (HIP)        | 34         | 13         | 4                 | 17         | 50%                                       |
| Health Net of New York                           | 61         | 22         | 1                 | 38         | 37.7%                                     |
| HealthNow New York, Inc.                         | 87         | 21         | 1                 | 65         | 25.3%                                     |
| Independent Health Association (IHA)             | 5          | 2          | 0                 | 3          | 40%                                       |
| MDNY   | 5          | 1          | 2                 | 2          | 60%                                       |
| MVP Health Plan                                  | 18         | 8          | 2                 | 8          | 55.6%                                     |
| Oxford   | 290        | 96         | 29                | 165        | 43.1%                                     |
| Rochester Area HMO (Preferred Care)              | 7          | 4          | 1                 | 2          | 71.4%                                     |
| Vytra  | 7          | 3          | 0                 | 4          | 42.9%                                     |
| WellCare*  | 1          | 0          | 0                 | 1          | 0%  |
| <b>Totals</b>                                    | <b>764</b> | <b>279</b> | <b>54</b>         | <b>431</b> | <b>43.6%</b>                              |

\* Child Health Plus only.

| <b>Non-Profit Indemnity Insurers</b>         | <b>Total</b> | <b>Overtured</b> | <b>Overtured in Part</b> | <b>Upheld</b> | <b>Percentage Overtured or Overtured in Part</b> |
|--|--------------|------------------|--------------------------|---------------|--|
| Excellus Health Plan, Inc. (Central NY)      | 50           | 24               | 2                        | 24            | 52%  |
| Excellus Health Plan, Inc. (Rochester)       | 6            | 2                | 0                        | 4             | 33.3%  |
| Excellus Health Plan, Inc. (Utica-Watertown) | 19           | 7                | 2                        | 10            | 47.4%  |
| Group Health, Inc.                           | 93           | 26               | 13                       | 54            | 41.9%  |
| HealthNow New York Inc.                      | 27           | 7                | 0                        | 20            | 25.9%  |
| <b>Totals</b>                                | <b>195</b>   | <b>66</b>        | <b>17</b>                | <b>112</b>    | <b>44.2%</b>                                     |

| <b>Commercial Insurers</b>                       | <b>Total</b> | <b>Overtured</b> | <b>Overtured in Part</b> | <b>Upheld</b> | <b>Percentage Overtured or Overtured in Part</b> |
|--|--------------|------------------|--------------------------|---------------|--|
| Aetna Group                                      | 7            | 2                | 1                        | 4             | 42.9%  |
| CIGNA Health Group                               | 5            | 0                | 1                        | 4             | 20%  |
| Empire HealthChoice Assurance                    | 182          | 78               | 18                       | 86            | 52.7%  |
| First Reliance Standard Life Insurance Company   | 1            | 0                | 0                        | 1             | 0%   |
| GE Global Group                                  | 1            | 0                | 0                        | 1             | 0%   |
| Guardian Life Group                              | 5            | 2                | 1                        | 2             | 60%  |
| Guardian Life Group (Dental)                     | 3            | 1                | 0                        | 2             | 33.3%  |
| Horizon Healthcare Insurance Company of New York | 19           | 5                | 4                        | 10            | 47.4%  |
| Metropolitan Group                               | 13           | 7                | 0                        | 6             | 53.8%  |
| Nippon Life Insurance Company                    | 2            | 1                | 0                        | 1             | 50%  |
| Oxford Health Insurance                          | 47           | 22               | 3                        | 22            | 53.2%  |
| Principal Life Insurance Company                 | 1            | 0                | 0                        | 1             | 0%   |
| Trustmark Insurance Company                      | 1            | 0                | 1                        | 0             | 100%   |
| UniCare Life & Health Insurance Company          | 3            | 1                | 0                        | 2             | 33.3%  |
| Union Labor Life Insurance Company               | 3            | 0                | 1                        | 2             | 33.3%  |
| United Healthcare Insurance Company of New York  | 72           | 35               | 2                        | 35            | 51.4%  |
| <b>Totals</b>                                    | <b>365</b>   | <b>154</b>       | <b>32</b>                | <b>179</b>    | <b>51%</b>                                       |

| Medicaid Managed Care Coverage            | Total     | Overtured | Overtured in Part | Upheld    | Percentage Overtured or Overtured in Part |
|---|-----------|-----------|-------------------|-----------|---|
| Affinity Health Plan                      | 2         | 1         | 1                 | 0         | 100%                                      |
| AmeriChoice                               | 1         | 1         | 0                 | 0         | 100%                                      |
| CenterCare Health Plan                    | 1         | 0         | 0                 | 1         | 0%  |
| Community Choice                          | 1         | 1         | 0                 | 0         | 100%                                      |
| GHI HMO Select                            | 3         | 1         | 0                 | 2         | 33.3%                                     |
| Health Insurance Plan of Greater NY (HIP) | 4         | 3         | 0                 | 1         | 75%                                       |
| HealthNow New York                        | 1         | 0         | 0                 | 1         | 0%  |
| Health Plus                               | 2         | 0         | 1                 | 1         | 50%                                       |
| Fidelis Care New York                     | 7         | 2         | 0                 | 5         | 28.6%                                     |
| United Healthcare of New York             | 1         | 0         | 0                 | 1         | 0%  |
| WellCare                                  | 5         | 2         | 1                 | 2         | 60%                                       |
| <b>Totals</b>                             | <b>28</b> | <b>11</b> | <b>3</b>          | <b>14</b> | <b>50%</b>                                |

| Municipal Cooperative Health Benefit Plans             | Total     | Overtured | Overtured in Part | Upheld   | Percentage Overtured or Overtured in Part |
|--|-----------|-----------|-------------------|----------|---|
| Cayuga-Onondaga Area Schools Employees Health Plan     | 1         | 0         | 0                 | 1        | 0%  |
| Jefferson-Lewis School Employees Health Care Plan      | 2         | 0         | 0                 | 2        | 0%  |
| Putnam/Northern Westchester Health Benefits Consortium | 4         | 1         | 0                 | 3        | 25%                                       |
| State-Wide Schools Cooperative Health Plan             | 5         | 2         | 0                 | 3        | 40%                                       |
| <b>Totals</b>  | <b>12</b> | <b>3</b>  | <b>0</b>          | <b>9</b> | <b>25%</b>                                |

|                                      |             |            |            |            |              |
|--------------------------------------|-------------|------------|------------|------------|--------------|
| <b>Totals For All Coverage Types</b> | <b>1364</b> | <b>513</b> | <b>106</b> | <b>745</b> | <b>45.4%</b> |
|--------------------------------------|-------------|------------|------------|------------|--------------|

### Chapter 3(M): External Appeal Decisions by Health Plan July 1, 1999 – December 31, 2004

The following charts identify the total external appeal results by health plan since the program's inception in 1999 through 2004.

| Health Maintenance Organizations                 | Total        | Overtured    | Overtured in Part | Upheld       | Percentage Overtured or Overtured in Part |
|--|--------------|--------------|-------------------|--------------|---|
| Aetna Health                                     | 190          | 73           | 17                | 100          | 47.4%                                     |
| Atlantis Health Plan                             | 32           | 18           | 2                 | 12           | 62.5%                                     |
| Capital District Physicians' Health Plan (CDPHP) | 55           | 22           | 3                 | 30           | 45.5%                                     |
| CIGNA  | 78           | 33           | 11                | 34           | 56.4%                                     |
| Empire HealthChoice                              | 335          | 147          | 17                | 171          | 50%                                       |
| Excellus (Rochester)                             | 99           | 38           | 1                 | 60           | 39%                                       |
| Excellus (Utica Watertown)                       | 26           | 11           | 2                 | 13           | 50%                                       |
| Excellus (Central NY)                            | 50           | 19           | 6                 | 25           | 50%                                       |
| Excellus (Univera)                               | 150          | 57           | 4                 | 89           | 40.7%                                     |
| GHI HMO Select                                   | 12           | 6            | 1                 | 5            | 58.3%                                     |
| Health Insurance Plan of Greater NY (HIP)        | 135          | 57           | 10                | 68           | 49.6%                                     |
| Health Net of New York                           | 268          | 111          | 22                | 135          | 49.6%                                     |
| HealthNow New York, Inc.                         | 243          | 67           | 15                | 161          | 33.7%                                     |
| Health Plus*                                     | 3            | 1            | 0                 | 2            | 33.3%                                     |
| Independent Health Association (IHA)             | 20           | 6            | 1                 | 13           | 35%                                       |
| MDNY Healthcare, Inc.                            | 24           | 13           | 3                 | 8            | 66.7%                                     |
| MVP Health Plan, Inc.                            | 83           | 38           | 4                 | 41           | 50.6%                                     |
| Oxford Health Plans of New York, Inc.            | 1077         | 326          | 93                | 658          | 38.9%                                     |
| Rochester Area HMO, Inc. (Preferred Care)        | 25           | 15           | 1                 | 9            | 66.7%                                     |
| United Healthcare of New York, Inc.              | 28           | 14           | 0                 | 14           | 50%                                       |
| Vytra Health Plans Long Island, Inc.             | 68           | 30           | 10                | 28           | 58.8%                                     |
| WellCare   | 1            | 0            | 0                 | 1            | 0%  |
| <b>Totals</b>                                    | <b>3,002</b> | <b>1,102</b> | <b>223</b>        | <b>1,677</b> | <b>44.1%</b>                              |

\* Child Health Plus only.

\*\* Plans that are no longer in business have not been included.

| <b>Non-Profit Indemnity Insurers</b>            | <b>Total</b> | <b>Overtured</b> | <b>Overtured in Part</b> | <b>Upheld</b> | <b>Percentage Overtured or Overtured in Part</b> |
|---|--------------|------------------|--------------------------|---------------|--|
| Excellus Health Plan (Central NY)               | 225          | 88               | 16                       | 121           | 46.2%  |
| Excellus Health Plan (Rochester)                | 40           | 16               | 1                        | 23            | 42.5%  |
| Excellus Health Plan (Utica-Watertown)          | 66           | 20               | 3                        | 43            | 34.8%  |
| Group Health, Inc.                              | 389          | 114              | 68                       | 207           | 46.8%  |
| HealthNow New York Inc.                         | 99           | 34               | 6                        | 59            | 40.4%  |
| United Healthcare Insurance Company of New York | 11           | 8                | 0                        | 3             | 72.7%  |
| Vytra Health Services                           | 9            | 5                | 0                        | 4             | 55.6%  |
| <b>Totals</b>                                   | <b>839</b>   | <b>285</b>       | <b>94</b>                | <b>460</b>    | <b>45.2%</b>                                     |

| <b>Commercial Insurers</b>                         | <b>Total</b> | <b>Overtured</b> | <b>Overtured in Part</b> | <b>Upheld</b> | <b>Percentage Overtured or Overtured in Part</b> |
|--|--------------|------------------|--------------------------|---------------|--|
| Aetna Group  | 23           | 3                | 5                        | 15            | 34.8%  |
| Anthem Health & Life Insurance Company of New York | 5            | 2                | 0                        | 3             | 40%  |
| CIGNA Health Group                                 | 72           | 35               | 3                        | 34            | 20%  |
| Continental Assurance Company                      | 1            | 1                | 0                        | 0             | 100%   |
| Empire HealthChoice Assurance, Inc. *              | 785          | 308              | 74                       | 403           |  |
| Equitable Life Assurance Company of America        | 2            | 0                | 0                        | 2             | 0%   |
| First Reliance Standard Life Insurance Company     | 1            | 0                | 0                        | 1             | 0%   |
| GE Global Group                                    | 1            | 0                | 0                        | 1             | 0%   |
| Guardian Life Group                                | 17           | 4                | 3                        | 10            | 41.2%  |
| Guardian Life Group (Dental)                       | 4            | 1                | 1                        | 2             | 50%  |
| Health Net Insurance Company of New York           | 18           | 5                | 4                        | 9             | 50%  |
| Horizon Healthcare Insurance Company of New York   | 41           | 17               | 6                        | 18            | 56.1%  |
| Metropolitan Group                                 | 67           | 32               | 2                        | 33            | 50.7%  |
| Mutual of Omaha Group                              | 5            | 4                | 0                        | 1             | 80%  |

\* Empire HealthChoice, Inc. converted to a for-profit commercial insurer in October 2002. This number includes the appeals conducted while the insurer was a non-profit insurer and a commercial insurer.

|   |             |            |            |            |              |
|---|-------------|------------|------------|------------|--------------|
| New England Life Insurance Company              | 1           | 1          | 0          | 0          | 100%         |
| Nippon Life Insurance Company                   | 3           | 1          | 0          | 2          | 33.3%        |
| Oxford Health Insurance                         | 66          | 25         | 4          | 37         | 43.9%        |
| Phoenix Home Life                               | 1           | 0          | 0          | 1          | 0%           |
| Principal Life Insurance Company                | 1           | 0          | 0          | 1          | 0%           |
| Trustmark Insurance Company                     | 1           | 0          | 1          | 0          | 100%         |
| UniCare Life & Health Insurance Company         | 21          | 5          | 6          | 10         | 52.4%        |
| Union Labor Life Insurance Company              | 3           | 0          | 1          | 2          | 33.3%        |
| United Healthcare Insurance Company of New York | 272         | 119        | 12         | 141        | 48.2%        |
| U.S. Life Insurance Company                     | 1           | 0          | 0          | 1          | 0%           |
| <b>Totals</b>                                   | <b>1412</b> | <b>563</b> | <b>122</b> | <b>727</b> | <b>48.5%</b> |

| <b>Medicaid Managed Care Coverage</b>           | <b>Total</b> | <b>Overturned</b> | <b>Overturned in Part</b> | <b>Upheld</b> | <b>Percentage Overturned or Overturned in Part</b> |
|---|--------------|-------------------|---------------------------|---------------|--|
| Affinity Health Plan                            | 4            | 1                 | 1                         | 2             | 50%  |
| AmeriChoice                                     | 4            | 3                 | 0                         | 1             | 75%  |
| Buffalo Community Health Plan                   | 1            | 0                 | 0                         | 1             | 0%   |
| Capital District Physicians Health Plan (CDPHP) | 2            | 0                 | 0                         | 2             | 0%   |
| CenterCare Health Plan                          | 2            | 0                 | 1                         | 1             | 50%  |
| Community Choice                                | 1            | 1                 | 0                         | 0             | 100%   |
| Excellus (Rochester)                            | 1            | 0                 | 0                         | 1             | 0%   |
| Excellus (Central NY)                           | 1            | 0                 | 0                         | 1             | 0%   |
| GHI HMO Select                                  | 3            | 1                 | 0                         | 2             | 33.3%  |
| Health Insurance Plan of Greater NY (HIP)       | 10           | 5                 | 1                         | 4             | 60%  |
| HealthNow New York                              | 5            | 0                 | 2                         | 3             | 0%   |
| Health Plus                                     | 5            | 0                 | 1                         | 4             | 33.3%  |
| Healthsource/HHP                                | 2            | 1                 | 0                         | 1             | 50%  |
| Independent Health Association (IHA)            | 1            | 1                 | 0                         | 0             | 100%   |
| Fidelis Care New York                           | 17           | 4                 | 0                         | 13            | 23.5%  |
| Oxford  | 1            | 1                 | 0                         | 0             | 100%   |
| United Healthcare of New York                   | 3            | 2                 | 0                         | 1             | 66.7%  |
| Vytra   | 10           | 3                 | 0                         | 7             | 30%  |
| WellCare  | 7            | 2                 | 1                         | 4             | 42.9%  |
| <b>Totals</b>                                   | <b>80</b>    | <b>25</b>         | <b>7</b>                  | <b>48</b>     | <b>40%</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           | 4            | 2                | 0                        | 2             | 50%  |
| Cayuga-Onondaga Area Schools Employees Health Plan     | 2            | 0                | 0                        | 2             | 0%   |
| Jefferson-Lewis School Employees Health Care Plan      | 4            | 0                | 1                        | 3             | 25%  |
| Putnam/Northern Westchester Health Benefits Consortium | 7            | 2                | 0                        | 5             | 28.6%  |
| State-Wide Schools Cooperative Health Plan             | 10           | 4                | 1                        | 5             | 50%  |
| <b>Totals</b>  | <b>27</b>    | <b>8</b>         | <b>2</b>                 | <b>17</b>     | <b>37%</b>                                       |

|                                      |             |             |            |             |              |
|--------------------------------------|-------------|-------------|------------|-------------|--------------|
| <b>Totals For All Coverage Types</b> | <b>5360</b> | <b>1983</b> | <b>448</b> | <b>2929</b> | <b>45.3%</b> |
|--------------------------------------|-------------|-------------|------------|-------------|--------------|

## Chapter 4: Disaster Planning and Preparation

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

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

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

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

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

## Chapter 5: Health Plan Surveys

In 2004, the Department surveyed health plans and asked whether they had any questions or suggested improvements for the New York External Appeal Program. Of the 40 health plans surveyed, 17 health plans did not have comments on the External Appeal Program. Furthermore, 11 health plans stated that they had a favorable experience with the Program. We received the following input from health plans and provided health plans with the following clarifications and explanations:

- Health plans requested clarification as to the timeframe in which a health plan may reverse their adverse determination.
  - ✓ Health plans may reverse their adverse determination at any time during the external appeal process and should notify the Insurance Department and the external appeal agent.
  - ✓ There are also certain times during the external appeal process when a health plan is specifically provided an opportunity to reconsider its denial. If the external appeal request is not expedited, Insurance Department staff will contact the health plan prior to assigning the appeal to an agent and discuss whether the health plan will reverse its denial, providing the health plan 24 hours to consider this option. In some cases the health plan overturns its own denial through this option and review by an external appeal agent is not necessary.
  - ✓ Health plans may also reverse their adverse determination when new information is submitted with an external appeal application. If the appeal is not expedited, the agent must consider whether documentation submitted by the patient or the patient's provider represents a material change from the documentation upon which the health plan based its denial. If the information is material, the agent is statutorily required to forward the information to the health plan and the external appeal is tolled for three business days while the health plan considers the documentation and decides whether to overturn or uphold its adverse determination.
- Health plans requested that external appeal agents include detailed clinical rationale or criteria when the external appeal agent overturns a health plan's adverse determination.
  - ✓ The Insurance Department and Health Department have been working with external appeal agents to ensure that detailed clinical rationale is included.
- Health plans requested that external appeal agents' clinical peer reviewers be health care providers licensed in the same specialty as the insured's provider.
  - ✓ Section 4900 of the New York Insurance Law and Public Health Law permits clinical peer reviewers to be physicians in the same or similar specialty as the health care provider who typically manages the medical condition or provides the health care treatment under appeal. The law further provides that clinical peer reviewers that are not physicians must be in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or provides the health care treatment under appeal.

- Health plans requested that providers not be allowed to obtain designee status prior to services being rendered or denied.
  - ✓ New York Law does not include standards for designation. However, the U.S. Department of Labor Claims Payment Regulation provides that health plans may establish reasonable procedures for determining whether an individual has been authorized to act on behalf on an insured.
- Health plans requested that for a provider's external appeal, when an external appeal agent upholds the plan's denial, the provider should bear the cost of the external appeal instead of the health plan.
  - ✓ Under New York Insurance Law § 4914(d), payment for an external appeal is the responsibility of the health plan. Any change to this requirement would have to be made legislatively.
- Health plans commented that the cost of the external appeal program is occasionally higher than the cost of the claim being appealed.
  - ✓ Under Article 49 of the Insurance Law, the insured or the provider may have the right to appeal a medical necessity, experimental/investigational, or clinical trial denial, irrespective of the cost of such appeal compared to the cost of the disputed health care service.
- Health plans requested that a copy of the physician's attestation be provided to them in external appeals for experimental or investigational treatments.
  - ✓ Under 11 N.Y.C.R.R. § 410.7(e)(4), the Insurance Department does provide the health plan with the physician's attestation when an external appeal for an experimental or investigational treatment is eligible for review.

## Chapter 6: Update of U.S. Supreme Court Review of ERISA Preemption Issue

During the past five years, the Department has continued to provide updates as to developments on both the federal and state level that could impact the New York State External Appeal Program. Last year's report included a discussion of *Aetna Health Inc. et al. v Davila* (02-1845) and *CIGNA Healthcare of Texas, Inc. et al. v Calad* (03-83), two cases that questioned whether state law liability claims could be brought against a health plan for failure to authorize health care treatment, or whether such claims are preempted by ERISA. In 2004, the United States Supreme Court issued its decision in *Aetna Health, Inc. v Davila*, 542 U.S. 200, 124 S. Ct. 2488 (June 21, 2004), finding that state law causes of action against a health plan are preempted by ERISA.

### A. U.S. Supreme Court issued a decision finding that state law causes of action against a health plan are preempted by ERISA

On June 21, 2004, in *Aetna Health, Inc. v Davila*, 542 U.S. 200 the Supreme Court issued a decision, finding that state law liability causes of action against a health plan for failure to authorize health care treatment fall within ERISA § 502(a)(1)(B) and are, therefore, completely preempted by ERISA.

In *Aetna Health Inc. et al. v. Davila*, two individual insureds commenced separate Texas state court suits against their respective HMOs, alleging that their HMOs' refusal to cover certain medical services, on the basis of medical necessity, was in violation of their HMOs' duty to exercise "ordinary care" under the Texas Health Care Liability Act and that those refusals proximately caused their injuries. The HMOs removed the cases to federal district court arguing that the claims were preempted by ERISA. The insureds moved to remand the cases back to Texas state court. However, the federal district court declined to remand the cases, concluding that the insureds were challenging plan benefit determinations and that relief was available exclusively under ERISA so that the cases must be heard in federal court.

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

In 2003, the United States Supreme Court granted certiorari in *Aetna Health Inc. et al. v Davila* and in *CIGNA Healthcare of Texas, Inc. et al. v Calad*. to decide whether the insureds' causes of action were preempted by ERISA. After consolidating the two cases, the Supreme Court issued a decision on June 21, 2004, finding that the insureds' state tort causes of action fell squarely within ERISA § 502(a)(1)(B) and were therefore completely preempted by ERISA and removable to federal court. The Supreme Court held that since the insureds only brought

suit to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and because the insureds did not attempt to remedy any violation of a legal duty independent of ERISA, the state causes of action fell within the scope of ERISA § 502(a)(1)(B) and were therefore completely preempted.

As for New York in particular, the Supreme Court granted certiorari in a similar case, *Vytra Healthcare et. al. v. Cicio*, 124 S.Ct. 29021 (June 28, 2004), and remanded the case back to the United States Second Circuit Court of Appeals for further consideration in light of their decision in *Aetna v Davila*. In *Cicio*, the insured's health plan denied coverage of a stem cell transplant and the United States Court of Appeals for the Second Circuit originally determined that the case was not preempted by ERISA §502 or §514 so that the insured could bring a claim against Vytra Healthcare in state court. On September 23, 2004, the United States Court of Appeals for the Second Circuit vacated their previous decision and affirmed the judgment of the district court, finding that the insured's state law claims were preempted by ERISA in light of the Supreme Court's decision in *Aetna Health Inc. v Davila*.

These cases have attracted widespread interest because they not only impact Texas insureds, but insureds in any other state who may want to sue their health plans. Essentially, the Supreme Court has concluded that federal law precludes patients and their families from suing health plans for damages in state courts.

#### **B. Hawaii Supreme Court invalidated Hawaii's External Appeal Program in light of *Aetna v Davila***

In light of *Aetna Health Inc. v Davila*, the Hawaii Supreme Court invalidated Hawaii's external appeal program in November 2004, holding that the program was preempted by ERISA. (See *Hawaii Management Alliance Association v Insurance Commissioner*, 106 Haw. 21 (Haw. 2004)). In this case, the patient requested an external review after his request for a stem cell transplant was denied as experimental or investigational. In response, the health plan argued that Hawaii's external appeal statute was preempted by ERISA.

The Hawaii Supreme Court found that Hawaii's external review law was impliedly preempted by ERISA's civil enforcement remedy. The Court cited *Aetna v Davila* for the proposition that any state law that creates a claim for relief relating to an ERISA-regulated employee benefit plan conflicts with ERISA § 1132(a) and is therefore preempted. However, the Hawaii Supreme Court distinguished state laws that (1) create a state law claim for relief against an employee benefit plan and (2) those statutes that require insurers to provide certain procedural protections to insureds even if the insurance is provided as part of an ERISA-covered employee benefit plan.

The Court reasoned that Hawaii's external review law conflicted with ERISA § 1132(a) because the external review law resembled adjudication. Hawaii's external review law states that the commissioner shall appoint the members of the panel and shall conduct a review hearing that provides for judicial review of contested cases. The Hawaii Supreme Court noted that the Hawaii statute provides for a three-member panel (only one of whom must be a physician) to determine whether the HMO's actions were "reasonable" compared to the external appeals programs of other states, where a physician determines whether the services are medically necessary. The Court indicated that these distinctions are fatal to the external review law. The Court stated that the Hawaii external review hearing more closely resembles "contract

interpretation or evidentiary litigation before a neutral arbiter" than a practice (having nothing to do with arbitration) of obtaining another medical opinion". In light of the foregoing, the Hawaii Supreme Court held that the external appeal law was impliedly preempted by ERISA.

Representatives of Hawaii contacted the Insurance Department to discuss the New York External Appeal Program. These representatives advised us that after researching state external appeal programs, they are considering using the New York External Appeal Program as a model for Hawaii.

## Chapter 7: Lawsuits Against External Appeal Agents

The role of the external appeal agent in New York is to provide a clinical opinion as to whether the medical treatment requested by the insured and denied by the health plan should be provided in whole or in part, or whether the health plan's denial should be upheld. Section 4914 of the Insurance Law provides that the decision of the external appeal agent is binding on the health plan and the insured, but admissible in court proceedings. The law further provides that external appeal agents shall not be liable in damages to any person for the agent's external appeal decision unless the opinion was rendered in bad faith or involved gross negligence. Despite this statutory requirement, there have been increased incidences when court proceedings have been brought against external appeal agents and the Superintendent of Insurance because an insured has disagreed with the external appeal agent's decision upholding a health plan's denial, even though the insured did not bring an action to recover damages.

In the first proceeding, *Vellios v Superintendent*, 1 Misc. 3d 487 (New York County 2003), the insured commenced an Article 78 proceeding against the Superintendent of Insurance and IPRO, one of New York's certified external appeal agents, seeking to vacate and annul the health plan's decision to deny coverage of a clinical trial for stem cell therapy. IPRO moved to dismiss the petition on the grounds that it was not a proper party to an Article 78 proceeding and even if it were, the petitioner could not meet the arbitrary and capricious standard to sustain a cause of action. The Supreme Court of New York County held that an Article 78 proceeding was the proper vehicle for reviewing IPRO's determination because external appeal agents function in an administrative capacity on behalf of the state. Notwithstanding this, the court granted the Superintendent's motion to dismiss, finding that the Superintendent was not an appropriate party to the proceeding.

In a severed proceeding against IPRO, *Vellios v IPRO*, 1 Misc.3d 468 (New York County 2003), IPRO raised two defenses: (1) that its decision was well-founded with a rational basis because there had been no showing that the procedure was likely to benefit petitioner and (2) that pursuant to Section 4914 of the Insurance Law the determination of the majority of the external reviewers was binding on the insured. In response to IPRO's defense that the external appeal decision is binding, the Supreme Court found that external appeal is merely the end of any administrative appeal, but that does not bar review by a court. The court further questioned the statements of the two IPRO clinical peers who originally upheld the health plan's decision concerning the avoidance of radiotherapy and the use of temozolomidem, carboplatin and thiotepa, and the court determined that the statements could be construed as findings that the petitioner would be likely to benefit from the treatment. Thus, in a decision dated August 20, 2003, the Supreme Court of New York County vacated and annulled IPRO's determination to uphold the health plan's denial of coverage, finding that the costs of the proposed treatment shall be covered by the health plan.

In the second proceeding, *Matter of McBride v Serio et al.*, petitioner commenced an Article 78 proceeding in Nassau County against HAYES Plus, Inc., one of New York's certified external appeal agents, and the Superintendent of Insurance, seeking to vacate and annul HAYES' determination to uphold the health plan's decision to deny lyme disease treatment. Petitioner discontinued this matter against the Superintendent of Insurance. HAYES Plus, Inc. then moved to dismiss the petition on several grounds, including: (1) inconvenient forum; (2) failure to join a necessary party, the health plan; (3) the determination is binding on petitioner

pursuant to Section 4914 of the Insurance and there are no allegations of bad faith or gross negligence; (4) the health plan has an enforceable arbitration clause and (5) petitioner cannot meet the Article 78 arbitrary and capricious standard and the substantial evidence test has been met. Before the motion was argued, a settlement was reached.

In the third proceeding, *Matter of Tatro-Pradt v Serio et al.*, petitioner commenced an Article 78 proceeding in New York County against the Superintendent of Insurance and HAYES Plus, one of New York's certified external appeal agents, seeking to vacate and annul HAYES' determination to uphold the health plan's decision that 24 hours per day of private nursing duty was not medically necessary for petitioner's daughter, but that that 16 hours per day was sufficient. HAYES moved to dismiss the petition on several grounds: (1) petitioner failed to name a necessary party, the health plan; (2) HAYES' determination is binding on petitioner pursuant to Section 4914 of the Insurance because there are no allegations of bad faith or gross negligence; (3) the external review determination is entitled to collateral estoppel or res judicata and (4) petitioner failed to meet the arbitrary and capricious standard for an Article 78 proceeding. The Superintendent also sought dismissal of the petition on the following grounds: (1) petitioner alleged no basis for Article 78 relief against the Superintendent, citing *Vellios*; (2) the external appeal law does not provide for Article 78 review of external appeal agents' decisions and (3) petitioner failed to join a necessary party, the health plan. Defendants also requested that if the petition is not dismissed, this proceeding should be stayed because there is a proceeding pending in the federal Eastern District of New York against the health plan CIGNA on these same issues. See *Tatro v Connecticut General Life Insurance Company*, Civ. #1:04-cv-00811-RJD-RLM (E.D.N.Y.). To date, there has been no decision on defendants' motion to dismiss or on the merits of the case in federal court.

The Departments have several concerns with the increase in lawsuits against external appeal agents. First, the external appeal law specifically provides that external appeal agents shall not be liable in damages unless the opinion was rendered in bad faith or involved gross negligence. It was never intended that external appeal agents would have to defend all of their decisions in court proceedings.

Secondly, the external appeal fees agents charge are approved by the Insurance Department and the Health Department and do not include court costs. Due to the lawsuits, external appeal agents are requesting approval for fee increases in order to accommodate the costs associated with current and future litigation. If such fee increases were to be approved by the Departments, the cost increase would be borne by the individual health plans, and ultimately the insureds of those health plans through premium increases. If the Departments do not approve the fee increases, the external appeal agents may determine that the cost of conducting external appeals in New York is prohibitive, and the agents may ultimately withdraw from the program.

External appeal agents do not have a particular interest to protect by defending their decisions, nor are they the appropriate party to determine how the Insurance Law and Public Health Law should be interpreted in a court proceeding. Such actions could have the unintended effect of undermining the effectiveness and integrity of the external appeal program.

## **Chapter 8: Closing Remarks**

Since the External Appeal Program's inception five years ago, it continues to provide consumers with an effective means to gain access to an independent appeal process to review medical necessity, experimental, investigational, or clinical trial denials. Only through the mutual cooperation of the Health Department, the Insurance Department, providers, health plans and consumer groups has the external appeal program succeeded. The New York External Appeal Program continues to be used as a model for other states' programs and has experienced a higher volume of appeals than most states. The Insurance Department is committed to the External Appeal Program and will continue to work with consumers, providers and health plans to maintain standards of excellence and to ensure that consumers are able to access the critical protections that this program provides.