THE HENRY J. KAISER FAMILY FOUNDATION

Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation

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Table of Contents

List of Exhibits

Executive Summary

External review is a formal process for resolving disputes between health plans and consumers. It has been widely recognized as an important consumer protection, providing a way for disputes to be resolved fairly, expeditiously, and relatively inexpensively. Most states now require external review for some or all of the private health insurers they regulate. Under these state programs, external review generally is independent of disputing parties and has the capacity to evaluate and resolve at least those disputes involving medical issues.

The first state external review requirement was established by Michigan in 1978. Over the next twenty years, a dozen more states began operating external review programs. Recent state activity in the area of external review of health plan decisions has been extensive. By the end of 2001, 42 states, including the District of Columbia, had enacted external review laws,[1] with 27 of them becoming effective in the past 3 years. In addition, the Congress is considering patients' rights legislation that would establish a federal right to external review for all private health plan enrollees. This federal right would extend external review protections to people who are not now subject to state external review programs, including enrollees of self-insured employer health plans (47 percent of all employees with group health coverage), which are exempt from state regulation, and residents of states with no external review laws. Depending on if and how differences between patients' rights bills passed by the House and Senate are resolved, federal legislation could weaken protections in some states but strengthen them in others.

Today, external review programs vary significantly from one state to another in their scope, accessibility, independence, timeliness, and other respects. This report examines key features of state external review programs and how they vary across the states. It also compares these features of state programs to the federal standards that have been proposed. The major findings of this report are as follows:

Consumers are granted relief through external review about half of the time, on average. The rate at which external reviewers overturn health plan denials ranged from a low of 21 percent in Arizona and Minnesota to a high of 72 percent in Connecticut, and averaged 45 percent across all states. In addition, in about half of the states, reviewers have the option of partially overturning health plan denials, which they did, on average, another 6 percent of the time. (See Exhibit A)

Consumers continue to use external review infrequently. In each state reporting external review data, caseloads were very small. For example, in New York, where an estimated 8.4 million residents are covered by the state's external review law, 902

[1] The state of North Carolina passed an external review law as this report was being concluded, so this program is not discussed in this report. The District of Columbia is referred to as a "state" program for the remainder of this report.

Exhibit A. Number and Disposition of State External Review Cases

State	Effective Date	Reporting Period	Cases Accepted	Plan Decisions Overturned	Plan Decisions Modified
Alaska[1]	2001	-	-	-	-
Arizona	1998	2000	282	21%	6%
California	1998	1-9/2001	421	40%	n/a
Colorado	2000	6-12/2000	28	48%	n/a
Connecticut	1998	2000	29	72%	n/a
Delaware[1]	1999	-	-	-	-
District of Columbia	1999	2000	4	67%	0%
Florida	1985	7/00-7/01	223	50%	2%
Georgia	1999	2000	50	63%	n/a
Hawaii	1998	2000	7	50%	0%
Illinois	2000	2000	43	27%	5%
Indiana	1999	2000	20	50%	n/a
Iowa	2000	1/00-9/01	43	42%	3%
Kansas	2000	2000	22	45%	n/a
Kentucky	2000	7/00-9/01	82	47%	n/a
Louisiana[1]	2001	-	-	-	-
Maine	2001	8/00-10/01	32	38%[2]	8%
Maryland	1999	2000	255	67%	6%
Massachusetts	2001	1-9/2001	58	33%	0%
Michigan	1978	10/00-8/01	271	50%[2]	n/a
Minnesota	2000	4-12/2000	28	21%	11%
Missouri	1994	2000	25	52%	12%
Montana	1999	1/00- 9/01	6	40%	n/a
New Hampshire	2000	9/00-9/01	26	43%	10%
New Jersey	1997	1-9/2001	169	39%	13%
New Mexico	1997	7/00-8/01	18	50%	n/a
New York	1999	7/99-6/00	902	38%[2]	12%
Ohio	1998	5/00-4/01	104	37%	11%
Oklahoma	2000	2-12/2000	8	43%	n/a
Oregon[1]	2002	-	-	-	-
Pennsylvania	1991	1/99-9/01	243	44%	0%
Rhode Island	1997	2000	52	69%	-[3]
South Carolina[1]	2002	-	-	-	-
Tennessee	1999	2000	41	44%	n/a
Texas	1997	2000	404	58%	10%
Utah[4]	2001	-	-	-	-
Vermont	1996	2000	10	40%	n/a
Virginia	2000	5/00-10/01	51	60%	0%
Washington[1]	2001	-	-	-	-
West Virginia[1]	2001	-	-	-	-
Wisconsin[1]	2000	-	-	-	-
Total/Average			3,957	45%	6%

[1] States with recent effective dates do not have caseload data to include in this table.

[2] In these states, the overturned rate does not include cases where the plan reversed itself following acceptance of the case for external review but prior to the completion of the process. In Maine, this accounts for 9 of 32, or 28% of the cases accepted for review. In Michigan, this accounts for 46 of 271, or 17% of the cases accepted for review. In New York, this accounts for 169 of 902, or 19% of the cases accepted for external review.

[3] In Rhode Island, partial reversals are reported as upheld denials. Also, providers can independently initiate an external appeal and the presented case volumes include both those cases initiated by consumers and providers.

[4] Utah does not track data on external review cases.

n/a indicates "not applicable" because the state does not provide for modified or partial overturn decisions.

consumers filed for external review in the reporting year ending June 2000 (the most cases of any state). This translates to rate of 10.7 cases per 100,000 – or one percent of one percent – of covered lives. Caseloads and external review rates in every other state, including other large states like California, Florida, and Texas, were much smaller. (See Exhibit A)

Many state external review programs include features that may affect access for consumers. All but one of the states studied require consumers to first exhaust their health plan's internal appeals and grievance process before seeking external review. There is evidence to suggest that many consumers have difficulty navigating this multi-level review process and fail to complete it. In addition, most states don't require health plan denial notices to advise consumers of their external review rights until the internal appeals process is completed. Fourteen states require consumers pay a fee, ranging from $25 to $50, to apply for external review; one state makes consumers pay half of the cost of review. Eleven states have a claims threshold, or minimum amount that must be in dispute before a case is eligible for external review. Thirty-five states have filing deadlines after the health plan's final adverse determination, in most cases two months or less, that consumers must meet in order to be eligible for external review.

Standards for the independence of external review vary. In 27 states, regulators select the external review entity, usually an independent review organization, or IRO. In 14 states, however, the health plan or the enrollee picks the review entity in some or all instances. In addition, in 10 states, the health plan determines when cases are eligible for external review in some or all instances. Seven states require the external reviewer to follow the health plan's definition of medical necessity in rendering his or her decision.

External review timelines also vary. All states establish timeframes for their external review programs. However, time limits vary, as does the way time is counted during the process. In 15 states, timelines are measured in calendar days; in 15 others, timelines are measured in business days; and in 11 states, timelines are comprised of both calendar and business days. External reviewers may be given anywhere from 5 days to 60 business days to render a decision. In addition, depending on the state, more time can be allotted for screening external review applications, assembling completed case files, and transmitting the external reviewer's determination. All states provide an expedited process for urgent or emergency cases. Generally such reviews must be completed in 72 hours or less, as medical exigencies indicate, although in 10 states, the timeline for expedited external review is 5 days or longer.

External review is almost always binding. Under all state programs, external review is a statutory right and must be offered to enrollees. In all but 3 jurisdictions, the health plan must abide by the external review decision.

Proposed federal standards for external review programs go beyond what states have enacted in many important respects, but in other instances are less protective of consumers. Congress is considering two bills to establish a federal "Patients' Bill of Rights." As is discussed further below, both bills would have implications for state

external review programs; the Senate bill would set a minimum standard for external review that could preempt weaker state programs, while the House bill would set a single standard to preempt all state programs. Aside from this key difference, provisions in the two bills are similar in most respects. Both bills would establish a federal right to independent external review of health plan denials for consumers in all types of health plans, including self-insured employer plans currently exempt from state regulation. In addition, the two bills are almost identical in the scope of what would be eligible for external review and in standards they would set for accessibility, timelines, and independence of the process.

Several provisions of proposed federal legislation – relating to limiting barriers to access, improving consumer notice, expanding eligibility, and protecting the independence of the external review process – go beyond what many states have enacted. For example, under the proposed federal standards, consumers would be required to spend less time in a plan's internal appeals process before accessing external review than is the case in most states today. On several other provisions, however, most states are more protective than proposed federal standards. In particular, the majority of states do not impose filing fees for external review, as federal standards would do. (See Exhibit B)

How a federal standard would work in practice, however, is unclear. Two different approaches are being discussed with respect to preemption of state programs. The Senate-passed patients' rights bill (S. 1052) seeks to establish a floor that would preempt state external review programs that do not meet federal standards, but preserve state programs that meet or exceed federal standards. The House-passed bill (H.R. 2563), by contrast, seeks to preempt all state programs – those that fall below, meet, or exceed federal standards. Under either bill, however, it is not clear how federal preemption standards would work in practice.

Preemption language in the Senate bill directs the Secretary of Health and Human Services to evaluate state patient protection laws – including external review – to determine whether they "substantially comply" with federal standards. The Senate bill directs the Secretary to give deference to states' interpretation of their own laws and how they comply with federal requirements. Further, the bill would give the Secretary 90 days to carry out his review. If the Secretary fails to make a timely determination, the state law is automatically deemed to substantially comply. These provisions in the Senate bill leave open the possibility that significant variation in state external review programs could persist, including the continuation of some state program features that fall below federal standards.

The House-passed bill, on the other hand, intends to preempt all state laws relating to internal and external review. However, the House bill does not specify a new preemption standard for external review; rather, the bill references existing preemption language in the federal law known as the Employee Retirement Income Security Act which has long been a source of conflicting judicial interpretation over the extent to which it limits the ability of states to regulate employer-provided health insurance. Therefore, it is questionable whether the House bill would, in fact, preempt state external review.

Exhibit B. Comparison of State Program Features to Pending Federal Standards[1]

Proposed Federal Standard	Number of States with Weaker Features	Number of States with Equivalent Features	Number of States with Stronger Features	Number of States Where Comparison is Ambiguous
Scope				
All health plans	13	28	0	0
Only disputes involving medical necessity	4	27	8	2
Accessibility				
Limit internal review process to 21 days for prior authorization cases	39	0	2	0
Filing fee of $25	5	10	27	0
No claims thresholds	11	31	0	0
Filing deadline of 180 days	28	5	9	0
Notice required in health plan information	2	39	0	0
Notice required in the initial denial letter	30	11	0	0
Independence				
Plan accepts application	0	20	21	0
IRO determines eligibility	8	8	23	2
Disputing parties may not select review entity	14	27	0	0
Reviewer may only uphold or reverse (House bill)	0	14	22	5
Reviewer may uphold, reverse, or modify (Senate bill)	15	22	0	4
Reviewer not bound by the plan's medical necessity definition	7	34	0	0
Timely resolution				
Prior authorization cases within 21 days	40	1	1	0
Expedited review within 72 hours or sooner, as medically indicated	27	9	4	1
Binding on plan	3	38	0	0

[1] Rows sometimes do not sum to 41 because 2 states (Vermont and Minnesota) have separate external review programs for mental health services. These programs are counted separately in rows where the mental health program feature differs from that in the state's other, non-mental health external review program. For example, Vermont's mental health external review program does not have a claims threshold, but Vermont's external review program for other services does. Each program is counted separately in that row.

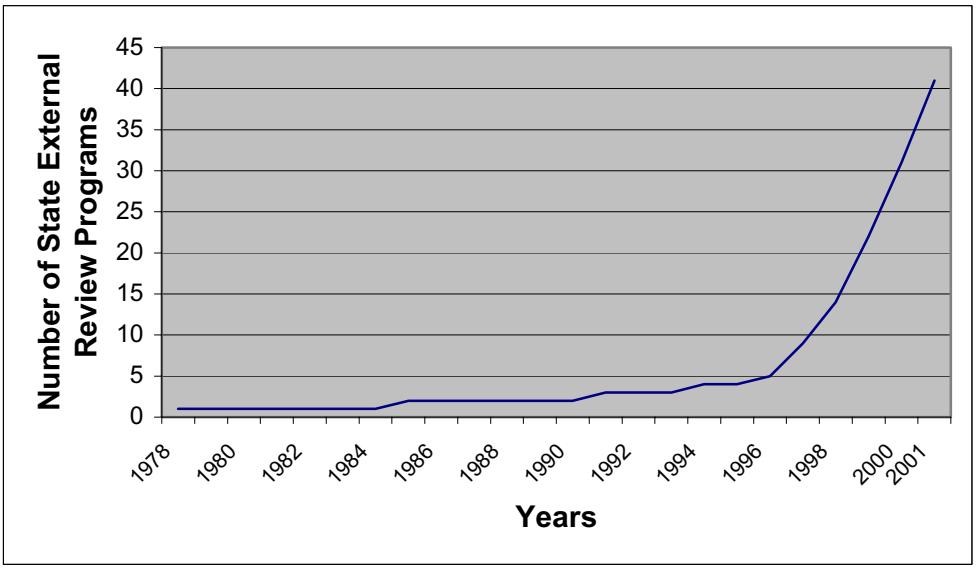
Even if the preemption language in the House bill is clarified, other questions as to the practical impact of the House bill remain. While a federal system for appealing health plan denials could raise to a consistent floor the multiplicity of state appeals systems that exist today, it would also restrict greater protections enjoyed by some consumers in some state programs. Furthermore, it is not clear that a common system would result from the House-passed bill. The bill directs that some significant administrative responsibilities would be carried out by health plans (accepting external review applications, collecting consumer fees, contracting with external review entities). In practice, therefore, some aspects of external review could vary from health plan to health plan under the proposed House standard.

I. Introduction

A common government response to public concern about the fairness of health plan decisions has been to establish external review programs. These are formal dispute resolution processes, independent of the disputing parties, which can expertly and fairly resolve disagreements over the medical necessity of health care treatments and services, and, sometimes, other types of disputes. Generally, external review follows any internal appeals processes that health plans (or states) might require.

States have passed external review laws for the health plans they regulate in the individual and group insurance markets.[2] The number of state external review programs has grown considerably in recent years. (See Exhibit 1) Michigan was the first state to establish such a program in 1978. By 1998, 17 states had passed external review laws (although not all programs were operational in that year). Over the next three years, the number of states with external review programs more than doubled. By the end of 2001, 42 states, including the District of Columbia, had enacted external review laws.[3]

Exhibit 1.
Number of State External Review Programs, 1978-2001



A federal law, known as the Employee Retirement Income Security Act, or ERISA, prevents states from regulating self-insured employer health plans and sometimes preempts state regulation of fully insured employer group health plans. Approximately 47% of covered workers are enrolled in self-insured employer health plans and therefore

[2] Medicare and Medicaid enrollees have different mechanisms for external appeals (as do federal and Congressional employees) that are not addressed in this report.
[3] In this report, the District of Columbia's program will be referred to as a "state" program. As this report was being concluded, North Carolina passed an external review law that will take effect on July 1, 2002. Features of North Carolina's program are not described in this report.

are not eligible for the external review process required under state laws.[4] There is little dispute that self-insured employer health plans are exempt from state external review programs under ERISA. But conflicting interpretations of ERISA's scope have raised some questions about whether state external review laws apply to fully insured group health plans. At this writing, this question is pending in the U.S. Supreme Court.[5] In addition, the Congress is considering legislation to establish a federal right to external review for all private health plan enrollees.[6]

This report looks at the use of state-mandated external review programs and their decisions. It also describes and contrasts key structural features of state programs, and analyzes them in light of pending federal legislation that could modify these programs or supercede them altogether. Information for this report was gathered through interviews with senior regulatory officials who administer or oversee external review programs in every state, and by analysis of state laws and regulations. This is the third look at state external review programs that the Institute for Health Care Research and Policy has conducted for the Henry J. Kaiser Family Foundation since 1998.[7]

[4] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2001 Annual Survey,* September 2001.
[5] Rush Prudential HMO, Inc. v. Moran, 230 F.3d 5959 (7th cir. 2000), *cert. granted*, 121 S. Ct. 2598. (U.S. June 29, 2001) (No. 00-1021).
[6] Stephanie Lewis, "A Guide to the Federal Patients' Bill of Rights Debate," prepared for Kaiser Family Foundation, August 2001.
[7] "External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare," November 1998; and "External Review of Health Plan Decisions: An Update," May 2000. These reports are available on the Kaiser Family Foundation web site at http://www.kff.org. See also a joint Foundation/Consumers Union report, "Consumer Guide to Handling Disputes With Your Health Plan," November 2001, at the same website.

II. Consumer Use of Appeals Processes and Disposition of Cases

As our 1998 report found, consumers today are granted relief through external review about half of the time, on average. The rate at which external reviewers overturn health plan denials ranged from a low of 21 percent in Arizona and Minnesota to a high of 72 percent in Connecticut and averaged 45 percent across all states. In addition, in about half of the states with external review programs, reviewers have the option of partially overturning health plan denials, which they did, on average, another 6 percent of the time. (See Exhibit 2)

In some states, the overturn rate includes a significant number of cases where the health plan reversed its denial after the external review process was initiated, but before it was completed. In Florida, for example, regulators encourage the disputing parties to negotiate before and during the external review process. Of the 223 cases that the state accepted for external review in the last year, 66 (almost 30 percent) resulted in the insurer reversing its denial prior to the external review hearing. More than one state regulator reported that this happens because the external review process involves a more careful and comprehensive compilation of information than sometimes occurs during the health plan internal appeal process. In this respect, external review can offer the first opportunity for plans to see all the relevant information about a case, including a broad literature review or a careful review of the medical evidence.

Some other states do not track data on these "settled" cases. Yet others, such as New York, Michigan, and Maine, track such cases but do not include them as cases overturned by the external review process. In those three states, "settled" cases accounted for between 17 and 28 percent of all cases that entered external review during the most recent reporting period.

These findings suggest that consumers should pursue external appeal rights when they believe their health plan has inappropriately denied coverage. Nonetheless, they seldom do. In all state external review programs, caseloads are strikingly low. New York's program handled the largest volume of cases in any state; 902 cases were accepted for external review in the most recent reporting year. This translates to a rate of 10.7 cases per 100,000 insured lives in that state. Caseloads and external review rates in every other state, including other large states like California, Florida, and Texas, were much smaller.

Taken at face value, these numbers might suggest either that consumers experience very few denials by their health plans or that health plans are finding ways to effectively resolve disputes with consumers before they reach external review. However, other evidence suggests that this may not be the case.

Consider the findings of a recent national survey of consumer experiences with health plans.[8] When asked if they have personally had any problems with their health plan in

[8] Kaiser Family Foundation and Harvard School of Public Health, *National Survey on Consumer Experiences With and Attitudes Toward Health Plans*, August 2001.

Exhibit 2. Number and Disposition of State External Review Cases

State	Program Effective Date	Reporting Period	Cases Accepted[1]	Cases Completed	Plan Decisions Overturned	Plan Decisions Modified
AK[2]	2001	-	-	-	-	-
AZ	1998	2000	282	265	21%	6%
CA	1998	1-9/2001	421	353	40%	n/a
CO	2000	6-12/2000	28	27	48%	n/a
CT	1998	2000	29	29	72%	n/a
DC	1999	2000	4	3	67%	0%
DE[2]	1999	-	-	-	-	-
FL	1985	7/00-7/01	223	218	50%	2%
GA	1999	2000	50	49	63%	n/a
HI	1998	2000	7	2	50%	0%
IL	2000	2000	43	41	27%	5%
IN	1999	2000	20	20	50%	n/a
IA	2000	1/00-9/01	43	38	42%	3%
KS	2000	2000	22	22	45%	n/a
KY	2000	7/00-9/01	82	75	47%	n/a
LA[2]	2001	-	-	-	-	-
ME	2001	8/00-10/01	32	13	38%[3]	8%
MD	1999	2000	255	255	67%	6%
MA	2001	1-9/2001	58	39	33%	0%
MI	1978	10/00-8/01	271	220	50%[3]	n/a
MN	2000	4-12/2000	28	28	21%	11%
MO	1994	2000	25	25	52%	12%
MT	1999	1/00- 9/01	6	5	40%	n/a
NH	2000	9/00-9/01	26	21	43%	10%
NJ	1997	1-9/2001	169	132	39%	13%
NM	1997	7/00-8/01	18	9	50%	n/a
NY	1999	7/99-6/00	902	659	38%[3]	12%
OH	1998	5/00-4/01	104	100	37%	11%
OK	2000	2-12/2000	8	7	43%	n/a
OR[2]	2002	-	-	-	-	-
PA	1991	1/99-9/01	243	219	44%	0%
RI	1997	2000	52	52	69%	-[4]
SC[2]	2002	-	-	-	-	-
TN	1999	2000	41	41	44%	n/a
TX	1997	2000	404	404	58%	10%
UT[5]	2001	-	-	-	-	-
VT	1996	2000	10	10	40%	n/a
VA	2000	5/00-10/01	51	43	60%	0%
WA[2]	2001	-	-	-	-	-
WV[2]	2001	-	-	-	-	-
WI[2]	2000	-	-	-	-	-
Total/Average			3,957	3,424	45%	6%

[1]Because many state programs limit the scope of disputes that are eligible for external review and/or impose other eligibility requirements, not all consumers who apply for external review may have their cases accepted. See below in report for discussion of scope and other eligibility issues.

[2]Some states with recent effective dates do not have caseload data to include in this table.

[3]In these states, the overturned rate does not include cases where the plan reversed itself following acceptance of the case for external review but prior to the completion of the process. In Maine, this accounts for 9 of 32, or 28% of the cases accepted for review. In Michigan, this accounts for 46 of 271, or 17% of the cases accepted for review. In New York, this accounts for 169 of 902, or 19% of the cases accepted for external review.

[4] In Rhode Island, partial reversals are reported as upheld denials. Also, providers can independently initiate an external appeal, and the presented case volumes include those cases initiated by both consumers and providers.

[5] Utah does not track data on external review cases.

the past year, 22 percent of respondents cited problems with billing or payment for services, 14 percent cited problems with the plan not covering a particular treatment or service, 7 percent cited delays in receiving care or treatment, and 6 percent cited being denied care or treatment. While not all of these problems might be addressed by external review in all states, these findings imply that consumers are experiencing problems in far greater numbers than the caseloads of state external review programs indicate.

Further, it appears that many more consumers are challenging health plan denials, at least initially, than are reaching the external appeals process. In most states, consumers are required to exhaust their health plan's internal appeal process – usually a two-stage process – before they are allowed to apply for external review. To learn how well health plans are resolving consumer disputes, several states have begun to collect data on stages of the appeals process that precede external review. Collection of this information has been problematic in some states. Regulators observe that it is self-reported by health plans, and therefore can be difficult to verify and make consistent. For example, some plans may report denial and appeals data on all enrollees, including those in self-insured employer plans, instead of just enrollees subject to state regulatory jurisdiction.

Even so, across the states that collect this information, a pattern emerges. (See Exhibit 3) Appeals of medical necessity denials initiated in these states numbered in the thousands to tens of thousands. While health plans reversed their own decisions on appeal in a significant number of cases, in 5 of the 7 states, health plans upheld a majority of their denial decisions at every level of appeal. Yet, the number of consumers applying for external review in each state numbered in the dozens to hundreds. At each stage of the process, a substantial proportion of consumers do not challenge adverse decisions by their health plans. For example, in Pennsylvania, from January 1999 through September 2000, consumers appealed almost 8,200 health plan denials. Health plans upheld 4,469 denials at the first level of appeal, but only 1,062 consumers filed level 2 appeals. At level 2, health plans upheld 618 denials, but only 124 consumers filed for external review.

Some state officials expressed concern that consumers may become discouraged with this multi-level process and give up before they reach external review. One regulator worried that plans don't actively encourage consumers to pursue internal appeals. She also observed consumers can feel intimidated in the internal appeals process because plans control its timing, setting, agenda, and participants, sometimes frustrating consumer efforts to plead their case. Finally, other regulators commented that during the internal appeals process, patients' doctors are not always as helpful as they might be in documenting the medical need for services. In some cases this information isn't fully assembled until the external appeal case is filed. In addition to conducting audits of activity at the first and second levels for all health plans, Pennsylvania regulators are auditing some health plan appeal programs in response to complaints that such programs are structured to inhibit consumer participation.

Exhibit 3. What Happens to Consumer Disputes Before the External Review Process?

State	Plan Denials	Internal Plan Appeals				External Review		Source
		Level 1 Appeals	Upheld	Level 2 Appeals	Upheld	External Review Cases Accepted	Upheld	
AZ	…	8,025	3,272 (41%)	2,744	1,362 (50%)	282	194 (73%)	Health Care Appeals Report, Arizona Department of Insurance, December 2000. Data reported by 185 health insurers responding to departmental survey. Reporting period is July 1,1999 to June 30,2000.
CT	74,721	4,509	…	…	2,538 (56%)	29	8 (28%)	Denials and appeals reported to Department by utilization review companies. Reporting period is calendar year 2000. Department does not track each level of internal appeal.
MD	…	4,545	…	…	2,042 (45%)	255	69 (27%)	The Maryland Insurance Administration's 2000 Report on the Health Care Appeals and Grievance Law, February 2001. Upheld denials include 221 cases, eligible for external review, where plan partially upheld its denial. Reporting period is calendar year 2000. Department does not track each level of internal appeal.
NJ	…	3,826	2,728 (71%)	935	611 (65%)	147	72 (49%)	Department of Health and Senior Services information on utilization management appeals collected from HMOs. Note data is self reported by HMOs and not audited by the department. Reporting period is 1999.
NY	…	25,527	13,810 (54%)	…	…	910	462 (51%)	2001 New York Guide to Health Insurers, New York Departments of Insurance and Health. Report does not track each level of internal appeal. Reporting period is calendar year 2000.
PA	…	8,196	4,469 (55%)	1,062	618 (58%)	124	68 (55%)	Act 68 Complaint and Grievance Activity, Pennsylvania Department of Health, February 12, 2001. unpublished. Reporting period is January, 1999 – September, 2000
RI	10,274	5,427	1,764 (33%)	732	491 (67%)	52	16 (31%)	2000 Rhode Island Utilization Data, Rhode Island Department of Health. Unpublished.

[1] Uphold rate is the rate at which health plan decisions are upheld on appeal, and is calculated based on number of cases completing (not entering) external review. Note that for various reasons, the reporting period for the most recent internal appeals data available does not track that for external review in New Jersey, New York, and Pennsylvania. In this exhibit for these 3 states, external review caseloads are reported for the same period that internal appeals data were collected, and so do not match the information presented in Exhibit 2.

Data from an organization that assists consumers echo these concerns. The Patient Advocate Foundation (PAF) helps seriously ill consumers nationwide when their health plans deny health services. The PAF assists approximately 29,000 consumers annually. Most PAF clients are in search of outside assistance, having abandoned other formal appeals channels they could not navigate on their own. A sample of PAF logs indicated that 51 percent of clients approached the organization having tried no more than one level of health plan appeals; another 29 percent tried the second level of plan appeal; and only 20 percent tried a third (or higher) level of appeal on their own.[9]

Taken together, these findings suggest that the internal appeals process is too lengthy and difficult for most consumers to complete, and may result in the very low use of external review observed in every state. Congress is considering "Patients' Bill of Rights" legislation to establish new, federal standards for health plan internal appeals. Under these standards, only a single level of internal appeal would be required of consumers, and the amount of time consumers would be required to participate in internal appeals would be limited. If enacted, this standard could streamline existing appeals programs that currently pose a barrier to consumers seeking external review.

[9] Correspondence from Nancy Davenport Ennis, Executive Director, Patient Advocate Foundation, September 26, 2001.

III. Structural Features of External Review Programs That May Affect the Ability of Consumers to Seek Consumer Review

Some state external review programs have specific features that may hinder some consumers from exercising their appeal rights. Certain states have also recognized that many consumers may need help in resolving their health care problems and have created consumer assistance programs to facilitate the use of external review and otherwise simplify navigation of the health insurance system for individuals. This section reviews features of state external review programs that may make them more or less accessible to consumers. [10]

Scope

One factor affecting whether consumers avail themselves of external review programs relates to whether the program handles their type of plan or their type of dispute. The scope of what is eligible for external review varies considerably across state programs. (See Exhibit 4) Because of these differences in scope, consumers' problems that could be resolved by external review in one state may not be eligible in another.

In 28 states, enrollees of all insured health plans have access to external review.[11] In 12 states, however, only managed care plan enrollees are eligible for external review. Eligibility also depends on other health plan characteristics. No state external review programs are available for enrollees of self-insured employer health plans. In Alaska, external review does not apply to enrollees of individually purchased health plans. Dental plan enrollees are explicitly included under Maryland and Arizona's external review law, but specifically excluded under Indiana's or Iowa's.

In 9 states, denials of coverage and authorization for services based on any reason can be appealed to the external review program. In 32 states, only denials based on medical necessity (or other clinically-based reasons) are eligible for external review. In almost all of these states, scope also includes disputes regarding experimental and investigational treatments. Most of these 32 states have a separate process, distinct from the external review process, for reviewing non-medical necessity denials, for example, denials based on whether the consumer was, in fact, enrolled in the health plan.[12]

Some states that confine scope to medical necessity denials have clarified further the types of disputes that may or may not be eligible for external review. In New York, for example, medical necessity denials encompass plan determinations that a service is cosmetic, custodial, or purely for the patient's convenience, but do not include determinations that a service was for a pre-existing condition or disputes over whether a health plan enrollee needs to seek care outside of the plan's network. In Maine, New

[10] Utah is currently drafting regulations for external review process. Information concerning Utah reflects the most recent draft of proposed regulations.

[11] In some of these states, such as New Jersey, health plans that employ some utilization management programs or activities are subject to external review.

[12] For further discussion of the difference between medical necessity denials and other types of disputes, see "External Review of Health Plan Decisions: An Update," May 2000, at www.kff.org.

Hampshire, and Vermont, however, pre-existing condition determinations are eligible for external review. In New Hampshire and Vermont, denials of access to out-of-network care are also eligible for external review.[13]

Three states (California, Connecticut, and Texas) will not review denials of non-emergency care that has already been delivered, even if that retrospective denial is made on the basis of medical necessity.[14] In California, 10 percent of all requests for external review are ineligible because of this limitation in scope, although regulators did note that some of these cases might also have been ineligible for other reasons.

Two other states limit the scope of external review for denials of experimental or investigational therapies. In Georgia, such disputes are only reviewable in cases of terminal illness, while in South Carolina the patient must have a life-threatening or severely disabling condition.

Exhibit 4. Scope of State External Review Programs

Program Feature	States	Comments
Types of health plans subject to external review:		
All health plans	AZ, CA, CO, DC, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, OH, NJ, NY, OR, RI, SC, TX, UT, VT, VA, WA, WI	In Iowa and Indiana, external review does not apply to dental-only plans, but in Maryland and Arizona, it does.
Managed care plans only	CT, DE, FL, GA, HI, IL, NH, NM, OK, PA, TN, WV	
Other limits on types of plans	AK	Only managed care plans providing group health coverage
Types of disputes eligible for external review:		
All denials	AZ, FL, GA, HI, KY, MI, MN, OH, WA	
Only denials based on medical necessity	AK, CA, CO, CT, DE, DC, IL, IN, IA, KS, LA, ME, MD, MA, MO, MT, NH, NJ, NM, NY, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WI, WV	
Other limits on scope	CA, CT, TX	No retrospective denials (In CA and CT retrospective denials of emergency care and urgent care cases are eligible for external review)
	GA	Experimental therapy disputes only in cases of terminal illness
	SC	Experimental therapy disputes only in cases of life-threatening or seriously disabling condition

[13] In Vermont, disputes over pre-existing conditions would have to involve a medical issue, such as when the onset of the condition occurred, in order to be eligible for external review. Denials of out-of network care would have to involve a dispute over whether adequate care was available in-network.

[14] In Texas, retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

Notice

The timeliness and adequacy of notice about the right to external review is another important feature in state programs. Consumers who are unaware of appeal rights cannot be expected to exercise them. All state external review laws include some notice provisions, but the extent and specificity vary. (See Exhibit 5)

Exhibit 5. Notice Requirements in State External Review Programs

Program Feature	States
Notice required in plan enrollment information or member handbook	
Yes	AK, AZ, CA, CO, CT, DE, DC, FL, HI, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MO, MT, NH, NJ, NM, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, WI
No	GA, KS
Notice required in denial letter?	
Yes	AK, AZ, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NH, NJ, NM, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, WI
No	
When is external review notice first required?	
Initial denial letter	AZ, CA, CT, IN, MA, MI, NJ, NY, SC, TX, WI
Final denial letter	AK, CO, DE, DC, FL, GA, HI, IL, IA, KS, KY, LA, ME, MD, MN, MO, MT, NH, NM, OH, OK, OR, PA, RI, TN, UT, VT, VA, WA, WV

Almost all states require health plan enrollment materials to include information about external review rights. Typically, these requirements also specify that notice must be in clear, understandable language. Because consumers may not always read or retain these enrollment materials, however, most states require subsequent notice of external review rights.

Health plans generally must notify consumers in writing of adverse determinations and to include in that written notice the rationale for the denial, an explanation of the right to external review, and procedures on how to initiate the appeal. Eleven states require plans to notify enrollees of their appeal rights, including external review, in the initial denial letter. However, in 30 states, only the final adverse determination notice (conveying the internal appeals process decision) must give notice of the right to external review. When notice is timed this way, it may fail to reach most consumers because most do not complete the internal appeals process.

Seven states and the District of Columbia require the notice letter to include forms needed to initiate an external review. Other states just require inclusion of contact information where consumers can request an appeal. West Virginia is the only state that requires mention of the party responsible for the cost of external review in the denial letter.

Some states explicitly require the notice to be displayed prominently in large-size type and written in a format and language that can be easily understood by a person with an eighth-grade reading level. In South Carolina, for example, the notice must achieve a score of no lower than 70 on the Flesch Reading Ease Test[15] and must be printed in no smaller than 12-point type.

In addition to these notice requirements, many states have adopted other practices to raise public awareness about external review. Colorado, for example, produces and distributes a brochure called, *"What to Do When Your Health Insurance Says No."* Many other states also publish pamphlets and flyers and distribute them as broadly as possible.

The Managed Care Ombudsman in Connecticut coordinates a comprehensive public education outreach program to educate consumers of the existence of the appeals procedure. This program includes, among other things, the production and dissemination of information through mass media, interactive approaches, and a variety of written materials. Connecticut also put into service a 211 access number as a recent initiative to broaden consumer/provider education efforts of the review process. Ombudsman programs in seven other states engage in extensive public education activities relating to external appeal rights.[16]

The Massachusetts Department of Public Health publicizes their external review program through links such as the Massachusetts Hospital Association's web site. Several states, including New Jersey, New York, Ohio, and Michigan provide consumer information on the regulatory agency's web page. In a unique approach, Virginia advertises in movie theatres to educate consumers of their right to external review. Also, under The Health Law Project, Virginia regulators have formed a partnership with the Virginia Bar Association to disseminate information to the legal community regarding the right to external review in that state. In California, through its Office of Patient Advocate, the Department of Managed Health Care sponsors a wide-ranging advertising campaign. This includes primetime television ads for the Department's toll-free hotline, which provides information about external review and other protections.

Other Consumer Assistance

A number of states provide additional, hands-on assistance to consumers seeking external review, helping them to navigate the process and, in some cases, to prepare their appeal.

When consumers need assistance navigating the appeals process, the Vermont Office of Health Care Ombudsman can help them from beginning to end. The Ombudsman offers comprehensive consumer services, including legal representation when necessary. Maryland's Attorney General operates a Health Education and Advocacy Unit (HEAU) that also assists consumers through the external review process. In the experience of both these programs, intervention by the ombudsman can help clarify misunderstandings between consumers and health plans and sometimes results in resolution of problems

[15] This test rates text on a 100-point scale. The higher the score, the easier it is to understand. Below 30 is very difficult; above 80 is quite easy.

[16] Families USA, "Consumer Health Assistance Programs: Report on a National Survey," June 2001.

informally. When a formal appeal is pursued, the ombudsman guides consumers through each step of the process, sometimes acting or speaking on their behalf, so their interests are represented as effectively as possible. California's Department of Managed Health Care runs an independent ombudsman program known as the Office of the Patient Advocate. Among the other external review states, publicly funded consumer health assistance programs have also been established in Florida, Georgia, Maine, and Texas.

In states without consumer ombudsman programs, regulators may try to provide some degree of consumer assistance, for example, explaining what information and documentation must be assembled, and even helping consumers obtain this from their health plans and providers. In the end, however, regulators must maintain a greater degree of impartiality than ombudsman programs, which expressly advocate on behalf of consumers.

Additional Factors That Affect Access

Other features of State external review programs may affect access for consumers. (See Exhibit 6) These include:

- **Exhaustion of internal plan appeals**
  As noted earlier, a key factor that limits access to external review is the requirement that consumers must go through a health plan's internal complaint and appeals process before being eligible to request an external review. All states except Missouri, which only requires a consumer to receive an adverse determination (denial letter), require consumers to exhaust the internal complaints and appeals process. [17] In half of the states, however, exceptions or time limits apply. Exceptions include: cases of emergency or urgent care; cases where the health plan has not followed statutory procedures for issuing a determination; and cases where both parties have agreed to waive the internal exhaustion requirement. In states that limit the time consumers must spend in the internal appeals process, these limits range from 18 business days to 90 calendar days. Two states limit the stages of internal appeal that consumers are required to exhaust. Vermont's mental health external review process requires consumers to complete only one level of health plan appeal before they can apply for external review. New York also requires completion of only the first level of internal appeal. However, health plans in New York are permitted to have two or more internal appeal levels, and consumers who remain in the plan system beyond the first appeal are likely to miss the filing deadline for external review and, thus, become ineligible for this protection

- **Consumer fees**
  Most states that operate external review programs do not allow consumers to be charged to request an external review. However, in 10 states, consumers can be charged a filing fee of $25, and in 4 other states, consumers can be charged $50. In Tennessee, consumers seeking external review can apply to their health plan or

[17] In practice, in Missouri, most eligible consumers do complete the internal review process before proceeding to external review.

directly to the state; they pay a $50 fee only when they apply through the plan. Rhode Island requires the consumer to pay half of the cost of the external review.

Most states that allow filing fees provide for them to be waived in cases of financial hardship or for other showings of good cause. In 6 states (including Rhode Island), consumer fees are refundable if the enrollee wins the external review.

- **Claims thresholds**
  A claims threshold is the minimum amount that must be in dispute before a case is eligible for external review. Most states do not have claims thresholds. In the 11 states that do, the threshold ranges from $100 to $1,000.

- **Filing deadlines**
  Thirty-five states have imposed filing deadlines. Consumers in these states must file for external review within a limited time following the health plan's final adverse determination. For a standard case, state filing deadlines range from 15 days to one year. Twenty-four states have filing deadlines from 30 days to 60 days. In Pennsylvania, the enrollee has 15 days, from receipt of the final denial letter, to request an external review. In New Mexico, a grievant must file a request for external review within 20 business days from receipt of the final denial letter; however, regulators may allow an extension of time for good cause. Most states maintain a separate deadline for requesting an expedited review. For example, in Arizona, a consumer has only 5 days from completion of the internal review process and receipt of the final notice of the denial to request an external expedited review. The 6 states that have no filing deadline are: Georgia, Minnesota, Missouri, Montana, Texas, and Washington. In addition, Vermont does not impose a filing deadline for mental health and substance abuse appeals.

State External Review Programs for Mental Health Claims

Two states, Vermont and Minnesota, have separate external review processes for denials of mental health and substance abuse treatment. Neither state imposes the same barriers to access that apply to external review of other kinds of health services.

Vermont's mental health program pre-dates the broader external review program. Consumers seeking review of mental health care denials are not required to meet a filing deadline, pay a fee, or meet a claims threshold, but they are required to exhaust the internal appeals process.

Minnesota's attorney general recently established a new external review process for denials of adolescent mental health and substance abuse treatment. Pursuant to a settlement with health plans sued by the state for wrongfully denying such services, plans must automatically forward these denials for external review. Outside experts must complete their binding review in 72 hours. No fees or other consumer barriers apply.

Exhibit 6. Additional Factors That Affect Access to State External Review Programs

Program Feature	Yes	No
Exhaustion of internal plan appeals required?	AK, AZ[1], CA[1], CO[1], CT, DE[1], DC[1], FL[1], GA, HI[1], IL[1], IN, IA, KS[1], KY[1], LA, ME[1], MD[1], MA[1], MI[1], MN, MT[1], NH, NJ[1], NM[1], NY[1], OH[1], OR, OK, PA, RI, SC, TN, TX, UT, VT (mental health)[1], VT (non-mental health), VA, WA[1], WV, WI	MO[2]
Consumer charged a fee to request external review?	**$25:** CT, IN, IA, KY, MA, MN, NJ, PA, VT (non-mental health), WI **$50:** NY, OK, TN,[3] VA **Other:** RI (½ of predetermined cost of review).	AK, AZ, CA, CO, DE, DC, FL, GA, HI, IL, KS, LA, ME, MD, MI, MO, MT, NH, NM, OH, OR, SC, TX, UT, VT (mental health), WA, WV
Is there a minimum $ amount that must be in dispute (Claims Threshold)?	GA, KY, NH, OH[4], OK, SC, TN, VT (non-mental health), VA, WV, WI	AK, AZ, CA, CO, CT, DE, DC, FL, HI, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MO, MT, OR, NJ, NM, NY, PA, RI, TX, UT, VT (mental health), WA
Do consumers have limited time to request external review (Filing Deadline)?	**> 180 days:** FL, ME **180 days:** AK, CA, NH, OR, UT **< 180 days:** AZ, CO, CT, DE, DC, HI, IL, IN, IA, KS, KY, LA, MD, MA, MI, NJ, NM, NY, OH, OK, PA, RI, SC, TN, VT (non-mental health), VA, WV, WI	GA, MN, MO, MT, TX, VT (mental health), WA

[1] In these states, consumers are considered to have exhausted the internal review process after a limited period of participation. For more information, see a joint Foundation/Consumers Union report, "Consumer Guide to Handling Disputes With Your Health Plan," as cited on page two.
[2] In practice, most eligible consumers in Missouri do complete the internal review process before proceeding to external review.
[3] Fee applies only to consumers who apply for external review through their health plan, not through the state.
[4] In Ohio, standard reviews for medical necessity denials are subject to a $500 claims threshold. Expedited reviews and reviews for experimental denials are not subject to this threshold.

IV. External Review Qualifications and Independence

This section discusses the qualification of external reviewers and program features that protect against conflicts of interest and promote independent decision-making by reviewers. States are similar in the standards they set to ensure expertise of external reviewers, but vary in the standards they set to protect independence.

Qualifications of Reviewers

In general, external reviewers are health care professionals (usually physicians) who are board certified, practice actively in the field or specialty under review, and have extensive experience in the type of case under review. Other state requirements can apply. For example, external reviewers in Missouri must be licensed to practice in that state. Oklahoma and the District of Columbia permit only physicians to perform external reviews, while other states, such as Iowa, permit other practitioners, such as chiropractors, to review cases as well.

Most state external review programs contract with private independent review organizations (IROs) that establish and maintain a network of such reviewers across many fields of expertise. IROs have credentialing programs to ensure the expertise of reviewers and to verify licensure and other requirements. IROs also train their reviewers in the external review process and usually examine their recommendations and rationale before forwarding these results to state regulators and/or the disputing parties.

In 3 states – Hawaii, Florida, and New Mexico – external review is done by a panel of state-appointed committee members who may consult with outside medical experts on a case-by-case basis. Montana contracts with an IRO for external review; however, health plans and consumers may instead mutually agree to seek binding external review from a single expert, called a "peer," that both parties select. In Tennessee, consumers have the option of applying for external review either through their health plan, in which case an IRO performs the review, or through the state, in which case the review is conducted by regulatory staff, advised by a physician. Finally, as noted earlier, Vermont and Minnesota each have a separate external review process for mental health and substance abuse cases. Instead of contracting with IROs for these cases, as both states do for their general external review program, a panel of experts is convened to hear mental health and substance abuse appeals. In Vermont, this is a standing panel, comprised of psychiatrists and other mental health professionals. Minnesota's program, established pursuant to a lawsuit, is comprised of members appointed by the state attorney general, Blue Cross (the defendant in the lawsuit), and the District Court Judge who heard the case. This appeal program was established initially for enrollees of Minnesota Blue Cross and Blue Shield, but is open to other managed care plans in the state and may be mandated for them in the future.

Independence

The independence of external review can be protected on two levels. Process safeguards prevent one party (usually the health plan) from exerting undue influence at various stages in the process, such as eligibility screening, while decision-making safeguards protect the external reviewer's ability to exercise his or her own independent, expert judgment in making decisions.

In order to safeguard independence of the external review process, many states control the selection of the IRO, the screening of cases for external review, and even the initial application process. State practices vary, however, and the result may affect the independence – or at least the appearance of independence – of the overall process. (See Exhibit 7)

- **Who selects the independent review organization (IRO)?**
  In 27 states, regulators select the IRO. In all other external review programs, either the health plan or, less commonly, the enrollee selects the review entities. Seven states allow the health plan to select the IRO. Two states—Iowa and Oklahoma—permit the plan to select the IRO from an approved list, but allow the enrollee to object to the plan's choice. In Illinois, the plan, the enrollee, and the enrollee's physician or other health care provider must jointly select the IRO. In Montana, the state contracts with the IRO, but in cases where a peer is to perform the review, the peer is selected by the health plan and enrollee, jointly.[18] In Wisconsin, the enrollee selects the IRO, while in Rhode Island, the enrollee or his physician picks the IRO, depending on who files the appeal. In Tennessee, where residents may apply for external review directly to the state, plans select the IRO for cases they receive; cases received by the state are reviewed by regulatory staff, advised by a physician.

- **Who determines if a case is eligible for external review?**
  In most states (22), regulators screen cases to determine their eligibility for external review. Screening involves review of objective facts (such as whether the consumer was enrolled in the health plan at the time of the denial) and – a somewhat more subjective decision – whether the case involves issues of medical necessity. In 8 states, regulators delegate the screening function to the IRO. In New Jersey, screening is shared by IROs – which determine whether disputes involve medical necessity issues – and regulators – who determine whether other eligibility requirements have been met. In 8 states, the health plan screens potential external review cases for eligibility. In Tennessee, the state or the health plan may conduct the screening, depending on where the consumer applied for external review. In Ohio, health plans screen for eligibility, but consumers can appeal the screening decision to state regulators.

- **Who accepts applications?**
  In 20 states, consumers apply directly to state regulators for external review. In 20 others, consumers must apply through their health plans. Tennessee lets

[18] Explanation of "peer" reviewers in Montana occurs at page 16.

enrollees decide where to apply for external review and, if an enrollee applies through their health plan, the plan will screen their case for eligibility and select the external review entity.

Exhibit 7. Independence of State External Review Process

Program Feature	States
Who selects the external review entity?	
State	AZ, CA, CO, CT, DE, DC, FL, GA, HI, IN, KS, ME, MD, MA, MI, MN, MO, NH, NJ, NM, NY, OR, PA, TX, VT, VA, WV
Plan	AK, KY, LA, SC, TN, UT, WA
Enrollee	WI
Other[1]	IL, IA, OK, MT, RI, OH
Who decides if a dispute is eligible for external review?	
State	CA, DE, DC, FL, GA, HI, IA, KS, ME, MD, MA, MI, MN, MO, NH, NM, NY, PA, VT, VA, WA, WV
IRO	AK, CT, IN, MT, OK, OR, SC, WI
Plan	AZ, CO, IL, KY, LA, RI, TX, UT
Other[2]	NJ, TN, OH
Who accepts applications for external review?	
State	CA, CT, DC, FL, GA, HI, IA, KS, ME, MD, MA, MI, MN, MO, NH, NJ, NM, NY, VT, VA
Plan	AK, AZ, CO, DE, IL, IN, KY, LA, MT, OH, OK, OR, PA, RI, SC, TX, UT, WA, WV, WI
Other[3]	TN

[1] In Illinois, the plan, the enrollee and the enrollee's physician or other health care provider must jointly select the IRO. In Iowa and Oklahoma, the health plan selects the review entity but the enrollee may object. In Montana, when the plan and the enrollee cannot agree on a peer, then the plan must forward the case to the external review entity designated by the state. In Rhode Island, the provider or the enrollee picks the review entity, depending on who initiates the request for external review. In Ohio, the health plan chooses from two IROs randomly selected by the state.

[2] In New Jersey, the state and the IRO share the screening process. In Tennessee, the state or the health plan may screen for eligibility, depending on where the enrollee first applied for external review. In Ohio, the health plan reviews each request for eligibility. The enrollee may seek review by the Department of Insurance if she disagrees with the health plan's screening decision.

[3] In Tennessee, consumers may apply to either their health plan or to the state.

- **What conflict of interest standards apply?**
  All states establish explicit standards to ensure that external reviewer entities and reviewers are independent and free of conflicts of interest. Most states specify that an IRO and its expert reviewers shall not have any material professional, familial, or financial conflict of interest with the health plan, any officer, director, or management employee of the health plan, the enrollee, the enrollee's health care provider, the provider's medical group or independent practice association, the health care facility where service would be provided, and the developer or manufacturer of the service being proposed. Most states also require that an IRO may not own or control, be a subsidiary of, or in any way be owned or controlled

by, or exercise control with a health insurance plan, a national, state, and local trade association of health insurance plans, and a national, state, and local trade association of health care providers.

In addition to these safeguards on independence, some states have taken steps to protect the independence of the external reviewer's decision making, while others have placed some constraints on the judgment reviewers can exercise. (See Exhibit 8)

- **What decisions can external reviewers render?**
  Sixteen state programs require external reviewers to either uphold or reverse a plan's decision in its entirety. This prevents reviewers from partially agreeing with a plan's denial. For example, if a patient appeals the denial of 20 physical therapy visits for rehabilitation of an injury, the reviewer must find that all or none of the days are medically necessary, but may not decide that a 10-day rehabilitation is sufficient and appropriate. In 22 states, external reviewers do have discretion to uphold, reverse, or modify a health plan decision. Three states do not specify what external reviewers may decide.

- **Are reviewers bound by the health plan's definition of medical necessity?**
  In most state programs (34), the external reviewer can exercise his or her own expert judgment in determining whether care is medically necessary or appropriate. These states often specify the types of evidence a reviewer may or must consider (for example, published clinical practice guidelines, peer reviewed medical literature, information in the patient's own medical record), but give reviewers wide discretion in weighing this evidence based on their own experience and expert medical judgment.

  In Georgia, for example, the Georgia Administrative Code states,

  "…criteria for medical necessity determination must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis."

  New York directs reviewers to "make a determination as to whether the insurer acted reasonably and with sound medical judgment and in the best interest of the enrollee."

  Expert reviewers in Maryland may also rely on their own judgment of what is medically necessary. In addition, Maryland asks the reviewing entity to evaluate the plan's medical necessity criteria, and these, too, can be overturned if they are determined to be inadequate or inappropriate.

  In 7 states, by contrast, external reviewers are required to apply the health plan's definition of "medical necessity" in evaluating health plan denials. In these states, reviewers are limited in the exercise of their own expert judgment of what is

medically necessary, and must instead determine whether the health plan's denial was consistent with its own protocols for deciding what is medically necessary and appropriate.

Exhibit 8. Limits on External Reviewer Decision-Making

Program Feature	States
Are there limits on what reviewers can recommend?	
Uphold or reverse plan decision	CA, CO, CT, DE, GA, IN[1], KS, KY, MI[1], MT, NM, OK, OR, SC, TN, WV
Uphold, reverse, or modify plan decision	AK, AZ, CA, DC, FL, HI, IL, IA, LA, ME, MD, MA, MN, MO, NH, NJ, NY, OH, PA, RI, TX, UT, VA
Not specified	VT, WA, WI
Are reviewers bound by plan's definition of "medical necessity?"	
Yes	AK, AZ, KS, PA, TN, WV, WI
No	CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MO, MT, NH, NJ, NM, NY, OH, OK, OR, RI, SC, TX, UT, VT, VA, WA

[1] Indiana and Michigan statutes require reviewers to only uphold or reverse the determination. However, state regulators indicate that modified determinations have been allowed in some cases.

V. External Review Process and Timelines

Most state external review programs employ a similar process. However, the timelines for external review vary considerably across states.

External Review Process

In most states, the external review process is a paper review. A case file is assembled documenting all pertinent information, including the medical reasons why the disputed service was requested and denied. This file is forwarded to the external reviewer who evaluates its contents and renders a decision. In 8 states, however (District of Columbia, Florida, Maine, Maryland, Massachusetts, New Hampshire, New Mexico, Vermont (mental health only)), a hearing must or may be conducted. Disputing parties may attend this hearing, with representation, to present and respond to arguments.

Prior to the actual medical review, consumers must also apply for external review and, in most states, have their cases screened for eligibility. When case files are incomplete, there may also be a process for assembling missing information. Following the actual medical review, there may also be a process for transmitting the reviewer's determination to the state and/or to the disputing parties. These pre- and post-review activities (application, screening, documentation, and transmittal) may or may not be subject to specific rules and timelines, depending on the state.

Timelines

Every state imposes limits to encourage the completion of external review in a timely manner. However, states vary in how they measure time; they also vary with respect to the steps of the review process to which time limits apply, and whether extensions are permitted. (See Exhibit 9)

- **Calendar or business days**
  States that specify time limits vary in their use of calendar or business days. This distinction can significantly affect the timeliness of reviews. For example, an external review case initiated on November 30 and conducted in 30 calendar days would be concluded on December 30. If conducted over 30 business days, however, the same case would be concluded on January 17, almost 3 weeks later. Fifteen states establish timelines for external review using business days; 15 use calendar days; and 11 use both business days and calendar days to specify limits on certain components of their external review timelines.

- **Time limits on external reviewers**
  In 15 states the external review entity is allowed up to 30 days to complete a standard expert review, while in another 16 states the review entity must complete its review within 30 business days. Eight states give the IRO greater than 30 calendar or business days to make a determination on the case. In Maryland and Utah, the time available to the reviewer depends on whether the case involves a

prospective or retrospective denial of coverage (that is, coverage was denied before or after the care was rendered). Massachusetts allows 60 business days (or 3 months). Florida, by statute, gives its review panel 120 days to review and hear a case. Another 45 days is allowed for processing and issuing a final order. The unusually long time is given to accommodate retrieval of documentation, an in-depth review, and scheduling of the many parties that participate in the hearing. Except for emergency situations, all hearings, except local ones, are held by video-teleconference using state facilities in area offices throughout the state. Even so, the Department's practice is for routine cases to be reviewed and heard within 60 days.

- **Length of entire process**
  Twenty-eight states set firm time limits that bind the length of the entire process. The rest permit more flexibility by allowing time extensions in some circumstances, or by not limiting the time permitted for certain steps of the review process (such as screening or transmittal). Alaska, an example of a state with firm time limits, requires completion of the entire process within 21 business days. In New Jersey, the review entity is required to complete a standard review within 30 business days of receiving the case; however a reasonable time of extension is available with approval by the department, but the completion of the entire process is required within 90 days. Virginia allows, upon the showing of good cause, an extension of any component of the process to either party. By allowing an open extension without defining a specific overall time limit, the external review process in Virginia could be extended significantly, depending on the circumstances of the case.

  Adding up the time permitted for each step, the total time allotted for an external review can be extensive. For example, in Georgia, regulators are given 3 business days to screen a case for external review eligibility; plans are given 3 business days to submit a complete case file to the IRO; the IRO has 5 business days to assess the completeness of the file and request additional information, and the plan has 5 more business days to respond to this request; finally, additional extensions up to 10 business days are authorized in certain circumstances. Consequently, a maximum 41 business days, or two months, may be taken to complete the entire external review process in Georgia. Many states, however, report that the process typically is completed in far less than the total time allowed.

Exhibit 9. Timelines for External Review

State	Total Available Time To Complete Entire Process	Typical Time To Complete Entire Process	Time Limit for Review Entity to Reach Decision	Time Limit for Expedited Review
AK	21 business days	no data	21 business days	72 hours [1]
AZ	Medical Necessity issues: 15 business days plus 51 days Coverage Issues: 20 business days	no data	21 days	5 business days [2]
CA	33 days +	no data	30 days	3 days [1,2]
CO	40 business days	no data	30 business days	7 business days [2]
CT	35 business days +	no data	30 business days	Within time limit determined by state screening process
DE	45 days plus 3 business days	no data	45 days	72 hours [1]
DC	47 business days +	20-25 business days	30 business days	72 hours [1, 2]
FL	165 days +	within 60 days	120 days	Expedited: 45 days [2] Urgent: 24 hours [2]
GA	41 business days +	no data	15 business days	72 hours [2]
HI	90 days +	no data	60 days	72 hours [1, 2]
IL	35 days	no data	5 days	24 hours [1, 2]
IN	15 business days plus 3 days	7 days	15 business days	72 hours [2]
IA	35 business days	<30 business days	30 business days	72 hours [1, 2]
KS	45 business days	15.7 business days	30 business days	7 business days [1]
KY	35 days plus 10 business days	21 days	21days	24 hours [2]
LA	37 days +	no data	30 days	72 hours [2]
ME	45 days	no data	30 days.	72 hours [1,
MD	Pending: 60 business days Retrospective: 75 business days	no data	Pending: 30 business days Retrospective: 45 business days	24 hours
MA	80 business days	15-61 days	60 business days	5 business days [2]
MI	26 days	< 26 days	14 days	72 hours [1]
MN	40 days plus 2 business days	32 days	40 days	72 hours [1]
MO	35 days plus 20 business days +	no data	20 days	Within time limit determined by state screening process[3]
MT	30 days +	no data	30 days	72 hours
NH	47 business days	47 business days	20 business days	72 hours [1]
NJ	90 days	30-52 days	30 business days	48 hours [1]
NM	45 business days	45 days	30 business days.	72 hours [1]
NY	37 days plus 5 business days +	< 30 days	30 days.	72 hours [2]
OH	30 days	no data	30 days	7 days
OK	30 days plus 23 business days	no data	30 days	72 hours [1]
OR	30 days	no data	30 days	3 days
PA	60 days	45 days	40 days	2 business days [1, 2]
RI	15 business days	no data	10 business days	2 business days
SC	45 days	no data	45 days	3 business days [1]
TN	Insurer Initiated: 30 days plus 10 business days Department Initiated: 30days	no data	30 days	5 days [2]

Exhibit 9 continues on the next page

[1] Or sooner, as determined by medical exigencies of the case.
[2] Indicates additional time, with specific limits, for certain tasks in the external review process for expedited cases.
[3] In Missouri, the current contract between the state and review entity requires the review entity to complete an expedited review within 3 days.
+ Indicates additional time, without specific limits, is available within the external review process.

Exhibit 9. Timelines for External Review (continued)

State	Total Available Time To Complete Entire Process	Typical Time To Complete Entire Process	Time Limit for Review Entity to Reach Decision	Time Limit for Expedited Review
TX	24 business days	no data	15 business days after receipt of information but no longer than 20 days after receiving the request.	5 days following receipt of information but no later than 8 days after receiving the request.
UT	Pre-service cases: 30 days Post-service cases: 60 days	no data	Pre-service: 30 days Post-service: 60 days	72 hours [1]
VT	8 business days plus 40 days +	no data	30 business days	5 business days [1, 2]
VA	65 business days +	35 business days	30 business days	5 business days [1]
WA	25 days plus 3 business days	no data	15 business days after receipt of information but no longer than 20 days after receiving the request.	72 hours following receipt of information but no later than 8 days after receiving the request
WV	45 days +	no data	45 days	7 days [1, 2]
WI	47 business days	no data	30 business days	72 hours [1, 2]

[1] Or sooner, as determined by medical exigencies.
[2] Indicates additional time, with specific limits, for certain tasks in the external review process for expedited cases.
[3] In Missouri, the current contract between the state and review entity requires the review entity to complete an expedited review within 3 days.
+ Indicates additional time, without specific limits, is available within the external review process.

- **Expedited review**
  All states provide for expedited consideration of urgent cases when the patient's life or health would be endangered by waiting for the completion of a standard review. In most states, a physician or other health care provider must certify the need for expedited external review. Sometimes the state or IRO makes this determination. In Hawaii and Utah, the health plan can decide whether a case merits expedited review.

  Unlike standard reviews, most states require completion of the expedited external review within a specific time frame. Generally this specifies time allowed for each step in the review process - screening cases, collecting and transmitting information, decision-making by the external reviewer, and notifying parties of the final determination. In 16 states, the entire process for expedited external review must be completed in 72 hours or less. Nine other states give the external review entity 72 hours or less to render a decision, but allow additional time for other review process tasks. Eleven states allow the expedited review process to take 7 days or longer. One of these states, Florida, has two levels of expedited review, with urgent cases requiring resolution within 24 hours.

  Another key feature, found in 22 states, is the requirement that the expedited review process be completed within a time frame appropriate to the medical exigencies of each individual case, regardless of any other applicable time deadlines.

  Due to the urgent nature of these cases, access to those persons who can initiate the expedited process is essential. Some states have responded by increasing access to state regulators during non-business hours. For example, in New York

and Vermont, department staff carry beepers so they can be respond immediately to urgent external review requests 24 hours a day, 7 days a week. In California, along with a 24-hour Managed Care Hot Line, counsel and clinical staff are on call to respond to time critical complaints, including expedited requests for external review.

VI. Other Features of State External Review Programs

Some other important features of state external review programs include: whether the external review decision is binding, the cost of external review, and the regulatory oversight and monitoring of such programs.

Binding

External review decisions are binding on health plans in almost all states. This means that the health plan is required by law to implement the external review decision, although in a number of states, the health plan can appeal. Only in the District of Columbia, Oklahoma, and Oregon are health plans not required to follow the external review determination. Even in these 3 jurisdictions, however, external review is a statutory right and must be offered to the entire covered population, regardless of whether the plan decides to accept the final decision. In Oklahoma, regulators report that all plans are voluntarily abiding by the decision of the reviewer. In Oregon, each plan has the option of legally binding itself to the external review determination and must specify to consumers its intention in the plan literature. As recently as 1998, two other states – New Jersey and Pennsylvania – maintained non-binding external review programs, but these states have since approved legislation making external review determinations binding on the plan.

In some states, the law specifies that health plans may seek judicial or administrative review of a binding external review determination. In Maryland and Florida, a decision by the insurer to seek such review will stay the external review determination, while in Arizona, Kansas, and New Mexico, it will not. [19]

Cost Per Case

Because states use different approaches to paying for external review, it is difficult to calculate an average cost per case. (See Exhibit 10) Several states declined to disclose the amount they pay for external review. Several others only provided an approximate amount that they pay for external review. For all other states, payment for external review varies based on a number of factors.

In states where health plans select and contract with external reviewers, the cost is negotiated between these parties. In states that negotiate payment with external review entities, different terms have been reached. New Mexico is the only state that relies on volunteer reviewers, and Missouri pays for external review on an hourly basis ($100/hour). All other states pay for external review on a per case basis. Nineteen states reported that a standard review could be completed for $500 or less. However, in 9 of these states, payment for a standard review could exceed $500, for example, if the state contracts with multiple IROs that charge different fees. The District of Columbia, which estimates that external reviews cost between $1,200-$2,200 per case, appears to pay the

[19] In Maryland, a decision by the insurer to seek court review will stay the external review determination only for non-emergent situations. In emergent situations, a stay is not allowed.

most. Montana does not set a limit on the payment for a single review. Instead, plans are charged those costs required to complete the review plus 5 percent for administrate fees. Regulators in Florida noted that the actual review entity fee is just a small portion of the overall costs of running an external review program, and does not reflect salaries and overhead expenses of 9 state employees who conduct external reviews.

In some states, the cost of external review is higher for an expedited case, or for a case requiring a panel of expert reviewers. For example, in California, the standard fee for a single-physician medical necessity review from the primary contractor is $395, while a three-physician review for a standard experimental/investigational review is $1,750 and $2,500 in expedited cases. Hawaii is the only state that allows attorneys fees to be recovered from the health plan. State officials in Hawaii indicate that these fees can be significant.

Thirty states require the disputing health plan to pay for the cost of external review. Nine states pay for external review out of governmental funds, although these funds typically are derived from fees assessed on health plans. Rhode Island is unique in that the cost of the review is split equally between the health plan and the consumer.

State Oversight

State oversight of external review also varies. Formal audits are rare, but informal monitoring of external review decisions for patterns indicating problems are much more common. Many states periodically review the actions taken by IROs in the course of renewing their contracts with these review entities. For example, in Georgia, IROs must be re-certified annually and the quality and reasoning of their decisions is a factor considered in this process. California law requires regular oversight and review of the external review program to be conducted by state regulators, as well as by a Clinical Advisory Panel comprised of five professors of medicine. In Iowa, where health plans can select the IRO, state regulators review IRO decisions for indications of bias. Recently, patterns have been detected indicating that plans may be selecting IROs that are less likely to overturn plan denials. Iowa officials are looking into this matter more closely.

In most states, external review is an important source of information to regulators, signaling the possible presence of problems requiring further investigation and enforcement action. In Maryland, when external review overturns a health plan denial that regulators find to be especially egregious, the Insurance Commissioner's order to cover the service may be accompanied by a fine on the plan.

In some states, such as Arizona, Connecticut, District of Columbia, Maryland, Missouri, New Jersey, New York, and Rhode Island, regulators issue periodic reports on their external review programs. New York also includes information about external review findings in its consumer health plan report card. These published reports can provide important information to consumers and their advocates about the health care system.

Exhibit 10. Cost Per Case of External Review

State	Cost Per Case	Who Pays?
Alaska	Not available	Insurer
Arizona	Standard: $385-$790; Expedited: $410-$790	State (with plan regulatory fees)
California	Standard: $295 Expedited:$500 Experimental: $1,750 -$2,500	State (subject to periodic assessments from the plans)
Colorado	Standard: $280-$800; Expedited: $500-$1300	Insurer
Connecticut	Approx. $500	State (with plan licensing fees)
Delaware	Not available	Insurer
District of Columbia	$1,200-$2,200	Insurer
Florida	$309	State (with plan licensing fees)
Georgia	$1,000-$1,500	Insurer
Hawaii	Not available	State
Illinois	Not available	Insurer
Indiana	$325-$725	Insurer
Iowa	$300-$600	Insurer
Kansas	$500	State
Kentucky	$600-$700; limited by statute to $800	Insurer
Louisiana	Not available	Insurer
Maine	$800	Insurer
Maryland	$400	Insurer
Massachusetts	$500, more for expedited reviews	Insurer
Michigan	$400-$600	State (with plan regulatory fees)
Minnesota	$350	Insurer
Missouri	$100/hour	State (with plan regulatory fees)
Montana	Actual cost plus 5% administrative fee	Insurer
New Hampshire	$425	Insurer
New Jersey	Preliminary review: $50 Full review: $350	Insurer
New Mexico	Not available	Reviews use uncompensated volunteer reviewers
New York	Not available	Insurer
Ohio	Standard: $702.85 Expedited: $1,597.31	Insurer
Oklahoma	Not available	Insurer
Oregon	Not available	Insurer
Pennsylvania	$750	Insurer (When provider initiates appeal, the non-prevailing party pays)
Rhode Island	$288.40-$475	Shared equally by insurer and enrollee
South Carolina	Not available	Insurer
Tennessee	Not available	Insurer
Texas	Reviews by MDs or DOs: $650 Reviews by other medical providers: $460	Insurer
Utah	$500-$1,500	Insurer
Vermont	$700	Insurer
Virginia	$450	State (with plan regulatory fees)
Washington	Not available	Insurer
West Virginia	Not available	Insurer
Wisconsin	Not available	Insurer

Links to Judicial System

Recently, some state legislatures have begun explicitly outlining or expanding the grounds on which enrollees can bring suit against a managed care organization in state court. Today, there are 9 so-called "right to sue" states.[20] In all of them except Arizona, participation in the external review process is required to advance a lawsuit. In 4 states, consumers must complete the external review process without exceptions, while in 4 others, specific exceptions are permitted if the consumer has already suffered harm or if harm would likely occur in the course of the external review. In West Virginia, the consumer must prevail at the external review level in order to bring suit.

In 2 states, the result of the external review process can have lasting effect on future legal proceedings. In Georgia and Maine, external review findings are admissible in subsequent court proceedings. Further, in Georgia, the determination of the expert review produces a rebuttable presumption in any subsequent lawsuit. This means that the party that contests the external review decision must meet a high legal standard in order to prevail at overturning the external review decision. In none but these two "Right to Sue" states does the determination of the external review process affect future legal actions.

Exhibit 11. State Right-to-Sue Laws and External Review

Provision	States
Consumers can sue managed care plans	AZ, CA, GA, ME, NJ, OK, TX, WV, WA
Prior to legal action	
-Enrollee must exhaust external review process, no exceptions	ME, OK, WV, WA
-Enrollee must exhaust external review process: with exceptions	CA, GA, NJ, TX
- Enrollee must win the external review process	WV
-Enrollee can complete external review process or provide written notice 30 days prior filing suit.	AZ
Effect on future legal action	
-External review determination is admissible in court	GA, ME
-External review determination creates a rebuttable presumption	GA

[20] Some other states recognize a right for a health plan enrollee to pursue a case for damages for bad faith denial of a claim.

VII. How Pending Federal Legislation Might Affect State External Review Programs

Congress is considering two bills to establish a federal "Patients' Bill of Rights."[21] Both bills would establish a federal right to independent external review of health plan denials for consumers in all types of health plans, including self-insured employer plans currently exempt from state regulation. With respect to external review, however, the two bills take a different approach to already-enacted state laws.

The Senate bill would establish a federal floor (or minimum standard) for external review protections, leaving in place features of state external review programs that are more protective of consumers, but superceding those that are less protective. The federal floor is flexible, however, requiring deference to states in interpreting whether their external review programs substantially comply with federal standards.

The House bill, by contrast, aims to preempt all state external review programs (as well as state requirements for internal appeals), replacing them with a single federal standard.[22]

Determining the impact of federal legislation on state external review programs is a difficult task for several reasons:

The Content of Federal External Review Standards is Not Yet Settled

Because Congress has not yet completed action on these bills, it is not entirely clear what the federal external review standard would be. Provisions in the two bills are similar in most respects. (See Exhibit 12) For example, both bills require that enrollees in all health plans have the right to external review of health plan decisions involving medical necessity-related issues. Other eligibility requirements are identical under the two bills, as are the timelines established for external review. One difference is that the Senate bill would allow external reviewers broader discretion in decision-making: while the House bill would require an external review decision to either uphold or reverse a health plan's decision, the Senate bill would also permit external reviewers to modify a health plan's decision.

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[21] S. 1052 passed the Senate June 29, 2001; H.R. 2563 passed the House August 2, 2001. These bills are awaiting conference committee action to resolve their differences. For further information see Stephanie Lewis, "A Guide to the Federal Patients' Bill of Rights Debate," prepared for the Kaiser Family Foundation, August 2001.

[22] Although the House bill intends to preempt all state internal and external review laws, it is not clear that the bill has this effect. The House bill adds new external review provisions to Part 5 of ERISA without amending the existing preemption standards in Part 5. However, federal courts have not yet settled the question of whether ERISA currently preempts state external review laws. Some federal courts have found that state external review programs are preempted while others have reached the opposite result. While the Supreme Court is scheduled to review this conflict in *Rush Prudential HMO, Inc. v. Moran* early in 2002, regardless of the outcome, the utility of this case may be limited because the Court will not be addressing the question of whether the new federal external review standards preempt state external review law. By contrast, the Senate bill establishes a new preemption standard that applies to new patient protections, including external review. The House bill also establishes a similar new preemption standard, but specifically excludes external review from its application (Section 152(b)(2)).

The House and Senate bills share an important ambiguity relating to who selects the external review entity. Both bills state,

> "The …Secretary… shall implement procedures to assure that the selection process among qualified external review entities will not create any incentives for external review entities to make a decision in a biased manner… No such selection process under the procedures implemented by the appropriate Secretary may give either the patient or the plan or issuer any ability to determine or influence the selection of a qualified external review entity to review the case of any participant, beneficiary or enrollee."[23]

However, both bills also specifically provide that

> "…the external review process…shall be conducted under a contract between the plan or issuer and one or more qualified external review entities."[24]

This contract requirement seems to suggest some health plan involvement in selecting its contractor, despite other language prohibiting health plan involvement in the selection of the external review entity. Notwithstanding these provisions, both bills also provide that states may continue to select and contract with external review entities that will conduct external reviews for all residents in state-regulated plans, so long as the state selection process is unbiased. In the House bill, however, this language raises further ambiguity, since the House bill also seeks to preempt all state activity relating to external review.

Because the process for selecting the external review entity could affect the independence of the process, clarification of this ambiguity in federal bills could have important implications for how existing state programs operate.

[23] S.1052, 107th Cong. § 104(h)(1)(A) (2001) and H.R. 2563, 107th Cong. § 503C(h)(1)(A) (2001).
[24] S.1052, 107th Cong. § 104(h)(2) (2001) and H.R. 2563, 107th Cong. § 503C(h)(2) (2001).

Exhibit 12. External Review Provisions of Pending Federal Legislation

	H.R. 2563	S.1052
Scope		
Types of issues	Medically reviewable decisions	Medically reviewable decisions
Types of plans	All health plans	All health plans
Accessibility		
Exhaust IR process	Yes	Yes
Limits on participation in IR:		
Retrospective cases	60 days	60 days
Prior authorization cases	28 days	28 days
Expedited cases	72 hours or less, as medically indicated	72 hours or less, as medically indicated
Ongoing care	As quickly as medically indicated	As quickly as medically indicated
Consumer fees	$25	$25
Claims thresholds	None	None
Filing deadlines	180 days	180 days
Notice in plan information	Yes	Yes
Notice in denial letter	Yes	Yes
Independence		
Who accepts application	Plan	Plan
Who determines eligibility	Review entity	Review entity
Who selects review entity	Process to be determined by Secretary; or State	Process to be determined by Secretary; or State
Limits on recommendations	Uphold, Reverse	Uphold, Reverse, or Modify
Are reviewers bound by the plan's medical necessity definition?	No	No
Maximum timeline		
Prior authorization cases	21 calendar days	21 calendar days
Retrospective cases	60 calendar days	60 calendar days
Expedited review	72 hours or sooner, as indicated by medical exigencies	72 hours or sooner, as indicated by medical exigencies
Binding on the plan	Yes	Yes
Future legal action		
Enrollee must exhaust external review prior to legal action	Yes	Yes
Enrollee must win at external review prior to legal action	No	No
Review determination is admissible	Yes	Yes
Review determination is rebuttable presumption	Yes	No
Preemption of State Laws	All state laws are intended to be preempted	State laws that are substantially similar to or more protective than federal standard are not preempted

Pending Federal Standards Are Both Stronger and Weaker Than State Standards

Considering the key features of external review programs and how these vary across states, the standards established under the House- and Senate passed bills are stronger than state requirements in many instances, but weaker in others. (See Exhibit 13) For example:

- Federal bills would limit the amount of time a consumer would be required to participate in the health plan's internal appeals process – where many consumers appear to founder currently – before proceeding to external review. The federal standard is more protective than in all states but 2.

- Federal standards for timely completion of external review cases are tighter than in states but Rhode Island.

- Proposed federal standards require consumers to be given earlier notice about their external review rights than three-fourths of state programs now require.

- Consumers would also have more time to file for external review under federal rules than they do in over two-thirds of state programs.

- The scope of external review rights under federal proposals is broader than in 40 percent of state programs.

- Congressional bills prohibit health plans from picking the external reviewer, unlike one-third of state programs today. (As noted above, however, there is some ambiguity in Congressional bills on this point.)

- Congressional bills do not set a claims threshold for external review, while more than one-fourth of states limit eligibility in this way.

- Finally, compared to 17 percent of state programs that require external reviewers to abide by the health plan's definition of medical necessity, Congressional proposals permit external reviewers to exercise more independent judgment.

In some key instances, however, states are more protective of consumers than federal external review standards would be:

- Two-thirds of states do not charge consumers a filing fee, compared to Congressional bills that would charge $25.

- In a majority of states, external reviewers have the flexibility to modify health plan decisions. The House-passed bill would require reviewers to uphold or deny plan decisions in their entirety, while the Senate passed bill would permit modifications, or "partial overturns" as most states now do.

- Federal proposals also provide that consumers would apply for external review through their health plans, whereas in the majority of states, consumers make application to state regulators. In light of indications that consumers tend not to pursue appeal rights within their health plans, this may be an important distinction that could discourage some consumers from pursuing external review.

- Finally, one-fourth of states give consumers more time to file for external review than federal bills would permit.

Exhibit 13. Comparison of State Program Features to Pending Federal Standards

Proposed Federal Standard	States with Weaker Program Features	States with Equivalent Program Features	States with Stronger Program Features	States Where Comparison is Ambiguous
Scope				
All health plans	AK, CT, DE, FL, GA, HI, IL, NH, NM, OK, PA, TN, WV	AZ, CA, CO, DC, IN, IA, KS, LA, KY, ME, MD, MA, MI, MN, MO, MT, OH, NJ, NY, OR, RI, SC, TX, UT, VT, VA, WA, WI	None	
Only disputes involving medical necessity	CA, CT, SC, TX	AK, CA, CO, CT, DE, DC, IL, IN, IA, KS, LA, ME, MD, MA, MO, MT, NH, NJ, NM, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WI, WV	AZ, FL, HI, KY, MI, MN, OH, WA	GA, NY
Accessibility				
Limit internal review process to 28 days for prior authorization cases	AK, AZ, CA, CO, CT, DE, DC, FL, GA, HI, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MT, NH, NJ, NM, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, WI	None	IL, MO	
Filing fee of $25	NY, OK, RI, TN, VA	CT, IN, IA, KY, MA, MN, NJ, PA, VT (non-mental health), WI	AK, AZ, CA, CO, DE, DC, FL, GA, HI, IL, KS, LA, ME, MD, MI, MO, MT, NH, NM, OH, OR, SC, TX, UT, VT (mental health), WA, WV	
No claims thresholds	GA, KY, NH, OH, OK, SC, TN, VT (non-mental health), VA, WV, WI	AK, AZ, CA, CO, CT, DE, DC, FL, HI, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MO, MT, OR, NJ, NM, NY, PA, RI, TX, UT, VT (mental health), WA	None	
Filing deadline of 180 days	AZ, CO, CT, DE, DC, HI, IL, IN, IA, KS, KY, LA, MD, MA, MI, NJ, NM, NY, OH, OK, PA, RI, SC, TN, VT (non-mental health), VA, WV, WI	AK, CA, NH, OR, UT	FL, GA, ME MN, MO, MT, TX, VT (mental health), WA	
Notice required in health plan information	GA, KS	AK, AZ, CA, CO, CT, DE, DC, FL, HI, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MO, MT, NH, NJ, NM, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, WI	None	
Notice required in initial denial letter	AK, CO, DE, DC, FL, GA, HI, IL, IA, KS, KY, LA, ME, MD, MN, MO, MT, NH, NM, OH, OK, OR, PA, RI, TN, UT, VT, VA, WA, WV	AZ, CA, CT, IN, MA, MI, NJ, NY, SC, TX, WI	None	

Exhibit 13 continues on next page

Exhibit 13. Comparison of State Provisions to Pending Federal Standards (continued)

Proposed Federal Standard	States with Weaker Program Features	States with Equivalent Program Features	States with Stronger Program Features	States Where Comparison is Ambiguous
Independence				
Plan accepts application	None	AK, AZ, CO, DE, IL, IN, KY, LA, MT, OH, OK, OR, PA, RI, SC, TX, UT, WA, WV, WI	CA, CT, DC, FL, GA, HI, IA, KS, ME, MD, MA, MI, MN, MO, NH, NJ, NM, NY, TN, VT, VA	
IRO determines eligibility	AZ, CO, IL, KY, LA, RI, TX, UT	AK, CT, IN, MT, OK, OR, SC, WI	CA, DE, DC, FL, GA, HI, IA, KS, ME, MD, MA, MI, MN, MO, NH, NJ, NM, NY, PA, VT, VA, WA, WV	OH, TN
Disputing parties may not select review entity	AK, IL, IA, KY, LA, MT, OH, OK, RI, SC, TN, UT, WA, WI	AZ, CA, CO, CT, DE, DC, FL, GA, HI, IN, KS, ME, MD, MA, MI, MN, MO, NH, NJ, NM, NY, OR, PA, TX, VT, VA, WV	None	
Reviewer may only uphold or reverse (House bill)	None	CA, CO, CT, DE, GA, KS, KY, MT, NM, OK, OR, SC, TN, WV	AK, AZ, DC, FL, HI, IL, IA, LA, ME, MD, MA, MN, MO, NH, NJ, NY, OH, PA, RI, TX, UT, VA	IN, MI, VT, WA, WI
Reviewer may uphold, reverse, or modify (Senate bill)	CA, CO, CT, DE, GA, KS, KY, MI, MT, NM, OK, OR, SC, TN, WV	AK, AZ, DC, FL, HI, IL, IA, LA, ME, MD, MA, MN, MO, NH, NJ, NY, OH, PA, RI, TX, UT, VA	None	IN, VT, WA, WI
Reviewer not bound by the plan's medical necessity definition	AK, AZ, KS, PA, TN, WV, WI	CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MO, MT, NH, NJ, NM, NY, OH, OK, OR, RI, SC, TX, UT, VT, VA, WA	None	
Timely resolution				
Prior authorization cases within 21 days	AK, AZ, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NH, NJ, NM, NY, OH, OK, OR, PA, SC, TN, TX, UT, VT, VA, WA, WV, WI	RI	MN (adolescent mental health and substance abuse cases)	
Expedited review within 72 hours or sooner, as medically indicated	AZ, CA, CO, DC, FL, GA, HI, IN, IA, KS, LA, MA, MO, MT, NY, OH, OR, PA, RI, SC, TN, TX, VT, VA, WA, WV, WI	AK, DE, ME, MI, MN, NH, NM, OK, UT	IL, KY, MD, NJ	CT
Binding on plan	DC, OK, OR	AK, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NJ, NM, NY, OH, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, WI	None	

How Federal Preemption Would Work is Unclear

Finally, both the House and Senate bills leave unanswered some important questions that could be key in determining the impact of federal legislation on state programs.

The House-passed bill is sweeping in its approach, seeking to preempt all state activity relating to the external review process. While a federal system for appealing health plan denials could raise to a consistent floor the multiplicity of state appeals systems that exist today, it would also restrict greater protections enjoyed by some consumers in some state programs. Nevertheless, it is not clear that a common system would result from the House-passed bill. The bill directs that some significant administrative responsibilities would be carried out by health plans (accepting external review applications, collecting consumer fees, contracting with external review entities). In practice, therefore, some aspects of external review could vary from health plan to health plan under the proposed House standard.

Other key oversight and enforcement responsibilities are assigned to the Secretary of Labor and the Secretary of Health and Human Services, but the legislation makes no provision for additional resources to carry out these responsibilities.[25] Federal agencies may not be able to replicate the public education, consumer assistance, oversight, and enforcement activities currently underway in states without such additional resources.

The Senate-passed bill, by contrast, seeks to establish a federal floor (or minimum standard) of external review protections, preempting weaker state programs but preserving features in state programs that are more protective of consumers. Under the Senate-passed bill, the Secretary of Health and Human Services would review state patient protection laws – including external review laws – to determine whether they "substantially comply" with federal requirements. The bill directs the Secretary to give deference to states' interpretation of their own laws and how they comply with federal requirements. Further, the bill gives the Secretary 90 days from the time a state requests such a review of its law(s) to make this determination.[26] If the Secretary fails to make a timely determination, the state law is automatically deemed to substantially comply.

The Senate bill defines "substantial compliance" as laws having the same or similar provisions and the same or similar effect. This definition still leaves room for subjective evaluation, as the two largest state programs illustrate. New York's external review program meets or exceeds many of the standards established under federal bills. However, New York interprets "medically reviewable decisions" to exclude disputes over pre-existing conditions and access to out-of-network providers. New York also charges a $50 filing fee, and some of its timelines do not match federal standards. Some might argue these variances should prevent New York from meeting a "substantial compliance" standard. Others might disagree. Similarly, many features of California's external review program are equivalent to or stronger than those in federal legislation.

[25] The House bill does permit the Secretary to enter into agreements with States to delegate some or all authority to enforce federal patient protection requirements. It is not clear, however, that states would accept such responsibility.
[26] A 60-day extension is available in cases where the Secretary determines he needs additional information to make this decision. Similar deference language is found in HR 2563, which requires the Secretary to follow this process for reviewing other state patient protection laws, such as those requiring managed care plan networks to be adequate.

California, however, does not permit external review for retrospective medical necessity denials. Some might argue that this key feature would prevent California from meeting a "substantial compliance" standard, while others might not. However, if programs in New York and California, in their entirety, were determined to substantially comply with federal standards, residents in these states would not be able to rely on external review in as many instances as consumers in other states. In addition, in New York, residents would have to pay more for this protection than would people in other states.

In other states, interpretation of the "substantial compliance" standard might be more straightforward. For example, Oklahoma requires external review only for managed care plan enrollees; imposes a $50 filing fee, a $1,000 claims threshold, and a 30-day filing deadline; and lets health plans select the external review entity. It seems less likely that the Secretary could determine that this program substantially complies with federal standards, though nothing prevents the state from arguing that it does.

The practical impact of the preemption provisions of S. 1052 depend on the approach to preemption that is actually implemented. If each specific federal standard is strictly enforced, states would need to strengthen weaker aspects of their external review programs to avoid federal preemption. On the other hand, if language requiring deference to state programs is followed literally, states could be excused from meeting many specific external review standards, compromising the concept of a federal floor. Under this approach, the status quo of variant state external review rights could be reinforced.

VIII. Summary of Findings

External review has been widely recognized as an important consumer protection, providing a way for disputes between health plans and consumers to be resolved fairly, expeditiously, and relatively inexpensively. On average, external reviewers reverse health plan decisions about as often as they uphold them. Consumers use this process infrequently; while the reasons for this are unclear, it is possible that the length and multiple stages of the entire appeals process (including internal health plan appeals) may be a contributing factor. So may other features that could discourage consumer participation in external review, including the scope of eligible disputes, the adequacy of consumer notice, filing fees, filing deadlines, and claims thresholds.

Recent state activity in the area of external review of health plan decisions has been extensive. Today all but a handful of states have laws requiring external review. These programs vary in many important respects, however, so it cannot be said that all residents in these states enjoy similar protections. In particular, which residents and decisions are eligible for external review varies significantly, as do barriers that can prevent consumer access to this protection. External review timelines vary significantly across states. In addition, the independence of the process is not comparable in all states. In many, extensive procedures have been adopted to prevent disputing parties from controlling the process or influencing the decision-making of external reviewers. However, in a significant number of states, health plans pick the external review entity, and expert reviewers are required to follow the health plan's definition of medical necessity.

Congressional proposals have been advanced to establish national standards for external review as part of the patients' rights debate. National standards would apply to enrollees in self-insured employer plans that states cannot regulate (almost half of covered workers). In addition, federal standards could promote more uniformity in state external review programs. Proposed federal standards for external review programs go beyond what states have enacted in many important respects – such as limiting barriers to access, improving consumer notice, expanding eligibility, and protecting the independence of the external review process. On several key provisions, however, most states have gone farther in limiting barriers and promoting independence than federal standards would provide.

Two different approaches are being debated in Congress with respect to preemption of state programs. The Senate-passed bill seeks to establish a floor that would preempt state external review programs that do not meet federal standards, but preserve state programs that meet or exceed federal standards. The House-passed bill, by contrast, seeks to preempt all state programs – those that fall below, meet, or exceed federal standards. Under either bill, however, it is not clear how federal preemptions standards would work in practice. The Senate bill leaves open the possibility that significant variation in state external review programs could persist, including the continuation of some state program features that fall below federal standards. The House bill allows for some variation due to health plan administrative responsibilities, and does not provide implementation

resources for federal agencies, raising questions about the administrability of external review.

In summary, while there remain issues involving the design and operation of state external review programs – most significantly, the relatively small number of appeals that are filed – external review itself is widely viewed as successful in resolving disputes between individuals and their health plans. However, although most states have now established these programs, their future is somewhat in doubt. The House- and Senate-passed patients' rights bills are awaiting resolution of their differences by a conference committee, and any legislation agreed to may or may not force states to change their programs. External review programs may also be affected by the pending Supreme Court case. If the Court decides that state programs are preempted by ERISA (which does not currently confer a right to external review), it could put this protection in a state of flux for consumers.

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