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External Review of Health Plan Decisions:

An Overview of Key Program Features in the States and Medicare

Executive Summary

Prepared for the Kaiser Family Foundation by:

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EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN OVERVIEW OF KEY PROGRAM FEATURES IN THE STATES AND MEDICARE

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EXECUTIVE SUMMARY

In 1978, the state of Michigan established a system to call on independent medical experts to help resolve disputes between health plans and patients about the medical necessity and appropriateness of care. Since then, twelve other states and the Medicare program have established similar kinds of external review programs. In the first half of 1998, five more states enacted external review laws (and two states passed laws modifying or expanding existing programs).

The term "external review" means different things to different people. In this paper, "external review" refers to a formal dispute resolution process, established by a state or federal agency to be independent of disputing parties, that has the capacity to evaluate and resolve at least those disputes involving medical issues. State health plan regulators have other responsibilities that are sometimes characterized as external review. For example, virtually all state insurance departments, and many state health departments, accept, investigate and help resolve consumer complaints about their health plans regarding marketing behavior, premiums, and contractual terms of coverage and exclusion of benefits. However, these complaint resolution processes were not included in this study unless they also incorporate a formal process for resolving disputes over medical issues.

Using this definition, this research identified and studied external review programs in thirteen states and in the Medicare program. Medicare's external review system, established in 1989, is one of the oldest—behind Michigan (1978) and Florida (1985). Unlike state programs, which require consumers to affirmatively request an appeal, Medicare requires that all denials upheld by the health plan's internal review process must automatically be forwarded for external review. Only in three states and Medicare are external review systems set up to resolve all types of consumer disputes – whether or not they involve clinical issues. The other ten study states have established a separate external review process for disputes involving issues of medical necessity or appropriateness; other disputes not about clinical issues must be pursued through a different process. Based on a review of these programs and interviews of experts involved with them, this paper identifies critical features of external review systems and how they vary. (See Table 1.) State and federal policymakers contemplating creation of new external review requirements may benefit from the lessons learned by the states and Medicare.

Major Findings

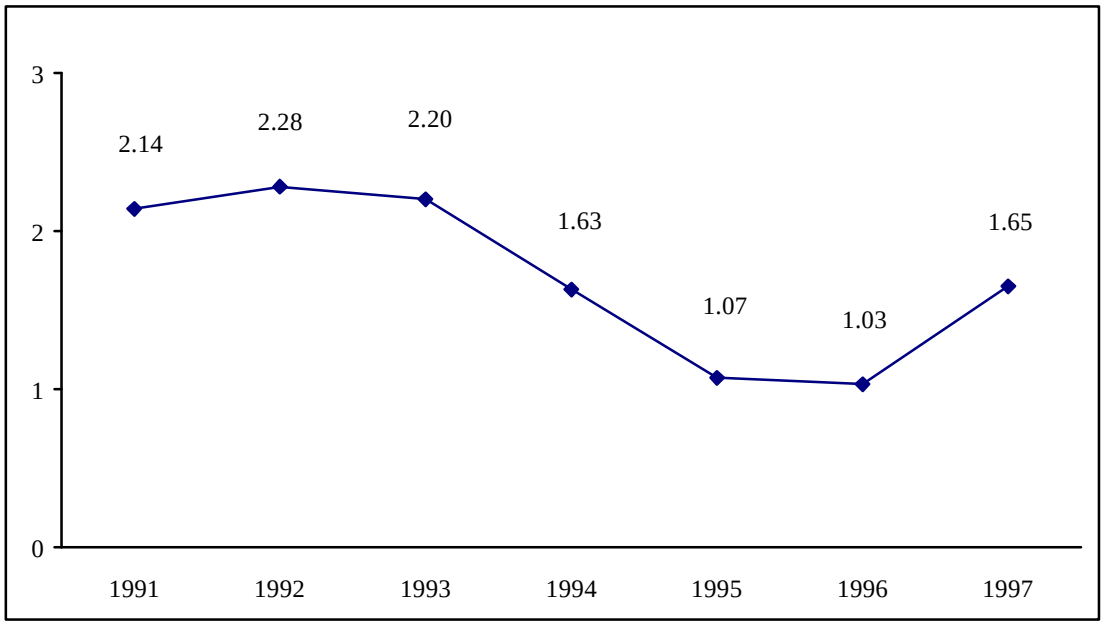
Consumers seek external review of health plan decisions on a wide range of health care services based on issues that are medical, legal, or both. Disputes arise in all types of health plans, over denials of health services ranging from routine to life-saving. (See Table 1, Scope of External Review.) Such denials might be justified on the grounds that services are not medically necessary or appropriate. Or, they might be denied based on other coverage limitations in the health plan contract. Some external review programs hear all types of disputes. Experts from these programs believe their broad scope affords consumers the most comprehensive protection. Other external review programs limit their scope only to disputes over medical issues. Experts from these programs acknowledge that it can be difficult to disentangle clinical issues from other contractual and coverage issues in some cases. State programs that try to separate disputes by type tend to rely on regulatory staff experts to distinguish cases and steer non-clinical issues to other appropriate forums for resolution.

The types of cases for which consumers seek external review are varied and often complex. For example, Rhode Island reviews a significant number of mental health and substance abuse cases relating to the need for inpatient services. In Texas, the largest number of cases has been for pain management and substance abuse treatment, followed by oncology cases. Approximately half of the prospective review cases in Texas have been for "life-threatening" conditions. Cases reaching external review in Missouri included questions of whether speech therapy is restorative, whether hysterectomy or hormone therapy is appropriate treatment, whether a heart bypass surgery patient should receive cardiac rehabilitation, and whether therapy following knee surgery was medically necessary. Consumers also seek external review of health plan decisions involving less expensive care. For example, 20 percent of Medicare's external reviews in 1997 involved denials of medical equipment and supplies, averaging $124 per case.

External review upholds health plan decisions about as frequently as it overturns them. The disposition of cases under external review splits fairly evenly. Across all programs studied, external review overturned health plan decisions between 32 and 68 percent of the time (See Table 1, No. and Disposition of Cases.)

Consumers seek external review infrequently; certain program features may further limit the use of external review. To date, the volume of cases under external review programs is small. In Medicare, external review is performed at a rate of about two cases per 1,000 managed care enrollees per year. (See Figure 1.)

Figure 1
Medicare External Review Cases Per 1000 Managed Care Enrollees, 1991-1997



Source: The Center for Health Dispute Resolution, March 31, 1998.

By contrast, even in large states with long-established external programs, external reviews are performed at a rate that is only a tiny fraction of Medicare's. In Pennsylvania, for example, the external review rate in 1997 was less than 0.04 cases per 1,000 enrollees—less than one-fortieth the rate in Medicare in the same year. In several states, the rate is much lower than had been predicted at the program's outset. Rates of external review per covered enrollees are not presented for all the study states because the scope of external review programs varies and not all health plan regulators were able to provide estimates of the number of consumers covered by their programs. However, the volume of cases in states is uniformly low – less than 250 cases per year in the largest states and even fewer in smaller states. For three states whose scope of external review is similar, Michigan had 49 cases from 1995 through June 1998, Florida had 403 cases from 1993 through April 1998, and Pennsylvania had 729 complaints from 1991 through June 1998. (See Table 1, No. and Disposition of Cases.)

Managed care industry representatives suggested that the small number of cases reflects the generally high quality of care provided by plans and the effectiveness of their internal appeals systems in resolving consumer disputes. However, several state regulators expressed concern over the infrequent use of external review. They cited lack of consumer awareness as a principal reason, followed by the burden of illness, which may prevent consumers from pursuing external review. Some states are exploring new strategies for consumer outreach to expand awareness of external review protections. In Medicare, consumers do not have to request external review. It is automatic for all denials upheld by a managed care plan's internal review process.

Some state external review programs include features that were designed to deter frivolous cases or otherwise keep caseloads manageable – application fees, limits on the types and/or size of claims eligible for review, and imposition of filing deadlines, after which external review is no longer available. However, appeals volumes have been small and the problem of frivolous appeals has not materialized in states, with or without these features. While some health plan regulators did not view these features as impeding consumer access, others expressed concern that they might do so.

The administrative cost of external review is less than $500 in all study states except Texas. In all but one state program, the external reviewer or review entity is paid less than $500 per case. In Medicare, the cost per case is less than $300. In states that rely on volunteer reviewers, the cost is generally much lower. Taking into account the low volume of cases that reach external review, total costs for the program are likely to be small. (See Table 1, Review Cost.)

Independent expertise is a key element of external review. All but one program studied set standards to prohibit conflicts of interest by external reviewers. Objectivity of external reviewers was widely cited as critical to the effectiveness of such programs. Programs vary widely in their approach to accessing appropriate medical experts to participate in external review, though most attempt to include in their process a physician specialist trained in a field relevant to the case under review. Recognizing that disputes often involve both clinical and contractual issues, several programs also include attorneys and other experts in the review process.

Prompt action is another key feature of external review. While timeframes for routine external review vary, in all but one program routine reviews are to be completed in 30 days or less; a two-week time frame is not uncommon. Most programs provide for expedited review of urgent cases in 72 hours or less, as medical exigencies require. Regulators stressed that prompt review is critical to safeguarding meaningful access to care for consumers. Over time, health

plan regulators have taken additional actions to enforce external review time frames, in particular making sure that complete case information is available to reviewers in a timely fashion.

External review decisions usually are binding on health plans. In Medicare and all but two states studied, the decision of the independent external reviewer is binding on health plans. In the two non-binding states, health plans rarely, if ever, fail to follow the external reviewer's recommendation.

External review appears to have a sentinel effect on health plan behavior. Experts we interviewed stressed this repeatedly, citing their own impressions as well as data indicating positive health plan responses to the process. At the outset of Pennsylvania's program, for example, a significant portion of reviews involved denial of emergency room care. Over time, the number of such reviews has dwindled and regulators attribute this to HMOs learning and understanding the state's expectations.

External review programs are widely regarded as valuable and fair. The health plan regulators, external review agency staff, and industry representatives interviewed, alike, reached this conclusion about the process. The fact that the disposition of external review equally favored consumers and plans was cited as both an indication of the need for the process as well as evidence of its objectivity and credibility. Regulators stressed their reliance on these programs for independent medical expertise. Several experts also noted that the growing number of private health plans voluntarily submitting to external review can be interpreted as a vote of confidence in the external review process. Health plan industry representatives stressed external review helps improve public perceptions about managed care and suggested it may reduce the need for health plan liability laws.

TABLE 1. SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Review Cost	Who Pays for Review?	No. of Covered Enrollees	No. and Disposition of Cases *	Program Effective Date
AZ	Medical necessity determinations	Negotiated between health plans and reviewers	Health plan	Not available	Not applicable	July 1998
CA	Experimental and investigational therapies for terminally ill persons	Negotiated between health plans and reviewers	Health plan	Not available	Not applicable	July 1998 (postponed)
CT	Medical necessity determinations	$ 285-$410 depending on contractor	State (with plan licensing fees) Consumer pays $25 filing fee	Not available	18 cases January - July 1998 (6 dismissed at preliminary review, 12 to full review) 66% decided for consumer (of 9 cases decided; 3 reviews pending)	January 1998
FL	Any consumer grievance not resolved by the plan	$65/hour	State (with plan licensing fees)	4.4 million (include 400,000 Medicaid enrollees)	403 cases from 1993 through April 98 (100 cases settled prior to full review; 303 cases to full review) 60% decided for consumer (cases going to full review)	1985
MI	Any consumer grievance not resolved by the plan	Nominal (volunteer reviewers paid expenses)	State	1.8 million commercial and Medicaid HMO enrollees	49 cases from 1995 through June 1998 39% of cases decided for consumer	1978
MO**	Medical necessity determinations (statutory process) Informal regulatory process still applies to coverage issues and preexisting condition determinations	$76/hour	State	1.6 million managed care enrollees	60 cases from 1994 through June 1998 50% of cases decided for consumer	1994
NJ	Medical necessity determinations	$330-$350 (depending on contractor)	Health plan Consumer pays $25 filing fee, reduced to $2 for hardship	3.5 million managed care enrollees	69 cases from March 1997 through July 1998 42% of cases decided for consumer	March 1997
NM	Medical necessity determinations	Nominal (volunteer reviewers)	State	Not available	10 cases March 1997-March 1998 (8 dismissed after preliminary review; 2 to full review) 50 % of cases decided for consumer	March 1997

TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Review Cost	Who Pays for Review?	No. of Covered Enrollees	No. and Disposition of Cases *	Program Effective Date
OH	Experimental and investigational therapies for terminally ill persons	Negotiated between health plans and reviewers	Health plan	2.6 million HMO enrollees	Not applicable	October 1998
PA* **	Any consumer grievance not resolved by the plan	$300 or less	State	5 million	729 cases from 1991 through June 1998; 185 cases in 1997 37% of cases decided for consumer	1991
RI	Emergency cases (prospective and retrospective) and prospective non-emergency medical necessity determinations	$250-$475 (depending on contractor)	Plan pays half, consumer pays half	Not available	59 cases in 1997 68% of cases decided for consumer	1997
TX	Medical necessity determinations	$460-650 (depending on type of case)	Health plan	2.7 million enrollees	218 cases from November 1997 to September 4,1998 (194 cases decided and 24 pending) 48% of cases decided for consumer (includes 11 partially overturned cases)	November 1997
VT** **	Medical necessity determinations in mental health and substance abuse claims	Volunteer reviewers paid honoraria and expenses	State (with licensing fees)	275,000	15 cases sent to independent panel (3 completed formal review; remainder were dismissed at preliminary review or plan paid for care prior to full review) 33% of cases decided for consumer	November 1996
Medicare	Any disputed HMO denial not resolved by the plan	Less than $300 per case	Medicare	5.2 million	Approximately 40,000 cases since 1989, 9025 cases in 1997 31.5% of cases decided for consumer	1989

* Percentage applies to number of cases reaching full external review.

**Table includes information about both Missouri's current external review program, mandated by law, and prior program established by regulatory authority.

***Information in table pertains to Pennsylvania's existing external review program established by regulatory authority. A modified program with different features was enacted in 1998 and will take effect in 1999.

****Information in table pertains to program for Vermont's mental health and substance abuse claims. The state recently enacted a law expanding a somewhat different external review program for other types of health claims. It will take effect in 1999

I. INTRODUCTION

A longstanding role of health insurance regulators has been to help resolve disputes between consumers and their health plans. With the rise of managed care, more and more of these disputes involve health plan decisions to deny or limit coverage based on judgments about the medical necessity or appropriateness of care. As early as the 1970s, regulators began to call on medical experts, independent of the disputing parties, to help resolve these questions.

> "The impetus for the [independent review organization] was a consumer complaint we had in early 1994. An insurer had denied a claim for therapy for a child with a birth defect. The family's physician insisted that the proposed therapy was well established and medically necessary. The company insisted that the therapy was experimental, and therefore not covered. In a meeting with the company on the issue, the company's attorney told me, in effect, that they had medical expertise and the Department of Insurance did not; therefore, we had no say in the matter. As a result, I proposed establishing the IRO, and it went into effect a few months later."
>
> Tom Bixby
> Director, Division of Consumer Affairs
> Missouri Department of Insurance

In 1978, Michigan instituted an external review process to resolve all kinds of disputes (including those involving clinical issues) between consumers and health plans. Florida established an external review program of similar scope in 1985, as did Pennsylvania (in 1991) and Medicare (in 1989). All state external review programs established after 1991 created a new process to review denials of care only on grounds of medical necessity. In these states, the prior regulatory process for reviewing other kinds of disputes remained in place along side the new external review program.

In all, 18 states and Medicare have acted to provide independent expert review of health plan decisions that deny coverage for enrollee health services – 13 states prior to 1998 and five more in 1998. All of these programs review denials based on medical necessity grounds. While several programs have a broader scope, several others only review a subset of such denials. For example, California and Ohio external review programs are limited to denials of experimental therapies for terminally ill patients. Bills to create new external review protections are expected to be considered in Congress and in other state legislatures in 1999.

This report describes existing programs, in 13 states and Medicare, requiring independent external review of health plan decisions that deny coverage for health care services. These programs vary in both scope and structure, and their differences suggest options for policymakers who are considering enactment of new external appeals program. In this paper, we lay out what we found to be the key features of external appeals programs. For each feature, we present options that have been tried and review the experiences encountered so far.

Methodology

We reviewed the external review process in 13 states and the Medicare program. For this paper, we defined "external review" as a process, established by a state or federal government to be independent of disputing parties, that can evaluate and resolve at least those disputes involving medical issues. The states included in the study are: Arizona, California, Connecticut, Florida, Michigan, Missouri, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, Texas, and Vermont.[1] These programs were established prior to 1998 and either had been successfully implemented or – in the cases of Arizona, California and Ohio -- implementation was close enough to completion that detailed information about their expected operation was available.

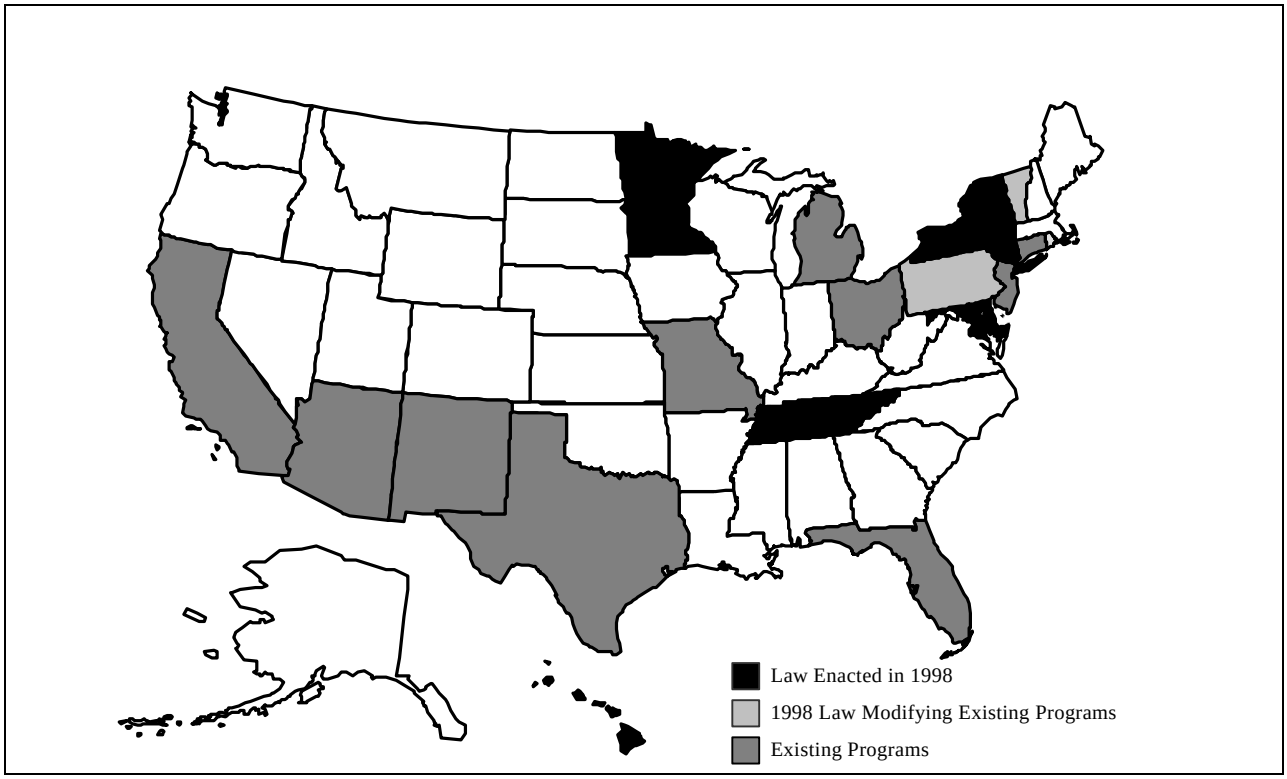
Seven new state external review laws were enacted in 1998 in Hawaii, Maryland, Minnesota, New York, Pennsylvania, Tennessee, and Vermont. (See Figure 1.) The 1998 Pennsylvania law codifies and makes significant changes to that state's program, currently operating by regulation since 1991. A 1998 Vermont law establishes external review rights for all health care services, in contrast with the state's current program for mental health and substance abuse claims only. Hawaii, Maryland, Minnesota, New York, and Tennessee laws also establish new external review protections for all types of health care services. We did not include these seven programs in the study because they have not yet been implemented and there is incomplete information on how these programs will work. A table summarizing these seven state statutes appears in Appendix A.

The information in this study was obtained from a number of sources:

- Interviews with key regulators in each study state and the Medicare program with responsibility for implementing and oversight of the external review process.
- Interviews with representatives of review agencies that had contracts with the study states and Medicare to conduct external reviews.
- Interviews with representatives of health plan associations.
- Analysis of state and Medicare legislation and regulations relating to the external review process.
- Analysis of materials sent by regulators, including contracting requirements for external review entities and data on the number and types of external reviews.

[1] We did not include New Hampshire and North Carolina in this study. Although legislation in each of these states appears to authorize an external review process, this is not the case. New Hampshire legislation authorizes the state to conduct external reviews of whether a plan's appeals process is working, not on grievance decisions made by the plan. In North Carolina, legislation requiring independent review of a plan decision simply requires plans to include in a plan's second level appeals process a physician who was not involved in the initial adverse determination. The physician may not be an employee of the plan, but may be a plan contracting provider.

Figure 1
STATES WITH EXTERNAL REVIEW PROGRAMS
(As of July 1998)



Interviews with experts were conducted on a "background" basis. Consequently, their remarks and observations are described in summary and not attributed to a specific person. A list of experts interviewed appears at the end of this paper in Appendix C.

In our reviews of each external review program, we examined 14 key features:

1. Program history (including total number of reviews to date and examples of cases receiving external review);

2. Types of plans subject to review;

3. Types of issues subject to review;

4. Features affecting consumer access to external review (such as filing fees, minimum dollar thresholds for claims, and requirements that consumers first exhaust their plans' internal appeals process);

5. Notice to consumers of external review rights;

6. Process for choosing the review entity;

7. Qualification of the review entity;

8. Composition of the review entity or reviewers;

9. Review process, including timeframes for regular and expedited reviews;

10. Whether the external review decision is binding or advisory;

11. Source of funding for reviews;

12. Costs of reviews;

13. Government costs associated with the review process; and

14. Government oversight of the review process.

This Report

Chapter II of this paper presents the major findings of our study. Chapters III through VIII examine the variation across states and Medicare of specific features of their external review programs. In Chapter III we review the types of health plans and issues that are subject to external review. Chapter IV examines consumer access to external review as it is affected by various program features. Chapter V discusses the characteristics of external reviewers, including features affecting the independence of their reviews. Chapter VI looks at the external review process, including timelines governing the review process and whether reviews are binding on health plans. In Chapter VII we present findings on the cost of external review in the study states and in Medicare. Chapter VIII looks at oversight of the external review process. Chapter IX presents conclusions.

II. FINDINGS

Our study of the experience of external review programs in thirteen states and Medicare reveals a substantial degree of variation in approach and structure. Some programs, for example, conduct external review through professional independent review organizations (IROs), while others employ less formal arrangements using volunteer reviewers in the community. Some external review programs provide for hearings while others do not. Most provide for external review by a specialist trained in the field of medicine most appropriately related to the case, though some also include other outside legal and lay experts on their review panels.

Even with this variation, however, external review programs exhibit striking similarities in many respects:

Consumers seek external review of a range of health plan decisions. The types of cases for which consumers seek external review are varied and often complex. For example, Rhode Island reviews a significant number of mental health and substance abuse cases relating to the need for inpatient services. In Texas, the largest number of cases has been for pain management and substance abuse treatment, followed by oncology cases. Approximately half of the prospective review cases in Texas have been for "life-threatening" conditions. Cases reaching external review in Missouri included questions of whether speech therapy is restorative, whether hysterectomy or hormone therapy is appropriate treatment, whether a heart bypass surgery patient should receive cardiac rehabilitation, and whether therapy following knee surgery was medically necessary. Consumers also seek external review of health plan decisions involving routine care. For example, 20 percent of Medicare's external reviews in 1997 involved denials of medical equipment and supplies, averaging $124 per case.

The issues involved in external reviews can be medical, contractual, or both. Most state external review programs have separate processes for disputes that involve clinical issues and those that do not. However, because clinical and contractual issues sometimes can be hard to distinguish, some external review programs are set up to review all types of disputes between consumers and health plans.

External review upholds health plan decisions about as frequently as it overturns them. The disposition of cases under external review programs splits fairly evenly. In several states we studied, half of the external reviews to date overturned the health plan's decision. Across all programs studied, external review overturned health plan decisions between one-third and two-thirds of the time. These rates reflect program-wide data, and may not hold true for a particular health plan (See Table 1).

Consumers seek external review infrequently; certain program features may further limit the use of external review. The volume of cases for which state external review has been sought to date is small (See Table 1), though caseloads generally increase over time. Even so, in Pennsylvania, where the external review program operated by the Department of Health is well established and available to some 5 million managed care enrollees, only 185 cases -- or less than 0.04 cases per 1000 covered enrollees – were reviewed in 1997. By contrast, Medicare's external review program (covering a comparable number of health plan enrollees) had a caseload of 9,000 reviews in 1997 alone – a rate of 1.6 reviews per 1000 managed care enrollees, or 40 times that in Pennsylvania.

Health plan association officials generally cited the effectiveness of their plan utilization review procedures and internal appeals programs to explain the small external review caseload. Several state

regulators we interviewed expressed the view that external review may, in fact, be underutilized. They cited lack of consumer awareness as a principal barrier, followed by burdens of illness that may prevent consumers from pursuing external review. Other features of external review programs might serve to limit case loads, including application fees, limits on the types and/or size of claims eligible for review, and imposition of tight filing deadlines, after which external review is no longer an option for consumers. Some of these features were adopted in existing programs – and increasingly have been included in newly enacted programs – to deter "frivolous" appeals. (See Appendix A.) However, regulators report that the problem of meritless appeals and unmanageable caseloads has not materialized in any state program, with or without these features.

The administrative cost of external review is less than $500 in all study states but one. In all but Texas, the external reviewer is paid less than $500 per case. In Medicare, the cost per case is less than $300. In states that rely on volunteer reviewers, the cost is generally much lower. Taking into account the volume of cases that reach external review, total costs for the program are likely to be small.

Independent expertise is a key element of external review. All but one program we studied set standards to prohibit conflicts of interest on the part of external reviewers. Objectivity of external reviewers was widely cited as critical to the effectiveness of such programs. Programs vary widely in their approach to accessing appropriate medical experts to participate in external review, though most attempt to include in their process a physician specialist trained in a field relevant to the case under review. Recognizing that disputes often involve both clinical and contractual issues, several programs also include lawyers and other types of outside experts in their review process, while other state programs rely on in-house legal and regulatory expertise when reviewing disputes that do not involve clinical issues.

Prompt action is another key feature of external review. While time frames for routine external review vary, in all but one program routine reviews must be completed in 30 days or less; a two-week time frame is not uncommon. Most programs provide for expedited review in urgent cases in 72 hours or less, as medical exigencies require. Regulators stressed that prompt review is critical to safeguarding meaningful access to care for consumers. Over time, regulators have taken additional actions to enforce external review time frames, in particular making sure that complete case information is available to reviewers in a timely fashion.

External review decisions usually are binding on health plans. In Medicare and all but two study states, the decision of the independent external reviewer is binding on health plans. In the two non-binding states, health plans rarely, if ever, fail to follow the external reviewer's recommendation.

External review appears to have a sentinel effect on health plan behavior. Regulators we interviewed stressed this repeatedly, citing their own impressions as well as data from their external review programs indicating positive health plan responses to the process. At the outset of Pennsylvania's program, for example, a significant portion of reviews involved denial of emergency room care. Over time, the number of such reviews has dwindled; regulators attribute this to HMOs learning and understanding the state's expectations. Overall in that state, the proportion of all cases decided for the consumer was high at the program's outset in 1991, and has gradually decreased over time.

External review programs are widely regarded as valuable and fair. Regulators, external review agency staff, and industry representatives, alike, reached this conclusion about the process. The fact that the disposition of external review equally favored consumers and plans was cited as both an indication of the need for the process as well as evidence of its objectivity and credibility. Regulators stressed their

reliance on these programs for independent medical expertise. Several experts also noted that the growing number of private health plans voluntarily submitting to external review can be interpreted as a vote of confidence in the external review process. Health plan industry representatives suggested that the external review process helped improve public perceptions about managed care and reduced the need for health plan liability laws.

Comments About the External Review Process

"Hopefully people will feel they have another avenue to go to when they really are in a

"People who take it this far need it the most or feel they have been badly treated by the system. [External review] gives objective resolution that everyone can live with."

"Whenever there is [an external] review process, [plans] factor the review process in their

"For people who feel they have not gotten what they need in the plan, the external review process is very important. Reviews are the best way of improving medical care."

"External review provides incentives [for plans] to solve problems internally."

"People need to feel confident that good medical decisions are being made. There is a sense that people don't trust their plans. This gives them comfort there is somewhere they can turn for credibility and accountability."

TABLE 1. SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Who Performs Reviews?	Review Binding?	Review Cost	Who Pays for Review?	Number of Covered Enrollees	Number and Disposition of Cases *	Program Effective Date
AZ	Medical necessity determinations	Insurance Department-approved IRO or individual physicians	Yes	Negotiated between health plans and reviewers	health plan	not available	not applicable	July 1998
CA	Experimental and investigational therapies for terminally ill persons	Accredited IROs, which may also be academic health centers	Yes	Negotiated between health plans and reviewers	health plan	not available	not applicable	July 1998 (postponed)
CT	Medical necessity determinations	One of 3 contracting IROs	Yes	$ 285-$410 depending on contractor	state (with plan licensing fees) consumer pays $25 filing fee	not available	18 cases January - July 1998 (6 dismissed at preliminary review, 12 to full review) 66% decided for consumer (of 9 cases decided; 3 reviews pending)	January 1998
FL	Any consumer grievance not resolved by the plan	State employee panel, advised by outside physicians	Yes	$65/hour	state (with plan licensing fees)	4.4 million (include 400,000 Medicaid enrollees)	403 cases from 1993 through April 98 (100 cases settled prior to full review; 303 cases to full review) 60% decided for consumer (cases going to full review)	1985

TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Who Performs Reviews?	Review Binding?	Review Cost	Who Pays for Review?	Number of Covered Enrollees	Number and Disposition of Cases	Program Effective Date
MI	Any consumer grievance not resolved by the plan	Health Department-appointed task force	Yes	Nominal (volunteer reviewers paid expenses)	state	1.8 million commercial and Medicaid HMO enrollees	49 cases from 1995 through June 1998 39% of cases decided for consumer	1978
MO**	Medical necessity determinations (statutory process) Informal regulatory process still applies to coverage issues and preexisting condition determinations	IRO contracting with state	Yes	$76/hour	state	1.6 million managed care enrollees	60 cases from 1994 through June 1998 50% of cases decided for consumer	1994
NJ	Medical necessity determinations	One of 2 IROs contracting with state	No	$330-$350 (depending on contractor)	health plan consumer pays $25 filing fee, reduced to $2 for hardship	3.5 million managed care enrollees	69 cases from March 1997 through July 1998 42% of cases decided for consumer	March 1997
NM	Medical necessity determinations	Insurance Department-appointed Independent Review Board	Yes	nominal (volunteer reviewers)	state	not available	10 cases March 1997-March 1998 (8 dismissed after preliminary review; 2 to full review) 50 % of cases decided for consumer	March 1997

TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Who Performs Reviews?	Review Binding?	Review Cost	Who Pays for Review	Number of Covered Enrollees	Number and Disposition of Cases	Program Effective Date
OH	Experimental and investigational therapies for terminally ill persons	Insurance Department-approved IROs, which may be academic health centers	Yes	negotiated between health plans and reviewers	health plan	2.6 million HMO enrollees	Not applicable	October 1998
PA* **	Any consumer grievance not resolved by the plan	Committee of state regulatory staff, advised by outside physicians	No	$300 or less	state	5 million	729 cases from 1991 through June 1998; 185 cases in 1997 37% of cases decided for consumer	1991
RI	Emergency cases (prospective and retrospective) and prospective non-emergency medical necessity determinations	One of 2 IROs contracting with state	Yes	$250-$475 (depending on contractor)	plan pays half, consumer pays half	not available	59 cases in 1997 68% of cases decided for consumer	1997

TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Who Performs Reviews?	Review Binding?	Review Cost	Who Pays for Review	Number of Covered Enrollees	Number and Disposition of Cases	Program Effective Date
TX	Medical necessity determinations	IRO contracting with state	Yes	$460-650 (depending on type of case)	health plan	2.7 million enrollees	218 cases from November 1997 to September 4,1998 (194 cases decided and 24 pending) 48% of cases decided for consumer (includes 11 partially overturned cases)	November 1997
VT****	Medical necessity determinations in mental health and substance abuse claims	Insurance Department-appointed panel of providers	Yes	volunteer reviewers paid honoraria and expenses	State (with licensing fees)	275,000	15 cases sent to independent panel (3 completed formal review; remainder were dismissed at preliminary review or plan paid for care prior to full review) 33% of cases decided for consumer	November 1996
Medicare	Any disputed HMO denial not resolved by the plan	IRO contracting with Medicare	Yes	less than $300 per case	Medicare	5.2 million	approximately 40,000 cases since 1989, 9025 cases in 1997 31.5% of cases decided for consumer	1989

* Percentage applies to number of cases reaching full external review.

**Table includes information about both Missouri's current external review program, mandated by law, and prior program established by regulatory authority.

***Information in table pertains to Pennsylvania's existing external review program established by regulatory authority. A modified program with different features was enacted in 1998 and will take effect in 1999.

****Information in table pertains to program for Vermont's mental health and substance abuse claims. The state recently enacted a law expanding a somewhat different external review program for other types of health claims. It will take effect in 1999.

III. TYPES OF HEALTH PLANS AND ISSUES SUBJECT TO EXTERNAL REVIEW

The programs we studied establish different rules about what types of plans and disputes will be subject to external review. As a result the scope of external review programs varies considerably. Table 2, at the end of this chapter, summarizes different approaches adopted by states and Medicare.

Types of Plans Subject to External Review

Most state external review programs apply to all state-licensed health plans.[2] However, some states require external review only for HMOs or other managed care plans.

Experience:

Seven states extend the right to external review to enrollees of any licensed health insurer or plan, or of any plan that imposes utilization review requirements.[3] (See Table 2.) Connecticut applies external review to plans with utilization review components that also have a network of participating providers. Five states (Missouri, New Mexico, Michigan, Ohio, and Pennsylvania) limit external review to managed care plans only. This limitation generally flows from the licensing law or jurisdiction of the agency responsible for external review. The Medicare external review program applies to beneficiaries who enroll in HMOs,[4] although fee-for-service Medicare beneficiaries also have administrative and judicial appeal rights.

A recent federal court decision raises questions about states' continued ability to require external review for fully insured employer group health plans. (See Appendix B.) In September 1998, the United States District Court for the Southern District of Texas held that federal law (the Employee

[2] All state external review requirements are limited to state-regulated health insurers—that is, carriers who write coverage for individual health plans and fully insured group health plans. The Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of self-funded employer plans and, in some instances, even state regulation of the insurer in a fully insured group health plan arrangement.

[3] Utilization review refers to techniques used by health plans to control costs by managing enrollees' use of health care services. Examples of prospective utilization review techniques include requiring prior authorization of hospital care or expensive ambulatory services such as MRI, requiring primary care physician referrals for specialist visits, and requiring second opinions for surgery. Health plans also conduct concurrent and retrospective utilization review to manage care that is ongoing, or to limit payment for services about which questions arise after the fact.

[4] The Balanced Budget Act of 1997 extends external review to all Medicare+Choice (M+C) plans, including M+C fee-for-service, medical savings account, and PPO-type plans.

Retirement Income Security Act of 1974, or ERISA) preempts Texas's external review law as it applies to fully insured group health plans. However, this decision is not likely to be the last word on the subject of preemption. This Court's jurisdiction includes only Texas, and in past decisions on related issues, other federal courts have interpreted ERISA's requirements and preemption clause differently. Further, even in Texas, the insurer that initiated the federal lawsuit – which included a challenge to a malpractice provision in the same statute as the external review law – has joined the state in asking the federal judge to temporarily leave the external review process in place. According to a spokesperson for the Texas HMO association, the federal suit was not brought with the intent of overturning external review, a process the industry views positively. The state and the industry are exploring options to retain the process in some form following the judge's ruling.

Types of Issues Subject to External Review

Several external review programs are established to resolve all types of disputes, though most only hear cases involving medical necessity or other clinical issues. To illustrate the difference between clinical and other contractual coverage issues, consider four different reasons why a plan might deny coverage for a health care service:

- the denied service, although covered by the plan, was determined not to be medically necessary (i.e., appropriate or effective for the particular patient in that case);
- the service was provided by an out-of-network physician;
- the consumer did not obtain required pre-authorization for the service; or
- the service was for a preexisting condition, and therefore excluded under the contract.

While the first of these reasons for denial clearly is based on grounds of medical necessity, the other three reasons might or might not be challenged on clinical grounds – regarding the ability of plan providers to render needed care; the extent to which illness hampered a patient's ability to seek prior authorization; or medical evidence indicating the origin or discovery of a patient's condition.

The separation of dispute resolution processes based on the nature of the dispute may create more complexity in the system from the consumers' perspective, or it may limit their access to external review altogether for certain types of disputes. It also raises issues about ERISA preemption of state external review programs. (See Appendix B.)

Experience:

State programs and Medicare differ in the types of issues that are eligible for external review. In three states (Florida, Michigan and Pennsylvania) and in Medicare, a single external review program is set up to investigate and resolve the broadest possible range of disputes between consumers and health plans —including both contractual coverage issues and clinical issues relating to medical necessity. Regulators for states that provide reviews for all disputes believe their states' policies afford the greatest degree of protection to consumers with the least complexity. A Pennsylvania regulator cited an example where the state overturned a health plan decision to deny care based on a contractual limitation. The consumer needed extensive physical therapy and her primary care physician issued referrals for those services at a participating physical therapy facility. The plan later demanded repayment from the consumer for physical therapy visits beyond 60 days because the contract contained a 60-day-per-calendar-year limit. Upon external review, the Department of Health recommended the plan not require the member to pay for the excess therapy visits because neither the plan nor the primary care physician bothered to track the number

of visits as they were provided. The Department believed the member was entitled to rely on referrals provided by her primary care physician and should not be held liable for the failure of the HMO to monitor and medically manage care.

Similarly, a representative from the Medicare review entity argued that meaningful consumer protection requires objective external review of all types of disputes. He gave as an example the case of an enrollee who obtained durable medical equipment from a non-contracting supplier after being told orally by the plan provider that he could do so. The plan denied the services as non-covered, but was overturned by the independent review organization (IRO). Over half of Medicare external reviews relate to non-medical necessity disputes, such as enrollee failure to follow the plan's service approval procedures, or the use of out-of-network providers.[5]

In all ten other state programs we studied, disputes involving questions of medical necessity or clinical judgment are handled separately from coverage questions. The reasons for this separation vary. In some states, the existing regulatory framework was deemed adequate to resolve disputes over contract and market conduct issues, but not for medical necessity issues calling for clinical expertise. One external medical reviewer we interviewed felt his review organization was not as well equipped as the state insurance department to assess coverage issues. Generally, in states that have separate review processes for coverage and medical disputes, a screening process is in place to refer coverage issues for investigation and resolution in some other manner. Depending on how this screening is handled, rerouting of complaints lodged initially with the wrong review process may or may not pose a burden on consumers.

When dual-review processes exist, distinguishing issues that involve medical judgments from those that do not is not always straightforward. Take as an example a case reviewed in Florida involving a health plan that covers out-of-network care only in cases where no providers in the plan's network are qualified to render the services. In this case, a patient had a dual diagnosis of mental illness and addiction. A number of clinicians in her plan's network were trained to treat one condition, but none had experience treating the two conditions simultaneously. When the patient sought treatment from an out-of-network specialist who was qualified to treat the dual diagnosis, her health plan denied reimbursement because providers qualified to treat the two conditions separately were available in-network. In appealing this denial, the consumer was arguably raising a contractual coverage issue. On the other hand, doctors reasonably disagreed about whether the difference in quality of care received from the out-of-network doctor was medically necessary (and therefore covered under the plan contract). This case was, in fact, referred for external review and the health plan's decision to deny access to out-of-network care was overturned.

In many other states, such "gray" issues involving both medical necessity and coverage questions also would be referred to medical external review. For example, the recently enacted law in New York explicitly states that any appeal involving "in whole or in part" a decision about medical necessity is eligible for external review. In some states, however, the case might be referred elsewhere – for example, to a consumer complaints division in the insurance department – or might be denied review altogether.

Of the ten states that apply external review only to medical decisions, four further restrict the types of claims eligible for external review. Three states limit external reviews to specific conditions. California

[5] National Health Policy Forum, The George Washington University*, Issue Brief: ERISA Health Plan Denials: Exploring Models for External Review*, June 1997.

and Ohio provide external review only for cases of experimental and investigational therapies for persons with a terminal illness (defined as having a high probability of death within two years). Vermont currently limits reviews to mental health and substance abuse determinations, although a new law enacted in May 1998 will extend reviews to all issues of medical necessity when it is implemented in 1999. In a fourth state, Rhode Island, only prospective denials of care (denials made when the enrollee seeks prior authorization for care) and denials of emergency services (either prospective or retrospective) are eligible for external review. This limitation was opposed by the Department of Health, but adopted by the legislature.

TABLE 2. TYPES OF HEALTH PLANS AND ISSUES SUBJECT TO EXTERNAL REVIEW		
State/Program	**Plans Subject to External Review**	**Issues Subject to External Review**
AZ	All plans with utilization review	Issues relating to determinations of medical necessity
CA	All health plans	Only experimental and investigational therapies for persons with terminal illness
CT	All plans with utilization review that also have a network of participating providers	Issues relating to determinations of medical necessity
FL	All health plans	Any consumer grievance not resolved internally by the plan
MI	HMOs and alternative financing and delivery system plans	Any consumer grievance not resolved internally by the plan
MO	Only managed care plans with network (not indemnity plans)	Statutory process applies to issues relating to adverse determinations, including medical necessity, experimental treatment, etc. Previous informal process still applies to coverage issues and preexisting condition determinations
NJ	All health benefit plans that use utilization review	Issues relating to determinations of medical necessity Coverage and network issues only as they relate to medical necessity
NM	Only managed care plans (includes PPOs)	Issues relating to determinations of medical necessity Coverage issues only as they relate to medical necessity
OH	Only managed care plans (licensed health insuring corporations)	Only experimental and investigational therapies for persons with terminal illness
PA	Only plans licensed as HMOs and gatekeeper PPOs	Any consumer grievance not resolved internally by the plan
RI	All utilization review entities, including HMOs that have UR certificates	Only prospective and concurrent non-emergency determinations of medical necessity and all emergency service denials
TX	All health plans with utilization review	Issues relating to determinations of medical necessity and appropriateness Coverage and network issues only as they relate to medical necessity, such as experimental treatment issues
VT	All health plans with utilization review of mental health	Mental health and substance abuse claims only
Medicare	All Medicare+Choice plans	Any consumer appeal not resolved internally by the plan

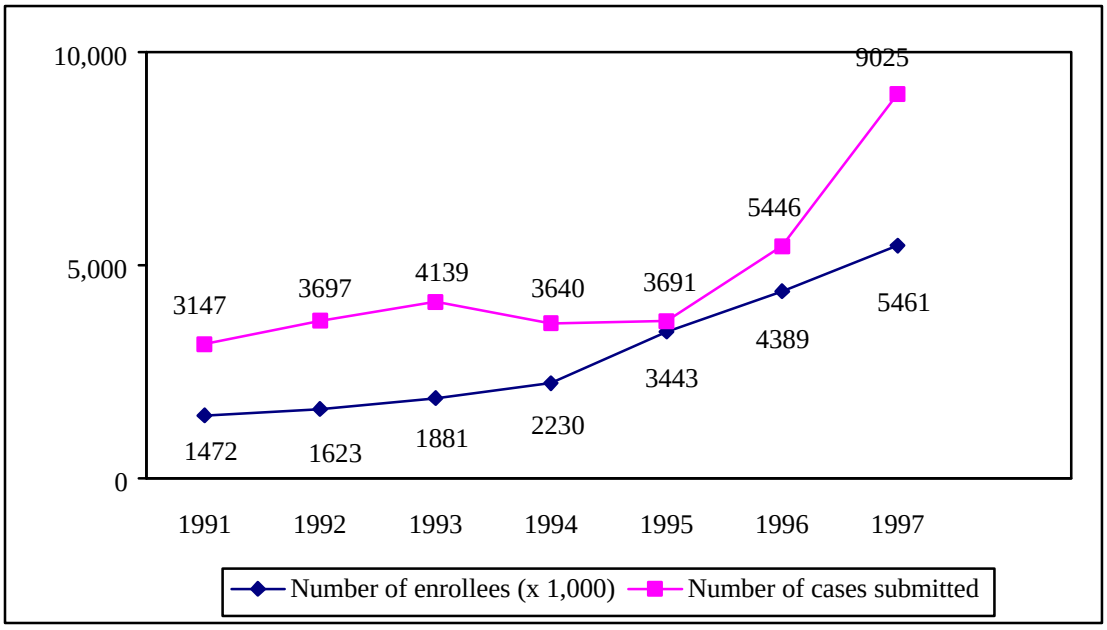
IV. CONSUMER ACCESS TO EXTERNAL REVIEW

One notable feature of all external review programs is the low volume of cases, either in absolute numbers, or relative to the number of covered consumers, or both. This chapter reviews the volume of external review cases experienced by programs and explores its significance and possible factors contributing to it.

Volume of Cases

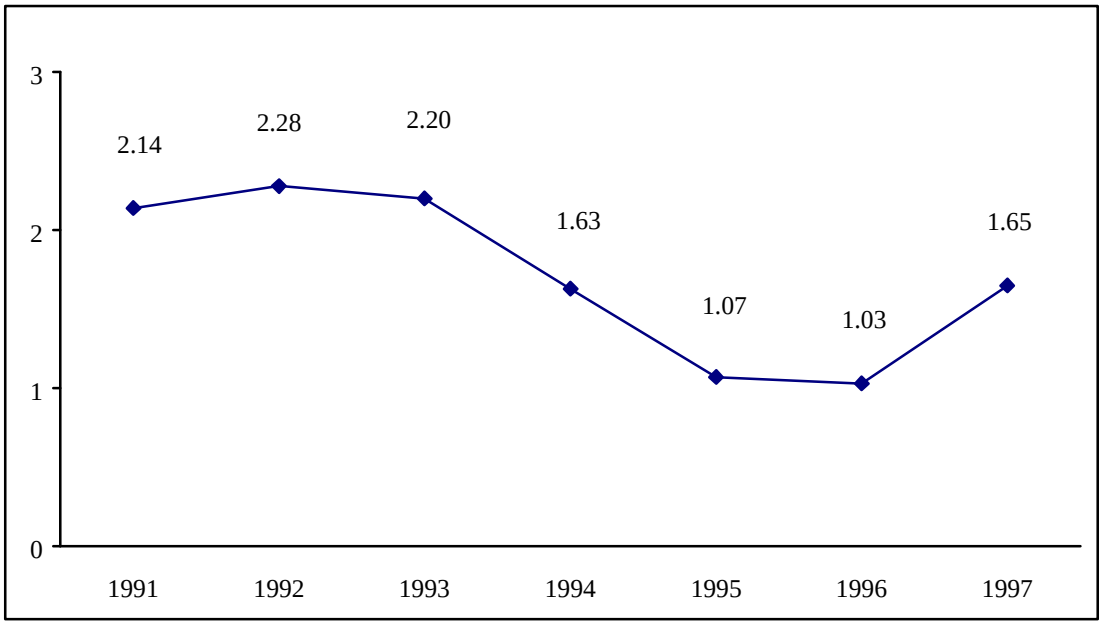
Relative to the broad array of managed care plans subject to external review, the number of cases brought to external review is quite low in all state programs. By far, the largest external review caseload is found in Medicare, where some 40,000 external reviews of managed care plan decisions have been conducted since 1989. The number of cases per year has grown steadily with Medicare managed care enrollment. (See Figure 2.) However, the rate of external reviews has remained near or below two cases per 1,000 enrollees during this time. (See Figure 3.)

Figure 2
Medicare Managed Care Enrollees and External Review Cases, 1991 - 1997



Source: The Center for Health Dispute Resolution, March 31, 1998.

Figure 3
Medicare External Review Cases Per 1000 Managed Care Enrollees, 1991-1997



Source: The Center for Health Dispute Resolution, March 31, 1998.

By comparison, state external review programs have experienced a small fraction of Medicare's caseload. In Pennsylvania, for example, whose managed care enrollment size is similar to Medicare's, the external review rate per 1,000 enrollees in 1997 was less than 0.04 – less than one-fortieth the rate in Medicare in the same year. Normalized rates of external review are not presented for all the study states because the scope of external review programs vary and not all regulators were able to provide estimates of the number of consumers covered by their programs. However, the volume of cases in states is uniformly low – less than 250 cases per year in the largest states and even fewer in smaller states. (See Table 1.)

oad may be due to a number of factors. First, elderly and disabled Medicare beneficiaries tend to use health services more heavily than the non-Medicare population, and so may have more opportunities for health plan disputes in the first place. Second, as Medicare managed care grows rapidly, beneficiaries may be less familiar with health plan rules (and/or health plans may be less familiar with how to serve Medicare beneficiaries), also giving rise to more disputes. Third, Medicare beneficiaries are served by a community of consumer advocates that may be more organized and attuned to this issue than is true for consumers under age 65. Finally, and possibly most importantly, under Medicare all denials upheld by the health plan's internal review process must be automatically forwarded for external review. This contrasts with state programs, under which consumers must appeal denials at every step in the review process.

In addition to these factors, state regulators cited two other key reasons that may explain the apparently low volume of external review cases. First, consumers may not be aware they have the right to external review of adverse health plan decisions. Second, when consumers are ill, disabled, or in pain, they may not be able to take action in response to a health plan denial. Other studies have supported what these state

regulators believe to be true.[6] Certain other features of external review programs may serve either to encourage or discourage consumers to pursue the process. These are examined below and summarized in Tables 3 and 4.

Plan representatives have a somewhat different explanation for the low rate of external appeals. They argue that it is evidence of the generally high quality of care provided by plans and the effectiveness of plans' internal appeals processes in resolving consumer complaints.

Required Exhaustion of the Internal Appeals Process

Most programs require consumers to first exhaust the internal appeals process in their health plan before seeking external review. The purpose of this requirement is to encourage disputes to be resolved internally whenever possible. However, some officials worried that this requirement, in some or all circumstances, might inappropriately hinder consumer access to external review.

Experience:

Missouri is the only state that explicitly does not require citizens to use their health plan internal appeals process before requesting external review. Staff members in the Insurance Department believe Missouri citizens should not face barriers to petitioning their state government for relief.

The other 12 study states require (as a matter of law or policy) consumers to exhaust a plan's internal appeals process before requesting an external review. Medicare also requires consumers to complete the managed care plan's internal appeals process before seeking external review. In four of these twelve states, exceptions permit direct access to external review in some circumstances. Florida permits direct access to external review for emergency cases, while Texas grants direct access for consumers with "life-threatening conditions." New Mexico's Superintendent of Insurance has discretion to accept cases directly for external review. Michigan allows consumers who have obtained an expedited plan review to bypass the rest of the plan's internal appeals process and go directly to external review if a physician states orally or in writing that the time frame for a standard grievance would jeopardize the enrollee's life. Medicare beneficiaries must pursue internal plan appeals first; however, if a plan does not provide for timely appeals, the internal appeal is interrupted and the case must be sent forward for external review.

Requiring consumers to exhaust a plan's appeals process reduces the caseload for external review and minimizes outside intervention in health plan decision making. However, because the time involved in

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[6] Insufficient use of complaint appeal systems also has been identified as a problem by the president of the National Association of Insurance Commissioners. See John K. Iglehart, "State Regulation of Managed Care: NAIC President Josephine Musser," *Health Affairs,* Vol. 16, No. 6 (Nov.-Dec. 1997).

See also U.S. General Accounting Office, *HMO Complaint and Appeals: Most Key Protections in Place, but Others Valued by Consumers Largely Absent,* May 1998. This report concluded that improved consumer knowledge might lead to more appropriate use of complaint and appeal systems;

See also the Lewin Group, Inc., and Survey Methods Group, Inc., *Survey of Consumer Experiences in Managed Care,* November 1997. This survey of consumers in Sacramento, California, found fewer than half contacted their health plan in response to their most recent difficulty with the plan. Of the consumers who did nothing in response to their problem, 26 percent said they did not think taking action would do any good, 24 percent said it was not worth the time, and 14 percent said they did not know what to do.

exhausting a plan's appeals process can be lengthy (see Chapter 6), a number of state regulators felt that direct access to external review is desirable in emergency cases and under other circumstances – for example if health plans do not complete their appeals process within required time frames.

Deadlines for Applying for External Review

Some states require consumers to request external review within a specified time after the health plan denial (or after the health plan appeals process upholds the denial). Others omit this feature due to concerns that some consumers in need of external review might be unable to meet filing deadlines.

Experience:

Seven of the state programs we reviewed—Arizona, Connecticut, Florida, Michigan, New Jersey, New Mexico, and Rhode Island—set a maximum time limit following an adverse determination (or completion of the health plan's internal appeals process) during which enrollees can request external review. In five of these states, this statute of limitations is between 30 and 60 days. Florida uses a one-year limit and Michigan a two-year limit, unless a consumer can show that circumstances required a longer period of time. Five of the seven state external review laws enacted in 1998 set filing deadlines on consumers. The shortest of these, enacted in Pennsylvania's new external review law, is 15 days from the conclusion of the internal plan grievance process. (See Appendix A.) Regulators in these states did not identify filing deadlines as a problem for consumers seeking external review.

The other six state programs—California, Missouri, Ohio, Pennsylvania (current system), Texas, and Vermont—do not impose any time limits for consumers to request an external review. According to several state regulators, too short timeframes could harm consumers who are unaware of limits or who cannot file in a timely manner. Regulators noted that compliance with statutes of limitations can be particularly difficult for sick, disabled, and elderly consumers.

In Medicare, where external review is automatic, the filing deadline applies only to health plans. Plans are required to send all denials they uphold in their internal appeals process to the IRO no later than 30 days after the enrollee requests internal appeal.

Minimum Dollar Threshold for External Review of Claims

In recent federal and state debates, it has been suggested that external review should be reserved only for disputes involving claims above a significant dollar threshold. This feature, it is argued, will focus review resources on the most serious disputes and prevent the system from incurring external review costs disproportionate to the claims amount involved.

Experience:

No state external review program in operation requires a minimum dollar threshold for external review. The Medicare program also sets no claims threshold for external reviews. However, for a Medicare managed care beneficiary to appeal the external reviewer's decision to a federal administrative law judge, the claim(s) must involve at least $100 in the aggregate.

Even so, as new external review programs are established or contemplated, there seems to be growing interest in establishing a dollar threshold for claims. The President's Advisory Commission on

Consumer Protection and Quality in the Health Care Industry recommended that consumers have access to an external review system only if the amount of the service "exceeds a significant threshold."[7] This recommendation assumed that the dollar amount of claims involved should be sufficient to warrant the expense of conducting an external review. Vermont's new external review law, enacted in 1998, includes a $100 claims threshold, while a new Tennessee law sets a $1000 claims threshold for external review.

Regulators we interviewed did not think such a threshold is necessary. Their experience is that disputes involving small amounts of money tend to be resolved well before the option of external review is reached. Theoretical concerns about a glut of low-dollar cases clogging the external review process simply have not come to pass. To the contrary, some regulators expressed concern that a claims threshold could become a barrier to consumers' access to external review. Regulators generally felt that beneficiaries should have access to the external review process for inappropriate denials, regardless of the dollar amount of the claim involved. Representatives from health plans noted that while they would prefer to see dollar thresholds added, caseloads so far have been low in their absence.

Consumer Charges

Recent debates also have focused on the appropriateness of user fees or other charges to consumers seeking external review. Some argue such charges fairly allocate a portion of review costs to consumers and help to discourage frivolous cases. Others see consumer charges as a barrier to external review protections.

Experience:

Only three states currently impose charges on consumers seeking external review. Connecticut and New Jersey require a $25 filing fee to defray review costs and to discourage appeals that lack merit. The fee is waived in Connecticut if individuals certify that they are indigent, and it is reduced to $2 in New Jersey for financial hardship. Rhode Island is the only state that requires consumers to pay a significant amount — 50 percent — of review costs. This fee cannot be waived for any reason. Of the seven newly enacted state external review laws, four require consumer fees.

The remaining 10 states and Medicare do not impose consumer fees. Reasons cited for not imposing fees were that such charges were not necessary, either to finance review cost or to discourage frivolous cases; fees could pose a barrier to consumer appeals; and fees could be administratively bothersome to collect. Although New Jersey and Connecticut regulators did not feel that the $25 filing fee was a barrier to individuals seeking review, interviewees familiar with the Rhode Island system felt that requiring consumers to pay half the review costs acted as a serious barrier to review in many cases. Several state regulators noted that policymakers in their states explicitly rejected imposing a filing fee because of a belief that consumers should not be charged for seeking state assistance. One regulator noted that consumers had already paid plan premiums as well as state taxes for government assistance and should not be charged further for seeking help.

Some health plan industry representatives said they supported consumer filing fees during their external review debate. In one state with no fees, the industry official said plans must depend on the

[7] The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Quality First: Better Health Care for All Americans: Final Report to the President of the United States* (Washington, D.C.: U.S. Government Printing Office, 1998).

insurance department to screen out frivolous cases. He acknowledged that department screening had been effective so far and hoped it would continue to be so in the future. Another state industry official, though, said he believes consumers in his state have more confidence in managed care as a result of external review, and therefore saw no need for consumer fees.

TABLE 3. CONSUMER ACCESS TO EXERNAL REVIEW				
Program	**Require Exhaustion of Plan's Internal Appeals?**	**Claims Threshold**	**Filing Deadline**	**Consumer Charges**
AZ	Yes	No	30 days	None
CA	Yes	No	None	None
CT	Yes	No	30 days	$25 waived if consumer certifies they are indigent
FL	Yes, except in extreme emergencies	No	One year	None
MI	Yes, unless members obtained expedited review in plan	No	Two years, unless consumer can show that a longer time frame is necessary	None
MO	No	No	None	None
NJ	Yes	No	60 days	$25 $2 if financial hardship
NM	Yes, although state can waive requirement	No	30 days	None
OH	Yes	No	None	None
PA	Yes	No	None	None *
RI	Yes	No	60 days after exhaustion of internal appeal	Consumer pays half of review costs
TX	Yes, except for life threatening conditions	No	None	None
VT	Yes	No**	None	None**
Medicare	Yes	No	Plans must automatically forward denials for review	None

*For its new external review program, to be implemented in 1999, Pennsylvania may require enrollees to pay a filing fee of up to $25.

**Applies to mental health/substance abuse reviews only. For its new external review program, to be implemented in 1999, Vermont will require that $100 or more be at dispute and that members pay a $25 filing fee, waived for financial hardship.

Enrollee Notice of External Review Rights

As noted above, some experts expressed concern that consumers are ill informed about their external review rights. Several states are exploring new options to raise public awareness about the external review process. (See Table 4.)

Experience:

Almost all of the states we studied and the Medicare program require health plan enrollment materials — including the evidence of coverage and enrollee handbooks — to include an explanation of external review rights in clear, understandable language. Some states explicitly require the notice to be displayed prominently in plan materials in large-size type.

All programs also require health plans to communicate each adverse decision to enrollees in writing, and to include in that written notice an explanation of the right to external review and instructions on how to make the appeal. Connecticut's Insurance Department also has an "External Appeal Consumer Guide," which explains the process for filing an appeal and includes a checklist of items that must be included.

In addition to these notice requirements, several states have adopted other practices to raise public awareness about their external review programs. Pennsylvania and Texas, for example, recently established new toll-free hotlines from which consumers can obtain more information about external review. Texas also provides consumer information on the Department of Insurance's web page. Vermont and Pennsylvania publish brochures explaining consumers' external review rights and distribute these as broadly as possible, including through state medical associations. In New Jersey, state-published health plan report cards also describe enrollees' external review rights. Several states mentioned outreach to physicians, through medical societies and other means, as part of their strategy to educate consumers. In a unique approach, Florida requires health plans to report quarterly to the state on all adverse decisions upheld by the plan's internal appeals process. The state then directly notifies each consumer with an unresolved dispute, explaining the external review process and offering to assist in the filing of an appeal. Florida estimates that about one-half of consumers respond to this state notice about their opportunity for external review. In about one-fourth of these cases, the health plan settles with the consumer before the case goes to full review.

Vermont recently enacted a law creating a new consumer ombudsman office. Working with existing regulatory staff, this office will help consumers individually to understand their protections and navigate health plan and regulatory rules and procedures.

As stated earlier, Medicare requires that *all* health plan denials upheld in whole or in part by the plan internal appeals process be forwarded automatically for external review. This factor would appear to contribute to the significantly higher caseload of external reviews (per 1000 enrollees) under the Medicare program. Automatic referral of adverse determinations for external review has the effect of eliminating many barriers to consumers who seek this redress.

TABLE 4. ENROLLEE NOTICE OF RIGHT TO EXTERNAL REVIEW			
Program	**Notice in Plan Enrollment/Member Information?**	**Notice in Letter of Denial?**	**Other**
AZ	yes	Yes	--
CA	yes	yes	--
CT	yes	yes	Department prints brochures explaining appeal rights and distributes broadly
FL	yes	yes	Department learns of adverse decisions through quarterly plan reports and directly notifies enrollee of right to external review of the decision
MI	yes	yes	--
MO	yes	yes	--
NJ	yes	yes	The New Jersey HMO report card includes information on the external review process
NM	yes	yes	--
OH	yes	yes	--
PA	yes Health plans also are required to inform members of external review rights at least annually, usually through publication in plan's consumer newsletter or magazine	Yes	Bureau of Managed Care publishes consumer brochures and recently established a toll free number for consumer external review inquiries
RI	yes	yes	--
TX	yes	yes	Toll free IRO hot-line and information on Department's web page
VT	yes	yes	Department publishes consumer brochures explaining mental health appeal rights New consumer ombudsman program will promote outreach and assistance, beginning in 1999
Medicare	yes	yes	Health plans are required to automatically forward all adverse determinations for external review

V. CHARACTERISTICS OF EXTERNAL REVIEWERS

Independence and recognized expertise of reviewers are commonly cited as key features of a successful and effective external review programs. We found a fair amount of variation across states and Medicare relating to who conducts external reviews, the qualifications of reviewers, and how independence is assured. These issues are discussed below and summarized in Tables 5 and 6.

Independence

To assure that the external reviewer is independent of the disputing parties, two state programs (Florida and Pennsylvania) rely on regulatory agency staff, sometimes assisted by outside clinical experts, to conduct external review. All other state programs and Medicare use an outside entity or panel to conduct external reviews. These programs vary in their strategy for assuring independence of the outside reviewers. Two key features to consider in these states are their rules governing conflicts of interest and who selects the external reviewer.

Experience:

All but two state external review programs and Medicare provide for explicit standards to ensure that external reviewers are independent and free of conflicts of interest. (See Table 5.) These programs have explicit criteria for independence that reviewers must meet. For example, the review entity and/or reviewing provider must not have any contracts or other financial interests in the health plan nor any relationship with the appellant. A formal disclosure process also is required of reviewers to be sure that all potential conflicts of interest are disclosed and screened. Michigan's program stresses balance as much as independence. The state-appointed Task Force that hears reviews includes consumers, providers and plan representatives. Task Force members who are plan representatives or who contract with plans must recuse themselves from cases involving those plans.

Arizona is the only state external review program that permits reviewers to have other business arrangements with the health plan whose decision is under review. Arizona requires that the reviewing physician not be involved in the case that is being appealed (for example, as a treating or consulting clinician), but other relationships between the external reviewer and the health plan are not prohibited. The Arizona external review program had not yet been implemented at this writing, and so there are no data by which to evaluate the impact of this review structure on the outcome of reviewer decisions. Several state regulators and expert reviewers we interviewed vigorously endorsed a stricter standard for independence of reviewers and expressed skepticism about the Arizona model.

Also key to independence is the process for selecting the external reviewer. Programs use different methods for selecting or appointing reviewers to assure this independence. In five states (Florida, Michigan, New Mexico, Pennsylvania, and Vermont), the regulatory agency itself either is the review entity or selects review panel members directly.

In all other external review programs, the state is at least once removed from choosing the actual reviewer. Either an independent review organization (or IRO) appointed by or contracting with the state

or, less commonly, the health plan or consumer choose the reviewers or reviewing entities. Five states (Connecticut, Missouri, New Jersey, Rhode Island, and Texas) and Medicare contract with one or more qualified IROs, which then refer external review cases to one of their contracting expert reviewers. Three of these five states contract with multiple IROs. In Connecticut and New Jersey, the state assigns cases to these IROs on a rotating basis. In Rhode Island, the consumer selects which of the state's two IROs will conduct their review.

Ohio and California, which both limit reviews to experimental and investigational therapies, have established different systems for selecting independent outside reviewers. Ohio law requires that plans contract with IROs (which can be academic medical centers). Plans can contract with multiple IROs. California contracts with a private nonprofit organization, called the Institute for Medical Quality, that accredits IROs. California health plans must contract with one or more of the accredited IROs to perform their reviews. As of June 1998, only two out-of-state IROs had applied for California accreditation. Because neither state had implemented its external review program when this report was written, it was not possible to evaluate whether permitting the health plan to choose the IRO affects the external review process or outcome.

TABLE 5. INDEPENDENCE OF EXTERNAL REVIEWERS

Program	Standard for Independence	Who Selects Reviewer
AZ	Individual reviewer is not precluded from having business arrangements with the health plan, but may not have a direct financial interest in or connection to the case	Health plan picks reviewer on case-by-case basis from list approved by state
CA	Reviewers must have no conflict of interest with the plan, referring physician, or patient, except that experts affiliated with academic medical centers may serve as reviewers if they have no relationship with the enrollee or with the provider recommending the therapy under review	State appoints outside agency to accredit IROs. Health plan contracts with accredited IRO (which may be an academic medical center) for all reviews. IRO assigns case to panel usually of 3 experts
CT	IRO and reviewing physicians must be free of all conflicts of interest. Disclosure of all business arrangements with health plan and treating physician is required	Insurance Department contracts with 3 IROs; assigns cases to IROs on rotating basis. IRO assigns case to one of its contracting reviewers
FL	State regulatory employees are reviewers	State employee reviewers select outside medical expert advisers as needed
MI	Task force members who are plan representatives or contract with plans must recuse themselves from cases involving their plan	Health Department appoints task force
MO	IRO and reviewing physicians must be free of all conflicts of interest. Disclosure of all business arrangements with health plan and treating physician is required	Insurance Department contracts with IRO. IRO assigns case to one of its reviewers
NJ	IRO and reviewing physicians must be free of all conflicts of interest. Disclosure of all business arrangements with health plan and treating physician is required	Health Department contracts with 2 IROs; assigns cases to IRO on rotating basis. IRO assigns case to one of its reviewers
NM	Potential review board members must disclose all health related business arrangements and any other potential conflicts of interest. Conflicts can disqualify members	Insurance Department creates lists of approved reviewers; appoints review board for each case from these lists
OH	Reviewers must have no professional, familial, or financial affiliation with the plan except that experts affiliated with academic health centers may serve as reviewers if they have no relationship with the enrollee or with the provider recommending the therapy under review	Plans select IRO (which may be an academic medical center). IRO assigns case to a panel, usually of three reviewers
PA	State regulatory employees are reviewers	State employees are reviewers but may obtain outside medical expert advice if necessary on complex cases
RI	IRO and reviewing physicians must be free of all conflicts of interest Disclosure of all business arrangements with health plan and treating physician is required	State contracts with 2 IROs. Enrollee chooses IRO. IRO assigns case to one of its reviewers
TX	IRO and reviewing physicians must be free of all conflicts of interest. Disclosure of all business arrangements with health plan and treating physician is required	Health Department licenses IRO(s) to perform reviews. IRO assigns case to one of its reviewers
VT	Each panel member must disclose and be free of any conflict of interest for the case under consideration	Insurance Department appoints independent panel of providers.

TABLE 5. INDEPENDENCE OF EXTERNAL REVIEWERS		
Medicare	IRO and reviewing physicians must be free of all conflicts of interest Disclosure of all business arrangements with health plan and treating physician is required	Medicare contracts with IRO; IRO assigns cases to reviewer.

Type of Review Entity

All external review programs ultimately rely on practicing physicians and/or other experts in the community to perform reviews. However, some programs rely on independent review organizations (IROs) to arrange for these expert reviews while others do not. (See Table 6.)

Experience:

Five states and the Medicare program contract with IROs — organizations in the business of performing external medical reviews for health plans and other insurers. For example, for external review of plan decisions for HMO enrollees, Medicare contracts with a single IRO, the Center for Health Dispute Resolution (CHDR).[8] CHDR also has contracts to conduct external reviews for two of the study states (Connecticut and Rhode Island) and for a growing number of private health plans.

In Arizona, California, and Ohio, health plans have the option of contracting with IROs to perform their external reviews. In California and Ohio, health plans also can choose to contract with academic medical centers, while in Arizona health plans have the option of contracting directly with individual physician reviewers.

IROs contract with a large number of practicing physicians who agree to be available to review cases. For example, the Missouri IRO contracts with 200 physicians practicing in that state. To meet state requirements and to respond to the full range of possible cases, IROs also contract with other providers, such as social workers, physical therapists, and podiatrists. Usually, IROs assign cases to a single clinician reviewer.[9] Most IROs provide initial and/or periodic training for their contracting reviewers. Other professional support is available as well. One IRO we interviewed publishes a newsletter to update its reviewing physicians on changes in practice guidelines and review standards. Others require periodic certification of their contracting reviewers. IRO medical directors typically supervise the selection and training of reviewers and approve their recommendations. Because of their size and specialization, IROs claim they are best equipped to provide the most expert, highly trained reviewer for any particular case.

Even so, half of the existing state external review programs do not use IROs. Instead, they use other, sometimes less formal, means to access medical expertise that will be perceived as sound and acceptable to all parties involved.

While IROs generally use a single clinician reviewer per case, backed by the organization's support and oversight, all but one of the non-IRO states use a panel of external reviewers. Vermont, for example, appoints a standing panel of mental health professionals to review medical necessity of mental health and substance abuse services. In Michigan, a seven-member task force, including two physician members, hears all non-expedited appeals. Arizona is the only non-IRO state where a single physician, not affiliated with an IRO, can be selected as an external reviewer.

Several non-IRO states rely on their state medical societies to recommend reviewers based on their

[8] The federal Balanced Budget Act of 1997 requires external review for all Medicare+Choice plans.

[9] In California and Ohio, the IRO or a medical school must appoint a panel of three clinicians with expertise in the life-threatening condition and experimental therapy under review. In California, one clinician must also have expertise in alternatives to the proposed experimental therapy.

expertise and professional standing. In Vermont, for example, panel members are chosen by regulators who are required to seek—though are not bound by—recommendations from state professional societies (such as the Vermont Psychiatric Association) and licensed mental health review agents. New Mexico regulators seek assistance from the state medical society when selecting medical experts for the state's independent review boards.

Regulators in states that have chosen a non-IRO model expressed satisfaction with their systems and the collective judgment and wisdom of their review panels. However, one of these states (Pennsylvania) will adopt the IRO model beginning in 1999 for appeals involving medical necessity determinations. Appeals of other adverse actions will continue to be heard by the Department of Health or the Department of Insurance. A formal evaluation of different external review models might yield more data on how they impact appeal rates, effectiveness, and outcomes.

Composition/Qualifications of Reviewers

All external review programs we studied use physicians or other health care providers as sources of clinical expertise. Programs vary in their use of other types of experts (such as lawyers) as external reviewers.

Experience:

The seven states that have adopted the IRO model of external review all use physicians or other health care providers as reviewers. In addition, Vermont's independent panel of mental health reviewers is comprised of practicing mental health providers from six fields—psychiatry, psychology, clinical social work, psychiatric nursing, mental health counseling, and substance abuse treatment. Arizona permits only qualified physicians to perform external reviews.

By contrast, in other state programs, external reviewers include non-clinicians. (See Table 6.) In two states (Florida and Pennsylvania), the review panel is comprised of government employees who can seek advice from one or more outside physician experts. The Florida external review panel, called the "Statewide Provider and Subscriber Assistance Panel," is comprised of six employees (three each) from the Department of Insurance (DOI) and the Agency for Health Care Administration (AHCA). Panel members from AHCA include a staff physician and nurse; AHCA has two alternate members as well – another staff physician and nurse. When specialized clinical expertise is needed, the Florida panel contracts with outside medical and dental experts. In Pennsylvania, a committee of staff members from the Health Department's Bureau of Managed Health Care conducts external reviews. The committee includes a staff nurse specialist. Both state panels can and do contract with outside physician experts on a case-by-case basis.

Four other state programs also include reviewers who are not health care providers. In two of these states (Michigan and New Mexico) the review entity is a panel which must include non-physician members. In Michigan, a seven-member task force, comprised of consumer representatives, health plan representatives, and physicians, conducts non-expedited reviews on a monthly basis. In addition to medical necessity issues, the Michigan panel also reviews other kinds of consumer/health plan disputes. In New Mexico, a separate independent review board is appointed to hear each case. Each review board must include two physicians and one attorney. Though external review in that state is limited to cases involving medical necessity, some issues also involve coverage aspects, and legal expertise is helpful in sorting through the issues. Usually, the attorney member chairs the review board meeting.

Medicare's contracting IRO, the Center for Health Dispute Resolution (CHDR), has a staff of 25 employees. Five are nurses or other licensed health professionals. About 20 are attorneys, eight of whom

hold other professional degrees or licenses (e.g., nursing, M.D., social work and podiatry). Every Medicare external review case is subject to a multidisciplinary review by CHDR staff attorneys and/or health experts. Those cases requiring medical or other specialty review are forwarded with written clarification on how non-medical factors (such as coverage rules or other evidence pertinent to the case) impact the medical necessity determination.

States that involve non-clinicians in their external review process perceive value in including these additional points of view and sources of expertise. In particular, as discussed earlier, because the distinction between medical necessity and other coverage issues is not always so clear, reviewers with other kinds of expertise can be helpful in parsing the contractual, legal, and medical issues that may be intertwined. States that rely solely on clinicians as external reviewers told us that non-clinician expertise is available at other points in their process, often when regulatory staffs perform a preliminary review of the appeal and prepare the case for the external reviewer.

TABLE 6. WHO ARE EXTERNAL REVIEWERS?		
Program	**Type of Review Entity**	**Composition/Qualification of Reviewer(s)**
AZ	Department-approved list of IROs and individual physicians published 6/1, includes approximately 125 individuals and IRO entities	Single physician (either contracting directly with health plan or through an IRO) reviews each case Physician reviewer must be in similar scope of practice or typically manage the medical condition under review
CA	Accredited IROs, which may also be academic health centers	Panel of 3 physicians (fewer under specified circumstances) review each case Reviewers must have expertise in the condition and in the experimental therapy and alternate therapies that are the subject of the dispute
CT	3 IROs (Center for Health Dispute Resolution; Empire State Medical Foundation; and Island Peer Review Organization)	Single physician or other clinician reviews each case Reviewer in same or similar specialty as case under review
FL	State employee panel (the Statewide Provider and Subscriber Assistance Panel)	Six regulatory staff (3 from the Department of Insurance and 3 from the Agency for Health Care Administration) including several AHCA staff physicians Additional outside specialists consulted when Panel requires such expertise
MI	Department-appointed task force	7-member task force of consumers, physicians and plan representatives (except in expedited cases when Department of Health physicians substitute for task force) Additional outside specialists consulted when Task Force requires such expertise
MO	One IRO (Missouri Patient Care Review Foundation)	Single physician or other clinician reviews each case Reviewer in same or similar specialty (and, when possible, in same or similar geographic practice setting) as case under review
NJ	Two IROs (Peer Review Organization of New Jersey and Island Peer Review Organization)	Single physician or other clinician reviews each case Reviewer in same or similar specialty as case under review
NM	Department-appointed independent review board	Each review board has 2 physicians and 1 attorney Physician reviewer in same or similar specialty as case under review
OH	Department-approved IROs, which may be individual physicians or academic health centers	Panel of 3 physicians (fewer under specified circumstances) review each case Reviewers must have expertise in the condition and in the experimental therapy and alternate therapies that are the subject of the dispute
PA	Committee of Department of Health staff	Staff include at least one nurse specialist, with ability to request input on clinical issues from consulting physicians in appropriate specialties
RI	2 IROs (MassPRO; and Center for Health Dispute Resolution)	Single physician or other clinician reviews case Reviewer in same or similar specialty as case under review
TX	One or more IROs. (Currently Department contracts with the Texas Medical Foundation)	Single physician or other clinician reviews case Reviewer in same or similar specialty as case under review
VT	Independent panel of mental health providers, appointed to one-year term	A psychiatrist, psychologist, mental health social worker, psychiatric nurse, mental health counselor, and drug and alcohol counselor, chosen by the Commissioner with advice from state professional societies and licensed mental health review agents
Medicare	One IRO (Center for Health Dispute Resolution)	CHDR staff (physician and nurse lawyers) review all cases. CHDR contracting physician reviewer in appropriate specialty consulted for each case involving medical necessity issues

VI. EXTERNAL REVIEW PROCESS

The process of external review also varies significantly from program to program. All of the external review programs studied conduct *de novo* reviews. That is, all previously determined facts are considered anew, additional information may be introduced, and the external review findings or decisions are not bound by prior conclusions. Across states and Medicare, different types of review process are employed. Time lines for external review also vary, as do provisions for expedited review in medically urgent cases.

Type of Process

In some programs external review is conducted through a hearing process. In others, experts conduct a paper review of the case file. The type of information brought to bear in external review can vary with different types of review processes.

Experience:

Most external review programs begin with some type of screening of new cases. In states that have different review processes for coverage and medical necessity issues, screening is used to steer cases to the appropriate process. In states that impose other eligibility rules for external review (for example, filing deadlines, exhaustion of the internal plan appeals process, etc.) screening also determines whether the case has standing. In most of the states that screen cases, regulatory agency staff perform the preliminary review. However sometimes the state contracts with an IRO to screen cases. In Arizona, health plans perform the initial screen. In three states—Florida, Michigan and Pennsylvania—no screening of cases takes place. A Florida official explained that screening is deliberately omitted so that no consumers will be denied their due process protections. This practice results in the occasional frivolous case, but the official noted that these are rare and often dropped in the course of discussions between agency staff and consumers.

External review in Medicare and eight states (Arizona, California, Connecticut, Missouri, New Jersey, Pennsylvania, Rhode Island, and Texas) consists of a paper review of the patient history and plan decision. (See Table 7.) In these programs, the case file is usually prepared by regulatory staff. These staff tend to be attorneys or other analysts with background in health plan regulation and consumer complaints. Often staff preparation includes ensuring the case file is complete, obtaining missing information when it is not, and preparing a summary of key facts and issues for the expert reviewer. Staff then send the case file via mail or fax to a designated reviewer, who considers the facts and reports back a recommendation or decision. Where the review entity is an IRO, the reviewer's recommendation may also be reviewed by the medical director, who is authorized to submit the case for a second opinion. Often the reviewers gather additional information and consult outside experts on their own.

In Pennsylvania, the regulatory review panel meets to discuss the case and consumers may submit additional materials for consideration, but the affected parties do not participate. Ohio law does not specify a required review format, though a hearing is permitted.

In other states (Florida, Michigan, New Mexico and Vermont) external review includes a hearing in which both parties can participate, with representation if they wish. To protect patient confidentiality Vermont's hearing begins in open session but immediately moves to a closed meeting in which both parties can address the panel privately. Parties can have representation but no right of cross examination. The final vote is taken in a public meeting, as required by Vermont's open meeting law.

States that conduct external review hearings generally have a different process for expedited cases. In Michigan, for example, no Task Force is convened in urgent cases. Instead, external review is conducted by staff physicians in the Department of Community Health. Vermont's Independent Panel is not always convened in expedited cases. Panel members can meet by conference call, or in extremely urgent cases the Chairman of the Independent Panel can review the case himself.

Some programs using paper review of cases at the external appeals level require health plans to hold a hearing as part of their internal appeals process. In Medicare, enrollees who disagree with the IRO decision can appeal to a federal administrative law judge and present their case in a hearing. Several experts suggested it is important for parties to be able to present their case and respond to issues raised by the other side. In particular, because much of the "evidence" is originally compiled by health plans, a hearing gives consumers an opportunity to respond and offer additional information. However, another expert we interviewed felt strongly that a hearing is an inappropriate forum, arguing that external review should consider only the weight of documented medical evidence, and not the persuasiveness of parties' oral arguments.

TABLE 7. EXTERNAL REVIEW PROCESS

Program	Process Type	Process Description
AZ	Paper review	Consumer requests external review from plan which assigns case to state approved reviewer or review entity, except for coverage issues, which plan forwards to Insurance Department. Notice to enrollees provides them with details for filing appeals.
CA	Paper review	Consumer requests external review and provides supporting evidence from doctor that experimental therapy is appropriate. Plan assigns case to approved IRO, which appoints 3-physician expert panel. Decision requires majority of panel. Under specified circumstances, fewer than 3 physicians may be used.
CT	Paper review	Application for external review can be filed by patient or agent empowered to act on their behalf (e.g., relative with power of attorney). Consumer guide provides enrollees with information on how to file an appeal. Enrollee is contacted within 5 days of receipt of appeal by external review entity and notified of whether appeal has been accepted for full review.
FL	Informal hearing	Applications for external review are triaged by regulatory staff to see if expedited review is necessary. State requests case information from plan and other parties. The Panel conducts hearings, traveling to major cities throughout the state quarterly. However, urgent reviews can be held by conference call at other times. In routine cases, parties also can participate by teleconference. Representation (by legal counsel or other agent) is permitted. Each side presents its case to review panel. Panel then adjourns to consider the case at a later time. Within 30 days of hearing, panel reports its findings and recommendations to the appropriate agency (Department of Insurance for indemnity plans or Agency for Health Care Administration for managed care plans) which enforces decision.
MI	Paper review followed by Task Force hearing	Health Department first investigates the grievance and attempts to mediate. If unsuccessful, the Department prepares a report and recommendation for the Task Force. Department physicians can be consulted in the review process, and are the sole reviewers in expedited cases. Task Force meets at call of the Chair and holds a public hearing at which 2 to 3 cases are heard. Enrollees often appear at the hearing, sometimes with their physician and/or attorney. Task Force makes recommendation to the Director whose decision is binding.
MO	Paper review	Enrollee must file written complaint with Insurance Department (oral complaints accepted in emergency cases). Upon receipt of complaint, Department makes preliminary review of case. Department sends inquiry to the health plan requesting written response with plan's position and supporting documentation. Upon receipt of plan's response, the Department sends unresolved cases to IRO with plan records and any additional information submitted by the member. The IRO sends materials/records to appropriate consulting physician. Within 20 calendar days of receipt of all materials, the IRO submits its opinion to the Department, whose decision is binding.
NJ	Paper review	Enrollee must file written review request to Health Department, which assigns cases to a review organization on a rotating basis. The IRO conducts a preliminary review and notifies the member and/or provider in writing of whether the review is accepted, and if not, the reasons. When appropriate, the IRO assigns the case to a consulting physician with expertise in the area under review. Decisions are based on medical records and other submitted materials, on generally accepted practice guidelines and any applicable clinical protocols or guidelines developed by the HMO. Final recommendations of the IRO must be approved by its medical director. The IRO recommendation is not binding on the plan. Within 10 business days of receipt of the recommendation, the plan must send a written report to the parties indicating whether it will implement the recommendation, and if not, the basis for its rejection.

TABLE 7. (continued) EXTERNAL REVIEW PROCESS

Program	Process Type	Process Description
NM	Paper review of case by agency, followed by hearing	Enrollee and/or provider acting on enrollee's behalf must file written request for external review. Insurance Department screens cases in preliminary review, then appoints an independent review board. Review board convenes a hearing, after which it can request additional information from either party. Board adjourns to consider case, then reports recommendations to Department, plan, and enrollee. Binding decision is issued by the Superintendent. Plan can appeal decision to the Superintendent or in court.
OH	Process not specified	A majority of reviewing experts must agree to either uphold or overturn the plan decision. In the event of a tie, the plan must pay for the requested experimental procedure.
PA	Paper review	Senior consumer specialist in Bureau of Managed Care prepares case record, case summary and presents facts to a committee of Bureau staff. Informal mechanism exists for the Bureau to obtain an independent medical opinion from a specialty physician when complex clinical issues are involved. Bureau staff then decide and make recommendations to the health plan. On occasion Bureau staff will uphold plan decision to deny care but suggest the plan consider alternative covered treatment, medical management, or other alternative intervention. In most cases plans have accepted these suggestions and covered the alternative treatment.
RI	Paper review	Enrollee requests external review and selects IRO. Enrollees may but do not have to submit any additional information. Plan forwards case to IRO. Review entity selects appropriate physician reviewer to consider case. External review organization notifies both parties, and the Department of Health, of the determination and the determination is binding. To appeal the decision further, enrollee must pursue the case in court.
TX	Paper review	Enrollee and/or representative or provider acting on enrollee's behalf submits request for review to plan or UR agent. Plan or UR agent has 14 days to request review from Department, who assigns case to IRO. IRO selects appropriate physician reviewer to consider case. Decisions of the IRO are binding on the plan. If plan or UR agent fails to request review, member has a cause of action against the plan. If the member has bypassed the IRO review process and instead sought redress directly from the court, the court may order the parties to submit to an IRO review.
VT	Paper review followed by closed hearing, then public meeting	Enrollee must file written request for review with state. Insurance/Health Department prepares case and forwards to Independent Panel. Chair of Independent Panel appoints 3-member investigating committee to review case, gather additional information if needed, and reports finding to full Panel. Panel meets in executive session to protect patient confidentiality. Final vote occurs in open meeting without disclosure of patient identity.
Medicare	Paper review	Plan forwards all reconsideration denials to IRO (CHDR). CHDR staff assess completeness of case file, analyze coverage and other issues, and determine key issues. If expert medical review required, case is referred to appropriate specialist with instructions on how coverage and other non-medical issues impact on medical necessity determination. CHDR staff review expert recommendations and draft decision letter. Enrollee can appeal CHDR decision to a federal administrative law judge in a hearing.

Time Line for Routine External Review

Limits can be imposed to assure that external review is completed in a timely manner. However if only certain aspects of the review process are subject to time limits, the total time involved in external review can be extensive.

Experience:

Most external review programs impose limits on the duration of all or portions of their external review process. (See Table 8.) Even with these limits, many disputes are not resolved until months following the original denial. Judgments about the appropriate time frame for external review must consider the nature of the case under review. In retrospective cases, where care has already been provided and only the question of reimbursement is at issue, we did not find much support for expediting the process. When a case involves care that will not be provided until the review process is completed, however, some regulators and external reviewers expressed concern that existing timeframes may be too long.

In most programs external reviewers are given two weeks to one month to analyze the case and make a recommendation, though variation across programs is considerable. Generally, states that hold external review hearings allow more time for review, although this is not consistently the case. Vermont, for example, has one of the tightest time frames (15 days) during which both a paper review and hearing are conducted. One review expert suggested that tighter time limits for review can make it harder to find an available and appropriately credentialed clinician reviewer. However, most of the experts we interviewed told us they have not experienced difficulty completing timely reviews, irrespective of the various timelines imposed across external review programs.

Generally, the time allotted for the review activity constitutes only a portion of the total time involved in external review. If one also counts time for preliminary screening of cases, assembling a complete case history, and implementing a final written decision, the entire process extends to one to two months in most states and even longer in Florida and Michigan. Furthermore, most external review programs require exhaustion of one or more level of plan appeals, extending the time for resolving disputes even longer.

Regulators cited several factors lengthening total time for external review that are problematic. One factor is the time required to compile a complete record for review. In some states, the time allotted for external review is not tolled until the case file is complete. Delays by health plans or other providers in submitting information relevant to the case file can lengthen the review process considerably. Several programs have adopted measures to address this issue. In Florida, parties not responding timely to the Health or Insurance Department's request for information are liable for civil fines. In New Mexico, Vermont and in Medicare, external reviewers are authorized to presumptively find against the party that fails to submit complete information within specified time frames.

In states that require consumers to submit written documentation of the plan denial when they file for external review, the time plans take to provide a written denial notice can be another factor lengthening the process. California gives plans five business days to notify enrollees in writing about their denial and external review rights. In addition to the plan notification, Florida notifies enrollees of their appeal rights on a quarterly basis.

In New Jersey, plans are given 10 days after receiving the external review decision to indicate whether they will implement the decision.

Time Line for Expedited Review

Most programs provide for expedited external review of cases for patients with urgent medical needs. When expedited review is permitted and how quickly it occurs also varies across programs.

Experience:

All but three states (Arizona, Connecticut, and Missouri) require expedited consideration of urgent cases and two of these (Connecticut and Missouri) informally provide for expedited review when regulators deem necessary. (See Table 8.) Four states and Medicare require expedited review to be completed within 72 hours or less. Four other states allot four to eight days for expedited review. Florida requires expedited reviews to be done in 45 days. Florida also provides for urgent external review in 24 hours for life-threatening cases, though the state has never had such a case. New Jersey requires expedited review, but does not specify a time frame for it. Regulators in that state note that the IRO can act within a matter of hours, if necessary.

The expedited review caseload has been small in all states. Standards for expedited review usually consider whether the patient's life or health would be threatened by delay. In most programs, the patient's physician must certify the need for expedited review. Since expedited review was first required in April 1997 for Medicare managed care enrollees, this program has experienced a significant number of requests for expedited reviews.

TABLE 8. TIME LINES FOR EXTERNAL REVIEW

Program	Time Permitted for Review of Completed Case	Total Time Involved for Typical Case	Time for Expedited Review
AZ	30 days	65 days Includes 5 days for plan to initiate review; additional 30 days for review activity, if approved by Department	No provision
CA	30 days	40 days Includes 5 business days for plan to notify enrollee of denial and external review option; 5 days following enrollee request for review for plan to forward case to IRO	7 days
CT	30 days	35 days + Case forwarded immediately to IRO; 5 days for IRO to complete and file results of preliminary review.	Informal process
FL	120 days	120 days	45 days 24 hours for life threatening cases
MI	15-20 days	75 days+ Includes 30-60 days for department to investigate appeal and make recommendation to Task Force; call Task Force meeting (Task Force meets monthly); 3-4 weeks to transcribe Task Force deliberations and findings; 10 days to get order signed.	72 hours
MO	20 days	40+ days Includes time (unspecified) Department takes to screen case and request additional information from plan; 20 days for health plan to provide requested information.	Informal process
NJ	30 days	41 days+ Includes 1-2 days for Department to assign case to IRO; 10 days for health plan to indicate in writing whether it will implement the IRO decision	Required, not specified
NM	30 days	47 days+ Includes 7 days for Department preliminary review and to appoint an independent review board; time (unspecified other than as soon as possible) for review board to schedule a hearing; time (unspecified) for review board to report findings to plan, enrollee, and state; 10 days for health plan to indicate whether it will implement review board decision	48 hours

TABLE 8. (continued) TIME LINES FOR EXTERNAL REVIEW

Program	Time Permitted for Review of Completed Case	Total Time Involved for Typical Case	Time for Expedited Review
OH	30 days	30 days	7 days
PA	10 days (informal)	60 days + (informal) Includes time (unspecified) for Department to review case and ask health plan for additional information; 15-30 days (no binding requirement) for health plan to submit requested information	48 hours
RI	10 days	15 days + Includes 5 business days for plan to forward complete case file to IRO chosen by consumer. Ten day time period is time limit for decision *and* notification after receipt of all necessary information.	48 hours
TX	15 days	20 days + Includes time (unspecified) for Department to screen case and forward to IRO; 3 business days for plan to submit additional information requested by IRO. IRO must make determination no later than 15 days from receipt of necessary information or 20 days from receipt of request for review.	5-8 days
VT	15 days	20 days + Includes 5 business days for plan to forward complete case file to Department; time (unspecified) for investigative committee to gather additional information it may require; 15 days for panel to hear case and deliver written decision to Department	48 hours (immediate order can be issued in dire emergency)
Medicare	30 days (although most reviews done in less than 14 days)	30 days + Includes time (unspecified) to notify enrollee and up to 60 days for plan to provide required services.	72 hours

Is External Review Binding on Plans?

There is some debate over whether external review decisions should be binding on health plans and, if so, what this implies for the legal liability of external reviewers for their decisions.

Experience:

All but two programs (New Jersey and Pennsylvania) mandate that plans and insurers abide by the external review decision. (See Table 9.) Recommendations by IROs that contract with the New Jersey Department of Health and Senior Services are not binding on plans or insurers. Plans must notify the reviewing entity, the Department, and the consumer within 10 business days if they will implement the recommendation and if not, the basis for the decision. Of the 69 external reviews completed since March 1997, plans have refused to implement four IRO recommendations. The decision to make the IRO decision advisory only was thought to prevent the process from becoming quasi-legal. Policymakers also believed that allowing plans to challenge an IRO decision would result in a more careful review process.

Like New Jersey, decisions by Pennsylvania's Bureau of Managed Care review committee are non-binding. However, in the seven years that the state has conducted external reviews, no plan has refused to follow the agency's recommendation. Under Pennsylvania's new external review law, decisions by certified IROs will be binding on the plan unless appealed to a court of competent jurisdiction, in which case there will be a rebuttable presumption in favor of the IRO's decision.

As the California legislature debated a broad external review bill in 1998, an emerging issue involved whether binding external review might expose reviewers to liability. Several existing state programs have addressed this issue in different ways. A few review entities keep the identity of the reviewer anonymous to shield them from liability. Vermont and Michigan extend to volunteer external reviewers the same limited immunity from liability that protects state employees. In New Mexico, the decision of the independent review board is transmitted to the Superintendent of Insurance as advice. The Superintendent then makes a decision that is binding. Texas legislation specifically shields the IRO from liability, except in cases of bad faith or gross negligence. Ohio's statute provides IROs with immunity from liability, as well, and also protects the anonymity of the reviewers. One reviewer whose state has made no provisions to shield external reviewers from liability felt it was only a matter of time until his review agency was sued for one of its decisions. However, in a number of other states, including Arizona, Florida, Missouri, and Michigan, the issue of liability has not been raised.

TABLE 9. ARE REVIEW DECISIONS BINDING ON PLANS?

Program	Yes	No
AZ	Reviewer decision binding.	
CA	If majority of review panel recommends, or if panel evenly divided, decision is binding.	
CT	IRO makes recommendation to Insurance Department. Department required by statute to accept IRO decision; Department decision binding.	
FL	Yes, but plans can appeal review panel decision to the Department of Insurance or Agency for Health Care Administration, as applicable.	
MI	Task Force makes recommendation to Health Department. Department decision binding.	
MO	IRO provides opinion to Insurance Department. Department decision is binding (Department has never overturned IRO decision).	
NJ		If plan rejects IRO recommendation, it must provide basis for decision. Only four times has a plan refused to follow an IRO recommendation.
NM	Superintendent of Insurance decision is binding. Independent review board decision to Superintendent is advisory.	
OH	If majority of review panel recommends, or if panel evenly divided, decision is binding.	
PA		However, no plan has refused to follow Health Department recommendation.
RI	IRO decision is binding.	
TX	IRO decision is binding.	
VT	Panel decision is binding.	
Medicare	IRO decision is binding.	

VII. ADMINISTRATIVE COST OF EXTERNAL REVIEW

Cost of Conducting External Review

Most external review programs have taken steps to minimize direct costs, either by relying on volunteer external reviewers or negotiating contracts that limit external reviewer charges.

Experience:

The cost per case to conduct external medical review ranges from minimal in states using volunteer outside experts to several hundred dollars in states that contract with professional IROs.[10] (See Table 10.)

In programs where external reviewers are paid, contract rates vary somewhat. Florida and Missouri pay contracting physicians $65 and $76 per hour, respectively. Medicare pays CHDR less than $300 per external review. Connecticut, New Jersey, Pennsylvania, and Rhode Island contract with their IROs for a per-case rate that typically is less than $500. The highest contract rate experienced to date is paid by the state of Texas, which pays $650 per case for external review of medical/surgical cases, and less for other types of cases. A few other states also pay different rates depending on the type of case (for example, medical/surgical vs. psychiatric or podiatric; regular or expedited time frame). Two states (Connecticut and New Jersey) pay the external reviewer a partial rate to perform preliminary reviews. These states pay the full rate only for cases recommended for full external review.

In three states that let health plans contract directly with external reviewers (Arizona, California and Ohio), the marketplace will determine the cost per case of conducting reviews. Implementation schedules for these three state programs were such that no information was available on the rates incurred by health plans when this paper was written.

Data were not available to formally evaluate whether the use of paid vs. volunteer reviewers affects the capacity or outcome of external review programs. We did ask interviewees for their impressions, though, and regulators in states that depend on unpaid reviewers reported they were generally satisfied with their systems. One Vermont reviewer, for example, took pride in his state's tradition of volunteerism and commitment to community and thought the state's reliance on volunteer external reviewers was consistent with that tradition. However, one official from another state worried that an increase in caseload could strain volunteer reviewers' ability to handle cases in a timely fashion.

Given modest rates paid to reviewers and low caseloads experienced in all programs, the overall cost of conducting external reviews experienced by existing programs is very low. In Missouri, for example, the total amount paid to reviewers for all external reviews is less than $3,000 per year. In Medicare's program, with by far the largest caseload of external reviews, the total cost is less than $3 million per year, or a fraction of one percent of total managed care plan premiums.

Who Pays the Costs to Conduct External Review?

[10] Vermont pays a $50 honorarium to each volunteer reviewer on its independent panel; because of the panel size, the honorarium payments can reach $300 or more per case.

External review programs have used different strategies to finance the cost of conducting reviews.

Experience:

Five states (Arizona, California, New Jersey, Ohio, and Texas) require health plans to pay for external review on a case-by-case basis. Rhode Island assesses consumers one-half of the review cost, with plans paying the other half. As noted earlier, two other states (Connecticut and New Jersey) require consumers to pay a $25 filing fee, which defrays a portion of external review costs. Both of these states reduce or waive fees for low-income consumers.

In seven states and Medicare, external review costs are paid by the regulatory agency. In three of these states the public costs are financed through plan licensing fees and, therefore, are paid indirectly by health plans. For example in Florida, external review and all other health plan regulatory activities are financed by a state assessment on the industry of approximately $0.10 per enrollee per year. (See Table 10.)

TABLE 10. DIRECT COST PER CASE AND FINANCING OF EXTERNAL REVIEW		
Program	**Direct Cost of External Review Per Case**	**Who Pays?**
AZ	Negotiated directly between health plan and reviewer	Health plan
CA	Negotiated directly between health plan and reviewer	Health plan
CT	$285 - $410, depending on contractor (includes $40 - 100 for preliminary review)	State (cost borne indirectly by health plans. State financing is from an existing pool funded by plan licensing fees) Consumer pays $25 filing fee
FL	$65/hour	State (costs borne indirectly by health plans. Assessment of less than 10 cents per enrollee per year finances all state regulatory activity, including external review)
MI	Nominal (volunteer reviewers paid expenses)	State
MO	$76/hour (less than $200 a case)	State
NJ	$330 - $350 (includes $47-49 for preliminary review)	Health plan Consumer pays $25 filing fee, reduced to $2 for hardship
NM	Nominal (volunteer reviewers)	State
OH	Negotiated directly between health plan and reviewer	Health plan
PA	$300 or less	State
RI	$250-$475, depending on contractor, type of case	Health plan pays half Consumer pays half
TX	$460-$650, depending on type of case	Health plan
VT	Volunteer reviewers reimbursed expenses plus $50 honorarium	State (costs borne indirectly by health plans. Review costs financed by a portion of licensing fee)
Medicare	Less than $300	Medicare

mandates on agencies. Most officials agreed that government should be as small and efficient as possible. Nevertheless, some believe external review caseloads may, even should, grow over time, and agencies' ability to run growing programs effectively could be strained if not properly staffed. Regulators also expressed strong interest in the data that can be gleaned from external review programs and its possible value in promoting health plan accountability and other uses. They noted that the ability to collect and analyze data also could be constrained by inadequate resources.

Other Costs Associated with External Review

We asked industry representatives about additional direct costs health plans might incur in complying with external review programs. Several said additional costs can arise depending on the amount of time plan attorneys and medical directors spend reviewing case files or attending external review hearings. All told us they believed administrative costs to plans generally are nominal, in most cases limited to the cost of supplying external reviewers with a copy of the case file previously assembled during the plan's internal review process. Industry representatives also cited the low volume of external reviews as a reason for low costs, overall, attributable to these programs. One industry official commented that, whatever costs plans might incur from external review, they are modest and a "well spent business expense" in light of the contribution to improved customer relations he believes external review generates.

Other studies have attempted to estimate indirect costs attributable to external review (i.e., the cost

of care associated with overturned denials). The Congressional Budget Office (CBO) recently estimated potential costs that might arise from enactment of a federal external review requirement similar to many existing state programs."[11] The CBO estimate did not separate the cost of external review from plan internal appeal programs that also would be required by the federal legislation. Combined costs were predicted to be 0.3% of premium, assuming that consumers request external review at a rate at least four times higher than currently. CBO suggested these costs would arise not only from the cost of conducting reviews, but also from plans providing additional services in order to avoid external review.

In another cost estimate, Coopers and Lybrand projected an increase in premiums of ten cents per person per month, or 0.08% of premium, attributable to external review.[12] This estimate included actual administrative costs of the process, the cost of medical services that would be covered by health plans resulting from an overturned decision, and changes in health plan utilization review practices that could result in higher utilization rates if health plans decide the cost of the external review process exceeds the value of constraining utilization through their existing practices.

At the state level, Price Waterhouse recently estimated costs that might arise from proposed external review legislation in California to be three cents per member per month.[13] Components of this estimate included the direct cost of performing reviews and the cost of additional care resulting from overturned plan decisions.

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[11] Congressional Budget Office Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Rights Act of 1998, as modified by the sponsors, July 16, 1998.

[12] "Estimated Costs of Selected Consumer Protection Proposals: A Cost Analysis of the President's Advisory Commission's Consumer Bill of Rights and the Patient Access to Responsible Care Act (PARCA)," prepared for the Kaiser Family Foundation, Coopers and Lybrand L.L.P., April 1998.

[13] Jack Rodgers, Ph.D., et al., "Benefits and Costs of Consumer Protection Proposals in California," prepared for the Kaiser Family Foundation by Price Waterhouse, June 1998.

VIII. OVERSIGHT OF REVIEW PROCESS

States monitor the external review process in several ways. Regulators in Connecticut, Missouri, New Jersey, and Rhode Island report annually or biannually to their legislatures or governors about the external review process. In California, the independent agency that accredits IROs reports to the Department of Corporations quarterly on external reviews.

External review also informs general oversight of health plans and their utilization review activities. Connecticut's Department of Insurance plans to use patterns of problems revealed by external review to trigger further investigation by its consumer affairs division and on-site reviews. In Vermont, a feedback loop is evolving from the external review of mental health claims to the state's licensing of mental health utilization review (UR) agents. Licensed UR agents are required to file the clinical guidelines and other decision criteria they will use. In one recent external review case, reviewers not only voted to overturn the plan decision, they also recommended that the state reexamine the appropriateness of the plan's utilization review criteria. For the plan's UR agent to maintain its license, it will need to make any changes in its guidelines that the state requests.

In another state, one IRO is finding distinct patterns in its review decisions. The IRO director noted that although reviews statewide generally found equally for plans and consumers, at least one plan had an 80 percent reversal rate. His report to the State Department of Insurance, he believes, will result in more scrutiny of plans with unusually high reversal rates.

All state regulators and review entity personnel interviewed for this report said that the existence of an external review mechanism had a sentinel effect. The right of consumers to seek external review, they believe, makes plans and utilization reviewers more cautious about ensuring that decisions are well supported by clinical standards and made according to a reasonable process. Regulators also said external review enhances general oversight of health plans.

IX. CONCLUSION

Based on interviews and other information we collected, the right to seek and obtain an independent judgement on a plan's service or claim's payment denial appears to be an important consumer protection. Every state regulator, external reviewer, and health plan representative we spoke to said external review is valuable. The existence of such a process, they believe, builds consumer trust in managed care and results in a higher quality health care system. For consumers, it serves as a safety valve, allowing them redress if plans make mistakes or ill-advised decisions. For plans, it offers feedback that helps them improve their service to consumers and quality of care, and it builds consumer trust in their health plans. Both internal and external review are components of our health care system's quality monitoring efforts. To the extent that plans receive and respond to feedback on their decisions from independent medical experts, the process by which these decisions are made should be improved. Moreover, several IRO representatives noted that private health plans not subject to mandatory external review are voluntarily contracting to conduct reviews, which they interpreted as a vote of confidence in the external review process.

The reasons why health plans might deny coverage for a service – and the reasons why consumers might appeal that decision – are varied and often complex. Consequently, the most comprehensive external review programs apply to all licensed health plans and attempt to resolve all types of claims denials. In general, more comprehensive programs cover greater numbers of consumers and are less complicated to understand.

Features incorporated in some external review programs to limit caseloads and frivolous appeals appear to be unnecessary. The volume of external review cases is small across all programs, regardless of whether such features are in place. As a result, some experts recommended that these features –including consumer fees and dollar thresholds for claims – not be adopted lest they pose unnecessary burdens on consumers seeking assistance. Many state programs are also pursuing creative public education and outreach strategies to increase awareness about external review.

In almost all programs, external review is performed by independent experts who must be free of financial conflicts of interest. Selection of external reviewers by someone independent of the disputing parties (usually the state or an IRO contracting with the state) further ensures independence. A variety of medical, legal, and other experts are included in external review programs, enabling review of a range of complex issues. The review process, itself, varies considerably across programs. External review decisions are binding in almost all programs. Ensuring prompt review is another key process issue. Several programs have mandated tighter, more explicit deadlines for each aspect of the process to ensure that external review – from the time a consumer applies until the time the decision is implemented – occurs within a reasonably prompt time frame. Expedited review generally is available in urgent cases.

The cost involved in obtaining this consumer protection is modest. With the exception of Texas, where reviews of medical and surgical cases cost $650, the cost of reviews range from less than $300 to $500 per case in states that contract with external review agencies. In addition to the low cost per case, the volume of cases appealed to an external review entity is also small, yielding total costs that, so far, are minimal. It is likely, however, that the number of cases reaching external review will increase as more consumers learn about this right.

Medicare's external review costs of four cents per enrollee per month currently represent the outer

bound experienced to date. In Medicare, external review has been available for nine years, and automatic external review is required for every adverse action upheld by a managed care plan's internal appeals process. Even under these rules, only 1.6 cases per 1000 beneficiaries reached the external review stage in 1997. This rate has been relatively consistent over the history of the program.

Short of a Medicare-like requirement mandating universal, automatic external review, it seems unlikely that the volume or cost of private health plan external reviews would ever approach those under Medicare. However, even if Medicare's experience is replicated by private health plans, costs still would be small enough to allay any concerns about significant increases in premiums.

Studies that have considered the indirect as well as direct costs of external review (i.e., the cost of care for overturned plan decisions) have found these costs to be modest. In addition, any estimate of external review costs also should consider the possibility cited by experts that external review may reduce the risk of litigation over plan failure to provide covered benefits, thus offsetting some of the costs of the external review process.

In the thirteen states reviewed for this study and in Medicare, external review of plan-consumer disputes appears to add an additional layer of consumer protection at modest cost.

Appendix A
RECENTLY ENACTED STATE EXTERNAL REVIEW PROGRAMS

Seven states passed external review legislation in 1998. Five of these laws established new programs; two others modified or added to existing programs. A summary of key features, as they are discernable from the legislation, follows in Table 11. A significant amount of detail appears to be left to the discretion of regulators and implementing regulations, so the ultimate structure of these new programs is yet to be determined. Even so, relative to established external review programs, state legislators in 1998 were more likely to adopt features that may hinder consumer access to external review. In particular, two of the seven new state laws establish dollar thresholds for claims to be eligible for external review. By contrast, no existing external review program includes this feature. Four of the seven new laws require consumer fees for external review. This compares to only three of fourteen existing programs. Five of the seven new laws set deadlines of 60 days or less for consumers to apply for external review. By contrast, only half of existing external review programs impose filing deadlines on consumers and in only five of the fourteen existing programs is this deadline shorter than one year.

TABLE 11. SELECTED FEATURES OF RECENTLY ENACTED STATE EXTERNAL REVIEW PROGRAMS

State	HAWAII	MARYLAND	MINNESOTA	NEW YORK

Types of plans subject to review	managed care plans	all health plans	all health plans	HMOs
Types of actions subject to review	any dispute not resolved internally by plan	disputes involving medical necessity and other issues to be addressed in regulations	any dispute not resolved internally by plan	disputes involving medical necessity and experimental/ investigational treatment
Access to external review				
Exhaust internal appeals process	yes	yes, with exception if compelling reason exists	not specified	yes, with exception if jointly waived by plan and enrollee
Minimum claims threshold	not specified	not specified	not specified	not specified
Filing deadline	30 day limit	30 day limit	not specified	45 days
Patient filing fee	not specified	not specified	not specified	up to $40
Type of review entity	3-person panel including non-involved health plan representative, non-involved physician, insurance commissioner	IRO or medical expert	not specified	IRO
Who chooses review entity?	state	state	not specified	state
Review process				
Time frame for routine review	30+ days	30-45+ days	not specified	30+ days
Expedited review available?	not specified	24 hours	not specified	3 days
External review binding?	yes	not specified	not specified	yes
Who pays for external review?	not specified	health plan	not specified	health plan

TABLE 11. (continued) SELECTED FEATURES OF RECENTLY ENACTED STATE EXTERNAL REVIEW PROGRAMS

State	PENNSYLVANIA	TENNESSEE	VERMONT
Types of plans subject to review	managed care plans	HMOs	all health plans

Types of actions subject to review	disputes involving medical necessity (separate independent review process exists for coverage determinations, operations, etc.)	disputes involving medical necessity	disputes involving medical necessity or coverage issues
Access to external review			
exhaust internal appeals process	yes	yes	yes
minimum claims threshold	not specified	$1000	$100
filing deadline	15 days	60 days	not specified
patient filing fee	up to $25	$100	up to $25
Type of review entity	IRO	IRO	IRO
Who chooses review entity?	state	not specified	not specified
Review process			
time frame for routine review	60 days	30 days	"timely" not defined
expedited review available?	not specified	7+ days	"expedited" not defined
External review binding?	yes	yes	yes
Who pays for external review?	health plan (non-prevailing party pays when filed by provider)	not specified	health plan

Appendix B
ERISA PREEMPTION OF STATE EXTERNAL REVIEW LAWS

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law regulating employee pension and benefit plans. Although its provisions establishing minimum standards for pension plans are detailed and comprehensive, ERISA contains few standards specifically targeted at employee health benefit plans. Even so, the federal law preempts state laws that relate to employee health plans, ostensibly to protect multi-state employers from multiple and conflicting state requirements. However, ERISA expressly "saves" from preemption state laws that regulate insurance. Federal courts' interpretations of the reach of ERISA's preemption of state laws have changed over time and some arguably conflicting decisions have been rendered.

ERISA preempts the application of state health insurance laws to employer plans that "self-fund" their coverage. Such plans are not considered to be "insurance" because the employer is retaining all or a portion of the risk of incurring health costs for its covered employees.[14] Therefore, under ERISA, state insurance laws do not apply to these plans. Yet state laws found to have minimal or indirect impact on such plans may not be preempted, as was the case in the Supreme Court case of *N.Y.S. Conference of Blue Cross and Blue Shield Plans v. Travelers et al.*[15]

Federal court decisions offer an even more complex and uncertain picture of ERISA's preemption of state laws regulating fully insured group health insurance plans purchased by employers. On the one hand, in *Metropolitan Life Insurance Company vs. Massachusetts,* [16] the U.S. Supreme Court upheld a state law mandating coverage of certain mental health benefits under all fully insured group and individual health plans. On the other hand, in *Pilot Life Insurance Company vs. Dedeaux,*[17] the U.S. Supreme Court ruled that participants in ERISA plans — either fully insured or self-funded — may not sue a health plan under state law for alleged improper processing of claims. The court ruled that ERISA's remedies (which are limited to provision of the denied service) preempt state remedies that participants in insured and self-funded employer health plans otherwise could have sought.

To date, only one federal court has addressed whether ERISA preempts state laws requiring external review of decisions of state regulated health plans. The United States District Court for the Southern District of Texas, Houston Division, recently held that such a provision of Texas law was

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[14] Such plans often control the level of risk they assume by purchasing "stop-loss" insurance. A stop-loss policy is an insurance product and insurance regulation of that product is not preempted under ERISA. Such insurance generally covers only catastrophic losses; however, some employer plans purchase policies that cover many of their claims, and therefore assume a significant portion of the employer's risk. Such instances call into question whether such employer plans are actually purchasing health insurance, rather than true "stop-loss" insurance.

[15] 514 U.S. 645 (1995).

[16] 471 U.S. 724 (1985).

[17] 481 U.S. 41 (1987).

preempted by ERISA.[18] It reasoned that the external review process mandated under Texas law improperly mandated the administration of ERISA plans in violation of ERISA since "Congress intended ERISA to preempt state laws…that mandate employee benefit structures or their administration… Interestingly, that court quickly dismissed the argument that the law would be preserved from preemption because it regulated insurance. In a potentially controversial holding that differs from other federal appellate court decisions,[19] the court held that HMOs and other managed care entities were not insurers.

In the same case, the District Court upheld another provision of Texas law, which allows individuals to sue their health plans for poor quality of medical treatment. The court distinguished the liability provisions from the external review requirements by noting that individuals could sue their plans on the grounds that the plan provided poor medical care without interfering with a plan's administration of benefits. Consistent with its reasoning on the Texas external review law, the court found that a suit alleging that the health plan wrongfully denied benefits *would* be preempted for interfering with an ERISA plan's administration of benefits. The court noted that courts will need to examine claims under the Texas liability law on a case-by-case basis to determine whether the claim addresses the handling or denial of a benefit (and therefore would be preempted.)[20]

The issue of ERISA preemption of external review laws is not yet settled. The Texas District Court decision is being appealed and other Circuit Courts could decide the issue differently. Existing case law could support arguments for and against ERISA's preemption of such laws. For example, one might argue that *Metropolitan Life* supports a state's ability to regulate many aspects of an insurance contract, and that external review provisions fall within this category. Other federal courts have held that HMOs are engaged in the business of insurance and that state regulation of such plans is preserved from ERISA preemption under the "insurance savings clause." Following this reasoning, a court might decide to preserve a state's external review law. Another possible argument that could support such state laws is the view that ERISA does not provide for an exclusive and comprehensive enforcement scheme in this area since external review laws involve reviews of plan "health care treatment decisions," such as

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[18] *Corporate Health Insurance Inc., et al. v. Texas Department of Insurance,* at 49.

[19] Some federal courts that have considered this issue have held that HMOs are, indeed, engaged in the business of insurance. For example, in *Washington Physicians Service Association v. Gregoire,* 147 F. 3d 1039, the federal Court of Appeals for the Ninth Circuit held that "HMOs function the same way as a traditional health insurer: The policy holder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs…are in the business of insurance." *Id.* at 9. Also, in *Anderson v. Humana,* 24 F.3d 889, the U.S. Court of Appeals for the Seventh Circuit characterized HMOs as insurers: "Because HMOs spread risk, both across patients and over time for any given person, they are *Id.* at 891. On the other hand, other courts have held that HMOs are not insurers. See *New York State HMO Conference v. Curiale,* S.D.N.Y., 93 Civ. 1298, February 25, 1994, *reversed on other grounds,* 64 F.3d 794 (2d Cir. 1995); *OraCare DPO v. Merin,* 13 Employee Benefits Cases 2720 (D.N.J. 1991); and *McManus v. Travelers Health Network of Texas,* 742 F.Supp. 377 (S.D.Tex. 1990). (Cites to cases that characterized HMOs as not insurers are taken from Patricia A. Butler, "State Managed Care Oversight: Policy Implications of Recent ERISA Court Decisions," (Washington, D.C.: National Governors' Association Center for Best Practices, 1998)).

[20] *Id.* at 58.

decisions relating to the medical necessity of services, not simply plan decisions regarding contractual coverage disputes. Under this view, the state external review laws arguably address issues exclusive of ERISA's scheme for claims administration.

Nevertheless, citing *Pilot Life*, it could be argued that external review laws are preempted because they attempt to replace ERISA's scheme for the administration of plan benefits, which was intended to be the exclusive claims administration mechanism. Indeed, the Texas court focused its decision on the law's alleged impact on employer plans' benefit administration.

At a minimum, the Texas District Court decision clearly raises the possibility that other federal courts could find that ERISA preempts state external review laws. If more courts adopt the view of the Texas court, the protection of external review laws would be restricted to a small minority of Americans (some 16 million) insured under individual health plans. However, recent Supreme Court cases have presumed that state laws regulating health care, an area of traditional state regulation, remain within the states' jurisdiction, and have required that laws have a more direct, significant impact on employer plans before they are found to be preempted under ERISA. Consequently, other courts may take a narrower view of ERISA's preemptive reach. In the meantime, state officials continue to administer their external review programs, perceiving this to be an appropriate part of their regulatory duties.

Appendix C
LIST OF SOURCES

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