Health Plan Appeal Rights in New York After the Affordable Care Act

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NOTE: has some updates enacted 2020 - see pp. 32, 37. Thanks to Community Services Society.

Introduction

Patients in New York have long had the right to appeal when they disagree with their health plans. The Patient Protection and Affordable Care Act (the "ACA" or "federal health reform") strenghthens and expands those protections. It requires plans to allow patients to appeal adverse plan decisions, and it roughly doubles the number of New Yorkers with the right to external review. The ACA also encourages states to strenghthen their own external review laws, which New York did this past summer. After these changes to federal and state law, nearly all of New York's commercially insured citizens, more than 10 million people,[1] now have new rights when they disagree with their health plans. Though procedural in nature, these rights are critical. Far less expensive and time-consuming than court proceedings, these protections allow patients access to life-saving treatments and prevent families from being forced into bankruptcy after their insurers deny expensive claims. While many aspects of the ACA become effective in 2014, these safeguards are already in place. This article is designed as a reference for advocates seeking to acquaint themselves with this new landscape of procedural protections.

A commercially insured patient's appeal rights vary depending on the answers to three questions: (1) Is the patient enrolled in a self-insured plan or a fully insured plan? (2) Is the patient's plan grandfathered? and (3) Is the patient's plan covered by ERISA? Part I of this article explains how to answer these three questions and provides some background as to why they are important. The first of these questions—self-insured vs. fully insured—is the most important. Part II of this article describes in detail the appeal rights of patients enrolled in self-insured plans, and Part III does the same for the fully insured context. The last sections of each of these two Parts discuss the significance of a plan's grandfathered and/or non-ERISA status. Part IV provides a full-page chart synthesizing the most important information from the article.

I. Identifying the Type of Plan, and Why It Matters

This article describes the appeal rights of the roughly 60% of New York's nonelderly population who are covered by employer- or union-sponsored insurance, as well as the roughly 4% who purchase commercial coverage directly as individuals or families.[2] Within this commercially insured group, though, there are many types of health plans. Sections I.A through I.C explain how to distinguish self-insured from fully insured plans, grandfathered from non-grandfathered plans, and ERISA from non-ERISA plans.

A. Self-Insured vs. Fully Insured

There are two main ways employers can structure their health plans, and the legal consequences of this choice are significant. In a "fully insured" plan, the employer pays regular premiums to a health insurance company, which in turn assumes the risk of paying the bills when enrollees utilize health services. In a "self-insured" plan, by contrast, the employer or union itself is responsible to pay the bills when enrollees get sick. Employers who opt for self-insured plans, though, usually hire insurance companies to administer the plan (e.g., creating coverage rules, reviewing claims, handling member services inquires, and negotiating prices with network providers). In New York, roughly 45% of those enrolled in work-based insurance are in self-insured plans and the remaining 55% are in fully insured plans.[3]

"[N]early all of New York's commercially insured citizens, more than 10 million people, now have new rights when they disagree with their health plans."

Since patients are interacting with an insurance company in either type of plan, as well as carrying insurance cards with insurance company corporate brands (e.g., United, Aetna, etc.), employees rarely know whether they are enrolled in a self-insured or fully insured plan. A patient's summary plan description or certificate of coverage will disclose whether her plan is self-insured or fully insured, and employers must provide these documents to health plan enrollees free of charge.[4] As a general rule of thumb, fully insured plans are more common at smaller employers, while self-insured plans are more common at larger firms with employees in several states: In New York more than 80% of those covered through firms with fewer than 50 employees are in fully insured plans, while more than 70% at firms with more than 1,000 employees are in self-insured plans.[5] Ordinarily, the employer's human resources department will know whether the plan is fully or self-insured.

The distinction between self-insured and fully insured plans is important because of the effects of the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA applies to all employer- and union-sponsored plans (whether self- or fully insured) other than those provided through government or church employers. For plans

As of Aug.t 20, 2021, New York-regulated plans must disclosed on health insurance identification (ID)cards that the plan is fully insured. 11 NYCRR Sec. 52.69(a)(4)

within ERISA's purview ("ERISA plans"), the self-insured variety is exempted from state law by ERISA's preemption provision.[6] ERISA's savings clause then explicitly preserves the right of states to regulate the insurance industry, and thus the insurance products purchased by fully insured ERISA plans.[7] This leaves a legal framework where self-insured ERISA plans are only subject to federal law, while fully insured plans are subject to both federal and state law.[8] In cases of conflict between federal and state law, the aspects of each law that are most protective of the patient usually apply.[9]

B. Grandfathered vs. Non-Grandfathered

A grandfathered plan is one that existed on March 23, 2010—the date of passage of the ACA—and has not changed substantially since then.[10] During President Obama's push for health reform, he often promised that Americans who liked their current health insurance could keep it; grandfathered plans are the result of that promise. When a plan makes substantial changes, for instance to co-pays or deductibles, it loses its grandfathered status. The federal government predicts that many large employer plans will maintain grandfathered status for some time, while the plans of small businesses are more likely to become non-grandfathered over the next few years.[11]

To keep patients informed, any grandfathered plan must disclose its grandfathered status in all materials describing benefits.[12] A plan's grandfathered status is important because grandfathered plans are exempt from many aspects of the ACA, including the ACA provisions regarding appeals of health plan benefit decisions.[13] New York State's appeal laws apply to grandfathered plans, making the grandfathered distinction particularly important with regard to self-insured plans, which are not subject to state law. The effects of a plan's grandfathered status on a patient's appeal rights are further discussed in Sections II.F and III.F.

C. ERISA vs. Non-ERISA

ERISA is a federal law that applies to all employer- and union-sponsored health plans other than those provided by government or church employers ("ERISA plans").[14] ERISA does not apply to plans purchased on the individual market, or to plans offered to New York State, county, or city employees, retirees and dependents. Non-ERISA plans are relatively common; at least two million New Yorkers are enrolled in New York's two biggest government employer plans—the New York State Health Insurance Program and the New York City Health Benefits Program—and another several hundred thousand purchase plans on the individual market.[15] Besides ERISA's preemption provision, ERISA is also important because of a set of regulations promulgated about a decade ago that require ERISA plans to follow their own written rules and to establish reasonable claims and internal appeals procedures (hereinafter "Old ERISA Appeals Regulations" or "ERISA Regulations").[16] These regulations apply to ERISA plans but not to non-ERISA plans.

The ACA appeal provisions and their implementing regulations build on the ERISA Regulations and make them applicable to all non-grandfathered health plans, whether covered by ERISA or not.[17] This means that a plan's non-ERISA status will only affect patients' appeal rights if that plan is *also* grandfathered and thus not subject to this aspect of the ACA. For that reason non-ERISA plans are discussed below together with grandfathered plans in Sections II.F and III.F.

II. Self-Insured Plans

Part II describes the procedural protections available to patients enrolled in self-insured plans when they disagree with their health plan, with a focus on non-grandfathered ERISA plans. Section II.A starts with identifying the laws applicable to self-insured plans. The next three sections outline the most fundamental protections now enjoyed by patients. Section II.B describes the system of internal appeals, Section II.C discusses external review, and Section II.D highlights a patient's rights to adequate notice and information throughout these processes. Section II.E briefly discusses judicial review. Section II.F then explores the availability of these procedures in grandfathered and/or non-ERISA plans.

A. What Laws Apply to Self-Insured Plans?

The ACA did not amend ERISA's preemption provisions, therefore self-insured ERISA plans are still exempt from state law. The ACA, though, provides far more substantive protections than federal law had previously contained. For example, most self-insured plans are now required to cover preventive services with no cost-sharing,[18] allow dependents under 26 years old to stay on a parent's coverage,[19] and provide at least partial coverage for out-of-network emergency care.[20] The ACA also precludes most plans from enforcing pre-existing condition exclusions against minors,[21] as well as from imposing lifetime caps or unreasonably low annual caps on essential benefits.[22] Plans are also still required to follow their own written rules, both substantive and procedural, and many appeals are won because plans fail to follow their own rules.

From a procedural perspective, the ACA requires self-insured plans to allow patients to appeal coverage determinations both internally to plan employees, and externally to neutral external reviewers.[23] The relevant regulatory bodies—the Department of Labor ("DOL"), the Department of Health and Human Services ("HHS"), and the Internal Revenue Service ("IRS")—jointly issued regulations on July 23, 2010, which they later amended on June 24, 2011, outlining these procedural protections in detail (the "New ACA Appeals Regulations" or "ACA Regulations").[24] The rest of Section II is dedicated to describing how the New ACA Appeals Regulations affect the rights of New Yorkers enrolled in self-insured ERISA plans.

B. Internal Appeals in Self-Insured ERISA Plans

1. Who Decides Internal Appeals? Based on What Factors?

Internal appeals are the first layer of procedural protection for patients who want to dispute health plans decisions. These appeals are decided by health plan employees, but federal law provides for a minimum level of independence. For example, the appeal decision-maker cannot be the same person or a subordinate of the person who handled the initial denial, and the decision-maker cannot afford deference to the initial denial.[25] Further, plans are barred from hiring, compensating, terminating, or promoting employees based on their propensity to uphold denials.[26] If the decision involves medical judgment, then the decision-maker must consult a medical professional with training or experience in the relevant field.[27]

Internal Appeals Self-Insured Plans

(non-grandfathered)

- Appeal decided by health plan employee.
- Available to dispute all adverse benefit determinations and rescissions.
- 180-day filing period after first notice of adverse benefit determination or rescission.
- Plans may offer 2nd-level internal appeal.

Internal appeals are decided based on the plan's internal rules and any applicable laws, so it will be difficult, for example, to argue in an internal appeal that a plan's medical guidelines are deficient. Internal appeals may not seem so appealing—contesting a plan's application of its own rules to its own employee—but nonetheless many internal appeals result in the plan overturning itself.[28]

2. Timelines and Scope

Self-insured ERISA plans must allow patients at least 180 days within which to file an internal appeal of any "adverse benefit determination."[29] This is not new; the Old ERISA Appeals Regulations long gave patients this right, and defined an adverse benefit determination as a "denial, reduction, termination, or failure to make payment (in whole or in part) for a benefit," whether on the basis of eligibility for membership in the plan, utilization review, or otherwise.[30] The New ACA Appeals Regulations build on this old system and add that plans must allow appeals of rescissions, whether or not they have any effect on a current benefit payment.[31] Patients thus do not have a right to appeal absolutely *any* plan decision, but many of the most important decisions, including any that affect benefit payments, will be subject to internal appeal.

Patients may appoint a representative to pursue an appeal on their behalf, and after the patient or advocate gathers all the information and lodges an internal appeal, the plan typically has 60 days to answer.[32] Some plans also allow second-level internal appeals, but they are not legally required to do so.

There are two special situations that give rise to unique rules: urgent care and concurrent care. In an urgent care situation—where, in the opinion of the attending provider, a delay could seriously jeopardize the life, health, or recovery of the patient or would subject the patient to severe pain—the plan must answer the appeal "as soon as possible" but not later than 72 hours after receiving the appeal.[33] In these situations the patient also has a right to file an appeal orally.[34] In a concurrent care situation—where the plan pre-approves a patient for a course of treatment for a specific period of time or a set number of treatments, but then later issues a denial before that course of treatment is completed—the patient has a right to continued care while the appeal is pending.[35] As described below, these two special situations also create special rights with regard to external review.

C. External Review in Self-Insured Plans

1. Who Decides on External Review? Based on What Factors?

With passage and implementation of the ACA, self-insured plans are now required for the first time to offer external review. Unlike internal appeals, external reviews are decided by accredited "independent review organizations" ("IROs"), companies that employ personnel with the requisite expertise to resolve these disputes. For self-insured ERISA plans, these IROs operate under contract with the plan itself,[36] but this is still considered a more neutral forum than an internal appeal, where a health plan employee serves as adjudicator.

External Review Self-Insured Plans

(non-grandfathered)

- Appeal decided by third-party IRO, under contract with health plan.
- Available to dispute decisions that involve medical judgment and rescissions.
- Four-month filing period after exhaustion of *all* internal appeals.
- For urgent or concurrent care, can file for external review immediately.

Importantly, IROs are required to consider current research on evidence-based practice guidelines, nationally accepted clinical standards, and peer-reviewed medical literature, in addition to the health plan's internal rules.[37] This openness on medical standards, the reviewer's medical expertise, and the fact that the decision-maker is not employed by the plan combine to make external review an attractive venue for adjudication from a patient's perspective.

2. Timelines and Scope

For claims within the scope of external review, plans must give patients a period of at least **four months** following the exhaustion of internal appeals within which to file for external review.[38] In the self-insured plan context, external review is available for two types of health plan decisions: (i) those "involving medical judgment" and (ii) rescissions.[39] This means that if a patient's claim is denied because the plan thinks it is not a covered benefit under the policy, for instance, it would arguably not be subject to external review because that determination may not involve medical judgment. The term "involves medical judgment" just appeared in the regulation this past summer, and the author is aware of no court decisions interpreting the term. The regulation itself provides two useful examples that suggest the term was meant to be interpreted broadly,[40] so advocates are encouraged to be open-minded; as this system becomes better established the meaning of key terms will crystallize.

For concurrent and urgent care situations, as defined in Section II.B above, patients may file for external review at the same time as their first-level internal appeal, an important right allowing them to reach a neutral arbiter before enduring months of internal appeals while awaiting medical treatment.[41] Standard external appeals are to be answered within 45 days; urgent external appeals are to be answered as "expeditiously" as possible, but always within 72 hours.[42]

D. Notice Rights in Self-Insured Plans

The New ACA Appeals Regulations give patients strong rights to the adequate notice and information necessary to prosecute both internal and external appeals. The new rules require for denial notices, whether issued initially or as the result of an internal appeal, to:[43]

- Sufficiently identify the claim in question (e.g., by date of service, provider, etc.);
- Describe the reasons for the denial;
- Describe the plan's internal and external review processes;
- Notify the patient that relevant diagnosis and treatment codes, and their meanings, are available upon request; and
- Include contact information for the state's designated consumer assistance or ombudsman program (which in New York is Community Health Advocates).

In addition to what must be included in adverse benefit determination notices, a great deal of other important information is available only upon request. It can take time for plans and employers to provide this documentation, so an advocate should place requests long before any deadlines are approaching. The information available upon request includes:

- All the plan documents constituting the patient's plan, including the summary plan description;[44] This is typically available from the employer, not from the insurer administering the plan. For some plans it is also available online.
- The diagnosis and treatment codes relevant to the denial, and their meanings;[45]
- Copies of all documents, records, and other information relevant to the claim, including the legal/medical standard used to deny a claim;[46] and
- Copies of all call logs, e.g., from a client's calls to member services.[47]

The ACA requires plans to furnish these notices in a "culturally and linguistically appropriate manner."[48] The regulations implementing this provision require plans to: (i) offer translated oral language services (e.g., member services hotline); (ii) provide, upon request, translated notices, and (iii) include a prominently displayed statement on all English notices informing patients of their right to translated notices and phone services.[49] But plans only need to do so with respect to a given language if *ten percent or more* of the population of the patient's home county is literate only in that language, a very high bar.[50] In New York State, for instance, self-insured plans must provide translations into Spanish in only Manhattan, Queens, and the Bronx.[51] Aside from Spanish-speaking residents of these three counties, New Yorkers in self-insured plans have essentially *no* right to linguistically appropriate notices or phone translation. Advocates have questioned whether this framework satisfies the ACA's mandate for culturally and linguistically appropriate notices, so far to no effect.[52]

E. Judicial Review

Patients enrolled in ERISA plans have a right to bring an action in federal or state court after exhausting all internal appeals offered by the plan.[53] Courts hearing these actions typically only review to determine that the plan properly applied its own written guidelines based on the information available during the internal appeals process.[54] For example, courts may reverse a plan's decision when a plan administrator ignores relevant factors,[55] inconsistently applies its own rules,[56] reverses a prior decision without new evidence,[57] or fails to properly consider the opinion of a treating physician.[58]

This limited scope of review has two important consequences. First, it is very difficult to introduce arguments that the plan's guidelines are defective—making external review a more attractive venue for many cases. Though patients may seek judicial review even after an unsuccessful external appeal, it is difficult to convince a court

Applicable Laws—Self-Insured Plans Effect of Grandfathered and/or Non-ERISA Status			
Type of Plan		**Internal Appeal**	**External Review**
ERISA	Non-Grandfathered	New ACA Appeals Regulation Old ERISA Appeals Regulation	New ACA Appeals Regulation
	Grandfathered	Old ERISA Appeals Regulation	NONE
Non-ERISA	Non-Grandfathered	New ACA Appeals Regulation	New ACA Appeals Regulation
	Grandfathered	NONE	NONE

that it should disturb a decision made by neutral medical experts.[59] Second, it is also very difficult to introduce evidence not contained in the internal appeal record. If a lawyer expects to end up in court, she should be very careful to prepare a strong record during the internal appeals process.

F. Grandfathered and/or Non-ERISA Plans

Grandfathered self-insured plans are exempt from the New ACA Appeals Regulations, but patients enrolled in grandfathered plans are not entirely unprotected. Those covered by grandfathered ERISA plans, at least, still have the right to internal appeals under the Old ERISA Appeals Regulations, which are nearly identical to the ACA-based internal appeal rights. These patients will not, though, have a legally protected right to external review.

Grandfathered self-insured plans that are also non-ERISA plans are not subject to the Old ERISA Appeals Regulations, thus patients enrolled in this type of plan may have no legally protected appeal rights at all. And if a grandfathered non-ERISA plan offers appeal rights in its plan documents, then this offer must be honored. Fortunately these plans are rare in New York. The relevance of grandfathered and/or non-ERISA status is demonstrated by the chart above.

III. Fully Insured and Individual Market Plans

Unlike self-insured plans, which are subject to federal law, fully insured plans are subject to state as well as federal law. This difference affects patients' rights in important ways. Part III is structured exactly as Part II, focusing first on non-grandfathered ERISA plans. Section III.A provides background on the sources of substantive and procedural law that apply to fully insured plans. Section III.B covers internal appeals in fully insured plans, which are very similar to those available in self-insured plans. New York's external review system, which differs in many respects from the federal system, is described in Section III.C. Section III.D outlines patients' notice rights, and Section III.E briefly describes judicial review. Section III.F analyzes the effects of a plan's grandfathered and/or non-ERISA status on this framework.

A. What Laws Apply to Fully Insured Plans?

In addition to the new ACA protections described in Section II.A above, fully insured plans and individual market plans are also subject to a variety of important patient protections under New York State law. For example, New York's guaranteed issue and community rating laws preclude plans in the individual and small group markets from charging higher premiums to sicker or older enrollees,[60] and New York's Managed Care Bill of Rights requires managed care plans to allow patients access to out-of-network care in certain situations.[61] New York law also includes specific benefit mandates, protecting patients' rights to coverage for treatments such as mammography screening, second surgical opinions, and second opinions for cancer diagnoses.[62] These New York laws exist on top of their federal counterparts, and the rules that are most protective of the patient apply.

With regard to internal appeals, fully insured plans are subject to both state and federal regulation. New York State law divides patients' challenges of plan decisions into two camps: "utilization review" is the process used when the dispute is based on medical necessity,[63] and the "grievance" process is used for all other disputes.[64] The federal internal appeal procedures from the ERISA and ACA Regulations also apply to fully insured plans, and Section III.B analyzes how these sets of rules interact with each other.

Since 1999, New York has required insurers to participate in an external review system where neutral third-party experts can overturn certain plan decisions.[65] The New ACA Appeals Regulations provide that plans participating in state external review systems that meet certain minimum federal standards are subject *only* to those state rules.[66] New York's system meets that test, thus fully insured plans are subject *only* to New York's external review laws, even if the federal standard may be more protective in some minor respects.[67] Section III.C below describes New York's external review system.

B. Internal Appeals in Fully Insured and Individual Market Plans

Both federal and state laws apply to internal appeals in fully insured plans, and the aspects of each law that are most protective of the patient are applied. Thus those enrolled in fully insured plans have some additional protections on internal appeal that are not available in the self-insured context.

Internal Appeals Fully Insured Plans

(non-grandfathered)

- Appeal decided by health plan employee.
- Available to dispute all adverse benefit determinations and rescissions.
- 180-day filing period after first notice of adverse benefit determination or rescission.
- Group plans may offer 2nd-level internal appeal.
- Grievance procedure also available for all other disputes.

1. Who Decides Internal Appeals? Based on What Factors?

Just as in self-insured plans, internal appeals in fully insured plans are decided by health plan employees based on the medical record and the plan's internal medical guidelines. All of the federal rules protecting the independence of these decisions-makers, as described in Section II.B.1, also apply in the fully insured context. In addition, New York State law requires that internal appeals be conducted by clinical peer reviewers, defined as either: (1) licensed or accredited non-physician medical professionals with expertise in the specialty relevant to the case, or (2) licensed physicians of whatever specialty.[68] The internal appeal framework in fully insured plans is extremely similar to that in self-insured plans, and roughly half of all internal appeals in fully insured plans result in the plan overturning itself.[69]

2. Scope and Timelines

The time frames in the New ACA Appeals Regulations are generally more protective of consumers than New York's utilization review and grievance procedures. Therefore, the federal timelines previously described in Section II.B.2 typically apply to all disputes of adverse benefit determinations or rescissions. One exception to this is that New York's urgent appeal response deadlines can be more stringent, requiring a plan's resolution within two business days after receiving all necessary information, which can sometimes be a shorter period than the maximum of 72 hours allowed under the federal rule.[70] But this difference is relatively minor; the thrust of the New ACA Appeals Regulations will apply to fully insured and individual market plans just as they apply to self-insured plans, at least with respect to internal appeals.

New York's grievance procedure allows patients in fully insured plans to appeal *any* decision made by their health plan, even those that are not subject to appeal under the New ACA Appeals Regulations.[71] Grievances can be initiated in writing or by phone (for certain issues) and plans must answer most grievances within 30 or 45 days, depending on the issue, or within 48 hours if urgent. Patients can appeal negative grievance determinations within 60 days. One could file a grievance if, for example, she wanted to challenge the plan's determination of when her coverage was set to start or end (and this did not yet have any effect on the payment of benefits), or if she wanted to complain that her plan never sent her information that she requested. Neither of these examples would be subject to appeal under the New ACA Regulations because they are not adverse benefit determinations.

C. External Review in Fully Insured and Individual Market Plans

1. Who Decides on External Review? Based on What Factors?

Since 1999, New York has operated a successful external review system. In 2011, the state external review law was amended to comply with minimum requirements under the ACA. External reviews in New York are, and will continue to be, heard by neutral third-party organizations under contract with the State Department of Financial Services (formerly known as the Department of Insurance). The state currently contracts with three different independent reviewers and assigns cases to them randomly.[72] This contrasts with the self-insured model where IROs contract directly with the health plans, and provides for an extra level of independence. In New York, about 40% to 50% of external reviews end with the plan's decision being overturned.[73]

External Review Fully Insured Plans

- Appeal decided by third-party IRO, under contract with state.
- Four-month filing period after final adverse determination, which is the *first* internal appeal decision.
- For urgent or concurrent care, can file for external review immediately.
- Available for denials due to:
  - medical necessity (incl. four subtypes),
  - experimental/ investigational (special rules for rare diseases, clinical trials)
  - out-of-network *service* in HMO.

The factors applicable to a given external review vary in New York depending on the type of issue under dispute. Accordingly the discussions of the relevant evidence and standards of review are found in Section III.C.2, together with a description of each type of dispute eligible for external review.

UPDATE Part YY of Chapter 56 of the Laws of 2020 changes to Insurance Law are described in NYS DFS Insurance Circular Letter No. 4 (2021)(https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_04) - Sec. IV - reducing time for insurer to make a decision on a standard appeal from 60 to 30 calendar days (15 calendar days if plan has 2 levels of internal appeal) and other changes (added by Community Services Society)

2. Scope and Timelines

In New York, patients have four months to file for external review after receiving their final adverse determination ("FAD"), which is a bit of a misnomer.[74] The FAD is issued after the *first* unsuccessful internal appeal, even if the plan offers further internal appeals. By contrast, the federal system for self-insured ERISA plans allows external review only after exhausting *all* internal appeals, and applicable time periods only start after reaching that point. Many patients, and even advocates, have missed their opportunity for external review, a very important right, by filing a second-level internal appeal and waiting for a response as their external appeal deadline expires. As with self-insured plans, patients appealing in urgent or concurrent care situations have the right to seek external review at the same time as filing a first-level internal appeal.[75]

New York law does not provide for external review in as broad a selection of cases as does the federal system that applies to self-insured plans, which allows patients to apply for external review of any plan decision involving medical judgment as well as rescissions.[76] In contrast, New York only allows for external review for three specific types of denials: (1) denials because a treatment is not medically necessary, (2) denials because a treatment is experimental or investigational (including rare diseases and clinical trials), and (3) denials of access to an out-of-network service for patients enrolled in HMOs. The rules are a bit different for each category, addressed in turn below:

a. Disputes Regarding Medical Necessity

New Yorkers enrolled in fully insured plans have long had the right to seek external review for disputes as to medical necessity. As of January 1, 2012, this category was expanded to include: (1) disputes as the "appropriateness" of a treatment (e.g., chemotherapy vs. surgery to treat a certain cancer); (2) disputes as to "health care setting" (e.g., breast surgeon vs. general surgeon for a mastectomy); (3) disputes regarding "level of care" (e.g., inpatient vs. outpatient for substance abuse rehabilitation); (4) and disputes as to the "effectiveness of a covered benefit" (e.g., whether physical therapy is still improving patient's condition).[77] These four subcategories are new and the examples above are only one attempt at interpreting their scope; as time passes perhaps a new understanding will emerge.

For this category of dispute, the external reviewer is tasked to decide whether the plan acted "reasonably and with sound medical judgment *and in the best interest of the patient*."[78] The reviewer must consider the clinical standards of the health plan, the patient's medical records, and the attending physician's recommendation (as would be reviewed on internal appeal), but he also must consider any applicable and generally accepted practice guidelines developed by the federal government (e.g., for Medicare), or national or professional medical societies, boards, or associations. In cases where medical professional society guidelines are more flexible or patient-friendly than the guidelines of the insurance company, external review will be a better venue for patients than will internal appeal.

b. Disputes as to Whether a Treatment Is Experimental or Investigational

For this category of dispute, outside of the clinical trial and rare disease contexts, the reviewer is directed to decide if the recommended treatment is "likely to be more beneficial than any standard treatment."[79] The reviewer must consider all of the evidence described above for medical necessity cases, as well as specified "medical and scientific evidence," defined by statute to include things such as peer-reviewed medical literature and listed medical reference compendia and pharmacopeia.[80] In order for this type of case to be eligible for external review, the patient (or her advocate or doctor) must submit *two* such pieces of medical and scientific evidence.[81] As of January 1, 2012, applicants for this type of external review no longer need to show that they are suffering from a life-threatening or debilitating disease.

For patients suffering from rare diseases or seeking access to clinical trials, different rules apply. If the patient is suffering from a rare disease,[82] then the reviewer need only confirm that the treatment is likely to benefit the patient and that the benefit outweighs the risks. This can be supported by as little as a certification to that effect from a non-treating physician, rather than by two pieces of medical or scientific evidence.[83] Patients eligible for a qualifying clinical trial also need not submit two pieces of medical or scientific evidence, and the reviewer need only determine that the treatment is likely to benefit the patient in order to overturn the plan's denial.[84] Patients applying for rare disease or clinical trial external review are no longer required to show that they are suffering from a life-threatening or debilitating disease. The protections for these special situations are important, as it might otherwise be quite difficult to meet the required standard of evidence.

c. Disputes Over Access to Out-of-Network Service Where Plan Offers Alternative Service In-Network

HMO enrollees may also use the external review system when they are seeking access to an out-of-network *service* not available in-network, and the plan recommends the patient receive an *alternative service* in-network.[85] This category is far narrower than it first appears. It does *not* allow access to external review when a patient wants in-network benefits to see a more experienced out-of-network provider.[86] The dispute must be about a *service*—not provider—that is not available in the plan's

network. To win in this class of dispute, the patient must show that the recommended out-of-network treatment is materially different from any treatment available in-network, and that it is likely to be more clinically beneficial without substantially increased risk.[87]

The narrowness of this category may at first seem one way in which New York's system is less patient-friendly than the federal system that applies to self-insured plans. Under the federal system a dispute over access to an out-of-network provider would be eligible for external review since it involves medical judgment, at least if the patient can credibly argue that the in-network provider cannot "effectively" provide the needed service.[88] But it is also possible that the recent addition of language clearly including "health care setting" cases within the purview of external review in New York creates room for development with regard to this type of dispute. One advocate has argued that this language can encompass choice-of-provider disputes, citing discussions with federal regulators and noting that similar language in Virginia law is interpreted in that fashion.[89]

D. Notice Rights in Fully Insured and Individual Market Plans

A patient's right to adequate notice and information necessary to pursue an appeal are almost identical in fully insured plans as in self-insured plans, as described in Section II.D. The most notable exception to this parity is that New York's language access standards are a bit stronger than the federal rules.[90]

E. Judicial Review

For fully insured ERISA plans, the ERISA remedies described in Section II.E also apply. While state law that regulates *insurance* can still be effective against fully insured plans by virtue of ERISA's savings clause, most state law that does not fit into that category is rendered ineffective by ERISA's preemption provision.[91] Therefore, the procedural aspects of ERISA-based judicial review, including standards of review, form the exclusive framework for judicial review of internal appeals from fully insured ERISA plans. New York's external review law also clearly makes external review decisions admissible in court.[92] Since external reviewers are rightly viewed as neutral experts, it is very rare for patients to succeed in court after losing on external review.[93] For fully insured ERISA plans, judicial review looks much the same as it did for self-insured ERISA plans.

F. Grandfathered and/or Non-ERISA Plans

In the fully insured context, a patient's appeal rights are only substantially different if their plan is *both* grandfathered *and* non-ERISA, and this difference only shows up with regard to internal appeals.[94] For these grandfathered non-ERISA plans, none of the federal appeals rules from the ACA or ERISA apply. Consequently, with respect to internal appeals, patients in these plans must rely only on the utilization review[95] and grievance[96] systems available under New York State law. Critically, these patients may have as little as 45 days after an adverse determination to file an appeal, a far tighter period than the 180 days available for most other plans.[97] New York's external review laws, however, apply to all fully insured plans regardless of grandfathered or non-ERISA status. The chart below demonstrates the effect of grandfathered or non-ERISA status in the full insured context.

V. Conclusion and Summary Chart

Internal appeals and external review are important procedural tools that protect patients when their health plans make incorrect benefit decisions. The ACA and recent New York reforms strengthen these protections, for instance by extending deadlines and by making external review available to more patients and for a broader range of disputes. Hopefully this article provides a foundation

Applicable Laws—Fully Insured Plans
Effect of Grandfathered or Non-ERISA Status

Type of Plan		Internal Appeal	External Review
ERISA	Non-Grandfathered	ERISA and ACA Appeals Regulations NY State Utilization Review and Grievances	New York State External Review System
	Grandfathered	ERISA Appeals Regulations NY State Utilization Review and Grievances	
Non-ERISA	Non-Grandfathered	ERISA and ACA Appeals Regulations NY State Utilization Review and Grievances	
	Grandfathered	NY State U.R. and Grievances *only* as little as 45 days to file first appeal	

to allow advocates to navigate these new procedures successfully. In support of that goal, the table below summarizes the most important information from this article and provides citations to the principal sources of law applicable to each type of health plan.

Internal Appeal and External Review Rights in New York

Self-Insured Plans

Type of Plan	Internal Appeals	External Review
Self-Insured ERISA	• Appeal decided by health plan employee. • Available to dispute all adverse benefit determinations and rescissions. • 180-day filing period after first notice of adverse benefit determination or rescission. • Plans may allow 2nd-level internal appeal. • *Grandfathered plans*: Same rights, with only minor differences. Sources: A, C	• Appeal decided by third-party IRO, under contract with health plan. • Available to dispute decisions that involve medical judgment and rescissions. • Four-month filing period after exhaustion of *all* internal appeals. • For urgent or concurrent care, can file for external review immediately. • *Grandfathered plans*: Not legally required to offer external review. Sources: B, D
Self-Insured Non-ERISA	• Appeal decided by health plan employee. • Available to dispute all adverse benefit determinations and rescissions • 180-day filing period after first notice of adverse benefit determination or rescission. • Plans may allow 2nd-level internal appeal • *Grandfathered plans*: Not required to offer any appeal rights. Source: A	

Fully Insured Plans

Type of Plan	Internal Appeals	External Review
Fully Insured ERISA	• Appeal decided by health plan employee. • Available to dispute all adverse benefit determinations and rescissions. • 180-day filing period after first notice of adverse benefit determination or rescission. • Plans may allow 2nd-level internal appeal. • Grievances available for other disputes. • Grandfathered plans: Same rights, with only minor differences. Sources: A, C, E, G	• Appeal decided by third-party IRO, under contract with state. • Available for denials due to: – medical necessity (incl. four subtypes), – experimental/investigational (incl. special rules for rare diseases, clinical trials), – out-of-network *service* in HMO. • Four-month filing period after final adverse determination, which is the *first* internal appeal decision. • For urgent or concurrent care, can file for external review immediately. • *Grandfathered plans*: Same rights apply. Source: F
Fully Insured Non-ERISA (incl. individual market)	• Appeal decided by health plan employee. • Available to dispute all adverse benefit determinations and rescissions • 180-day filing period after first notice of adverse benefit determination or rescission. • Group plans may allow 2nd internal appeal. • Individual market plans allow one one internal appeal. • Grievances available for other disputes. • *Grandfathered plans*: May have as little as 45 days to file first internal appeal. Sources: A, E, G	

Sources

A - ACA Appeals Regulations, ¶ (b) (26 CFR 54.9815-2719T(b), 29 CFR 2590.715-2719(b), 45 CFR 147.136(b))*

B - ACA Appeals Regulations, ¶ (d) (26 CFR 54.9815-2719T(d), 29 CFR 2590.715-2719(d), 45 CFR 147.136(d))*

C - ERISA Appeals Regulations (29 CFR 2560.503-1)

D - DOL Technical Releases 2010-01 and 2011-02*

E - N.Y. Ins. Law and Pub. Health Law §§ 4900 et seq.

F - N.Y. Ins. Law and Pub. Health Law §§ 4910 et seq.

G - N.Y. Ins. Law § 4802; N.Y. Pub. Health Law § 4408-a.2

* - Does not apply to grandfathered plans.

Endnotes

1. United Hospital Fund, Health Coverage in New York, 2009 fig. 1 & tbl. 4 (2011), available at www.uhfnyc.org/assets/936.
2. Id. at fig. 1.
3. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2010 Medical Expenditure Panel Survey-Insurance Component tbl. II.B.2.b.(1)(2010), available at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tiib2b1.pdf.
4. Employers can be penalized up to $110 per day for failing to provide plan documentation within 30 days of request. 29 U.S.C. § 1132(c) (2006); 29 C.F.R. § 2575.502c-1 (2011); *see also* Kasireddy v. Bank of Am. Corp. Corporate Benefits Comm., 2010 U.S. Dist. LEXIS 109606 (N.D. Ill. 2010).
5. Agency for Healthcare Research and Quality, supra note 3, at tbl. II.B.2.b.(1)(2010).
6. 29 U.S.C. § 1144(a) (2006). For a small sample of seminal case law on ERISA preemption, *see, e.g.*, *Shaw v. Delta Airlines Inc.*, 463 U.S. 85 (1983) and *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).
7. 29 U.S.C. § 1144(b)(2)(A) (2006). ERISA's deemer clause prevents states from "deeming" self-insured plans to be insurance and then regulating them. 29 U.S.C. § 1144(b)(2)(B) (2006).
8. *See* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985) (recognizing fully insured plans are subject to state law while self-insured plans are not).
9. Some state remedies arising out of claim administration (such as punitive damage claims) may be preempted by ERISA even if more patient protective than the federal standard. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).
10. Patient Protection and Affordable Care Act (ACA) § 1251, 42 U.S.C.A § 18011 (2011). For detailed implementing regulations, see 26 C.F.R. § (2011), 29 C.F.R. § 2590.715-1251 (2011), 45 C.F.R. § 147.140 (2011). Information is also available at www.healthcare.gov.
11. Dep't of Health and Human Services, Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans, at www.healthcare.gov/news/factsheets/2010/06/keeping-the-health-plan-you-have-grandfathered.html (last visited Nov. 28, 2011).
12. 26 C.F.R. § 54.9815-1251T(a)(2) (2011); 29 C.F.R. § 2590.715-1251(a)(2) (2011); 45 C.F.R. § 147.140(a)(2) (2011).
13. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(a) (2011), 29 C.F.R. § 2590.715-2719(a) (2011), 45 C.F.R. § 147.136(a) (2011).
14. 29 U.S.C. § 1003 (2006).
15. United Hospital Fund, The Big Picture: Private and Public Health Insurance Markets in New York 34-42 (2009), available at www.uhfnyc.org/assets/753 (Empire Plan and New York City Health Benefits Program); United Hospital Fund, Health Coverage in New York, 2009 fig. 1 & tbl. 4 (2011), available at www.uhfnyc.org/assets/936 (estimating circa 600,000 insured on individual market). *But c.f.* Joel C. Cantor et al., *The Adequacy of Household Survey Data for Evaluating the Nongroup Health Insurance Market*, 42 Health Serv. Res. 1739 (2007) (arguing survey data greatly over-estimates size of individual market).
16. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1 (2011).
17. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(b)(2)(i) (2011), 29 C.F.R. § 2590.715-2719(b)(2)(i) (2011), 45 C.F.R. § 147.136(b)(2)(i) (2011).
18. ACA § 1001, 42 U.S.C.A. § 300gg-13 (2011) (may not apply to grandfathered plans). For parallel implementing regulations of the IRS, DOL, and HHS, see 26 C.F.R. § 54.9815-2713T (2011); 29 C.F.R. § 2590.715-2713 (2011); 45 C.F.R. § 147.130 (2011).
19. ACA § 1001, 42 U.S.C.A. § 300gg-14 (2011) (does not apply to grandfathered plans if the young adult has access to other group health coverage). For parallel implementing regulations of the IRS, DOL, and HHS, see 26 C.F.R. § 54.9815-2714T (2011); 29 C.F.R. § 2590.715-2714 (2011); 45 C.F.R. § 147.120 (2011).
20. ACA § 1001, 42 U.S.C.A. 300gg-19a (2011) (does not apply to grandfathered plans). For parallel implementing regulations of the IRS, DOL, and HHS, see 26 C.F.R. § 54.9815-2719AT(b) (2011); 29 C.F.R. § 2590.715-2719A(b) (2011); 45 C.F.R. § 147.138(b) (2011).
21. ACA § 1201, 42 U.S.C.A. 300gg (2011) (does not apply to grandfathered plans). For parallel implementing regulations of the IRS, DOL, and HHS, see 26 C.F.R. § 54.9815-2704T (2011); 29 C.F.R. § 2590.715-2704 (2011); 45 C.F.R. § 147.108 (2011).
22. ACA § 1001, 42 U.S.C.A. § 300gg-11 (2011) (applies to grandfathered plans). For parallel implementing regulations of the IRS, DOL, and HHS, see 26 C.F.R. § 54.9815-2711T (2011); 29 C.F.R. § 2590.715-2711 (2011); 45 C.F.R. § 147.126 (2011).
23. ACA § 1001, 42 U.S.C.A. § 300gg-19 (2011).
24. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T (2011), 29 C.F.R. § 2590.715-2719 (2011), 45 C.F.R. § 147.136 (2011).
25. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(3)(ii) (2011).
26. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(b)(2)(D) (2011), 29 C.F.R. § 2590.715-2719(b)(2)(D) (2011), 45 C.F.R. § 147.136(b)(2)(D) (2011).
27. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(3)(iii) (2011).
28. In the fully insured context, discussed in Part III below, about half of all internal appeals are successful for the patient. New York Dept. of Financial Services, New York Consumer Guide to Health Insurers 14-15 (2011), available at www.dfs.ny.gov/insurance/consumer/health/cg_health_2011.pdf.
29. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(b) (2011), 29 C.F.R. § 2590.715-2719(b) (2011), 45 C.F.R. § 147.136(b) (2011) (right to internal appeal); ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(3)(i) (giving 180 days).
30. ERISA Claims Procedure Rule, 29 C.F.R. § 2560-503-1(m); *see also* IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(a)(2)(i) (2011), 29 C.F.R. § 2590.715-2719(a)(2)(i) (2011), 45 C.F.R. § 147.136(a)(2)(i) (2011) (defining term by reference back to older ERISA regulation).
31. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(A) (2011), 29 C.F.R. § 2590.715-2719(b)(2)(ii)(A) (2011), 45 C.F.R. § 147.136(b)(2)

(ii)(A) (2011). A "rescission" is a cancelation or discontinuance of coverage with retroactive effect. 26 C.F.R. § 54.9815-2712T(a)(12), 29 C.F.R. § 2590.715-2712(a)(12), 45 C.F.R. § 147.128 (2011).

32. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(i) (2011) (60 days); 29 C.F.R. § 2560.503(1)(b)(4) (right to appoint representative).

33. ERISA Claims Procedure Rule 29 C.F.R. § 2560-503-1(m)(1) (defining urgent care); 29 C.F.R. § 2560.503-1(i)(2)(i) (giving time limit for plan to answer urgent appeal); *see also* IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(B) (2011), 29 C.F.R. § 2590.715-2719(b)(2)(ii)(B) (2011), 45 C.F.R. § 147.136(b)(2)(ii)(B) (2011) (discussing urgent cases in new ACA regulations by reference back to older ERISA regulations).

34. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(3)(vi)(A) (2011).

35. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(f)(2)(ii)(A) (2011).

36. As of January 1, 2012 each plan has been required to contract with at least two IROs, and by July 1, 2012 they must contract with at least three. Plans are not *required* to assign cases randomly to IROs, but any other method of assignment will receive close scrutiny from DOL. *See* Dept. of Labor, Employee Benefit Security Administration, Technical Release 2010-01, at 4 (Aug. 23, 2010), available at www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf; Dept. of Labor, Employee Benefit Security Administration, Technical Release 2011-02, at 8-9 (June 22, 2011), available at www.dol.gov/ebsa/pdf/tr11-02.pdf.

37. Dept. of Labor, Employee Benefit Security Administration, Technical Release 2010-01, at 5 (Aug. 23, 2010), available at www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf; *see also* URAC, Issue Brief: Affordable Care Act (PPACA) External Review Regulations (Dec. 2010), available at www.urac.org/savedfiles/1URAC_IROIB_2010.pdf.

38. Dept. of Labor, Employee Benefit Security Administration, Technical Release 2010-01, at 3 (Aug. 23, 2010), available at www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

39. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(d)(1)(ii) (2011), 29 C.F.R. § 2590.715-2719(d)(1)(ii) (2011), 45 C.F.R. § 147.136(d)(1)(ii) (2011).

40. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(d)(1)(iii) (2011), 29 C.F.R. § 2590.715-2719(d)(1)(iii) (2011), 45 C.F.R. § 147.136(d)(1)(iii) (2011).

41. Dept. of Labor, Employee Benefit Security Administration, Technical Release 2010-01, at 6-7 (Aug. 23, 2010), available at www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

42. Id. at 5, 7 (deadlines for answers to standard and urgent appeals, respectively).

43. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(E) (2011), 29 C.F.R. § 2590.715-2719(b)(2)(ii)(E) (2011), 45 C.F.R. § 147.136(b)(2)(ii)(E) (2011).

44. See supra note 4 and accompanying text.

45. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(E) (2011), 29 C.F.R. § 2590.715-2719(b)(2)(ii)(E) (2011), 45 C.F.R. § 147.136(b)(2)(ii)(E) (2011).

46. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(2)(iii); *see also* IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(C) (2011), 29 C.F.R. § 2590.715-2719(b)(2)(ii)(C) (2011), 45 C.F.R. § 147.136(b)(2)(ii)(C) (2011).

47. Rather than stemming from regulations on appeals, this right is actually provided by HIPAA, which protects people's rights to access their own medical records. *See* 45 C.F.R. §§ 164.502(a)(2), 164.524 (2011).

48. ACA § 1001, 42 U.S.C.A. 300gg-19(a)(1)(B) (2011).

49. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(e)(2) (2011), 29 C.F.R. § 2590.715-2719(e)(2) (2011), 45 C.F.R. § 147.136(e)(2) (2011).

50. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(e)(3) (2011), 29 C.F.R. § 2590.715-2719(e)(3) (2011), 45 C.F.R. § 147.136(e)(3) (2011). This standard was stronger in the original July 2010 version of the regulation, but weakened in the June 2011 amendment.

51. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 76 Fed. Reg. 37221-24 (June 24, 2011) (listing applicable languages and counties in preamble to regulation).

52. For a detailed discussion of advocates' recommendations for improvements to these language access rules, see Letter from National Health Law Program, Commenting on Amendment to Internal Appeals and External Review Regulations (July 25, 2011), available at http://www.healthlaw.org/images/stories/healthreform/2011_07_25_Appeals_Comments.pdf.

53. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (2006).

54. *See, e.g.*, Met Life Ins. Co. v. Glenn, 554 U.S. 105 (2008); Miller v. United Welfare Fund, 72 F.3d 1066 (2d Cir. 1995).

55. *See, e.g.*, Zuckerbrod v. Phoenix Mutual Life Ins. Co., 78 F.3d 46 (2d Cir. 1996).

56. *See, e.g.*, DeAngelis v. Warner Lambert Co., 641 F. Supp. 467 (S.D.N.Y. 1986) (finding no reversible inconsistency).

57. *See, e.g.*, Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130 (9th Cir. 2001).

58. *See, e.g.*, Miller v. United Welfare Fund, 72 F.3d 1066 (2d Cir. 1995).

59. *See* IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(d)(2)(iv) (2011), 29 C.F.R. § 2590.715-2719(d)(2)(iv) (2011), 45 C.F.R. § 147.136(d)(2)(iv) (2011); *see also* infra note 93 and accompanying text.

60. N.Y. Ins. Law § 3231 (McKinney 2011).

61. N.Y. Pub. Health Law. § 4403(6)(a) (McKinney 2011).

62. *See, e.g.*, N.Y. Ins. Law §§ 3216, 3221, & 4303 (McKinney 2011) (describing benefit mandates for individual commercial, group commercial, and group HMO products); *see also* New York Dept. of Financial Services, Mandated and Make Available Benefits: Commercial, HMO & Article 43 Insurance Contracts, at www.dfs.ny.gov/insurance/health/lbenall.htm (last visited Nov. 21, 2011).

63. N.Y. Ins. Law § 4900(h) (McKinney 2011).

64. N.Y. Pub Health Law § 4408-a.2 (McKinney 2011); N.Y. Ins. Law § 4802 (McKinney 2011). Grievance procedure requirements apply to any plan with a network, including EPOs. N.Y. Ins. Law § 4306-c (McKinney 2011).

65. N.Y. Ins. Law § 4910 et seq. (McKinney 2011); *see also* Mark Scherzer, Implementing Health Care Reform: External Review of Health Plan Decisions 4-5 (2011), available at www.uhfnyc.org/assets/901.

66. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(c) (2011), 29 C.F.R. § 2590.715-2719(c) (2011), 45 C.F.R. § 147.136(c) (2011); *see also* Dept. of Labor, Employee Benefit Security Administration, Technical Release 2011-02 (June 22, 2011), available at www.dol.gov/ebsa/pdf/tr11-02.pdf; Scherzer, supra note 65. There was great dismay among advocates when the July 2011 amendments to the ACA appeals regulations weakened the minimum protections required of state external review schemes, but New York's system already

met the higher bar set in the June 2010 version of the regulation, so the weakening of the amended regulations did not affect New Yorkers.

67. See Dept. of Health and Human Services, Center for Consumer Information & Insurance Oversight, Affordable Care Act: Working with States to Protect Consumers, at http://cciio.cms.gov/resources/files/external_appeals.html (last visited Nov. 11, 2011) (listing New York as compliant with strictest federal standards).

68. N.Y. Ins. Law §§ 4904(d); 4900(b) (McKinney 2011); N.Y. Pub. Health Law §§ 4904(4); 4900(2) (McKinney 2011).

69. New York Dept. of Financial Services, New York Consumer Guide to Health Insurers 15 (2011), available at www.dfs.ny.gov/insurance/consumer/health/cg_health_2011.pdf.

70. N.Y. Ins. Law § 4904(b) (McKinney 2011); N.Y. Pub. Health Law § 4904(2) (McKinney 2011).

71. N.Y. Pub. Health Law § 4408-a.2 (McKinney 2011); N.Y. Ins. Law § 4802 (McKinney 2011).

72. 11 N.Y.C.R.R. § 410.8 (2011) (random assignment); New York Dept. of Financial Services, External Appeals—Frequently Asked Questions, Instructions, and Applications, at www.dfs.ny.gov/insurance/extapp/extappqa.htm (last visited Nov. 12, 2011) (listing IMEDICS, IPRO, and MCMC as the three selected external reviewers).

73. New York State Insurance Dept. and New York State Dept. of Health, New York State External Appeal Program Annual Report 29-35 (2005) (most recent report publicly available), available at http://www.dfs.ny.gov/insurance/extapp/extapp05.pdf.

74. N.Y. Ins. Law § 4910(b)(1) (McKinney 2011); N.Y. Pub. Health Law § 4910(2)(a) (McKinney 2011). Prior to the recent amendments, the patient had 45 days to seek external review. The amended version of the statute is effective for all final adverse determinations issued on or after January 1, 2012. Any reader interested in the rules *before* the recent amendment became effective should refer to Scherzer, supra note 65.

75. N.Y. Ins. Law § 4914(b) (McKinney 2011); N.Y. Pub. Health Law § 4914(2) (McKinney 2011).

76. *See* Part II.C infra.

77. N.Y. Ins. Law § 4910(b)(1) (McKinney 2011); N.Y. Pub. Health Law § 4910(2)(a) (McKinney 2011).

78. N.Y. Ins. Law § 4914(b)(4)(A) (McKinney 2011); N.Y. Pub. Health Law § 4914(2)(d)(A) (McKinney 2011) (emphasis added).

79. N.Y. Ins. Law § 4914(b)(4)(B) (McKinney 2011); N.Y. Pub. Health Law § 4914(2)(d)(B) (McKinney 2011).

80. N.Y. Ins. Law § 4900(g-5) (McKinney 2011); N.Y. Pub. Health Law § 4900(7-e) (McKinney 2011).

81. N.Y. Ins. Law § 4910(b)(2)(C) (McKinney 2011); N.Y. Pub. Health Law § 4910(2)(b)(iii) (McKinney 2011).

82. A "rare disease" is defined by statute to be a condition or disease which is subject to research of the NIH Rare Diseases Clinical Research Network or affects fewer than 200,000 U.S. residents per year, and for which there is no standard treatment covered by the health plan. N.Y. Ins. Law § 4900(g-7) (McKinney 2011); N.Y. Pub. Health Law § 4910(7-g) (McKinney 2011).

83. N.Y. Ins. Law § 4910(b)(2)(C) (McKinney 2011); N.Y. Pub. Health Law § 4910(2)(b)(iii) (McKinney 2011).

84. N.Y. Ins. Law § 4914(b)(4)(B) (McKinney 2011); N.Y. Pub. Health Law § 4914(2)(d)(ii) (McKinney 2011) (standard to overturn); N.Y. Ins. Law § 4910(b)(2)(C) (McKinney 2011); N.Y. Pub. Health Law § 4910(2)(b)(iii) (McKinney 2011) (delineating when two pieces of scientific evidence are required).

85. N.Y. Ins. Law § 4910(b)(3) (McKinney 2011); N.Y. Pub. Health Law § 4910(2)(c) (McKinney 2011).

86. New York Dept. of Financial Services, External Appeals—Frequently Asked Questions, Instructions, and Applications, at www.dfs.ny.gov/insurance/extapp/extappqa.htm (last visited Nov. 12, 2011) ("Am I eligible for an external appeal if my health plan denies coverage because I requested services from a non-participating provider?… No, if the out-of-network service is available in-network, even if an out-of-network provider has more experience in diagnosing or treating your condition.").

87. N.Y. Ins. Law § 4914(b)(4)(C) (McKinney 2011); N.Y. Pub. Health Law § 4914(2)(d)(iii) (McKinney 2011).

88. IRS, DOL, and HHS Rule on Internal Appeals and External Review Under the ACA, 26 C.F.R. § 54.9815-2719T(d)(1)(iii) (2011), 29 C.F.R. § 2590.715-2719(d)(1)(iii) (2011), 45 C.F.R. § 147.136(d)(1)(iii) (2011) (example 2).

89. Scherzer, supra note 65, at 8-10. *But c.f.* N.Y. Ins. Law § 4900(h) (McKinney 2011) (listing provider choice cases as excluded from definition of utilization review, though not necessarily from class of cases eligible for external review).

90. *See* N.Y. Pub. Health Law § 4408-a.2 (McKinney 2011) (requiring insurers to assure the grievance procedure is "reasonably accessible" to non-English speakers); N.Y. Ins. Law § 4802 (McKinney 2011) (same); N.Y. Pub. Health Law § 4408.1 (requiring insurers to disclose how they address needs of non-English speaking enrollees).

91. Determining whether a particular state law regulates insurance can be a murky process. *See, e.g.*, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (finding state punitive damages law preempted by ERISA); UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999) (saving California law from preemption without meeting all criteria outlined in *Pilot Life*).

92. N.Y. Ins. Law § 4914(b)(4) (McKinney 2011); N.Y. Pub. Health Law § 4914(2)(d) (McKinney 2011).

93. *See* Scherzer, supra note 65, at 4.

94. Some minor differences will show up with grandfathered ERISA plans because only the ERISA Regulations, and not the ACA Regulations, will apply. Also, non-ERISA plans offered on the individual market are precluded from offering more than one level of internal appeal. 45 C.F.R. § 147.136(b)(3)(G) (2011).

95. N.Y. Ins. Law §§ 4900 et seq. (McKinney 2011); N.Y. Pub. Health Law §§ 4900 et seq. (McKinney 2011).

96. N.Y. Pub. Health Law § 4408-a.2 (McKinney 2011); N.Y. Ins. Law § 4802 (McKinney 2011).

97. N.Y. Ins. Law § 4906(c) (McKinney 2011); N.Y. Pub. Health Law § 4906(3) (McKinney 2011).

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