EXTERNAL REVIEW PROCESS REQUIREMENTS

For a State external review process to apply (or continue to apply) to health insurance issuers (and certain plans) for plan years (in the individual market, policy years) beginning on or after July 1, 2011, the State process was required to include the 16 minimum consumer protection standards set forth in paragraph (c)(2) of the July 2010 federal regulations. These 16 minimum consumer protection standards were amended, in limited respects, by an amendment to the July 2010 regulations that was issued in June 2011. That amendment to the July 2010 regulations also modifies the transition period described in the first sentence of this paragraph.

These 16 minimum consumer protection standards, as amended, may be summarized as follows:

Minimum Consumer Protection Standard	BCBSND Option 1	BCBSND Option 2
1. The process must provide for external review of adverse benefit determinations and final internal adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.	No (appeal of rescissions not included)	No (appeal of rescissions not included)
2. Issuers must be required to provide effective written notice to claimants of their rights to external review.	Yes (2(b)). Lacks detail though.	Yes (2(b)). Lacks detail though.
3. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (a) the issuer waives the exhaustion requirement; (b) the issuer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review.	Yes 2(c). Doesn't track the exact language of T.R. No. 2011-02	Yes 2(c). Doesn't track the exact language of T.R. No. 2011-02
4. The cost of an independent review organization (IRO) to conduct an external review must be borne by the issuer, although the process may require a nominal filing fee from the claimant requesting external review.	Yes 2(d).	Yes 2(d).
5. There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for	Yes 2(e).	Yes 2(e).

external review.		
6. The process must allow at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.	Yes 2(f).	Yes 2(f).
7. The IRO must be assigned by the State or an independent entity, on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process (such as rotational assignment), and in no event assigned by the issuer, the plan, or the individual.	No. 2(g) conflicts in that it allows the insurer to assign the IRO.	Yes 2(g).
8. The process must provide for the maintenance of a list of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review based on the nature of the health care service that is the subject of the review.	Yes 2(g).	Yes 2(g).
9. Approved IROs must have no conflicts of interest that will influence their independence.	Yes 2(h).	Yes 2(h).
10. Claimants must be allowed to submit to the IRO additional information in writing that the IRO must consider when conducting the external review, and the claimant must be notified of the right to submit additional information to the IRO; the IRO must allow the claimant at least 5 business days to submit any additional information and any additional information submitted by the claimant must be forwarded to the issuer within one business day of receipt by the IRO.	Yes 2(i).	Yes 2(i).
11. The IRO decision must be binding on the claimant, as well as the plan or issuer (except to the extent that other remedies are available under State or Federal law).	Unclear if this would be met due to the exception in 2(j).	Unclear if this would be met due to the exception in 2(j).
12. For standard external review, the IRO must provide written notice to the issuer and the claimant of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request for external review.	Yes 2(k). Unclear how giving the decision to the Insurance Dept. in	Yes 2(k)

	addition to the claimant and issuer might be viewed though.	
13. The process must provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review (and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision).	Yes 2(k). Unclear how giving the decision to the Insurance Dept. in addition to the claimant and issuer might be viewed though.	Yes 2(k)
14. Issuers must provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees, substantially similar to section 17 of the NAIC Uniform Model Act.	Unclear if this would be met due to the lack of detail in 2(l).	Unclear if this would be met due to the lack of detail in 2(l).
15. The IRO must maintain written records and make them available upon request to the State, substantially similar to section 15 of the NAIC Uniform Model Act.	Unclear if this would be met due to the lack of detail in 2(m).	Unclear if this would be met due to the lack of detail in 2(m).
16. The process must follow procedures for external reviews involving experimental or investigational treatment, substantially similar to section 10 of the NAIC Uniform Model Act.	No. Lacks provision for: oral requests; Commissioner authority to override company's determination that external review request isn't eligible for review; treating physician to certify why treatment is necessary; IRO to select health care professionals	No. Lacks provision for: oral requests; Commissioner authority to override company's determination that external review request isn't eligible for review; treating physician to certify why treatment is necessary; IRO to select

	who are experts in the treatment of the covered person's condition; decision to be issued by IRO within 20 days; description and analysis by IRO of any medical or scientific evidence used in reaching its opinion.	health care professionals who are experts in the treatment of the covered person's condition; decision to be issued by IRO within 20 days; description and analysis by IRO of any medical or scientific evidence used in reaching its opinion.