



AHIP

*Center for Policy
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An Update on State External Review Programs, 2006

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SUMMARY

Most states rely upon external review programs as a means to resolve coverage disputes between consumers and health insurance plans. External review programs provide a way to resolve disputes in a fair, timely, and less costly manner than through the courts. Currently, 44 states and the District of Columbia operate external review programs.

This report provides an analysis of publicly available data from state external review programs operating in 2006. It is a follow-up to previous studies conducted by America's Health Insurance Plans (AHIP) for programs operational in 1999, 2000¹, 2003, and 2004.² For this update, 33 states and the District of Columbia provided data from their external review programs for 2006. AHIP will continue to update this study as new data become available.

In all the states for which data were reported, on average, fewer than one out of every 10,000 eligible individuals submitted appeals for external review of coverage disputes. Specifically, the appeal rate in 2006 was approximately 0.94 appeals per 10,000 eligible health plan members, slightly higher than the rate of roughly 0.84 appeals per 10,000 in 2003 and 2004, and 0.7 appeals per 10,000 in 1999 and 2000.

In 2006, external reviewers upheld the original decision of the health insurance plans in 59 percent of cases. In 37 percent of cases, the reviewers fully agreed with the consumer who filed the appeal. In the remaining four percent of cases, the independent reviewers partially agreed with the consumer. Overall, the percentage of cases in which the decisions of the health insurance plans were upheld has been above 50 percent in each year of the AHIP study.

SUMMARY OF EXTERNAL APPEALS OVER TIME

	1999	2000	2003	2004	2006
Appeal rate per 10,000 eligible health plan members	0.7	0.7	0.84	0.84	0.94
Percent of appeals upheld	55%	51%	60%	61%	59%
Percent of appeals overturned	45%	49%	40%	39%	37%
Percent of appeals overturned in part	-	-	-	-	4%

Source: America's Health Insurance Plans.

Note: AHIP collected information on partially overturned appeals for the first time in 2006.

¹ American Association of Health Plans (AAHP), "Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions," April 2001. See <http://www.ahip.org/content/default.aspx?bc=38|82|2246>.

² America's Health Insurance Plans (AHIP), "Update on State External Review Programs," January 2006. See http://www.ahipresearch.org/pdfs/External_ReviewJan06.pdf.

BACKGROUND

Throughout the country, external review laws are providing a successful mechanism for resolving health care coverage disputes between consumers and their health insurance plans. External review, also known as independent medical review, is a formal process that allows consumers to appeal coverage determinations to a third party. Currently, 44 states and the District of Columbia have external review programs that apply to private health insurance plans, usually in both the group and individual markets.³

In general, external review laws provide consumers with a mechanism to resolve coverage disputes when a health insurance plan determines that a proposed service or treatment does not meet medical necessity criteria or is experimental or investigational.

State external review laws generally apply to a broad range of health insurance plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and in some instances, Medicaid managed care organizations.

Typically, external review programs are operated by a state's Department of Insurance, and apply to health insurance plans regulated by the states. While state regulators usually determine the eligibility of an external review appeal, almost all states select an independent review organization (IRO) to evaluate cases. In all states, the IROs' reviewers are health care professionals who are board certified and have an expertise in the specialty under review and cannot have a conflict of interest that would impair their ability to perform an unbiased review. Typically, external review laws also require that consumers exhaust all internal appeals processes before submitting a case for review.

APPEAL RATE

The aggregate appeal rate in 2006 was 0.94 per 10,000 eligible individuals, or one appeal per 10,650 covered persons. This appeal rate is slightly higher than the rate of 0.84 per 10,000 eligible health plan members (one appeal per 12,000) calculated in 2003 and 2004, and 0.7 appeals per 10,000 eligible individuals (one appeal per 14,000) in 1999 and 2000. The appeal rate was calculated by dividing the number of cases accepted for full review by the estimated number of eligible health plan members.

EXTERNAL REVIEW RESULTS

In 2006, external review organizations issued decisions in 6,387 of the 7,135 reported appeals accepted for review in the states studied. There is a difference between the number of appeals accepted and the number of decisions made by external review organizations because some cases were settled before a decision was made, some were withdrawn by the consumer, and some were still pending at year's end. In some cases, the external review process may bring to light new or more comprehensive information and appeals may be withdrawn or settled before the external review organization completes its review.

Cases Decided in Favor of Health Insurance Plans' Original Decisions

The "upheld rate" represents the number of cases in which the external review organization ruled in favor of the health insurance plan, upholding the plan's original coverage determination. In aggregate, external review organizations upheld the health plan's original coverage determination in approximately 59 percent of cases in 2006.

³States with operational external review programs include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. Alabama was not included in the 44 as its HMO law does not provide for any external review requirements. It simply allows individuals to appeal a denial of a benefit request to the state complaint committee through the State Health Officer or the Commissioner of the Alabama Department of Insurance.

Cases Decided in Favor of Consumers

The “overturn rate” represents the number of cases in which the external review organization rules in favor of the consumer, overturning in full the health plan’s coverage decision. The aggregate overturn rate was approximately 37 percent in 2006.

Cases Decided Partially in Favor of Consumers

In 2006, AHIP collected information on cases that were decided partially in favor of consumers. In these cases, part of a health insurance plan’s coverage decision was overturned, but part of the decision was upheld. In prior years, AHIP did not collect data on cases decided partially in favor of consumers. Among the states studied, the aggregate rate of partially overturned cases in 2006 was approximately four percent.

COMMON ISSUES ADDRESSED BY EXTERNAL REVIEW CASES

There is significant variation in the scope and process requirements of external review programs across the states. For example, external review laws in Colorado, Delaware, Illinois, Iowa, Louisiana, Maryland, Minnesota, Missouri, Montana, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, Texas, Utah, and the District of Columbia, apply to medical necessity determinations. However, the external review laws of Alaska, Arkansas, California, Connecticut, Florida, Kansas, Kentucky, Maine, Massachusetts, Nevada, New York, North Carolina, Oregon, South Carolina, Tennessee, Vermont, Virginia, West Virginia, and Wisconsin apply to medical necessity determinations as well as determinations involving experimental services or treatments. In some states, such as Arizona and Washington, any adverse determination affecting coverage is subject to external review.

Of the states reporting information in the survey, external review cases most commonly involved disputed coverage decisions for prescription drugs, inpatient hospital stays, and various surgical procedures. However, the reasons for appeal

varied from state to state. For example, in California, decisions on prescription drug coverage were the most commonly cited reason for external reviews, and in North Carolina, external appeals most commonly involved surgical services.

STUDY CRITERIA AND METHODOLOGY

In order to assess the volume and disposition of external review appeals in the 44 states and the District of Columbia, AHIP contacted all states with independent appeals laws in effect. The state had to have an appeals process in operation for six months or longer and have data available on case disposition in order to be included in the study. Thirty-four jurisdictions met these criteria for 2006 and were able to provide data (AR, CA, CO, CT, DE, DC, FL, HI, IL, IN, IA, KS, KY, ME, MD, MA, MN, MO, MT, NH, NJ, NM, NY, NC, OH, OK, OR, PA, RI, SC, TX, VA, WA, and WI). The remaining states either do not publicly report this information or did not yet have data available for 2006.

For states submitting data, the report gives the number of appeals filed, the number of cases accepted for full review, the number of cases receiving the full review, and the number and percentage of cases decided that were upheld, overturned, and partially overturned. In general, external review laws apply only to fully-insured health plans, which are regulated by the states. The appeal rates were calculated by dividing the number of cases accepted for full review by the estimated number of individuals eligible for the state’s external review law. In their survey responses, some states provided estimates of the eligible population. In other states, AHIP estimated the eligible population based on the state laws and a state-by-state estimate of the number of people enrolled in fully-insured plans from the Medical Expenditures Panel Survey (MEPS).⁴ Where the state law applied to the Medicaid managed care population, we used enrollment data from the Centers for Medicare and Medicaid Services (CMS) for 2006. The approximate number of eligible health plan members was rounded to the nearest thousand.

⁴See MEPS Table I.B.2.b(1)(2005) Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm and selected characteristics: United States, 2005. The percentage of workers with self-insured coverage was subtracted from 100 percent to derive an estimate of the number of people with fully-insured coverage. This percentage was then multiplied by the number of people with private insurance according to the U.S. Census Bureau’s Current Population Survey.

ACKNOWLEDGEMENTS

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APPENDICES

Appendix A: State External Review Data, 2006

This appendix contains data from 33 states and the District of Columbia on the number of appeals filed, the number of cases accepted for full review, the number of cases decided, the number of appeals upheld, the number of cases overturned, and the number of cases partially overturned. Reporting periods varied from state to state. Florida, Hawaii, New Hampshire, Virginia, and the District of Columbia use a fiscal year instead of a calendar year. Therefore, we labeled FY 2005-2006 data from these states as “2006” for reporting purposes.

State	Reporting Period	Approximate Number of Eligible Health Plan Members	Number of Appeals Filed	Number of Cases Accepted for Full Review	Number of Appeals Receiving Full Review	Appeals Upheld		Appeals Overturned		Appeals Partially Overturned		Appeal Rate per 10,000
						Number	Percent	Number	Percent	Number	Percent	
AR	Jan. 06 - Dec. 06	550,000	11	11	11	10	91%	1	9%	0	0%	0.2
CA	Jan. 06 - Dec. 06	17,000,000	1,985	1,416	1,080	638	59%	442	41%	0	0%	0.8
CO	Jan. 06 - Dec. 06	1,594,000	129	125	125	85	68%	39	31%	1	<1%	0.8
CT	Jan. 06 - Dec. 06	1,261,000	176	157	157	87	55%	56	36%	14	9%	1.2
DE	Jan. 06 - Dec. 06	145,000	21	21	21	14	67%	7	33%	0	0%	1.4
DC	Oct. 05 - Sept. 06	390,000	70	28	28	22	79%	4	14%	2	7%	0.7
FL	July 05 - June 06	3,700,000	371	156	118	87	74%	27	23%	4	3%	0.4
HI*	July 05 - June 06	160,000	16	7	7	0	0%	7	100%	0	0%	0.4
IL	Jan. 06 - Dec. 06	1,425,000	69	69	69	50	72%	19	28%	0	0%	0.5
IN	Jan. 06 - Dec. 06	1,723,000	309	309	309	172	56%	136	44%	1	<1%	1.8
IA	Jan. 06 - Dec. 06	749,000	52	43	43	28	65%	13	30%	2	5%	0.6
KS	Jan. 06 - Dec. 06	809,000	50	36	36	11	31%	25	69%	0	0%	0.4
KY	Jan. 06 - Dec. 06	1,000,000	91	91	91	52	57%	39	43%	0	0%	0.9
ME	Jan. 06 - Dec. 06	380,000	50	26	23	16	70%	4	17%	3	13%	0.7
MD	Jan. 06 - Dec. 06	1,997,000	1,005	386	386	204	53%	182	47%	0	0%	1.9
MA	Jan. 06 - Dec. 06	2,488,000	325	218	218	149	68%	53	24%	16	7%	0.9

* In 2004, the Hawaii Supreme Court narrowed the scope of the state’s external review law, and subsequently there was a decline in the number of cases filed for review.

State	Reporting Period	Approximate Number of Eligible Health Plan Members	Number of Appeals Filed	Number of Cases Accepted for Full Review	Number of Appeals Receiving Full Review	Appeals Upheld		Appeals Overturned		Appeals Partially Overturned		Appeal Rate per 10,000
						Number	Percent	Number	Percent	Number	Percent	
MN	Jan. 06 - Dec. 06	2,607,000	204	170	160	139	87%	18	11%	3	2%	0.7
MO	Jan. 06 - Dec. 06	1,646,000	10	10	10	5	50%	4	40%	1	10%	0.1
MT	Jan. 06 - Dec. 06	316,000	24	24	20	10	50%	10	50%	0	0%	0.8
NH	Oct. 05 - Sept. 06	495,000	77	50	50	24	48%	25	50%	1	2%	1.0
NJ	Jan. 06 - Dec. 06	2,900,000	524	357	343	214	62%	89	26%	40	12%	1.2
NM	Jan. 06 - Dec. 06	280,000	16	12	8	0	0%	7	88%	1	13%	0.4
NY	Jan. 06 - Dec. 06	10,035,000	2,858	1,981	1,694	869	51%	713	42%	112	7%	2.0
NC	Jan. 06 - Dec. 06	2,100,000	255	113	107	66	62%	41	38%	0	0%	0.5
OH	Jan. 06 - Dec. 06	3,236,000	156	156	156	99	63%	51	33%	6	4%	0.5
OK	Jan. 06 - Dec. 06	794,000	15	13	13	10	77%	3	23%	0	0%	0.2
OR	Jan. 06 - Dec. 06	1,270,000	89	78	73	48	66%	23	32%	2	3%	0.6
PA	Jan. 06 - Dec. 06	4,431,000	284	278	263	163	62%	83	32%	17	6%	0.6
RI	Jan. 06 - Dec. 06	1,100,000	72	72	72	45	63%	23	32%	4	6%	0.7
SC	Jan. 06 - Dec. 06	972,000	12	12	12	8	67%	2	17%	2	17%	0.1
TX	Jan. 06 - Dec. 06	5,233,000	277	241	232	115	50%	103	44%	14	6%	0.5
VA	July 05 - June 06	2,423,000	251	111	99	57	58%	41	41%	1	1%	0.5
WA	Jan. 06 - Dec. 06	1,556,000	196	196	191	145	76%	46	24%	0	0%	1.3
WI	Jan. 06 - Dec. 06	1,900,000	184	162	162	119	73%	32	20%	11	7%	0.9
TOTAL		78,665,000	10,234	7,135	6,387	3,761	59%	2,368	37%	258	4%	0.9

Note: We estimated the size of the eligible population based on data provided by the state or an estimate based upon the number of people with individual and fully-insured group coverage (and, if applicable, the Medicaid managed care population), rounded to the nearest thousand. The eligible population and appeal rate are approximations based upon the best available data. Items may not add to totals due to rounding.

Appendix B: Summary of State External Review Laws

This appendix contains summary information on the types of plans subject to review and the issues subject to review on a state-by-state basis. These laws are subject to change.

As of July 1, 2007, independent medical review laws and/or regulations have been enacted in 44 states and the District of Columbia:

Alaska	Indiana	Montana	Pennsylvania
Arizona	Iowa	Nevada	Rhode Island
Arkansas	Kansas	New Hampshire	South Carolina
California	Kentucky	New Jersey	Tennessee
Colorado	Louisiana	New Mexico	Texas
Connecticut	Maine	New York	Utah
Delaware	Maryland	North Carolina	Vermont
Florida	Massachusetts	North Dakota	Virginia
Georgia	Michigan	Ohio	Washington
Hawaii	Minnesota	Oklahoma	West Virginia
Illinois	Missouri	Oregon	Wisconsin

The following chart highlights key provisions of state independent medical review laws and regulations established to date.

State	Types of Entities Covered	Issues Subject to Review
AK	Managed care entities offering group and individual health insurance.	Denials of claims based on a decision of medical necessity or appropriateness, investigational or experimental status, or medical judgment.
AZ	Utilization review (UR) agents and health care insurers with UR.	Medical and coverage decisions made by UR agents and health care insurers.
AR	Health carriers in the group and individual markets.	Final adverse determinations, including any service denial, reduction, or termination due to medical necessity or experimental or investigational status.
CA	Health care service plans and insurers in the group and individual markets, including Medicaid and Medicare plans unless preempted by law.	“Disputed health care services” and adverse determinations that were denied, delayed, or modified based upon medical necessity or experimental or investigational therapies.
CO	Health coverage plans in the group and individual markets.	Adverse determinations based on medical necessity.
CT	Managed care organizations, health insurers in the group and individual markets, and utilization review companies.	Denials based on medical necessity or experimental treatment if the individual has a life expectancy of less than two years.
DE	Health carriers in the group and individual markets.	Final medical necessity utilization review decisions to deny, reduce, or terminate benefits.
DC	Health carriers in the group and individual markets.	Decisions to deny, terminate, or limit covered health care services based on medical necessity.
FL	Managed care organizations in the group market.	Grievances unresolved internally, including health care quality and access; medical necessity; emergency services; excluded benefits; billing; unauthorized in-network and out-of-plan services; and experimental treatments.
GA	Managed care entities in the group and individual markets.	Adverse outcomes pursuant to a grievance procedure and denials of coverage for experimental treatments in certain situations.

State	Types of Entities Covered	Issues Subject to Review
HI*	Non-ERISA managed care plans.	Final internal appeals determinations.
IL	Health care plans in the group and individual markets.	Denials of service, treatment, or procedure based on medical necessity; specific tests or procedures; referrals; or hospitalization length of stay requests.
IN	HMOs in the group and individual markets.	Adverse utilization review determinations.
IA	Carriers and organized delivery systems (i.e., entities authorized under state law and licensed by the Director of Public Health that performs utilization reviews).	Adverse coverage decisions based on medical necessity.
KS	Health insurance companies, HMOs, fraternal benefit societies, nonprofit hospitals, medical services corporations, municipal group funded pools, and self-funded coverages established by the state.	Final adverse determinations based on medical necessity or experimental or investigational status.
KY	Insurers issuing health benefit plans to individuals, groups, associations, and employer-organized associations.	Adverse determinations based on medical necessity or experimental or investigational services, and coverage denials that require resolution of a medical issue.
LA	Managed care entities in the group and individual markets and medical necessity review organizations.	Coverage decisions based on medical necessity.
ME	Carriers offering health plans in the group and individual markets.	Adverse health care treatment decisions based on medical necessity; pre-existing conditions; experimental or investigational treatment; and medical care, diagnosis, and treatment.
MD	Carriers in the group and individual markets (i.e., insurers, nonprofit health service plans, HMOs, dental plan organizations, and any other organizations providing health benefit plans).	Complaints or adverse determinations based on medical necessity.
MA	Licensed health insurers in the group and individual markets.	Adverse determinations based on medical necessity, experimental or investigational status, appropriateness of health care setting, and level of care or effectiveness.
MI	Health carriers in the group and individual markets that perform utilization review.	Any adverse determination unresolved internally by the plan.
MN	Health plan companies (i.e., managed care plans and indemnity carriers) in the group and individual markets.	Adverse determinations relating to medical necessity.
MO	Health carriers in group and individual markets or their utilization review organizations.	Adverse determinations, including medical necessity, appropriateness of health care setting, and level of care or effectiveness.
MT	Health carriers, (i.e., entities providing health benefits) in the group and individual markets.	Adverse determinations involving medical necessity.
NV	Managed care organizations, HMOs, or "certain insurers" in the group and individual markets.	Adverse determinations based on medical necessity, or experimental/investigational status.
NH	Health carriers in the group and individual markets that perform utilization review.	Adverse determinations for requested services, supplies or drugs, or payment based on medical necessity; experimental or investigational status; cosmetic procedures based on medical reasons; access to out-of-network health care professionals or providers; appropriateness; health care setting; or level of care or effectiveness.
NJ	Health carriers in the group and individual markets.	Decisions to deny, reduce, or terminate benefits.
NM	Managed health care plans and health insurers in the group and individual markets.	Utilization management determinations.

* Although the Hawaii Supreme Court found that the application of the state's external review law to ERISA plans was preempted by federal law, the external review requirements continue to apply to non-ERISA managed care plans.

State	Types of Entities Covered	Issues Subject to Review
NY	Health care plans including all health carriers that conduct utilization review in the group and individual markets.	Adverse medical necessity determinations and experimental treatment decisions. Includes Medicaid managed care.
NC	Insurers offering health benefit plans and performing utilization review in the group and individual markets.	Determination that an admission, availability of care, continued stay, or other health care service is denied, reduced, or terminated due to medical necessity, appropriateness, health care setting, or level of care or effectiveness. Also includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.
ND	Insurance companies in the group and individual markets, nonprofit health service corporations, and HMOs.	Medically necessary and appropriate health care.
OH	Health insurers, HMOs, and Public Employee Benefit Plans in the group and individual markets.	Experimental or investigational treatment for patients with life expectancies of two years or less and cases involving medical necessity.
OK	Any medical insurance coverage in both group and individual markets, including HMOs, PPOs, indemnity plans, and MEWAs (Multiple Employer Welfare Arrangements).	Adverse determinations based on medical necessity.
OR	Health insurers and health benefit plans in the group and individual markets.	Adverse decisions based upon medical necessity, experimental or investigational status, or continuity of care.
PA	Managed care plans in the group and individual markets.	Denials of a grievance regarding medical necessity or appropriateness.
RI	Health insurance entities in the group or individual markets.	Any adverse determinations involving a decision not to certify a health care service, or a formulary or non-formulary medication.
SC	Health carriers with utilization review.	Adverse determinations involving medical necessity or experimental or investigational services if it involves a condition that is life-threatening or seriously disabling.
TN	HMOs in the group and individual markets.	Denials of coverage based on medical necessity, experimental, or investigational status.
TX	Health insurance carriers, HMOs, utilization review agents, and managed care entities.	Adverse utilization review determinations based on medical necessity.
UT	Insurers, individual or group health plans, HMOs, TPAs, and income replacement of disability income policies.	Adverse medical necessity determinations.
VT	Health benefit plans and third party payors in the group and individual markets.	Adverse decisions based on medical necessity, experimental or investigational status, medical appropriateness of off-label use of a drug, selection of a provider that is claimed by the insurance to be inconsistent with the plan or applicable law, or a medically-based determination on pre-existing conditions. There is a separate process for mental health/substance abuse denials.
VA	Managed care health insurance plans.	Final adverse determinations denying benefits or coverage.
WA	Health insurance carriers in the group and individual markets.	Decisions to deny, modify, reduce, or terminate coverage or payment for health care services.
WV	Managed care plans in the group and individual markets.	Determinations that deny, reduce, or terminate coverage for a health care service based on medical necessity or experimental status.
WI	Insurers offering health benefit plans in group and individual markets.	Adverse determinations involving medical necessity or experimental treatments.



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