

# Update on State External Review Programs

January 2006

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## I. Summary

External review programs continue to serve the interests of both consumers and health insurance plans by providing a way to resolve coverage disputes in a fair, timely and less costly manner than through the courts. Currently, forty-four 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 2003 and 2004. It is a follow-up to a study conducted previously by the American Association of Health Plans (AAHP) that analyzed state external review data from 1999 and 2000.<sup>1</sup> Thirty-seven states provided data from their external review programs for 2003 and 2004. A number of states either do not track this information or did not have data available at the time of publication. For greater detail, please see the study criteria and methodology section below.

With more states operating external review programs, consumer awareness of these programs has increased and the number of appeals filed nationwide has more than doubled since America's Health Insurance Plans (AHIP) conducted its first analysis. In 2000, 2,567 cases were accepted for full review under state external review laws.<sup>2</sup> In both 2003 and 2004, over 6,000 cases were accepted for full review.

The aggregate rate of appeal across all external review programs in 2003 and 2004 was approximately one appeal per 12,000 eligible individuals, slightly higher than the rate of one appeal per 14,000 eligible individuals calculated in 1999 and 2000.

The new data from 2003 and 2004 indicate that, in approximately 60 percent of cases, independent reviewers concur with the original decision of the health insurance plan, and in about 40 percent of cases, reviewers agree with the consumer who filed the appeal.

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<sup>1</sup> 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>

<sup>2</sup> American Association of Health Plans (AAHP), "Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions," April 2001.

## II. 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, forty-four 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.<sup>3</sup>

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 commonly 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. However, the Employee Retirement Income Security Act (ERISA) prevents states from regulating self-insured employer-sponsored health plans, and consequently, such plans typically fall outside the scope of external review laws.<sup>4</sup>

Typically, a state's Department of Insurance operates the external review program. 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 IRO's reviewers are required to be health care professionals who are board-certified and have expertise in the specialty under review. In addition, external review laws contain specific conflict-of-interest provisions that bar the independent reviewers from having any affiliation with either the health plan or consumer involved in the dispute. These requirements are intended to protect against conflicts of interest and to ensure a fair and independent process. In general, external review laws also require that consumers exhaust all internal appeals processes before submitting a case for review.

## III. Case Volume

With an increased number of states implementing external review programs and reporting data, the number of appeals accepted for full review has more than doubled since 2000, when 2,567 cases were accepted for full review.<sup>5</sup> In 2003, 6,190 cases were accepted for full review by external review organizations. This number remained nearly constant in 2004, with 6,154 cases accepted for full

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<sup>3</sup> States operating 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, Wisconsin, and the District of Columbia. Alabama was not included in this list as its HMO law does not provide for any external review requirements.

<sup>4</sup> Note that a number of recent court rulings addressing ERISA preemption and external review laws are having practical effects on state programs. For example, in November 2004, the Hawaii Supreme Court ruled that the state's external review law was preempted by ERISA since it provided for remedies in addition to those provided by the federal statute. As the majority of health insurance plans in the state fall under ERISA, the ruling greatly narrowed the scope of the law and the number of cases filed for external review has since declined.

<sup>5</sup> American Association of Health Plans (AAHP), "Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions," April 2001.

review. Caseloads vary from state to state, with New York's program handling the largest number of appeals (1,053 and 1,364 cases accepted for full review in 2003 and 2004, respectively).

#### **IV. Appeal Rate**

The aggregate appeal rate remained approximately constant between 2003 and 2004, at approximately one appeal per 12,000 eligible individuals. This appeal rate is slightly higher than the rate of one appeal per 14,000 eligible individuals calculated in 1999 and 2000.

#### **V. External Review Results**

In 2003, of the 6,190 appeals accepted for review, the independent review organizations issued decisions in 5,615 of those cases. In 2004, there were 6,154 appeals accepted for review with 5,673 cases ultimately producing decisions. When decisions are issued, the independent review organization may rule in favor of the health plan's original coverage determination, overturn the health insurance plan's decision, or partially overturn or modify the plan's coverage denial. There is a difference between the number of appeals accepted for full review and the number of cases decided by independent review organizations because some cases were settled before a decision was made; some were withdrawn by the health insurance plan or consumer; and some were still pending at year's end. The external review process often brings to light new or more comprehensive information, and coverage decisions may then be reversed by the health insurance plan, withdrawn, or settled before the external review organization completes its review.

##### *Cases Decided in Favor of the Health Insurance Plan's Coverage Determination*

The "upheld rate" represents the number of cases in which the independent review organization ruled in favor of the health insurance plan, upholding the plan's original coverage determination. In aggregate, independent review organizations upheld the health insurance plan's original coverage determination in approximately 60 percent of cases in both 2003 and 2004. States varied significantly in their "upheld" and "overturned" rates. For example, upheld rates in 2003 ranged from a high of 83 percent in Arizona to a low of 21 percent in Tennessee.<sup>6</sup>

##### *Cases Decided in Favor of the Consumer's Appeal*

The "overturned rate" represents the number of cases in which the independent review organization ruled in favor of the consumer, either overturning in full or in part, the health plan's coverage denial. The aggregate overturned rate was approximately 40 percent in both 2003 and 2004. Similar to upheld rates, state overturn rates varied significantly, for example, ranging in 2004 from a high of approximately 67 percent in Vermont, to a low of zero percent in Arkansas.<sup>7</sup>

#### **VI. Common Issues Addressed by External Review Cases**

There is significant variation in the scope and process requirements of external review laws across the states. For example, in Colorado, Delaware, Iowa, Louisiana, Maryland, Minnesota, Montana,

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<sup>6</sup> Note that the low "upheld rate" in Tennessee in 2003 is based upon only 24 decided cases. In contrast, the high "upheld" rate in Arizona is based upon 262 decided cases.

<sup>7</sup> Note that the low "overturned rate" in Arkansas is based upon only 9 decided cases.

North Dakota, Pennsylvania, Tennessee, Texas and Utah, external review laws apply only to medical necessity determinations. However, the external review laws of Alaska, Arkansas, Connecticut, Kansas, Maine, Missouri, Nevada, New York, Oregon, South Carolina, Vermont, 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 Virginia, any adverse determination impacting coverage is subject to external review.

Of the states reporting information, external review cases most commonly involved denials for inpatient hospital admissions, mental health services, and prescription drug coverage. However, this varied from state to state. For example, in New Jersey, denial of inpatient hospital days was the most common reason for appeals; in California, denial of prescription drug coverage was most common; and in North Carolina, denial of coverage for surgical services and durable medical equipment was the most common reason for appeals.

## **VII. 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 with external review laws, AHIP contacted each jurisdiction with an independent appeals process in operation beginning no later than January 1, 2003 (with the exception of Nevada which implemented its program in July of 2004). 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-seven jurisdictions met these criteria for 2003 (Arizona, Arkansas, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wisconsin). In 2004, 37 jurisdictions were able to provide data (Arizona, Arkansas, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington and Wisconsin). The remaining states either do not publicly report this information or did not yet have data available.

For states submitting data, the report provides the number of cases accepted for full review, the number of cases decided, and the number and percentage of cases decided that were upheld or overturned by the independent review organization. The appeal rate is an estimate calculated by dividing the number of cases accepted for full review by the number of individuals covered by the law. An approximation of the covered population was determined by information provided by the state and/or a compilation done by Milliman for the Employee Benefit Research Institute based upon the Census Bureau's Current Population Survey (March 2002). Allocations between fully-insured and self-funded plans are estimated using the Medical Expenditures Panel Survey (MEPS) estimates of the percentage of employees enrolled in employer-sponsored, self-funded plan options. Where the state law included the Medicaid managed care population, enrollment data from the Centers for Medicare and Medicaid Services (CMS) for 2002 were included. The approximated eligible population was then rounded to the nearest thousand to determine the appeal rate. The covered population and appeal rate are rough approximations based upon the best-available data.

## **VIII. Appendices**

### *Appendix A: State External Review Data, 2003*

This appendix contains data from 37 jurisdictions on the number of cases accepted for full review, the number of cases decided, the number of appeals upheld and the number of cases overturned. Reporting periods varied from state to state. Arizona, Florida, Maryland, New Hampshire, New Jersey, Oregon, Virginia, and the District of Columbia use a fiscal year instead of a calendar year. Data from fiscal year 2002 to 2003 was considered “2003” data for Florida, Maryland, New Hampshire, Oregon, Virginia, and the District of Columbia. Data from fiscal year 2003 to 2004 was considered “2003” data for Arizona and New Jersey. Alaska, Delaware, North Dakota, Oklahoma, Utah, Washington, and West Virginia have external review programs but either did not collect or make 2003 data available.

### *Appendix B: State External Review Data, 2004*

This appendix contains data from 37 states on the number of cases accepted for full review, the number of cases decided, the number of appeals upheld and the number of cases overturned. Reporting periods varied from state to state. Arizona, Florida, Maryland, Nevada, New Hampshire, New Jersey, Oregon, Virginia and the District of Columbia use a fiscal year instead of a calendar year. Data from fiscal year 2003 to 2004 was considered “2004” data for Florida, Maryland, New Hampshire, Oregon, Virginia and the District of Columbia. Data from fiscal year 2004 to 2005 was considered “2004” data for Arizona and New Jersey. Nevada’s external review program went into effect on July 1, 2004 and therefore only data for part of the year is reported. Alaska, Delaware, Indiana, North Dakota, Oklahoma, Rhode Island, Utah, and West Virginia have external review programs but either do not collect data or did not make 2004 data available.

### *Appendix C: Summary of State External Review Laws*

This appendix contains a brief overview of each state’s external review law and the types of health insurance plans and issues subject to review.

## **IX. Acknowledgements**

Thanks to all State Departments of Insurance and other State agencies that participated in AHIP’s survey and submitted information on their external review program.

This report was written by Elyse Greenwald, Policy Analyst at AHIP’s Center for Policy and Research. Special thanks to Kaylene Lewek and Bryan Ooley for helping compile the data.

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## Appendix A: State External Review Data 2003

State	Reporting Period	Number of Covered Individuals*	Number of Cases Accepted for Full Review	Number of Appeals Decided (%)	Number of Appeals Upheld (%)	Number of Appeals Overturned (%)	Appeal Rate per 10,000
AZ	07/01/03 to 06/30/04	1,340,000	280	262	217 (82.8%)	45 (17.2%)	2.1
AR	01/01/03 to 12/31/03	586,000	3	3	1 (33.3%)	2 (66.7%)	.1
CA	01/01/03 to 12/31/03	17,000,000	800	731	451 (61.7%)	280 (38.3%)	.5
CO	01/01/03 to 12/31/03	980,000	66	66	39 (59.1%)	27 (40.9%)	.7
CT	01/01/03 to 12/31/03	978,000	76	76	33 (43.4%)	43 (56.6%)	.8
DC	10/01/02 to 09/30/03	178,000	23	23	13 (56.5%)	10 (43.5%)	1.3
FL	07/01/02 to 06/30/03	3,700,000	160	135	94 (69.6%)	41 (30.4%)	.4
GA	01/01/03 to 12/31/03	1,300,000	32	30	16 (53.3%)	14 (46.7%)	.3
HI	01/01/03 to 12/31/03	373,000	39	10	5 (50.0%)	5 (50.0%)	1.1
IL	01/01/03 to 12/31/03	1,593,000	86	86	65 (75.6%)	21 (24.4%)	.5
IN	01/01/03 to 12/31/03	1,909,000	36	36	21 (58.3%)	15 (41.7%)	.2
IA	01/01/03 to 12/31/03	918,000	46	46	22 (47.8%)	24 (52.2%)	.5
KS	01/01/03 to 12/31/03	680,000	16	13	8 (61.5%)	5 (38.5%)	.2
KY	01/01/03 to 12/31/03	995,000	147	147	70 (47.6%)	77 (52.4%)	1.5
LA	01/01/03 to 12/31/03	872,000	51	47	31 (66.0%)	16 (34.0%)	.6
ME	01/01/03 to 12/31/03	355,000	24	22	10 (45.5%)	12 (54.5%)	.7
MD	01/01/03 to 12/31/03	1,185,000	255	206	137 (66.5%)	69 (33.5%)	2.2
MA	07/01/02 to 06/30/03	2,312,000	351	296	151 (51.0%)	145 (49.0%)	1.5
MI	01/01/03 to 12/31/03	2,605,000	438	313	244 (78.0%)	69 (22.0%)	1.7
MN	01/01/03 to 12/31/03	1,559,000	62	51	33 (64.7%)	18 (35.3%)	.4
MO	01/01/03 to 12/31/03	1,494,000	16	16	9 (56.2%)	7 (43.8%)	.1
MT	01/01/03 to 12/31/03	281,000	17	17	8 (47.1%)	9 (52.9%)	.6
NH	10/01/02 to 09/30/03	419,000	19	15	11 (73.3%)	4 (26.7%)	.5
NJ	01/16/03 to 01/15/04	3,100,000	309	205	118 (57.6%)	87 (42.4%)	1.0
NM	01/01/03 to 12/31/03	289,000	28	12	6 (50.0%)	6 (50.0%)	1.0
NY	01/01/03 to 12/31/03	7,052,000	1053	1053	604 (57.4%)	449 (42.6%)	1.5
NC	01/01/03 to 12/31/03	1,590,000	90	89	49 (55.1%)	40 (44.9%)	.6
OH	01/01/03 to 12/31/03	3,000,000	176	176	104 (59.1%)	72 (40.9%)	.6
OR	07/01/02 to 06/30/03	1,121,000	73	72	52 (73.2%)	20 (27.8%)	.7
PA	01/01/03 to 12/31/03	4,251,000	335	335	239 (71.3%)	96 (28.7%)	.8
RI	01/01/03 to 12/31/03	373,000	164	164	115 (70.1%)	49 (29.9%)	4.4
SC	01/01/03 to 12/31/03	749,000	12	11	6 (54.6%)	5 (45.4%)	.2
TN	01/01/03 to 12/31/03	1,265,000	24	24	5 (20.8%)	19 (79.2%)	.2
TX	01/01/03 to 12/31/03	4,415,000	557	557	250 (44.9%)	307 (55.1%)	1.3
VT	01/01/03 to 12/31/03	160,000	26	17	5 (29.4%)	12 (70.6%)	1.6
VA	07/01/02 to 06/30/03	1,100,000	82	77	37 (48.1%)	40 (51.9%)	.8
WI	01/01/03 to 12/31/03	1,511,000	218	176	115 (65.3%)	61 (34.7%)	1.4
<b>Total</b>		<b>73,588,000</b>	<b>6,190</b>	<b>5,615</b>	<b>3,394 (60.45%)</b>	<b>2,221 (39.55%)</b>	<b>.84</b>

\* The number of covered individuals is an estimate based upon the individual and group fully-insured populations (and if applicable, the Medicaid managed care population), rounded to the nearest thousand.

## Appendix B: State External Review Data 2004

State	Reporting Period	Number of Covered Individuals*	Number of Cases Accepted for Full Review	Number of Appeals Decided	Number of Appeals Upheld	Number of Appeals Overturned	Appeal Rate per 10,000
AZ	07/01/04 to 06/30/05	1,340,000	258	242	202 (83.5%)	40 (16.5%)	1.9
AR	01/01/04 to 12/31/04	586,000	9	9	9 (100.0%)	0 (0.0%)	.2
CA	01/01/04 to 12/31/04	17,000,000	839	787	482 (61.3%)	305 (38.7%)	.5
CO	01/01/04 to 12/31/04	980,000	87	87	62 (71.3%)	25 (28.7%)	.9
CT	01/01/04 to 12/31/04	978,000	70	70	42 (60.0%)	28 (40.0%)	.7
DC	10/01/03 to 09/30/04	178,000	23	23	12 (52.2%)	11 (47.8%)	1.3
FL	07/01/03 to 06/30/04	3,700,000	173	173	121 (69.9%)	52 (30.1%)	.5
GA	01/01/04 to 12/31/04	1,300,000	31	26	17 (65.4%)	9 (34.6%)	.2
HI	01/01/04 to 12/31/04	373,000	44	3	1 (33.3%)	2 (66.7%)	1.2
IL	01/01/04 to 12/31/04	1,593,000	94	90	69 (76.7%)	21(23.3%)	.6
IA	01/01/04 to 12/31/04	918,000	40	39	19 (48.7%)	20 (51.3%)	.4
KS	01/01/04 to 12/31/04	680,000	25	22	10 (45.5%)	12 (54.5%)	.4
KY	01/01/04 to 12/31/04	995,000	240	240	88 (36.0%)	152 (63.3%)	2.4
LA	01/01/04 to 12/31/04	872,000	59	56	28 (50.0%)	28 (50.0%)	.7
ME	01/01/04 to 12/31/04	355,000	17	16	7 (43.8%)	9 (56.2%)	.5
MD	07/01/03 to 6/30/04	1,185,000	380	268	194 (72.4%)	74 (27.6%)	3.2
MA	01/01/04 to 12/31/04	2,312,000	170	140	82 (58.6%)	58 (41.4%)	.7
MI	01/01/04 to 12/31/04	2,605,000	361	281	226 (80.4%)	55 (19.6%)	1.4
MN	01/01/04 to 12/31/04	1,559,000	45	41	27 (65.9%)	14 (34.1%)	.3
MO	01/01/04 to 12/31/04	1,494,000	6	5	4 (80.0%)	1 (20.0%)	.03
MT	01/01/04 to 12/31/04	281,000	28	27	14 (51.9%)	13 (48.1%)	1.0
NV	07/01/04 to 12/31/04	490,000	8	8	5 (62.5%)	3 (37.5%)	.2
NH	10/01/03 to 09/30/04	419,000	20	20	12 (60.0%)	8 (40.0%)	.5
NJ	01/16/04 to 01/15/05	3,100,000	314	260	142 (54.6%)	118 (45.4%)	1.0
NM	01/01/04 to 12/31/04	289,000	21	7	5 (71.4%)	2 (28.6%)	.7
NY	01/01/04 to 12/31/04	7,052,000	1364	1364	745 (54.6%)	619 (45.4%)	1.9
NC	01/01/04 to 12/31/04	1,590,000	77	77	46 (59.7%)	31 (40.3%)	.5
OH	01/01/04 to 12/31/04	3,000,000	177	177	108 (61.0%)	69 (39.0%)	.6
OR	07/01/03 to 06/30/04	1,121,000	48	46	36 (78.3%)	10 (21.7%)	.4
PA	01/01/04 to 12/31/04	4,251,000	365	356	250 (70.2%)	106 (29.8%)	.9
SC	01/01/04 to 12/31/04	749,000	7	7	4 (57.1)	3 (42.9%)	.1
TN	01/01/04 to 12/31/04	1,265,000	28	28	13 (46.4%)	15 (53.6%)	.2
TX	01/01/04 to 12/31/04	4,415,000	292	292	132 (45.2%)	160 (54.8%)	.7
VT	01/01/04 to 12/31/04	160,000	43	21	7 (33.3%)	14 (66.7%)	2.7
VA	07/01/03 to 06/30/04	1,100,000	74	65	35 (53.9%)	30 (46.1%)	.7
WA	01/01/04 to 12/31/04	1,610,000	169	165	131 (79.4%)	34 (20.6%)	1.0
WI	01/01/04 to 06/30/04	1,511,000	148	135	83 (61.5%)	52 (38.5%)	1.0
<b>Total</b>		<b>73,413,000</b>	<b>6,154</b>	<b>5,673</b>	<b>3,470 (61.2%)</b>	<b>2,203 (38.8%)</b>	<b>.84</b>

\* The number of covered individuals is an estimate based upon the individual and group fully-insured populations (and if applicable, the Medicaid managed care population), rounded to the nearest thousand.

## Appendix C: Summary of State External Review Laws

State	Effective Date	Amended Date	Types of Entities Covered	Issues Subject to Review
AK	2000		Managed care entities offering group health insurance.	Denials of claims based on a decision of medical necessity or appropriateness, investigational or experimental status, or medical judgment.
AZ	1998	2000	Utilization review (UR) agents and health care insurers with UR.	Coverage decisions made by UR agents and health care insurers.
AR	2003		Health carriers.	Final adverse determinations, including any service denial, reduction, or termination due to medical necessity or experimental or investigational status.
CA	1998	2001, 2003, 2005	Knox-Keene health care service plans and health insurers.	“Disputed health care services” that were denied, delayed, or modified based upon medical necessity or experimental or investigational therapies.
CO	2000	2005	Health coverage plans.	Adverse determinations based on medical necessity.
CT	1997	1999, 2004, 2005	Managed care organizations and utilization review companies.	Denials based on medical necessity or experimental treatment if the individual has a life expectancy of less than 2 years.
DE	1998	2000, 20002	Health carriers.	Final medical necessity utilization review decisions to deny, reduce, or terminate benefits.
DC	1998		Health insurers.	Decisions to deny, terminate, or limit covered health care services.
FL	1985	1998, 2003, 2004	Managed care organizations.	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	1999	2005	Managed care entities.	Adverse outcomes pursuant to a grievance procedure and denials of coverage for experimental treatments in certain situations.
HI	1998	2000, 2004	Managed care plans.	Final internal appeals determinations.
IL	2000		Health care plans.	Denials of service, treatment, or procedure based on medical necessity; specific tests or procedures, referrals, or hospitalization length of stays.
IN	2000		HMOs.	Adverse utilization review determinations.
IA	2000	2001	Carriers and organized delivery systems (i.e., an entity authorized under state law and licensed by the Director of Public Health that performs utilization reviews).	Adverse coverage decisions based on medical necessity.
KS	2000		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	2000	2001, 2003	Health insurers.	Adverse determinations or coverage denials based on medical necessity or experimental or investigational status.
LA	2000		Managed care entities and medical necessity review organizations.	Coverage decisions based on medical necessity.
ME	2000		Carriers offering health plans.	Adverse health care treatment decisions based on medical necessity or preexisting condition determinations regarding experimental or investigational services.
MD	1999	2000, 2004	Carriers, 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	2000	2001	Managed care organizations and utilization review organizations.	Adverse determinations based on medical necessity, appropriateness of health care setting, and level of care or effectiveness.
MI	1978	2000	Health carriers that perform utilization review.	Any adverse determination unresolved internally by the plan.
MN	1997	2000	Health plan companies (i.e., managed care plans and indemnity carriers).	Adverse determination relating to medical necessity.
MO	1997		Health carriers or their utilization review organizations.	Adverse determinations including medical necessity, experimental treatment, or relating to covered services.

MT	1999		Health carriers (i.e., entities providing health benefit plans).	Adverse determinations involving medical necessity.
NV	2004	2005	Managed care organizations, HMOs, or “certain insurers.”	Adverse determinations based on medical necessity, or experimental/investigational status.
NH	1998	2000	Health carriers that perform utilization review.	Adverse determinations based on medical necessity, appropriateness, health care setting, level of care or effectiveness.
NJ	1997	1998, 2001	Health carriers.	Decisions to deny, reduce or terminate benefits or coverage and network issues.
NM	1997	2003	Managed health care plans and health insurers.	Utilization management determinations.
NY	1999	2001	Health care plans including all health carriers that conduct utilization review.	Adverse medical necessity determinations and experimental treatment decisions.
NC	1997	2002	Insurers offering health benefit plans and performing utilization review.	Utilization review determinations involving a “non-certification decision” which is a determination that an admission, availability of care, continued stay, or other health care service is denied, reduced, or terminated due to medical necessity.
ND	2005		Insurance companies, nonprofit health service corporations, and HMOs.	Medically necessary and appropriate health care.
OH	1997	2000	Health insuring corporations.	Experimental treatment for dying patients; in 2000, expanded to cases involving medical necessity.
OK	1999		Any medical insurance coverage, including HMOs, PPOs, indemnity plans, MEWAs.	Adverse determinations based on medical necessity.
OR	2001	2002	Health insurers and health benefit plans.	Adverse decisions based upon medically necessity, experimental or investigational status.
PA	1999		Managed care plans.	Denial of a grievance regarding medical necessity or appropriateness.
RI	1992	1999	HMOs and utilization review agents.	Any adverse determinations involving a decision not to certify a health care service, or a formulary or non-formulary medication.
SC	2000		Health carriers with utilization review.	Adverse determinations involving medical necessity or experimental or investigational services if it involves a condition that is life-threatening.
TN	1997	1998, 1999	HMOs	Denials of coverage based on a medical necessity determination.
TX	1997	1999, 2000, 2003	Health insurance carriers, HMOs, utilization review agents, and managed care entities.	Adverse utilization review determinations based on medical necessity.
UT	2000	2003, 2005	Insurers, individual or group health plans, HMOs, TPAs, and income replacement for disability income policies.	Adverse medical necessity determinations.
VT	1999		Health benefit plans and third party payors.	Denials of coverage based on medical necessity, experimental treatments, or pre-existing conditions.
VA	1999	2000, 20002	Utilization review entities that contract with managed care health insurance plans.	Final adverse determinations denying coverage.
WA	2000	2001	Health insurance carriers.	Decisions to deny, modify, reduce or terminate coverage of health care services.
WV	2002		Managed care plans.	Determinations that deny, reduce, or terminate coverage for a health care service based on medical necessity or experimental status.
WI	2000	2002, 2005	Insurers offering health benefit plans.	Adverse determinations involving medical necessity or experimental treatments.



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