THE SENATE
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

S.B. NO. 940 S.D. 2 H.D. 1

A BILL FOR AN ACT

RELATING TO THE PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES ACT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Section 432E-6, Hawaii Revised Statutes, is amended to read as follows:

"**§432E-6 External review procedure.** (a) After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination [~~to a three-member review panel appointed by the commissioner composed of a representative from a managed care plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee~~] in the following manner:

(1) The enrollee shall submit a request for external review to the commissioner [~~within~~] no later than sixty days from the date of the final internal determination by the managed care plan;

(2) The commissioner may [~~retain~~]:

(A) Without regard to chapter 76, retain an independent medical expert trained in the field of medicine most appropriately related to the matter under review[~~;~~] to conduct the external review. The review by the independent medical expert shall be limited to issues of medical necessity and coverage exclusions for experimental and investigational medical procedures. Presentation of evidence for this purpose shall be exempt from section 91-9(g)[~~; and~~]. The commissioner shall transfer the request for review and the submissions of the enrollee and the plan to the independent medical expert. The managed care plan that is the subject of the external review shall be responsible for paying the reasonable fee and costs of the independent medical expert selected by the commissioner. The independent medical expert shall submit an invoice for services and costs to the commissioner together with the expert's determination. The commissioner shall

1 review the invoice for reasonableness and shall
2 transmit the invoice to the managed care plan for
3 payment by the managed care plan within thirty
4 days of receipt. The selection and hiring of the
5 independent medical expert by the commissioner
6 shall not be subject to chapter 103D;
7 (B) [The services of] Select an independent review
8 organization from an approved list maintained by
9 the commissioner[;] to conduct the external
10 review. The review by an independent review
11 organization shall be limited to issues of
12 medical necessity and coverage exclusions for
13 experimental and investigational medical
14 procedures. Presentation of evidence for this
15 purpose shall be exempt from section 91-9(g).
16 The commissioner shall transfer the request for
17 review and the submissions of the enrollee and
18 the plan to an independent review organization
19 that has available to conduct the review, a
20 medical expert trained in the field of medicine
21 most appropriately related to the matter under
22 review. The managed care plan that is the

1 subject of the external review shall be
2 responsible for paying the reasonable fee and
3 costs of the independent review organization
4 selected by the commissioner to conduct the
5 review. The independent review organization
6 shall submit its invoice for services and costs
7 to the commissioner together with its
8 determination. The commissioner shall review the
9 invoice for reasonableness and shall transmit the
10 invoice to the managed care plan for payment by
11 the managed care plan within thirty days of
12 receipt. The selection and hiring of the
13 independent review organization by the
14 commissioner shall not be subject to chapter
15 103D; or
16 (C) Upon determination that an employee benefit plan
17 within Title 29 of the United States Code Section
18 1003(a) is not implicated, appoint the members of
19 a three-member external review panel composed of
20 a representative from a managed care plan not
21 involved in the complaint, a provider licensed to
22 practice and practicing medicine in Hawaii not

1 involved in the complaint, and the commissioner
2 or the commissioner's designee, to conduct the
3 external review. The review panel shall conduct
4 a hearing pursuant to chapter 91. If the amount
5 in controversy is less than $1,000, the
6 commissioner or the commissioner's designee may
7 conduct a review hearing pursuant to chapter 91,
8 without appointing a review panel. The
9 commissioner shall make the determination whether
10 Title 29 United States Code Section 1003(a)
11 applies to the enrollee's plan within twenty days
12 after receipt of the managed care plan's
13 position, if any, on whether Title 29 United
14 States Code Section 1003(a) applies to the
15 enrollee's plan, and any other documents,
16 information, or affidavits the commissioner shall
17 require of the requestor or the managed care
18 plan, and shall notify the managed care plan, the
19 requestor, and the enrollee of the commissioner's
20 determination. The notice to the enrollee shall
21 provide a statement that the enrollee's request
22 for external review shall be without prejudice to

the enrollee's right to file a civil action in state or federal court for a determination of the enrollee's entitlement to benefits, and that the employee may have other rights, including the right to an award of reasonable attorney's fees and costs;

(3) Within seven days after receipt of the request for external review, a managed care plan or its designee utilization review organization shall provide to the commissioner [~~or the assigned independent review organization~~]:

(A) Any documents or information related to or used in making the final internal determination, including the enrollee's medical records;

(B) Any documentation or written information submitted to the managed care plan in support of the enrollee's initial complaint; [~~and~~]

(C) A list of the names, addresses, and telephone numbers of each licensed health care provider who cared for the enrollee and who may have medical records relevant to the external review;

(D) An estimate of the amount in controversy; and

1 (E) The managed care plan's position, if any, on
2 whether Title 29 United States Code Section
3 1003(a) applies to the enrollee's plan; provided
4 that where an expedited appeal is involved, the
5 managed care plan or its designee utilization
6 review organization shall provide the documents
7 and information within forty-eight hours of
8 receipt of the request for external review.
9 Failure by the managed care plan or its
10 designee utilization review organization to
11 provide the documents and information within the
12 prescribed time periods shall not delay the
13 conduct of the external review. Where the plan
14 or its designee utilization review organization
15 fails to provide the documents and information
16 within the prescribed time periods, the
17 commissioner may issue a decision to reverse the
18 final internal determination, in whole or part,
19 and shall promptly notify the independent review
20 organization, the enrollee, the enrollee's
21 appointed representative, if applicable, the

1 enrollee's treating provider, and the managed
2 care plan of the decision;
3 (4) [~~Upon receipt of the request for external review and~~
4 ~~upon a showing of good cause, the commissioner shall~~
5 ~~appoint the members of the external review panel and~~
6 ~~shall conduct a review hearing pursuant to chapter 91.~~
7 ~~If the amount in controversy is less than $500, the~~
8 ~~commissioner may conduct a review hearing without~~
9 ~~appointing a review panel;~~] The commissioner shall
10 determine whether the disputed service, supply, or
11 treatment is specifically excluded under the terms of
12 the enrollee's insurance policy, evidence of coverage,
13 or similar document;
14 (5) [~~The review hearing shall be conducted~~] If the
15 commissioner finds that the disputed service, supply,
16 or treatment is not specifically excluded, the
17 commissioner, the independent medical expert selected
18 by the commissioner pursuant to subsection (a)(2)(A),
19 the independent review organization selected by the
20 commissioner pursuant to subsection (a)(2)(B), or the
21 external review panel appointed by the commissioner
22 pursuant to subsection (a)(2)(C) shall review the

1 final internal determination as soon as practicable,
2 taking into consideration the medical exigencies of
3 the case; provided that:
4 (A) [~~The~~] In the case of a review by an independent
5 medical expert pursuant to subsection (a)(2)(A)
6 or by an independent review organization pursuant
7 to subsection(a)(2)(B), the decision shall be
8 made no later than sixty days after the date of
9 the request for external review. In the case of
10 a hearing by an external review panel or by the
11 commissioner without a panel when the amount in
12 controversy is less than $1,000, the hearing
13 shall be held no later than sixty days from the
14 date of the request for the hearing; and
15 (B) An external review conducted as an expedited
16 appeal shall be determined no later than seventy-
17 two hours after receipt of the request for
18 external review;
19 (6) In the case of a review by an independent review
20 organization, the independent review organization
21 shall use a physician with expertise in the relevant
22 medical field to make the determination;

[~~(6)~~] (7) After considering the enrollee's complaint, the managed care plan's response, and any affidavits filed by the parties, the commissioner may dismiss the request for external review if it is determined that the request is frivolous or without merit;[~~and~~]

[~~(7)~~] (8) The [~~review panel~~] external reviewer shall review every final internal determination to determine whether the managed care plan involved acted reasonably. The plan has the burden of proving reasonableness, and no deference shall be accorded to the decision by the plan, nor shall there be any presumption of objectivity by the medical director or other plan administrator making the benefit determination. The commissioner or the commissioner's designee, the independent medical expert, the independent review organization, or the external review panel [~~and the commissioner or the commissioner's designee~~] shall consider:

(A) The terms of the agreement of the enrollee's insurance policy, evidence of coverage, or similar document;

1 (B) Whether the medical director properly applied the
2 medical necessity criteria in section 432E-1.4 in
3 making the final internal determination;
4 (C) All relevant medical records;
5 (D) The clinical standards of the plan;
6 (E) The information provided;
7 (F) The attending physician's recommendations; and
8 (G) Generally accepted practice guidelines[.];
9 (9) [The] When the review is conducted by an external
10 review panel, the commissioner, upon a majority vote
11 of the panel, shall issue an order affirming,
12 modifying, or reversing the [decision] final internal
13 determination within thirty days of the hearing[.];
14 (10) When the amount in controversy is less than $1,000 and
15 the review is conducted by the commissioner or the
16 commissioner's designee, the commissioner shall issue
17 an order affirming, modifying, or reversing the final
18 internal determination no later than sixty days from
19 the date of the request for review; and
20 (11) The independent medical expert or independent review
21 organization shall issue a written decision stating
22 whether the managed care plan acted reasonably in

1 denying coverage for the service or treatment on
2 grounds of medical necessity or experimental and
3 investigational procedures. If the independent
4 medical expert or independent review organization
5 decides that the final internal determination was not
6 reasonable, the external review decision shall be
7 final and shall not be subject to appeal by the plan,
8 and the plan shall forthwith provide the service,
9 supply, or treatment.
10 (b) The procedure set forth in this section shall not
11 apply to claims or allegations of health provider malpractice,
12 professional negligence, or other professional fault against
13 participating providers[.], and the procedure set forth in this
14 section shall not apply to QUEST medical plans under the
15 department of human services.
16 (c) No person shall serve on [the] an external review
17 panel, as a medical expert, as an independent medical expert, or
18 in the independent review organization who, through a familial
19 relationship within the second degree of consanguinity or
20 affinity, or for other reasons, has a direct and substantial
21 professional, financial, or personal interest in[:] or conflict
22 of interest with any of the following:

1 (1) The plan involved in the complaint, including an
2 officer, director, or employee of the plan; [or]
3 (2) The treatment of the enrollee, including but not
4 limited to the developer or manufacturer of the
5 principal drug, device, procedure, or other therapy at
6 issue[.];
7 (3) The treating physician who proposes to render or
8 provide the service, supply, or treatment that is the
9 subject of the external review;
10 (4) The healthcare facility at which the service or
11 treatment was provided or will be provided; or
12 (5) The enrollee.
13 (d) Members of the review panel shall be granted immunity
14 from liability and damages relating to their duties under this
15 section. Independent medical experts and independent review
16 organizations and their expert reviewers shall not be liable for
17 injuries or damages arising from decisions made pursuant to this
18 section; provided that this subsection shall not apply to any
19 act or omission by an independent medical expert, independent
20 review organization, or expert reviewer that is made in bad
21 faith or that involves gross negligence.

1 (e) An enrollee may be allowed, at the commissioner's
2 discretion, an award of a reasonable sum for attorney's fees and
3 reasonable costs incurred in connection with the external review
4 under this section, unless the commissioner in an administrative
5 proceeding determines that the appeal was unreasonable,
6 fraudulent, excessive, or frivolous.
7 (f) Disclosure of an enrollee's protected health
8 information shall be limited to disclosure for purposes relating
9 to the external review.
10 (g) Future contractual or employment action by the managed
11 care plan regarding the treating health care provider shall not
12 be based on participation in the external review process."
13 SECTION 2. This Act does not affect rights and duties that
14 matured, penalties that were incurred, and proceedings that were
15 begun, before its effective date.
16 SECTION 3. Statutory material to be repealed is bracketed
17 and stricken. New statutory material is underscored.
18 SECTION 4. This Act shall take effect upon its approval.

SB NO 940 SD2 HD1

Report Title:
Patients' Bill of Rights; Independent Review Organization

Description:
Provides for review of medical necessary decisions for ERISA plans by an independent medical expert or by an independent review organization, following screening of those cases by the insurance commissioner. Non-ERISA plan members will still be entitled to external review by the three member panel as in the present statute. (SB940 HD1)