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# 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:**

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

3 **"§432E-6 External review procedure.** (a) After exhausting  
4 all internal complaint and appeal procedures available, an  
5 enrollee, or the enrollee's treating provider or appointed  
6 representative, may file a request for external review of a  
7 managed care plan's final internal determination [~~to a three-~~  
8 ~~member review panel appointed by the commissioner composed of a~~  
9 ~~representative from a managed care plan not involved in the~~  
10 ~~complaint, a provider licensed to practice and practicing~~  
11 ~~medicine in Hawaii not involved in the complaint, and the~~  
12 ~~commissioner or the commissioner's designee]~~ in the following  
13 manner:

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



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

2 (A) Without regard to chapter 76, retain an  
3 independent medical expert trained in the field  
4 of medicine most appropriately related to the  
5 matter under review[+] to conduct the external  
6 review. The review by the independent medical  
7 expert shall be limited to issues of medical  
8 necessity and coverage exclusions for  
9 experimental and investigational medical  
10 procedures. Presentation of evidence for this  
11 purpose shall be exempt from section 91-9(g) [+  
12 and]. The commissioner shall transfer the  
13 request for review and the submissions of the  
14 enrollee and the plan to the independent medical  
15 expert. The managed care plan that is the  
16 subject of the external review shall be  
17 responsible for paying the reasonable fee and  
18 costs of the independent medical expert selected  
19 by the commissioner. The independent medical  
20 expert shall submit an invoice for services and  
21 costs to the commissioner together with the  
22 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



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

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

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

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

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

22          (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;



1       ~~(6)~~ (7) After considering the enrollee's complaint, the  
2           managed care plan's response, and any affidavits filed  
3           by the parties, the commissioner may dismiss the  
4           request for external review if it is determined that  
5           the request is frivolous or without merit;~~and]~~

6       ~~(7)~~ (8) The ~~[review panel]~~ external reviewer shall review  
7           every final internal determination to determine  
8           whether the managed care plan involved acted  
9           reasonably. The plan has the burden of proving  
10          reasonableness, and no deference shall be accorded to  
11          the decision by the plan, nor shall there be any  
12          presumption of objectivity by the medical director or  
13          other plan administrator making the benefit  
14          determination. The commissioner or the commissioner's  
15          designee, the independent medical expert, the  
16          independent review organization, or the external  
17          review panel ~~[and the commissioner or the~~  
18          ~~commissioner's designee]~~ shall consider:

- 19       (A) The terms of the agreement of the enrollee's  
20           insurance policy, evidence of coverage, or  
21           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 on July 1, 2050.



S. B. No. 770

S. D. 2, H. D. 1

**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 HD2)

SB940 HD2 HMS 2006-3031

