H.B. NO. 2318

A BILL FOR AN ACT

RELATING TO THE PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES.

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 review the invoice for reasonableness and

shall transmit the invoice to the managed care plan for payment by the managed care plan within thirty days of receipt. The selection and hiring of the independent medical expert by the commissioner shall not be subject to chapter 103D; or

(B) [~~The services of~~] Select an independent review organization from an approved list maintained by the commissioner[~~,~~] to conduct the external review. The review by an independent review organization 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). The commissioner shall transfer the request for review and the submissions of the enrollee and the plan to an independent review organization that has available to conduct the review a medical expert trained in the field of medicine most appropriately related to the matter under review. 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 review organization selected by the commissioner to conduct the review. The independent review organization shall submit its invoice for services and costs to the commissioner together with its determination. The commissioner shall review the invoice for reasonableness and shall transmit the invoice to the managed care plan for payment by the managed care plan within thirty days of receipt. The selection and hiring of the independent review organization by the commissioner shall not be subject to chapter 103D; or

(C) Upon determination that an employee benefit plan within title 29 of the United States Code section 1003(a) is not implicated, appoint the members of a three-member external review panel 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, to conduct the external review. The review panel shall conduct a hearing pursuant to chapter 91. If the amount in controversy is less than $1,000, the commissioner or the commissioner's designee may conduct a review hearing pursuant to chapter 91, without appointing a review panel. The commissioner shall make the determination whether title 29 United States Code section 1003(a) applies to the enrollee's plan within twenty days after receipt of the managed care plan's position, if any, on whether title 29 United States Code section 1003(a) applies to the enrollee's plan, and any other documents, information, or affidavits the commissioner shall require of the requestor or the managed care plan, and shall notify the managed care plan, the requestor, and the enrollee of the commissioner's determination. The notice to the enrollee shall provide a statement that the enrollee's request 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 attorneys' 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

(E) The managed care plan's position, if any, on whether title 29 United States Code section 1003(a) applies to the enrollee's plan; provided that where an expedited appeal is involved, the managed care plan or its designee utilization review organization shall provide the documents and information within forty-eight hours of receipt of the request for external review.

Failure by the managed care plan or its designee utilization review organization to provide the documents and information within the prescribed time periods shall not delay the conduct of the external review. Where the plan or its designee utilization review organization fails to provide the documents and information within the prescribed time periods, the commissioner may issue a decision to reverse the final internal determination, in whole or part, and shall promptly notify the independent review organization, the enrollee, the enrollee's appointed representative, if applicable, the

enrollee's treating provider, and the managed care plan of the decision;

(4) [~~Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the external review panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel;~~] The commissioner shall determine whether the disputed service, supply, or treatment is specifically excluded under the terms of the enrollee's insurance policy, evidence of coverage, or similar document;

(5) [~~The review hearing shall be conducted~~] If the commissioner finds that the disputed service, supply, or treatment is not specifically excluded, the commissioner, the independent medical expert selected by the commissioner pursuant to subsection (a)(2)(A), the independent review organization selected by the commissioner pursuant to subsection (a)(2)(B), or the external review panel appointed by the commissioner pursuant to subsection (a)(2)(C) shall review the final

internal determination as soon as practicable, taking into consideration the medical exigencies of the case[~~,~~], provided that:

(A) [~~The~~] In the case of a review by an independent medical expert pursuant to subsection (a)(2)(A) or by an independent review organization pursuant to subsection(a)(2)(B), the decision shall be made no later than sixty days after the date of the request for external review. In the case of a hearing by an external review panel or by the commissioner without a panel when the amount in controversy is less than $1,000, the hearing shall be held no later than sixty days from the date of the request for the hearing; and

(B) [~~An~~] Provided, that an external review conducted as an expedited appeal shall be determined no later than seventy-two hours after receipt of the request for external review;

(6) In the case of a review by an independent review organization, the independent review organization shall use a physician with expertise in the relevant 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;

(B) Whether the medical director properly applied the medical necessity criteria in section 432E-1.4 in making the final internal determination;

(C) All relevant medical records;

(D) The clinical standards of the plan;

(E) The information provided;

(F) The attending physician's recommendations; and

(G) Generally accepted practice guidelines.

(9) [~~The~~] When the review is conducted by an external review panel, the commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the [~~decision~~] final internal determination within thirty days of the hearing.

(10) When the amount in controversy is less than $1,000 and the review is conducted by the commissioner or the commissioner's designee, the commissioner shall issue an order affirming, modifying, or reversing the final internal determination no later than sixty days from the date of the request for review; and

(11) The independent medical expert or independent review organization shall issue a written decision stating whether the managed care plan acted reasonably in

denying coverage for the service or treatment on grounds of medical necessity or experimental and investigational procedures. If the independent medical expert or independent review organization decides that the final internal determination was not reasonable, the external review decision shall be final and shall not be subject to appeal by the plan and the plan shall forthwith provide the service, supply, or treatment.

(b) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers[~~.~~] ; and the procedure set forth in this section shall not apply to QUEST medical plans under the department of human services.

(c) No person shall serve on [~~the~~] an external review panel, as a medical expert, as an independent medical expert or in the independent review organization who, through a familial relationship within the second degree of consanguinity or affinity, or for other reasons, has a direct and substantial professional, financial, or personal interest in[~~:~~] or conflict of interest with any of the following:

(1) The plan involved in the complaint, including an officer, director, or employee of the plan; [~~or~~]

(2) The treatment of the enrollee, including but not limited to the developer or manufacturer of the principal drug, device, procedure, or other therapy at issue [~~.~~] ;

(3) The treating physician who proposes to render or provide the service, supply, or treatment that is the subject of the external review;

(4) The healthcare facility at which the service or treatment was provided or will be provided; or

(5) The enrollee.

(d) Members of the review panel shall be granted immunity from liability and damages relating to their duties under this section. Independent medical experts and independent review organizations and their expert reviewers shall not be liable for injuries or damages arising from decisions made pursuant to this section; provided that this subsection shall not apply to any act or omission by an independent medical expert, independent review organization, or expert reviewer that is made in bad faith or that involves gross negligence.

(e) An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable costs incurred in connection with the external review under this section, unless the commissioner in an administrative proceeding determines that the appeal was unreasonable, fraudulent, excessive, or frivolous.

(f) Disclosure of an enrollee's protected health information shall be limited to disclosure for purposes relating to the external review.

(g) Future contractual or employment action by the managed care plan regarding the treating health care provider shall not be based on participation in the external review process."

SECTION 2. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun, before its effective date.

SECTION 3. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 4. This Act shall take effect upon its approval.

INTRODUCED BY: Calvin K.Y. Say

BY REQUEST

JAN 23 2006

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JUSTIFICATION SHEET

DEPARTMENT: Commerce and Consumer Affairs

TITLE: A BILL FOR AN ACT RELATING TO THE PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES.

PURPOSE: To provide for an independent review process that would not be pre-empted by the federal Employees Retirement Income Security Act ("ERISA"). This bill provides for review of medical necessity 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.

MEANS: Amend section 432E-6, Hawaii Revised Statutes.

JUSTIFICATION: Hawaii Revised Statutes chapter 432E provides for an independent review of health insurance coverage decisions made by a managed care plan. The Hawaii Supreme Court ruled in the case of Hawaii Management Alliance Association v. The Insurance Commissioner, et al., 106 Hawaii 21 (2004), that the external review process is pre-empted by ERISA as to employee benefit plans that fall under ERISA. The vast majority of health plans in Hawaii fall under ERISA. There are numerous disputes between managed care plans and their enrollees regarding medical necessity. These disputes (for both ERISA and non-ERISA employee benefit plans) were formerly handled through the external review process involving a three member panel and an administrative hearing. However, since that process has been deemed pre-empted by ERISA as to ERISA employee benefit plans, there should be a quick and inexpensive process for the resolution of these disputes arising in the State. This

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bill creates such a process by sending the ERISA plan disputes to an independent medical expert or independent review organization selected by the insurance commissioner. Presently, this process is followed in about 40 states for ERISA plans. For non-ERISA plans, the existing external review process shall be maintained.

Impact on the public: There should be a positive impact on the public as they are provided with an independent review process for their ERISA plan health insurance coverage disputes that does not require the cost and time associated with arbitration or litigation.

Impact on the department and other agencies: The cost of using an independent review organization is estimated at an average of $700 per review. Fewer than twenty external reviews per year, on average, advance further than review for good cause. This bill provides that these costs are to be paid by the managed care plan, so that there is no impact on the Compliance Resolution Fund. At the request of the Department of Human Services this bill clarifies that the external review procedure does not apply to the QUEST program.

GENERAL FUND: None.

OTHER FUNDS: None.

PPBS PROGRAM DESIGNATION: CCA-106.

OTHER AFFECTED AGENCIES: None.

EFFECTIVE DATE: Upon approval.