THE SENATE
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

S.B. NO. 940 S.D. 2

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~~] under this section in the following manner:

(1) The [~~enrollee shall submit a request for external review to the commissioner within~~] request for external review shall be filed with the commissioner or postmarked no later than sixty days from the date

of the final internal determination by the managed care plan[~~,~~], which shall include a copy of the final internal determination, a statement of the type of review requested, and the requestor's position on whether title 29 United States Code section 1003(a) applies to the enrollee's 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. Presentation of evidence for this purpose shall be exempt from section 91-9(g); [~~and~~]

(B) [~~The~~] Retain the services of an independent review organization from an approved list maintained by the commissioner[~~,~~]. An expert reviewer assigned by an independent review organization or the independent review organization selected by the commissioner shall not have a direct professional, familial, or financial interest in or conflict of interest with any of the following:

(i) The managed care plan that is the subject of the external review;

(ii) Any officer or director of the managed care plan that is the subject of the external review;

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

(iv) The health care facility at which the service or treatment was provided or will be provided;

(v) The developer or manufacturer of the supply, that is, the principal drug, device, procedure, or other therapy that is being proposed for the enrollee; or

(vi) The enrollee.

The commissioner shall establish procedures consistent with this section for transferring the request for review and the submissions of the enrollee and the plan to the independent review organization. The managed care plan that is the

subject of the external review shall be responsible for paying the reasonable expenses of the independent medical expert or review organization selected by the commissioner to conduct the review; and

(C) Upon a showing of good cause and determination that title 29 United States Code section 1003(a) does not apply, 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, and shall conduct a review hearing pursuant to chapter 91, as provided under subsection (a)(7). If the amount in controversy is less than $500, the commissioner may conduct a review hearing 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 enrollee may have other rights, including the right to an award of reasonable attorneys' fees and costs, pursuant to title 29 United States Code section 1132;

(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; and

(D) 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. Where the commissioner has

determined that title 29 United States Code section 1003(a) does not apply to the enrollee's plan, the commissioner may appoint a hearing officer and hold an administrative hearing pursuant to chapter 91 for the purpose of determining whether the disputed service, supply, or treatment is specifically excluded from coverage;

(5) [~~The review hearing shall be conducted~~] Upon determination that the disputed service, supply, or treatment is not specifically excluded, the commissioner, the independent review organization retained by the commissioner under subsection (a)(2)(B), or the review panel appointed by the commissioner under 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) In the case of a review without a hearing under subsection (a)(2)(A) or (a)(2)(B), the decision shall be made no later than sixty days after the date of the request for external review. The commissioner shall inform the enrollee and the

managed care plan of the decision of the independent review organization as soon as practicable but not later than thirty days after the commissioner receives that decision. The decision shall be final and shall not be subject to appeal by the plan;

(B) In the case of a review under subsection (a)(2)(B), when determining medical necessity or other issues where the independent review organization determines that medical expertise is necessary, the independent review organization shall use a physician with expertise in the relevant medical field to make the determination;

(C) In the event that the review under subsection (a)(2)(A) or (a)(2)(B) determines that the covered service, supply, or treatment is medically necessary or that the service, supply, or treatment is covered under the terms of the enrollee's insurance policy, evidence of coverage, or similar document, the managed care plan shall provide the service, supply, or treatment;

(D) In cases in which the enrollee retains a right or is exercising the concurrent right to a civil action under title 29 United States Code section 1132, any evidence considered in a review under subsection (a)(2)(A) or (a)(2)(B) of this subsection shall be deemed to have been reviewed by the plan administrator during the administration process, and the decision in the review shall provide a statement to that effect;

[~~The~~] (E) In the case of a hearing under subsection (a)(2)(C), hearing shall be held no later than sixty days from the date of the request for the hearing; and except that

[~~(B) An~~] (F) In all cases 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) [~~After~~] Notwithstanding paragraph (5), if the commissioner determines under paragraph (4) that the disputed service, supply, or treatment is specifically excluded from coverage, or if 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~~] determines that the request is frivolous or without merit[~~.~~], the commissioner may dismiss the request for external review without prejudice to the enrollee's rights; and

(7) The review [~~panel~~] shall [~~review every final internal determination to~~] determine whether the managed care plan involved acted reasonably. [~~The~~] No deference shall be accorded 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 review organization, or the 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.

The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing.

(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.

(c) No person shall serve on [~~the~~] a review panel 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:

(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.

(d) Members of the review panel shall be granted immunity from liability and damages relating to their duties under this section.

(e) An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable cos78ts 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) The commissioner shall retain an organization that is a qualified tax-exempt organization pursuant to section 501(c)(3) of the Internal Revenue Code to serve as the state health consumer advocate to assist the commissioner in evaluating requests for external review, resolving disputes in a cost-effective manner, and otherwise carrying out the purposes

of this chapter. The advocate selected by the commissioner shall not have a direct professional, familial, or financial relationship in or conflict of interest with any managed care plan or any officer or director of the managed care plan. The advocate shall assist or facilitate discussions between managed care plans and treating providers on guidelines and protocols as requested; assist enrollees and their representatives in appealing determinations by managed care plans, including but not limited to assisting enrollees and their representatives preparing requests for internal and external reviews, identifying appropriately qualified experts and information relating to the health intervention in issue; and make referrals for independent medical, legal, or social assistance. Every mutual benefit society, health maintenance organization, and other entity offering or providing health benefits or services under the regulation of the commissioner, except an insurer licensed to offer accident and health or sickness insurance under article 10A of chapter 431, shall deposit with the commissioner on July 1 of each year a fee in the amount of not less than twenty cents per member enrolled on June 1 of that year, to be credited to the compliance resolution fund to provide for the advocate's retainer."

SECTION 2. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 3. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun, before its effective date.

SECTION 4. This Act shall take effect on July 1, 2050.

SB940, SD2

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

Description:
Provides for review of ERISA-covered managed care plan coverage disputes by independent review organization, and review of non-ERISA plans by external review panel. Requires Commissioner to retain nonprofit as state health consumer advocate. (SD2)