HOUSE OF REPRESENTATIVES
TWENTY-FOURTH LEGISLATURE, 2008
STATE OF HAWAII

H.B. NO. 2836

A BILL FOR AN ACT

RELATING TO THE PATIENTS' BILL OF RIGHTS.

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

1 SECTION 1. Under chapter 432E, Hawaii Revised Statutes,
2 Hawaii's patients' bill of rights law, a patient who has been
3 denied coverage for a health treatment by a health plan, or
4 "managed care plan", has a right to an external review of that
5 decision by a three-member panel, and the decision of the three-
6 member panel is also subject to review in the state courts.
7 Recently, the Hawaii state supreme court struck down this
8 external review procedure in *Hawaii Management Alliance*
9 *Association v. Baldado*, Slip Op. No. 24801, finding that the
10 procedure was preempted by the federal Employee Retirement
11 Income Security Act of 1974 (ERISA). As a result, patients with
12 health plans subject to ERISA (private-sector employer-sponsored
13 health plans) must challenge a denial of coverage by seeking
14 arbitration or judicial review. But as these procedures are
15 both expensive and time consuming, the patient may be unwilling
16 or unable to challenge a health plan's final internal denial of
17 coverage.

1 The legislature finds that a new external appeals process
2 must be established to give patients who may be unreasonably
3 denied coverage for medical treatment, access to a quick,
4 inexpensive alternative method of appeal.
5 The purpose of this Act is to establish a new, non-judicial
6 external review procedure by which patients may challenge a
7 health plan's final, internal denial of coverage.
8 SECTION 2. Chapter 432E, Hawaii Revised Statutes, is
9 amended by adding nine new sections to be appropriately
10 designated and to read as follows:
11 "**§432E-A External review procedure; contractual benefit**
12 **coverage.** (a) Upon any adverse determination by a managed care
13 plan, and after exhausting all available internal complaint and
14 appeal procedures, an enrollee, or the enrollee's treating
15 licensed health care provider or appointed representative may
16 request an external review by the insurance commissioner to
17 determine whether the plan's adverse determination is consistent
18 with the benefit coverage as stated in the contract between the
19 insured and the managed care plan. If the commissioner finds
20 that a request for external review requires an interpretation of
21 medical necessity or a finding regarding the experimental or
22 investigational nature of a proposed service, the request shall

1 be subject to review under section 432E-B. Any review by the
2 commissioner regarding a plan benefit interpretation shall not
3 involve an independent review organization.
4 (b) A request for an external review based upon plan
5 benefit interpretation shall be made and processed in the
6 following manner:
7 (1) The enrollee shall submit the request to the
8 commissioner within sixty days from the date of the
9 managed care plan's final internal determination;
10 (2) The commissioner shall notify the managed care plan in
11 writing of the request within fourteen days after
12 receipt of the request for external review; provided
13 that if the commissioner authorizes an expedited
14 appeal pursuant to section 432E-6.5, the commissioner
15 shall provide the required notice immediately upon
16 receipt and approval of the request for expedited
17 appeal;
18 (3) Within fourteen days of receipt of notice under
19 paragraph (2) the managed care plan or its designee
20 utilization review organization shall provide the
21 commissioner with:

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1 (A) All medical records and supporting documentation
2 pertaining to the case; and
3 (B) A summary of the applicable issues, including a
4 statement of the managed care plan's decision and
5 the criteria the managed care plan used to make
6 its decision; provided that if the external
7 review is to be conducted as an expedited appeal,
8 the managed care plan or its designee utilization
9 review organization shall provide the
10 commissioner with the required information within
11 forty-eight hours of receipt of notice under
12 paragraph (2).
13 The managed care plan shall also provide the
14 information required by this paragraph to the enrollee
15 or the enrollee's treating licensed health care
16 provider or appointed representative;
17 (4) Within seven business days after receipt of the
18 information submitted by the managed care plan under
19 paragraph (3), the enrollee or the enrollee's treating
20 licensed health care provider or appointed
21 representative may provide to the commissioner any
22 additional records, information, material, counter

1 summary of the applicable issues, or other matters
2 that the enrollee believes should be considered by the
3 commissioner;
4 (5) Within fourteen business days after receipt of the
5 information submitted by the managed care plan under
6 paragraph (3) or within seven business days after
7 receipt of the information submitted by an enrollee
8 under paragraph (4), the commissioner shall notify the
9 managed care plan and the enrollee or the enrollee's
10 treating licensed health care provider or appointed
11 representative of any request for additional
12 information that the commissioner requires. Within
13 seven business days of receipt of the request for
14 additional information, the managed care plan and the
15 enrollee or the enrollee's treating licensed health
16 care provider or appointed representative shall submit
17 the additional information or an explanation as to why
18 the additional information cannot be submitted;
19 provided that if the external review is to be
20 conducted as an expedited appeal, the commissioner's
21 request for additional information shall be made
22 within twenty-four hours of receipt of the information

1 required by paragraph (3) and shall allow the managed
2 care plan or enrollee not less than forty-eight hours
3 to provide the information;
4 (6) The commissioner shall review the final internal
5 determination of the managed care plan to determine
6 whether the managed care plan acted reasonably with
7 respect to the benefit coverage issues subject to
8 review under this section. The commissioner shall
9 consider:
10 (A) The terms of the agreement of the enrollee's
11 insurance policy, evidence of coverage, or
12 similar document; and
13 (B) All relevant medical records and any other
14 information provided; and
15 (7) The commissioner shall issue a written decision
16 stating whether the managed care plan acted reasonably
17 in denying the service or treatment on the basis of
18 whether or not these services were covered under the
19 insured's policy, given the circumstances presented in
20 the particular case. The decision shall be sent to
21 the enrollee or the enrollee's treating licensed
22 health care provider or appointed representative, and

1 the managed care plan within sixty days after receipt
2 of the information required by paragraph (3); provided
3 that:
4 (A) The review that is the basis for the decision
5 shall be conducted as soon as practicable, taking
6 into consideration the medical exigencies of the
7 case;
8 (B) If the external review is conducted as an
9 expedited appeal, the decision shall be sent
10 within forty-eight hours after receipt of the
11 information required by paragraph (3) or, if
12 additional information is received under
13 paragraph (4) or requested under paragraph (5),
14 not later than forty-eight hours after the
15 earlier of the receipt of the additional
16 information requested, or the end of any period
17 afforded the managed care plan or the enrollee to
18 provide the additional information.
19 (c) Any decision of the commissioner made pursuant to this
20 section shall be binding on the enrollee, the enrollee's
21 appointed representative, the treating licensed health care
22 provider, and the managed care plan for purposes of the coverage

1 to be provided to the enrollee by the managed care plan. If the
2 commissioner determines that the managed care plan did not act
3 reasonably in concluding the health care service was not covered
4 under the insured's contract, and there are no issues to be
5 resolved under section 432E-B, the managed care plan shall pay
6 for the health care service.
7 (d) The managed care plan at its discretion may determine
8 that additional information provided by the enrollee or the
9 enrollee's treating licensed health care provider or appointed
10 representative justifies a reconsideration of the decision to
11 deny the coverage or reimbursement that is the subject of an
12 external review. Upon notice to the enrollee or the enrollee's
13 treating licensed health care provider or appointed
14 representative, and the commissioner, a decision by the managed
15 care plan to grant the coverage or reimbursement based upon such
16 reconsideration shall terminate the external review.
17 (e) The procedures set forth in this section shall not
18 apply to claims or allegations of health care provider
19 malpractice, professional negligence, or other professional
20 fault against participating providers, or to adverse
21 determinations based on the medical necessity of a proposed

service or whether a proposed service is experimental or investigational.

§432E-B External review procedure; medical necessity. (a) Upon any adverse determination by a managed care plan, and after exhausting all available internal complaint and appeal procedures, an enrollee, or the enrollee's treating licensed health care provider or appointed representative, may request an external review by the insurance commissioner to determine whether the adverse determination is consistent with the benefit coverage as stated in the contract between the insured and the managed care plan. If the commissioner finds that the request for external review requires an interpretation of contractual plan benefits, the request shall be subject to review under 432E-A, and not this section. If the commissioner finds that the request for external review requires a determination of medical necessity or a finding regarding the experimental or investigational nature of a proposed service, the request shall be subject to review under this section.

(b) A request for an external review based upon an interpretation of medical necessity or a finding regarding the experimental or investigational nature of a proposed service shall be made and processed in the following manner:

1 (1) The enrollee shall submit the request to the
2 commissioner within sixty days from the date of the
3 managed care plan's final internal determination;
4 (2) The commissioner shall select and retain the services
5 of at least one independent review organization, the
6 cost of which shall be covered by the managed care
7 plan whose benefit denial is in dispute, and shall
8 refer external review requests to the independent
9 review organization. The commissioner's selection of
10 any independent review organization shall be based in
11 part on a bidding process to help ensure that these
12 costs are not excessive;
13 (3) The commissioner shall notify the managed care plan in
14 writing of the request within fourteen days after
15 receipt of the request for external review; provided
16 that if the commissioner authorizes an expedited
17 appeal pursuant to section 432E-6.5, the commissioner
18 shall provide the required notice immediately upon
19 receipt and approval of the request for expedited
20 appeal;
21 (4) Within fourteen days of receipt of notice under
22 paragraph (3) the managed care plan or its designee

1 utilization review organization shall provide the
2 independent review organization with:
3 (A) All medical records and supporting documentation
4 pertaining to the case;
5 (B) A summary of the applicable issues, including a
6 statement of the managed care plan's decision and
7 the criteria the managed care plan used to make
8 its decision;
9 (C) The medical and clinical reasons for the
10 decision; and
11 (D) A copy of section 432E-1.4 detailing the
12 statutory definition of medical necessity;
13 provided that if the external review is to be
14 conducted as an expedited appeal, the managed
15 care plan or its designee utilization review
16 organization shall provide the independent review
17 organization with the required information within
18 forty-eight hours of receipt of notice under
19 paragraph (3).
20 The managed care plan shall also provide the
21 information required by this paragraph to the enrollee

1 or the enrollee's treating licensed health care
2 provider or appointed representative;
3 (5) Within seven business days after receipt of the
4 information submitted by the managed care plan under
5 paragraph (4), the enrollee or the enrollee's treating
6 licensed health care provider or appointed
7 representative may provide to the independent review
8 organization any records, information, material,
9 counter summary of the applicable issues, or other
10 matters that the enrollee believes should be
11 considered by the independent review organization;
12 (6) Within fourteen business days after receipt of the
13 information submitted by the managed care plan under
14 paragraph (4) or within seven business days after
15 receipt of the information or material submitted by an
16 enrollee under paragraph (5), the independent review
17 organization shall notify the managed care plan and
18 the enrollee or the enrollee's treating licensed
19 health care provider or appointed representative of
20 any request for additional information that the expert
21 reviewer requires. Within seven business days of
22 receipt of the request for additional information, the

1 managed care plan and the enrollee or the enrollee's
2 treating licensed health care provider or appointed
3 representative shall submit the additional information
4 or an explanation as to why the additional information
5 cannot be submitted; provided that if the external
6 review is to be conducted as an expedited appeal, an
7 independent review organization's request for
8 additional information shall be made within twenty-
9 four hours of receipt of the information required by
10 paragraph (4) and shall allow the managed care plan or
11 the enrollee not less than forty-eight hours to
12 provide the information;
13 (7) The expert reviewer appointed by the independent
14 review organization shall review the final internal
15 determination of the managed care plan to determine
16 whether the managed care plan acted reasonably. The
17 expert reviewer shall consider:
18 (A) The terms of the agreement of the enrollee's
19 insurance policy, evidence of coverage, or
20 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 and any other information provided;

(D) The treating licensed health care provider's recommendations;

(E) The clinical standards of the managed care plan; and

(F) Generally accepted practice guidelines; and

(8) The 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. The decision shall be sent to the commissioner within sixty days after receipt of the original request for external review under paragraph (1); provided that the review that is the basis for the decision shall be conducted as soon as practicable, taking into consideration the medical exigencies of the case; provided further that if the external review is to be conducted as an expedited appeal, the decision shall

1 be sent within forty-eight hours after receipt of the
2 information required by paragraph (4) or, if
3 additional information is received under paragraph (5)
4 or requested under paragraph (6), not later than
5 forty-eight hours after the earlier of the receipt of
6 the additional information requested, or the end of
7 the period afforded the enrollee to provide the
8 additional information.
9 (c) The decision of an independent review organization
10 made pursuant to this section as to the medical necessity or
11 experimental or investigational status of the proposed service
12 for the enrollee involved shall be binding on the enrollee, the
13 enrollee's appointed representative, the treating licensed
14 health care provider, and the managed care plan for purposes of
15 the coverage to be provided to the enrollee by the managed care
16 plan. If the expert reviewer determines the managed care plan
17 did not act reasonably in concluding the health care service was
18 not medically necessary, and the managed care plan has asserted
19 no other basis for denying coverage, the managed care plan shall
20 pay for the health care service.

(d) The managed care plan shall be required to pay for the services of only one independent review organization per external review request made under this section.

(e) The managed care plan at its discretion may determine that additional information provided by the enrollee or the enrollee's treating licensed health care provider or appointed representative justifies a reconsideration of the decision to deny the coverage or reimbursement that is the subject of an external review. Upon notice to the enrollee or the enrollee's treating licensed health care provider or appointed representative, the commissioner, and the independent review organization, a decision by the managed care plan to grant the coverage or reimbursement based upon the reconsideration shall terminate the external review.

(f) The procedures set forth in this section shall not apply to claims or allegations of health care provider malpractice, professional negligence, or other professional fault against participating providers.

§432E-C Disclosure and confidentiality of external review information. (a) Disclosure under section 432E-A of any health information protected by law shall be limited to disclosure for purposes relating to the external review.

1 (b) An independent review organization in receipt of
2 information pursuant to section 432E-B shall maintain the
3 confidentiality of:
4 (1) Medical records in accordance with state and federal
5 law; and
6 (2) Proprietary information of the managed care plan.
7 **§432E-D Liability under the external review procedure.**
8 (a) Nothing in this section shall be construed to:
9 (1) Create any private right or cause of action for or on
10 behalf of any insured person; or
11 (2) Render the managed care plan liable for injuries or
12 damages arising from any act or omission of the
13 independent review organization or expert reviewer.
14 (b) An independent review organization and its expert
15 reviewers shall not be liable for injuries or damages arising
16 from decisions made pursuant to section 432E-B; provided that
17 this subsection shall not apply to any act or omission by an
18 independent review organization or expert reviewer that is made
19 in bad faith or that involves gross negligence.
20 **§432E-E Certification of independent review organizations;**
21 **minimum standards.** (a) The commissioner shall establish
22 minimum standards for the certification of independent review

organizations. An entity wishing to become certified shall demonstrate that it:

(1) Has no conflicts of interest under section 432E-G and is not owned, a subsidiary of, or an affiliate of a managed care plan or utilization review organization;

(2) Has the ability to maintain the confidentiality of medical records and other enrollee information, and the proprietary information of a managed care plan;

(3) Is accredited by the Utilization Review Accreditation Commission as an independent review organization; and

(4) Is registered, domiciled, and does the majority of its business outside of the State.

(b) Professional trade associations of health care providers or their subsidiaries or affiliates shall not be eligible for certification as an independent review organization.

§432E-F Expert reviewer qualifications. An expert reviewer shall be a physician and shall:

(1) Have no conflicts of interest under section 432E-G;

(2) Have expertise in the specific health condition of the enrollee whose appeal is under review and knowledge

1 regarding the recommended service or treatment through
2 actual clinical experience;
3 (3) Hold an unrestricted license to practice medicine in a
4 state of the United States;
5 (4) Be currently certified by an American medical
6 specialty board recognized by the American Osteopathic
7 Association or the American Board of Medical
8 Specialties, or both, in the areas appropriate to the
9 subject of review; and
10 (5) Have no history of disciplinary action or sanctions
11 related to quality of care, fraud, or other criminal
12 activity.
13 **§432E-G Conflicts of interest prohibited; disclosure.** (a)
14 Neither the expert reviewer nor the independent review
15 organization shall have any relationship with the following
16 entities or activities that may create a material, professional,
17 familial, or financial conflict of interest related to the
18 expert reviewer's or independent review organization's duties
19 under this chapter:
20 (1) The managed care plan;
21 (2) Any officer, director, or management employee of the
22 managed care plan;

(3) The physician, the physician's medical group, or the independent practice association proposing the service or treatment subject to review;

(4) The institution at which the service or treatment would be provided;

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the enrollee whose appeal is under review; or

(6) The enrollee or the enrollee's treating licensed health care provider or appointed representative who requested the review.

(b) A potential expert reviewer shall disclose any information regarding a potential conflict of interest to the commissioner.

§432E-H Remedies preserved. Nothing contained in this chapter shall prevent or be construed as prohibiting or limiting an enrollee's right to seek contractual or other civil remedies allowed by law in lieu of the external review procedures provided in this chapter and an enrollee shall not be required to exhaust any remedies under this chapter prior to seeking civil redress in court or by arbitration. Any action in court or by arbitration shall not be brought as an appeal from any

1 decision rendered by the commissioner or independent review
2 organization under this chapter but shall be an action
3 independent of and separate from the external review procedure
4 provided in this chapter.
5 **§432E-I Enrollees rights.** An enrollee shall be entitled
6 to present medical testimony, the results of medical trials, or
7 other documentation to the independent review organization for
8 its consideration in support of a finding of medical necessity
9 or in dispute of a finding regarding the experimental or
10 investigational nature of a proposed service."
11 SECTION 3. Section 432E-1, Hawaii Revised Statutes, is
12 amended by amending the definition of "external review" to read
13 as follows:
14 ""External review" means an administrative review requested
15 by an enrollee under section [~~432E-6~~] 432E-A of a managed care
16 plan's final internal determination of an enrollee's complaint."
17 SECTION 4. Section 432E-6.5, Hawaii Revised Statutes, is
18 amended by amending subsection (a) to read as follows:
19 "(a) An enrollee may request that the following be
20 conducted as an expedited appeal:
21 (1) The internal review under section 432E-5 of the
22 enrollee's complaint; or

(2) [~~The external review under section 432E-6 of the managed care plan's final internal determination.~~] The external review under section 432E-A of the managed care plan's final internal determination.

If a request for expedited appeal is approved by the managed care plan or the commissioner, the appropriate review shall be completed within seventy-two hours of receipt of the request for expedited appeal[~~.~~], except as otherwise provided in section 432E-A."

SECTION 5. Section 432E-6, Hawaii Revised Statutes, is repealed.

["~~**§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 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, 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 services of an independent review organization from an approved list maintained by the commissioner;~~

~~(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 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;~~

~~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;~~

~~(5) The review hearing shall be conducted as soon as practicable, taking into consideration the medical exigencies of the case; provided that:~~

~~(A) The hearing shall be held no later than sixty days from the date of the request for the hearing; and~~

~~(B) 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 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) The review panel shall review every final internal determination to determine whether the managed care plan involved acted reasonably. 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 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 costs incurred in connection with the external review under this section, unless the commissioner in an administrative~~

1 ~~proceeding determines that the appeal was unreasonable,~~
2 ~~fraudulent, excessive, or frivolous.~~
3 ~~(f) Disclosure of an enrollee's protected health~~
4 ~~information shall be limited to disclosure for purposes relating~~
5 ~~to the external review.~~"]
6 SECTION 6. In codifying the new sections added by section
7 2 of this Act, the revisor of statutes shall substitute
8 appropriate section numbers for the letters used in designating
9 the new sections in this Act.
10 SECTION 7. Statutory material to be repealed is bracketed
11 and stricken. New statutory material is underscored.
12 SECTION 8. This Act shall take effect on July 1, 2008.
13

INTRODUCED BY: ____________________

JAN 21 2008

H.B. NO. 2836

Report Title:
External Review Procedure; Patients' Bill of Rights Law

Description:
Conforms the law to a recent Hawaii supreme court decision by amending the Patients' Bill of Rights external review procedure under which patients may appeal a managed care plan's final, internal decision denying coverage of a health intervention.