H.B. NO. 1047

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. Chapter 432E, Hawaii Revised Statutes, is amended by adding a new part to be appropriately designated and to read as follows:

"PART

EXTERNAL REVIEW OF HEALTH INSURANCE DETERMINATIONS

§432E- A. Applicability and scope. (a) Except as provided in subsection (b), this part shall apply to all health carriers.

(b) The provisions of this part shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long term care insurance, vision care, or any other limited supplemental benefit or to a Medicare supplement policy of insurance, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under chapter 55 of Title 10, United States Code (federal Medical and Dental Care)and any coverage issued as supplemental to that

coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance, any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis, or the employer union health benefits trust fund so long as it is self-funded.

§432E- Notice of right to external review. The notice of the right to external review shall set forth the options available to the enrollee under this part. The commissioner may specify the form and content of the notice of external review.

§432E- Request for External Review. (a) All requests for external review shall be made in writing to the commissioner. The request for external review shall include a copy of the final internal determination of the health carrier.

(b) Pursuant to section 432E-5, the internal appeals process of the health carrier must be completed before an external review request can be made except in the following circumstances:

(1) If the health carrier has waived the completion; or

(2) The enrollee has applied for an expedited external review at the same time as applying for an expedited internal appeal.

§432E- Standard External Review. (a) Within one hundred and thirty days after the date of receipt of a notice of an adverse determination or final adverse determination, an enrollee or the enrollee's authorized representative may file a request for an external review with the commissioner. Within one business day after the receipt of a request for external review pursuant to this section, the commissioner shall send a copy of the request to the health carrier.

(b) Within five business days following the date of receipt of the copy of the external review request from the commissioner under subsection (a), the health carrier shall complete a preliminary review of the request to determine whether:

(1) The individual is or was an enrollee in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was an enrollee in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is

not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

(3) The enrollee has exhausted the health carrier's internal appeals process, unless the enrollee is not required to exhaust the health carrier's internal appeals process pursuant to section 432E- A ; and

(4) The enrollee has provided all the information and forms required to process an external review.

(c) Within one business day after completion of the preliminary review, the health carrier shall notify the commissioner and enrollee and, if applicable, the enrollee's authorized representative in writing whether the request is:

(1) Complete; and

(2) Eligible for external review.

If the request is not complete, the health carrier shall inform the enrollee and, if applicable, the enrollee's authorized representative and the commissioner in writing and include in the notice what information or materials are needed to make the request complete.

If the request is not eligible for external review, the health carrier shall inform the enrollee and, if applicable, the enrollee's authorized representative and the commissioner in writing and include in the notice the reasons for the ineligibility.

(d) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice. The notice of initial determination shall include a statement informing the enrollee and, if applicable, the enrollee's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(e) The commissioner may determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review. In making a determination that a request is eligible for external review, the commissioner's decision shall be made in accordance with the terms of the enrollee's health benefit plan and shall be subject to all applicable provisions of this chapter.

(f) Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (b), within one business day after the receipt of the notice, the commissioner shall:

(1) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section (m), to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(2) Notify in writing the enrollee and, if applicable, the enrollee's authorized representative of the request's eligibility and acceptance for external review.

(g) In reaching a decision, the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process or internal appeals process.

(h) The commissioner shall include in the notice provided to the enrollee and, if applicable, the enrollee's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing

to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subsection (f) additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

(i) Within five business days after the date of receipt of the notice provided pursuant to subsection (f), the health carrier or its designated utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(j) Except as provided in this subsection, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subsection (i) shall not delay the conduct of the external review.

If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subsection (i), the assigned independent review organization may terminate the external

review and make a decision to reverse the adverse determination or final adverse determination.

(k) Within one business day after making the decision under subsection (j), the independent review organization shall notify the enrollee, the enrollee's authorized representative, if applicable, the health carrier, and the commissioner.

(l) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (i) and any other information submitted in writing to the independent review organization by the enrollee or the enrollee's authorized representative pursuant to subsection (h).

Upon receipt of any information submitted by the enrollee or the enrollee's authorized representative pursuant to subsection (h), the assigned independent review organization shall within one business day forward the information to the health carrier.

(m) Upon receipt of the information, if any, required to be forwarded pursuant to subsection (l), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or

terminate the external review. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(n) Within one business day after making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (m), the health carrier shall notify the enrollee, the enrollee's authorized representative, if applicable, the assigned independent review organization, and the commissioner in writing of its decision. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier.

(o) In addition to the documents and information provided pursuant to subsections (h) and (i), the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The enrollee's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, enrollee, the enrollee's authorized representatives, or the enrollee's treating provider;

(4) The terms of coverage under the enrollee's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the enrollee's benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designated utilization review organization; and

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the

information or documents are available and the clinical reviewer or reviewers consider appropriate.

(p) Within forty-five days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the enrollee, the enrollee's authorized representative, if applicable, the health carrier, and the commissioner. The independent review organization shall include in the notice:

(1) A general description of the reason for the request for external review;

(2) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(3) The date the external review was conducted;

(4) The date of its decision;

(5) The principal reason or reasons for its decision, including any evidence-based standards that were a basis for its decision;

(6) The rationale for its decision; and

(7) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

(q) The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 432E- D(d) .

§432E- Expedited External Review. (a) Except as provided in subsection (l), an enrollee or the enrollee's authorized representative may make a request for an expedited external review with the commissioner at the time the enrollee receives:

(1) An adverse determination that involves a medical condition of the enrollee for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the enrollee, would seriously jeopardize the enrollee's ability to gain maximum functioning, or would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination;

(2) A final adverse determination if the enrollee has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the enrollee's ability to gain maximum functioning, or would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination; or

(3) A final adverse determination if the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) Upon receipt of a request for an expedited external review, the commissioner immediately shall send a copy of the request to the health carrier. Immediately upon receipt of the request, the health carrier shall determine whether the request meets the reviewability requirements set forth in 432E- A(e). The health carrier shall immediately notify the enrollee or the enrollee's authorized representative, if applicable, of its eligibility determination.

(c) The commissioner may specify the form for the health carrier's notice of initial determination under this section and any supporting information to be included in the notice.

The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request that is ineligible for review may be appealed to the commissioner.

(d) The commissioner may determine that a request is eligible for external review under section 432E- A(e), notwithstanding a health carrier's initial determination that the request is ineligible, and require that the case be referred for external review. In making a determination that a request

is eligible for external review, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this part.

(e) Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner. The commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

(f) In reaching a decision in accordance with subsection (i), the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal appeals process.

(g) Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in

making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(h) In addition to the documents and information provided or transmitted pursuant to subsection (g), the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The enrollee's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, enrollee, the enrollee's authorized representative or the enrollee's treating provider;

(4) The terms of coverage under the enrollee's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

(i) As expeditiously as the enrollee's medical condition or circumstances requires, but in no event more than seventy-two hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in section 432E- A(e), the assigned independent review organization shall:

(1) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(2) Notify the enrollee, the enrollee's authorized representative, if applicable, the health carrier, and the commissioner of the decision.

(j) If the notice provided pursuant to subsection (i) was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall:

(1) Provide written confirmation of the decision to the enrollee, the enrollee's authorized representative, if applicable, the health carrier, and the commissioner; and

(2) Include the information set forth in section 432E-A(p).

(k) Upon receipt of the notice of a decision reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(l) An expedited external review shall not be provided for retrospective adverse or final adverse determinations.

(m) The assignment by the commissioner of an approved independent review organization to conduct an external review in

accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 432E- D(d) .

§432E-__ External review of experimental or investigational treatment adverse determinations. (a) Within one hundred and thirty days after the date of receipt of a notice of adverse determination or final adverse determination pursuant to section 432E- A that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an enrollee or the enrollee's authorized representative, if applicable, may file a request for external review with the commissioner.

(b) An enrollee or the enrollee's authorized representative, if applicable, may make an oral request for an expedited external review of the adverse determination or final adverse determination if the enrollee's treating physician certifies, in writing, that the recommended or requested health

care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated. Upon receipt of a request for an expedited external review, the commissioner immediately shall notify the health carrier.

(c) Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the requirements of subsection (). The health carrier shall immediately notify the commissioner and the enrollee and, if applicable, the enrollee's authorized representative of its eligibility determination.

The commissioner may specify the form for the health carrier's notice of initial determination and any supporting information to be included in the notice.

(d) The notice of initial determination under subsection (c) shall include a statement informing the enrollee and, if applicable, the enrollee's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(e) The commissioner may determine that a request is eligible for external review under subsection (h) notwithstanding a health carrier's initial determination that

the request is ineligible and require that it be referred for external review. In making a determination that a request is eligible for external review, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this part.

(f) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subsection (c), the commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations complied and maintained by the commissioner and notify the health carrier of the name of the assigned independent review organization.

(g) At the time the health carrier receives the notice of the assigned independent review organization, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(h) Except for a request for an expedited external review made pursuant to subsection (b), within one business day after the date of receipt of the request, the commissioner shall notify the health carrier.

Within five business days following the date of receipt of the notice, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(1) The individual is or was an enrollee in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was an enrollee in the health benefit plan at the time the health care service or treatment was provided;

(2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(A) Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(B) Is not explicitly listed as an excluded benefit under the enrollee's health benefit plan with the health carrier;

(3) The enrollee's treating physician has certified that one of the following situations is applicable:

(A) Standard health care services or treatments have not been effective in improving the condition of the enrollee;

(B) Standard health care services or treatments are not medically appropriate for the covered person; or

(C) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in subparagraph (4) of this paragraph;

(4) The enrollee's treating physician:

(A) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than

any available standard health care services or treatments; or

(B) Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the enrollee's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the enrollee that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the enrollee than any available standard health care services or treatments;

(5) The enrollee has exhausted the health carrier's internal appeals process unless the enrollee is not required to exhaust the health carrier's internal appeals process pursuant to section 432E-5; and

(6) The enrollee has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under section 432E- A .

(i) Within one business day after completion of the preliminary review, the health carrier shall notify the commissioner and the enrollee and, if applicable, the enrollee's authorized representative in writing whether the request is:

(1) Complete; and

(2) Eligible for external review.

If the request is not complete, the health carrier shall inform in writing the commissioner and the enrollee and, if applicable, the enrollee's authorized representative and include in the notice what information or materials are needed to make the request complete.

If the request is not eligible for external review, the health carrier shall inform the enrollee, the enrollee's authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its ineligibility.

(j) The commissioner may specify the form for the health carrier's notice of initial determination under subsection (i)(2) and any supporting information to be included in the notice.

The notice of initial determination provided under subsection (i)(2) shall include a statement informing the

enrollee and, if applicable, the enrollee's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(k) The commissioner may determine that a request is eligible for external review under subsection (h) notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

In making a determination whether a request is eligible for external review, the commissioner's decision shall be made in accordance with the terms of the enrollee's health benefit plan and shall be subject to all applicable provisions of this part.

(l) Whenever a request for external review is determined eligible for external review, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative.

(m) Within one business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subsection (e) or subsection (l), the commissioner shall:

(1) Assign an independent review organization to conduct the external review from the list of approved independent review organizations complied and maintained by the commissioner and notify the health carrier of the name of the assigned independent review organization; and

(2) Notify in writing the enrollee and, if applicable, the enrollee's authorized representative of the request's eligibility and acceptance for external review.

The commissioner shall include in the notice provided to the enrollee and, if applicable, the enrollee's authorized representative a statement that the enrollee or the enrollee's authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subsection (m) additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

(n) Within one business day after the receipt of the notice of assignment to conduct the external review pursuant to

subsection (m), the assigned independent review organization shall:

(1) Select one or more clinical reviewers, as it determines is appropriate, pursuant to this subsection to conduct the external review; and

(2) Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

In selecting clinical reviewers, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in 432E- C and, through clinical experience in the past three years, are experts in the treatment of the enrollee's condition and knowledgeable about the recommended or requested health care service or treatment.

(o) Neither the enrollee, the enrollee's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(p) In accordance with subsection (y), each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process or internal appeals process.

(q) Within five business days after the date of receipt of the notice provided pursuant to subsection (m), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

Except as provided in subsection (r), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified shall not delay the conduct of the external review.

(r) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in subsection (q), the assigned independent review organization may terminate the

external review and make a decision to reverse the adverse determination or final adverse determination.

(s) Immediately upon making the decision under subsection (r), the independent review organization shall notify the enrollee, the enrollee's authorized representative, if applicable, the health carrier and the commissioner.

(t) Each clinical reviewer selected pursuant to subsection (m) shall review all of the information and documents received pursuant to subsection (q) and any other information submitted in writing by the enrollee or the enrollee's authorized representative pursuant to subsection (m).

(u) Upon receipt of any information submitted by the enrollee or the enrollee's authorized representative, within one business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

(v) Upon receipt of the information required to be forwarded, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(w) Immediately upon making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the enrollee, the enrollee's authorized representative, if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(x) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subsection (w).

(y) Except as provided in subsection (z), within twenty days after being selected to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection (aa) on

whether the recommended or requested health care service or treatment should be covered.

Except for an opinion provided pursuant to subsection (z), each clinical reviewer's opinion shall be in writing and include the following information:

(1) A description of the enrollee's medical condition;

(2) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(3) A description and analysis of any medical or scientific evidence, as that term is defined in section 432E- , considered in reaching the opinion;

(4) A description and analysis of any evidence-based standard, as that term is defined in section 432E- ; and

(5) Information on whether the reviewer's rationale for the opinion is based on subsection (aa)(5)(A) or (B).

(z) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five calendar days after being selected in accordance with subsection (m).

If the opinion provided was not in writing, within forty-eight hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under subsection (y).

(aa) In addition to the documents and information provided pursuant to subsection (b) or (q), each clinical reviewer selected, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection (y):

(1) The enrollee's pertinent medical records;

(2) The attending physician or health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, enrollee, the enrollee's authorized representative, or the enrollee's treating physician or health care professional;

(4) The terms of coverage under the enrollee's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the enrollee's health benefit plan with the health carrier; and

(5) Whether:

(A) The recommended health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

(B) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care

service or treatment is more likely than not to be beneficial to the enrollee than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(bb) Except as provided in subsection (cc), within twenty days after the date it receives the opinion of each clinical reviewer pursuant to subsection (aa), the assigned independent review organization, in accordance with subsection (dd), shall make a decision and provide written notice of the decision to the enrollee, if applicable, the enrollee's authorized representative, the health carrier, and the commissioner.

(cc) For an expedited external review, within forty-eight hours after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, in accordance with subsection (dd), shall make a decision and provide notice of the decision orally or in writing to the persons listed in subsection (bb).

If the notice provided was not in writing, within forty-eight hours after the date of providing that notice, the

assigned independent review organization shall provide written confirmation of the decision to the persons listed in subsection (bb) and include the information set forth in subsection (gg).

(dd) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(ee) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(ff) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers.

The additional clinical reviewer shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions.

The selection of the additional clinical reviewer shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected.

(gg) The independent review organization shall include in the notice provided pursuant to subsection (bb):

(1) A general description of the reason for the request for external review;

(2) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(3) The date the independent review organization was assigned by the commissioner to conduct the external reviewer;

(4) The date the external review was conducted;

(5) The date of its decision;

(6) The principal reason or reasons for its decision; and

(7) The rationale for its decision.

(hh) Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health

carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

(ii) The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns.

§432E-B Binding nature of external review decision. (a) An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

(b) An external review decision is binding on the enrollee except to the extent the covered person has other remedies available under applicable federal or State law.

(c) An enrollee or the enrollee's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse

determination for which the covered person has already received an external review decision pursuant to this part.

§432E-C Approval of independent review organizations. (a) The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this part.

(b) In order to be eligible for approval by the commissioner under this section to conduct external reviews under this part an independent review organization:

(1) Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under this part; and

(2) Shall submit an application for approval in accordance with subsection (d).

(c) The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(d) Any independent review organization wishing to be approved to conduct external reviews under this part shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under this part.

An independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations.

(e) The commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(f) The commissioner may charge an application fee that independent review organizations shall submit to the commissioner with an application for approval and re-approval.

(g) An approval is effective for two years, unless the commissioner determines before its expiration that the

independent review organization does not meet the minimum qualifications established under this part. Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this part that is maintained by the commissioner.

The commissioner shall maintain and periodically update a list of approved independent review organizations.

(h) The commissioner may adopt rules to carry out the provisions of this chapter.

§432E-D Minimum qualifications for independent review organizations. (a) To be approved under this part to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this part that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

(A) That external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) The selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(C) The confidentiality of medical and treatment records and clinical review criteria; and

(D) That any person employed by or under contract with the independent review organization adheres to the requirements of this part;

(2) A toll-free telephone service to receive information on a twenty-four-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(3) Agrees to maintain and provide to the commissioner the information required by this part.

(b) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or

regulatory body that raise a substantial question as to the clinical reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a), an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c), to be approved pursuant to this section to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(1) The health carrier that is the subject of the external review;

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(3) Any officer, director, or management employee of the health carrier that is the subject of the external review;

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review;

(5) The facility at which the recommended health care service or treatment would be provided; or

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest, the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a

clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in this part, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(e) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under this part.

The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a

review conducted by the NAIC for the purpose of the determination under this section.

Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

(f) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

§432E-E Hold harmless for independent review organizations. No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Act,

unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

§432E-F External review reporting requirements. (a) An independent review organization assigned pursuant to this part to conduct an external review shall maintain written records in the aggregate by State and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under subsection (b).

(b) Each independent review organization required to maintain written records on all requests for external review pursuant to subsection (a) for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner. The report shall include in the aggregate by state, and for each health carrier:

(1) The total number of requests for external review;

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(3) The average length of time for resolution;

(4) The summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(5) The number of external reviews pursuant to section this Act that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(6) Any other information the commissioner may request or require.

The independent review organization shall retain the written records required pursuant to this subsection for at least three years.

(c) Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the commissioner pursuant to this part.

Each health carrier required to maintain written records on all requests for external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

The report shall include in the aggregate, by state, and by type of health benefit plan:

(1) The total number of requests for external review;

(2) From the total number of requests for external review reported, the number of requests determined eligible for a full external review; and

(3) Any other information the commissioner may request or require.

The health carrier shall retain the written records required pursuant to this subsection for at least three years.

§432E-G Funding of external review. The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review. There shall be no recourse against the commissioner for the cost of conducting the external review and the selection of an independent review organization shall not be subject to chapter 103D.

§432E-H Disclosure requirements. (a) Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

The disclosure shall be in a format prescribed by the commissioner.

(b) The description required under subsection (a) shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the telephone number and address of the commissioner.

(c) In addition to the requirements of subsection (b), the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the

covered person that may be required to be reviewed for the purpose of reaching a decision on the external review."

SECTION 2. Chapter 432E, Hawaii Revised Statutes, is amended by designating sections 432E-1 to 432E-2 as part I, entitled "General Provisions".

SECTION 3. Chapter 432E, Hawaii Revised Statutes, is amended by designating sections 432E-3 to 432E-8 as part II, entitled "General Policies".

SECTION 4. Chapter 432E, Hawaii Revised Statutes, is amended by designating sections 432E-9 to 432E-13 as part III, entitled "Reporting and Other Provisions".

SECTION 5. Section 432E-1, Hawaii Revised Statutes, is amended to read as follows:

"**§432E-1 Definitions.** As used in this chapter, unless the context otherwise requires:

"Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the

requested service or payment for the service is therefore denied, reduced, or terminated.

"Ambulatory review" means a utilization review of health care services performed or provided in an outpatient setting.

"Appeal" means a request from an enrollee to change a previous decision made by the [~~managed care plan.~~] health carrier.

"Appointed representative" or "authorized representative" means a person who is expressly permitted by the enrollee or who has the power under Hawaii law to make health care decisions on behalf of the enrollee, including:

(1) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) A person authorized by law to provide substituted consent for a covered person;

(3) A family member of the covered person or the covered person's treating health care professional, only when the covered person is unable to provide consent;

[~~(1)~~] (4) A court-appointed legal guardian;

[~~(2)~~] (5) A person who has a durable power of attorney for health care; or

[~~(3)~~] (6) A person who is designated in a written advance directive.

"Best evidence" means evidence based on:

(1) Randomized clinical trials;

(2) If randomized clinical trials are not available, cohort studies or case-control studies;

(3) If the trials in paragraphs (1) and (2) are not available, case-series; or

(4) If the sources of information in paragraphs (1), (2), and (3) are not available, expert opinion.

"Case-control study" means a prospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

"Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

"Case-series" means an evaluation of a patients with a particular outcome, without the use of a control group.

"Certification" means a determination by a health carrier or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information

provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

"Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

"Commissioner" means the insurance commissioner.

"Complaint" means an expression of dissatisfaction, either oral or written.

"Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in health benefit plan.

"Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

"Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

"Emergency services" means services provided to an enrollee when the enrollee has symptoms of sufficient severity that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the enrollee's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death.

"Enrollee" means a person who enters into a contractual relationship or who is provided with health care services or benefits through a [~~managed care plan.~~] health carrier.

[~~"Expedited appeal" means the internal review of a complaint or an external review of the final internal determination of an enrollee's complaint, which is completed~~

~~within seventy-two hours after receipt of the request for expedited appeal.~~]

[~~"External review" means an administrative review requested by an enrollee under section 432E-6 of a managed care plan's final internal determination of an enrollee's complaint.~~]

"Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

"Expert opinion" means a belief or interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

"Facility" means an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health

carrier or its designated utilization review organization at the completion of the health carrier's internal grievance process procedures.

"Health care [~~provider"~~] professional" means an individual licensed, accredited, or certified to provide or perform specified health care services in the ordinary course of business or practice of a profession[~~.~~] consistent with state law.

"Health care provider" or "provider" means a health care professional or a facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health maintenance organization" means a health maintenance organization as defined in section 432D-1.

"Independent review organization" means an independent entity [~~that:~~

~~(1) Is unbiased and able to make independent decisions;~~

~~(2) Engages adequate numbers of practitioners with the appropriate level and type of clinical knowledge and expertise;~~

~~(3) Applies evidence-based decisionmaking;~~

~~(4) Demonstrates an effective process to screen external reviews for eligibility;~~

~~(5) Protects the enrollee's identity from unnecessary disclosure; and~~

~~(6) Has effective systems in place to conduct a review.~~] that conducts independent external reviews of adverse determinations and final adverse determinations.

"Internal review" means the review under section 432E-5 of an enrollee's complaint by a [~~managed care plan~~] health carrier.

[~~"Managed care plan"~~] "Health benefit plan" or "health carrier" means any [~~plan,~~] policy, contract, certificate, or agreement, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and any other mixed model, that provides for the financing or delivery of health care services or benefits to enrollees through:

(1) Arrangements with selected providers or provider networks to furnish health care services or benefits; and

(2) Financial incentives for enrollees to use participating providers and procedures provided by a plan;

provided, that for the purposes of this chapter, an employee benefit plan shall not be deemed a [~~managed care plan~~] health carrier with respect to any provision of this chapter or to any requirement or rule imposed or permitted by this chapter which is superseded or preempted by federal law.

"Medical director" means the person who is authorized under a [~~managed care plan~~] health carrier and who makes decisions for the [~~plan~~] health carrier denying or allowing payment for medical treatments, services, or supplies based on medical necessity or other appropriate medical or health plan benefit standards.

"Medical necessity" means a health intervention as defined in section 432E-1.4.

"Medical or scientific evidence" means evidence found in the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts, who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) Medical journals recognized by the United States Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) The following standard reference compendia:

(i) The American Hospital Formulary Service-Drug Information;

(ii) Drug Facts and Comparisons;

(iii) The American Dental Association Accepted Dental Therapeutics; and

(iv) The United States Pharmacopoeia-Drug Information;

(5) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(i) The federal Agency for Healthcare Research and Quality;

(ii) The National Institutes of Health;

(iii) The National Cancer Institute;

(iv) The National Academy of Sciences;

(v) The Centers for Medicare & Medicaid Services;

(vi) The federal Food and Drug Administration; and

(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (1) through (5).

"NAIC" means the National Association of Insurance Commissioners.

"Participating provider" means a licensed or certified provider of health care services or benefits, including mental health services and health care supplies, that has entered into an agreement with a [~~managed care plan~~] health carrier to provide those services or supplies to enrollees.

"Prospective review" means utilization review conducted prior to an admission or a course of treatment.

"Protected health information" means health information as defined in section 431:3A-102.

"Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

"Retrospective review" means a review of medical necessity conducted after services that have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

"Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

"Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

"Utilization review organization" means an entity that conducts utilization review other than a health carrier performing a review for its own health benefit plans."

SECTION 6. Section 432E-5, Hawaii Revised Statutes, is amended to read as follows:

"**§432E-5 Complaints and appeals procedure for enrollees.** (a) A [~~managed care plan~~] health carrier with enrollees in this State shall establish and maintain a procedure to provide for the resolution of an enrollee's complaints and appeals. The procedure shall provide for expedited appeals under section 432E-

6.5. The definition of medical necessity in section 432E-1.4 shall apply in a [~~managed care plan's~~] health carrier's complaints and appeals procedures.

(b) The [~~managed care plan~~] health carrier shall at all times make available its complaints and appeals procedures. The complaints and appeals procedures shall be reasonably understandable to the average layperson and shall be provided in a language other than English upon request.

(c) A [~~managed care plan~~] health carrier shall decide any expedited appeals as soon as possible after receipt of the complaint, taking into account the medical exigencies of the case, but not later than seventy-two hours after receipt of the request for expedited appeal.

(d) A [~~managed care plan~~] health carrier shall send notice of its final internal determination within sixty days of the submission of the complaint to the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the commissioner. The notice shall include the following information regarding the enrollee's rights and procedures:

(1) The enrollee's right to request an external review;

(2) The [~~sixty-day~~] one-hundred-thirty-day deadline for requesting an external review;

(3) Instructions on how to request an external review; and

(4) Where to submit the request for an external review.

In addition to these general requirements, the notice shall conform to the requirements of section 432E- ."

SECTION 7. Section 432E-6.5, Hawaii Revised Statutes, is amended by amending the title to read as follows:

"**§432E-6.5 Expedited internal appeal, when authorized; standard for decision.**"

SECTION 8. Section 432E-6.5, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) An enrollee may request that the [~~following~~] internal review under section 432E-5 be conducted as an expedited [~~appeal:~~] appeal."

[~~(1) The internal review under section 432E-5 of the enrollee's complaint; or~~

~~(2) The external review under section 432E-6 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,~~] plan, the appropriate

review shall be completed within seventy-two hours of receipt of the request for expedited appeal."

SECTION 9. 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 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.~~"]

SECTION 10. If any provision of this Act, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 11. In codifying the new sections added by section 1 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating the new sections in this Act.

SECTION 12. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 13. This Act shall take effect on January 1, 2012.

INTRODUCED BY: _____

BY REQUEST

JAN 24 2011

H. B. 1047

Report Title:
Insurance; Health; External Review Procedure

Description:
Provides uniform standards for external review procedures based on NAIC Uniform Health Carrier External Review Model Act, in order to comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010.

H. B. 1047

JUSTIFICATION SHEET

DEPARTMENT: Commerce and Consumer Affairs

TITLE: A BILL FOR AN ACT RELATING TO HEALTH INSURANCE

PURPOSE: To comply with the requirements of the Patient Protection and Affordable Care Act of 2010 by updating the Patients' Bill of Rights and Responsibilities Act, chapter 432E, Hawaii Revised Statutes (HRS). The bill provides uniform standards for external review procedures based on the NAIC Uniform Health Carrier External Review Model Act. Specifically, the bill ensures that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination by:

(1) Adding a new part to HRS chapter 432E regarding external review of health insurance determinations

(2) Updating the definitions in HRS 432E-1;

(3) Amending the internal complaints and appeals procedures for enrollees contained in HRS 432E-5;

(4) Amending the expedited appeal process contained in HRS 432E-6.5; and

(5) Repealing HRS 432E-6 regarding external review procedures;

MEANS: Add a new part to chapter 432E, amend sections 432E-1, 432E-5, 432E-6.5; and repeal section 432E-6, HRS.

JUSTIFICATION: This bill addresses the external review procedure requirements of the Patient Protection and Affordable Care Act of 2010.

and is based on the NAIC Uniform Health Carrier External Review Model Act. Also, only non-ERISA health plans are subject to the jurisdiction of the commissioner. This bill will provide a uniform and consistent external review procedure.

Impact on the public: This bill will make the insurance statutes governing the external review of adverse determinations by health plans consistent and available to enrollees.

Impact on the department and other agencies: These amendments will reduce confusion and inefficiencies in implementing Hawaii law.

GENERAL FUND: None.

OTHER FUNDS: None.

PPBS PROGRAM DESIGNATION: CCA-106.

OTHER AFFECTED AGENCIES: None.

EFFECTIVE DATE: January 1, 2012.