
A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

1 SECTION 1. The legislature finds that the purpose of this
2 Act is to comply with the requirements of the Patient Protection
3 and Affordable Care Act of 2010, Public Law No. 111-148, and its
4 implementing regulations by updating Hawaii's Patients' Bill of
5 Rights and Responsibilities Act, chapter 432E, Hawaii Revised
6 Statutes, to conform to the requirements of the federal law.

7 SECTION 2. Chapter 432E, Hawaii Revised Statutes, is
8 amended by adding a new part to be appropriately designated and
9 to read as follows:

10 "PART . **EXTERNAL REVIEW OF HEALTH**

11 **INSURANCE DETERMINATIONS**

12 **§432E-A Applicability and scope.** (a) Except as provided
13 in subsection (b), this part shall apply to all health carriers.

14 (b) This part shall not apply to a policy or certificate
15 that provides coverage only for a specified disease, specified
16 accident or accident-only coverage, credit, dental, disability
17 income, hospital indemnity, long-term care insurance, vision
18 care, or any other limited supplemental benefit; to a medicare



1 supplemental policy of insurance, coverage under a plan through
2 medicare, medicaid, or the federal employees health benefits
3 program, any federal medical and dental care coverage issued
4 under chapter 55 of Title 10 United States Code and any coverage
5 issued as supplemental to that coverage; any coverage issued as
6 supplemental to liability insurance, workers' compensation, or
7 similar insurance; automobile medical-payment insurance; any
8 insurance under which benefits are payable with or without
9 regard to fault, whether written on a group blanket or
10 individual basis; or the employer union health benefits trust
11 fund so long as it is self-funded.

12 **§432E-B Notice of right to external review.** Notice of the
13 right to external review issued pursuant to this part shall set
14 forth the options available to the enrollee under this part.
15 The commissioner may specify the form and content of notice of
16 external review.

17 **§432E-C Request for external review.** (a) All requests
18 for external review of a health carrier's adverse action shall
19 be made in writing to the commissioner and shall include:

20 (1) A copy of the final internal determination of the
21 health carrier, unless exempted pursuant to subsection
22 (b);



1 (2) A signed authorization by or on behalf of the enrollee
2 for release of the enrollee's medical records relevant
3 to the external review;

4 (3) A disclosure for conflict of interests evaluation, as
5 provided in section 432E-M; and

6 (4) A filing fee of \$, which shall be refunded if the
7 adverse determination or final internal adverse
8 determination is reversed through external review.

9 The commissioner shall waive the filing fee required by this
10 subsection if the commissioner determines that payment of the
11 fee would impose an undue financial hardship to the enrollee.

12 The annual aggregate limit on filing fees for any enrollee
13 within a single plan year shall not exceed \$.

14 (b) The internal appeals process of a health carrier shall
15 be completed before an external review request shall be
16 submitted to the commissioner except in the following
17 circumstances:

18 (1) The health carrier has waived the requirement of
19 exhaustion of the internal appeals process;

20 (2) The enrollee has applied for an expedited external
21 review at the same time that the enrollee applied for
22 an expedited internal appeal; provided that the



1 enrollee is eligible for an expedited external review;
2 or

3 (3) The health carrier has substantially failed to comply
4 with its internal appeals process.

5 §432E-D Standard external review. (a) An enrollee or the
6 enrollee's appointed representative may file a request for an
7 external review with the commissioner within one hundred thirty
8 days of receipt of notice of an adverse action. Within three
9 business days after the receipt of a request for external review
10 pursuant to this section, the commissioner shall send a copy of
11 the request to the health carrier.

12 (b) Within five business days following the date of
13 receipt of the copy of the external review request from the
14 commissioner pursuant to subsection (a), the health carrier
15 shall determine whether:

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

21 (2) The health care service that is the subject of the
22 adverse determination or the final adverse



1 determination would be a covered service under the
2 enrollee's health benefit plan but for a determination
3 by the health carrier that the health care service
4 does not meet the health carrier's requirements for
5 medical necessity, appropriateness, health care
6 setting, level of care, or effectiveness;

7 (3) The enrollee has exhausted the health carrier's
8 internal appeals process or the enrollee is not
9 required to exhaust the health carrier's internal
10 appeals process pursuant to section 432E-C(b); and

11 (4) The enrollee has provided all the information and
12 forms required to process an external review,
13 including a completed release form and disclosure form
14 as required by section 432E-C(a).

15 (c) Within three business days after a determination of an
16 enrollee's eligibility for external review pursuant to
17 subsection (b), the health carrier shall notify the
18 commissioner, the enrollee, and the enrollee's appointed
19 representative in writing as to whether the request is complete
20 and whether the enrollee is eligible for external review.

21 If the request for external review submitted pursuant to
22 this section is not complete, the health carrier shall inform



1 the commissioner, the enrollee, and the enrollee's appointed
2 representative in writing that the request is incomplete and
3 shall specify the information or materials required to complete
4 the request.

5 If the enrollee is not eligible for external review
6 pursuant to subsection (b), the health carrier shall inform the
7 commissioner, the enrollee, and the enrollee's appointed
8 representative in writing that the enrollee is not eligible for
9 external review and the reasons for ineligibility.

10 Notice of ineligibility for external review pursuant to
11 this section shall include a statement informing the enrollee
12 and the enrollee's appointed representative that a health
13 carrier's initial determination that the external review request
14 is ineligible for review may be appealed to the commissioner by
15 submission of a request to the commissioner.

16 (d) Upon receipt of a request for appeal pursuant to
17 subsection (c), the commissioner shall review the request for
18 external review submitted by the enrollee pursuant to subsection
19 (a), determine whether an enrollee is eligible for external
20 review and, if eligible, shall refer the enrollee to external
21 review. The commissioner's determination of eligibility for
22 external review shall be made in accordance with the terms of



1 the enrollee's health benefit plan and all applicable provisions
2 of this part. If an enrollee is not eligible for external
3 review, the commissioner shall notify the enrollee, the
4 enrollee's appointed representative, and the health carrier
5 within three business days of the reason for ineligibility.

6 (e) When the commissioner receives notice pursuant to
7 subsection (c) or makes a determination pursuant to subsection
8 (d) that an enrollee is eligible for external review, within
9 three business days after receipt of the notice or determination
10 of eligibility, the commissioner shall:

11 (1) Randomly assign an independent review organization
12 from the list of approved independent review
13 organizations qualified to conduct the external
14 review, based on the nature of the health care service
15 that is the subject of the adverse action and other
16 factors determined by the commissioner including
17 conflicts of interest pursuant to section 432E-M,
18 compiled and maintained by the commissioner to conduct
19 the external review and notify the health carrier of
20 the name of the assigned independent review
21 organization; and



1 (2) Notify the enrollee and the enrollee's appointed
2 representative, in writing, of the enrollee's
3 eligibility and acceptance for external review.

4 (f) An enrollee or an enrollee's appointed representative
5 may submit additional information in writing to the assigned
6 independent review organization for consideration in its
7 external review. The independent review organization shall
8 consider information submitted within five business days
9 following the date of the enrollee's receipt of the notice
10 provided pursuant to subsection (e). The independent review
11 organization may accept and consider additional information
12 submitted by an enrollee or an enrollee's appointed
13 representative after five business days.

14 (g) Within five business days after the date of receipt of
15 notice pursuant to subsection (e), the health carrier or its
16 designated utilization review organization shall provide to the
17 assigned independent review organization all documents and
18 information it considered in issuing the adverse action that is
19 the subject of external review. Failure by the health carrier
20 or its utilization review organization to provide the documents
21 and information within five business days shall not delay the
22 conduct of the external review; provided that the assigned



1 independent review organization may terminate the external
2 review and reverse the adverse action that is the subject of the
3 external review. The independent review organization shall
4 notify the enrollee, the enrollee's appointed representative,
5 the health carrier, and the commissioner within three business
6 days of the termination of an external review and reversal of an
7 adverse action pursuant to this subsection.

8 (h) The assigned independent review organization shall,
9 within one business day of receipt by the independent review
10 organization, forward all information received from the enrollee
11 pursuant to subsection (f) to the health carrier. Upon receipt
12 of information forwarded to it pursuant to this subsection, a
13 health carrier may reconsider the adverse action that is the
14 subject of the external review; provided that reconsideration by
15 the health carrier shall not delay or terminate an external
16 review unless the health carrier reverses its adverse action and
17 provides coverage or payment for the health care service that is
18 the subject of the adverse action. The health carrier shall
19 notify the enrollee, the enrollee's appointed representative,
20 the assigned independent review organization, and the
21 commissioner in writing of its decision to reverse its adverse
22 action within three business days of making its decision to



1 reverse the adverse action and provide coverage. The assigned
2 independent review organization shall terminate its external
3 review upon receipt of notice pursuant to this subsection from
4 the health carrier.

5 (i) In addition to the documents and information provided
6 pursuant to subsections (f) and (g), the assigned independent
7 review organization shall consider the following in reaching a
8 decision:

- 9 (1) The enrollee's medical records;
- 10 (2) The attending health care professional's
11 recommendation;
- 12 (3) Consulting reports from appropriate health care
13 professionals and other documents submitted by the
14 health carrier, enrollee, enrollee's appointed
15 representatives, or enrollee's treating provider;
- 16 (4) The application of medical necessity as defined in
17 section 432E-1;
- 18 (5) The most appropriate practice guidelines, which shall
19 include applicable evidence-based standards and may
20 include any practice guidelines developed by the
21 federal government or national or professional medical
22 societies, boards, and associations;



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

4 (7) The opinion of the independent review organization's
5 clinical reviewer or reviewers pertaining to the
6 information enumerated in paragraphs (1) through (5)
7 to the extent the information or documents are
8 available and the clinical reviewer or reviewers
9 consider appropriate.

10 In reaching a decision, the assigned independent review
11 organization shall not be bound by any decisions or conclusions
12 reached during the health carrier's utilization review or
13 internal appeals process; provided that the independent review
14 organization's decision shall not contradict the terms of the
15 enrollee's health benefit plan or this part.

16 (j) Within forty-five days after it receives a request for
17 an external review pursuant to subsection (e), the assigned
18 independent review organization shall notify the enrollee, the
19 enrollee's appointed representative, the health carrier, and the
20 commissioner of its decision to uphold or reverse the adverse
21 action that is the subject of the internal review. The



1 independent review organization shall include in the notice of
2 its decision:

- 3 (1) A general description of the reason for the request
4 for external review;
- 5 (2) The date the independent review organization received
6 the assignment from the commissioner to conduct the
7 external review;
- 8 (3) The date the external review was conducted;
- 9 (4) The date the decision was issued; and
- 10 (5) The basis for the independent review organization's
11 decision, including its reasoning, rationale, and the
12 supporting evidence or documentation, including
13 evidence-based standards, that the independent review
14 organization considered in reaching its decision.

15 Upon receipt of a notice of a decision reversing the
16 adverse action, the health carrier shall immediately approve the
17 coverage that was the subject of the adverse action.

18 **§432E-E Expedited external review.** (a) Except as
19 provided in subsection (i), an enrollee or the enrollee's
20 appointed representative may request an expedited external
21 review with the commissioner if the enrollee receives:



- 1 (1) An adverse determination that involves a medical
2 condition of the enrollee for which the timeframe for
3 completion of an expedited internal appeal would
4 seriously jeopardize the enrollee's life, health, or
5 ability to gain maximum functioning or would subject
6 the enrollee to severe pain that cannot be adequately
7 managed without the care or treatment that is the
8 subject of the adverse determination;
- 9 (2) A final adverse determination if the enrollee has a
10 medical condition where the timeframe for completion
11 of a standard external review would seriously
12 jeopardize the enrollee's ability to gain maximum
13 functioning, or would subject the enrollee to severe
14 pain that cannot be adequately managed without the
15 care or treatment that is the subject of the adverse
16 determination; or
- 17 (3) A final adverse determination if the final adverse
18 determination concerns an admission, availability of
19 care, continued stay, or health care service for which
20 the enrollee received emergency services; provided
21 that the enrollee has not been discharged from a



1 facility for health care services related to the
2 emergency services.

3 (b) Upon receipt of a request for an expedited external
4 review, the commissioner shall immediately send a copy of the
5 request to the health carrier. Immediately upon receipt of the
6 request, the health carrier shall determine whether the request
7 meets the reviewability requirements set forth in subsection
8 (a). The health carrier shall immediately notify the enrollee
9 or the enrollee's appointed representative of its determination
10 of the enrollee's eligibility for expedited external review.

11 Notice of ineligibility for expedited external review shall
12 include a statement informing the enrollee and the enrollee's
13 appointed representative that a health carrier's initial
14 determination that an external review request that is ineligible
15 for review may be appealed to the commissioner by submission of
16 a request to the commissioner.

17 (c) Upon receipt of a request for appeal pursuant to
18 subsection (b), the commissioner shall review the request for
19 expedited external review submitted pursuant to subsection (a)
20 and, if eligible, shall refer the enrollee for external review.
21 The commissioner's determination of eligibility for expedited
22 external review shall be made in accordance with the terms of



1 the enrollee's health benefit plan and all applicable provisions
2 of this part. If an enrollee is not eligible for expedited
3 external review, the commissioner shall immediately notify the
4 enrollee, the enrollee's appointed representative, and the
5 health carrier of the reasons for ineligibility.

6 (d) If the commissioner determines that an enrollee is
7 eligible for expedited external review even though the enrollee
8 has not exhausted the health carrier's internal review process,
9 the health carrier shall not be required to proceed with its
10 internal review process. The health carrier may elect to
11 proceed with its internal review process even though the request
12 is determined by the commissioner to be eligible for expedited
13 external review; provided that the internal review process shall
14 not delay or terminate an expedited external review unless the
15 health carrier decides to reverse its adverse determination and
16 provide coverage or payment for the health care service that is
17 the subject of the adverse determination. Immediately after
18 making a decision to reverse its adverse determination, the
19 health carrier shall notify the enrollee, the enrollee's
20 authorized representative, the independent review organization
21 assigned pursuant to subsection (c), and the commissioner in the
22 writing of its decision. The assigned independent review



1 organization shall terminate the expedited external review upon
2 receipt of notice from the health carrier pursuant to this
3 subsection.

4 (e) Upon receipt of the notice pursuant to subsection (a)
5 or a determination of the commissioner pursuant to subsection
6 (c) that the enrollee meets the eligibility requirements for
7 expedited external review, the commissioner shall immediately
8 randomly assign an independent review organization to conduct
9 the expedited external review from the list of approved
10 independent review organizations qualified to conduct the
11 external review, based on the nature of the health care service
12 that is the subject of the adverse action and other factors
13 determined by the commissioner including conflicts of interest
14 pursuant to section 432E-M, compiled and maintained by the
15 commissioner to conduct the external review and immediately
16 notify the health carrier of the name of the assigned
17 independent review organization.

18 (f) Upon receipt of the notice from the commissioner of
19 the name of the independent review organization assigned to
20 conduct the expedited external review, the health carrier or its
21 designee utilization review organization shall provide or
22 transmit all documents and information it considered in making



1 the adverse action that is the subject of the expedited external
2 review to the assigned independent review organization
3 electronically or by telephone, facsimile, or any other
4 available expeditious method.

5 (g) In addition to the documents and information provided
6 or transmitted pursuant to subsection (f), the assigned
7 independent review organization shall consider the following in
8 reaching a decision:

- 9 (1) The enrollee's pertinent medical records;
- 10 (2) The attending health care professional's
11 recommendation;
- 12 (3) Consulting reports from appropriate health care
13 professionals and other documents submitted by the
14 health carrier, enrollee, the enrollee's appointed
15 representative, or the enrollee's treating provider;
- 16 (4) The application of medical necessity criteria as
17 defined in section 432E-1;
- 18 (5) The most appropriate practice guidelines, which shall
19 include evidence-based standards, and may include any
20 other practice guidelines developed by the federal
21 government, national or professional medical
22 societies, boards, and associations;



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

5 (7) The opinion of the independent review organization's
6 clinical reviewer or reviewers pertaining to the
7 information enumerated in paragraphs (1) through (5)
8 to the extent the information and documents are
9 available and the clinical reviewer or reviewers
10 consider appropriate.

11 In reaching a decision, the assigned independent review
12 organization shall not be bound by any decisions or conclusions
13 reached during the health carrier's utilization review or
14 internal appeals process; provided that the independent review
15 organization's decision shall not contradict the terms of the
16 enrollee's health benefit plan or this part.

17 (h) As expeditiously as the enrollee's medical condition
18 or circumstances requires, but in no event more than seventy-two
19 hours after the date of receipt of the request for an expedited
20 external review that meets the reviewability requirements set
21 forth in subsection (a), the assigned independent review
22 organization shall:



1 (1) Make a decision to uphold or reverse the adverse
2 action; and

3 (2) Notify the enrollee, the enrollee's appointed
4 representative, the health carrier, and the
5 commissioner of the decision.

6 If the notice provided pursuant to this subsection was not
7 in writing, within forty-eight hours after the date of providing
8 that notice, the assigned independent review organization shall
9 provide written confirmation of the decision to the enrollee,
10 the enrollee's appointed representative, the health carrier, and
11 the commissioner that includes the information provided in
12 section 432E-G.

13 Upon receipt of the notice of a decision reversing the
14 adverse action, the health carrier shall immediately approve the
15 coverage that was the subject of the adverse action.

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

18 **§432E-F External review of experimental or investigational**
19 **treatment adverse determinations.** (a) An enrollee or an
20 enrollee's appointed representative may file a request for an
21 external review with the commissioner within one hundred thirty
22 days of receipt of notice of an adverse action that involves a



1 denial of coverage based on a determination that the health care
2 service or treatment recommended or requested is experimental or
3 investigational.

4 (b) An enrollee or the enrollee's appointed representative
5 may make an oral request for an expedited external review of the
6 adverse action if the enrollee's treating physician certifies,
7 in writing, that the health care service or treatment that is
8 the subject of the request would be significantly less effective
9 if not promptly initiated. A written request for an expedited
10 external review pursuant to this subsection shall include, and
11 oral request shall be promptly followed by, a certification
12 signed by the enrollee's treating physician and the
13 authorization for release and disclosures required by section
14 432E-C. Upon receipt of all items required by this subsection,
15 the commissioner shall immediately notify the health carrier.

16 (c) Upon notice of the request for expedited external
17 review, the health carrier shall immediately determine whether
18 the request meets the requirements of subsection (b). The
19 health carrier shall immediately notify the commissioner, the
20 enrollee, and the enrollee's appointed representative of its
21 eligibility determination.



1 Notice of eligibility for expedited external review
2 pursuant to this subsection shall include a statement informing
3 the enrollee and, if applicable, the enrollee's appointed
4 representative that a health carrier's initial determination
5 that the external review request is ineligible for review may be
6 appealed to the commissioner.

7 (d) Upon receipt of a request for appeal pursuant to
8 subsection (c), the commissioner shall review the request for
9 external review submitted by the enrollee pursuant to subsection
10 (a), determine whether an enrollee is eligible for external
11 review and, if eligible, shall refer the enrollee to external
12 review. The commissioner's determination of eligibility for
13 external review shall be made in accordance with the terms of
14 the enrollee's health benefit plan and all applicable provisions
15 of this part. If an enrollee is not eligible for external
16 review, the commissioner shall notify the enrollee, the
17 enrollee's appointed representative, and the health carrier of
18 the reason for ineligibility within three business days.

19 (e) Upon receipt of the notice pursuant to subsection (a)
20 or a determination of the commissioner pursuant to subsection
21 (d) that the enrollee meets the eligibility requirements for
22 expedited external review, the commissioner shall immediately



1 randomly assign an independent review organization to conduct
2 the expedited external review from the list of approved
3 independent review organizations qualified to conduct the
4 external review, based on the nature of the health care service
5 that is the subject of the adverse action and other factors
6 determined by the commissioner including conflicts of interest
7 pursuant to section 432E-M, compiled and maintained by the
8 commissioner to conduct the external review and immediately
9 notify the health carrier of the name of the assigned
10 independent review organization.

11 (f) Upon receipt of the notice from the commissioner of
12 the name of the independent review organization assigned to
13 conduct the expedited external review, the health carrier or its
14 designee utilization review organization shall provide or
15 transmit all documents and information it considered in making
16 the adverse action that is the subject of the expedited external
17 review to the assigned independent review organization
18 electronically or by telephone, facsimile, or any other
19 available expeditious method.

20 (g) Except for a request for an expedited external review
21 made pursuant to subsection (b), within three business days
22 after the date of receipt of the request, the commissioner shall



1 notify the health carrier that the enrollee has requested an
2 expedited external review pursuant to this section. Within five
3 business days following the date of receipt of notice, the
4 health carrier shall determine whether:

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

11 (2) The recommended or requested health care service or
12 treatment that is the subject of the adverse action:

13 (A) Would be a covered benefit under the enrollee's
14 health benefit plan but for the health carrier's
15 determination that the service or treatment is
16 experimental or investigational for the
17 enrollee's particular medical condition; and

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

20 (3) The enrollee's treating physician has certified in
21 writing that:



- 1 (A) Standard health care services or treatments have
2 not been effective in improving the condition of
3 the enrollee;
- 4 (B) Standard health care services or treatments are
5 not medically appropriate for the enrollee; or
- 6 (C) There is no available standard health care
7 service or treatment covered by the health
8 carrier that is more beneficial than the health
9 care service or treatment that is the subject of
10 the adverse action;
- 11 (4) The enrollee's treating physician:
- 12 (A) Has recommended a health care service or
13 treatment that the physician certifies, in
14 writing, is likely to be more beneficial to the
15 enrollee, in the physician's opinion, than any
16 available standard health care services or
17 treatments; or
- 18 (B) Who is a licensed, board certified or board
19 eligible physician qualified to practice in the
20 area of medicine appropriate to treat the
21 enrollee's condition, has certified in writing
22 that scientifically valid studies using accepted



1 protocols demonstrate that the health care
2 service or treatment that is the subject of the
3 adverse action is likely to be more beneficial to
4 the enrollee than any available standard health
5 care services or treatments;

6 (5) The enrollee has exhausted the health carrier's
7 internal appeals process or the enrollee is not
8 required to exhaust the health carrier's internal
9 appeals process pursuant to section 432E-C(b); and

10 (6) The enrollee has provided all the information and
11 forms required by the commissioner that are necessary
12 to process an external review, including the release
13 form and disclosure of conflict of interest
14 information as provided under section 432E-5.

15 (h) Within three business days after determining the
16 enrollee's eligibility for external review pursuant to
17 subsection (g), the health carrier shall notify the
18 commissioner, the enrollee, and the enrollee's appointed
19 representative in writing as to whether the request is complete
20 and eligible for external review.

21 If the request is not complete, the health carrier shall
22 inform the commissioner, the enrollee, and the enrollee's



1 appointed representative in writing of the information or
2 materials needed to complete the request.

3 If the enrollee is not eligible for external review
4 pursuant to subsection (g), the health carrier shall inform the
5 commissioner, the enrollee, and the enrollee's appointed
6 representative in writing of the ineligibility and the reasons
7 for ineligibility.

8 Notice of ineligibility pursuant to this subsection shall
9 include a statement informing the enrollee and the enrollee's
10 appointed representative that a health carrier's initial
11 determination that the external review request is ineligible for
12 review may be appealed to the commissioner by submitting a
13 request to the commissioner.

14 If a request for external review is determined eligible for
15 external review, the health carrier shall notify the
16 commissioner and the enrollee and, if applicable, the enrollee's
17 appointed representative.

18 (i) Upon receipt of a request for appeal pursuant to
19 subsection (h), the commissioner shall review the request for
20 external review submitted pursuant to subsection (a) and, if
21 eligible, shall refer the enrollee for external review. The
22 commissioner's determination of eligibility for expedited



1 external review shall be made in accordance with the terms of
2 the enrollee's health benefit plan and all applicable provisions
3 of this part. If an enrollee is not eligible for external
4 review, the commissioner shall notify the enrollee, the
5 enrollee's appointed representative, and the health carrier of
6 the reasons for ineligibility within three business days.

7 (j) When the commissioner receives notice pursuant to
8 subsection (h) or makes a determination pursuant to subsection
9 (i) that an enrollee is eligible for external review, within
10 three business days after receipt of the notice or determination
11 of eligibility, the commissioner shall:

12 (1) Randomly assign an independent review organization
13 from the list of approved independent review
14 organizations qualified to conduct the external
15 review, based on the nature of the health care service
16 that is the subject of the adverse action and other
17 factors determined by the commissioner including
18 conflicts of interest pursuant to section 432E-M,
19 compiled and maintained by the commissioner pursuant
20 to conduct the external review and notify the health
21 carrier of the name of the assigned independent review
22 organization; and



1 (2) Notify the enrollee and the enrollee's appointed
2 representative, in writing, of the enrollee's
3 eligibility and acceptance for external review.

4 (k) An enrollee or an enrollee's appointed representative
5 may submit additional information in writing to the assigned
6 independent review organization for consideration in its
7 external review. The independent review organization shall
8 consider information submitted within five business days
9 following the date of the enrollee's receipt of the notice
10 provided pursuant to subsection (j). The independent review
11 organization may accept and consider additional information
12 submitted by an enrollee after five business days.

13 (1) Within five business days after the date of receipt of
14 notice pursuant to subsection (j), the health carrier or its
15 designated utilization review organization shall provide to the
16 assigned independent review organization all documents and
17 information it considered in issuing the adverse action that is
18 the subject of external review. Failure by the health carrier
19 or its utilization review organization to provide the documents
20 and information within five business days shall not delay the
21 conduct of the external review; provided that the assigned
22 independent review organization may terminate the external



1 review and reverse the adverse action that is the subject of the
2 external review. The independent review organization shall
3 notify the enrollee, the enrollee's appointed representative,
4 the health carrier, and the commissioner within three business
5 days of the termination of an external review and reversal of an
6 adverse action pursuant to this subsection.

7 (m) Within three business days after the receipt of the
8 notice of assignment to conduct the external review pursuant to
9 subsection (j), the assigned independent review organization
10 shall:

11 (1) Select one or more clinical reviewers who each shall
12 be a physician or other health care professional who
13 meets the minimum qualifications described in section
14 432E-I and, through clinical experience in the past
15 three years, is an expert in the treatment of the
16 enrollee's condition and knowledgeable about the
17 recommended or requested health care service or
18 treatment to conduct the external review; provided
19 that neither the enrollee, the enrollee's appointed
20 representative, nor the health carrier shall choose or
21 control the choice of the physicians or other health



1 care professionals to be selected to conduct the
2 external review; and
3 (2) Based on the written opinion of the clinical reviewer,
4 or opinions if more than one clinical reviewer has
5 been selected, to the assigned independent review
6 organization on whether the recommended or requested
7 health care service or treatment should be covered,
8 make a determination to uphold or reverse the adverse
9 action.

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

14 Each clinical reviewer selected pursuant to this subsection
15 shall review all of the information and documents received
16 pursuant to subsection (1) and any other information submitted
17 in writing by the enrollee or the enrollee's authorized
18 representative pursuant to this subsection.

19 (n) The assigned independent review organization, within
20 one business day of receipt by the independent review
21 organization, shall forward all information received from the
22 enrollee pursuant to subsection (k) to the health carrier. Upon



1 receipt of information forwarded to it pursuant to this
2 subsection, a health carrier may reconsider the adverse action
3 that is the subject of the external review; provided that
4 reconsideration by the health carrier shall not delay or
5 terminate an external review unless the health carrier reverses
6 its adverse action and provides coverage or payment for the
7 health care service that is the subject of the adverse action.
8 The health carrier shall notify the enrollee, the enrollee's
9 appointed representative, the assigned independent review
10 organization, and the commissioner in writing of its decision to
11 reverse its adverse action and within three business days of
12 making its decision to reverse the adverse action and provide
13 coverage. The assigned independent review organization shall
14 terminate its external review upon receipt of notice pursuant to
15 this subsection from the health carrier.

16 (o) Except as provided in subsection (p), within twenty
17 days after being selected to conduct the external review, a
18 clinical reviewer shall provide an opinion to the assigned
19 independent review organization pursuant to subsection (q)
20 regarding whether the recommended or requested health care
21 service or treatment subject to an appeal pursuant to this
22 section shall be covered.



1 The clinical reviewers' opinion shall be in writing and
2 shall include:

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

4 (2) A description of the indicators relevant to
5 determining whether there is sufficient evidence to
6 demonstrate that the recommended or requested health
7 care service or treatment is more likely than not to
8 be more beneficial to the enrollee than any available
9 standard health care services or treatments and
10 whether the adverse risks of the recommended or
11 requested health care service or treatment would not
12 be substantially increased over those of available
13 standard health care services or treatments;

14 (3) A description and analysis of any medical or
15 scientific evidence, as that term is defined in
16 section 432E-1.4, considered in reaching the opinion;

17 (4) A description and analysis of any medical necessity
18 criteria defined in section 432E-1; and

19 (5) Information on whether the reviewer's rationale for
20 the opinion is based on approval of the health care
21 service or treatment by the federal Food and Drug
22 Administration for the condition or medical or



1 scientific evidence or evidence-based standards that
2 demonstrate that the expected benefits of the
3 recommended or requested health care service or
4 treatment is likely to be more beneficial to the
5 enrollee than any available standard health care
6 services or treatments and the adverse risks of the
7 recommended or requested health care service or
8 treatment would not be substantially increased over
9 those of available standard health care services or
10 treatments.

11 (p) Notwithstanding the requirements of subsection (o), in
12 an expedited external review, the clinical reviewer shall
13 provide an opinion orally or in writing to the assigned
14 independent review organization as expeditiously as the
15 enrollee's medical condition or circumstances require, but in no
16 event more than five calendar days after being selected in
17 accordance with subsection (m).

18 If the opinion provided pursuant to this subsection was not
19 in writing, within forty-eight hours following the date the
20 opinion was provided, the clinical reviewer shall provide
21 written confirmation of the opinion to the assigned independent



1 review organization and include the information required under
2 subsection (o).

3 (q) In addition to the documents and information provided
4 pursuant to subsection (b) or (l), a clinical reviewer may
5 consider the following in reaching an opinion pursuant to
6 subsection (o):

7 (1) The enrollee's pertinent medical records;

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

10 (3) Consulting reports from appropriate health care
11 professionals and other documents submitted by the
12 health carrier, enrollee, the enrollee's appointed
13 representative, or the enrollee's treating physician
14 or health care professional; and

15 (4) Whether:

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

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



1 service or treatment is more likely than not to
2 be beneficial to the enrollee than any available
3 standard health care service or treatment and the
4 adverse risks of the recommended or requested
5 health care service or treatment would not be
6 substantially increased over those of available
7 standard health care services or treatments;
8 provided that the independent review organization's decision
9 shall not contradict the terms of the enrollee's health benefit
10 plan or the provisions of this chapter.

11 (r) Except as provided in subsection (s), within twenty
12 days after the date it receives the opinion of the clinical
13 reviewer pursuant to subsection (o), the assigned independent
14 review organization, in accordance with subsection (t), shall
15 determine whether the health care service at issue in an
16 external review pursuant to this section shall be a covered
17 benefit and shall notify the enrollee, the enrollee's appointed
18 representative, the health carrier, and the commissioner of its
19 determination. The independent review organization shall
20 include in the notice of its decision:

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



- 1 (2) The written opinion of each clinical reviewer,
2 including the recommendation of each clinical reviewer
3 as to whether the recommended or requested health care
4 service or treatment should be covered and the
5 rationale for the reviewer's recommendation;
- 6 (3) The date the independent review organization was
7 assigned by the commissioner to conduct the external
8 reviewer;
- 9 (4) The date the external review was conducted;
- 10 (5) The date the decision was issued;
- 11 (6) The principal reason or reasons for its decision; and
- 12 (7) The rationale for its decision.

13 Upon receipt of a notice of a decision reversing the
14 adverse action, the health carrier immediately shall approve
15 coverage of the recommended or requested health care service or
16 treatment that was the subject of the adverse action.

17 (s) For an expedited external review, within forty-eight
18 hours after the date it receives the opinion of each clinical
19 reviewer, the assigned independent review organization, in
20 accordance with subsection (t), shall make a decision and
21 provide notice of the decision orally or in writing to the

1 enrollee, the enrollee's appointed representative, the health
2 carrier, and the commissioner.

3 If the notice provided was not in writing, within forty-
4 eight hours after the date of providing that notice, the
5 assigned independent review organization shall provide written
6 confirmation of the decision to the enrollee, the enrollee's
7 appointed representative, the health carrier, and the
8 commissioner.

9 (t) If a majority of the clinical reviewers recommends
10 that the recommended or requested health care service or
11 treatment should be covered, the independent review organization
12 shall make a decision to reverse the health carrier's adverse
13 determination or final adverse determination.

14 If a majority of the clinical reviewers recommends that the
15 recommended or requested health care service or treatment should
16 not be covered, the independent review organization shall make a
17 decision to uphold the health carrier's adverse determination or
18 final adverse determination.

19 If the clinical reviewers are evenly split as to whether
20 the recommended or requested health care service or treatment
21 should be covered, the independent review organization shall
22 obtain the opinion of an additional clinical reviewer in order



1 for the independent review organization to make a decision based
2 on the opinions of a majority of the clinical reviewers. The
3 additional clinical reviewer shall use the same information to
4 reach an opinion as the clinical reviewers who have already
5 submitted their opinions. The selection of the additional
6 clinical reviewer shall not extend the time within which the
7 assigned independent review organization is required to make a
8 decision based on the opinions of the clinical reviewers
9 selected.

10 **§432E-G Binding nature of external review decision. (a)**

11 An external review decision shall be binding on the health
12 carrier and the enrollee except to the extent that the health
13 carrier or the enrollee has other remedies available under
14 applicable federal or state law.

15 (b) An enrollee or the enrollee's appointed representative
16 shall not file a subsequent request for external review
17 involving the same adverse action for which the enrollee has
18 already received an external review decision pursuant to this
19 part.

20 **§432E-H Approval of independent review organizations. (a)**

21 An independent review organization shall be approved by the



1 commissioner in order to be eligible to be assigned to conduct
2 external reviews under this part.

3 (b) To be eligible for approval by the commissioner to
4 conduct external reviews under this part an independent review
5 organization shall:

6 (1) Submit an application on a form required by the
7 commissioner and include all documentation and
8 information necessary for the commissioner to
9 determine if the independent review organization
10 satisfies the minimum qualifications established under
11 this part; and

12 (2) Except as otherwise provided in subsection (c), shall
13 be accredited by a nationally-recognized private
14 accrediting entity that the commissioner has
15 determined has independent review organization
16 accreditation standards that are equivalent to or
17 exceed the minimum standards established by this
18 section and section 432E-I.

19 (c) The commissioner may approve independent review
20 organizations that are not accredited by a nationally-recognized
21 private accrediting entity if there are no acceptable



1 nationally-recognized private accrediting entities providing
2 independent review organization accreditation.

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

6 (e) Approval pursuant to this section is effective for two
7 years, unless the commissioner determines before its expiration
8 that the independent review organization does not meet the
9 minimum qualifications established under this part. If the
10 commissioner determines that an independent review organization
11 has lost its accreditation or no longer satisfies the minimum
12 requirements of this part, the commissioner shall terminate the
13 approval of the independent review organization and remove the
14 independent review organization from the list of independent
15 review organizations approved to conduct external reviews
16 maintained by the commissioner.

17 (f) The commissioner shall maintain and periodically
18 update a list of approved independent review organizations.

19 **§432E-I Minimum qualifications for independent review**
20 **organizations.** (a) To be eligible for approval under this part
21 to conduct external reviews, an independent review organization
22 shall have and maintain written policies and procedures that



1 govern all aspects of both the standard external review process
2 and the expedited external review process set forth in this part
3 that include, at minimum:

- 4 (1) A quality assurance mechanism in place that ensures:
 - 5 (A) That external reviews are conducted within the
6 specified time frames of this part and required
7 notices are provided in a timely manner;
 - 8 (B) The selection of qualified and impartial clinical
9 reviewers to conduct external reviews on behalf
10 of the independent review organization and
11 suitable matching of reviewers to specific cases;
12 provided that an independent review organization
13 shall employ or contract with an adequate number
14 of clinical reviewers to meet this objective;
 - 15 (C) Confidentiality of medical and treatment records
16 and clinical review criteria; and
 - 17 (D) That any person employed by or under contract
18 with the independent review organization complies
19 with the requirements of this part;
- 20 (2) Toll-free telephone, facsimile, and email capabilities
21 to receive information related to external reviews
22 twenty-four hours a day, seven days per week that are



1 capable of accepting, recording, or providing
2 appropriate instruction to incoming telephone callers
3 during other than normal business hours and
4 facilitating necessary communication under this part;
5 and

6 (3) An agreement to maintain and provide to the
7 commissioner the information required by this part.

8 (b) Each clinical reviewer assigned by an independent
9 review organization to conduct an external review shall be a
10 physician or other appropriate health care provider who:

11 (1) Is an expert in the treatment of the medical condition
12 that is the subject of the external review;

13 (2) Is knowledgeable about the recommended health care
14 service and treatment through recent or current actual
15 clinical experience treating patients with the same or
16 similar medical condition at issue in the external
17 review;

18 (3) Holds a non-restricted license in a state of the
19 United States and, for physicians, a current
20 certification by a recognized American Medical
21 Specialty Board in the area or areas appropriate to
22 the subject of the external review; and



1 (4) Has no history of disciplinary actions or sanctions,
2 including loss of staff privileges or participation
3 restrictions, imposed or pending by any hospital,
4 governmental agency or unit, or regulatory body that
5 raises a substantial question as to the clinical
6 reviewer's physical, mental, or professional
7 competence or moral character.

8 (c) An independent review organization shall not own or
9 control, be a subsidiary of, or in any way be owned or
10 controlled by, or exercise control over a health carrier, health
11 benefit plan, a national, state, or local trade association of
12 health benefit plans, or a national, state, or local trade
13 association of health care providers.

14 (d) To be eligible to conduct an external review of a
15 specified case, neither the independent review organization
16 selected to conduct the external review nor any clinical
17 reviewer assigned by the independent review organization to
18 conduct the external review shall have a material professional,
19 familial, or financial conflict of interest with any of the
20 following:

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



- 1 (2) The enrollee whose treatment is the subject of the
2 external review, the enrollee's appointed
3 representative, or the enrollee's immediate family;
- 4 (3) Any officer, director, or management employee of the
5 health carrier that is the subject of the external
6 review;
- 7 (4) The health care provider, the health care provider's
8 medical group, or independent practice association
9 recommending the health care service or treatment that
10 is the subject of the external review;
- 11 (5) The facility at which the recommended health care
12 service or treatment would be provided;
- 13 (6) The developer or manufacturer of the principal drug,
14 device, procedure, or other therapy recommended for
15 the enrollee whose treatment is the subject of the
16 external review; or
- 17 (7) The health benefit plan that is the subject of the
18 external review, the plan administrator, or any
19 fiduciary or employee of the plan.

20 The commissioner may determine that no material
21 professional, familial, or financial conflict of interest exists
22 based on the specific characteristics of a particular

1 relationship or connection that creates an apparent
2 professional, familial, or financial conflict of interest.

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

10 The commissioner shall review, initially upon approval of
11 an accredited independent review organization and periodically
12 during the time that the independent review organization remains
13 approved pursuant to this section, the accreditation standards
14 of the nationally-recognized private accrediting entity to
15 determine whether the entity's standards are, and continue to be
16 equivalent to, or exceed the minimum qualifications established
17 under this section; provided that a review conducted by the
18 National Association of Insurance Commissioners shall satisfy
19 the requirements of this section.

20 Upon request of the commissioner, a nationally-recognized
21 private accrediting entity shall make its current independent
22 review organization accreditation standards available to the



1 commissioner or the National Association of Insurance
2 Commissioners in order for the commissioner to determine if the
3 entity's standards are equivalent to or exceed the minimum
4 qualifications established under this section. The commissioner
5 may exclude any private accrediting entity that is not reviewed
6 by the National Association of Insurance Commissioners.

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

10 **§432E-J Hold harmless for independent review**
11 **organizations.** No independent review organization or clinical
12 reviewer working on behalf of an independent review organization
13 or an employee, agent, or contractor of an independent review
14 organization shall be liable in damages to any person for any
15 opinions rendered or acts or omissions performed within the
16 scope of the organization's or person's duties under the law
17 during or upon completion of an external review conducted
18 pursuant to this part, unless the opinion was rendered or the
19 act or omission was performed in bad faith or involved gross
20 negligence.

21 **§432E-K External review reporting requirements.** (a) An
22 independent review organization assigned pursuant to this part



1 to conduct an external review shall maintain written records in
2 the aggregate by state and by health carrier on all requests for
3 external review for which it conducted an external review during
4 a calendar year and upon request shall submit a report to the
5 commissioner, as required under subsection (b).

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

- 13 (1) The total number of requests for external review;
- 14 (2) The number of requests for external review resolved
15 and, of those resolved, the number resolved upholding
16 the adverse action and the number resolved reversing
17 the adverse action;
- 18 (3) The average length of time for resolution;
- 19 (4) The summary of the types of coverages or cases for
20 which an external review was sought, as provided in
21 the format required by the commissioner;



1 (5) The number of external reviews that were terminated as
2 the result of a reconsideration by the health carrier
3 of its adverse action after the receipt of additional
4 information from the enrollee or the enrollee's
5 appointed representative; and

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

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

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

16 Each health carrier required to maintain written records on
17 all requests for external review shall submit to the
18 commissioner, upon request, a report in the format specified by
19 the commissioner that includes in the aggregate, by state, and
20 by type of health benefit plan:

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



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

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

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

8 **§432E-L Funding of external review.** The health carrier
9 against which a request for a standard external review or an
10 expedited external review is filed shall pay the cost of the
11 independent review organization for conducting the external
12 review. There shall be no recourse against the commissioner for
13 the cost of conducting the external review and the selection of
14 an independent review organization shall not be subject to
15 chapter 103D.

16 **§432E-M Disclosure requirements.** (a) Each health carrier
17 shall include a description of the external review procedures in
18 or attached to the policy, certificate, membership booklet,
19 outline of coverage, or other evidence of coverage it provides
20 to enrollees.

21 (b) Disclosure shall be in a format prescribed by the
22 commissioner and shall include a statement informing the



1 enrollee of the right of the enrollee to file a request for an
2 external review of an adverse action with the commissioner. The
3 statement may explain that external review is available when the
4 adverse action involves an issue of medical necessity,
5 appropriateness, health care setting, level of care, or
6 effectiveness. The statement shall include the telephone number
7 and address of the commissioner.

8 (c) In addition to the requirements of subsection (b), the
9 statement shall inform the enrollee that, when filing a request
10 for an external review, the enrollee or the enrollee's appointed
11 representative shall be required to authorize the release of any
12 medical records of the enrollee that may be required to be
13 reviewed for the purpose of reaching a decision on the external
14 review and shall be required to provide written disclosures to
15 permit the commissioner to perform a conflict of interest
16 evaluation for selection of an appropriate independent review
17 organization.

18 (d) Each health carrier shall have available on its
19 website and provide upon request to any enrollee, forms for the
20 purpose of requesting an external review, which shall include an
21 authorization release form that complies with the federal Health
22 Insurance Portability and Accountability Act as well as a



1 disclosure form for conflict of interest evaluation purposes
2 that shall include the name of the enrollee, any authorized
3 representative acting on behalf of the enrollee, the enrollee's
4 immediate family members, the health carrier that is the subject
5 of the external review, the health benefit plan, the plan
6 administrator, plan fiduciaries and plan employees if the
7 enrollee is in a group health benefits plan, the health care
8 providers treating the enrollee for purposes of the condition
9 that is the subject of the external review and the providers'
10 medical groups, the health care provider and facility at which
11 the requested health care service or treatment would be
12 provided, and the developer or manufacturer of the principal
13 drug, device, procedure, or other therapy that is the subject of
14 the external review request.

15 (e) Each health carrier doing business in Hawaii shall
16 file with the commissioner by the effective date of this part,
17 information to permit the commissioner to perform a conflict of
18 interest evaluation for selection of an appropriate independent
19 review organization in the event of a request for external
20 review involving the health carrier. A filing pursuant to this
21 section shall include the name of the health carrier, its
22 officers, directors, and management employees. The health



1 carrier shall promptly amend its filing with the commissioner
2 when there is any change of officers, directors, or managing
3 employees.

4 (f) The commissioner may prescribe the form or format to
5 use for the release authorization required by subsection (d) and
6 the conflict of interest disclosures required by subsections (d)
7 and (e).

8 (g) No disclosure required for purposes of this part shall
9 include lawyer-client privileged communications protected
10 pursuant to the Hawaii Rules of Evidence Rule 503.

11 **§432E-N Rules.** The insurance commissioner shall adopt
12 rules pursuant to chapter 91 to effectuate the purpose of this
13 part including requirements for forms to request external review
14 and expedited external review, to request approval by
15 independent review organizations, and for disclosure of
16 conflicts of interest by enrollees and health carriers."

17 SECTION 3. Chapter 432E, Hawaii Revised Statutes, is
18 amended by designating sections 432E-1 through 432E-2 as part I,
19 entitled "General Provisions".

20 SECTION 4. Chapter 432E, Hawaii Revised Statutes, is
21 amended by designating sections 432E-3 through 432E-8 as part
22 II, entitled "General Policies".



1 SECTION 5. Chapter 432E, Hawaii Revised Statutes, is
2 amended by designating sections 432E-9 through 432E-13 as part
3 III, entitled "Reporting and Other Provisions".

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

6 **"§432E-1 Definitions.** As used in this chapter, unless the
7 context otherwise requires:

8 "Adverse action" means an adverse determination or a final
9 adverse determination.

10 "Adverse determination" means a determination by a health
11 carrier or its designated utilization review organization that
12 an admission, availability of care, continued stay, or other
13 health care service that is a covered benefit has been reviewed
14 and, based upon the information provided, does not meet the
15 health carrier's requirements for medical necessity,
16 appropriateness, health care setting, level of care, or
17 effectiveness, and the requested service or payment for the
18 service is therefore denied, reduced, or terminated.

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



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

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

8 (1) A person to whom an enrollee has given express written
9 consent to represent the enrollee in an external
10 review;

11 (2) A person authorized by law to provide substituted
12 consent for an enrollee;

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

16 ~~[(1)]~~ (4) A court-appointed legal guardian;

17 ~~[(2)]~~ (5) A person who has a durable power of attorney for
18 health care; or

19 ~~[(3)]~~ (6) A person who is designated in a written advance
20 directive~~[-]~~;



1 provided that an appointed representative shall include an
2 "authorized representative" as used in the federal Patient
3 Protection and Affordable Care Act.

4 "Best evidence" means evidence based on:

5 (1) Randomized clinical trials;

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

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

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

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

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

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

20 "Certification" means a determination by a health carrier
21 or its designated utilization review organization that an
22 admission, availability of care, continued stay, or other health



1 care service has been reviewed and, based on the information
2 provided, satisfies the health carrier's requirements for
3 medical necessity, appropriateness, health care setting, level
4 of care, and effectiveness.

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

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

12 "Commissioner" means the insurance commissioner.

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

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

17 "Covered benefits" or "benefits" means those health care
18 services to which an enrollee is entitled under the terms of a
19 health benefit plan.

20 "Discharge planning" means the formal process for
21 determining, prior to discharge from a facility, the



1 coordination and management of the care that an enrollee
2 receives following discharge from a facility.

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

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

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

17 ~~["Expedited appeal" means the internal review of a~~
18 ~~complaint or an external review of the final internal~~
19 ~~determination of an enrollee's complaint, which is completed~~
20 ~~within seventy two hours after receipt of the request for~~
21 ~~expedited appeal.~~



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

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

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

12 "External review" means a review of an adverse
13 determination (including a final adverse determination)
14 conducted by an independent review organization pursuant to this
15 chapter.

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



1 "Final adverse determination" means an adverse
2 determination involving a covered benefit that has been upheld
3 by a health carrier or its designated utilization review
4 organization at the completion of the health carrier's internal
5 grievance process procedures, or an adverse determination with
6 respect to which the internal appeals process is deemed to have
7 been exhausted under section 432E-C(b).

8 "Health benefit plan" means a policy, contract, certificate
9 or agreement offered or issued by a health carrier to provide,
10 deliver, arrange for, pay or reimburse any of the costs of
11 health care services.

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

17 "Health care provider" or "provider" means a health care
18 professional.

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



1 "Health carrier" means an entity subject to the insurance
 2 laws and rules of this State, or subject to the jurisdiction of
 3 the commissioner, that contracts or offers to contract to
 4 provide, deliver, arrange for, pay for, or reimburse any of the
 5 costs of health care services, including a sickness and accident
 6 insurance company, a health maintenance organization, a mutual
 7 benefit society, a nonprofit hospital and health service
 8 corporation, or any other entity providing a plan of health
 9 insurance, health benefits or health care services.

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

12 "Independent review organization" means an independent
 13 entity [~~that~~

- 14 ~~(1) Is unbiased and able to make independent decisions;~~
- 15 ~~(2) Engages adequate numbers of practitioners with the~~
 16 ~~appropriate level and type of clinical knowledge and~~
 17 ~~expertise;~~
- 18 ~~(3) Applies evidence-based decisionmaking;~~
- 19 ~~(4) Demonstrates an effective process to screen external~~
 20 ~~reviews for eligibility;~~
- 21 ~~(5) Protects the enrollee's identity from unnecessary~~
 22 ~~disclosure; and~~



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

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

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

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



1 (2) Financial incentives for enrollees to use
2 participating providers and procedures provided by a
3 plan;
4 provided[7] that for the purposes of this chapter, an employee
5 benefit plan shall not be deemed a managed care plan with
6 respect to any provision of this chapter or to any requirement
7 or rule imposed or permitted by this chapter [~~which~~] that is
8 superseded or preempted by federal law.

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

15 "Medical necessity" means a health intervention [~~as~~
16 ~~defined~~] that meets the criteria enumerated in section 432E-1.4.

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

19 (1) Peer-reviewed scientific studies published in or
20 accepted for publication by medical journals that meet
21 nationally-recognized requirements for scientific
22 manuscripts and that submit most of their published



1 articles for review by experts, who are not part of
2 the editorial staff;

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

11 (3) Medical journals recognized by the United States
12 Secretary of Health and Human Services under Section
13 1861(t)(2) of the federal Social Security Act;

14 (4) The following standard reference compendia:
15 (A) The American Hospital Formulary Service-Drug
16 Information;
17 (B) Drug Facts and Comparisons;
18 (C) The American Dental Association Accepted Dental
19 Therapeutics; and
20 (D) The United States Pharmacopeia Drug Information;

21 (5) Findings, studies, or research conducted by or under
22 the auspices of federal government agencies and



1 nationally-recognized federal research institutes,

2 including:

3 (A) The federal Agency for Healthcare Research and
4 Quality;

5 (B) The National Institutes of Health;

6 (C) The National Cancer Institute;

7 (D) The National Academy of Sciences;

8 (E) The Centers for Medicare and Medicaid Services;

9 (F) The federal Food and Drug Administration; and

10 (G) Any national board recognized by the National
11 Institutes of Health for the purpose of
12 evaluating the medical value of health care
13 services; or

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

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



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

3 "Protected health information" means health information as
4 defined in the federal Health Insurance Portability and
5 Accountability Act and related federal rules.

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

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

17 "Reviewer" means an independent reviewer with clinical
18 expertise either employed by or contracted by an independent
19 review organization to perform external reviews.

20 "Second opinion" means an opportunity or requirement to
21 obtain a clinical evaluation by a provider other than the one
22 originally making a recommendation for a proposed health care



1 service to assess the clinical necessity and appropriateness of
2 the initial proposed health care service.

3 "Specifically excluded" means that the coverage provisions
4 of the health care plan, when read together, clearly and
5 specifically exclude coverage for a health care service.

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

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

16 SECTION 7. Section 432E-5, Hawaii Revised Statutes, is
17 amended to read as follows:

18 **"§432E-5 Complaints and appeals procedure for enrollees.**

19 (a) A [~~managed care plan~~] health carrier with enrollees in this
20 State shall establish and maintain a procedure to provide for
21 the resolution of an enrollee's complaints and internal appeals.
22 The procedure shall provide for expedited internal appeals under



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

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

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

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

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



- 1 (2) The ~~[sixty-day]~~ one hundred thirty day deadline for
- 2 requesting an external review;
- 3 (3) Instructions on how to request an external review; and
- 4 (4) Where to submit the request for an external review.

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

7 SECTION 8. Section 432E-6.5, Hawaii Revised Statutes, is
 8 amended by amending its title to read as follows:

9 "**§432E-6.5 Expedited internal appeal, when authorized;**
 10 **standard for decision.**"

11 SECTION 9. Section 432E-6.5, Hawaii Revised Statutes, is
 12 amended by amending subsection (a) to read as follows:

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

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

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

21 If a request for expedited appeal is approved by the ~~[managed~~
 22 ~~care plan or the commissioner,]~~ health carrier, the appropriate



1 ~~[review]~~ internal appeal shall be completed within seventy-two
2 hours of receipt of the request for expedited appeal."

3 SECTION 10. Section 432E-6, Hawaii Revised Statutes, is
4 repealed.

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

16 ~~(1) The enrollee shall submit a request for external~~
17 ~~review to the commissioner within sixty days from the~~
18 ~~date of the final internal determination by the~~
19 ~~managed care plan;~~

20 ~~(2) The commissioner may retain:~~

21 ~~(A) Without regard to chapter 76, an independent~~
22 ~~medical expert trained in the field of medicine~~



1 ~~most appropriately related to the matter under~~
2 ~~review. Presentation of evidence for this~~
3 ~~purpose shall be exempt from section 91-9(g); and~~
4 ~~(B) The services of an independent review~~
5 ~~organization from an approved list maintained by~~
6 ~~the commissioner;~~
7 ~~(3) Within seven days after receipt of the request for~~
8 ~~external review, a managed care plan or its designee~~
9 ~~utilization review organization shall provide to the~~
10 ~~commissioner or the assigned independent review~~
11 ~~organization.~~
12 ~~(A) Any documents or information used in making the~~
13 ~~final internal determination including the~~
14 ~~enrollee's medical records;~~
15 ~~(B) Any documentation or written information~~
16 ~~submitted to the managed care plan in support of~~
17 ~~the enrollee's initial complaint; and~~
18 ~~(C) A list of the names, addresses, and telephone~~
19 ~~numbers of each licensed health care provider who~~
20 ~~cared for the enrollee and who may have medical~~
21 ~~records relevant to the external review;~~



1 ~~provided that where an expedited appeal is involved,~~
2 ~~the managed care plan or its designee utilization~~
3 ~~review organization shall provide the documents and~~
4 ~~information within forty eight hours of receipt of the~~
5 ~~request for external review.~~

6 ~~Failure by the managed care plan or its designee~~
7 ~~utilization review organization to provide the~~
8 ~~documents and information within the prescribed time~~
9 ~~periods shall not delay the conduct of the external~~
10 ~~review. Where the plan or its designee utilization~~
11 ~~review organization fails to provide the documents and~~
12 ~~information within the prescribed time periods, the~~
13 ~~commissioner may issue a decision to reverse the final~~
14 ~~internal determination, in whole or part, and shall~~
15 ~~promptly notify the independent review organization,~~
16 ~~the enrollee, the enrollee's appointed representative,~~
17 ~~if applicable, the enrollee's treating provider, and~~
18 ~~the managed care plan of the decision;~~

19 ~~(4) Upon receipt of the request for external review and~~
20 ~~upon a showing of good cause, the commissioner shall~~
21 ~~appoint the members of the external review panel and~~
22 ~~shall conduct a review hearing pursuant to chapter 91.~~



1 ~~If the amount in controversy is less than \$500, the~~
2 ~~commissioner may conduct a review hearing without~~
3 ~~appointing a review panel;~~

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

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

10 ~~(B) An external review conducted as an expedited~~
11 ~~appeal shall be determined no later than seventy-~~
12 ~~two hours after receipt of the request for~~
13 ~~external review;~~

14 ~~(6) After considering the enrollee's complaint, the~~
15 ~~managed care plan's response, and any affidavits filed~~
16 ~~by the parties, the commissioner may dismiss the~~
17 ~~request for external review if it is determined that~~
18 ~~the request is frivolous or without merit; and~~

19 ~~(7) The review panel shall review every final internal~~
20 ~~determination to determine whether the managed care~~
21 ~~plan involved acted reasonably. The review panel and~~



1 ~~the commissioner or the commissioner's designee shall~~
2 ~~consider:~~

3 ~~(A) The terms of the agreement of the enrollee's~~
4 ~~insurance policy, evidence of coverage, or~~
5 ~~similar document;~~

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

9 ~~(C) All relevant medical records;~~

10 ~~(D) The clinical standards of the plan;~~

11 ~~(E) The information provided;~~

12 ~~(F) The attending physician's recommendations; and~~

13 ~~(G) Generally accepted practice guidelines.~~

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

17 ~~(b) The procedure set forth in this section shall not~~
18 ~~apply to claims or allegations of health provider malpractice,~~
19 ~~professional negligence, or other professional fault against~~
20 ~~participating providers.~~

21 ~~(c) No person shall serve on the review panel or in the~~
22 ~~independent review organization who, through a familial~~



1 ~~relationship within the second degree of consanguinity or~~
2 ~~affinity, or for other reasons, has a direct and substantial~~
3 ~~professional, financial, or personal interest in:~~

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

6 ~~(2) The treatment of the enrollee, including but not~~
7 ~~limited to the developer or manufacturer of the~~
8 ~~principal drug, device, procedure, or other therapy at~~
9 ~~issue.~~

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

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

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



1 SECTION 11. If any provision of this Act, or the
2 application thereof to any person or circumstance is held
3 invalid, the invalidity does not affect other provisions or
4 applications of the Act, which can be given effect without the
5 invalid provision or application, and to this end the provisions
6 of this Act are severable.

7 SECTION 12. This Act shall be construed at all times in
8 conformity with the federal Patient Protection and Affordable
9 Care Act, Public Law No. 111-148. If any provision of this part
10 is interpreted to violate the Patient Protection and Affordable
11 Care Act, the commissioner is authorized to adopt by emergency
12 rule-making procedures, any rules as necessary to conform the
13 provisions and procedures of this part with the Patient
14 Protection and Affordable Care Act.

15 SECTION 13. In codifying the new sections added by section
16 2 of this Act, the revisor of statutes shall substitute
17 appropriate section numbers for the letters used in designating
18 the new sections in this Act.

19 SECTION 14. Statutory material to be repealed is bracketed
20 and stricken. New statutory material is underscored.

21 SECTION 15. This Act shall take effect on June 30, 2011,
22 and apply retroactively to January 1, 2011; provided that if the



1 United States Department of Health and Human Services by rule or
2 other written guidance extends the time period for the State's
3 existing external review process under section 432E-6, Hawaii
4 Revised Statutes, to any later date during 2011, then the
5 effective date of this Act shall be the sooner of the end date
6 of the transition period or January 1, 2012; provided further
7 that if the external review requirements of the federal Patient
8 Protection and Affordable Care Act of 2010 are held
9 unconstitutional by the United States Supreme Court, this Act
10 shall be repealed as of the date that the United States Supreme
11 Court issues its opinion and chapter 432E, Hawaii Revised
12 Statutes, shall be reenacted in the form in which it existed as
13 of the day before the United States Supreme Court issued its
14 decision.



Report Title:

Insurance; Health; External Review Procedure

Description:

Provides uniform standards for external review procedures based on the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act, to comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010. Effective June 30, 2011. (SB1274 HD3)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

