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# 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 measure is to comply with the requirements of the Patient  
3 Protection and Affordable Care Act of 2010 and its implementing  
4 regulations by updating Hawaii's patients' bill of rights and  
5 responsibilities, chapter 432E, Hawaii Revised Statutes, to  
6 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) The provisions of this part shall not apply to a  
15 policy or certificate that provides coverage only for a  
16 specified disease, specified accident or accident-only coverage,  
17 credit, dental, disability income, hospital indemnity, long term  
18 care insurance, vision care, any other limited supplemental



1 benefit; to a medicare supplemental policy of insurance,  
2 coverage under a plan through medicare, medicaid, or the federal  
3 employees health benefits program, any federal medical and  
4 dental care coverage issued under chapter 55 of Title 10 United  
5 States Code and any coverage issued as supplemental to that  
6 coverage; any coverage issued as supplemental to liability  
7 insurance, workers' compensation or similar insurance;  
8 automobile medical-payment insurance; any insurance under which  
9 benefits are payable with or without regard to fault, whether  
10 written on a group blanket or individual basis; or the employer  
11 union health benefits trust 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  
22 subsection(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 \$25, which shall be refunded if the  
7           adverse determination or final internal adverse  
8           determination is reversed through external review.

9   The commission shall waive the filing fee required by this  
10 subsection if payment of the fee would impose an undue financial  
11 hardship to the enrollee. The annual aggregate limit on filing  
12 fees for any enrollee within a single plan year shall not exceed  
13 \$75.

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, but is not required to, accept and consider  
12 additional information submitted by an enrollee or an enrollee's  
13 appointed 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 may 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 most appropriate practice guidelines, which shall  
17 include applicable evidence-based standards and may  
18 include any practice guidelines developed by the  
19 federal government or national or professional medical  
20 societies, boards, and associations;



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

4 (6) 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 the provisions of 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  
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 may 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 most appropriate practice guidelines, which shall  
17 include evidence-based standards, and may include any  
18 other practice guidelines developed by the federal  
19 government, national or professional medical  
20 societies, boards, and associations;
- 21 (5) Any applicable clinical review criteria developed and  
22 used by the health carrier or its designee utilization



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

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

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

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



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

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

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

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

16 **§432E-F External review of experimental or investigational**  
17 **treatment adverse determinations.** (a) An enrollee or an  
18 enrollee's appointed representative may file a request for an  
19 external review with the commissioner within one hundred thirty  
20 days of receipt of notice of an adverse action that involves a  
21 denial of coverage based on a determination that the health care



1 service or treatment recommended or requested is experimental or  
2 investigational.

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

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

21 Notice of eligibility for expedited external review  
22 pursuant to this subsection shall include a statement informing



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

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

17 (e) Upon receipt of the notice pursuant to subsection (a)  
18 or a determination of the commissioner pursuant to subsection  
19 (d) that the enrollee meets the eligibility requirements for  
20 expedited external review, the commissioner shall immediately  
21 randomly assign an independent review organization to conduct  
22 the expedited external review from the list of approved



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

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

18 (g) Except for a request for an expedited external review  
19 made pursuant to subsection (b), within three business days  
20 after the date of receipt of the request, the commissioner shall  
21 notify the health carrier that the enrollee has requested an  
22 expedited external review pursuant to this section. Within five



1 business days following the date of receipt of notice, the  
2 health carrier shall determine whether:

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

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

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

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

18 (3) The enrollee's treating physician has certified in  
19 writing that:

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



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





1                   the enrollee than any available standard health  
2                   care services or treatments;

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

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

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

18                If the request is not complete, the health carrier shall  
19          inform the commissioner, the enrollee, and the enrollee's  
20          appointed representative in writing of the information or  
21          materials needed to complete the request.



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

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

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

16           (i) Upon receipt of a request for appeal pursuant to  
17 subsection (h), the commissioner shall review the request for  
18 external review submitted pursuant to subsection (a) and, if  
19 eligible, shall refer the enrollee for external review. The  
20 commissioner's determination of eligibility for expedited  
21 external review shall be made in accordance with the terms of  
22 the enrollee's health benefit plan and all applicable provisions



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

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

10 (1) Randomly assign an independent review organization  
11 from the list of approved independent review  
12 organizations qualified to conduct the external  
13 review, based on the nature of the health care service  
14 that is the subject of the adverse action and other  
15 factors determined by the commissioner including  
16 conflicts of interest pursuant to section 432E-M,  
17 compiled and maintained by the commissioner pursuant  
18 to conduct the external review and notify the health  
19 carrier of the name of the assigned independent review  
20 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, but is not required to, accept and consider  
12 additional information submitted by an enrollee after five  
13 business days.

14           (1) Within five business days after the date of receipt of  
15 notice pursuant to subsection (j), 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 (m) Within three business days after the receipt of the  
9 notice of assignment to conduct the external review pursuant to  
10 subsection (j), the assigned independent review organization  
11 shall:

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



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

8 In reaching an opinion, the clinical reviewer is not bound  
9 by any decisions or conclusions reached during the health  
10 carrier's utilization review process or internal appeals  
11 process.

12 (n) The assigned independent review organization shall,  
13 within one business day of receipt by the independent review  
14 organization, forward all information received from the enrollee  
15 pursuant to subsection (k) to the health carrier. Upon receipt  
16 of information forwarded to it pursuant to this subsection, a  
17 health carrier may reconsider the adverse action that is the  
18 subject of the external review; provided that reconsideration by  
19 the health carrier shall not delay or terminate an external  
20 review unless the health carrier reverses its adverse action and  
21 provides coverage or payment for the health care service that is  
22 the subject of the adverse action. The health carrier shall



1 notify the enrollee, the enrollee's appointed representative,  
2 the assigned independent review organization, and the  
3 commissioner in writing of its decision to reverse its adverse  
4 action and within three business days of making its decision to  
5 reverse the adverse action and provide coverage. The assigned  
6 independent review organization shall terminate its external  
7 review upon receipt of notice pursuant to this subsection from  
8 the health carrier.

9 (o) Except as provided in subsection (p), within twenty  
10 days after being selected to conduct the external review, a  
11 clinical reviewer shall provide an opinion to the assigned  
12 independent review organization pursuant to subsection (q)  
13 regarding whether the recommended or requested health care  
14 service or treatment subject to an appeal pursuant to this  
15 section shall be covered.

16 The clinical reviewer's opinion shall be in writing and  
17 shall include:

- 18 (1) A description of the enrollee's medical condition;  
19 (2) A description of the indicators relevant to  
20 determining whether there is sufficient evidence to  
21 demonstrate that the recommended or requested health  
22 care service or treatment is more likely than not to



1 be more beneficial to the enrollee than any available  
2 standard health care services or treatments and  
3 whether the adverse risks of the recommended or  
4 requested health care service or treatment would not  
5 be substantially increased over those of available  
6 standard health care services or treatments;

7 (3) A description and analysis of any medical or  
8 scientific evidence, as that term is defined in  
9 section 432E-1, considered in reaching the opinion;

10 (4) A description and analysis of any evidence-based  
11 standard, as that term is defined in section 432E-1;  
12 and

13 (5) Information on whether the reviewer's rationale for  
14 the opinion is based on approval of the health care  
15 service or treatment by the federal Food and Drug  
16 Administration for the condition or medical or  
17 scientific evidence or evidence-based standards that  
18 demonstrate that the expected benefits of the  
19 recommended or requested health care service or  
20 treatment is likely to be more beneficial to the  
21 enrollee than any available standard health care  
22 services or treatments and the adverse risks of the





1 recommended or requested health care service or  
2 treatment would not be substantially increased over  
3 those of available standard health care services or  
4 treatments.

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

12 If the opinion provided pursuant to this subsection was not  
13 in writing, within forty-eight hours following the date the  
14 opinion was provided, the clinical reviewer shall provide  
15 written confirmation of the opinion to the assigned independent  
16 review organization and include the information required under  
17 subsection (o).

18 (q) In addition to the documents and information provided  
19 pursuant to subsection (b) or (l), a clinical reviewer may  
20 consider the following in reaching an opinion pursuant to  
21 subsection (o):

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



- 1           (2) The attending physician or health care professional's
- 2           recommendation;
- 3           (3) Consulting reports from appropriate health care
- 4           professionals and other documents submitted by the
- 5           health carrier, enrollee, the enrollee's appointed
- 6           representative, or the enrollee's treating physician
- 7           or health care professional; and
- 8           (4) Whether:
- 9           (A) The recommended health care service or treatment
- 10           has been approved by the federal Food and Drug
- 11           Administration, if applicable, for the condition;
- 12           or
- 13           (B) Medical or scientific evidence or evidence-based
- 14           standards demonstrate that the expected benefits
- 15           of the recommended or requested health care
- 16           service or treatment is more likely than not to
- 17           be beneficial to the enrollee than any available
- 18           standard health care service or treatment and the
- 19           adverse risks of the recommended or requested
- 20           health care service or treatment would not be
- 21           substantially increased over those of available
- 22           standard health care services or treatments;



1 provided that the independent review organization's decision  
2 shall not contradict the terms of the enrollee's health benefit  
3 plan or the provisions of this chapter.

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

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

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



- 1 (3) The date the independent review organization was  
2 assigned by the commissioner to conduct the external  
3 reviewer;
- 4 (4) The date the external review was conducted;
- 5 (5) The date the decision was issued;
- 6 (6) The principal reason or reasons for its decision; and  
7 (7) The rationale for its decision.

8 Upon receipt of a notice of a decision reversing the  
9 adverse action, the health carrier immediately shall approve  
10 coverage of the recommended or requested health care service or  
11 treatment that was the subject of the adverse action.

12 (s) For an expedited external review, within forty-eight  
13 hours after the date it receives the opinion of each clinical  
14 reviewer, the assigned independent review organization, in  
15 accordance with subsection (t), shall make a decision and  
16 provide notice of the decision orally or in writing to the  
17 enrollee, the enrollee's appointed representative, the health  
18 carrier, and the commissioner.

19 If the notice provided was not in writing, within forty-  
20 eight hours after the date of providing that notice, the  
21 assigned independent review organization shall provide written  
22 confirmation of the decision to the enrollee, the enrollee's



1 appointed representative, the health carrier, and the  
2 commissioner.

3 (t) If the clinical reviewer recommends that the health  
4 care service or treatment at issue in the external review  
5 pursuant to this section should be covered, the independent  
6 review organization shall reverse the health carrier's adverse  
7 action.

8 If the clinical reviewer recommends that the health care  
9 service or treatment at issue in the external review pursuant to  
10 this section should not be covered, the independent review  
11 organization shall make a decision to uphold the health  
12 carrier's adverse action.

13 **§432E-G Binding nature of external review decision. (a)**

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

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



1           **§432E-H Approval of independent review organizations. (a)**

2 An independent review organization shall be approved by the  
3 commissioner in order to be eligible to be assigned to conduct  
4 external reviews under this part.

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

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

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

21           (c) The commissioner may approve independent review  
22 organizations that are not accredited by a nationally recognized



1 private accrediting entity if there are no acceptable nationally  
2 recognized private accrediting entities providing independent  
3 review organization accreditation.

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

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

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

20 **§432E-I Minimum qualifications for independent review**  
21 **organizations.** (a) To be eligible for approval under this part  
22 to conduct external reviews, an independent review organization



1 shall have and maintain written policies and procedures that  
2 govern all aspects of both the standard external review process  
3 and the expedited external review process set forth in this part  
4 that include, at minimum:

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

6 (A) That external reviews are conducted within the  
7 specified time frames of this part and required  
8 notices are provided in a timely manner;

9 (B) The selection of qualified and impartial clinical  
10 reviewers to conduct external reviews on behalf  
11 of the independent review organization and  
12 suitable matching of reviewers to specific cases;  
13 provided that an independent review organization  
14 shall employ or contract with an adequate number  
15 of clinical reviewers to meet this objective;

16 (C) Confidentiality of medical and treatment records  
17 and clinical review criteria; and

18 (D) That any person employed by or under contract  
19 with the independent review organization complies  
20 with the requirements of this part;

21 (2) Toll-free telephone, facsimile, and email capabilities  
22 to receive information related to external reviews





1 twenty-four hours a day, seven days per week that are  
2 capable of accepting, recording or providing  
3 appropriate instruction to incoming telephone callers  
4 during other than normal business hours and  
5 facilitating necessary communication under this part;  
6 and

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

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

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

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

19 (3) Holds a non-restricted license in a state of the  
20 United States and, for physicians, a current  
21 certification by a recognized American Medical



1 Specialty Board in the area or areas appropriate to  
2 the subject of the external review; and

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

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

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



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



1           The commissioner may determine that no material  
2 professional, familial, or financial conflict of interest exists  
3 based on the specific characteristics of a particular  
4 relationship or connection that creates an apparent  
5 professional, familial, or financial conflict of interest.

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

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



1           Upon request of the commissioner, a nationally recognized  
2 private accrediting entity shall make its current independent  
3 review organization accreditation standards available to the  
4 commissioner or the National Association of Insurance  
5 Commissioners in order for the commissioner to determine if the  
6 entity's standards are equivalent to or exceed the minimum  
7 qualifications established under this section. The commissioner  
8 may exclude any private accrediting entity that is not reviewed  
9 by the National Association of Insurance Commissioners.

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

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



1 act or omission was performed in bad faith or involved gross  
2 negligence.

3       **§432E-K External review reporting requirements.** (a) An  
4 independent review organization assigned pursuant to this part  
5 to conduct an external review shall maintain written records in  
6 the aggregate by state and by health carrier on all requests for  
7 external review for which it conducted an external review during  
8 a calendar year and upon request shall submit a report to the  
9 commissioner, as required under subsection (b).

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

- 17       (1) The total number of requests for external review;
- 18       (2) The number of requests for external review resolved  
19             and, of those resolved, the number resolved upholding  
20             the adverse action and the number resolved reversing  
21             the adverse action;
- 22       (3) The average length of time for resolution;



- 1           (4) The summary of the types of coverages or cases for  
2           which an external review was sought, as provided in  
3           the format required by the commissioner;
- 4           (5) The number of external reviews that were terminated as  
5           the result of a reconsideration by the health carrier  
6           of its adverse action after the receipt of additional  
7           information from the enrollee or the enrollee's  
8           appointed representative; and
- 9           (6) Any other information the commissioner may request or  
10          require.

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

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

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



1 the commissioner that includes in the aggregate, by state, and  
2 by type of health benefit plan:

- 3 (1) The total number of requests for external review;  
4 (2) From the total number of requests for external review  
5 reported, the number of requests determined eligible  
6 for a full external review; and  
7 (3) Any other information the commissioner may request or  
8 require.

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

11 **§432E-L Funding of external review.** The health carrier  
12 against which a request for a standard external review or an  
13 expedited external review is filed shall pay the cost of the  
14 independent review organization for conducting the external  
15 review. There shall be no recourse against the commissioner for  
16 the cost of conducting the external review and the selection of  
17 an independent review organization shall not be subject to  
18 chapter 103D; provided that the commissioner may initially  
19 approve up to three independent review organizations to serve  
20 beginning as of the effective date of this part until the  
21 initial procurement process is completed; provided further that  
22 in any year in which procurement subject to chapter 103D does





1 not produce at least three independent review organizations  
2 eligible for selection under section 432E-I, the commissioner  
3 may approve up to three independent review organizations  
4 notwithstanding the requirements of chapter 103D.

5       **§432E-M Disclosure requirements.** (a) Each health carrier  
6 shall include a description of the external review procedures in  
7 or attached to the policy, certificate, membership booklet,  
8 outline of coverage, or other evidence of coverage it provides  
9 to enrollees.

10       (b) Disclosure shall be in a format prescribed by the  
11 commissioner and shall include a statement informing the  
12 enrollee of the right of the enrollee to file a request for an  
13 external review of an adverse action with the commissioner. The  
14 statement may explain that external review is available when the  
15 adverse action involves an issue of medical necessity,  
16 appropriateness, health care setting, level of care, or  
17 effectiveness. The statement shall include the telephone number  
18 and address of the commissioner.

19       (c) In addition to the requirements of subsection (b), the  
20 statement shall inform the enrollee that, when filing a request  
21 for an external review, the enrollee or the enrollee's appointed  
22 representative shall be required to authorize the release of any



1 medical records of the enrollee that may be required to be  
2 reviewed for the purpose of reaching a decision on the external  
3 review and shall be required to provide written disclosures to  
4 permit the commissioner to perform a conflict of interest  
5 evaluation for selection of an appropriate independent review  
6 organization.

7 (d) Each health carrier shall have available on its  
8 website and provide upon request to any enrollee, forms for the  
9 purpose of requesting an external review, which shall include an  
10 authorization release form that complies with the federal Health  
11 Insurance Portability and Accountability Act as well as a  
12 disclosure form for conflict of interest evaluation purposes  
13 which shall include the name of the enrollee, any authorized  
14 representative acting on behalf of the enrollee, the enrollee's  
15 immediate family members, the health carrier that is the subject  
16 of the external review, the health benefit plan, the plan  
17 administrator, plan fiduciaries and plan employees if the  
18 enrollee is in a group health benefits plan, the health care  
19 providers treating the enrollee for purposes of the condition  
20 that is the subject of the external review and the providers'  
21 medical groups, the health care provider and facility at which  
22 the requested health care service or treatment would be



1 provided, and the developer or manufacturer of the principal  
2 drug, device, procedure, or other therapy that is the subject of  
3 the external review request.

4 (e) Each health carrier doing business in Hawaii shall  
5 file with the commissioner by the effective date of this part,  
6 information to permit the commissioner to perform a conflict of  
7 interest evaluation for selection of an appropriate independent  
8 review organization in the event of a request for external  
9 review involving the health carrier. A filing pursuant to this  
10 section shall include the name of the health carrier, its  
11 officers, directors, and management employees. The health  
12 carrier shall promptly amend its filing with the commissioner  
13 when there is any change of officers, directors, or managing  
14 employees.

15 (f) The commissioner may prescribe the form or format to  
16 use for the release authorization required by subsection (d) and  
17 the conflict of interest disclosures required by subsections (d)  
18 and (e).

19 (g) No disclosure required for purposes of this part shall  
20 include lawyer-client privileged communications protected  
21 pursuant to Hawaii Rule of Evidence 503.



1       **§432E-N Rules.** The insurance commissioner shall adopt  
2 rules pursuant to chapter 91 to effectuate the purpose of this  
3 part including by adopting requirements for forms to request  
4 external review and expedited external review, to request  
5 approval by independent review organizations, and for disclosure  
6 of conflicts of interest by enrollees and health carriers."

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

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

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

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

18       "**§432E-1 Definitions.** As used in this chapter, unless the  
19 context otherwise requires:

20       "Adverse action" means an adverse determination or a final  
21 adverse determination.



1       "Adverse determination" means a determination by a health  
2 carrier or its designated utilization review organization that  
3 an admission, availability of care, continued stay, or other  
4 health care service that is a covered benefit has been reviewed  
5 and, based upon the information provided, does not meet the  
6 health carrier's requirements for medical necessity,  
7 appropriateness, health care setting, level of care, or  
8 effectiveness, and the requested service or payment for the  
9 service is therefore denied, reduced, or terminated.

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

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

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

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



- 1        (2) A person authorized by law to provide substituted
- 2        consent for a enrollee;
- 3        (3) A family member of the enrollee or the enrollee's
- 4        treating health care professional, only when the
- 5        enrollee is unable to provide consent;
- 6        [~~1~~] (4) A court-appointed legal guardian;
- 7        [~~2~~] (5) A person who has a durable power of attorney for
- 8        health care; or
- 9        [~~3~~] (6) A person who is designated in a written advance
- 10       directive[+];
- 11       provided that an appointed representative shall include an
- 12       "authorized representative" as defined by the federal Patient
- 13       Protection and Affordable Care Act.
- 14       "Best evidence" means evidence based on:
- 15       (1) Randomized clinical trials;
- 16       (2) If randomized clinical trials are not available,
- 17       cohort studies or case-control studies;
- 18       (3) If the trials in paragraphs (1) and (2) are not
- 19       available, case-series; or
- 20       (4) If the sources of information in paragraphs (1), (2),
- 21       and (3) are not available, expert opinion.



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

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

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

9       "Certification" means a determination by a health carrier  
10 or its designated utilization review organization that an  
11 admission, availability of care, continued stay, or other health  
12 care service has been reviewed and, based on the information  
13 provided, satisfies the health carrier's requirements for  
14 medical necessity, appropriateness, health care setting, level  
15 of care, and effectiveness.

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

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



1 "Commissioner" means the insurance commissioner.

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

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

6 "Covered benefits" or "benefits" means those health care  
7 services to which an enrollee is entitled under the terms of a  
8 health benefit plan.

9 "Discharge planning" means the formal process for  
10 determining, prior to discharge from a facility, the  
11 coordination and management of the care that an enrollee  
12 receives following discharge from a facility.

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

17 "Emergency services" means services provided to an enrollee  
18 when the enrollee has symptoms of sufficient severity that a  
19 layperson could reasonably expect, in the absence of medical  
20 treatment, to result in placing the enrollee's health or  
21 condition in serious jeopardy, serious impairment of bodily





1 functions, serious dysfunction of any bodily organ or part, or  
2 death.

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

6 ~~["Expedited appeal" means the internal review of a  
7 complaint or an external review of the final internal  
8 determination of an enrollee's complaint, which is completed  
9 within seventy two hours after receipt of the request for  
10 expedited appeal.~~

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

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

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



1       "External review" means a review of an adverse  
2 determination (including a final adverse determination)  
3 conducted by an independent review organization pursuant to this  
4 chapter.

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

12       "Final adverse determination" means an adverse  
13 determination involving a covered benefit that has been upheld  
14 by a health carrier or its designated utilization review  
15 organization at the completion of the health carrier's internal  
16 grievance process procedures, or an adverse determination with  
17 respect to which the internal appeals process is deemed to have  
18 been exhausted under section 432E-C(b).

19       "Health benefit plan" means a policy, contract, certificate  
20 or agreement offered or issued by a health carrier to provide,  
21 deliver, arrange for, pay or reimburse any of the costs of  
22 health care services.



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

6        "Health care provider" or "provider" means a health care  
7 professional.

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

11       "Health carrier" means an entity subject to the insurance  
12 laws and regulations of this State, or subject to the  
13 jurisdiction of the commissioner, that contracts or offers to  
14 contract to provide, deliver, arrange for, pay for or reimburse  
15 any of the costs of health care services, including a sickness  
16 and accident insurance company, a health maintenance  
17 organization, a mutual benefit society, a nonprofit hospital and  
18 health service corporation, or any other entity providing a plan  
19 of health insurance, health benefits or health care services.

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



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

- 3 ~~(1) Is unbiased and able to make independent decisions;~~  
4 ~~(2) Engages adequate numbers of practitioners with the~~  
5 ~~appropriate level and type of clinical knowledge and~~  
6 ~~expertise;~~  
7 ~~(3) Applies evidence based decisionmaking;~~  
8 ~~(4) Demonstrates an effective process to screen external~~  
9 ~~reviews for eligibility;~~  
10 ~~(5) Protects the enrollee's identity from unnecessary~~  
11 ~~disclosure; and~~  
12 ~~(6) Has effective systems in place to conduct a review.]~~

13 that conducts independent external reviews of adverse  
14 determinations and final adverse determinations.

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

18 "Managed care plan" means any plan, policy, contract,  
19 certificate, or agreement, regardless of form, offered or  
20 administered by any person or entity, including but not limited  
21 to an insurer governed by chapter 431, a mutual benefit society  
22 governed by chapter 432, a health maintenance organization



1 governed by chapter 432D, a preferred provider organization, a  
2 point of service organization, a health insurance issuer, a  
3 fiscal intermediary, a payor, a prepaid health care plan, and  
4 any other mixed model, that provides for the financing or  
5 delivery of health care services or benefits to enrollees  
6 through:

- 7 (1) Arrangements with selected providers or provider  
8 networks to furnish health care services or benefits;  
9 and
- 10 (2) Financial incentives for enrollees to use  
11 participating providers and procedures provided by a  
12 plan;
- 13 provided that for the purposes of this chapter, an employee  
14 benefit plan shall not be deemed a managed care plan with  
15 respect to any provision of this chapter or to any requirement  
16 or rule imposed or permitted by this chapter which is superseded  
17 or preempted by federal law.
- 18 "Medical director" means the person who is authorized under  
19 a ~~[managed care plan]~~ health carrier and who makes decisions for  
20 the ~~[plan]~~ health carrier denying or allowing payment for  
21 medical treatments, services, or supplies based on medical



1 necessity or other appropriate medical or health benefit plan  
2 benefit standards.

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

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

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

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



- 1       (3) Medical journals recognized by the United States  
2       Secretary of Health and Human Services under Section  
3       1861(t)(2) of the federal Social Security Act;
- 4       (4) The following standard reference compendia:
- 5       (A) The American Hospital Formulary Service-Drug  
6       Information;
- 7       (B) Drug Facts and Comparisons;
- 8       (C) The American Dental Association Accepted Dental  
9       Therapeutics; and
- 10       (D) The United States Pharmacopoeia-Drug Information;
- 11       (5) Findings, studies, or research conducted by or under  
12       the auspices of federal government agencies and  
13       nationally recognized federal research institutes,  
14       including:
- 15       (A) The federal Agency for Healthcare Research and  
16       Quality;
- 17       (B) The National Institutes of Health;
- 18       (C) The National Cancer Institute;
- 19       (D) The National Academy of Sciences;
- 20       (E) The Centers for Medicare & Medicaid Services;
- 21       (F) The federal Food and Drug Administration; and



1           (G) Any national board recognized by the National  
2           Institutes of Health for the purpose of  
3           evaluating the medical value of health care  
4           services; or

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

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

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

15           "Protected health information" means health information as  
16 defined in the federal Health Insurance Portability and  
17 Accountability Act and related federal rules.

18           "Randomized clinical trial" means a controlled, prospective  
19 study of patients who have been randomized into an experimental  
20 group and a control group at the beginning of the study with  
21 only the experimental group of patients receiving a specific





1 intervention, which includes study of the groups for variables  
2 and anticipated outcomes over time.

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

8 "Reviewer" means an independent reviewer with clinical  
9 expertise either employed by or contracted by an independent  
10 review organization to perform external reviews.

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

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

19 "Utilization review" means a set of formal techniques  
20 designed to monitor the use of, or evaluate the clinical  
21 necessity, appropriateness, efficacy, or efficiency of, health  
22 care services, procedures, or settings. Techniques may include



1 ambulatory review, prospective review, second opinion,  
2 certification, concurrent review, case management, discharge  
3 planning, or retrospective review.

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

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

9 **"§432E-5 Complaints and appeals procedure for enrollees.**

10 (a) A [~~managed care plan~~] health carrier with enrollees in this  
11 State shall establish and maintain a procedure to provide for  
12 the resolution of an enrollee's complaints and internal appeals.  
13 The procedure shall provide for expedited internal appeals under  
14 section 432E-6.5. The definition of medical necessity in  
15 section 432E-1.4 shall apply in a [~~managed care plan's~~] health  
16 carrier's complaints and internal appeals procedures.

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



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

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

- 13 (1) The enrollee's right to request an external review;  
14 (2) The [~~sixty day~~] one hundred thirty day deadline for  
15 requesting an external review;  
16 (3) Instructions on how to request an external review; and  
17 (4) Where to submit the request for an external review.

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

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



1           "§432E-6.5 Expedited internal appeal, when authorized;  
2 standard for decision."

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

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

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

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

12           If a request for expedited appeal is approved by the  
13 [~~managed care plan or the commissioner,~~] health carrier, the  
14 appropriate [~~review~~] internal appeal shall be completed within  
15 seventy-two hours of receipt of the request for expedited  
16 appeal."

17           SECTION 10. Section 432E-6, Hawaii Revised Statutes, is  
18 repealed.

19           [~~"§432E-6 External review procedure. (a) After~~  
20 ~~exhausting all internal complaint and appeal procedures~~  
21 ~~available, an enrollee, or the enrollee's treating provider or~~  
22 ~~appointed representative, may file a request for external review~~



1 ~~of a managed care plan's final internal determination to a~~  
2 ~~three member review panel appointed by the commissioner composed~~  
3 ~~of a representative from a managed care plan not involved in the~~  
4 ~~complaint, a provider licensed to practice and practicing~~  
5 ~~medicine in Hawaii not involved in the complaint, and the~~  
6 ~~commissioner or the commissioner's designee in the following~~  
7 ~~manner:~~

- 8       ~~(1) The enrollee shall submit a request for external~~  
9       ~~review to the commissioner within sixty days from the~~  
10       ~~date of the final internal determination by the~~  
11       ~~managed care plan;~~
- 12       ~~(2) The commissioner may retain:~~
- 13           ~~(A) Without regard to chapter 76, an independent~~  
14           ~~medical expert trained in the field of medicine~~  
15           ~~most appropriately related to the matter under~~  
16           ~~review. Presentation of evidence for this~~  
17           ~~purpose shall be exempt from section 91-9(g); and~~
- 18           ~~(B) The services of an independent review~~  
19           ~~organization from an approved list maintained by~~  
20           ~~the commissioner;~~
- 21       ~~(3) Within seven days after receipt of the request for~~  
22       ~~external review, a managed care plan or its designee~~



1 ~~utilization review organization shall provide to the~~  
2 ~~commissioner or the assigned independent review~~  
3 ~~organization.~~

4 ~~(A) Any documents or information used in making the~~  
5 ~~final internal determination including the~~  
6 ~~enrollee's medical records;~~

7 ~~(B) Any documentation or written information~~  
8 ~~submitted to the managed care plan in support of~~  
9 ~~the enrollee's initial complaint; and~~

10 ~~(C) A list of the names, addresses, and telephone~~  
11 ~~numbers of each licensed health care provider who~~  
12 ~~cared for the enrollee and who may have medical~~  
13 ~~records relevant to the external review;~~

14 ~~provided that where an expedited appeal is involved,~~  
15 ~~the managed care plan or its designee utilization~~  
16 ~~review organization shall provide the documents and~~  
17 ~~information within forty eight hours of receipt of the~~  
18 ~~request for external review.~~

19 ~~Failure by the managed care plan or its designee~~  
20 ~~utilization review organization to provide the~~  
21 ~~documents and information within the prescribed time~~  
22 ~~periods shall not delay the conduct of the external~~



1 ~~review. Where the plan or its designee utilization~~  
2 ~~review organization fails to provide the documents and~~  
3 ~~information within the prescribed time periods, the~~  
4 ~~commissioner may issue a decision to reverse the final~~  
5 ~~internal determination, in whole or part, and shall~~  
6 ~~promptly notify the independent review organization,~~  
7 ~~the enrollee, the enrollee's appointed representative,~~  
8 ~~if applicable, the enrollee's treating provider, and~~  
9 ~~the managed care plan of the decision;~~

10 ~~(4) Upon receipt of the request for external review and~~  
11 ~~upon a showing of good cause, the commissioner shall~~  
12 ~~appoint the members of the external review panel and~~  
13 ~~shall conduct a review hearing pursuant to chapter 91.~~  
14 ~~If the amount in controversy is less than \$500, the~~  
15 ~~commissioner may conduct a review hearing without~~  
16 ~~appointing a review panel;~~

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

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



- 1           ~~(B) An external review conducted as an expedited~~  
2           ~~appeal shall be determined no later than seventy-~~  
3           ~~two hours after receipt of the request for~~  
4           ~~external review;~~
- 5           ~~(6) After considering the enrollee's complaint, the~~  
6           ~~managed care plan's response, and any affidavits filed~~  
7           ~~by the parties, the commissioner may dismiss the~~  
8           ~~request for external review if it is determined that~~  
9           ~~the request is frivolous or without merit; and~~
- 10          ~~(7) The review panel shall review every final internal~~  
11          ~~determination to determine whether the managed care~~  
12          ~~plan involved acted reasonably. The review panel and~~  
13          ~~the commissioner or the commissioner's designee shall~~  
14          ~~consider:~~
- 15          ~~(A) The terms of the agreement of the enrollee's~~  
16          ~~insurance policy, evidence of coverage, or~~  
17          ~~similar document;~~
- 18          ~~(B) Whether the medical director properly applied the~~  
19          ~~medical necessity criteria in section 432E 1.4 in~~  
20          ~~making the final internal determination;~~
- 21          ~~(C) All relevant medical records;~~
- 22          ~~(D) The clinical standards of the plan;~~





- 1           ~~(E) The information provided,~~
- 2           ~~(F) The attending physician's recommendations, and~~
- 3           ~~(G) Generally accepted practice guidelines.~~

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

7           ~~(b) The procedure set forth in this section shall not~~  
8 ~~apply to claims or allegations of health provider malpractice,~~  
9 ~~professional negligence, or other professional fault against~~  
10 ~~participating providers.~~

11          ~~(c) No person shall serve on the review panel or in the~~  
12 ~~independent review organization who, through a familial~~  
13 ~~relationship within the second degree of consanguinity or~~  
14 ~~affinity, or for other reasons, has a direct and substantial~~  
15 ~~professional, financial, or personal interest in:~~

16          ~~(1) The plan involved in the complaint, including an~~  
17           ~~officer, director, or employee of the plan, or~~

18          ~~(2) The treatment of the enrollee, including but not~~  
19           ~~limited to the developer or manufacturer of the~~  
20           ~~principal drug, device, procedure, or other therapy at~~  
21           ~~issue.~~



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

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

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

13       SECTION 11. If any provision of this Act, or the  
14 application thereof to any person or circumstance is held  
15 invalid, the invalidity does not affect other provisions or  
16 applications of the Act, which can be given effect without the  
17 invalid provision or application, and to this end the provisions  
18 of this Act are severable.

19       SECTION 12. This Act shall be construed at all times in  
20 conformity with the federal Patient Protection and Affordable  
21 Care Act, Public Law 111-148. In the event any provision of  
22 this part is interpreted to violate the Patient Protection and



1 Affordable Care Act, the commissioner is authorized to adopt by  
2 emergency rule-making procedures, any rules as necessary to  
3 conform the provisions and procedures of this part with the  
4 Patient Protection and Affordable Care Act.

5 SECTION 13. In codifying the new sections added by section  
6 2 of this Act, the revisor of statutes shall substitute  
7 appropriate section numbers for the letters used in designating  
8 the new sections in this Act.

9 SECTION 14. Statutory material to be repealed is bracketed  
10 and stricken. New statutory material is underscored.

11 SECTION 15. This Act shall take effect on January 1, 2011;  
12 provided that if the United State Department of Health and Human  
13 Services by rule or other written guidance extends the time  
14 period for the State's existing external review process under  
15 section 432E-6 to any later date during 2011, then the effective  
16 date of this Act shall be the sooner of the end date of the  
17 transition period or January 1, 2012; provided further that if  
18 the external review requirements of the federal Patient  
19 Protection and Affordable Care Act of 2010 are held  
20 unconstitutional by the United States Supreme Court, this Act  
21 shall be repealed as of the date that the Supreme Court issues  
22 its opinion and chapter 432E shall be reenacted in the form in



1 which it existed as of the day before the effective date of this  
2 Act.  
3



**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, in order to comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010. (SD1)

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

