
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, Public Law No. 111-
4 148, and its implementing regulations by updating Hawaii's
5 Patients' Bill of Rights and Responsibilities Act, chapter 432E,
6 Hawaii Revised Statutes, to conform to the requirements of the
7 federal law.

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

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

12 **INSURANCE DETERMINATIONS**

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

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



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

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

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



- 1 (1) A copy of the final internal determination of the
- 2 health carrier, unless exempted pursuant to subsection
- 3 (b);
- 4 (2) A signed authorization by or on behalf of the enrollee
- 5 for release of the enrollee's medical records relevant
- 6 to the external review;
- 7 (3) A disclosure for conflict of interests evaluation, as
- 8 provided in section 432E-M; and
- 9 (4) A filing fee of \$, which shall be refunded if the
- 10 adverse determination or final internal adverse
- 11 determination is reversed through external review.

12 The commission shall waive the filing fee required by this
13 subsection if payment of the fee would impose an undue financial
14 hardship to the enrollee. The annual aggregate limit on filing
15 fees for any enrollee within a single plan year shall not exceed
16 \$.

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

- 21 (1) The health carrier has waived the requirement of
- 22 exhaustion of the internal appeals process;



1 (2) The enrollee has applied for an expedited external
2 review at the same time that the enrollee applied for
3 an expedited internal appeal; provided that the
4 enrollee is eligible for an expedited external review;
5 or

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

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

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

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



1 was an enrollee in the health benefit plan at the time
2 the health care service was provided;

3 (2) The health care service that is the subject of the
4 adverse determination or the final adverse
5 determination would be a covered service under the
6 enrollee's health benefit plan but for a determination
7 by the health carrier that the health care service
8 does not meet the health carrier's requirements for
9 medical necessity, appropriateness, health care
10 setting, level of care, or effectiveness;

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

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

19 (c) Within three business days after a determination of an
20 enrollee's eligibility for external review pursuant to
21 subsection (b), the health carrier shall notify the
22 commissioner, the enrollee, and the enrollee's appointed



1 representative in writing as to whether the request is complete
2 and whether the enrollee is eligible for external review.

3 If the request for external review submitted pursuant to
4 this section is not complete, the health carrier shall inform
5 the commissioner, the enrollee, and the enrollee's appointed
6 representative in writing that the request is incomplete and
7 shall specify the information or materials required to complete
8 the request.

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

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

20 (d) Upon receipt of a request for appeal pursuant to
21 subsection (c), the commissioner shall review the request for
22 external review submitted by the enrollee pursuant to subsection



1 (a), determine whether an enrollee is eligible for external
2 review and, if eligible, shall refer the enrollee to external
3 review. The commissioner's determination of eligibility for
4 external review shall be made in accordance with the terms of
5 the enrollee's health benefit plan and all applicable provisions
6 of this part. If an enrollee is not eligible for external
7 review, the commissioner shall notify the enrollee, the
8 enrollee's appointed representative, and the health carrier
9 within three business days of the reason for ineligibility.

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

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



1 the external review and notify the health carrier of
2 the name of the assigned independent review
3 organization; and

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

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

17 (g) Within five business days after the date of receipt of
18 notice pursuant to subsection (e), the health carrier or its
19 designated utilization review organization shall provide to the
20 assigned independent review organization all documents and
21 information it considered in issuing the adverse action that is
22 the subject of external review. Failure by the health carrier



1 or its utilization review organization to provide the documents
2 and information within five business days shall not delay the
3 conduct of the external review; provided that the assigned
4 independent review organization may terminate the external
5 review and reverse the adverse action that is the subject of the
6 external review. The independent review organization shall
7 notify the enrollee, the enrollee's appointed representative,
8 the health carrier, and the commissioner within three business
9 days of the termination of an external review and reversal of an
10 adverse action pursuant to this subsection.

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



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

8 (i) In addition to the documents and information provided
9 pursuant to subsections (f) and (g), the assigned independent
10 review organization may consider the following in reaching a
11 decision:

- 12 (1) The enrollee's medical records;
- 13 (2) The attending health care professional's
14 recommendation;
- 15 (3) Consulting reports from appropriate health care
16 professionals and other documents submitted by the
17 health carrier, enrollee, enrollee's appointed
18 representatives, or enrollee's treating provider;
- 19 (4) The most appropriate practice guidelines, which shall
20 include applicable evidence-based standards and may
21 include any practice guidelines developed by the



1 federal government or national or professional medical
2 societies, boards, and associations;

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

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

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

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



1 action that is the subject of the internal review. The
2 independent review organization shall include in the notice of
3 its decision:

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

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

19 **§432E-E Expedited external review.** (a) Except as
20 provided in subsection (i), an enrollee or the enrollee's
21 appointed representative may request an expedited external
22 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 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
12 authorization for release and disclosures required by section
13 432E-C. Upon receipt of all items required by this subsection,
14 the 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 of
16 the reason for ineligibility within three business days.

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 of
4 the reasons for ineligibility within three business days.

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 accept and consider additional information
12 submitted by an enrollee after five business days.

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



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

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

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



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

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

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



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

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

14 The clinical reviewer's opinion shall be in writing and
15 shall include:

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



1 whether the adverse risks of the recommended or
2 requested health care service or treatment would not
3 be substantially increased over those of available
4 standard health care services or treatments;
5 (3) A description and analysis of any medical or
6 scientific evidence, as that term is defined in
7 section 432E-1, considered in reaching the opinion;
8 (4) A description and analysis of any evidence-based
9 standard, as that term is defined in section 432E-1;
10 and
11 (5) Information on whether the reviewer's rationale for
12 the opinion is based on approval of the health care
13 service or treatment by the federal Food and Drug
14 Administration for the condition or medical or
15 scientific evidence or evidence-based standards that
16 demonstrate that the expected benefits of the
17 recommended or requested health care service or
18 treatment is likely to be more beneficial to the
19 enrollee than any available standard health care
20 services or treatments and the adverse risks of the
21 recommended or requested health care service or
22 treatment would not be substantially increased over



1 those of available standard health care services or
2 treatments.

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

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

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

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

21 (2) The attending physician's or health care

22 professional's recommendation;



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

6 (4) Whether:

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

11 (B) Medical or scientific evidence or evidence-based
12 standards demonstrate that the expected benefits
13 of the recommended or requested health care
14 service or treatment is more likely than not to
15 be beneficial to the enrollee than any available
16 standard health care service or treatment and the
17 adverse risks of the recommended or requested
18 health care service or treatment would not be
19 substantially increased over those of available
20 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 the 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 to be in
11 compliance with this section to be eligible for approval under
12 this part.

13 The commissioner shall review, initially upon approval of
14 an accredited independent review organization and periodically
15 during the time that the independent review organization remains
16 approved pursuant to this section, the accreditation standards
17 of the nationally recognized private accrediting entity to
18 determine whether the entity's standards are, and continue to be
19 equivalent to, or exceed the minimum qualifications established
20 under this section; provided that a review conducted by the
21 National Association of Insurance Commissioners shall satisfy
22 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 on the effective date of this part until the initial
21 procurement process is completed; provided further that in any
22 year in which procurement subject to chapter 103D does not



1 produce at least three independent review organizations eligible
2 for selection under section 432E-I, the commissioner may approve
3 up to three independent review organizations notwithstanding the
4 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 that 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 the Hawaii Rules of Evidence Rule 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 requirements for forms to request external review
4 and expedited external review, to request approval by
5 independent review organizations, and for disclosure of
6 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 used in 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 rules of this State, or subject to the jurisdiction of
13 the commissioner, that contracts or offers to contract to
14 provide, deliver, arrange for, pay for, or reimburse any of the
15 costs of health care services, including a sickness and accident
16 insurance company, a health maintenance organization, a mutual
17 benefit society, a nonprofit hospital and health service
18 corporation, or any other entity providing a plan of health
19 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~~] that is
17 superseded 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 plan benefit
2 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 Pharmacopeia 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 and 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 appeal 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 [~~managed~~
13 ~~care plan or the commissioner,~~] health carrier, the appropriate
14 [~~review~~] internal appeal shall be completed within seventy-two
15 hours of receipt of the request for expedited appeal."

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

18 [~~"§432E-6 External review procedure. (a) After~~
19 ~~exhausting all internal complaint and appeal procedures~~
20 ~~available, an enrollee, or the enrollee's treating provider or~~
21 ~~appointed representative, may file a request for external review~~
22 ~~of a managed care plan's final internal determination to a~~



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

7 ~~(1) The enrollee shall submit a request for external~~
8 ~~review to the commissioner within sixty days from the~~
9 ~~date of the final internal determination by the~~
10 ~~managed care plan;~~

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

12 ~~(A) Without regard to chapter 76, an independent~~
13 ~~medical expert trained in the field of medicine~~
14 ~~most appropriately related to the matter under~~
15 ~~review. Presentation of evidence for this~~
16 ~~purpose shall be exempt from section 91-9(g); and~~

17 ~~(B) The services of an independent review~~
18 ~~organization from an approved list maintained by~~
19 ~~the commissioner;~~

20 ~~(3) Within seven days after receipt of the request for~~
21 ~~external review, a managed care plan or its designee~~
22 ~~utilization review organization shall provide to the~~



1 ~~commissioner or the assigned independent review~~
2 ~~organization:~~

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

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

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

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

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



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

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

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

19 ~~(A) The hearing shall be held no later than sixty~~
20 ~~days from the date of the request for the~~
21 ~~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 No. 111-148. If any provision of this part
22 is interpreted to violate the Patient Protection and Affordable



1 Care Act, the commissioner is authorized to adopt by emergency
2 rule-making procedures, any rules as necessary to conform the
3 provisions and procedures of this part with the Patient
4 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 July 1, 2050,
12 and apply retroactively to January 1, 2011; provided that if the
13 United States Department of Health and Human Services by rule or
14 other written guidance extends the time period for the State's
15 existing external review process under section 432E-6, Hawaii
16 Revised Statutes, to any later date during 2011, then the
17 effective date of this Act shall be the sooner of the end date
18 of the transition period or January 1, 2012; provided further
19 that if the external review requirements of the federal Patient
20 Protection and Affordable Care Act of 2010 are held
21 unconstitutional by the United States Supreme Court, this Act
22 shall be repealed as of the date that the United States Supreme



1 Court issues its opinion and chapter 432E, Hawaii Revised
2 Statutes, shall be reenacted in the form in which it existed as
3 of the day before the United States Supreme Court issued its
4 decision.



Report Title:

Insurance; Health; External Review Procedure

Description:

Provides uniform standards for external review procedures based on the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act, in order to comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010. Effective 7/1/2050. (SD2)

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