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GOVERNOR

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TO THE HOUSE COMMITTEE ON FINANCE

TWENTY-SIXTH LEGISLATURE
Regular Session of 2011

Friday, April 1, 2011 – Agenda #3
4 p.m.

TESTIMONY ON SENATE BILL NO. 1274, S.D. 2, H.D. 2 – RELATING TO HEALTH INSURANCE.

TO THE HONORABLE MARCUS R. OSHIRO AND MEMBERS OF THE COMMITTEE:

My name is Gordon Ito, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department supports this Administration bill which replaces the existing external review process for deciding health insurance coverage disputes with a new process based on a review by an independent review organization ("IRO") that conforms to the requirements of the federal Patient Protection and Affordable Care Act ("PPACA"). An IRO is a private organization that contracts with a medical doctor to give a medical opinion on a health insurance coverage dispute.

Hawaii already has an existing external review process located at Hawaii Revised Statutes section 432E-6 which involves review by a 3 member panel, but the process has suffered some serious setbacks. In 2004, the Hawaii Supreme Court ruled that this process was pre-empted by ERISA which means that those members who get their health insurance through their private employers could no longer use the external review process. In 2008, the Department of the Attorney General ruled that the EUTF was also exempted from the external review process. Today, the external review

process only handles individual, non-group members and Medicaid members. Also, we should point out that because Medicaid offers an administrative hearing at the Department Human Services we are offering a duplicative process to Medicaid members. Today, we get about one request per month for an external review, if that. As a result, there is almost nothing left of the original external review process and the process therefore does not help very many of Hawaii's citizens.

The PPACA regulation on external reviews (see Federal Register / Vol. 75, no. 141, July 23, 2010 / Rules and Regulations) requires that by July 1, 2011, Hawaii come into compliance with federal requirements and contemplates an IRO process. The regulation also cites to the National Association of Insurance Commissioner's model act on external reviews using an IRO. This is the model we used in developing HB 1047. In order to meet the federal requirements, and restore a workable process to Hawaii's people, we believe it is advisable to enact SB 1274. Note that we have carved out the EUTF and Medicaid from the proposed IRO program because they both have their own existing administrative appeals process. If we do not create an external review process that is compliant with the federal law, then as of July 1, 2011, the federal HHS will take over the external review process for Hawaii. Although we do not have a definitive decision from HHS, we believe that our current external review process is noncompliant with the federal law in some respects.

The use of an IRO for external reviews is well established. Medicare uses an IRO process as do many other states.

We believe that an IRO can handle a review of Hawaii's medical necessity statute (see HRS section 432E-1.4), which is only applicable in selected cases where there is no specific coverage exclusion. Currently, medical directors of health plans must do a medical necessity review.

We thank this Committee for the opportunity to present testimony on this matter and ask for your favorable consideration.

HAWAII MEDICAL ASSOCIATION
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Friday, April 1, 2011 4:00 PM Conference Room 308

To: COMMITTEE ON WAYS AND MEANS
Rep. Marcus R. Oshiro, Chair
Rep. Marilyn B. Lee, Vice Chair

From: Hawaii Medical Association
Dr. Morris Mitsunaga, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB1274 - Relating to Health Insurance

Chairs & Committee Members:

In Opposition to current form.

The Hawaii Medical Association has concerns about this measure. In its current form, this bill will harm those who now have recourse when health insurers deny essential or life-saving procedures.

This measure would gut the external review process. The current provisions of the Patients' Bill of Rights and Responsibilities should be left as-is to continue to protect patients rights. The medical necessity standard is very important.

The IRO process proposed by the replacement legislation is simply not going to achieve the same results as Hawaii's current protections provide. **Very importantly, the replacement legislation allows for evaluation by a non-local doctor. Hawaii has a unique disease makeup and mainland physicians may not understand necessary medical factors. There is no appeal allowed.**

Taking way external review, evaluation by local doctors and the right of appeal will **hurt consumers who are the most vulnerable to medical denials, namely Medicaid patients.** These patients will lose many of their advocacy rights and be denied care, which they may deserve.

While PPACA sets minimum standards, it does not require our superior patient protections to be dismantled. Thank you for the opportunity to provide this testimony.

OFFICERS
PRESIDENT - MORRIS MITSUNAGA, MD PRESIDENT-ELECT –ROGER KIMURA, MD
SECRETARY - THOMAS KOSASA, MD IMMEDIATE PAST PRESIDENT – DR. ROBERT C. MARVIT, MD TREASURER – STEPHEN KEMBLE, MD EXECUTIVE DIRECTOR – CHRISTOPHER FLANDERS, DO

HMSA

Blue Cross
Blue Shield
of Hawaii

April 1, 2011

The Honorable Marcus R. Oshiro, Chair
The Honorable Marilyn B. Lee, Vice Chair

House Committee on Finance

Re: SB 1274 SD2 HD2 – Relating to Health Insurance

Dear Chair Oshiro, Vice Chair Lee, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 1274 SD2 HD2 which would provide uniform standards for external review procedures based on a National Association of Insurance Commissioners (NAIC) Act in order to comply with Affordable Care Act (ACA) requirements. HMSA supports this measure but would respectfully request an amendment which we believe is necessary to ensure that a standardized set of criteria is being used by all reviewers.

The ACA requires that plans in all markets comply with state external review requirements that, at minimum, include the protections in the NAIC's External Review Model Act or for states without an external review process that meets these requirements and for self-funded plans, implement an external review process that meets minimum standards established by HHS through guidance. We appreciate the Insurance Commissioner's intent to ensure that existing state law pertaining to external appeals will be compliant with this ACA requirement.

While we agree with this measure, we also support the inclusion of one amendment:

<u>Include the HRS definition of "medical necessity"</u>
Health plans base appeal decisions on the medical necessity definition contained in Hawaii law. It would be prudent to ensure that when an IRO is conducting a review, the reviewer applies the same medical necessity criteria. Therefore we would request that the definition of "medical necessity" contained in HRS 432E-1 be included in specific sections within the measure so that the reviewer will consider and address this when conducting a review. This consideration of the medical necessity statute would be taken into account by the IRO through the following amendments:

- Page 10, Line 10: Change "may" to "must"
- Page 10, Line 19: Insert "(4) The application of medical necessity criteria as that term is defined in 432E-1" and renumber thereafter
- Page 17, Line 7: Change "may" to "must"
- Page 17, Line 16: Insert "(4) The application of medical necessity criteria as that term is defined in 432E-1" and renumber thereafter
- Page 32, Line 16: Change the reference to "432E-1" to "432E-1.4"
- Page 32, Lines 17-18: Change "evidence-based standard" to "medical necessity criteria"

Hawaii Medical Service Association | 818 Keeaumoku St.• P.O. Box 860 Honolulu, HI 96808-0860 | (808) 948-5110 | Branch offices located on Hawaii, Kauai and Maui | Internet address www.HMSA.com

We believe that this change will assist both the state and health plans in complying with the requirements of the ACA. Thank you for the opportunity to provide comments on SB 1274 SD2 HD2.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

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Friday, April 1, 2011

To: The Honorable Marcus R. Oshiro
Chair, House Committee on Finance

From: 'Ohana Health Plan

Re: Senate Bill 1274, Senate Draft 2, House Draft 2-Relating to Health Insurance

Hearing: Friday, April 1, 2011, 4:00 p.m.
Hawai'i State Capitol, Room 308

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana has utilized WellCare's national experience to develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to submit testimony in strong support of Senate Bill 1274, Senate Draft 2, House Draft 2-Relating to Health Insurance, as it necessary in order to help the State of Hawai'i conform to requirements under the Patient Protection and Affordable Care Act of 2010 (ACA).

This bill seeks to update Hawai'i's insurance laws to conform to the requirements relating to external medical reviews as established under the ACA, also known as National Healthcare Reform, and is based on the National Association of Insurance Commissioners (NAIC)'s Uniform Health Carrier External Review Model Act. Passage of this bill will provide a uniform and consistent external review procedure and will make the insurance statutes governing the external review of adverse determinations by health plans consistent and available to enrollees, while reducing confusion and inefficiencies in implementing Hawaii law.

The external review process, through an independent review organization (IRO) is very clearly laid out in the bill and ensures the protection of rights for plan enrollees, while balancing the necessity of proper and timely medical treatment. According to this bill, the IRO shall be comprised of physicians or other health care professionals who meet the minimum qualifications described in 432E- C and, through clinical experience in the past three years, are experts in the treatment of the enrollee's condition and knowledgeable about the recommended or requested health care service or treatment.

Additionally, neither the enrollee, the enrollee's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review and in reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process or internal appeals process, thus preserving the integrity of the medical decisions being made in the best interest of the patient.

To ensure timely accessibility and transparency the IRO is required, under this bill to maintain a toll-free telephone service to receive information on a twenty-four-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours, and must agree to maintain and provide to the commissioner the information required by this part.

To further protect impartiality, under this proposal an IRO may also not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers, nor have a material professional, familial or financial conflict of interest with any of the health carriers that is the subject of the external review, the covered person whose treatment is the subject of the external review or the covered person's authorized representative, any officer, director, or management employee of the health carrier that is the subject of the external review, the health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review, the facility at which the recommended health care service or treatment would be provided, or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

The process and procedures laid out under this bill are consistent with the model utilized by the NAIC on a national level, and strike the necessary balance to best ensure patient protection and timely access to medical treatment and supplies. More importantly, passage of this measure is necessary in order to conform Hawai'i's insurance laws to provisions of ACA.

We respectfully request that you pass Senate Bill 1274, Senate Draft 2, House Draft 2-Relating to Health Insurance. Mahalo for this opportunity to provide testimony in support of this measure.

Faith Action for

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Gamaliel Foundation Affiliate

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Mr. Patrick Zukemura
Oahu Lead Organizer

Ms. Terri Erwin
Maui Lead Organizer

April 1, 2011

COMMITTEE ON FINANCE
Rep. Marcus Oshiro, Chair

SB 1274, SD2, HD2
RELATING TO HEALTH INSURANCE

Date: April 1, 2011
Time: 4:00 pm
Room: 308

TESIMONY IN OPPOSITION

Good Afternoon Chair Oshiro:

I am Rev. Bob Nakata and I am the Chair of the FACE Health Care Committee and its past President. FACE is the largest State inter-faith and community organizing non-profit. We have 24 institutions on Maui, 27 on Oahu and one statewide. There are 38 churches, a Buddhist Temple, 2 Jewish congregations, 10 community groups and non-profit organizations and one labor union. FACE has a statewide participating membership base in excess of 40,000.

WE DO NOT SUPPORT THIS BILL.

Our Courts and Attorney General have made decisions regarding the application of the external review process to certain other groups. However, the vulnerable population of the Medicaid beneficiaries continue to have the external review process at their disposal. While the may have administrative remedies available, with the severe cut backs of our government employees, it is extremely possible that these rights could be curtailed to those that most need health care. The external review process allows rights to those least able to protect themselves. Do not take these rights away.

FACE feels the discussion of the impact of the Federal Affordable Care Act (ACH) on this important consumer issue is premature. This decision by the legislature to remove the benefits of the External Review could be better addressed in 2012. This will allow the public and FACE to have public discussion with recommendations as we better understand the impacts of the ACH.

Rev. Bob Nakata
Chair, FACE Health Care Committee

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Testimony of Ellen Godbey Carson
Submitted on behalf of Kaiser Foundation Health Plan, Inc.

Before the House Committee on Finance
April 1, 2011, 4:00 p.m.
Conference Room 308

SB 1274, SD 2, HD2 RELATING TO HEALTH INSURANCE

Chairman Oshiro and committee members, thank you for this opportunity to provide testimony on behalf of Kaiser on SB 1274, which creates a new external review law to comply with Federal law.

Kaiser supports the purpose and most terms of this bill but has several requested amendments for compliance and clarity.

First, the new Federal health reform law mandates this form of external review. Contrary to some of the testimonies you have received, Hawai`i cannot continue to use the existing State external review law in HRS § 432E-6 for health insurance benefit disputes. **Hawai`i must, by July 1, 2011, either have an external review law that meets Federal health reform law requirements, or it will be subjected to a Federal external review process over which Hawai`i will have no control.** That is why the Insurance Division has sought enactment of a new external review law that will both comply with Federal law and promote uniformity in resolving health benefit disputes.

Second, minor amendments cannot fix our existing law. The Hawai`i Supreme Court has invalidated our existing law for most of our health plans, and it is inapplicable to the vast majority of our residents. Minor amendments cannot fix the legal defects and would still be in violation of Federal law.

Third, proposed "consumer protections" from our current law cannot be included in SB 1274. Rafael del Castillo and Prof. Richard Miller urge that the three-person review panel and attorneys fee provision from our current law be preserved. But those requirements have already been held preempted by Federal ERISA law -- by a unanimous Hawaii Supreme Court -- in *HMAA v. Insurance Commissioner*, 106 Hawaii 21 (2004). Mr. del Castillo and Prof. Miller admit that Federal reform staff have already informed them that "Nothing has changed in terms of ERISA preemption." (*See* attached letter). Federal staff have also informed them that Hawaii's law has a problem because it does not use the IRO external review model approved by the Federal health reform act, and if we do not meet Federal standards, "**then there will be a Federal external review process that will preempt the state review process.**" (*Id.*)

Third, our current External Review law (HRS 432E-6) suffers numerous serious deficiencies compared to SB 1274. For example, our current standard review process under existing law usually takes many months, and generally entails retaining legal counsel, submitting advance written testimonies of all witnesses and briefs on relevant facts and law, making a personal appearance at a contested hearing to be examined and cross-examined, and presenting expert medical testimony. This is much more time-consuming and stressful on consumers than the Federal model adopted by SB 1274, which provides a decision within 45 days without need for lawyers or the burden of an evidentiary hearing. Moreover, under our current law, the two non-medical panel members can overrule the medical panel member on any issues, even those requiring medical expertise, and the plan must pay the member's attorneys fees even when the plan wins and did nothing whatsoever wrong. This all violates Federal law. Mr. del Castillo seeks to preserve all of these major deficiencies. That should not occur. SB 1274 does not prohibit the use of an attorney or medical expert, but neither does it require such use.

Finally, Kaiser requests the following amendments:

(1) The retroactivity clause in Section 15 should be deleted.

(2) Hawai`i's criteria for "medical necessity" in HRS § 432E-1.4 should be incorporated as a matter that the independent review organization and its reviewer should consider and address in their review, to assure reviews will be consistent with this Hawai'i law (in Sections 432E-__D(i); -__E(g); and -__F(q)).

(3) Each IRO case should be decided by only one IRO reviewer so as to eliminate the burden, time and cost of sending IRO cases to more than one medical expert reviewer.

(4) The termination clause in Section 15 should be deleted, so as to assure the Legislature has the ability to consider the relative benefits of this new law after it has been in operation. We believe this new external review procedure will provide a faster, more economical, and more reliable means to assure fair outcomes for those who currently do not have that option.

(5) Other minor clarifications are needed before finalization of this bill:
- the filing fees in §432E-__C(a) should be returned to their original stated amounts ($25 fee for single filing/$75 maximum per year limit), as authorized by Federal law;
- Section §432E-__F(r), "shall be a covered benefit" should be revised to say "shall be covered", as the IRO only makes coverage determinations in individual cases, and is not an insurer writing contractual plan benefits.

In summary, Kaiser supports the purpose of SB 1274 but requests these amendments for compliance and clarification purposes. I would be glad to assist in incorporating these amendments into the pending bill. Thank you for your consideration.

Attachment: March 29, 2011 Letter to Senator Suzanne N.J. Chun Oakland

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March 29, 2011

Via Hand-Delivery

Honorable Suzanne N.J. Chun Oakland
Hawai'i State Senate
Hawai'i State Capitol
415 South Beretania St, Room 226
Honolulu, Hawai'i 96813

Re: **Hawai'i External Review and S.B. 1274**

Dear Senator Chun-Oakland:

We write on behalf of Kaiser Foundation Health Plan, Inc. ("Kaiser") to correct seriously inaccurate and misleading statements in the March 21, 2011 letter to you from Rafael del Castillo ("Letter") regarding SB 1274 and external review in Hawai'i.

Mr. del Castillo's legal analysis is contrary to rulings by our Hawai'i Supreme Court and the U. S. Supreme Court. His request will invalidate our State law and subject us to Federal law over which Hawai'i will have no control.

First, ERISA preempts (invalidates) State laws that provide a remedy inconsistent with ERISA's Federal remedies for employer group plans. The only form of state external review law the U. S. Supreme Court has saved from the powerful preemptive force of ERISA is an independent medical review organization (IRO) review. The U. S. Supreme Court has saved IRO laws from ERISA preemption only because IRO review "does not resemble either contract interpretation or evidentiary litigation before a neutral arbiter, as much as it looks like a practice (having nothing to do with arbitration) of obtaining another medical opinion." *Rush Prudential v. Moran*, 536 U.S. 355 (2002). The federal agency (HHS) has confirmed to Mr. del Castillo that the rules "require an IRO process" and

of the problem with Hawai'i's law "not having an IRO review the case." *See* his Letter, Ex. 4, p. 3.

Second, the Hawai'i Supreme Court has ruled that our existing external review law is preempted by ERISA, because it is inconsistent with ERISA's remedies. The three person panel hearing procedure in HRS § 432E-6 more closely resembles "contract interpretation or evidentiary litigation before a neutral arbiter" than "a practice (having nothing to do with arbitration) of obtaining another medical opinion." *Haw. Mgmt. Alliance Ass'n ("HMAA") v. Ins. Comm'r*, 106 Hawai'i 21 (2004). Mr. del Castillo argues this unanimous Supreme Court decision is somehow no longer controlling law. He is mistaken. This decision is solid law in this State and is mandated by U.S. Supreme Court precedent, including the *Rush* case above. This lawfirm litigated the *HMAA* case successfully before our Supreme Court. We urge the State not to adopt another law that will be illegal under the *HMAA* case and applicable Federal laws.

Third, nothing in PPACA modifies ERISA's preemptive effect. The federal HHS agents have already informed Mr. del Castillo this: "Nothing has changed in terms of ERISA preemption." *See* his Letter, Ex. 4, p. 3 at bottom. Rather, PPACA (§2719) mandates an external review law consistent with the NAIC Model Act, which uses solely an IRO model approved in the *Rush* case. This confirms Congress intended to impose review only to the extent of the IRO model already upheld by the U.S. Supreme Court. Moreover, the federal agents consulted by Mr. del Castillo have informed him that if the law does not meet PPACA standards, "then there will be a federal external review process **that will preempt the state review process.**" *See* his Letter, Ex. 4, p. 1.

Fourth, Mr. del Castillo's lawfirm makes major income from pursuit of benefit disputes under the existing external review law. They are seeking to preserve their economic livelihood by urging you to adopt an invalid law. Mr. del Castillo urges that Hawai'i's existing external review law should be retained with only minor changes, and that consumers should be allowed to "elect" to pursue benefit disputes under the existing law or under a new IRO law modeled on the NAIC Model Act. **The law he proposes will be just as invalid as our current law for the vast majority of our residents and will fail to meet the new PPACA requirements.** Such a law would still entail a three person hearing process that resembles evidentiary litigation, with an attorneys fee provision and other remedies inconsistent with ERISA. Such a law would be preempted under ERISA, Hawaii will have no valid external law for all or most residents, and Federal law will require an external review process over which Hawaii will have no control.

Finally, our existing external review law suffers numerous serious deficiencies compared to the Final Interim Rule. For example, the process usually takes many months to obtain a ruling because of the challenge of coordinating schedules and scarce resources for the required three-member panel administrative hearing. The standard review process usually entails retaining legal counsel, submitting advance written testimony of all witnesses and briefs on relevant facts and law, making a personal appearance at a hearing to be examined and cross-examined, and presenting expert medical testimony, all of which is much more time-consuming and stressful on consumers than the IRO process in the NAIC model. Moreover, the two non-medical panel members can overrule the medical panel member on any issues, even those requiring medical expertise. Mr. del Castillo's technical corrections do not alter any of these major deficiencies.

To ensure that Hawaii has an external review procedure that meets PPACA requirements as well as ERISA preemption standards, the Legislature must pass SB1274 SD2 without the amendments suggested by Mr. del Castillo. To meet Hawaii's needs, we recommend that SB 1274 be amended to (1) require the IRO to consider the medical necessity criteria in HRS § 432E-1.4; (2) provide for review by only one IRO reviewer, not multiple reviewers; and (3) eliminate the retroactive clause in Section 15.

Sincerely,

Ellen Godbey Carson
Dianne Winter Brookins

EGC:DWB:rjkp

cc: Honorable Neil Abercrombie, Governor
Honorable Shan Tsutsui, Senate President
Honorable Calvin Say, Speaker of the House
Members of the House Committee on Judiciary
Members of the House Committee on Commerce and Consumer Protection
Honorable Gordon I. Ito

Rafael del Castillo

Attorney at Law

TESTIMONY IN OPPOSITION TO S.B. 1274 SD2 HD2

From: Rafael del Castillo, Attorney at Law
Personal testimony, not on behalf of any particular client or organization

To: House Committee on Finance
Hon. Representative Marcus R. Oshiro, Chair
Hon. Representative Marilyn B. Lee, Vice Chair

Hearing: April 1, 2011, 4:00 p.m., Conference Room 308

Thank you for the opportunity to submit testimony in OPPOSITION to S.B. 1274 SD2 HD2's repeal of Hawai`i's powerful consumer protections in H.R.S. § 432E-6, part of the Patients Bill of Rights and Responsibilities Act of 1998. Please refer to the first page of the Exhibits for a summary of the REPEALS to which I am opposed. I am taking a risk submitting the information I have attached about the history of Hawai`i's external review process, because I received a letter from Ellen Godbey Carson last week, on behalf of unnamed health plans, threatening to sue me unless I "cease and desist" providing government officials with that information. The letter makes only vague allegations about unspecified breaches of confidentiality and violations of my clients' privacy rights. My clients control their own privacy rights, and I can assure you they OPPOSE the REPEAL of the consumer protections they relied upon to appeal, successfully in 80% of cases, their health plans denials of care. I believe all of the information I am providing is lawfully at your command. The threats do, however, emphasize how vitally important S.B. 1274 is to the health plans. The reason is simple: S.B. 1274 SD2 HD2 *REPEALS VERY IMPORTANT CONSUMER PROTECTIONS* against managed care abuses. You will not find a consumer in Hawaii to support the repeal of those protections.

I compared HD 2 with HD 1. THE REPEAL OF CONSUMER RIGHTS HAS NOT BEEN AMENDED OR DELETED. The health plans are happy this Bill is sleepwalking through this Legislature. CONSUMERS ARE NOT.

WILL THIS LEGISLATURE GO DOWN IN HAWAI`I'S HISTORY
AS THE WORST FOR CONSUMERS

THE FACTS IN A NUTSHELL:

S.B. 1274 SD2 HD2 repeals the following protections for Hawaii consumers without justification:

- **No local hearing** – is it okay with you if some doctor in North Carolina makes a final and binding decision that the health plan reasonably denied the chemotherapy the doctors recommend for your spouse?
- **No right to appeal** – if a consumer loses, she is stuck with the health plan's denial of life-saving care

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- **No enforcement** – the assistance consumers have under existing law to enforce the law is repealed and consumers are left to fend for themselves against billion-dollar entities
- **The poor have no external review** – this is classic class warfare, leaving the poor at the mercy of profit-seeking insurance companies with no one to fight for them
- The end of mandatory close oversight of all health plans by the Insurance Commissioner

A simple questions preliminary questions will assist you in considering the testimony you will hear on S.B. 1274: Are you prepared to believe that Congress, and our Congressional delegation, intended for the Patient Protection and Affordable Care Act of 2010 ("PPACA") to repeal long-standing Hawai`i consumer rights which are superior to federal minimum protections?

THE ARGUMENT BY ADMINISTRATION-HEALTH PLAN ALLIANCE

- The Administration has been telling legislators that it is ***afraid*** our law will be preempted.

The Administration is asking you to take the drastic step of repealing long-standing consumer protections based on an unconfirmed fear: On March 23, when S.B. 1274 SD2 HD1 was heard by the House Committees on Consumer Protection and Judiciary, the committee members learned through 45 minutes of testimony and close questioning that, in the many months since the interim regulations were published in July 2010, the Administration HAS NEVER GOTTEN CONFIRMATION FROM FEDERAL POLICY MAKERS WHETHER ITS *FEAR* IS TRUE.

In fact, Prof. Richard Miller and I were the first to speak with the staff at the Center for Consumer Information and Insurance Oversight about the S.B. 1274 repeal thanks to Congresswoman Colleen Hanabusa's intervention. **The Federal officials with PPACA authority have taken *no position* on Hawaii's existing law.**

If the Administration earnestly pursued this issue with Federal policymakers, do you really believe that Hawaii would be compelled to REPEAL its far better consumer protections and adopt the Federal minimum protections?

- The Administration has been telling legislators that we must dumb down the existing guarantee of a face-to-face hearing by a 3-member panel in Hawaii to a review by a doctor in Minnesota or North Carolina that some third party organization (an "IRO") chooses because that federal minimum protection somehow will preempt Hawaii's superior protection.

The Administration is asking you to accept this argument on faith. Not only does the Administration have no confirmation that our process will be preempted, but it is counter-

intuitive. How can they say with a straight face that our 3-member panel is not superior to the Federal minimum?

- ***The Administration is asking you to believe that we could have IRO's in Hawaii reviewing denials.***

Really? Read the Bill. No doctor practicing in Hawaii could review a Hawaii case because the conflict of interest provisions prohibit it. Furthermore, where are all the Hawaii IROs? IROs have been around for years. We don't have them because they you have to have hundreds of cases to be even marginally viable as an organization.

- ***The Administration is asking you to believe that 264,000 poor people, 40,000 of whom are aged, blind, and disabled, will be just fine with no external review.***

S.B. 1274 SD2 HD2 also EXCLUDES 264,000 Medicaid enrollees in managed care from the external review, leaving them to appeal to the agency that holds the purse strings – which is, of course, not an "external" review at all. So much for Governor Abercrombie's solemn promise to protect the most vulnerable. **Should you have greater rights to external review than the poor?**

- ***The Administration is asking you to accept, on faith, that we must repeal Hawaii law for ERISA plan members.***

At the March 23 hearing, Insurance Commissioner Ito also told the committee members that in the many months since July 2010, he has not asked the U.S. Department of Labor whether the Administration's ERISA "fear" is correct. You are being asked to accept purely on faith this position about a complex issue on which the courts have the final say. In fact, all ERISA plan members will continue to have the right to the federally mandated external review. The PPACA gives members of plans employers purchase under the Prepaid Health Care Act a choice of external reviews. The Administration has nothing confirming that our existing external review law has to be repealed so that ERISA members CAN HAVE A CHOICE OF TWO REVIEWS.

- ***The Administration is simply silent about the repeal of the enforcement provisions of external review in existing law.*** Are you going to accept that consumer rights no longer need enforcement?

You have NO JUSTIFICATION for repealing the enforcement provision of H.R.S. § 432E-6(e), which indemnifies consumers for the costs they incur in having their cases heard by the panel, including expert and attorneys' fees. It is just baby out with the bath water. Of course the health plans want you to repeal the enforcement provision – do you believe consumers want that repealed?

Thank you for the opportunity to comment on this measure.

Rafael del Castillo

Encl

LIST OF H.R.S. §432E-6 CONSUMER PROTECTIONS REPEALED BY S.B. 1274 HD1

H.R.S. §432E-6 Consumer Protections	S.B. 1274 HD1
Consumers presently awaiting a hearing are guaranteed all of the rights and protections H.R.S. §432E-6 affords	Consumers presently awaiting a hearing will apparently be stranded because S.B. 1274 HD1 fails to preserve all of the H.R.S. §432E-6 rights and protections they were guaranteed on the date they filed their requests for external review
Consumers have the right to a face-to-face hearing before the Commissioner or his designee for all denials, and to present evidence and witnesses, including expert witnesses. For all denials valued at $500 or more, the right to a face-to-face hearing by a 3-person panel. The panel is chaired by a lawyer versed in Hawaii law, and includes a managed care plan representative and a licensed provider practicing in Hawaii	Consumers get no hearing at all. All external reviews are conducted by third party independent review organizations, by a single clinician of the independent review organization's choosing. That clinician, who is not required to have any prior knowledge of Hawaii's medical necessity law, makes the binding, final decision whether the plan's denial was reasonable
Consumers have a remedy for errors of fact or law. Consumers are guaranteed the right to appeal adverse decisions to the circuit court, and appellate courts if necessary. Plans are required to comply with decisions in favor of consumers. There is no stay from the Commissioner's orders absent very extraordinary circumstances.	Consumers have no remedy for errors the IRO physician makes on the law or applying the law to the facts. S.B. 1274 HD1 makes decisions by the third party independent review organization binding on the consumer
Consumers are assured of a level playing field against the legal resources and information available to plans Consumers are indemnified for expenses reasonably incurred in having their case prepared and presented by their own attorneys and experts. Win, lose, or draw, the consumer may not be denied coverage of reasonable expenses absent proof, at a special hearing, that the consumer's case was frivolous or in bad faith.	Consumers must bear the cost of any assistance they receive from attorneys or experts
All consumers are assured that Hawaii has a strong deterrent, of proven effectiveness, against managed care abuses.	All consumers have no assurance that sending cases to a third party independent review organization will be as effective a deterrent against managed care abuses as H.R.S. §432E-6 has been

EXHIBIT 1

EXHIBIT NO.	CASE #	PLAN TYPE	CASE NAME	HEALTH CARRIER'S ATTORNEY	DATE REQ FILED	HRG DATE	Plan's denial of coverage reversed or upheld	Reversed/ upheld in court	DISPUTE
	PR-00-010	ERISA	Siddiqui v. KAISER HEALTH PLAN	Allston Hunt Floyd & Ing		1/25/01	Settled during hearing process		Emergency admission of critically ill infant to tertiary center for dialysis - issuer denied coverage; no exhibit due to confidentiality clause Kaiser required in settlement agreement
D1	PR-01-009	ERISA	Jouxson v. HMSA	Allston Hunt Floyd & Ing		8/12/01	REVERSED		Issuer denied coverage of PET scan for diagnosis of rectal cancer
D2 & D2A	PR-03-307	ERISA	Shelton v. KAISER HEALTH PLAN	Allston Hunt Floyd & Ing		4/24/03	UPHELD	REVERSED	Issuer denied statutorily-mandated coverage of one-time in vitro fertilization
D3	PR-02-298	ERISA	Ho v. HMSA	Allston Hunt Floyd & Ing		6/25/03	Ultimately REVERSED		Issuer denied coverage of remicaid for treatment of severe rheumatoid arthritis; initial denial upheld; subsequent denial reversed and issuer instructed to look to evidence outside of medical records before denying coverage
D4	PR-03-416	ERISA	Simon v. HMSA	Allston Hunt Floyd & Ing		7/29/03	REVERSED		Issuer denied IMRT for prostate cancer, substituted injurious 3D modulated radiation
D5	PR-03-318	ERISA	Chapman v. HMSA	Allston Hunt Floyd & Ing		9/11/03	REVERSED		Issuer denied Kyphoplasty for treatment of painful spinal fracture, cancer patient
	HER-04-119844		Ashford v. HMSA	Allston Hunt Floyd & Ing	1/12/04		Settled before hearing		Issuer denied interferon for treatment of idiopathic pulmonary fibrosis, otherwise fatal; ; no exhibit due to settlement agreement
D6 & D6A	HER-03-119511	ERISA	Naki v. HMAA	Allston Hunt Floyd & Ing		2/5/04	UPHELD	REVERSED	Issuer denied gastric bypass surgery for extreme obesity
	HER-03-119567		Ota v. HMSA	Allston Hunt Floyd & Ing		4/21/04	Settled before hearing		Issuer denied interferon for treatment of idiopathic pulmonary fibrosis, otherwise fatal; ; no exhibit due to settlement agreement

EXHIBIT A

EXHIBIT NO.	CASE #	PLAN TYPE	CASE NAME	HEALTH CARRIER'S ATTORNEY	DATE REQ FILED	HRG DATE	Plan's denial of coverage reversed or upheld	Reversed/ upheld in court	DISPUTE
D7	PR-03-429		Thayer v. HMAA	Allston Hunt Floyd & Ing		5/20/04	REVERSED		Issuer denied coverage for previously approved emergency cancer surgery at the Mayo Clinic
D8	HER-03-119705	ERISA	Nakama v. KAISER HEALTH PLAN	Allston Hunt Floyd & Ing		6/10/04	UPHELD		Issuer denied coverage of moyamoya bypass surgery at Stanford; substituted surgery by neurosurgeon who had never performed procedure on humans
D9	HER-04-123438	ERISA	Fisher v. KAISER HEALTH PLAN	Allston Hunt Floyd & Ing		10/6/04	UPHELD	Appeal aborted by Baldado	Issuer denied coverage for out-of-state treatment for eating disorder and other mental health problems.
D10	HER-05-129003	Individual	Jarvis v. HMSA	Allston Hunt Floyd & Ing		11/8/05	REVERSED		Issuer denied coverage of total parenteral nutrition so patient could spend final weeks of life at home (TPN was being covered by State in hospital)
	HER-05-127163	Quest	Goldstein v. HMSA	Allston Hunt Floyd & Ing		9/21/05	Settled before hearing		Issuer denied surgery at Stanford for treatment for intractible testicular pain; surgery not available in Hawaii; no exhibit - subject to confidentiality clause in settlement agreement
	HER-05-129440	EUTF	Natchtigall v. HMSA	Allston Hunt Floyd & Ing		1/26/06 cont 4/28/06	Settled before hearing		Issuer denied coverage of diagnositic test to facilitate choice of treatment for breast cancer; no exhibit due to settlement agreement
	HER-06-131623	Individual	Kurasic v. HMSA	Allston Hunt Floyd & Ing		5/11/06	Settled before hearing		Issuer denied IV home treatment for lung cancer and skilled nursing care; ; no exhibit due to settlement agreement
D11	HER-06-130964	tate worke	Yogi v. HMSA	Koshiba Agena & Kubota		7/14/06	REVERSED		Issuer denied coverage of surgery to implant intrethecal morphine pump for intractable pain due to spinal injury
	HER-06-131306	ERISA	Shinno v. KAISER HEALTH PLAN	Allston Hunt Floyd & Ing		9/28/06	UPHELD	Kaiser later covered care on mainland	Issuer denied coverage for open heart surgery on mainland

EXHIBIT A

EXHIBIT NO.	CASE #	PLAN TYPE	CASE NAME	HEALTH CARRIER'S ATTORNEY	DATE REQ FILED	HRG DATE	Plan's denial of coverage reversed or upheld	Reversed/ upheld in court	DISPUTE
	HER-06-136631	QUEST	Padeken v. HMSA	Allston Hunt Floyd & Ing		12/21/06	Settled before hearing		Issuer denied chemotherapy to treat life-threatening lung disease; ; no exhibit due to settlement agreement
D13	HER-07-138457	EUTF	Adams v. HMSA	Allston Hunt Floyd & Ing		3/23/07	REVERSED		Issuer denied bone marrow transplant for multiple myeloma
	HER-07-137180	Individual	Swartz v. KAISER HEALTH PLAN	Allston Hunt Floyd & Ing		4/4/07	Settled before hearing		Issuer denied coverage of skilled nursing during elderly patient's recovery from injury; ; no exhibit due to settlement agreement
	HER-07-137300	QUEST	Panzo v. ALOHA CARE	Edward Kemper			Settled before hearing		Issuer denied reconstructive surgery after breast cancer; ; no exhibit due to settlement agreement
	HER-07-142265	QUEST	Santos v. HMSA	Allston Hunt Floyd & Ing		1/24/08	Settled before hearing		Issuer denied coverage of growth hormone therapy for severely retarded growth.
	HER- 08-149423	Individual	Kauth v. KAISER HEALTH PLAN	pro se	2/22/08		Settled before hearing		Issuer denied coverage of stroke evaluation by mainland bypass expert surgeon; ; no exhibit due to settlement agreement
D14	HER-09-149553	tate worke	Wood v. KAISER HEALTH PLAN	Allston Hunt Floyd & Ing		5/20/09	UPHELD		Issuer denied coverage of stem cell treatment for cancer otherwise untreatable cancer
D15	HER-09-152591	QExA	Sorensen v. OHANA HP	McCorriston Miller Mukai MacKinnon		1/28/10	REVERSED		Issuer denied coverage of sufficient skilled nursing for quadraplegic young adult who expired due to lack of coverage during respiratory emergency
D16	HER-09-149952		LaRue v. SUMMERLIN	Patrick Gallagher, Segawa Kane, Leah Reyes		4/22/10	REVERSED		Issuer denied coverage of emergency cardiac surgery for 2 month old infant
D17	HER-l0-153040	QExA	Delos Santos v. EVERCARE	Allston Hunt Floyd & Ing		5/11/10	REVERSED		Issuer denied coverage of sufficient skilled nursing for special needs child with life-threatening seizures
	HER-10-153666	QExA	Jung v. EVERCARE	Allston Hunt Floyd & Ing	5/18/10		Settled before hearing		Issuer denied coverage of care not available in Hawaii; ; no exhibit due to settlement agreement

EXHIBIT A

EXHIBIT NO.	CASE #	PLAN TYPE	CASE NAME	HEALTH CARRIER'S ATTORNEY	DATE REQ FILED	HRG DATE	Plan's denial of coverage reversed or upheld	Reversed/ upheld in court	DISPUTE
D18	HER-09-152033	QExA	Metsch v. EVERCARE	Allston Hunt Floyd & Ing		8/4/10	UPHELD	UNDER APPEAL	Issuer denied coverage of sufficient skilled nursing for special needs child with life-threatening seizures
	HER-10-154681	QExA	Tully v. EVERCARE	Allston Hunt Floyd & Ing	9/8/10		Otherwise resolved - thanks to clinical trial child's condition is greatly improved		Issuer denied various benefits including necessary care to participate in clinical trial offering only hope of survivial for child with life-threatening congenital abnormality.
		QExA	Tully v. EVERCARE	Allston Hunt Floyd & Ing			Settled before hearing		Issuer denied coverage of wheelchair for child with life-threatening congenital abnormality; no opinion due to settlement
D19	HER-l0-154685	QExA	Delos Santos v. EVERCARE	Allston Hunt Floyd & Ing		1/7/11	UPHELD		Skilled nursing care to continue care for medically fragile child in her home.
	HER-11-155699	QExA	Kolomalu v. OHANA HP	McCorriston Miller Mukai MacKinnon	2/26/10		Settled before hearing		Issuer dramatically reduced coverage of personal assistance hours necessary to carry out daily care and prevent injury to total quadriplegic; no opinion because Ohana reversed decision prior to hearing

EXHIBIT A

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March 14, 2011

Mr. Steve Larsen
Ms. Julie Harada
Center for Consumer Information and Insurance Oversight, Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

RE: <u>CCIIO Review of Hawai`i's External Review Law</u>

Dear Mr. Larsen:

I write concerning CCIIO approval of Hawai`i's external review law, Haw. Rev. Stat. §§ 432E-5, 6, and 6.5, *see* Exhibit 1, with certain minor technical corrections. These statutory sections are part of Hawai`i's Patient Bill of Rights and Responsibilities Act. The entire Chapter 432E, H.R.S., as amended, is enclosed as Exhibit 1. The Act, which the Legislature found was necessary to protect consumers from managed care abuses, was signed into law twelve years ago. It was entirely in keeping with, and expected to further, Hawai`i's nation-leading healthcare social contract, which had its beginnings in the Prepaid Health Care Act of 1973, Chapter 393, H.R.S., requiring employers to provide prepaid health coverage for employees. Hawaii remains the only state in the nation requiring employers to provide prepaid health insurance coverage, requiring employers to pay at least one-half of the premium and strictly limiting employee contributions to 1.5 per cent of the employee's wages. H.R.S. § 393-13.

The purpose of this letter is to secure CCIIO approval of Hawai`i's law subject to certain minor technical corrections. In pursuit of that goal, I am providing you with an element-by-element comparison with the sixteen consumer protections in the federal regulations. I am also providing you with a detailed history which demonstrates consumer experience in external review under that law for the past ten years. It is my understanding that this effort has substantial support in Hawai`i's Legislature, and uniform support among consumers, as discussed below. As the enclosed cases illustrate, Hawaii's hearing by a 3-person panel provides superior protections for consumers, not just those whose cases are reviewed, but all consumers.

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Rafael G. del Castillo, Member

BACKGROUND

I consider myself one of the most knowledgeable persons you can consult regarding Hawai`i's external review law as I have been lead counsel on behalf of consumers in nearly every external review case. My firm has won or settled, in favor of the consumer, over eighty percent of those cases. *See* Exhibit A for a list of those cases with the results summarized; *and see* Exhibit D for the collected findings, conclusions, and orders, and related appeals in selected cases, with highlights were referred to herein. As you review this information, please keep in mind the fact that Hawai`i's legislature created our external review law as part of the Patient Bill of Rights and Responsibilities Act in 1998 based upon very substantial participation by organizations representing consumers. It was created in our unique context in which, unlike the other 49 states, we have long had mandatory prepaid health care for employees in this state. As you might imagine, that context has affected our external review experience for several reasons, as discussed below. In summary, it is one of the main reasons why we have had few cases make it to a hearing. The other main reason is the fact that the consumer protections in our existing law are so effective that we have settled more many more cases than we have filed. We have, however, recently had a substantial uptick in the number of cases filed for the unsurprising reason that we had two major issuers join the market in 2009 and they are still learning that their experience in the other 49 states is no guide for their conduct in Hawai`i.

Notably, the Task Force our Legislature created from the various stakeholders in connection with the Act, to advise it on improving the consumer protections in the law was not convened to consider the consumer protections in the interim regulations nor to make recommendations to the Legislature in keeping with its mandate, and as appropriate as one would imagine that would be. I am unable to account for our Insurance Commissioner's failure to consult the Task Force in this case. The Task Force first set to work on a medical necessity statute in 1998. Two years later, it sent our present very effective medical necessity statute, found at H.R.S. § 432E-1.4 in Exhibit 1, to the Legislature with a unanimous recommendation. The recommended language was enacted without amendment. As discussed below, our medical necessity section has been sufficiently powerful and flexible to eliminate exclusions based upon "experimental" or "investigative" simply, without the extensive NAIC provisions proposed by the NAIC.

The repeal of our external review law the Commissioner has proposed will eliminate the unique private attorney general section, found at H.R.S. § 432E-6(e) (enclosed), which ensures that consumers have proper assistance with their appeal. Hawai`i consumers will have nothing in its place, as the Acting Commissioner failed to consult the Task Force in connection with the availability of Consumer Assistance Program Grants, and the interest within the Division that requested my assistance with applying, was extinguished. Taken together, the failure to apply for a CAP Grant and the elimination of the long-standing private attorney general section would leave Hawai`i consumers uniquely without advocacy or assistance consumers across the nation have because of the Patient Protection and Affordable Care Act. I questioned our Commissioner

about this result and he simply agreed that my assessment is correct. Accordingly, and as you will learn from the following discussion, it simply cannot be reasonably argued that Hawai`i consumers will be as well protected under the substitution of the sixteen elements as they have for the past twelve years under our existing law, and the criteria for requiring issuers to comply with the federal external review law cannot be met.

INTRODUCTION

After Hawai`i's acting Insurance Commissioner introduced companion bills for the repeal of the existing statute, I began travelling to every inhabited island in the State, meeting with consumers, to make them aware of the repeal because the acting Commissioner and our new Governor's Administration failed to provide the public with any notice whatsoever of the proposed repeal. (In fact, I only learned about the proposed repeal after an attorney for one of the issuers bragged to me that it would not be long before there were no more external review hearings.) Only the issuers support the repeal, which should demonstrate to you and our new State Government, legislators and the Administration, that a repeal of Hawai`i's existing law will leave consumers with materially less protection rather than more. I am absolutely confident that consumers are united in their opposition to the repeal of our existing law, which provides them with protections that are superior to the sixteen minimum consumer protections in the interim regulations with negligible exceptions that can be corrected with technical amendments I am proposing and have included with this submission. *See* Exhibit B, providing for technical amendments to allow concurrent expedited reviews, a four month statute of limitations (presently 60 days), relating to IRO conflicts of interest in the event an IRO is employed, requiring issuers to provide consumers with express advance notice that they may be required to release medical records relating to their complaint, and, although not required by the interim regulations, requiring issuers to report every internal appeal and its disposition to the Insurance Commissioner quarterly. With those technical amendments, Hawaii's law will fully comply with or exceed the sixteen minimum protections in the interim regulations.

No consumer would willingly give up the rights Hawaii's external review provides, and thus unified consumer opposition to a repeal can be assumed. Nonetheless, I am providing with this letter substantial proof that consumers, as they hear of the proposed repeal, uniformly oppose it. I have included a DVD with a copy of the Hawaii Public Radio program, "Town Square," which, according to my understanding, has over 60,000 listeners. The broadcast, which occurred on March 3, 2011, covered health care related bills in the Legislature. The first topic of discussion was the repeal of our external review. (This was the third radio program thus far dealing with this subject and I anticipate another will occur on Kauai on Tuesday, March 15. I also expect there to be television coverage during the week of March 14.) The "Town Square" host, Beth Ann Koslovich, began the program questioning State Senator Josh Green, M.D. about his Health Committee's decision to advance the Senate version of the Administration's bill to repeal Hawaii's external review law. (The House Health Committee killed the companion bill.) Ms. Koslovich remarked that she had been hearing from listeners "at a higher rate than usual"

with concerns about the repeal. She also said "I think that's what a lot of people are really concerned about, that we have had some very consumer-friendly ways of being in Hawai`i when it comes to the Prepaid Health Care Act, and making sure that this is not something that's been lost. This seems to be the thread of the conversation that we have had for many, many months, and certainly as applied to external review."

Senator Green stated that he agreed with consumers that they should continue to have the right to the administrative hearing process they have enjoyed for the past twelve years. He said, "we don't want to give up any ground on what we've got." He also responded to consumer questions that cases presently pending would not be denied any of the rights under Hawai`i's existing law, no matter what happens. I further believe the opposition to the repeal has substantial support among government leaders because Senator Green told listeners of an ongoing conversation with Secretary Sebelius concerning a possible exemption for Hawai`i. That would be appropriate, and this submission provides you with a host of substantial facts justifying such an exemption to the extent necessary to permit Hawaii consumers to retain all of their external review rights.

Hawai`i consumers do not believe that they have a patriotic duty to surrender rights they have enjoyed for a dozen years to put their external review process on a par with the rest of the nation. After all, Hawai`i has led the nation in health care reform for nearly four decades. No reasonable argument can be made that Hawai`i consumers should accept less just because the rest of the nation might move significantly forward in catching up because any sacrifice they might make will do nothing to advance health care reform in the other 49 states. As revealed by this submission, Hawai`i has had nation-leading consumer protection in health care since 1998, and our law meets and exceeds the consumer protections in the interim regulations in all material respects. Thus, on behalf of the consumers I represent and will represent in the future, I request that the CCIIO approve Hawaii's existing law. I promise that I will lobby until our legislature abandon's the proposed repeal and passes technical amendments to bring the minor issues into line with the interim regulations.

Since I began this letter and since Senator Green answered consumer questions during his "Town Square" interview concerning the fate of cases that have been filed but not completed in Hawai`i's external review under our law, I have heard reports of a recent related development. I have been travelling around the State working to protect our most vulnerable consumers from denials of medically necessary care by UnitedHealthcare Insurance Company, one of two issuers new to Hawai`i. UnitedHealthcare has a contract with Hawai`i's Department of Human Services to manage care for approximately half of Hawai`i's aged, blind, and disabled. United has recently embarked on a very aggressive program of denying covered services to high risk enrollees. I have filed several complaints in the external review and there are several more proceeding through United's internal review that I was expecting to progress to the external review. *See* Exhibit C for a list of the pending cases. The number of presently pending cases is unprecedented, but it also demonstrates that Hawaii's external review law is protecting

consumers and shows that any criticism of our law based upon the low number of cases over the past ten years is very suspect. In connection with the cases against United, I flew a Certified Legal Nurse Consultant in from Portland, Oregon to perform detailed assessments of the needs of those consumers to support the orders of their treating health care providers. The review is consistent with past practice of providing the external review panel with expert opinions to prove the medical necessity of the benefit or services the consumer's treating physicians have prescribed. Over a week's time, we assessed fifteen cases. Within one week of Senator Green's broadcast assurances that existing cases would continue under existing law, I began receiving reports that United was reversing its decisions to deny or cut benefits in some cases ripe for external review. It thus may be inferred that United is eliminating cases so that it can represent to the Legislature and the Administration that there will be no cases left to complete under existing law if it is successful in its campaign to secure a repeal of Hawai`i's existing law. It can also be inferred from United's conduct, including the unprecedented number of cases we have had to file, that, in the event it succeeds in winning a repeal of Hawai`i's existing law, United will go back to cutting benefits for those virtually defenseless consumers. The question thus is whether the Obama Administration and the Abercrombie Administration are truly sincere in their pledges to protect society's most vulnerable citizens, or whether I made a mistake in campaigning for both of those administrations.

COMPARISON OF HAWAI`I LAW WITH 16 MINIMUM PROTECTIONS

This comparison will refer to various provisions of Hawai`i law relevant to our external review. The primary vehicle for external review under the Hawai`i statute is found at H.R.S. § 432E-6. Expedited external and internal appeals are governed by additional provisions in H.R.S. § 432E-6.5. Internal appeals are governed by H.R.S. § 432E-5. Finally, external review is conducted in accordance with the medical necessity section at H.R.S. § 432E-1.4, which mandates standards for all plans irrespective of whether the plan may have its own medical necessity criteria. Under Hawai`i law, the external review is considered a contested case heard by an agency, the Insurance Division of the Department of Commerce and Consumer Affairs (DCCA). The external review is thus governed by the Hawai`i Administrative Procedure Act, Chapter 91, H.R.S. Relevant provisions are included in Exhibit 2. The external review is also governed by Title 16, Chapter 201 of the DCCA administrative rules for contested case proceedings. Relevant provisions are included in Exhibit 3.

The following discussion demonstrates that Hawai`i's external review law meets and, in most cases exceeds, all of the material 16 minimum consumer protections[1] listed in the interim regulations:

(i) The State process must provide for the external review of adverse benefit determinations (including final

[1] Hawai`i law must be amended to extend the deadline for filing requests for external review.

> **internal adverse benefit determinations) by issuers (or, if applicable, plans) that are based on the issuer's (or plan's) requirements for medical necessity, appropriateness or effectiveness of a covered benefit.**

Hawai`i law exceeds this minimum. All plans are required to apply Hawai`i's medical necessity statute, H.R.S. § 432E-1.4: "For contractual purposes, a health intervention **shall be covered** if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b)." Exhibit 1 (emphasis added). This provision supersedes any medical necessity definition an issuer might have, assuring all consumers that the same criteria will be applied no matter which plan they have. Section governing internal appeals also explicitly requires issuers to apply section 1.4 in the internal appeals process as well: "The definition of medical necessity in section 432E-1 shall apply in a managed care plan's complaints and appeals procedures." Exhibit 1, H.R.S. § 432E-5(a). Section 1 defines "medical necessity" as, "'Medical necessity' means a health intervention as defined in section 432E-1.4." Exhibit 1, H.R.S. § 432E-1.

The H.R.S. § 432E-1.4 criteria meet the minimum requirements of the regulation:

- Medical necessity:

  (b) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:

  (1) For the purpose of treating a medical condition;

- Appropriateness, health care setting, and level of care:

  (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;

- Efficacy:

  (3) Known to be effective in improving health outcomes; provided that:

  (A) Effectiveness is determined first by scientific evidence;

  (B) If no scientific evidence exists, then by professional standards of care; and

  (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and

> **(4)** Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

For example, in the case of *Adams v. HMSA*, Exhibit D13, the consumer demonstrated with scientific evidence based upon clinical trials that the treatment his hematology team prescribed was the most effective and thus the most appropriate treatment for his disease, considering the potential harms and benefits. *Adams* was eventually reversed because an appellate court determined the treatment was specifically excluded under the plan, but, as discussed below, Adams got his treatment. The issuer has since removed the purported exclusion from its plans.

The cases of *Jouxson v. HMSA*, Exhibit D1, *Ho v. HMSA*, Exhibit D3, *Simon v. HMSA*, Exhibit D4 at 3, and *Chapman v. HMSA*, Exhibit D5, for example, the treatment modality prescribed by the consumer's treating provider will never be subjected to clinical trials because conducting a trial would require subjecting patients to the lower cost alternative the plan approved. The consumer in each case proved with expert testimony that the only treatment modalities the plan would approve were higher risk, involved greater pain and discomfort, significant rehabilitation, and permanent injury or disfigurement. The cancer involved in the case of *Wood v. KAISER HEALTH PLAN*, Exhibit D14, is so rare (1:10,000,000) that there will never be clinical trials. Wood lost because the treatment she needed had only been clinically trialed on colon cancer and she could not prove through expert testimony that adenocarcinoma of the appendix is a colon cancer.

> **(ii) The State process must require issuers (or, if applicable, plans) to provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination.**

Hawai`i law meets this minimum requirement:

> **(b)** The managed care plan shall at all times make available its complaints and appeals procedures. The complaints and appeals procedures shall be reasonably understandable to the average layperson and shall be provided in a language other than English upon request. . . .
>
> **(d)** A managed care plan shall send notice of its final internal determination within sixty days of the submission of the complaint to the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the commissioner. The notice shall include the following information regarding the enrollee's rights and procedures:
>
> **(1)** The enrollee's right to request an external review;

(2) The sixty-day deadline for requesting the external review;

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

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

H.R.S. § 432E-5(b), (d).

(iii) To the extent the State process requires exhaustion of an internal claims and appeals process, exhaustion must be unnecessary where the issuer (or, if applicable, the plan) has waived the requirement, the issuer (or the plan) is considered to have exhausted the internal claims and appeals process under applicable law (including by failing to comply with any of the requirements for the internal appeal process, as outlined in paragraph (b)(2) of this section), or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal.

Hawai`i's process expressly requires exhaustion of internal claims before the Insurance Commissioner acquires jurisdiction. H.R.S. § 432E-6(a).

> (a) After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination to a three-member review panel appointed by the commissioner. . .

The statute does not expressly state that exhaustion is unnecessary where the issuer has waived the requirement or fails to comply with the internal appeals process. I believe that is because under Hawai`i common law, exhaustion is not required when an internal appeal would be futile. *See, i.e., Poe v. Haw. Labor Rels. Bd.*, 97 Hawai`i 528, 536, 40 P.3d 930 (2002). Accordingly, the Commissioner in *Sorenson v. Ohana Health Plan*, Exhibit D15, and *Metsch v. Evercare*, Exhibit D18, accepted the petitions for external review because the issuer had failed to inform the enrollee of its final denial.

- Hawai`i's law does not provide for concurrent expedited reviews. I do not believe we have had such a situation arise, although we have had expedited reviews. Nonetheless, I just had an instance in which that would have been necessary but for the CMS Office of Civil Rights intervention. I thus firmly concur with the Secretary's position that concurrent expedited consumer reviews constitute a minimum consumer protection. Our Legislature should pass a technical amendment explicitly providing for concurrent reviews, such as the amendment I will be proposing. *See* Exhibit B.

(iv) The State process provides that the issuer (or, if applicable, the plan) against which a request for external review is filed must pay the cost of the IRO for conducting the external review. Notwithstanding this requirement, the State external review process may require a nominal filing fee from the claimant requesting an external review. For this purpose, to be considered nominal, a filing fee must not exceed $ 25, it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, it must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single plan year must not exceed $ 75.

Hawai`i law exceeds these minimum requirements because there is no fee for filing a request for external review. Our law also ensures, with one potential exception, that consumer-petitioners have access to advocates and experts, and incur no costs in pursuing an external review:

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

Exhibit 1, H.R.S. § 432E-6(e). The Commissioner has consistently awarded expert fees as part of the costs due to the consumer-petitioner. A consumer-petitioner could feasibly be faced with attorneys' fees and costs incurred only if the Commissioner rules, after a hearing, that the petition for review was unreasonable, fraudulent, excessive, or frivolous. The Commissioner may retain an independent review organization or his own expert in reviewing a petition, but there is provision whatsoever for the costs incurred to be imposed upon a consumer-petitioner. Exhibit 1, H.R.S. § 432E-6(a)(2)(B).

(v) The State process may not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review. Thus, the process may not impose, for example, a $ 500 minimum claims threshold.

Hawai`i law meets this minimum requirement because there is no minimum dollar value on requests for review. The law does provide that where the value of the benefit is less than $500, the review may be conducted by a single hearing officer:

> **(4)** Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the external review panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel;

Exhibit 1, H.R.S. § 432E-6(a)(4)

> **(vi) The State process must allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.**

Hawai`i law requires a technical amendment to meet this minimum requirement, *see* Exhibit B, because the statute of limitations under the present law is sixty days: "**(1)** The enrollee shall submit a request for external review to the commissioner within sixty days from the date of the final internal determination by the managed care plan. . ." Exhibit 1, H.R.S. § 432E-6(a)(1).

> **(vii) The State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan, or the individual.**

Hawai`i law exceeds this minimum requirement inasmuch as it provides consumers with a face-to-face hearing before a local three-person panel and prohibits conflicts of interest. As discussed below, such a panel is superior to an IRO, which is the minimum requirement in the regulation. The Commissioner selects a panel comprised of a practicing provider, a plan administrator, and the Commissioner or his designee, as follows:

> **(a)** After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination to a three-member review panel appointed by the commissioner composed of a representative from a managed care plan not involved in the complaint, a provider licensed to practice and practicing medicine

> in Hawai`i not involved in the complaint, and the commissioner or the commissioner's designee . . .

Exhibit 1, H.R.S. § 432E-6(a). The law expressly prohibits appointments to the panel that would result in a conflict:

> **(c)** No person shall serve on the review panel or in the independent review organization who, through a familial relationship within the second degree of consanguinity or affinity, or for other reasons, has a direct and substantial professional, financial, or personal interest in:
>
> **(1)** The plan involved in the complaint, including an officer, director, or employee of the plan; or
>
> **(2)** The treatment of the enrollee, including but not limited to the developer or manufacturer of the principal drug, device, procedure, or other therapy at issue.

Exhibit 1, H.R.S. § 432E-6(c).

In the case of *Wood v. KAISER HEALTH PLAN*, KAISER used an IRO for its internal appeal. The hearing process upheld KAISER's denial just as the IRO did, but the panel found:

> 8. The Respondent's use of an IRO is not something the Panel wishes to discourage. However, it appears that the use of the IRO in this case was designed as an ex post, defensive action to buttress decisions that had already been made previously. It also appears that the IRO opinion was so lacking in any explanation of its conclusions as to be impossible to evaluate for quality and correctness. Therefore, the Panel declines to say that the Respondent's use of the IRO in this case was reasonable.

Exhibit D14 at 11 (COL 8). Ms. Wood passed away due to complications of chemotherapy, but not before the Maui community raised enough for her to have the SentoClone treatment she sought. Before she passed away she had the satisfaction of knowing two things: she demonstrated that the treatment was effective in halting the progress of her cancer, and she demonstrated to KAISER's oncologists and other oncologists in Hawaii the existence of an effective treatment for colon cancer which extends lives and may replace highly destructive courses of chemotherapy. She could never have achieved those goals if Hawaii's external review was limited to submissions to an IRO.

(viii) The State process must provide for maintenance of a list of approved IROs qualified to conduct the external

review based on the nature of the health care service that is the subject of the review. The State process must provide for approval only of IROs that are accredited by a nationally recognized private accrediting organization.

Hawai`i law meets the first requirement, requiring maintenance of a list of approved IROs: "**(2)** The commissioner may retain: . . .**(B)** The services of an independent review organization from an approved list maintained by the commissioner. . ." Exhibit 1, H.R.S. § 432E-6(a)(2). The definition of independent review organization under Hawai`i law does not mention accreditation, although the express criteria mirror the principal accreditation requirements:

> "Independent review organization" means an independent entity that:
>
> (1) Is unbiased and able to make independent decisions;
> (2) Engages adequate numbers of practitioners with the appropriate level and type of clinical knowledge and expertise;
> (3) Applies evidence-based decision making;
> (4) Demonstrates an effective process to screen external reviews for eligibility;
> (5) Protects the enrollee's identity from unnecessary disclosure; and
> (6) Has effective systems in place to conduct a review.

Exhibit 1, H.R.S. § 432E-1.

(ix) The State process must provide that any approved IRO has no conflicts of interest that will influence its independence. . . . The State process must further provide that the IRO and the clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review; the claimant (and any related parties to the claimant) whose treatment is the subject of the external review; any officer, director, or management employee of the issuer; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

Hawai`i law meets the first minimum requirement of the regulation, as it implicitly bans conflicts of interest in the H.R.S. § 432E-1 definition above at subparagraph (1). Hawai`i law will require a technical amendment incorporating the language of the second minimum requirement to fully comply. I plan to propose an amendment adopting the above language without modification. *See* Exhibit B.

> **(x) The State process allows the claimant at least five business days to submit to the IRO in writing additional information that the IRO must consider when conducting the external review and it requires that the claimant is notified of the right to do so. The process must also require that any additional information submitted by the claimant to the IRO must be forwarded to the issuer (or, if applicable, the plan) within one business day of receipt by the IRO.**

Hawai`i law exceeds this minimum requirement. H.R.S. § 432E-6(a)(4) subjects the review to the requirements of the Hawai`i Administrative Procedures Act, Chapter 91, H.R.S., and specifically, the contested case hearing requirements of H.R.S. § 91-9. Exhibit 2. A claimant is thus guaranteed of "reasonable notice" of the hearing, the right to be represented by counsel, and an opportunity to "present evidence and argument on all issues involved." The record must include all pleadings, motions, intermediate rulings, evidence received or considered, including oral testimony, exhibits, and a statement of matters officially noticed, offers of proof and rulings thereon, proposed findings and exceptions, a report of the officer who presided at the hearing, and any staff memoranda submitted to members of the agency in connection with their consideration of the case. Furthermore, the underlying administrative rules by which the Insurance Commissioner must hold hearings requires that the claimant be allowed to present an opening statement and closing argument, and present evidence and rebuttal evidence, subject only to the following:

> (a) The admissibility of evidence at the hearing shall not be governed by the laws of evidence and all relevant oral or documentary evidence shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs.

Exhibit 3, HAR § 16-201-21. Claimants thus have every reasonable opportunity to present any information they believe is relevant to their claim.

> **(xi) The State process must provide that the decision is binding on the issuer (or, if applicable, the plan), as well as the claimant except to the extent that other remedies**

are available under State or Federal law.

The consumer protections under Hawai`i law exceed this federal minimum. The issuer must immediately comply with decisions in favor of a claimant because, by law, no stay is allowed from the decision. The only exception is the exception that would apply in any case in which a court would find an injunction is warranted because the issuer would be irreparably harmed, no harm would come to the claimant, and the public interest would be served by a stay. Thus, in the case of *Adams v. HMSA*, Exhibit D13, HMSA covered Adams bone marrow transplant even though it appealed. Subsequently, the Commissioner's decision was reversed by the Intermediate Court of Appeals after it the circuit court had upheld his decision.

Claimants have the right to appeal from an adverse decision upholding the issuer's denial of coverage. The right of appeal is an essential consumer right because mistakes can be made. *See* Exhibits D2A and D6A, both cases in which the decision upholding the issuer's denial was overturned on appeal. In *Naki v. HMAA*, Exhibit D6 and D6A, the panel concluded that the plan specifically excluded coverage of gastric bypass surgery "as a benefit in connection with weight loss." Exhibit D6 at 4. The circuit court reversed, holding that the plain language of the plan was too broad and in conflict with other terms, so the panel's determination that the surgery was specifically excluded was clearly erroneous. Exhibit D6A at 6. *Shelton v. KAISER HEALTH PLAN* was a majority opinion, with the hearing officer dissenting. Exhibit D2 at 10 n1. KAISER convinced the other two members of the panel in *Shelton* that the consumer's age was an exception to the unequivocal statutory mandate requiring it to provide a one-time *in vitro* fertilization benefit if the plan member met the statutory eligibility requirements. Exhibit D2 at 5-6 (FOF 17) and 9 (COL 5). The circuit court reversed, holding that because it was undisputed that the consumer met the minimum statutory criteria to qualify for IVF, she was entitled to coverage. In both cases, the access to an appeal which Hawai`i law assures, protected the consumer from a mistake. In particular, the right protects the consumer where one of the panel members dissents based on a strong conviction that the issuer's decision should be reversed.

(xii) The State process must require, for standard external review, that the IRO provide written notice to the claimant and the issuer (or, if applicable, the plan) of its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) within no more than 45 days after the receipt of the request for external review by the IRO.

Hawai`i law exceeds this minimum protection inasmuch as it requires: " The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing." Exhibit 1, H.R.S. § 432E-6(a). In the case of *Adams v. HMSA*, Exhibit D13, the panel provided notice of its decision without an hour of the hearing's conclusion.

> **(xiii) The State process must provide for an expedited external review if the adverse benefit determination (or final internal adverse benefit determination) concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function. As expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer (or, if applicable, the plan) of the determination. If the notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.**

Expedited external review is available for any medically necessary service. Coverage of emergency services is simply required unless a service is specifically excluded under the plan. H.R.S. § 432E-3(5) requires that an issuer demonstrate to the Commissioner upon request that it, "Provides payment or reimbursement for adequately documented emergency services. . ." See Exhibit 1. Emergency services are specifically defined as, "services provided to an enrollee when the enrollee has symptoms of sufficient severity that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the enrollee's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death." Exhibit 1, H.R.S. § 432E-1.

Additionally, Hawai`i law requires issuers to provide expedited internal review and decide any expedited internal appeal, "as soon as possible after receipt of the complaint, taking into account the medical exigencies of the case, but not later than seventy-two hours after receipt of the request for expedited appeal." H.R.S. § 432E-5(c). The law sets criteria for determining whether an appeal must be treated as expedited, which are consistent with the Federal regulations. However, Hawai`i exceeds the federal requirements inasmuch as it requires a request to be treated as expedited if the treating health care provider requests that the appeal be given expedited handling. Exhibit 1, H.R.S. § 432E-6.5(c). Hawai`i law requires the Commissioner to conduct an expedited external review within 72 hours. Exhibit 1, H.R.S. § 432E-6.5(a)(2). Hawai`i law requires the issuer to provide the Commissioner with any

documents and information involving the claimant's request within forty-eight hours of receipt of the request for external review. Exhibit 1, H.R.S. § 432E-6(a)(3)(C).

Under Hawai`i law, there is no express provision for concurrent internal and external expedited reviews, nor does Hawai`i law expressly provide for an appeal to the Commissioner to decide whether the criteria for expedited internal appeal have been met. The existence of an implied appeal to the Commissioner is insufficient, as is the absence of a provision for concurrent appeals. The first is implied and has been used. In Metsch v. Evercare, consumer–petitioner requested review when Evercare failed to respond to requests for a final denial so she could proceed to review. *See* Exhibit D18. The Commissioner accepted the request for review. A technical amendment providing for concurrent expedited appeals would resolve that issue, such as the one I will propose if the House takes up S.B. 1274 after the Senate bills cross over. *See* Exhibit B.

> **(xiv) The State process must require that issuers (or, if applicable, plans) include a description of the external review process in or attached to the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants, beneficiaries, or enrollees, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.**

Hawai`i law exceeds the protection in the federal regulation inasmuch as it requires issuers to provide the description of the external review process rights required in section 17 of the NAIC Uniform Model Act in the notice of final denial, better ensuring that the claimant is advised of the right without having to search through plan documents or the member handbook. Hawai`i law requires issuers to provide in the notice the information that the claimant has a right to external review with the Commissioner, and to include instructions on how to request an external review, the contact information for the Commissioner, and the deadline for requesting the review. Exhibit 1, H.R.S. § 432E-5(d). Hawai`i law does not expressly require issuers to advise the claimant that a release may be required for medical records necessary to reach a decision. Hawai`i law requires the issuer to submit all records relied upon and therefore, to meet HIPAA requirements, issuers secure such releases. Thus, the claimant ultimately is provided notice, albeit not necessarily the advance notice section 17 requires in the plan documents. A technical amendment addressing that requirement would resolve that issue, such as the one I plan to submit if the House takes up S.B. 1274. *See* Exhibit B.

> **(xv) The State process must require that IROs maintain written records and make them available upon request to the State, substantially similar to what is set forth in section 15 of the NAIC Uniform Model Act.**

Hawai`i law meets the requirements of section 15. The law requires the Commissioner to maintain the entire record of each external review, including the recording of the proceeding, under the Hawai`i document retention regulations. Hawai`i law implicitly requires issuers and their IROs, if they use one, to maintain records because H.R.S. 432E-6(a)(3) requires them to submit any documents or information used in making a final internal determination to the Commissioner within seven days of the his request. Likewise, Hawai`i law requires the Commissioner to report to the legislature annually on "the number of external review hearing cases reviewed, the type of cases reviewed, a summary of the nature of the cases reviewed, and the disposition of the cases reviewed. The identities of the plan and the enrollee shall be protected from disclosure in the report." H.R.S. § 432E-13.

I nonetheless plan to submit a proposed amendment if the House takes up S.B. 1274 after the Senate bills cross over, requiring issuers to report quarterly on the number of requests received for internal review and their disposition because the Commissioner has made that an issue in proposing a repeal of Hawai`i's existing law. The previous Commissioner advocated for some years for the additional requirement that issuers report the number of internal appeals, and it is my understanding that he was unconvinced that complainants were being appropriately directed to internal and external appeals by one or more plans. I do not doubt that he is correct because I have handled several cases in which one of the smaller plans has improperly attempted to refuse coverage on the grounds of preexisting condition, which is unlawful under Hawai`i's Prepaid Health Care Act, Chapter 393, H.R.S. I have referred those cases to Department of Labor and Industrial Relations investigators and they were promptly resolved in the complainant's favor without the need for a review. Nonetheless, I do not doubt that there are problems with proper notice by the smaller plans, and Hawai`i should address them.

From my discussion with CCIIO staff, it is my understanding that one justification the Acting Commissioner offered for repealing the existing law was that the number of external reviews in Hawai`i have been few in comparison to the population. Exhibit D contains summaries of the cases of which I am aware, and collected findings and conclusions. Note that, while historically we have had only a relatively small number of cases with plans domiciled in Hawai`i, there are several new cases which have arisen against one of the two new foreign issuers that started doing business subject to the external review in February 2009. While the relatively small number of prior cases is consistent with the previous Commissioner's concern, it is not a valid justification for repeal because it does not follow that the numbers of external appeals will increase on account of replacing the existing hearing process with an IRO. A requirement to report on internal appeals will, however, reveal whether the factors I suggest do largely account for the small number of external reviews, increased to some extent by the suspected problems with notice by the smaller plans.

No study has been carried out concerning Hawai`i's unique context, and obviously the NAIC Uniform Model Act was directed at setting a floor based upon problems observed across a nation where no other state requires employers to provide prepaid health care for employees. It is

clear, however, that a number of the protections imposed by the Patient Protection and Affordable Care Act have been in place in Hawai`i for decades. Issuers must be approved by the Department of Labor and Industrial Relations ("DLIR") to offer a Prepaid Health Care Act plan. Furthermore, issuers are prohibited from denying coverage. Their only resort is to rates. Fairly universal coverage naturally has spread the risk over a wider population, and issuers have had to adjust their projections accordingly. The need to maintain DLIR approval and the ban on cherry-picking undoubtedly deters denials of care. This is particularly the case where competitive factors deter the plan from denying an employee coverage for fear of losing the account.

Hawai`i has had issues with rating that have disproportionately affected small businesses and individuals, but the risk is clearly spread wider than in any other state. As previously discussed, it has for decades been unlawful to deny coverage on the basis of a preexisting condition under any coverage required by the Prepaid Health Care Act. Aside from a handful of cases arising from failure to comply by one or two small plans, the ban has eliminated a whole class of cases which are reportedly significant in other jurisdictions.

Certainly the decision that Hawai`i's process was preempted by ERISA has eliminated some cases. However, most ERISA plans purchase their health coverage from one of the approved Prepaid Health Care Act plans on account of the employer's need to comply with the that law. As I understand your CCIIO staff, those purchased plans are subject to the state's review law and will not be preempted. Thus, we can expect to see a proportionate number of additional cases filed under Hawai`i's review. Replacing Hawai`i's hearing process with an IRO will make no difference in the number of cases that will be filed on account of that change.

Additionally, Hawai`i's hearing process is a powerful behavior modifier. As indicated in the summary provided by Exhibit A, issuers have settled a significant number of cases after they were filed for external review. My firm has not maintained exact records on all of the cases we have settled prior to submitting a request for external review, but our count of the cases in which we maintained some sort of record indicates that we have settled at least an equal number of cases prior to filing for external review. Having practiced under the law for a decade, I am certain that issuers have become more careful with denials with experience, to avoid incurring the costs of a review. That conclusion is further supported by the fact that virtually all of the cases I presently have are against one issuer, which began a line of business subject to the external review in Hawai`i in February2009. The other new foreign plan had one case before the external review and has subsequently reversed its decision on the eve of the hearing in our second case against it. It thus is fair to conclude Hawai`i's external review is an effective deterrent affecting plan internal review behavior. Given the former Commissioner's lengthy experience with the issuers, his concerns about monitoring the internal appeals process appear to be well founded. Thus, a technical amendment requiring issuers to report the number of denials and internal appeals would better inform the Commissioner and the Legislature whether additional consumer protections are needed, such as the amendment I plan to submit if the House takes up S.B. 1274. *See* Exhibit B.

(xvi) The State process follows procedures for external review of adverse benefit determinations (or final internal adverse benefit determinations) involving experimental or investigational treatment, substantially similar to what is set forth in section 10 of the NAIC Uniform Model Act.

Hawai`i law provides the minimum consumer protections under the interim regulations. Hawai`i does not have a special process for cases involving a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational. The examples cited below illustrate why Hawai`i's flexible process provides equal or better consumer protection. Under Hawai`i law, the review proceeds through the hearing process just as under the federal minimum consumer protections, the review proceeds through an IRO. Issuers are required to cover a "health intervention"[2] if it is "an otherwise covered category of service, not specifically excluded. . ." Thus, the terms "experimental" and "investigational" are not considered specific exclusions, and thus are essentially disregarded in the external review process. Hawai`i's medical necessity statute instead supplies the criteria that found in section 10 of the NAIC Uniform Model Act: a health intervention is covered when prescribed by the treating physician for the purpose of treating a medical condition, determined, ultimately by the review panel, to be the most appropriate delivery or level of service considering potential benefits and harms to the patient, if it is known to be effective in improving health outcomes, as determined first by scientific evidence, and if no scientific evidence exists, then by professional standards of care, and if no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion. Whether the health intervention is experimental or investigative is immaterial if the complainant is able to show that it is known to be effective, through scientific evidence, professional standards of care, or by expert opinion.

As is the case in section 10, a complainant may show that standard health care services are not medically appropriate. In the cases of *Jouxson v. HMSA*, Exhibit D1, and *Simon v. HMSA*, Exhibit D4, both discussed above, the treating provider recommended avoiding one or more standard treatments on account of the associated risks risks or side effects. In *Jouxson v. HMSA*, the standard treatment was a major surgery with attendant risks, recuperation, and rehabilitation. The risks were exacerbated by Jouxson's age. He avoided the surgery with a non-invasive PET scan HMSA refused to cover. The medical necessity statute enabled Jouxson to avoid the standard treatment. *See* Exhibit D1. Likewise, Simon sought approval of intensity modulated radiation therapy ("IMRT") to avoid shocking side effects of 3D conformal radiation

[2] "[A]n item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability." Exhibit 1, H.RS. § 432E-1.4(d).

therapy, which would have caused him to suffer permanent loss of function to save his life. *See* Exhibit D4 at 4 (FOF 18). Simon showed that, while IMRT was not the standard treatment for his condition, IMRT was superior. He thus avoided the 3D conformal radiation therapy and its side effects altogether. In *Yogi v. HMSA, see* Exhibit D11, Yogi won coverage of an implanted intrethecal pain pump his treating physicians recommended by showing that he had undergone repeated trials of the standard pain treatment regimens unsuccessfully. The hearing panel rejected HMSA's argument that Yogi be required to undergo additional trials causing him continuing pain and severe side effects.

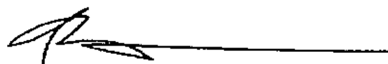
In *Wood v. KAISER HEALTH PLAN*, Exhibit D14, KAISER did not offer any treatment that was known to be effective or particularly beneficial for her very rare disease. The panel rejected KAISER's denial based upon the experimental nature of the adoptive immunotherapy treatment,SentoClone, for which Wood sought coverage. *See* Exhibit D14 at 7. Thus she was permitted to attempt to show that SentoClone was a more beneficial treatment than the destructive chemotherapy she could barely endure. Wood was unsuccessful basically because her disease is so rare and there is no agreement among experts that it is a form of the colon cancer SentoClone had been shown effective in treating. Nevertheless, Wood proved that for colon cancer patients, adoptive immunotherapy is an effective alternative to the chemotherapy which often leaves a patient disabled or shortens life because it destroys vital organs.

Hawai`i's hearing process provided an effective review of a treatment modality KAISER labeled "experimental," something an IRO under the interim regulations COULD NOT have achieved. In the *Wood* case, there were no experts in the United States who could have met the following requirements of section 10: "through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment." The SentoClone treatment Wood sought was developed in Sweden and undergoing clinical trials there. The only experts in the treatment to be found were at the Karolinska Institutet in Stockholm. Hawai`i's external review process was sufficiently flexible to include the Karolinska experts, thus utilizing experts effectively in evaluating an "experimental" treatment modality.

Hawai`i's process in each of the aforementioned cases afforded the claimant a fair hearing, and opportunity to offer scientific evidence and expert testimony to avoid standard treatments or undergo new treatments their treating providers had recommended, despite the plan's determination that the health intervention was experimental or investigative. Given my personal experience with these and other cases, I am confident that Hawai`i's law provides a more thorough examination of the efficacy and appropriateness of a recommended health intervention which the issuer has deemed experimental or investigative than is obtainable through the one or even several expert clinical reviewers. I do not believe that anyone can reasonably argue that an IRO will afford Hawaii consumers the same protections they have enjoyed for a dozen years thanks to the foresight and wisdom of our legislative leaders.

Thank you for your time and consideration reviewing Hawaii's external review law and these explanatory materials. I would appreciate the opportunity to discuss any concerns you may have which are not adequately addressed by these materials, and I am very willing to travel to Washington D.C. for that purpose if it would benefit Hawai`i's consumers.

Very truly yours,



Rafael del Castillo

Encl

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Hon. Colleen Hanabusa, United States House of Representatives
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Hon. Shan Tsutsui, President, Hawai`i State Senate
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Honolulu, Hawai`i 96813

RE: Hawaii External Review and S.B. 1274 HD1 Revision

Dear Senator Chun-Oakland:

In accordance with your request, I am attaching a table indicating the main protections Hawaii consumers have long enjoyed under H.R.S. §432E-6 which S. B. 1274 HD1 repeals. *See* Exhibit 1. Incidentally, I compared S. B. 1274 HD1 with S. B. 1274 SD2. S. B. 1274 HD1 replaces the word "commission" in section 432E-C(a)(4) with the word "commissioner" and changes the effective date to July 1, 2040. Otherwise HD1 is identical to SD2. SD2 significantly revised SD1, however.

With all due respect, repeal is the only way to describe the parts of the bill that strike H.R.S. §432E-6 in its entirety because S.B. 1274 HD1 does not replace those protections with equal or better rights. Striking H.R.S. §432E-6 constitutes a repeal of substantial rights. The table enclosed lists the rights Hawaii consumers enjoy under H.R.S. §432E-6 alongside any provision of S. B. 1274 HD1 providing discussion including any right in the same category, if S. B. 1274 HD1 provides any right. In accordance with your suggestion, I have included as Exhibit 3, a proposed HD2 which preserves existing protections and adds sections to our law incorporating a submission to a binding decision by an independent review organization in cases valued at less than $3,000, and an election by the consumer to submit cases valued at $3,000 or more to an independent review organization in lieu of the 3-member panel.

Federal Law Does Not Preempt or Require Repeal of Hawaii's More Strict Protections

Interim Federal regulations require Hawaii's external review law to provide sixteen minimum consumer protections. Those minimum protections are not intended to result in

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Rafael G. del Castillo, Member

consumers losing rights they already enjoy that are equal to or greater than the minimums. This is the wording of the federal act setting only minimum consumer protections in external reviews:

> EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage— "(1) shall comply with the applicable State external review process for such plans and issuers that, **at a minimum**, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; (Emphasis added.)

Contrary to this purpose of ensuring all states have minimum consumer protections in place, S. B. 1274 HD1 repeals substantial consumer protections. In their place, S. B. 1274 HD1 would leave Hawaii consumers with a regime favoring consumers with the greatest means and the highest levels of education. We hope that you will join with us in rejecting the institution of a large step backwards from Hawaii's historic commitment to fair and equal access to medically necessary care for all consumers, a move also counter to the spirit of the nation's long-overdue commitment to making health care a right.

How the Interim Federal Regulations Affect Existing Law

Reviewers at the Center for Consumer Information and Insurance Oversight ("CCIIO") will decide by July 1, 2011 whether Hawaii's external review law at least meets the sixteen minimum consumer protections. The Patient Protection and Affordable Care Act required universal minimum consumer protections because there were still four states which had no external review prior to its enactment, and other states which lacked some important consumer protections. **Hawaii was never one of the targets of the legislation or the regulations.** To understand how the minimum consumer protections are assured, the interim Federal regulations require all health insurance issuers and plans to comply with the Federal external review regulation in any state in which the CCIIO publishes a determination that the state's external review law does not provide the sixteen minimum protections. This HIPAA-style preemption operates until such time as state law is determined to meet the minimum consumer protections, at which time we expect the CCIIO would lift the requirement that issuers and plans comply with the Federal external review regulations. I am enclosing as Exhibit 4 a copy of the rough transcript of the telephone conference Professor Miller and I had with CCIIO staff on February 17, 2011, which confirms this description of the interim Federal regulations. The transcript also confirms that the Legislature has apparently been provided false information that S. B. 1274 HD1 is necessary to extend Hawaii's external review law to E.R.I.S.A. plans. As CCIIO staff stated, Hawaii's external review law will still be preempted for self-funded E.R.I.S.A. plans, which are required to comply with the Federal external review regulation.

It Is Not True That S. B. 1274 HD1 Is Necessary to Expand Coverage, the Opposite is True

Most consumer requests for external review will be subject to Hawaii's external review law going forward, irrespective of how Hawaii's external review law reads, and irrespective of what we retain of our existing law. The DLIR-approved group health plans employers purchase to comply with Hawaii's Prepaid Health Care Act **are subject to** Hawaii's external review law. This is a change from prior law which ensures that most consumer-members of E.R.I.S.A. plans have the right to external review under H.R.S. §432E-6 because the vast majority of employers purchase their group health plans. Finally, as noted in Exhibit 1, S. B. 1274 HD1 attempts to repeal significant existing consumer rights for approximately 264,000 members of QUEST and QExA plans. No measure this Legislature sends to this Governor for signature should deprive Hawaii's most vulnerable consumers of substantial protections they presently enjoy.

Hawaii's Existing External Review Provides the Protections the Federal Minimums Intend

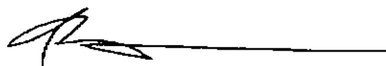
Hawaii law only requires some minor technical corrections to bring it into line with certain of the sixteen minimum consumer protections. I have listed the technical amendments I recommend in Exhibit 2, alongside the existing provisions under Hawaii law. I have already provided you with a list of the previous cases which have completed Hawaii's external review, in which consumers prevailed, either through settlement or eventual decision, including reversals on appeal, in approximately 80% of the cases. These statistics conclusively demonstrate that the Hawaii review works for consumers and support my conclusion that the technical amendments, while desirable, are not material or necessary to ensure full consumer protection under existing Hawaii law.

As we discussed, no legislation should deprive Hawaii consumers of existing substantive rights, and there is no reason why Hawaii law – as it has since the adoption of our Prepaid Health Law -- should not provide rights in addition to or greater than the sixteen minimum consumer protections in the interim Federal regulations. Thus, H.R.S. §432E-6, which provides those greater protections listed in Exhibit 1, should not be stricken. Neither should the provisions of S. B. 1274 HD1 imposing restrictions effectively repealing existing rights, also listed in Exhibit 1, be sent by our Legislature to the Governor for his signature. In keeping with your request, Professor Miller and I have redlined S. B. 1274 HD1 to incorporate the technical amendments listed in Exhibit 2 and eliminate the repeals of our existing substantive rights. Pursuant to Professor Miller's recommendation and Interim Commissioner Ito's request, we have incorporated a provision amending H.R.S. §432E-6 to require all disputes involving benefits valued at less than $3,000 to be submitted to an independent review organization from the list compiled and maintained by the Commissioner consistent with the minimum protections which assure the absence of conflicts of interest and the objectivity of independent review organizations. That amendment also allows consumers to opt for an independent review organization instead of the hearing Hawaii consumers are presently guaranteed under H.R.S.

§432E-6. This option ensures that our law will meet the minimum protection requirements of the Patient Protection and Affordable Care Act in PHS §2719.

Thank you for your consideration and anticipated assistance in assuring Hawaii consumers continue to enjoy all of their long-standing rights assuring protection from managed care abuses. I look forward to addressing any questions or concerns you might have and to working with you to ensure we maintain Hawaii's leadership in protecting consumer rights.

Very truly yours,



Rafael del Castillo

Encl

cc: Hon. Neil Abercrombie, Governor
Hon. Shan Tsutsui, Senate President
Hon. Calvin Say, Speaker of the House
Members of the House Committee on Judiciary
Members of the House Committee on Commerce and Consumer Protection
Hon. Gordon I. Ito

LIST OF H.R.S. §432E-6 CONSUMER PROTECTIONS REPEALED BY S.B. 1274 HD1

H.R.S. §432E-6 Consumer Protections	S.B. 1274 HD1
Consumers presently awaiting a hearing are guaranteed all of the rights and protections H.R.S. §432E-6 affords	Consumers presently awaiting a hearing will apparently be stranded because S.B. 1274 HD1 fails to preserve all of the H.R.S. §432E-6 rights and protections they were guaranteed on the date they filed their requests for external review
Consumers have the right to a face-to-face hearing before the Commissioner or his designee for all denials, and to present evidence and witnesses, including expert witnesses. For all denials valued at $500 or more, the right to a face-to-face hearing by a 3-person panel. The panel is chaired by a lawyer versed in Hawaii law, and includes a managed care plan representative and a licensed provider practicing in Hawaii	Consumers get no hearing at all. All external reviews are conducted by third party independent review organizations, by a single clinician of the independent review organization's choosing. That clinician, who is not required to have any prior knowledge of Hawaii's medical necessity law, makes the binding, final decision whether the plan's denial was reasonable
Consumers have a remedy for errors of fact or law. Consumers are guaranteed the right to appeal adverse decisions to the circuit court, and appellate courts if necessary. Plans are required to comply with decisions in favor of consumers. There is no stay from the Commissioner's orders absent very extraordinary circumstances.	Consumers have no remedy for errors the IRO physician makes on the law or applying the law to the facts. S.B. 1274 HD1 makes decisions by the third party independent review organization binding on the consumer
Consumers are assured of a level playing field against the legal resources and information available to plans Consumers are indemnified for expenses reasonably incurred in having their case prepared and presented by their own attorneys and experts. Win, lose, or draw, the consumer may not be denied coverage of reasonable expenses absent proof, at a special hearing, that the consumer's case was frivolous or in bad faith.	Consumers must bear the cost of any assistance they receive from attorneys or experts
All consumers are assured that Hawaii has a strong deterrent, of proven effectiveness, against managed care abuses.	All consumers have no assurance that sending cases to a third party independent review organization will be as effective a deterrent against managed care abuses as H.R.S. §432E-6 has been

EXHIBIT 1

EXHIBIT 2

SECTION 1. The legislature finds that the purpose of this measure is to comply with the requirements of the Patient Protection and Affordable Care Act of 2010 and its implementing regulations by updating Hawaii's patients' bill of rights and responsibilities, chapter 432E, Hawaii Revised Statutes, to conform to the requirements of the federal law.

SECTION 2. Chapter 432E, Hawaii Revised Statutes, is amended by correcting the statute of limitations and adding certain additional consumer protections to align with Federal Interim Regulations defining sixteen minimum consumer protections for external reviews.

SECTION 3. *Section 432E-6, Hawaii Revised Statutes, is amended* by amending subsection (a)(1) to read as follows:

"**(a)** After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination[A>. NOT LATER THAN FIFTEEN DAYS AFTER REQUESTING EXTERNAL REVIEW, EXCEPT IN THE CASE OF AN EXPEDITED EXTERNAL REVIEW SUBMITTED UNDER SECTION 432E-6.5, THE ENROLLEE SHALL SUBMIT WRITTEN NOTICE TO THE COMMISSIONER IF THE ENROLLEE ELECTS TO HAVE THE REVIEW PERFORMED BY AN INDEPENDENT REVIEW ORGANIZATION PURSUANT TO SECTION 432E-6.1. IF THE COMMISSIONER RECEIVES NO SUCH NOTICE OF ELECTION TO SUBMIT THE MANAGED CARE PLAN'S FINAL INTERNAL DETERMINATION TO AN INDEPENDENT REVIEW ORGANIZATION UNDER SECTION 432E-6.1, THE REVIEW SHALL BE BY<A] [D>to<D] a three-member review panel appointed by the commissioner composed of a representative from a managed care plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for external review to the commissioner within [D>sixty days<D] [A>FOUR MONTHS<A] from the date of the final internal determination by the managed care plan;

(2) T[A>O IDENTIFY OR CLARIFY THE ISSUES UNDER REVIEW, FOR HIS OWN USE, T<A]he commissioner may retain:

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

(B) The services of an independent review organization from an approved list maintained by the commissioner;"

SECTION 4. *Section 432E-6.5, Hawaii Revised Statutes, is amended* by adding a provision, amending subsection (a)(2) to read as follows:

"**(2)** The external review under section 432E-6 of the managed care plan's final internal determination. [A>THE ENROLLEE SHALL HAVE THE RIGHT TO REQUEST THAT THE EXPEDITED INTERNAL AND EXPEDITED EXTERNAL REVIEWS BE CONDUCTED

CONCURRENTLY WITHIN THE 72 HOUR TIME LIMITS SET FORTH IN SECTION 432E-5(c) AND 432E-6(a)(5)(B).<A]"

SECTION 5. *Section 432E-5, Hawaii Revised Statutes, is amended* by inserting a provision in subsections (a) and (d), to read as follows:

"**(a)** A managed care plan with enrollees in this State shall establish and maintain a procedure to provide for the resolution of an enrollee's complaints and appeals. The procedure shall provide for expedited appeals under section 432E-6.5. [A>THE MANAGED CARE PLAN SHALL PROVIDE THE ENROLLEE WITH WRITTEN NOTICE WITH ANY DENIAL OF THE ENROLLEE'S RIGHT TO REQUEST CONCURRENT EXPEDITED INTERNAL AND EXTERNAL REVIEWS, AS PROVIDED IN SECTION 432E-6.5(a)(2), BY MAKING APPLICATION TO THE COMMISSIONER.<A] The definition of medical necessity in section 432E-1 shall apply in a managed care plan's complaints and appeals procedures."

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

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

(2) The sixty-day deadline for requesting the external review;

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

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

[A> **(5)** THAT THE ENROLLEE MAY BE REQUIRED TO RELEASE MEDICAL RECORDS RELATING TO THE ENROLLEE'S COMPLAINT.<A]"

SECTION 6. *Section 432E-1, Hawaii Revised Statutes, is amended* by adding provisions to the definition of Independent review organization, to read as follows:

"'Independent review organization" means an independent entity that:

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

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

(3) Applies evidence-based decision making;

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

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

(6) Has effective systems in place to conduct a review.

[A>(7) HAS NO MATERIAL PROFESSIONAL, FAMILIAL, OR FINANCIAL CONFLICT OF INTEREST WITH THE ISSUER OR PLAN THAT IS THE SUBJECT OF

THE EXTERNAL REVIEW; THE CLAIMANT (AND ANY RELATED PARTIES TO THE CLAIMANT) WHOSE TREATMENT IS THE SUBJECT OF THE EXTERNAL REVIEW; ANY OFFICER, DIRECTOR, OR MANAGEMENT EMPLOYEE OF THE ISSUER; THE PLAN ADMINISTRATOR, PLAN FIDUCIARIES, OR PLAN EMPLOYEES; THE HEALTH CARE PROVIDER, THE HEALTH CARE PROVIDER'S GROUP, OR PRACTICE ASSOCIATION RECOMMENDING THE TREATMENT THAT IS SUBJECT TO THE EXTERNAL REVIEW; THE FACILITY AT WHICH THE RECOMMENDED TREATMENT WOULD BE PROVIDED; OR THE DEVELOPER OR MANUFACTURER OF THE PRINCIPAL DRUG, DEVICE, PROCEDURE, OR OTHER THERAPY BEING RECOMMENDED.

(8) ASSIGNS ONLY CLINICAL REVIEWERS TO CONDUCT AN EXTERNAL REVIEW WHO HAVE NO NO MATERIAL PROFESSIONAL, FAMILIAL, OR FINANCIAL CONFLICT OF INTEREST WITH THE ISSUER OR PLAN THAT IS THE SUBJECT OF THE EXTERNAL REVIEW; THE CLAIMANT (AND ANY RELATED PARTIES TO THE CLAIMANT) WHOSE TREATMENT IS THE SUBJECT OF THE EXTERNAL REVIEW; ANY OFFICER, DIRECTOR, OR MANAGEMENT EMPLOYEE OF THE ISSUER; THE PLAN ADMINISTRATOR, PLAN FIDUCIARIES, OR PLAN EMPLOYEES; THE HEALTH CARE PROVIDER, THE HEALTH CARE PROVIDER'S GROUP, OR PRACTICE ASSOCIATION RECOMMENDING THE TREATMENT THAT IS SUBJECT TO THE EXTERNAL REVIEW; THE FACILITY AT WHICH THE RECOMMENDED TREATMENT WOULD BE PROVIDED; OR THE DEVELOPER OR MANUFACTURER OF THE PRINCIPAL DRUG, DEVICE, PROCEDURE, OR OTHER THERAPY BEING RECOMMENDED.<A]"

SECTION 7. *Section 432E-10, Hawaii Revised Statutes, is amended* by adding a provision to subsection (b)(1) requiring managed care organizations to report every internal appeal and its disposition to the commissioner quarterly, to read as follows:

"[A>**(H)** MANAGED CARE PLANS SHALL ALSO REPORT QUARTERLY TO THE COMMISSIONER SUMMARY INFORMATION LISTING THE NUMBER OF INTERNAL APPEALS RECEIVED DURING THE QUARTER, THE NUMBER OF APPEALS COMPLETED WHICH WERE PENDING FROM THE PREVIOUS QUARTER, THE NUMBER OF APPEALS RECEIVED DURING THE QUARTER WHICH WERE COMPLETED, AND THE NUMBER OF APPEALS PENDING ON THE LAST DAY OF THE QUARTER. MANAGED CARE PLANS SHALL FURTHER REPORT TO THE COMMISSIONER ON EACH COMPLETED INTERNAL APPEALS THE NATURE OF THE HEALTH INTERVENTION REQUESTED AND THE DISPOSITION OF THE APPEAL, WHETHER GRANTED, DENIED, OR OTHER INTERVENTION SUBSTITUTED.<A]"

EXHIBIT 3

SENATE BILL 1274

THE SENATE S.B. NO.1274 H.D.2
TWENTY-SIXTH LEGISLATURE, 2011
STATE OF HAWAII

NOTICE:
PROPOSED AMENDMENTS TO HD1 FOR HD2 ARE INDICATED AS FOLLOWS:
New text is double-underlined
~~Deleted text is doublestricken.through~~

Amendments to existing statutory text within the amendments to HD1 are indicated as follows:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]
[D> ~~Text within these symbols is deleted~~ <D]

VERSION: House Draft [D>1<D] [A>2<A]

VERSION-DATE: March __, 2011

SYNOPSIS: A BILL FOR AN ACT RELATING TO HEALTH INSURANCE.

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

SECTION 1. The legislature finds that the purpose of this measure is to preserve Hawaii's existing external review consumer protections while complying ~~comply~~ with the requirements of the Patient Protection and Affordable Care Act of 2010, Public Law No. 111-148, and its implementing regulations by updating Hawaii's Patients' Bill of Rights and Responsibilities Act, chapter 432E, Hawaii Revised Statutes, to conform to the requirements of the federal law.

SECTION 2. *Section 432E-1, Hawaii Revised Statutes, is amended* to read as follows:

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

(a) [A>This part shall apply to all health carriers except where a policy or certificate provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long term care insurance, vision care, any other limited supplemental benefit; to a medicare supplemental policy of insurance, or the federal employees health benefits program, any federal medical and dental care coverage issued under chapter 55 of Title 10 United States Code and any coverage issued as supplemental to that coverage; any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance; automobile medical-payment insurance; any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis; or the employer union health benefits trust fund so long as it is self-funded.<A]

After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a [D>managed care plan<D][A>health carrier<A]'s final internal determination[A>. All requests for

external review of a health carrier's adverse action shall be made in accordance with the requirements of this section and section 432E-C. Where the amount of the denial in controversy is less than $3,000, the health carrier's final internal determination shall be submitted to an independent review organization as provided under section 432E-D. In all other cases, except in the case of an expedited external review submitted under section 432E-6.5, the enrollee shall submit written notice to the commissioner with the request for external review if the enrollee elects to have the review performed by an independent review organization pursuant to section 432E-D. If the commissioner receives no such notice of election to submit the health carrier's final internal determination to an independent review organization under section 432E-D, the review shall be by<A] [D> ~~to~~<D] a three-member review panel appointed by the commissioner composed of a representative from a [A>health carrier<A][D>~~managed care plan~~<D] not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for external review to the commissioner within [D> ~~sixty~~<D] [A>one hundred thirty <A] days from the date of the final internal determination by the managed care plan;

(2) T[A>o identify or clarify the issues under review, for his own use, t<A]he commissioner may retain:

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

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

(3) Within seven days after receipt of the request for external review, a [A>health carrier<A][D> ~~managed care plan~~<D] or its designee utilization review organization shall provide to the commissioner or the assigned independent review organization:

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

(B) Any documentation or written information submitted to the [A>health carrier<A][D> ~~managed care plan~~<D] in support of the enrollee's initial complaint; and

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

provided that where an expedited appeal is involved, the [A>health carrier<A][D> ~~managed care plan~~<D] or its designee utilization review organization shall provide the documents and information within forty-eight hours of receipt of the request for external review.

Failure by the managed care plan or its designee utilization review organization to provide the documents and information within the prescribed time periods shall not delay the conduct of the external review. Where the [A>carrier<A][D>~~plan~~<D] or its designee utilization review organization fails to provide the documents and information within the prescribed time periods, the commissioner may issue a decision to reverse the final internal determination, in whole or part, and shall promptly notify the independent review organization, the enrollee, the enrollee's appointed

representative, if applicable, the enrollee's treating provider, and the [A>health carrier<A][D> ~~managed care plan~~<D] of the decision;

(4) Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the external review panel and shall conduct a review hearing pursuant to chapter 91. [D> ~~If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel~~<D];

~~"PART . EXTERNAL REVIEW OF HEALTH~~

~~INSURANCE DETERMINATIONS~~

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

~~(b) This part shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, any other limited supplemental benefit; to a medicare supplemental policy of insurance, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any federal medical and dental care coverage issued under chapter 55 of Title 10 United States Code and any coverage issued as supplemental to that coverage; any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance; automobile medical-payment insurance; any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis; or the employer union health benefits trust fund so long as it is self-funded.~~

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

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

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

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

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

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

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

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

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

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

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

Section 432E-D ~~Standard e~~External review by independent review organization. (a) All requests for external review of an adverse decision where the amount of the denial in controversy is valued at less that $3,000 and all external reviews, where the enrollee submits a valid election for review by independent review organization shall be subject to this section. ~~An enrollee or the enrollee's appointed representative may file a request for an external review with the commissioner within one hundred thirty days of receipt of notice of an adverse action.~~ Within three business days after the receipt of a request for external review pursuant to this section, the commissioner shall send a copy of the request to the health carrier.

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

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

(2) The health care service that is the subject of the adverse determination or the final adverse determination would be a covered service under the enrollee's health benefit plan but for a determination by the health carrier that the health care service does not meet the ~~health carrier's~~ requirements for medical necessity under section 432E-1.4~~, appropriateness, health care setting, level of care, or effectiveness~~;

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

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

(c) Within three business days after a determination of an enrollee's eligibility for external review pursuant to subsection (b), the health carrier shall notify the commissioner, the enrollee, and the enrollee's appointed representative in writing as to whether the request ~~is~~ appears to be complete and whether the health carrier agrees that the enrollee is eligible for external review.

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

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

Notice of ineligibility for external review pursuant to this section shall include a statement informing the enrollee and the enrollee's appointed representative that a health carrier's initial

determination that the external review request is ineligible for review may be appealed to the commissioner by submission of a request to the commissioner.

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

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

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

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

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

(g) Within five business days after the date of receipt of notice pursuant to subsection (e), the health carrier or its designated utilization review organization shall provide to the assigned independent review organization all documents and information it considered in issuing the adverse action that is the subject of external review. Failure by the health carrier or its utilization review organization to provide the documents and information within five business days shall not delay the conduct of the external review; provided that the assigned independent review organization may terminate the external review and reverse the adverse action that is the subject of the external review. The independent review organization shall notify the enrollee, the enrollee's appointed representative, the health carrier, and the commissioner within three business days of the termination of an external review and reversal of an adverse action pursuant to this subsection.

(h) The assigned independent review organization shall, within one business day of receipt by the independent review organization, forward all information received from the enrollee pursuant to subsection (f) to the health carrier. Upon receipt of information forwarded to it pursuant to this subsection, a health carrier may reconsider the adverse action that is the subject of the external review; provided that reconsideration by the health carrier shall not delay or terminate an external review unless the health carrier reverses its adverse action and provides coverage or payment for the

health care service that is the subject of the adverse action. The health carrier shall notify the enrollee, the enrollee's appointed representative, the assigned independent review organization, and the commissioner in writing of its decision to reverse its adverse action within three business days of making its decision to reverse the adverse action and provide coverage. The assigned independent review organization shall terminate its external review upon receipt of notice pursuant to this subsection from the health carrier.

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

(1) The enrollee's medical records;

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

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

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

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

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

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

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

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

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

(3) The date the external review was conducted;

(4) The date the decision was issued; and

(5) The basis for the independent review organization's decision, including its reasoning, rationale, and the supporting evidence or documentation, including evidence-based standards, that the independent review organization considered in reaching its decision.

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

Section 432E-E Expedited external review by an independent review organization. (a) Except as provided in subsection (i) and section 432E-6(a) for review by a 3-member panel, an enrollee or the enrollee's appointed representative may request an expedited external review ~~with the commissioner~~by an independent review organization if the enrollee receives:

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

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

(3) A final adverse determination if the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services; provided that the enrollee has not been discharged from a facility for health care services related to the emergency services.

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

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

(c) Upon receipt of a request for appeal pursuant to subsection (b), the commissioner shall review the request for expedited external review submitted pursuant to subsection (a) and, if eligible, shall refer the enrollee for external review. The commissioner's determination of eligibility for expedited external review shall be made in accordance with the terms of the enrollee's health benefit plan and all applicable provisions of this part. If an enrollee is not eligible for expedited external review, the commissioner shall immediately notify the enrollee, the enrollee's appointed representative, and the health carrier of the reasons for ineligibility.

(d) If the commissioner determines that an enrollee is eligible for expedited external review even though the enrollee has not exhausted the health carrier's internal review process, the health carrier shall not be required to proceed with its internal review process. The health carrier may elect to proceed with its internal review process even though the request is determined by the commissioner to be eligible for expedited external review; provided that the internal review process shall not delay or terminate an expedited external review unless the health carrier decides to reverse

its adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination. Immediately after making a decision to reverse its adverse determination, the health carrier shall notify the enrollee, the enrollee's authorized representative, the independent review organization assigned pursuant to subsection (c), and the commissioner in writing of its decision. The assigned independent review organization shall terminate the expedited external review upon receipt of notice from the health carrier pursuant to this subsection.

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

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

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

(1) The enrollee's pertinent medical records;

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

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

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

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

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

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

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

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

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

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

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

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

Section 432E-F External review of experimental or investigational treatment adverse determinations <u>by an independent review organization</u>. (a) <u>Where</u> ~~An~~ <u>an</u> enrollee or an enrollee's appointed representative ~~may~~ <u>has</u> file<u>d</u> a request for an external review <u>by an independent review organization and for external reviews subject to review by independent review organization pursuant to section 432E-6(a),</u> ~~with the commissioner within one hundred thirty days of receipt of notice of an~~<u>where the</u> adverse action ~~that~~ involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational.

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

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

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

(d) Upon receipt of a request for appeal pursuant to subsection (c), the commissioner shall review the request for external review submitted by the enrollee pursuant to subsection (a), determine whether an enrollee is eligible for external review and, if eligible, shall refer the enrollee

to external review. The commissioner's determination of eligibility for external review shall be made in accordance with the terms of the enrollee's health benefit plan and all applicable provisions of this part. If an enrollee is not eligible for external review, the commissioner shall notify the enrollee, the enrollee's appointed representative, and the health carrier of the reason for ineligibility within three business days.

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

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

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

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

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

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

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

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

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

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

(C) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the health care service or treatment that is the subject of the adverse action;

(4) The enrollee's treating physician:

(A) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the enrollee, in the physician's opinion, than any available standard health care services or treatments; or

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

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

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

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

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

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

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

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

(i) Upon receipt of a request for appeal pursuant to subsection (h), the commissioner shall review the request for external review submitted pursuant to subsection (a) and, if eligible, shall refer the enrollee for external review. The commissioner's determination of eligibility for expedited external review shall be made in accordance with the terms of the enrollee's health benefit plan and all applicable provisions of this part. If an enrollee is not eligible for external review, the commissioner shall notify the enrollee, the enrollee's appointed representative, and the health carrier of the reasons for ineligibility within three business days.

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

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

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

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

(l) Within five business days after the date of receipt of notice pursuant to subsection (j), the health carrier or its designated utilization review organization shall provide to the assigned independent review organization all documents and information it considered in issuing the adverse action that is the subject of external review. Failure by the health carrier or its utilization review organization to provide the documents and information within five business days shall not delay the conduct of the external review; provided that the assigned independent review organization may terminate the external review and reverse the adverse action that is the subject of the external review. The independent review organization shall notify the enrollee, the enrollee's appointed representative, the health carrier, and the commissioner within three business days of the termination of an external review and reversal of an adverse action pursuant to this subsection.

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

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

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

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

(n) The assigned independent review organization, within one business day of receipt by the independent review organization, shall forward all information received from the enrollee pursuant to subsection (k) to the health carrier. Upon receipt of information forwarded to it pursuant to this subsection, a health carrier may reconsider the adverse action that is the subject of the external

review; provided that reconsideration by the health carrier shall not delay or terminate an external review unless the health carrier reverses its adverse action and provides coverage or payment for the health care service that is the subject of the adverse action. The health carrier shall notify the enrollee, the enrollee's appointed representative, the assigned independent review organization, and the commissioner in writing of its decision to reverse its adverse action and within three business days of making its decision to reverse the adverse action and provide coverage. The assigned independent review organization shall terminate its external review upon receipt of notice pursuant to this subsection from the health carrier.

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

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

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

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

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

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

(5) Information on whether the reviewer's rationale for the opinion is based on approval of the health care service or treatment by the federal Food and Drug Administration for the condition or medical or scientific evidence or evidence-based standards that demonstrate that the expected benefits of the recommended or requested health care service or treatment is likely to be more beneficial to the enrollee than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

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

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

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

(1) The enrollee's pertinent medical records;

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

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

(4) Whether:

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

(B) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the enrollee than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

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

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

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

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

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

(4) The date the external review was conducted;

(5) The date the decision was issued;

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

(7) The rationale for its decision.

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

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

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

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

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

Section 432E-G Binding nature of external review decision by an independent review organization. (a) An external review decision shall be binding on the health carrier and the enrollee except to the extent that the health carrier or the enrollee has other remedies available under applicable federal or state law.

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

Section 432E-H Approval of independent review organizations. (a) An independent review organization shall be approved by the commissioner in order to be eligible to be assigned to conduct external reviews under this part.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Toll-free telephone, facsimile, and email capabilities to receive information related to external reviews twenty-four hours a day, seven days per week that are capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours and facilitating necessary communication under this part; and

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

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

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

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

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

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

(c) An independent review organization shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control over a health carrier, health benefit plan, a

national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

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

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

(2) The enrollee whose treatment is the subject of the external review, the enrollee's appointed representative, or the enrollee's immediate family;

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

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

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

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

(7) The health benefit plan that is the subject of the external review, the plan administrator, or any fiduciary or employee of the plan.

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

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

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

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

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

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

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

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

The report shall include in the aggregate by state, and for each health carrier:

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

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

(3) The average length of time for resolution;

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

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

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

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

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

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

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

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

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

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

Section 432E-L Funding of external review. The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review. There shall be no recourse against the commissioner for the cost of conducting the external review and the selection of an independent review organization shall not be subject to chapter 103D; provided that the commissioner may initially approve up to three independent review organizations to serve beginning on the effective date of this part until the initial procurement process is completed; provided further that in any year in which procurement subject to chapter 103D does not produce at least three independent review organizations eligible for selection under section 432E-I, the commissioner may approve up to three independent review organizations notwithstanding the requirements of chapter 103D.

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

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

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

(d) Each health carrier shall have available on its website and provide upon request to any enrollee, forms for the purpose of requesting an external review, which shall include an authorization release form that complies with the federal Health Insurance Portability and Accountability Act as well as a disclosure form for conflict of interest evaluation purposes that shall include the name of the enrollee, any authorized representative acting on behalf of the enrollee, the enrollee's immediate family members, the health carrier that is the subject of the external review, the health benefit plan, the plan administrator, plan fiduciaries and plan employees if the enrollee is in a group health benefits plan, the health care providers treating the enrollee for purposes of the condition that is the subject of the external review and the providers' medical groups, the health care provider and facility at which the requested health care service or treatment would be provided, and the developer or manufacturer of the principal drug, device, procedure, or other therapy that is the subject of the external review request.

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

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

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

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

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

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

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

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

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

[A> "ADVERSE ACTION" MEANS AN ADVERSE DETERMINATION OR A FINAL ADVERSE DETERMINATION. <A]

[A> "ADVERSE DETERMINATION" MEANS A DETERMINATION BY A HEALTH CARRIER OR ITS DESIGNATED UTILIZATION REVIEW ORGANIZATION THAT AN ADMISSION, AVAILABILITY OF CARE, CONTINUED STAY, OR OTHER HEALTH CARE SERVICE THAT IS A COVERED BENEFIT HAS BEEN REVIEWED AND, BASED UPON THE INFORMATION PROVIDED, DOES NOT MEET THE HEALTH CARRIER'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE, OR EFFECTIVENESS, AND THE REQUESTED SERVICE OR PAYMENT FOR THE SERVICE IS THEREFORE DENIED, REDUCED, OR TERMINATED. <A]

[A> "AMBULATORY REVIEW" MEANS A UTILIZATION REVIEW OF HEALTH CARE SERVICES PERFORMED OR PROVIDED IN AN OUTPATIENT SETTING. <A]

"Appeal" means a request from an enrollee to change a previous decision made by the [D> managed care plan. <D] [A> HEALTH CARRIER. <A]

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

[A> (1) A PERSON TO WHOM A ENROLLEE HAS GIVEN EXPRESS WRITTEN CONSENT TO REPRESENT THE ENROLLEE IN AN EXTERNAL REVIEW; <A]

[A> (2) A PERSON AUTHORIZED BY LAW TO PROVIDE SUBSTITUTED CONSENT FOR A ENROLLEE; <A]

[A> (3) A FAMILY MEMBER OF THE ENROLLEE OR THE ENROLLEE'S TREATING HEALTH CARE PROFESSIONAL, ONLY WHEN THE ENROLLEE IS UNABLE TO PROVIDE CONSENT; <A]

[D> (1) <D] [A> (4) <A] A court-appointed legal guardian;

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

[D> (3) <D] [A> (6) <A] A person who is designated in a written advance directive [D> . <D] [A> ; <A]

[A> PROVIDED THAT AN APPOINTED REPRESENTATIVE SHALL INCLUDE AN "AUTHORIZED REPRESENTATIVE" AS USED IN THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. <A]

[A> "BEST EVIDENCE" MEANS EVIDENCE BASED ON: <A]

[A> (1) RANDOMIZED CLINICAL TRIALS; <A]

[A> (2) IF RANDOMIZED CLINICAL TRIALS ARE NOT AVAILABLE, COHORT STUDIES OR CASE-CONTROL STUDIES; <A]

[A> (3) IF THE TRIALS IN PARAGRAPHS (1) AND (2) ARE NOT AVAILABLE, CASE-SERIES; OR <A]

[A> (4) IF THE SOURCES OF INFORMATION IN PARAGRAPHS (1), (2), AND (3) ARE NOT AVAILABLE, EXPERT OPINION. <A]

[A> "CASE MANAGEMENT" MEANS A COORDINATED SET OF ACTIVITIES CONDUCTED FOR INDIVIDUAL PATIENT MANAGEMENT OF SERIOUS, COMPLICATED, PROTRACTED, OR OTHER HEALTH CONDITIONS. <A]

[A> "CASE-CONTROL STUDY" MEANS A PROSPECTIVE EVALUATION OF TWO GROUPS OF PATIENTS WITH DIFFERENT OUTCOMES TO DETERMINE WHICH SPECIFIC INTERVENTIONS THE PATIENTS RECEIVED. <A]

[A> "CASE-SERIES" MEANS AN EVALUATION OF PATIENTS WITH A PARTICULAR OUTCOME, WITHOUT THE USE OF A CONTROL GROUP. <A]

[A> "CERTIFICATION" MEANS A DETERMINATION BY A HEALTH CARRIER OR ITS DESIGNATED UTILIZATION REVIEW ORGANIZATION THAT AN ADMISSION, AVAILABILITY OF CARE, CONTINUED STAY, OR OTHER HEALTH CARE SERVICE HAS BEEN REVIEWED AND, BASED ON THE INFORMATION PROVIDED, SATISFIES THE HEALTH CARRIER'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE, AND EFFECTIVENESS. <A]

[A> "CLINICAL REVIEW CRITERIA" MEANS THE WRITTEN SCREENING PROCEDURES, DECISION ABSTRACTS, CLINICAL PROTOCOLS, AND PRACTICE GUIDELINES USED BY A HEALTH CARRIER TO DETERMINE THE NECESSITY AND APPROPRIATENESS OF HEALTH CARE SERVICES. <A]

[A> "COHORT STUDY" MEANS A PROSPECTIVE EVALUATION OF TWO GROUPS OF PATIENTS WITH ONLY ONE GROUP OF PATIENTS RECEIVING A SPECIFIC INTERVENTION. <A]

"Commissioner" means the insurance commissioner.

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

[A> "CONCURRENT REVIEW" MEANS A UTILIZATION REVIEW CONDUCTED DURING A PATIENT'S HOSPITAL STAY OR COURSE OF TREATMENT. <A]

[A> "COVERED BENEFITS" OR "BENEFITS" MEANS THOSE HEALTH CARE SERVICES TO WHICH AN ENROLLEE IS ENTITLED UNDER THE TERMS OF A HEALTH BENEFIT PLAN. <A]

[A> "DISCHARGE PLANNING" MEANS THE FORMAL PROCESS FOR DETERMINING, PRIOR TO DISCHARGE FROM A FACILITY, THE COORDINATION AND MANAGEMENT OF THE CARE THAT AN ENROLLEE RECEIVES FOLLOWING DISCHARGE FROM A FACILITY. <A]

[A> "DISCLOSE" MEANS TO RELEASE, TRANSFER, OR OTHERWISE DIVULGE PROTECTED HEALTH INFORMATION TO ANY PERSON OTHER THAN THE INDIVIDUAL WHO IS THE SUBJECT OF THE PROTECTED HEALTH INFORMATION. <A]

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

"Enrollee" means a person who enters into a contractual relationship [A> UNDER <A] or who is provided with health care services or benefits through a [D> managed care plan. <D] [A> HEALTH BENEFIT PLAN. <A]

[D> "Expedited appeal" means the internal review of a complaint or an external review of the final internal determination of an enrollee's complaint, which is completed within seventy-two hours after receipt of the request for expedited appeal. <D]

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

[A> "EVIDENCE-BASED STANDARD" MEANS THE CONSCIENTIOUS, EXPLICIT, AND JUDICIOUS USE OF THE CURRENT BEST EVIDENCE BASED ON THE OVERALL SYSTEMATIC REVIEW OF THE RESEARCH IN MAKING DECISIONS ABOUT THE CARE OF INDIVIDUAL PATIENTS. <A]

[A> "EXPERT OPINION" MEANS A BELIEF OR INTERPRETATION BY SPECIALISTS WITH EXPERIENCE IN A SPECIFIC AREA ABOUT THE SCIENTIFIC EVIDENCE PERTAINING TO A PARTICULAR SERVICE, INTERVENTION, OR THERAPY. <A]

[A> "EXTERNAL REVIEW" MEANS A REVIEW OF AN ADVERSE DETERMINATION (INCLUDING A FINAL ADVERSE DETERMINATION) CONDUCTED BY AN INDEPENDENT REVIEW ORGANIZATION PURSUANT TO THIS CHAPTER. <A]

[A> "FACILITY" MEANS AN INSTITUTION PROVIDING HEALTH CARE SERVICES OR A HEALTH CARE SETTING, INCLUDING BUT NOT LIMITED TO, HOSPITALS AND OTHER LICENSED INPATIENT CENTERS, AMBULATORY SURGICAL OR TREATMENT CENTERS, SKILLED NURSING CENTERS, RESIDENTIAL TREATMENT CENTERS, DIAGNOSTIC, LABORATORY AND IMAGING CENTERS, AND REHABILITATION AND OTHER THERAPEUTIC HEALTH SETTINGS. <A]

[A> "FINAL ADVERSE DETERMINATION" MEANS AN ADVERSE DETERMINATION INVOLVING A COVERED BENEFIT THAT HAS BEEN UPHELD BY A HEALTH CARRIER OR ITS DESIGNATED UTILIZATION REVIEW ORGANIZATION AT THE COMPLETION OF THE HEALTH CARRIER'S INTERNAL GRIEVANCE PROCESS PROCEDURES, OR AN ADVERSE DETERMINATION WITH RESPECT TO WHICH THE INTERNAL APPEALS PROCESS IS DEEMED TO HAVE BEEN EXHAUSTED UNDER SECTION 432E-C(B). <A]

[A> "HEALTH BENEFIT PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE OR AGREEMENT OFFERED OR ISSUED BY A HEALTH CARRIER TO PROVIDE, DELIVER, ARRANGE FOR, PAY OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES. <A]

"Health care [D> provider" <D] [A> PROFESSIONAL" <A] means an individual licensed [A> , ACCREDITED, <A] or certified to provide [A> OR PERFORM SPECIFIED <A] health care [A> SERVICES <A] in the ordinary course of business or practice of a profession [D> . <D] [A> CONSISTENT WITH STATE LAW. <A]

[A> "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL. <A]

[A> "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION, TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE. <A]

[A> "HEALTH CARRIER" MEANS AN ENTITY SUBJECT TO THE INSURANCE LAWS AND RULES OF THIS STATE, OR SUBJECT TO THE JURISDICTION OF THE COMMISSIONER, THAT CONTRACTS OR OFFERS TO CONTRACT TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES, INCLUDING A SICKNESS AND ACCIDENT INSURANCE COMPANY, A HEALTH MAINTENANCE ORGANIZATION, A MUTUAL BENEFIT SOCIETY, A NONPROFIT HOSPITAL AND HEALTH SERVICE CORPORATION, OR ANY OTHER ENTITY PROVIDING A PLAN OF HEALTH INSURANCE, HEALTH BENEFITS OR HEALTH CARE SERVICES. <A]

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

"Independent review organization" means an independent entity [D> that: <D]

[D> (1) Is unbiased and able to make independent decisions; <D]

[D> (2) Engages adequate numbers of practitioners with the appropriate level and type of clinical knowledge and expertise; <D]

[D> (3) Applies evidence-based decisionmaking; <D]

[D> (4) Demonstrates an effective process to screen external reviews for eligibility; <D]

[D> (5) Protects the enrollee's identity from unnecessary disclosure; and <D]

[D> (6) Has effective systems in place to conduct a review. <D]

[A> THAT CONDUCTS INDEPENDENT EXTERNAL REVIEWS OF ADVERSE DETERMINATIONS AND FINAL ADVERSE DETERMINATIONS. <A]

"Internal review" means the review under section 432E-5 of an enrollee's complaint by a [D> managed care plan. <D] [A> HEALTH CARRIER. <A]

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

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

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

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

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

"Medical necessity" means a health intervention [D> as defined <D] [A> THAT MEETS THE CRITERIA ENUMERATED <A] in section 432E-1.4.

[A> "MEDICAL OR SCIENTIFIC EVIDENCE" MEANS EVIDENCE FOUND IN THE FOLLOWING SOURCES: <A]

[A> (1) PEER-REVIEWED SCIENTIFIC STUDIES PUBLISHED IN OR ACCEPTED FOR PUBLICATION BY MEDICAL JOURNALS THAT MEET NATIONALLY RECOGNIZED REQUIREMENTS FOR SCIENTIFIC MANUSCRIPTS AND THAT SUBMIT MOST OF THEIR PUBLISHED ARTICLES FOR REVIEW BY EXPERTS, WHO ARE NOT PART OF THE EDITORIAL STAFF; <A]

[A> (2) PEER-REVIEWED MEDICAL LITERATURE, INCLUDING LITERATURE RELATING TO THERAPIES REVIEWED AND APPROVED BY A QUALIFIED INSTITUTIONAL REVIEW BOARD, BIOMEDICAL COMPENDIA, AND OTHER MEDICAL LITERATURE THAT MEET THE CRITERIA OF THE NATIONAL INSTITUTES OF HEALTH'S NATIONAL LIBRARY OF MEDICINE FOR INDEXING IN INDEX MEDICUS AND ELSEVIER SCIENCE LTD. FOR INDEXING IN EXCERPTA MEDICUS; <A]

[A> (3) MEDICAL JOURNALS RECOGNIZED BY THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES UNDER SECTION 1861(T)(2) OF THE FEDERAL SOCIAL SECURITY ACT; <A]

[A> (4) THE FOLLOWING STANDARD REFERENCE COMPENDIA: <A]

[A> (A) THE AMERICAN HOSPITAL FORMULARY SERVICE-DRUG INFORMATION; <A]

[A> (B) DRUG FACTS AND COMPARISONS; <A]

[A> (C) THE AMERICAN DENTAL ASSOCIATION ACCEPTED DENTAL THERAPEUTICS; AND <A]

[A> (D) THE UNITED STATES PHARMACOPEIA DRUG INFORMATION; <A]

[A> (5) FINDINGS, STUDIES, OR RESEARCH CONDUCTED BY OR UNDER THE AUSPICES OF FEDERAL GOVERNMENT AGENCIES AND NATIONALLY RECOGNIZED FEDERAL RESEARCH INSTITUTES, INCLUDING: <A]

[A> (A) THE FEDERAL AGENCY FOR HEALTHCARE RESEARCH AND QUALITY; <A]

[A> (B) THE NATIONAL INSTITUTES OF HEALTH; <A]

[A> (C) THE NATIONAL CANCER INSTITUTE; <A]

[A> (D) THE NATIONAL ACADEMY OF SCIENCES; <A]

[A> (E) THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; <A]

[A> (F) THE FEDERAL FOOD AND DRUG ADMINISTRATION; AND <A]

[A> (G) ANY NATIONAL BOARD RECOGNIZED BY THE NATIONAL INSTITUTES OF HEALTH FOR THE PURPOSE OF EVALUATING THE MEDICAL VALUE OF HEALTH CARE SERVICES; OR <A]

[A> (6) ANY OTHER MEDICAL OR SCIENTIFIC EVIDENCE THAT IS COMPARABLE TO THE SOURCES LISTED IN PARAGRAPHS (1) THROUGH (5). <A]

"Participating provider" means a licensed or certified provider of health care services or benefits, including mental health services and health care supplies, [D> that <D] [A> WHO <A] has entered into an agreement with a [D> managed care plan <D] [A> HEALTH CARRIER <A] to provide those services or supplies to enrollees.

[A> "PROSPECTIVE REVIEW" MEANS UTILIZATION REVIEW CONDUCTED PRIOR TO AN ADMISSION OR A COURSE OF TREATMENT. <A]

[A> "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION AS DEFINED IN THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND RELATED FEDERAL RULES. <A]

[A> "RANDOMIZED CLINICAL TRIAL" MEANS A CONTROLLED, PROSPECTIVE STUDY OF PATIENTS WHO HAVE BEEN RANDOMIZED INTO AN EXPERIMENTAL GROUP AND A CONTROL GROUP AT THE BEGINNING OF THE STUDY WITH ONLY THE EXPERIMENTAL GROUP OF PATIENTS RECEIVING A SPECIFIC INTERVENTION, WHICH INCLUDES STUDY OF THE GROUPS FOR VARIABLES AND ANTICIPATED OUTCOMES OVER TIME. <A]

[A> "RETROSPECTIVE REVIEW" MEANS A REVIEW OF MEDICAL NECESSITY CONDUCTED AFTER SERVICES THAT HAVE BEEN PROVIDED TO A PATIENT, BUT DOES NOT INCLUDE THE REVIEW OF A CLAIM THAT IS LIMITED TO AN EVALUATION OF REIMBURSEMENT LEVELS, VERACITY OF DOCUMENTATION, ACCURACY OF CODING, OR ADJUDICATION FOR PAYMENT. <A]

[A> "REVIEWER" MEANS AN INDEPENDENT REVIEWER WITH CLINICAL EXPERTISE EITHER EMPLOYED BY OR CONTRACTED BY AN INDEPENDENT REVIEW ORGANIZATION TO PERFORM EXTERNAL REVIEWS. <A]

[A> "SECOND OPINION" MEANS AN OPPORTUNITY OR REQUIREMENT TO OBTAIN A CLINICAL EVALUATION BY A PROVIDER OTHER THAN THE ONE ORIGINALLY MAKING A RECOMMENDATION FOR A PROPOSED HEALTH CARE SERVICE TO ASSESS THE CLINICAL NECESSITY AND APPROPRIATENESS OF THE INITIAL PROPOSED HEALTH CARE SERVICE. <A]

[A> "SPECIFICALLY EXCLUDED" MEANS THAT THE COVERAGE PROVISIONS OF THE HEALTH CARE PLAN, WHEN READ TOGETHER, CLEARLY AND SPECIFICALLY EXCLUDE COVERAGE FOR A HEALTH CARE SERVICE. <A]

[A> "UTILIZATION REVIEW" MEANS A SET OF FORMAL TECHNIQUES DESIGNED TO MONITOR THE USE OF, OR EVALUATE THE CLINICAL NECESSITY, APPROPRIATENESS, EFFICACY, OR EFFICIENCY OF, HEALTH CARE SERVICES, PROCEDURES, OR SETTINGS. TECHNIQUES MAY INCLUDE AMBULATORY REVIEW, PROSPECTIVE REVIEW, SECOND OPINION, CERTIFICATION, CONCURRENT REVIEW, CASE MANAGEMENT, DISCHARGE PLANNING, OR RETROSPECTIVE REVIEW. <A]

[A> "UTILIZATION REVIEW ORGANIZATION" MEANS AN ENTITY THAT CONDUCTS UTILIZATION REVIEW OTHER THAN A HEALTH CARRIER PERFORMING A REVIEW FOR ITS OWN HEALTH BENEFIT PLANS. <A] "

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

"Section 432E-5 Complaints and appeals procedure for enrollees. (a) A [D> managed care plan <D] [A> HEALTH CARRIER <A] with enrollees in this State shall establish and maintain a procedure to provide for the resolution of an enrollee's complaints and [A> INTERNAL <A] appeals. The procedure shall provide for expedited [A> INTERNAL <A] appeals under section 432E-6.5. The definition of medical necessity in section 432E-1.4 shall apply in a [D> managed care plan's <D] [A> HEALTH CARRIER'S <A] complaints and [A> INTERNAL <A] appeals procedures.

(b) The [D> managed care plan <D] [A> HEALTH CARRIER <A] shall at all times make available its complaints and [A> INTERNAL <A] appeals procedures. The complaints and [A> INTERNAL <A] appeals procedures shall be reasonably understandable to the average layperson and shall be provided in a language other than English upon request.

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

(d) A [D> managed care plan <D] [A> HEALTH CARRIER <A] shall send notice of its final internal determination within sixty days of the submission of the complaint to the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the commissioner. Notice of the right to external review issued pursuant to this part shall set forth the options available to the enrollee under this part. The commissioner may specify the form and content of notice of external review. The notice shall include at least the following information regarding the enrollee's rights and procedures:

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

(2) The [D> sixty-day <D] [A> ONE HUNDRED THIRTY DAY <A] deadline for requesting an external review;

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

(4) Where to submit the request for an external review[A>; and<A][D>.<D]

[A>(5) That the enrollee may be required to release medical records relating to the enrollee's complaint.<A]

~~[A> IN ADDITION TO THESE GENERAL REQUIREMENTS, THE NOTICE SHALL CONFORM TO THE REQUIREMENTS OF SECTION 432E-E. <A]~~ "

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

"Section 432E-6.5 Expedited [A> INTERNAL <A] appeal, when authorized; standard for decision."

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

"(a) An enrollee may request that the [D> following <D] [A> INTERNAL APPEAL UNDER SECTION 432E-5 <A] be conducted as an expedited [D> appeal: <D]

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

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

[A> APPEAL. <A]

If a request for expedited appeal is approved by the [D> managed care plan or the commissioner, <D] [A> HEALTH CARRIER, <A] the appropriate [D> review <D] [A>

INTERNAL APPEAL <A] shall be completed within seventy-two hours of receipt of the request for expedited appeal."

SECTION 10. *Section 432E-10, Hawaii Revised Statutes, is amended* by adding a provision to subsection (b)(1) requiring managed care organizations to report every internal appeal and its disposition to the commissioner quarterly, to read as follows:

"[A>**(H)** Health carriers shall also report quarterly to the commissioner summary information listing the number of internal appeals received during the quarter, the number of appeals completed which were pending from the previous quarter, the number of appeals received during the quarter which were completed, and the number of appeals pending on the last day of the quarter. Health carriers shall further report to the commissioner on each completed internal appeals the nature of the health intervention requested and the disposition of the appeal, whether granted, denied, or other intervention substituted.<A]"

~~*Section 432E-6, Hawaii Revised Statutes, is repealed.*~~

~~" [D> Section 432E-6 External review procedure. <D] [D> (a) After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination to a three-member review panel appointed by the commissioner composed of a representative from a managed care plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner: <D]~~

~~[D> (1) The enrollee shall submit a request for external review to the commissioner within sixty days from the date of the final internal determination by the managed care plan; <D]~~

~~[D> (2) The commissioner may retain: <D]~~

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

~~[D> (B) The services of an independent review organization from an approved list maintained by the commissioner; <D]~~

~~[D> (3) Within seven days after receipt of the request for external review, a managed care plan or its designee utilization review organization shall provide to the commissioner or the assigned independent review organization: <D]~~

~~[D> (A) Any documents or information used in making the final internal determination including the enrollee's medical records; <D]~~

~~[D> (B) Any documentation or written information submitted to the managed care plan in support of the enrollee's initial complaint; and <D]~~

~~[D> (C) A list of the names, addresses, and telephone numbers of each licensed health care provider who cared for the enrollee and who may have medical records relevant to the external review; <D]~~

[D> provided that where an expedited appeal is involved, the managed care plan or its designee utilization review organization shall provide the documents and information within forty-eight hours of receipt of the request for external review. <D]

[D> Failure by the managed care plan or its designee utilization review organization to provide the documents and information within the prescribed time periods shall not delay the conduct of the external review. Where the plan or its designee utilization review organization fails to provide the documents and information within the prescribed time periods, the commissioner may issue a decision to reverse the final internal determination, in whole or part, and shall promptly notify the independent review organization, the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the managed care plan of the decision; <D]

[D> (4) Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the external review panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $ 500, the commissioner may conduct a review hearing without appointing a review panel; <D]

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

[D> (A) The hearing shall be held no later than sixty days from the date of the request for the hearing; and <D]

[D> (B) An external review conducted as an expedited appeal shall be determined no later than seventy-two hours after receipt of the request for external review; <D]

[D> (6) After considering the enrollee's complaint, the managed care plan's response, and any affidavits filed by the parties, the commissioner may dismiss the request for external review if it is determined that the request is frivolous or without merit; and <D]

[D> (7) The review panel shall review every final internal determination to determine whether the managed care plan involved acted reasonably. The review panel and the commissioner or the commissioner's designee shall consider: <D]

[D> (A) The terms of the agreement of the enrollee's insurance policy, evidence of coverage, or similar document; <D]

[D> (B) Whether the medical director properly applied the medical necessity criteria in section 432E-1.4 in making the final internal determination; <D]

[D> (C) All relevant medical records; <D]

[D> (D) The clinical standards of the plan; <D]

[D> (E) The information provided; <D]

[D> (F) The attending physician's recommendations; and <D]

[D> (G) Generally accepted practice guidelines. <D]

[D> The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing. <D]

~~[D> (b) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers. <D]~~

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

~~[D> (1) The plan involved in the complaint, including an officer, director, or employee of the plan; or <D]~~

~~[D> (2) The treatment of the enrollee, including but not limited to the developer or manufacturer of the principal drug, device, procedure, or other therapy at issue. <D]~~

~~[D> (d) Members of the review panel shall be granted immunity from liability and damages relating to their duties under this section. <D]~~

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

~~[D> (f) Disclosure of an enrollee's protected health information shall be limited to disclosure for purposes relating to the external review. <D]~~ "

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

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

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

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

SECTION 15. This Act shall take effect on July 1, 2040, and apply retroactively to January 1, 2011; provided that if the United States Department of Health and Human Services by rule or other written guidance extends the time period for the State's existing external review process under section 432E-6, Hawaii Revised Statutes, to any later date during 2011, then the effective date of this Act shall be the sooner of the end date of the transition period or January 1, 2012; provided further that if the external review requirements of the federal Patient Protection and Affordable Care Act of 2010 are held unconstitutional by the United States Supreme Court, this Act shall be repealed as of the date that the United States Supreme Court issues its opinion and chapter 432E, Hawaii

Revised Statutes, shall be reenacted in the form in which it existed as of the day before the United States Supreme Court issued its decision.

SPONSOR: Tsutsui

SUBJECT: HEALTH INSURANCE (95%); LEGISLATORS (92%); APPEALS (63%); LEGISLATIVE BODIES (62%); US STATE GOVERNMENT (62%); CONFLICTS OF INTEREST (62%); LEGISLATION (61%);

LOAD-DATE: March 19, 2011

EXHIBIT 4

Transcript of telephone conference on February 17, 2011

Ellen, Kara, and Julie Harada, Office of Consumer Information and Insurance Oversight, DHHS , with Prof. Richard Miller and Rafael del Castillo.

RdC: What's happened in our state is that our Administration has introduced a bill to repeal the external review law we've had on the books for a dozen years, and we are concerned about that because we believe the legislators have been misinformed, inasmuch as it appears that they have been told that we are mandated to repeal our law and replace it with the NAIC law. It was my guess, and Julie told me she thought I was correct, that you all have not actually reviewed our review statute. I did forward a copy of it to her. There are a couple of features we are loathe to lose, and one of them is that our review provides for a face-to-face hearing with a 3-person panel at which a patient who has a complex situation can present expert testimony and has an afternoon to present the case. It also provides for them to have advocacy on their behalf, whereas the NAIC model act of course goes off to an IRO and you submit whatever you have in writing and there you are. They also are repealing the right to appeal to our circuit courts, but that is probably not constitutional, so that's not going to stand. In any event, we've been through hearings on companion bills, and on the House side, the bill was deferred because the Insurance Commissioner's representative said "We really don't have to have do anything this year. . . "-- and that is how I figured out that they have been told [repeal] is mandated – "as long as we make progress." Then on the Senate side, the bill is still alive. They are actually waiting for amendments from us [not correct]. But I think the key information, and Senator Green, who is the chair of the Health Committee asked me to confirm, we don't believe that there is a mandate that we repeal our law. As we read [section] 2719, it says that we have to have a good or better than the NAIC. So we want to confirm a few things with you all, such as whether or not you have reviewed our law, and a few other things about the situation.

Ellen: Okay. I think the first basic thing is that there is confusion between being mandated to do something versus being given a set of standards which, if they are not met, will invoke federal preemption. The Affordable Care Act sits, as you know, sits inside of HIPAA, which means that we set a floor, and the states can exceed that floor, but, at a minimum, they have to meet that floor. It's not the NAIC model in its totality. It is actually the sixteen elements that are listed in the interim final rule that was published on July 23rd. So those 16 elements that we, the three federal agencies articulated, as the minimum consumer protections elements contained in the [NAIC] model, those sixteen elements must be met by a state in order for a state to continue to run an external review process. If they are not met, then there will be a federal external review process that will preempt the state review process.

There's nothing in the federal law or the regulation that requires a state to take its existing law in total off the books. What is required is that the state meet the 16 articulated elements of an external review process in order to continue running their state external review process. In the interim final rule, we articulated that the current state external review process will stand as acceptable until July 1, 2011. We are in the process of determining and watching each state's legislature to see what changes may be made, but we are in the process of determining which

EXHIBIT 4

states meet the minimum consumer protections and which states do not. On July 1st, the states that do not meet the minimum consumer protections, their external review laws will be preempted.

Prof: Could you generalize about what the 16 elements amount to? We currently have a very comprehensive external review program which even allows a losing patient to recover attorneys' fees as long s his claim is not unreasonable or outrageous, or in bad faith. It's worked rather well. There have been about 30 hearings, of which about 80% were won by the patient. What is the essence of the 16 elements.

Ellen: Very, very generally. They have to allow for reviews of medical necessity cases. Claimants have to get written notice of their rights to external review. There are certain conditions when the internal appeal process has been exhausted. One is that the issuer waived it. Two is that it is an urgent care situation, so that you can do simultaneous internal and external review process. Three, in the internal appeals process if there is not strict compliance, then the claimant can go onto external. Only a nominal filing fee is allowed, and if you have that fee, it has to be refunded if the claimant wins, there should be a financial waiver, and there is an annual limit of $75. There is no claim threshold. You have four months to file an external review. It's an independent review organization that conducts the review, and the IRO has to be assigned randomly. It must be impartial and independent. The state must maintain a list of IROs, and their qualified to conduct reviews. They cannot have any conflict with the plan or issuer or person or provider. The claimant should have the right to submit additional information to the IRO, to be notified of that right. The decision must be binding. The decision must be issued within 45 days after the IRO receives the request unless it is an expedited case, which is 72 hours or less depending on the medical exigencies of the case. The external review rights must be included in the coverage materials, such as summary plan documents, the IRO must maintain certain records for at least three years, and there must be a process for reviewing experimental and investigational cases that is substantially similar to the NAIC model.

RdC: The part that we take issue with is the independent review organization. We believe that our face-to-face hearing is better because the panel actually hears testimony from live experts, by telephone albeit and it is an administrative hearing, so it is quite efficient so we do not operate on the rules of evidence,. And then the panel deliberates over the issue, and it is a local panel which is capable of applying local standards and being culturally competent for Hawaii. We believe that exceeds an IRO. We are proposing that we keep our review panel, and we can import the IRO as an option. We actually do not believe that we need to repeal our law at all, but there is some confusion in our legislature that we have to do something, so calling a middle ground, we were looking at an IRO option. What are the prospects that you all will take a look at Hawaii's law in the near future. We could tell our senators that you are going to review our law and you will have comments about it. We know that there is at least one technical correction we have to make, and that is, under our law you have sixty days to file, not four months. So what are the prospects that you will actually take a look at our existing statute and determine that it has all of the sixteen rights that are required.

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Ellen: We actually have taken a look at Hawaii's statue and we found the issue of not having an IRO review the case because it is implied in the 16 protections that it will be an independent review organization. We also talked to Lloyd Lim and, we did not get into the specifics, because he started off the conversation that they were going to put forward the NAIC model because they recognize that the Hawaii process is being used by so few people at this point, a lot having to do with the state supreme court case [*HMAA v. Commissioner*].

RdC: That is another issue. We do want to ask you about ERISA, it would be more uniform if ERISA cases were included, but our law does not exclude ERISA, it is just that supreme court held that it was preempted. Now we have this other legislation in the Patient Protection Act which appears to make it a requirement that the plans offer the state's review option. I don't understand how you can conclude that an IRO is better than a three-person face-to-face panel. That mystifies me.

Ellen: I don't think we are coming to a conclusion that one is better than the other. I think we are telling you that the reg requires an IRO process.

RdC: And therefore we actually have a better process preempted because of that? I don't think that is consistent with the law.

Ellen: I think you would have to make an argument, we are staff. We are not the policy makers. I think you would have to make an argument at the policy level that what you are providing meets the requirement. I don't know how you get to this meeting the requirement. We are not arguing with you about whether it is better.

Prof: Right now we are thinking about leaving the option to the hearing or the IRO to the patient. We are thinking of leaving all of the NAIC stuff, but leaving it to the patient.

Ellen: That would have to be an argument made to the policy makers. What is happening is the policy makers are figuring out how to make the determinations for each state. Having made the arguments to us, it is just a matter of us articulating that this is what is going on in Hawaii, that this is where Hawaii is, and this is the argument that you have put forth.

RdC: I think we would want to submit a written brief on that at the least.

Ellen: I think if you want to submit a letter to us and why you think that it meets or exceeds the floor, that would be terrific.

RdC: We appreciate the opportunity to do that and to do that and to provide evidence of what we believe are our excellent results. On the issue of ERISA, as we read the Patient Protection Act, ERISA plans are not exempt from the requirement that they provide the state's review.

Ellen: That's not quite correct. What ERISA plans must do under the Patient Protection and Affordable Care Act is provide an external review. Nothing has changed in terms of ERISA preemption, or the fact are not subject to state law. So, the one instance in which you would have an ERISA

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plan tangentially touched by state law is, if you have an ERISA plan that went to one of your issuers and purchased for their employees a fully-insured product, in that case, because they purchased a fully-insured product, the employees of that ERISA plan would have access to the state appeal rights because they have a full-insured health product. If you have an ERISA plan that self-insures, and they have a flat-out ERISA self-insured health plan, those are not subject to the state external review law. Instead, there is a federal external review process, and the Dept. of Labor has published technical guidance telling ERISA plans how to comply with the law in providing external review to their members.

RdC: That is actually consistent with the review law that we have had on the books all along. We have a couple of other questions that you may be able to answer. We are curious about how this law applies to Medicare Advantage plans because that is a fully-insured product.

Ellen: I think we will have to get back to you on that.

RdC: Shall we take from the discussion that federal employee plans are exempt?

Ellen: Yes federal employee benefit plans fall under FEHBP under the office of personnel management and they have an external review process.

RdC: Are here any other major exemptions, other than the military plans, that you are aware of.

Ellen: Any state or municipality self-insured plans have the ability to utilize the state process if the state allows it. If they choose not to use the state process, they fall under the federal review process unless the state process is in compliance. Some states have specific laws on their books which say the state employee plans shall comply with certain elements of the insurance law, and that usually includes the state external review process. If that is the case, then the state employee plans will continue to use the state process as long as the state review is compliant. However, if there is no such law on the books, the state plan is, by definition a non-federal governmental plan, it's a self-insured plan, but it is not an ERISA plan. It is under the jurisdiction of DHHS. As such, it will utilize the federal external review program. The July 23rd regulations articulate what the federal external review process is.

EXHIBIT 4

COMMITTEE ON FINANCE
Rep. Marcus R. Oshiro, Chair
Rep. Marilyn B. Lee, Vice Chair

Rep. Pono Chong
Rep. Isaac W. Choy
Rep. Denny Coffman
Rep. Ty Cullen
Rep. Sharon E. Har
Rep. Mark J. Hashem
Rep. Linda Ichiyama
Rep. Jo Jordan
Rep. Chris Lee
Rep. Dee Morikawa
Rep. James Kunane Tokioka
Rep. Kyle T. Yamashita
Rep. Barbara C. Marumoto
Rep. Gil Riviere
Rep. Gene Ward

Brian Carter RPh
4420 Puolo rd
Hanapepe, HI 96716
808 335-5342

I OPPOSE SB 1274

This bill undermines patient rights and gives insurance companies a way to deny services without any oversight. The external review process in our state is one that gives patients the right to take the decisions made by their insurance companies and have a review made by non biased court. Second opinions made by the court may mandate the care of any individual that they deem worthy of care. These cases are far and few between thankfully but to take away this option is inhumane. Corporate structures like insurance companies are biased toward making money (like any business) not caring for the patient. We need an external process to check these decisions by the corporate giants to insure the safety and wellbeing of all the citizens of this state. SB1274 would take this right away from patients. I ask that you hold this bill for the good of the people of Hawaii.

TO: Members of the Committee on Finance

FROM: Natalie Iwasa
Honolulu, HI 96825
808-395-3233

HEARING: 4 p.m. Friday, April 1, 2011

SUBJECT: SB1274, SD2, HD2 Relating to Health Insurance - **OPPOSED**

Aloha Chair Oshiro, Vice Chair Lee and Committee Members,

This bill would change the review process for medical decisions made by health insurance companies.

When Congress was discussing a federal healthcare bill, they looked to Hawaii as a model upon which to build the federal law. The current external review law under HRS Sec. 432E-6 works well. The fact that several large insurance companies support this bill and nonprofit watchdog organizations oppose it speaks volumes to me.

Please vote "no" on this bill.

RE: HB 1047 and SB 1274

To Whom It May Concern:

I am writing as a concerned parent on behalf of my son, as well as the many other seriously ill patients that may not be able to speak out on their own behalf. The current review process by the Insurance Commission should not be discontinued in favor of a mainland external review. Firstly, being reviewed by a local board gives the patient an opportunity to be represented locally and levels the playing ground. Secondly, the current process affords additional protection for the patient as the Insurance Commission is, or primarily should be concerned with the protection of the consumer rather than the financial interests of the insurance companies. Finally, the legislature must understand that this decision can determine life or death for some patients. Having seen the results many times of the medical insurance companies' decisions in regards to treating patients that are less healthy and as a result more costly to treat, it is clear that an impartial body is necessary to perform oversight into this process that will protect those that are, unfortunately, poorly equipped to protect themselves. I have faith that our legislators have the foresight to determine that any change will be disastrous for this population. The purpose of medical insurance is to treat those that are sick, not just to enrich companies that insure and treat only the healthy.

Sincerely,

/s/

Joanne M. Short
911020 Hooilo Pl
Ewa Beach HI 96706

<u>**TESTIMONY IN OPPOSITION TO S.B. 1274**</u>

To: House Finance Committee
From: Tred R. Eyerly
Occupation: Attorney
Hearing: April 1, 2011, 4 p. m.

I **strongly oppose** Senate Bill 1274 (and the companion House Bill 1047), which will unjustifiably and irreversibly damage health care consumer protection in Hawaii. Hawaii's external review law, Haw. Rev. Stat. § 432E-6, has served health care consumers well for over a decade. It gives health care consumers a more level playing field against powerful insurance companies. Consumers have access to experienced advocates to assist them with preparing and presenting their cases in a manner consistent with Hawaii's medical necessity law. Decisions are made by a local expert panel, and consumers are able to present expert testimony and other evidence in a fair, but efficient, hearing process.

Instead of repealing our existing external review statute, it should be expanded to grant external review to ERISA plan members who, under the health care reform act, currently have no such rights. Without an external review before the Insurance Division, ERISA plan members must file a lawsuit in federal court. The expense of going immediately to court is prohibitive for many, if not most, of our citizens. The Insurance Commissioner should be directed to require ERISA plans to make our existing external review available to their members. Decisions on health care in Hawaii should be made in Hawaii, not outsourced as contemplated by S.B. 1274 to mainland doctors who are not in touch with our values, our culture, and our people.

The process for proposed review under S.B. 1274 is far more complex (you have only to compare the length of our existing law, Haw. Rev. Stat. § 432E-6 with S.B. 1274 to see how much more complex it will be), and, ironically, health care consumers will have a lot less help. S.B. 1274 simply cannot be seen as anything more than a huge favor for insurers. How is this bill fair to your constituents and patients across Hawaii?

The Legislature should not make such a sweeping change in our laws, repealing long-standing rights, especially when the fate of federal healthcare reform is up in the air. The Legislature should fully inform itself of whether an alternative course of action that avoids a repeal is available. The Legislature should also be fully aware of the impact of such a repeal on health care consumers. Please convene a task force or commission of health care consumers and legislators to study the proposal and report back to the Legislature. The task force can meet during the period before the 2012 legislature, and accept testimony and information from consumers, providers, and managed care plans, and convey that information to the Legislature in a report of the committee's recommendations.

Vote "No" S.B. 1274 because of the irreversible damage it will do to an inestimable number of Hawai`i citizens when they are sick and need your wholehearted support.

Thank you for the opportunity to express my strong opposition to this measure.

Tred R. Eyerly
Address: 1164 Kaeleku St., Honolulu, HI 96825

TESTIMONY IN OPPOSITION TO SB 1274

From: MeleLani C. Llanes

Kapolei Resident

To: COMMITTEE ON FINANCE

Rep. Marcus R. Oshiro, Chair
Rep. Marilyn B. Lee, Vice Chair

Rep. Pono Chong
Rep. Isaac W. Choy
Rep. Denny Coffman
Rep. Ty Cullen
Rep. Sharon E. Har
Rep. Mark J. Hashem
Rep. Linda Ichiyama
Rep. Jo Jordan
Rep. Chris Lee
Rep. Dee Morikawa
Rep. James Kunane Tokioka
Rep. Kyle T. Yamashita
Rep. Barbara C. Marumoto
Rep. Gil Riviere
Rep. Gene Ward

Hearing: April 1, 2011, 4:00 p.m., Conference Room 308

Emailed to: http://www.capitol.hawaii.gov/emailtestimony

I am **strongly opposed** to Senate Bill 1274, which will unjustifiably and irreversibly damage health care consumer protection in Hawai`i. Our external review law, H.R.S. § 432E-6, has served health care consumers well for over a decade. It gives health care consumers a more level playing field against powerful insurance companies. Consumers have access to experienced advocates to assist them with preparing and presenting their cases in a manner consistent with Hawai`i's medical necessity law. Decisions are made by a local expert panel, and consumers are able to present expert testimony and other evidence in a fair, but efficient, hearing process.

Instead of repealing our existing external review statute, it should be expanded to include ERISA plan members now that the health care reform act has made that possible. The Insurance Commissioner should be directed to require ERISA plans to make our existing external review available to their members. (If the Commissioner can order ERISA plans to use the outsource

review process proposed in S.B. 1274, he can order them to use our existing process.) Decisions on health care in Hawai`i should be made in Hawai`i, not outsourced to mainland doctors who are not in touch with our values, our culture, and our people.

The Administration has inaccurately described S.B. 1274 as providing "uniform standards for external review procedures." In fact, more than a quarter of a million people who now have the right to external review under H.R.S. § 432E-6 will lose it. Nearly half of Hawai`i's population will have to use various other forms of external review.

Personally, I lost an ERISA case for medical care I received in 2007. I paid out of pocket over $100,000.00 for my care and the insurance company refused to reimburse me $50,000.00 of benefits still due me. A mainland company upheld their decision despite the fact that I noted numerous entries in my chart that supported my need for care. I am now losing my house because of the shortfall.

Currently, I have an appeal approved for hearing with the External Review board for a durable medical devise that I am seeking in lieu of expensive knee replacement surgery. I am actually trying to save the insurance company and the State tens of thousands of dollars and the insurance company is still refusing to reimburse me for the devise.

Under the S.B. 1274 proposed review, the process is far more complex (you have only to compare the length of our existing law, H.R.S. § 432E-6 with S.B. 1274 to see how much more complex it will be), and, ironically, health care consumers will have a lot less help. S.B. 1274 simply cannot be seen as anything more than a huge favor for insurers. I want you to know that I consider this a VERY IMPORTANT issue, and I ask you to heed the voices of those of us who oppose S.B. 1274. Vote "NO" on S.B. 1274 because of the irreversible damage it will do to an inestimable number of Hawai`i citizens when they are sick and need our wholehearted support.

Thank you for the opportunity to express my strong opposition to this measure.

Very truly yours,

MeleLani C. Llanes
P.O. Box 701013
Kapolei, HI 96709
(808) 220-0905

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, March 31, 2011 11:42 PM
To: FINTestimony
Cc: stiver-aloha@hawaii.rr.com
Subject: Testimony for SB1274 on 4/1/2011 4:00:00 PM

Testimony for FIN 4/1/2011 4:00:00 PM SB1274

Conference room: 308
Testifier position: oppose
Testifier will be present: No
Submitted by: Robert H. Stiver
Organization: Individual
Address:
Phone:
E-mail: stiver-aloha@hawaii.rr.com
Submitted on: 3/31/2011

Comments:
I've been following this bill from its inception. Please action based on the needs of the people and add our consumer protections back into the bill!

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, March 31, 2011 11:39 PM
To: FINTestimony
Cc: daniel_d_kauth@yahoo.com
Subject: Testimony for SB1274 on 4/1/2011 4:00:00 PM
Attachments: APEALS.txt

Testimony for FIN 4/1/2011 4:00:00 PM SB1274

Conference room: 308
Testifier position: oppose
Testifier will be present: No
Submitted by: daniel kauth
Organization: Individual
Address:
Phone:
E-mail: daniel_d_kauth@yahoo.com
Submitted on: 3/31/2011

Comments:
save our rites to have a appeal outlet
we (Patents) our being left to die,
because ur HMO want to denie us care!
I am being denied as we speak!

TO Kaiser Permanente Hawaii Appeals

CC CEO Kaiser Permanente, Kaiser Dr's (1-19)
Hawaii state Insurance Commissioner
U.S.Senetors Daniel Inouye, Daniel Akaka
State of Hawaii R.I.C.O. KMGB News

I have appealed many times before to Kaiser And they to not only denie me coverage, but as to lie to the Insurance Commissioner, I have to go outside the Kaiser system to get proper medical treatment for strokes, Kaiser does not allow me to have rehabilitaintion, or assces to a brain nerosugon after 4 years of lie's and misstreatment please dont take more of our rights because what so ever you do to the least of my brothers, that you do unto me.DanielDavid

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Friday, April 01, 2011 12:21 AM
To: FINTestimony
Cc: Onyx_Rose@hotmail.com
Subject: Testimony for SB1274 on 4/1/2011 4:00:00 PM

Testimony for FIN 4/1/2011 4:00:00 PM SB1274

Conference room: 308
Testifier position: comments only
Testifier will be present: No
Submitted by: Dana Nolen
Organization: Individual
Address:
Phone:
E-mail: Onyx_Rose@hotmail.com
Submitted on: 4/1/2011

Comments:

I am writing you all on an issue that I feel so strongly about that I simply cannot in good conscience just sit still and let such a grave injustice occur without making the best attempt that I can to let you know what it is that you are voting on when it comes to SB1274, an incredibly harmful bill that you will hear on April 1st.

As things currently stand, if a disagreement comes up between your medical insurer and you, you have the right to bring the dispute before an impartial group here in Hawaii where you and your insurance company can both have a say. If a decision is made that seems unfair, or there are other considerations, an appeal may be made. Our insurance premiums provide the insurance companies with a battery of lawyers to see to their best interests at such meetings, and current provisions have the insurance company provide a lawyer for the patient also, (paid for by our premiums, so in effect, the patient is paying all legal expenses) The new law proposes to streamline and centralize this process in order to cut medical costs and to standardize this procedure for all states under proposed federal guidelines. The external review of disputes will be held in the mainland, lawyers will no longer be provided and the decisions made will be final--no appeal allowed.

While this sounds good on paper, and we all see a need to cut medical costs as a large portion of the population is living longer and inevitably aging, this, my friends, is not the answer.

The first problem is that the meetings are to be held in the mainland. For patients in the contiguous United States, centralization may mean that they may have to travel a little further, but even if they have to go into another state, it would not be much more than a Sunday Drive. For our patients, however, this would mean crossing half the entire Ocean, and definitely not in a car, to present their side of the story. A lot of our patients need an act of Congress and all of God's angels just to get them out of their houses, and at great medical risk, let alone a trip to the mainland! I heard a commentator once say, "but they can video conference!" Now, how well do you suppose our Kupuna and the underprivileged parents of some of our most unfortunate keiki will use that to their advantage--especially without the advice and aid of the lawyer that will be denied them by this bill? There is no provision for anyone to even tell them what they can and cannot legally do. I would remind you that for the insurance companies, they would still have the

battery of lawyers paid for with our premiums, and mainland offices that would be just across town from where these meetings will be held. Patients can still pay for a lawyer to advise them out of their own pockets, but with medical conditions that are already taxing their finances terribly, and in this day and age where no one seems to have a lot of money just laying around, these disadvantages may be insurmountable. The new bill will, in effect, silence a person's right to have a say in their medical decisions. They just as well might have duct tape across their mouths! All this, while the insurance representatives can be right there with deep pockets, and we all know how loudly money can speak.

In cases of life-saving procedures, this unfairly biased group will be making life and death decisions, many times without being presented both sides or even being aware of the gravity of the situation. If you allow this bill to pass, I would remind you of your culpability in allowing this to occur. Each one of you that votes yes on this bill will be morally, if not legally, responsible for literally pulling the plug on some patient's lifelines. Some of your own constituents whose only crime would be wanting their money's worth from their insurance would be so affected. They would be given a death sentence with your complicity---and that without appeal.

I realize that we are talking about a relatively few amount of people at any given time, and so could be classified as a "special interest" group, but there are reminders every day that "There, but for the Grace of God" go we. At any time, you or a loved one could contract cancer, become injured, or God forbid, become the victim of violence like Senator Giffords, who is a classmate of my Arizona-born-and-bred husband. This bill will give the insurance companies practically carte blanche to withhold medical care at their discretion, and virtually unopposed. Naturally, this will reduce medical costs for them, but will increase out-of-pocket expenses for patients if they wish to continue getting care. At the same time, the news has been recently bombarded by the effects of recent premium hikes and increases in share-of-cost and co-pay expenses. Where is the savings in medical costs for you, I and the people of Hawaii?

I suppose if you have stock or other interest in the insurance companies or related big-business enterprises, then you could possibly receive a higher profit share. Perhaps you truly believe that the insurance companies will put their patient's needs before profit considerations or that by saving money on their most-expensive care, there will be more money to care for the rest of us, not simply divvied up as profit. This would fly in opposition of everything that we have ever seen of their practices, but God bless you for having faith in your fellow man, and I earnestly hope you are right! While we may hope for a more secure financial future in general, on a personal level, this bill sets us up to have our throats cut by withholding needed care, regardless of Doctor's orders, medical necessity or even prior arrangements. It reminds me of the Bible verse "How does it profit a man to gain the whole world, but lose his own soul?" Could you really look into the eyes of a handicapped child who will be killed by reduction of her care and tell her "It is for the greater good?" This is NOT an exaggeration. I personally care for one such child who's life stands precariously in the balance, and know of several others.

The more cynical of you may be thinking, "Aha! She is a nurse! She is only trying to protect her job!" This could be said of the lawyers that represent these patients as well. I would proudly admit to being a nurse and serving my patients as best I can, including this foray into politics that I honestly know very little about. I would also ask just what is wrong with trying to save jobs? I have a family to support. I think it likely that any of you in my shoes would do the same, but of far greater importance than saving my job, and the real reason for my writing you, is because I take the nurse's role of patient advocate very seriously. I feel it is my duty to speak on behalf those who cannot. In this case, I speak for my patients, anyone who has ever cared for or loved a patient, or who, God forbid, may ever become one. That would include all of you, personally, your friends and loved ones, all your constituents and all the people who reside in our beautiful state. I may be but one

voice, but I hope that it is the voice of Aloha and compassion that you will hear in my plea to please defeat this detrimental bill.

Please forgive me for being so long-winded and taking so much of your time if you have been so gracious as to have read all the way through this. I do not envy the responsibility that you each bear, and am sure it can be very tiring and aggravating at times. Also, forgive me for going all "Patrick Henry" on you, but this is something I feel very strongly about. Passage of SB1274 may have some ill-defined benefits but it's cost in human suffering will be immeasurable. This, or similar bills of this sort may work on the mainland, but surely you can see how it would not work for us.

I thank you for all of the work you each do in representing us, the people of Hawaii, and keeping our best interests at heart. As always, I will be praying for you, that God give you courage and wisdom to do what's right.

Aloha, and God Bless,
Dana Nolen, LPN