GOV. MSG. NO. 1334

EXECUTIVE CHAMBERS

HONOLULU

NEIL ABERCROMBIE
GOVERNOR

July 12, 2011

The Honorable Shan Tsutsui, President
and Members of the Senate
Twenty-Sixth State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Calvin Say, Speaker
and Members of the House
Twenty-Sixth State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

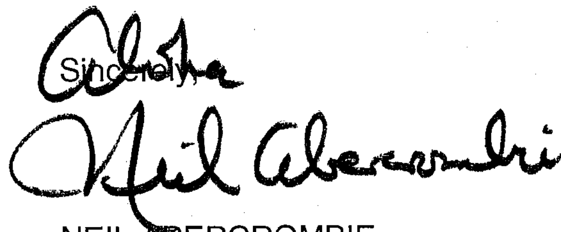
Dear President Tsutsui, Speaker Say and Members of the Legislature:

This is to inform you that on July 12, 2011, the following bill was signed into law:

SB1274 SD2 HD3 CD1

RELATING TO HEALTH INSURANCE
Act 230 (11)

Sincerely,



NEIL ABERCROMBIE
Governor, State of Hawaii

Approved by the Governor
on JUL 12 2011

THE SENATE
TWENTY-SIXTH LEGISLATURE, 2011
STATE OF HAWAII

ACT 230

S.B. NO. 1274 S.D. 2 H.D. 3 C.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

1 SECTION 1. The legislature finds that the purpose of this
2 Act is to comply with the requirements of the Patient Protection
3 and Affordable Care Act of 2010, Public Law No. 111-148, and its
4 implementing regulations by updating Hawaii's Patients' Bill of
5 Rights and Responsibilities Act, chapter 432E, Hawaii Revised
6 Statutes, to conform to the requirements of the federal law.
7 SECTION 2. Chapter 432E, Hawaii Revised Statutes, is
8 amended by adding a new part to be appropriately designated and
9 to read as follows:
10 **"PART . EXTERNAL REVIEW OF HEALTH**
11 **INSURANCE DETERMINATIONS**
12 **§432E-A Applicability and scope.** (a) Except as provided
13 in subsection (b), this part shall apply to all health carriers.
14 (b) This part shall not apply to a policy or certificate
15 that provides coverage only for a specified disease, specified
16 accident or accident-only coverage, credit, dental, disability
17 income, hospital indemnity, long-term care insurance, vision
18 care, or any other limited supplemental benefit; to a medicare

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

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

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

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

1 (2) A signed authorization by or on behalf of the enrollee
2 for release of the enrollee's medical records relevant
3 to the external review;
4 (3) A disclosure for conflict of interests evaluation, as
5 provided in section 432E-M; and
6 (4) A filing fee of $15, which shall be deposited into the
7 compliance resolution fund established pursuant to
8 section 26-9(o); provided that the filing fee shall be
9 refunded if the adverse determination or final
10 internal adverse determination is reversed through
11 external review.
12 The commissioner shall waive the filing fee required by this
13 subsection if the commissioner determines that payment of the
14 fee would impose an undue financial hardship to the enrollee.
15 The annual aggregate limit on filing fees for any enrollee
16 within a single plan year shall not exceed $60.
17 (b) The internal appeals process of a health carrier shall
18 be completed before an external review request shall be
19 submitted to the commissioner except in the following
20 circumstances:
21 (1) The health carrier has waived the requirement of
22 exhaustion of the internal appeals process;

1 (2) The enrollee has applied for an expedited external
2 review at the same time that the enrollee applied for
3 an expedited internal appeal; provided that the
4 enrollee is eligible for an expedited external review;
5 or
6 (3) The health carrier has substantially failed to comply
7 with its internal appeals process.
8 **§432E-D Standard external review.** (a) An enrollee or the
9 enrollee's appointed representative may file a request for an
10 external review with the commissioner within one hundred thirty
11 days of receipt of notice of an adverse action. Within three
12 business days after the receipt of a request for external review
13 pursuant to this section, the commissioner shall send a copy of
14 the request to the health carrier.
15 (b) Within five business days following the date of
16 receipt of the copy of the external review request from the
17 commissioner pursuant to subsection (a), the health carrier
18 shall determine whether:
19 (1) The individual is or was an enrollee in the health
20 benefit plan at the time the health care service was
21 requested or, in the case of a retrospective review,

1 was an enrollee in the health benefit plan at the time
2 the health care service was provided;
3 (2) The health care service that is the subject of the
4 adverse determination or the final adverse
5 determination would be a covered service under the
6 enrollee's health benefit plan but for a determination
7 by the health carrier that the health care service
8 does not meet the health carrier's requirements for
9 medical necessity, appropriateness, health care
10 setting, level of care, or effectiveness;
11 (3) The enrollee has exhausted the health carrier's
12 internal appeals process or the enrollee is not
13 required to exhaust the health carrier's internal
14 appeals process pursuant to section 432E-C(b); and
15 (4) The enrollee has provided all the information and
16 forms required to process an external review,
17 including a completed release form and disclosure form
18 as required by section 432E-C(a).
19 (c) Within three business days after a determination of an
20 enrollee's eligibility for external review pursuant to
21 subsection (b), the health carrier shall notify the
22 commissioner, the enrollee, and the enrollee's appointed

1 representative in writing as to whether the request is complete
2 and whether the enrollee is eligible for external review.
3 If the request for external review submitted pursuant to
4 this section is not complete, the health carrier shall inform
5 the commissioner, the enrollee, and the enrollee's appointed
6 representative in writing that the request is incomplete and
7 shall specify the information or materials required to complete
8 the request.
9 If the enrollee is not eligible for external review
10 pursuant to subsection (b), the health carrier shall inform the
11 commissioner, the enrollee, and the enrollee's appointed
12 representative in writing that the enrollee is not eligible for
13 external review and the reasons for ineligibility.
14 Notice of ineligibility for external review pursuant to
15 this section shall include a statement informing the enrollee
16 and the enrollee's appointed representative that a health
17 carrier's initial determination that the external review request
18 is ineligible for review may be appealed to the commissioner by
19 submission of a request to the commissioner.
20 (d) Upon receipt of a request for appeal pursuant to
21 subsection (c), the commissioner shall review the request for
22 external review submitted by the enrollee pursuant to subsection

1 (a), determine whether an enrollee is eligible for external
2 review and, if eligible, shall refer the enrollee to external
3 review. The commissioner's determination of eligibility for
4 external review shall be made in accordance with the terms of
5 the enrollee's health benefit plan and all applicable provisions
6 of this part. If an enrollee is not eligible for external
7 review, the commissioner shall notify the enrollee, the
8 enrollee's appointed representative, and the health carrier
9 within three business days of the reason for ineligibility.
10 (e) When the commissioner receives notice pursuant to
11 subsection (c) or makes a determination pursuant to subsection
12 (d) that an enrollee is eligible for external review, within
13 three business days after receipt of the notice or determination
14 of eligibility, the commissioner shall:
15 (1) Randomly assign an independent review organization
16 from the list of approved independent review
17 organizations qualified to conduct the external
18 review, based on the nature of the health care service
19 that is the subject of the adverse action and other
20 factors determined by the commissioner including
21 conflicts of interest pursuant to section 432E-M,
22 compiled and maintained by the commissioner to conduct

1 the external review and notify the health carrier of
2 the name of the assigned independent review
3 organization; and
4 (2) Notify the enrollee and the enrollee's appointed
5 representative, in writing, of the enrollee's
6 eligibility and acceptance for external review.
7 (f) An enrollee or an enrollee's appointed representative
8 may submit additional information in writing to the assigned
9 independent review organization for consideration in its
10 external review. The independent review organization shall
11 consider information submitted within five business days
12 following the date of the enrollee's receipt of the notice
13 provided pursuant to subsection (e). The independent review
14 organization may accept and consider additional information
15 submitted by an enrollee or an enrollee's appointed
16 representative after five business days.
17 (g) Within five business days after the date of receipt of
18 notice pursuant to subsection (e), the health carrier or its
19 designated utilization review organization shall provide to the
20 assigned independent review organization all documents and
21 information it considered in issuing the adverse action that is
22 the subject of external review. Failure by the health carrier

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

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

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

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

1 include any practice guidelines developed by the
2 federal government or national or professional medical
3 societies, boards, and associations;
4 (6) Any applicable clinical review criteria developed and
5 used by the health carrier or its designated
6 utilization review organization; and
7 (7) The opinion of the independent review organization's
8 clinical reviewer or reviewers pertaining to the
9 information enumerated in paragraphs (1) through (5)
10 to the extent the information or documents are
11 available and the clinical reviewer or reviewers
12 consider appropriate.
13 In reaching a decision, the assigned independent review
14 organization shall not be bound by any decisions or conclusions
15 reached during the health carrier's utilization review or
16 internal appeals process; provided that the independent review
17 organization's decision shall not contradict the terms of the
18 enrollee's health benefit plan or this part.
19 (j) Within forty-five days after it receives a request for
20 an external review pursuant to subsection (e), the assigned
21 independent review organization shall notify the enrollee, the
22 enrollee's appointed representative, the health carrier, and the

1 commissioner of its decision to uphold or reverse the adverse
2 action that is the subject of the internal review. The
3 independent review organization shall include in the notice of
4 its decision:
5 (1) A general description of the reason for the request
6 for external review;
7 (2) The date the independent review organization received
8 the assignment from the commissioner to conduct the
9 external review;
10 (3) The date the external review was conducted;
11 (4) The date the decision was issued; and
12 (5) The basis for the independent review organization's
13 decision, including its reasoning, rationale, and the
14 supporting evidence or documentation, including
15 evidence-based standards, that the independent review
16 organization considered in reaching its decision.
17 Upon receipt of a notice of a decision reversing the
18 adverse action, the health carrier shall immediately approve the
19 coverage that was the subject of the adverse action.
20 **§432E-E Expedited external review.** (a) Except as
21 provided in subsection (i), an enrollee or the enrollee's

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

1 that the enrollee has not been discharged from a
2 facility for health care services related to the
3 emergency services.

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

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

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

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

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

1 transmit all documents and information it considered in making
2 the adverse action that is the subject of the expedited external
3 review to the assigned independent review organization
4 electronically or by telephone, facsimile, or any other
5 available expeditious method.
6 (g) In addition to the documents and information provided
7 or transmitted pursuant to subsection (f), the assigned
8 independent review organization shall consider the following in
9 reaching a decision:
10 (1) The enrollee's pertinent medical records;
11 (2) The attending health care professional's
12 recommendation;
13 (3) Consulting reports from appropriate health care
14 professionals and other documents submitted by the
15 health carrier, enrollee, the enrollee's appointed
16 representative, or the enrollee's treating provider;
17 (4) The application of medical necessity criteria as
18 defined in section 432E-1;
19 (5) The most appropriate practice guidelines, which shall
20 include evidence-based standards, and may include any
21 other practice guidelines developed by the federal

1 government, national or professional medical
2 societies, boards, and associations;
3 (6) Any applicable clinical review criteria developed and
4 used by the health carrier or its designee utilization
5 review organization in making adverse determinations;
6 and
7 (7) The opinion of the independent review organization's
8 clinical reviewer or reviewers pertaining to the
9 information enumerated in paragraphs (1) through (5)
10 to the extent the information and documents are
11 available and the clinical reviewer or reviewers
12 consider appropriate.
13 In reaching a decision, the assigned independent review
14 organization shall not be bound by any decisions or conclusions
15 reached during the health carrier's utilization review or
16 internal appeals process; provided that the independent review
17 organization's decision shall not contradict the terms of the
18 enrollee's health benefit plan or this part.
19 (h) As expeditiously as the enrollee's medical condition
20 or circumstances requires, but in no event more than seventy-two
21 hours after the date of receipt of the request for an expedited
22 external review that meets the reviewability requirements set

1 forth in subsection (a), the assigned independent review
2 organization shall:
3 (1) Make a decision to uphold or reverse the adverse
4 action; and
5 (2) Notify the enrollee, the enrollee's appointed
6 representative, the health carrier, and the
7 commissioner of the decision.
8 If the notice provided pursuant to this subsection was not
9 in writing, within forty-eight hours after the date of providing
10 that notice, the assigned independent review organization shall
11 provide written confirmation of the decision to the enrollee,
12 the enrollee's appointed representative, the health carrier, and
13 the commissioner that includes the information provided in
14 section 432E-G.
15 Upon receipt of the notice of a decision reversing the
16 adverse action, the health carrier shall immediately approve the
17 coverage that was the subject of the adverse action.
18 (i) An expedited external review shall not be provided for
19 retrospective adverse or final adverse determinations.
20 **§432E-F External review of experimental or investigational**
21 **treatment adverse determinations.** (a) An enrollee or an
22 enrollee's appointed representative may file a request for an

1 external review with the commissioner within one hundred thirty
2 days of receipt of notice of an adverse action that involves a
3 denial of coverage based on a determination that the health care
4 service or treatment recommended or requested is experimental or
5 investigational.
6 (b) An enrollee or the enrollee's appointed representative
7 may make an oral request for an expedited external review of the
8 adverse action if the enrollee's treating physician certifies,
9 in writing, that the health care service or treatment that is
10 the subject of the request would be significantly less effective
11 if not promptly initiated. A written request for an expedited
12 external review pursuant to this subsection shall include, and
13 oral request shall be promptly followed by, a certification
14 signed by the enrollee's treating physician and the
15 authorization for release and disclosures required by section
16 432E-C. Upon receipt of all items required by this subsection,
17 the commissioner shall immediately notify the health carrier.
18 (c) Upon notice of the request for expedited external
19 review, the health carrier shall immediately determine whether
20 the request meets the requirements of subsection (b). The
21 health carrier shall immediately notify the commissioner, the

1 enrollee, and the enrollee's appointed representative of its
2 eligibility determination.
3 Notice of eligibility for expedited external review
4 pursuant to this subsection shall include a statement informing
5 the enrollee and, if applicable, the enrollee's appointed
6 representative that a health carrier's initial determination
7 that the external review request is ineligible for review may be
8 appealed to the commissioner.
9 (d) Upon receipt of a request for appeal pursuant to
10 subsection (c), the commissioner shall review the request for
11 external review submitted by the enrollee pursuant to subsection
12 (a), determine whether an enrollee is eligible for external
13 review and, if eligible, shall refer the enrollee to external
14 review. The commissioner's determination of eligibility for
15 external review shall be made in accordance with the terms of
16 the enrollee's health benefit plan and all applicable provisions
17 of this part. If an enrollee is not eligible for external
18 review, the commissioner shall notify the enrollee, the
19 enrollee's appointed representative, and the health carrier of
20 the reason for ineligibility within three business days.
21 (e) Upon receipt of the notice pursuant to subsection (a)
22 or a determination of the commissioner pursuant to subsection

1 (d) that the enrollee meets the eligibility requirements for
2 expedited external review, the commissioner shall immediately
3 randomly assign an independent review organization to conduct
4 the expedited external review from the list of approved
5 independent review organizations qualified to conduct the
6 external review, based on the nature of the health care service
7 that is the subject of the adverse action and other factors
8 determined by the commissioner including conflicts of interest
9 pursuant to section 432E-M, compiled and maintained by the
10 commissioner to conduct the external review and immediately
11 notify the health carrier of the name of the assigned
12 independent review organization.
13 (f) Upon receipt of the notice from the commissioner of
14 the name of the independent review organization assigned to
15 conduct the expedited external review, the health carrier or its
16 designee utilization review organization shall provide or
17 transmit all documents and information it considered in making
18 the adverse action that is the subject of the expedited external
19 review to the assigned independent review organization
20 electronically or by telephone, facsimile, or any other
21 available expeditious method.

1 (g) Except for a request for an expedited external review
2 made pursuant to subsection (b), within three business days
3 after the date of receipt of the request, the commissioner shall
4 notify the health carrier that the enrollee has requested an
5 expedited external review pursuant to this section. Within five
6 business days following the date of receipt of notice, the
7 health carrier shall determine whether:
8 (1) The individual is or was an enrollee in the health
9 benefit plan at the time the health care service or
10 treatment was recommended or requested or, in the case
11 of a retrospective review, was an enrollee in the
12 health benefit plan at the time the health care
13 service or treatment was provided;
14 (2) The recommended or requested health care service or
15 treatment that is the subject of the adverse action:
16 (A) Would be a covered benefit under the enrollee's
17 health benefit plan but for the health carrier's
18 determination that the service or treatment is
19 experimental or investigational for the
20 enrollee's particular medical condition; and
21 (B) Is not explicitly listed as an excluded benefit
22 under the enrollee's health benefit plan;

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

1 enrollee's condition, has certified in writing
2 that scientifically valid studies using accepted
3 protocols demonstrate that the health care
4 service or treatment that is the subject of the
5 adverse action is likely to be more beneficial to
6 the enrollee than any available standard health
7 care services or treatments;
8 (5) The enrollee has exhausted the health carrier's
9 internal appeals process or the enrollee is not
10 required to exhaust the health carrier's internal
11 appeals process pursuant to section 432E-C(b); and
12 (6) The enrollee has provided all the information and
13 forms required by the commissioner that are necessary
14 to process an external review, including the release
15 form and disclosure of conflict of interest
16 information as provided under section 432E-5.
17 (h) Within three business days after determining the
18 enrollee's eligibility for external review pursuant to
19 subsection (g), the health carrier shall notify the
20 commissioner, the enrollee, and the enrollee's appointed
21 representative in writing as to whether the request is complete
22 and eligible for external review.

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

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

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

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

20 (i) Upon receipt of a request for appeal pursuant to
21 subsection (h), the commissioner shall review the request for
22 external review submitted pursuant to subsection (a) and, if

1 eligible, shall refer the enrollee for external review. The
2 commissioner's determination of eligibility for expedited
3 external review shall be made in accordance with the terms of
4 the enrollee's health benefit plan and all applicable provisions
5 of this part. If an enrollee is not eligible for external
6 review, the commissioner shall notify the enrollee, the
7 enrollee's appointed representative, and the health carrier of
8 the reasons for ineligibility within three business days.
9 (j) When the commissioner receives notice pursuant to
10 subsection (h) or makes a determination pursuant to subsection
11 (i) that an enrollee is eligible for external review, within
12 three business days after receipt of the notice or determination
13 of eligibility, the commissioner shall:
14 (1) Randomly assign an independent review organization
15 from the list of approved independent review
16 organizations qualified to conduct the external
17 review, based on the nature of the health care service
18 that is the subject of the adverse action and other
19 factors determined by the commissioner including
20 conflicts of interest pursuant to section 432E-M,
21 compiled and maintained by the commissioner pursuant
22 to conduct the external review and notify the health

1 carrier of the name of the assigned independent review
2 organization; and
3 (2) Notify the enrollee and the enrollee's appointed
4 representative, in writing, of the enrollee's
5 eligibility and acceptance for external review.
6 (k) An enrollee or an enrollee's appointed representative
7 may submit additional information in writing to the assigned
8 independent review organization for consideration in its
9 external review. The independent review organization shall
10 consider information submitted within five business days
11 following the date of the enrollee's receipt of the notice
12 provided pursuant to subsection (j). The independent review
13 organization may accept and consider additional information
14 submitted by an enrollee after five business days.
15 (l) Within five business days after the date of receipt of
16 notice pursuant to subsection (j), the health carrier or its
17 designated utilization review organization shall provide to the
18 assigned independent review organization all documents and
19 information it considered in issuing the adverse action that is
20 the subject of external review. Failure by the health carrier
21 or its utilization review organization to provide the documents
22 and information within five business days shall not delay the

1 conduct of the external review; provided that the assigned
2 independent review organization may terminate the external
3 review and reverse the adverse action that is the subject of the
4 external review. The independent review organization shall
5 notify the enrollee, the enrollee's appointed representative,
6 the health carrier, and the commissioner within three business
7 days of the termination of an external review and reversal of an
8 adverse action pursuant to this subsection.
9 (m) Within three business days after the receipt of the
10 notice of assignment to conduct the external review pursuant to
11 subsection (j), the assigned independent review organization
12 shall:
13 (1) Select one or more clinical reviewers who each shall
14 be a physician or other health care professional who
15 meets the minimum qualifications described in section
16 432E-I and, through clinical experience in the past
17 three years, is an expert in the treatment of the
18 enrollee's condition and knowledgeable about the
19 recommended or requested health care service or
20 treatment to conduct the external review; provided
21 that neither the enrollee, the enrollee's appointed
22 representative, nor the health carrier shall choose or

1 control the choice of the physicians or other health
2 care professionals to be selected to conduct the
3 external review; and
4 (2) Based on the written opinion of the clinical reviewer,
5 or opinions if more than one clinical reviewer has
6 been selected, to the assigned independent review
7 organization on whether the recommended or requested
8 health care service or treatment should be covered,
9 make a determination to uphold or reverse the adverse
10 action.
11 In reaching an opinion, the clinical reviewers are not
12 bound by any decisions or conclusions reached during the health
13 carrier's utilization review process or internal appeals
14 process.
15 Each clinical reviewer selected pursuant to this subsection
16 shall review all of the information and documents received
17 pursuant to subsection (l) and any other information submitted
18 in writing by the enrollee or the enrollee's authorized
19 representative pursuant to this subsection.
20 (n) The assigned independent review organization, within
21 one business day of receipt by the independent review
22 organization, shall forward all information received from the

1 enrollee pursuant to subsection (k) to the health carrier. Upon
2 receipt of information forwarded to it pursuant to this
3 subsection, a health carrier may reconsider the adverse action
4 that is the subject of the external review; provided that
5 reconsideration by the health carrier shall not delay or
6 terminate an external review unless the health carrier reverses
7 its adverse action and provides coverage or payment for the
8 health care service that is the subject of the adverse action.
9 The health carrier shall notify the enrollee, the enrollee's
10 appointed representative, the assigned independent review
11 organization, and the commissioner in writing of its decision to
12 reverse its adverse action and within three business days of
13 making its decision to reverse the adverse action and provide
14 coverage. The assigned independent review organization shall
15 terminate its external review upon receipt of notice pursuant to
16 this subsection from the health carrier.
17 (o) Except as provided in subsection (p), within twenty
18 days after being selected to conduct the external review, a
19 clinical reviewer shall provide an opinion to the assigned
20 independent review organization pursuant to subsection (q)
21 regarding whether the recommended or requested health care

1 service or treatment subject to an appeal pursuant to this
2 section shall be covered.
3 The clinical reviewers' opinion shall be in writing and
4 shall include:
5 (1) A description of the enrollee's medical condition;
6 (2) A description of the indicators relevant to
7 determining whether there is sufficient evidence to
8 demonstrate that the recommended or requested health
9 care service or treatment is more likely than not to
10 be more beneficial to the enrollee than any available
11 standard health care services or treatments and
12 whether the adverse risks of the recommended or
13 requested health care service or treatment would not
14 be substantially increased over those of available
15 standard health care services or treatments;
16 (3) A description and analysis of any medical or
17 scientific evidence, as that term is defined in
18 section 432E-1.4, considered in reaching the opinion;
19 (4) A description and analysis of any medical necessity
20 criteria defined in section 432E-1; and
21 (5) Information on whether the reviewer's rationale for
22 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

1 written confirmation of the opinion to the assigned independent
2 review organization and include the information required under
3 subsection (o).
4 (q) In addition to the documents and information provided
5 pursuant to subsection (b) or (l), a clinical reviewer may
6 consider the following in reaching an opinion pursuant to
7 subsection (o):
8 (1) The enrollee's pertinent medical records;
9 (2) The attending physician's or health care
10 professional's recommendation;
11 (3) Consulting reports from appropriate health care
12 professionals and other documents submitted by the
13 health carrier, enrollee, the enrollee's appointed
14 representative, or the enrollee's treating physician
15 or health care professional; and
16 (4) Whether:
17 (A) The recommended health care service or treatment
18 has been approved by the federal Food and Drug
19 Administration, if applicable, for the condition;
20 or
21 (B) Medical or scientific evidence or evidence-based
22 standards demonstrate that the expected benefits

1 of the recommended or requested health care
2 service or treatment is more likely than not to
3 be beneficial to the enrollee than any available
4 standard health care service or treatment and the
5 adverse risks of the recommended or requested
6 health care service or treatment would not be
7 substantially increased over those of available
8 standard health care services or treatments;
9 provided that the independent review organization's decision
10 shall not contradict the terms of the enrollee's health benefit
11 plan or the provisions of this chapter.
12 (r) Except as provided in subsection (s), within twenty
13 days after the date it receives the opinion of the clinical
14 reviewer pursuant to subsection (o), the assigned independent
15 review organization, in accordance with subsection (t), shall
16 determine whether the health care service at issue in an
17 external review pursuant to this section shall be a covered
18 benefit and shall notify the enrollee, the enrollee's appointed
19 representative, the health carrier, and the commissioner of its
20 determination. The independent review organization shall
21 include in the notice of its decision:

1 (1) A general description of the reason for the request
2 for external review;
3 (2) The written opinion of each clinical reviewer,
4 including the recommendation of each clinical reviewer
5 as to whether the recommended or requested health care
6 service or treatment should be covered and the
7 rationale for the reviewer's recommendation;
8 (3) The date the independent review organization was
9 assigned by the commissioner to conduct the external
10 reviewer;
11 (4) The date the external review was conducted;
12 (5) The date the decision was issued;
13 (6) The principal reason or reasons for its decision; and
14 (7) The rationale for its decision.
15 Upon receipt of a notice of a decision reversing the
16 adverse action, the health carrier immediately shall approve
17 coverage of the recommended or requested health care service or
18 treatment that was the subject of the adverse action.
19 (s) For an expedited external review, within forty-eight
20 hours after the date it receives the opinion of each clinical
21 reviewer, the assigned independent review organization, in
22 accordance with subsection (t), shall make a decision and

1 provide notice of the decision orally or in writing to the
2 enrollee, the enrollee's appointed representative, the health
3 carrier, and the commissioner.
4 If the notice provided was not in writing, within forty-
5 eight hours after the date of providing that notice, the
6 assigned independent review organization shall provide written
7 confirmation of the decision to the enrollee, the enrollee's
8 appointed representative, the health carrier, and the
9 commissioner.
10 (t) If a majority of the clinical reviewers recommends
11 that the recommended or requested health care service or
12 treatment should be covered, the independent review organization
13 shall make a decision to reverse the health carrier's adverse
14 determination or final adverse determination.
15 If a majority of the clinical reviewers recommends that the
16 recommended or requested health care service or treatment should
17 not be covered, the independent review organization shall make a
18 decision to uphold the health carrier's adverse determination or
19 final adverse determination.
20 If the clinical reviewers are evenly split as to whether
21 the recommended or requested health care service or treatment
22 should be covered, the independent review organization shall

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

11 **§432E-G Binding nature of external review decision.** (a)
12 An external review decision shall be binding on the health
13 carrier and the enrollee except to the extent that the health
14 carrier or the enrollee has other remedies available under
15 applicable federal or state law.

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

21 **§432E-H Approval of independent review organizations.** (a)
22 An independent review organization shall be approved by the

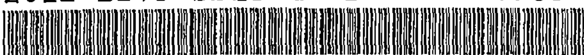
1 commissioner in order to be eligible to be assigned to conduct
2 external reviews under this part.
3 (b) To be eligible for approval by the commissioner to
4 conduct external reviews under this part an independent review
5 organization shall:
6 (1) Submit an application on a form required by the
7 commissioner and include all documentation and
8 information necessary for the commissioner to
9 determine if the independent review organization
10 satisfies the minimum qualifications established under
11 this part; and
12 (2) Except as otherwise provided in subsection (c), shall
13 be accredited by a nationally-recognized private
14 accrediting entity that the commissioner has
15 determined has independent review organization
16 accreditation standards that are equivalent to or
17 exceed the minimum standards established by this
18 section and section 432E-I.
19 (c) The commissioner may approve independent review
20 organizations that are not accredited by a nationally-recognized
21 private accrediting entity if there are no acceptable

1 nationally-recognized private accrediting entities providing
2 independent review organization accreditation.
3 (d) The commissioner may charge an application fee that
4 the independent review organizations shall submit to the
5 commissioner with an application for approval and re-approval.
6 (e) Approval pursuant to this section is effective for two
7 years, unless the commissioner determines before its expiration
8 that the independent review organization does not meet the
9 minimum qualifications established under this part. If the
10 commissioner determines that an independent review organization
11 has lost its accreditation or no longer satisfies the minimum
12 requirements of this part, the commissioner shall terminate the
13 approval of the independent review organization and remove the
14 independent review organization from the list of independent
15 review organizations approved to conduct external reviews
16 maintained by the commissioner.
17 (f) The commissioner shall maintain and periodically
18 update a list of approved independent review organizations.
19 **§432E-I Minimum qualifications for independent review**
20 **organizations.** (a) To be eligible for approval under this part
21 to conduct external reviews, an independent review organization
22 shall have and maintain written policies and procedures that

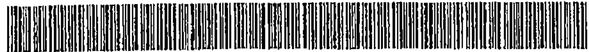
1 govern all aspects of both the standard external review process
2 and the expedited external review process set forth in this part
3 that include, at minimum:
4 (1) A quality assurance mechanism in place that ensures:
5 (A) That external reviews are conducted within the
6 specified time frames of this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

1 capable of accepting, recording, or providing
2 appropriate instruction to incoming telephone callers
3 during other than normal business hours and
4 facilitating necessary communication under this part;
5 and
6 (3) An agreement to maintain and provide to the
7 commissioner the information required by this part.
8 (b) Each clinical reviewer assigned by an independent
9 review organization to conduct an external review shall be a
10 physician or other appropriate health care provider who:
11 (1) Is an expert in the treatment of the medical condition
12 that is the subject of the external review;
13 (2) Is knowledgeable about the recommended health care
14 service and treatment through recent or current actual
15 clinical experience treating patients with the same or
16 similar medical condition at issue in the external
17 review;
18 (3) Holds a non-restricted license in a state of the
19 United States and, for physicians, a current
20 certification by a recognized American Medical
21 Specialty Board in the area or areas appropriate to
22 the subject of the external review; and

1 (4) Has no history of disciplinary actions or sanctions,
2 including loss of staff privileges or participation
3 restrictions, imposed or pending by any hospital,
4 governmental agency or unit, or regulatory body that
5 raises a substantial question as to the clinical
6 reviewer's physical, mental, or professional
7 competence or moral character.
8 (c) An independent review organization shall not own or
9 control, be a subsidiary of, or in any way be owned or
10 controlled by, or exercise control over a health carrier, health
11 benefit plan, a national, state, or local trade association of
12 health benefit plans, or a national, state, or local trade
13 association of health care providers.
14 (d) To be eligible to conduct an external review of a
15 specified case, neither the independent review organization
16 selected to conduct the external review nor any clinical
17 reviewer assigned by the independent review organization to
18 conduct the external review shall have a material professional,
19 familial, or financial conflict of interest with any of the
20 following:
21 (1) The health carrier that is the subject of the external
22 review;



1 (2) The enrollee whose treatment is the subject of the
2 external review, the enrollee's appointed
3 representative, or the enrollee's immediate family;
4 (3) Any officer, director, or management employee of the
5 health carrier that is the subject of the external
6 review;
7 (4) The health care provider, the health care provider's
8 medical group, or independent practice association
9 recommending the health care service or treatment that
10 is the subject of the external review;
11 (5) The facility at which the recommended health care
12 service or treatment would be provided;
13 (6) The developer or manufacturer of the principal drug,
14 device, procedure, or other therapy recommended for
15 the enrollee whose treatment is the subject of the
16 external review; or
17 (7) The health benefit plan that is the subject of the
18 external review, the plan administrator, or any
19 fiduciary or employee of the plan.
20 The commissioner may determine that no material
21 professional, familial, or financial conflict of interest exists
22 based on the specific characteristics of a particular



1 relationship or connection that creates an apparent
2 professional, familial, or financial conflict of interest.
3 (e) An independent review organization that is accredited
4 by a nationally-recognized private accrediting entity that has
5 independent review accreditation standards that the commissioner
6 has determined are equivalent to or exceed the minimum
7 qualifications of this section shall be presumed to be in
8 compliance with this section to be eligible for approval under
9 this part.
10 The commissioner shall review, initially upon approval of
11 an accredited independent review organization and periodically
12 during the time that the independent review organization remains
13 approved pursuant to this section, the accreditation standards
14 of the nationally-recognized private accrediting entity to
15 determine whether the entity's standards are, and continue to be
16 equivalent to, or exceed the minimum qualifications established
17 under this section; provided that a review conducted by the
18 National Association of Insurance Commissioners shall satisfy
19 the requirements of this section.
20 Upon request of the commissioner, a nationally-recognized
21 private accrediting entity shall make its current independent
22 review organization accreditation standards available to the

1 commissioner or the National Association of Insurance
2 Commissioners in order for the commissioner to determine if the
3 entity's standards are equivalent to or exceed the minimum
4 qualifications established under this section. The commissioner
5 may exclude any private accrediting entity that is not reviewed
6 by the National Association of Insurance Commissioners.
7 (f) An independent review organization shall establish and
8 maintain written procedures to ensure that it is unbiased in
9 addition to any other procedures required under this section.
10 **§432E-J Hold harmless for independent review**
11 **organizations.** No independent review organization or clinical
12 reviewer working on behalf of an independent review organization
13 or an employee, agent, or contractor of an independent review
14 organization shall be liable in damages to any person for any
15 opinions rendered or acts or omissions performed within the
16 scope of the organization's or person's duties under the law
17 during or upon completion of an external review conducted
18 pursuant to this part, unless the opinion was rendered or the
19 act or omission was performed in bad faith or involved gross
20 negligence.
21 **§432E-K External review reporting requirements.** (a) An
22 independent review organization assigned pursuant to this part

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;

1 (2) From the total number of requests for external review
2 reported, the number of requests determined eligible
3 for a full external review; and
4 (3) Any other information the commissioner may request or
5 require.
6 The health carrier shall retain the written records
7 required pursuant to this subsection for at least three years.
8 **§432E-L Funding of external review.** The health carrier
9 against which a request for a standard external review or an
10 expedited external review is filed shall pay the cost of the
11 independent review organization for conducting the external
12 review. There shall be no recourse against the commissioner for
13 the cost of conducting the external review and the selection of
14 an independent review organization shall not be subject to
15 chapter 103D; provided that the commissioner may initially
16 approve up to three independent review organizations to serve
17 beginning on the effective date of this part until the initial
18 procurement process is completed; provided further that in any
19 year in which procurement subject to chapter 103D does not
20 produce at least three independent review organizations eligible
21 for selection under section 432E-I, the commissioner may approve

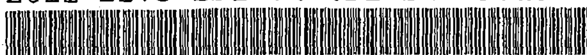
1 up to three independent review organizations notwithstanding the
2 requirements of chapter 103D.

3 **§432E-M Disclosure requirements.** (a) Each health carrier
4 shall include a description of the external review procedures in
5 or attached to the policy, certificate, membership booklet,
6 outline of coverage, or other evidence of coverage it provides
7 to enrollees.

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

17 (c) In addition to the requirements of subsection (b), the
18 statement shall inform the enrollee that, when filing a request
19 for an external review, the enrollee or the enrollee's appointed
20 representative shall be required to authorize the release of any
21 medical records of the enrollee that may be required to be
22 reviewed for the purpose of reaching a decision on the external

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



1 drug, device, procedure, or other therapy that is the subject of
2 the external review request.

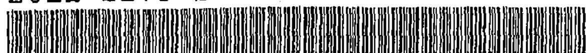
3 (e) Each health carrier doing business in Hawaii shall
4 file with the commissioner by the effective date of this part,
5 information to permit the commissioner to perform a conflict of
6 interest evaluation for selection of an appropriate independent
7 review organization in the event of a request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

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

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

21 **§432E-N Rules.** The insurance commissioner shall adopt
22 rules pursuant to chapter 91 to effectuate the purpose of this

1 part including requirements for forms to request external review
2 and expedited external review, to request approval by
3 independent review organizations, and for disclosure of
4 conflicts of interest by enrollees and health carriers."
5 SECTION 3. Chapter 432E, Hawaii Revised Statutes, is
6 amended by designating sections 432E-1 through 432E-2 as part I,
7 entitled "General Provisions".
8 SECTION 4. Chapter 432E, Hawaii Revised Statutes, is
9 amended by designating sections 432E-3 through 432E-8 as part
10 II, entitled "General Policies".
11 SECTION 5. Chapter 432E, Hawaii Revised Statutes, is
12 amended by designating sections 432E-9 through 432E-13 as part
13 III, entitled "Reporting and Other Provisions".
14 SECTION 6. Section 432E-1, Hawaii Revised Statutes, is
15 amended to read as follows:
16 "**§432E-1 Definitions.** As used in this chapter, unless the
17 context otherwise requires:
18 "Adverse action" means an adverse determination or a final
19 adverse determination.
20 "Adverse determination" means a determination by a health
21 carrier or its designated utilization review organization that
22 an admission, availability of care, continued stay, or other



1 health care service that is a covered benefit has been reviewed
2 and, based upon the information provided, does not meet the
3 health carrier's requirements for medical necessity,
4 appropriateness, health care setting, level of care, or
5 effectiveness, and the requested service or payment for the
6 service is therefore denied, reduced, or terminated.
7 "Ambulatory review" means a utilization review of health
8 care services performed or provided in an outpatient setting.
9 "Appeal" means a request from an enrollee to change a
10 previous decision made by the [~~managed care plan.~~] health
11 carrier.
12 "Appointed representative" means a person who is expressly
13 permitted by the enrollee or who has the power under Hawaii law
14 to make health care decisions on behalf of the enrollee,
15 including:
16 (1) A person to whom an enrollee has given express written
17 consent to represent the enrollee in an external
18 review;
19 (2) A person authorized by law to provide substituted
20 consent for an enrollee;

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

1 "Case-control study" means a prospective evaluation of two
2 groups of patients with different outcomes to determine which
3 specific interventions the patients received.
4 "Case-series" means an evaluation of patients with a
5 particular outcome, without the use of a control group.
6 "Certification" means a determination by a health carrier
7 or its designated utilization review organization that an
8 admission, availability of care, continued stay, or other health
9 care service has been reviewed and, based on the information
10 provided, satisfies the health carrier's requirements for
11 medical necessity, appropriateness, health care setting, level
12 of care, and effectiveness.
13 "Clinical review criteria" means the written screening
14 procedures, decision abstracts, clinical protocols, and practice
15 guidelines used by a health carrier to determine the necessity
16 and appropriateness of health care services.
17 "Cohort study" means a prospective evaluation of two groups
18 of patients with only one group of patients receiving a specific
19 intervention.
20 "Commissioner" means the insurance commissioner.
21 "Complaint" means an expression of dissatisfaction, either
22 oral or written.

1 "Concurrent review" means a utilization review conducted
2 during a patient's hospital stay or course of treatment.
3 "Covered benefits" or "benefits" means those health care
4 services to which an enrollee is entitled under the terms of a
5 health benefit plan.
6 "Discharge planning" means the formal process for
7 determining, prior to discharge from a facility, the
8 coordination and management of the care that an enrollee
9 receives following discharge from a facility.
10 "Disclose" means to release, transfer, or otherwise divulge
11 protected health information to any person other than the
12 individual who is the subject of the protected health
13 information.
14 "Emergency services" means services provided to an enrollee
15 when the enrollee has symptoms of sufficient severity that a
16 layperson could reasonably expect, in the absence of medical
17 treatment, to result in placing the enrollee's health or
18 condition in serious jeopardy, serious impairment of bodily
19 functions, serious dysfunction of any bodily organ or part, or
20 death.

"Enrollee" means a person who enters into a contractual relationship <u>under</u> or who is provided with health care services or benefits through a [~~managed care plan.~~] <u>health benefit plan.</u>

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

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

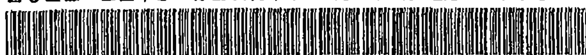
<u>"Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.</u>

<u>"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.</u>

<u>"External review" means a review of an adverse determination (including a final adverse determination)</u>

1 conducted by an independent review organization pursuant to this
2 chapter.
3 "Facility" means an institution providing health care
4 services or a health care setting, including but not limited to,
5 hospitals and other licensed inpatient centers, ambulatory
6 surgical or treatment centers, skilled nursing centers,
7 residential treatment centers, diagnostic, laboratory and
8 imaging centers, and rehabilitation and other therapeutic health
9 settings.
10 "Final adverse determination" means an adverse
11 determination involving a covered benefit that has been upheld
12 by a health carrier or its designated utilization review
13 organization at the completion of the health carrier's internal
14 grievance process procedures, or an adverse determination with
15 respect to which the internal appeals process is deemed to have
16 been exhausted under section 432E-C(b).
17 "Health benefit plan" means a policy, contract, certificate
18 or agreement offered or issued by a health carrier to provide,
19 deliver, arrange for, pay or reimburse any of the costs of
20 health care services.
21 "Health care [~~provider"~~] professional" means an individual
22 licensed, accredited, or certified to provide or perform

1 specified health care services in the ordinary course of
2 business or practice of a profession[-] consistent with state
3 law.
4 "Health care provider" or "provider" means a health care
5 professional.
6 "Health care services" means services for the diagnosis,
7 prevention, treatment, cure, or relief of a health condition,
8 illness, injury, or disease.
9 "Health carrier" means an entity subject to the insurance
10 laws and rules of this State, or subject to the jurisdiction of
11 the commissioner, that contracts or offers to contract to
12 provide, deliver, arrange for, pay for, or reimburse any of the
13 costs of health care services, including a sickness and accident
14 insurance company, a health maintenance organization, a mutual
15 benefit society, a nonprofit hospital and health service
16 corporation, or any other entity providing a plan of health
17 insurance, health benefits or health care services.
18 "Health maintenance organization" means a health
19 maintenance organization as defined in section 432D-1.
20 "Independent review organization" means an independent
21 entity [~~that:~~
22 ~~(1) Is unbiased and able to make independent decisions;~~



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

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

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

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

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

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

"Managed care plan" means any plan, policy, contract, certificate, or agreement, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and

1 any other mixed model, that provides for the financing or
2 delivery of health care services or benefits to enrollees
3 through:
4 (1) Arrangements with selected providers or provider
5 networks to furnish health care services or benefits;
6 and
7 (2) Financial incentives for enrollees to use
8 participating providers and procedures provided by a
9 plan;
10 provided[~~,~~] that for the purposes of this chapter, an employee
11 benefit plan shall not be deemed a managed care plan with
12 respect to any provision of this chapter or to any requirement
13 or rule imposed or permitted by this chapter [~~which~~] that is
14 superseded or preempted by federal law.
15 "Medical director" means the person who is authorized under
16 a [~~managed care plan~~] health carrier and who makes decisions for
17 the [~~plan~~] health carrier denying or allowing payment for
18 medical treatments, services, or supplies based on medical
19 necessity or other appropriate medical or health plan benefit
20 standards.
21 "Medical necessity" means a health intervention [~~as~~
22 ~~defined~~] that meets the criteria enumerated in section 432E-1.4.

1 "Medical or scientific evidence" means evidence found in
2 the following sources:
3 (1) Peer-reviewed scientific studies published in or
4 accepted for publication by medical journals that meet
5 nationally-recognized requirements for scientific
6 manuscripts and that submit most of their published
7 articles for review by experts, who are not part of
8 the editorial staff;
9 (2) Peer-reviewed medical literature, including literature
10 relating to therapies reviewed and approved by a
11 qualified institutional review board, biomedical
12 compendia, and other medical literature that meet the
13 criteria of the National Institutes of Health's
14 National Library of Medicine for indexing in Index
15 Medicus and Elsevier Science Ltd. for indexing in
16 Excerpta Medicas;
17 (3) Medical journals recognized by the United States
18 Secretary of Health and Human Services under Section
19 1861(t)(2) of the federal Social Security Act;
20 (4) The following standard reference compendia:
21 (A) The American Hospital Formulary Service-Drug
22 Information;

1 (B) Drug Facts and Comparisons;
2 (C) The American Dental Association Accepted Dental
3 Therapeutics; and
4 (D) The United States Pharmacopeia Drug Information;
5 (5) Findings, studies, or research conducted by or under
6 the auspices of federal government agencies and
7 nationally-recognized federal research institutes,
8 including:
9 (A) The federal Agency for Healthcare Research and
10 Quality;
11 (B) The National Institutes of Health;
12 (C) The National Cancer Institute;
13 (D) The National Academy of Sciences;
14 (E) The Centers for Medicare and Medicaid Services;
15 (F) The federal Food and Drug Administration; and
16 (G) Any national board recognized by the National
17 Institutes of Health for the purpose of
18 evaluating the medical value of health care
19 services; or
20 (6) Any other medical or scientific evidence that is
21 comparable to the sources listed in paragraphs (1)
22 through (5).

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

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

8 "Protected health information" means health information as
9 defined in the federal Health Insurance Portability and
10 Accountability Act and related federal rules.

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

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

1 "Reviewer" means an independent reviewer with clinical
2 expertise either employed by or contracted by an independent
3 review organization to perform external reviews.
4 "Second opinion" means an opportunity or requirement to
5 obtain a clinical evaluation by a provider other than the one
6 originally making a recommendation for a proposed health care
7 service to assess the clinical necessity and appropriateness of
8 the initial proposed health care service.
9 "Specifically excluded" means that the coverage provisions
10 of the health care plan, when read together, clearly and
11 specifically exclude coverage for a health care service.
12 "Utilization review" means a set of formal techniques
13 designed to monitor the use of, or evaluate the clinical
14 necessity, appropriateness, efficacy, or efficiency of, health
15 care services, procedures, or settings. Techniques may include
16 ambulatory review, prospective review, second opinion,
17 certification, concurrent review, case management, discharge
18 planning, or retrospective review.
19 "Utilization review organization" means an entity that
20 conducts utilization review other than a health carrier
21 performing a review for its own health benefit plans."

1 SECTION 7. Section 432E-5, Hawaii Revised Statutes, is
2 amended to read as follows:
3 "§432E-5 **Complaints and appeals procedure for enrollees.**
4 (a) A [~~managed care plan~~] health carrier with enrollees in this
5 State shall establish and maintain a procedure to provide for
6 the resolution of an enrollee's complaints and internal appeals.
7 The procedure shall provide for expedited internal appeals under
8 section 432E-6.5. The definition of medical necessity in
9 section 432E-1.4 shall apply in a [~~managed care plan's~~] health
10 carrier's complaints and internal appeals procedures.
11 (b) The [~~managed care plan~~] health carrier shall at all
12 times make available its complaints and internal appeals
13 procedures. The complaints and internal appeals procedures
14 shall be reasonably understandable to the average layperson and
15 shall be provided in a language other than English upon request.
16 (c) A [~~managed care plan~~] health carrier shall decide any
17 expedited internal appeal as soon as possible after receipt of
18 the complaint, taking into account the medical exigencies of the
19 case, but not later than seventy-two hours after receipt of the
20 request for expedited appeal.
21 (d) A [~~managed care plan~~] health carrier shall send notice
22 of its final internal determination within sixty days of the

1 submission of the complaint to the enrollee, the enrollee's
2 appointed representative, if applicable, the enrollee's treating
3 provider, and the commissioner. The notice shall include the
4 following information regarding the enrollee's rights and
5 procedures:
6 (1) The enrollee's right to request an external review;
7 (2) The [~~sixty-day~~] one hundred thirty day deadline for
8 requesting an external review;
9 (3) Instructions on how to request an external review; and
10 (4) Where to submit the request for an external review.
11 In addition to these general requirements, the notice shall
12 conform to the requirements of section 432E-E."
13 SECTION 8. Section 432E-6.5, Hawaii Revised Statutes, is
14 amended by amending its title to read as follows:
15 **"§432E-6.5 Expedited internal appeal, when authorized;**
16 **standard for decision."**
17 SECTION 9. Section 432E-6.5, Hawaii Revised Statutes, is
18 amended by amending subsection (a) to read as follows:
19 "(a) An enrollee may request that the [~~following~~] internal
20 appeal under section 432E-5 be conducted as an expedited
21 [~~appeal:~~
22 ~~(1) The internal review under section 432E-5 of the~~

~~enrollee's complaint; or~~

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

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

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

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

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

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

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

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

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

~~the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the managed care plan of the decision;~~

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

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

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

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

~~(6)~~ ~~After considering the enrollee's complaint, the managed care plan's response, and any affidavits filed~~

1 ~~by the parties, the commissioner may dismiss the~~
2 ~~request for external review if it is determined that~~
3 ~~the request is frivolous or without merit; and~~
4 ~~(7) The review panel shall review every final internal~~
5 ~~determination to determine whether the managed care~~
6 ~~plan involved acted reasonably. The review panel and~~
7 ~~the commissioner or the commissioner's designee shall~~
8 ~~consider:~~
9 ~~(A) The terms of the agreement of the enrollee's~~
10 ~~insurance policy, evidence of coverage, or~~
11 ~~similar document;~~
12 ~~(B) Whether the medical director properly applied the~~
13 ~~medical necessity criteria in section 432E-1.4 in~~
14 ~~making the final internal determination;~~
15 ~~(C) All relevant medical records;~~
16 ~~(D) The clinical standards of the plan;~~
17 ~~(E) The information provided;~~
18 ~~(F) The attending physician's recommendations; and~~
19 ~~(G) Generally accepted practice guidelines.~~
20 ~~The commissioner, upon a majority vote of the panel, shall~~
21 ~~issue an order affirming, modifying, or reversing the decision~~
22 ~~within thirty days of the hearing.~~

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

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

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

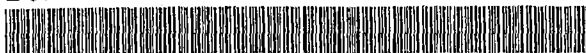
~~(2) The treatment of the enrollee, including but not limited to the developer or manufacturer of the principal drug, device, procedure, or other therapy at issue.~~

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

~~(e) An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable costs incurred in connection with the external review under this section, unless the commissioner in an administrative~~

1 ~~proceeding determines that the appeal was unreasonable,~~
2 ~~fraudulent, excessive, or frivolous.~~
3 ~~(f) Disclosure of an enrollee's protected health~~
4 ~~information shall be limited to disclosure for purposes relating~~
5 ~~to the external review.~~"]
6 SECTION 11. The insurance commissioner shall submit a
7 report to the legislature no later than twenty days prior to the
8 convening of the 2012 regular session on the implementation of
9 this Act including the names of all independent review
10 organizations contracted by the State pursuant to section
11 432E-L, Hawaii Revised Statutes, and data on the number of
12 requests for external review and outcomes of external reviews as
13 maintained by each independent review organization pursuant to
14 section 432E-K(b), Hawaii Revised Statutes.
15 SECTION 12. The insurance commissioner shall assist the
16 department of human services and the Hawaii employer-union
17 health benefits trust fund in compiling data relating to each
18 entity's own administrative review process comparable to that
19 maintained by independent review organizations pursuant to
20 section 432E-K(b), Hawaii Revised Statutes, and submitting a
21 report of the data and findings to the legislature no later than
22 twenty days prior to the convening of the 2012 regular session.

1 The report submitted pursuant to this section shall include a
2 comparison between outcomes in the review processes maintained
3 by the department of human services and Hawaii employer-union
4 health benefits trust fund, respectively, and outcomes of the
5 review processes of independent review organizations, as well as
6 an analysis of whether or not consumers would have achieved
7 better access to health care services under a review process
8 maintained by an independent review organization.
9 SECTION 13. If any provision of this Act, or the
10 application thereof to any person or circumstance is held
11 invalid, the invalidity does not affect other provisions or
12 applications of the Act, which can be given effect without the
13 invalid provision or application, and to this end the provisions
14 of this Act are severable.
15 SECTION 14. This Act shall be construed at all times in
16 conformity with the federal Patient Protection and Affordable
17 Care Act, Public Law No. 111-148. If any provision of this part
18 is interpreted to violate the Patient Protection and Affordable
19 Care Act, the commissioner is authorized to adopt by emergency
20 rule-making procedures, any rules as necessary to conform the
21 provisions and procedures of this part with the Patient
22 Protection and Affordable Care Act.



1 SECTION 15. In codifying the new sections added by section
2 2 of this Act, the revisor of statutes shall substitute
3 appropriate section numbers for the letters used in designating
4 the new sections in this Act.
5 SECTION 16. Statutory material to be repealed is bracketed
6 and stricken. New statutory material is underscored.
7 SECTION 17. This Act shall take effect on June 30, 2011;
8 provided that if the United States Department of Health and
9 Human Services by rule or other written guidance extends the
10 time period for the State's existing external review process
11 under section 432E-6, Hawaii Revised Statutes, to any later date
12 during 2011, then the effective date of this Act shall be the
13 sooner of the end date of the transition period or January 1,
14 2012; provided further that if the external review requirements
15 of the federal Patient Protection and Affordable Care Act of
16 2010 are held unconstitutional by the United States Supreme
17 Court, this Act shall be repealed as of the date that the United
18 States Supreme Court issues its opinion and chapter 432E, Hawaii
19 Revised Statutes, shall be reenacted in the form in which it
20 existed as of the day before the United States Supreme Court
21 issued its decision.

S.B. NO. 1274 S.D. 2 H.D. 3 C.D. 1

APPROVED this 12 day of JUL, 2011

GOVERNOR OF THE STATE OF HAWAII