



Annual External Review Report

In Accordance with Hawaii Revised Statutes §432E-13

Prepared by the

INSURANCE DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

December 2012

Foreword

Hawaii Revised Statutes (“HRS”) section 432E-13 requires the Insurance Commissioner to submit to the Legislature a report that contains the number of external review hearing cases reviewed, the type of cases reviewed, a summary of the nature of the cases reviewed, and the disposition of the cases reviewed. Furthermore, the identities of the plan and the enrollee shall be protected from disclosure in the report.

The external review process is an important component to the Patients’ Bill of Rights and Responsibilities Act, HRS chapter 432E. As such, the Insurance Division has provided a general overview of the external review statistics for fiscal year 2011-2012.

GORDON I. ITO
Insurance Commissioner

External Review Report for Fiscal Year 2011-2012

This annual report is filed pursuant to Hawaii Revised Statutes (“HRS”) section 432E-13, which requires the Insurance Commissioner to submit an annual report concerning external review cases to the Legislature.

The Insurance Division administers the external review process under the Patients’ Bill of Rights and Responsibilities Act, HRS chapter 432E (“Act”). The Act provides patients with a mechanism for appealing adverse coverage decisions made by their health plans. After exhausting the health plans’ internal appeals process, patients may file a petition for external review with the Insurance Commissioner. Until December 31, 2011, if the Commissioner found that there was good cause for a petition, a hearing was scheduled on the petition. The Insurance Commissioner could conduct the hearing for cases where the amount in controversy was less than \$500. Cases in excess of \$500 were heard by a three-member panel, consisting of the Commissioner or his representative, a representative of a health plan not involved in the case, and a practicing physician. The Act also provided for expedited hearings in cases involving serious jeopardy to life or health.

From July 1, 2011 to December 31, 2011, eleven (11) external review requests were filed under the original external review statute. The nature of the cases reviewed involved ten (10) cases regarding policy coverage and one (1) case regarding termination of coverage. Of the eleven (11) requests, five (5) cases were dismissed, a settlement between the parties was reached in five (5) cases, and the health plan’s denial was overturned in one (1) case.

In November 2004, the Hawaii Supreme Court ruled in *Hawaii Management Alliance Association v. Insurance Commissioner*, 106 Haw. 21 (2004), that the external review process is pre-empted by the federal Employee Retirement Income Security Act (“ERISA”) as to health plans that fall under ERISA. The vast majority of health plans fall under ERISA because they are provided by private employers. As a result, the number of external review cases has been substantially lower since 2005.

On January 1, 2012, the external review provision of Hawaii’s Patients’ Bill of Rights and Responsibilities Act was amended to conform to the requirements of the federal Patient Protection and Affordable Care Act of 2010, Public Law No. 111-148 (“PPACA”) and its implementing regulations. Act 230 (SLH 2011) created a new external review process for resolving health insurance coverage disputes that utilizes independent review organizations (“IROs”). That process is contained in HRS sections 432E-31 through 432E-44.

Members of health plans issued by private health insurance companies may request an external review of coverage denials involving medical necessity and rescission of coverage upon the payment of a refundable filing fee of \$15. This option is not available for Medicare and Medicaid members or for members of self-funded plans. The external review is performed by private accredited independent review organizations

which contract medical professionals with varying specialized knowledge who review the medical records and health plan contracts and issue medical opinions. There are three types of external reviews: the standard external review which covers denials based on medical necessity, appropriateness, health care setting, level of care, or effectiveness; the expedited external review for cases involving a medical emergency where the patient cannot wait to receive medical treatment; and the investigational or experimental procedure denial in which the health plan has determined that the denied procedure is not validated as standard medical practice.

From January 1, 2012 to June 30, 2012, under the new IRO external review statute, three (3) IRO external review requests were filed. The nature of the cases reviewed involved three (3) cases regarding denial of coverage. Of the three (3) requests received, the health plan's denial was upheld in three (3) cases.

Although prior legal opinions found members of health plans subject to ERISA (employer sponsored group plans) and members of the EUTF to be excluded from the external review process, these formerly excluded classes are now eligible to request an IRO external review. The federal government has clarified that ERISA plan participants are covered under the external review provisions of PPACA. In addition, the EUTF health plans became fully insured as of January 1, 2012. Since the EUTF no longer self-funds the health benefits of EUTF members, EUTF members are eligible for the external review process.