
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 2002-2003.

J.P. SCHMIDT
Insurance Commissioner

External Review Report for Fiscal Year 2002-2003

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 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. If the Commissioner finds that there is good cause for a petition, a hearing is scheduled on the petition. The Insurance Commissioner conducts hearings for cases where the amount in controversy is less than \$500. Cases in excess of \$500 are 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 provides for expedited hearings in cases involving serious jeopardy to life or health.

For fiscal year '02-'03 thirty-five (35) requests for external review were filed. Fourteen (14) were dismissed as not being for good cause, three (3) were withdrawn, two (2) were dismissed for lack of jurisdiction, and twelve (12) were heard and decided by a three-member review panel in favor of the managed care plan. As of June 30, 2003, four cases were pending.

The nature of cases reviewed is as follows. The majority of the requests involved denial of coverage. There were twenty-three (23) cases involving denial of coverage, five (5) cases involving level of reimbursement, one (1) case involving enrollment, and two (2) cases that failed to meet the 60 day filing requirement. The following page lists a graph with a breakdown of these cases.

