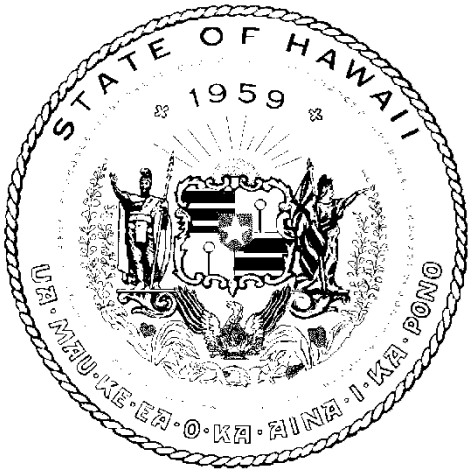

THIRTY-THIRD LEGISLATURE
REGULAR SESSION OF 2025

Annual External Review Report

INSURANCE DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

Submitted December 2024

This report is filed pursuant to Hawaii Revised Statutes (HRS) section 432E-13, which requires the Insurance Commissioner to submit to the Legislature an annual report containing 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. This report provides an overview of external review statistics for fiscal year 2023-2024.

The external review process is an important component of the Patients' Bill of Rights and Responsibilities Act, HRS chapter 432E. The Insurance Division administers the external review process, which gives patients a mechanism to appeal 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.

On January 1, 2012, the external review provision of HRS chapter 432E was amended to conform to the requirements of the federal Patient Protection and Affordable Care Act of 2010, Public Law No. 111-148, and its implementing regulations. Act 230, Session Laws of Hawaii 2011, created a new external review process to resolve health insurance coverage disputes through independent review organizations. That process is set forth in HRS sections 432E-31 through 432E-44.

In the 2024 Legislative Session, certain provisions of HRS chapter 432E relating to external review procedures were amended to improve consistency with the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act. Those amendments will go into effect on July 1, 2025.

Members of health plans issued by health carriers may request an external review of coverage denials involving medical necessity and rescission of coverage upon payment of a $15 refundable filing fee. This option is not available to Medicare members, Medicaid members, or members of self-funded plans.

The external review is performed by private accredited independent review organizations that contract medical professionals with varying specialized knowledge. These medical professionals review the medical records and health plan contracts and issue medical opinions. There are three types of external reviews: (1) the standard external review of denials based on medical necessity, appropriateness, health care setting, level of care, or effectiveness; (2) an expedited external review of medical emergency cases where the patient cannot wait to receive medical treatment; and (3) an investigational or experimental procedure denial in which the health plan has determined the denied procedure is not standard medical practice.

From July 1, 2023, to June 30, 2024, 21 external review requests were filed. Of the 21 requests, 11 cases involved denial of coverage, 6 cases involved policy coverage, 3 cases involved claims appeal and 1 case involved par-non-par. The health plan's denial was upheld in 5 cases; 6 cases were dismissed on grounds of statutory ineligibility for the external review process; 6 cases were overturned; and 4 cases were withdrawn. The external review process during this period resulted in consumer savings of over $51,978.