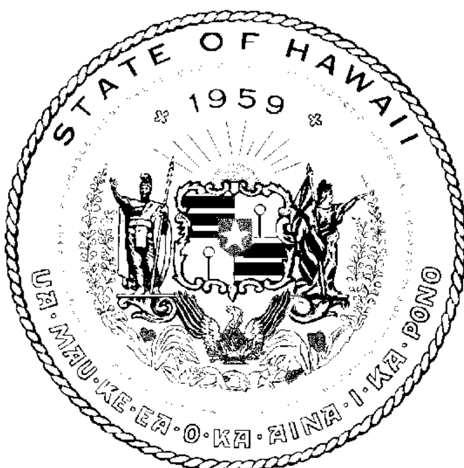

TWENTY-NINTH LEGISLATURE
STATE OF HAWAII
REGULAR SESSION OF 2018

Annual External Review Report

INSURANCE DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

December 2017

Foreword

Hawaii Revised Statutes (HRS) section 432E-13 requires the Insurance Commissioner to submit to the Legislature a 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. 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 of 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 2016-2017.

GORDON I. ITO
Insurance Commissioner

Annual External Review Report for Fiscal Year 2016-2017

This annual report is filed pursuant to HRS section 432E-13, which requires the Insurance Commissioner to submit an annual report to the Legislature concerning external review cases.

The Insurance Division administers the external review process under the Patients' Bill of Rights and Responsibilities Act, HRS chapter 432E (Act). The Act 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 the 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, Session Laws of Hawaii 2011, created a new external review process to resolve health insurance coverage disputes through independent review organizations (IROs). That process is set forth 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 payment of a $15 refundable filing fee. This option is not available to Medicare members, Medicaid members, or members of self-funded plans. Although prior legal opinions excluded members of health plans subject to the Employee Retirement Income Security Act of 1974 (ERISA) (employer-sponsored group plans) and members of the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) from the external review process, these 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.

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, 2016 to June 30, 2017, 14 IRO external review requests were filed. Of the 14 requests received, 12 were from members of private employer-sponsored group health plans, two involved individual coverage, and no requests were received from EUTF members. The nature of the cases reviewed involved one case regarding a claims appeal, four cases regarding denial of coverage, four cases regarding policy coverage disputes, and five cases regarding participating versus non-participating provider reimbursements. Of the 14 requests received, the health plan's denial was upheld in all 14 cases, zero denials were overturned, seven cases were dismissed on grounds of statutory ineligibility for the external review process, and one request was withdrawn.