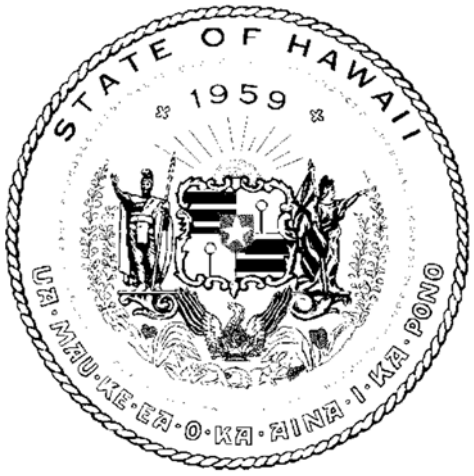

Annual External Review Report

In Accordance with Hawaii Revised Statutes §432E-13

Prepared by the

INSURANCE DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

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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 2014-2015.

GORDON I. ITO
Insurance Commissioner

External Review Report for Fiscal Year 2014-2015

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.

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. 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.

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 July 1, 2014 to June 30, 2015, 11 IRO external review requests were filed. Of the 11 requests received, 10 were from members of private employer sponsored group health plans, one (1) request involved individual coverage, and

no requests were from EUTF members. The nature of the cases reviewed involved three (3) cases regarding non-covered services; three (3) cases regarding non-participating provider reimbursements; three (3) cases involving pre-authorization denials for medical treatment; and two (2) cases regarding the medical necessity of medical services provided. Of the 11 requests received, the health plan's denial was upheld in five (5) cases; six (6) cases were dismissed as they were not eligible for the external review process per the statutory requirements; and no cases resulted in the health plan's denial being partially or fully overturned. The external reviews resolved during this period resulted in no consumer savings.