JAN 25 2023

A BILL FOR AN ACT

RELATING TO TITLE 24, HAWAII REVISED STATUTES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. Section 431:10A-116, Hawaii Revised Statutes, is
2 amended to read as follows:
3 "**§431:10A-116 Coverage for specific services.** Every
4 person insured under a policy of accident and health or sickness
5 insurance delivered or issued for delivery in this State shall
6 be entitled to the reimbursements and coverages specified below:
7 (1) Notwithstanding any provision to the contrary,
8 whenever a policy, contract, plan, or agreement
9 provides for reimbursement for any visual or
10 optometric service, which is within the lawful scope
11 of practice of a duly licensed optometrist, the person
12 entitled to benefits or the person performing the
13 services shall be entitled to reimbursement whether
14 the service is performed by a licensed physician or by
15 a licensed optometrist. Visual or optometric services
16 shall include eye or visual examination, or both, or a
17 correction of any visual or muscular anomaly, and the
18 supplying of ophthalmic materials, lenses, contact

1 lenses, spectacles, eyeglasses, and appurtenances
2 thereto;
3 (2) Notwithstanding any provision to the contrary, for all
4 policies, contracts, plans, or agreements issued on or
5 after May 30, 1974, whenever provision is made for
6 reimbursement or indemnity for any service related to
7 surgical or emergency procedures, which is within the
8 lawful scope of practice of any practitioner licensed
9 to practice medicine in this State, reimbursement or
10 indemnification under the policy, contract, plan, or
11 agreement shall not be denied when the services are
12 performed by a dentist acting within the lawful scope
13 of the dentist's license;
14 (3) Notwithstanding any provision to the contrary,
15 whenever the policy provides reimbursement or payment
16 for any service, which is within the lawful scope of
17 practice of a psychologist licensed in this State, the
18 person entitled to benefits or performing the service
19 shall be entitled to reimbursement or payment, whether
20 the service is performed by a licensed physician or
21 licensed psychologist;
22

1 (4) Notwithstanding any provision to the contrary, each
2 policy, contract, plan, or agreement issued on or
3 after February 1, 1991, except for policies that only
4 provide coverage for specified diseases or other
5 limited benefit coverage, but including policies
6 issued by companies subject to chapter 431, article
7 10A, part II, and chapter 432, article 1, shall
8 provide coverage for screening by low-dose mammography
9 for occult breast cancer as follows:
10 (A) For women forty years of age and older, an annual
11 mammogram; and
12 (B) For a woman of any age with a history of breast
13 cancer or whose mother or sister has had a
14 history of breast cancer, a mammogram upon the
15 recommendation of the woman's physician.
16 The services provided in this paragraph are
17 subject to any coinsurance provisions that may be in
18 force in these policies, contracts, plans, or
19 agreements[.]; provided that the insured's dollar
20 limits, deductibles, and copayments for services shall
21 be on terms at least as favorable to the insured as
22 those applicable to other radiological examinations.

1 For the purpose of this paragraph, the term "low-
2 dose mammography" means the x-ray examination of the
3 breast using equipment dedicated specifically for
4 mammography, including but not limited to the x-ray
5 tube, filter, compression device, screens, films, and
6 cassettes, with an average radiation exposure delivery
7 of less than one rad mid-breast, with two views for
8 each breast. An insurer may provide the services
9 required by this paragraph through contracts with
10 providers; provided that the contract is determined to
11 be a cost-effective means of delivering the services
12 without sacrifice of quality and meets the approval of
13 the director of health; and
14 (5) (A) (i) Notwithstanding any provision to the
15 contrary, whenever a policy, contract, plan,
16 or agreement provides coverage for the
17 children of the insured, that coverage shall
18 also extend to the date of birth of any
19 newborn child to be adopted by the insured;
20 provided that the insured gives written
21 notice to the insurer of the insured's
22 intent to adopt the child prior to the

1 child's date of birth or within thirty days
2 after the child's birth or within the time
3 period required for enrollment of a natural
4 born child under the policy, contract, plan,
5 or agreement of the insured, whichever
6 period is longer; provided further that if
7 the adoption proceedings are not successful,
8 the insured shall reimburse the insurer for
9 any expenses paid for the child; and
10 (ii) Where notification has not been received by
11 the insurer prior to the child's birth or
12 within the specified period following the
13 child's birth, insurance coverage shall be
14 effective from the first day following the
15 insurer's receipt of legal notification of
16 the insured's ability to consent for
17 treatment of the infant for whom coverage is
18 sought; and
19 (B) When the insured is a member of a health
20 maintenance organization, coverage of an adopted
21 newborn is effective:

1 (i) From the date of birth of the adopted
2 newborn when the newborn is treated from
3 birth pursuant to a provider contract with
4 the health maintenance organization, and
5 written notice of enrollment in accord with
6 the health maintenance organization's usual
7 enrollment process is provided within thirty
8 days of the date the insured notifies the
9 health maintenance organization of the
10 insured's intent to adopt the infant for
11 whom coverage is sought; or
12 (ii) From the first day following receipt by the
13 health maintenance organization of written
14 notice of the insured's ability to consent
15 for treatment of the infant for whom
16 coverage is sought and enrollment of the
17 adopted newborn in accord with the health
18 maintenance organization's usual enrollment
19 process if the newborn has been treated from
20 birth by a provider not contracting or
21 affiliated with the health maintenance
22 organization."

SECTION 2. Section 432:1-605, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) The services provided in subsection (a) are subject to any coinsurance provisions that may be in force in these policies, contracts, plans, or agreements[~~.~~]; provided that the member's dollar limits, deductibles, and copayments for services shall be on terms at least as favorable to the member as those applicable to other radiological examinations."

SECTION 3. Section 432E-34, Hawaii Revised Statutes, is amended as follows:

1. By amending subsection (d) to read as follows:

"(d) [~~Upon receipt of a request for appeal pursuant to subsection (c), the commissioner shall review the request for external review submitted by the enrollee pursuant to subsection (a), determine whether an enrollee is eligible for external review and, if eligible, shall refer the enrollee to external review. The commissioner's determination of eligibility for external review shall be made in accordance with the terms of the enrollee's health benefit plan and all applicable provisions of this part. If an enrollee is not eligible for external review, the commissioner shall notify the enrollee, the~~

~~enrollee's appointed representative, and the health carrier within three business days of the reason for ineligibility.~~]

(1) The commissioner may determine that a request is eligible for external review under subsection (b) notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review; and

(2) In making a determination under paragraph (1), the commissioner's decision shall be made in accordance with the terms of the enrollee's health benefit plan and shall be subject to all applicable provisions of this chapter."

2. By amending subsection (g) to read as follows:

"(g) Within five business days after the date of receipt of notice pursuant to subsection (e), the health carrier or its designated utilization review organization shall provide to the assigned independent review organization all documents and information it considered in issuing the adverse action that is the subject of external review[~~.~~] and any documents related to the request for external review that have been received by the health carrier or its designated utilization review organization. Failure by the health carrier or its utilization

1 review organization to provide the documents and information
2 within five business days shall not delay the conduct of the
3 external review; provided that the assigned independent review
4 organization may terminate the external review and reverse the
5 adverse action that is the subject of the external review. The
6 independent review organization shall notify the enrollee, the
7 enrollee's appointed representative, the health carrier, and the
8 commissioner within three business days of the termination of an
9 external review and reversal of an adverse action pursuant to
10 this subsection."
11 SECTION 4. Section 432E-35, Hawaii Revised Statutes, is
12 amended by amending subsections (b), (c), (d), (e), and (f) to
13 read as follows:
14 "(b) Upon receipt of a request for an expedited external
15 review, the commissioner shall immediately send a copy of the
16 request to the health carrier. Immediately upon receipt of the
17 request, the health carrier shall determine whether the request
18 meets the reviewability requirements set forth in [~~subsection~~
19 ~~(a).~~] <u>section 432E-34(b).</u> The health carrier shall immediately
20 notify the enrollee or the enrollee's appointed representative
21 of its determination of the enrollee's eligibility for expedited
22 external review.

Notice of ineligibility for expedited external review shall include a statement informing the enrollee and the enrollee's appointed representative that a health carrier's initial determination that an external review request that is ineligible for review may be appealed to the commissioner by submission of a request to the commissioner.

(c) [~~Upon receipt of a request for appeal pursuant to subsection (b), the commissioner shall review the request for expedited external review submitted pursuant to subsection (a) and, if eligible, shall refer the enrollee for external review. The commissioner's determination of eligibility for expedited external review shall be made in accordance with the terms of the enrollee's health benefit plan and all applicable provisions of this part. If an enrollee is not eligible for expedited external review, the commissioner shall immediately notify the enrollee, the enrollee's appointed representative, and the health carrier of the reasons for ineligibility.~~]

(1) The commissioner may determine that a request is eligible for external review under subsection (b) notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review; and

1 (2) In making a determination under paragraph (1), the
2 commissioner's decision shall be made in accordance
3 with the terms of the enrollee's health benefit plan
4 and shall be subject to all applicable provisions of
5 this chapter.
6 (d) If the commissioner determines that an enrollee is
7 eligible for expedited external review [~~even though the enrollee~~
8 ~~has not exhausted the health carrier's internal review process,~~]
9 pursuant to subsection (c) and the request for expedited
10 external review is based on an adverse determination as provided
11 under subsection (a)(1), the health carrier shall not be
12 required to proceed with its internal review process[~~. The~~
13 ~~health carrier~~] but may elect to proceed with its internal
14 review process [~~even though the request is determined by the~~
15 ~~commissioner to be eligible for expedited external review~~];
16 provided that the internal review process shall not delay or
17 terminate an expedited external review unless the health carrier
18 decides to reverse its adverse determination and provide
19 coverage or payment for the health care service that is the
20 subject of the adverse determination. Immediately after making
21 a decision to reverse its adverse determination, the health
22 carrier shall notify the enrollee, the enrollee's authorized

representative, the independent review organization assigned pursuant to subsection (e), and the commissioner in writing of its decision. The assigned independent review organization shall terminate the expedited external review upon receipt of notice from the health carrier pursuant to this subsection.

(e) Upon receipt of the notice pursuant to subsection (b) or a determination of the commissioner pursuant to subsection [~~(d)~~] (c) that the enrollee meets the eligibility requirements for expedited external review, the commissioner shall immediately randomly assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations qualified to conduct the external review, based on the nature of the health care service that is the subject of the adverse action and other factors determined by the commissioner including conflicts of interest pursuant to section 432E-43, compiled and maintained by the commissioner to conduct the external review and immediately notify the health carrier of the name of the assigned independent review organization.

(f) Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review, the health carrier or its

designee utilization review organization shall provide or transmit all documents and information it considered in making the adverse action that is the subject of the expedited external review, and any documents related to the request for expedited external review that have been received by the health carrier or its designated utilization review organization, to the assigned independent review organization electronically or by telephone, facsimile, or any other available expeditious method."

SECTION 5. Section 432E-36, is amended as follows:

1. By amending subsection (c) to read as follows:

"(c) Upon notice of the request for expedited external review, the health carrier shall immediately determine whether the request meets the requirements of subsection [~~(b).~~] (g). The health carrier shall immediately notify the commissioner, the enrollee, and the enrollee's appointed representative of its eligibility determination.

Notice of eligibility for expedited external review pursuant to this subsection shall include a statement informing the enrollee and, if applicable, the enrollee's appointed representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner."

2. By amending subsection (d) to read as follows:

"(d) [~~Upon receipt of a request for appeal pursuant to subsection (c), the commissioner shall review the request for external review submitted by the enrollee pursuant to subsection (a), determine whether an enrollee is eligible for external review and, if eligible, shall refer the enrollee to external review. The commissioner's determination of eligibility for external review shall be made in accordance with the terms of the enrollee's health benefit plan and all applicable provisions of this part. If an enrollee is not eligible for external review, the commissioner shall notify the enrollee, the enrollee's appointed representative, and the health carrier of the reason for ineligibility within three business days.~~]

(1) The commissioner may determine that a request is eligible for external review under subsection (g) notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review; and

(2) In making a determination under paragraph (1), the commissioner's decision shall be made in accordance with the terms of the enrollee's health benefit plan

1 and shall be subject to all applicable provisions of
2 this chapter."
3 3. By amending subsection (e) to read as follows:
4 "(e) Upon receipt of the notice pursuant to subsection
5 [~~(a)~~] (c) or a determination of the commissioner pursuant to
6 subsection (d) that the enrollee meets the eligibility
7 requirements for expedited external review, the commissioner
8 shall immediately randomly assign an independent review
9 organization to conduct the expedited external review from the
10 list of approved independent review organizations qualified to
11 conduct the external review, based on the nature of the health
12 care service that is the subject of the adverse action and other
13 factors determined by the commissioner including conflicts of
14 interest pursuant to section 432E-43, compiled and maintained by
15 the commissioner to conduct the external review and immediately
16 notify the health carrier of the name of the assigned
17 independent review organization."
18 4. By amending subsection (f) to read as follows:
19 "(f) Upon receipt of the notice from the commissioner of
20 the name of the independent review organization assigned to
21 conduct the expedited external review, the health carrier or its
22 designee utilization review organization shall provide or

transmit all documents and information it considered in making the adverse action that is the subject of the expedited external review, and any documents related to the request for expedited external review that have been received by the health carrier or its designated utilization review organization, to the assigned independent review organization electronically or by telephone, facsimile, or any other available expeditious method."

5. By amending subsection (g) to read as follows:

"(g) Except for a request for an expedited external review made pursuant to subsection (b), within three business days after the date of receipt of the request, the commissioner shall notify the health carrier that the enrollee has requested an [~~expedited~~] external review pursuant to this section. Within five business days following the date of receipt of notice, the health carrier shall determine whether:

(1) The individual is or was an enrollee in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was an enrollee in the health benefit plan at the time the health care service or treatment was provided;

1 (2) The recommended or requested health care service or
2 treatment that is the subject of the adverse action:
3 (A) Would be a covered benefit under the enrollee's
4 health benefit plan but for the health carrier's
5 determination that the service or treatment is
6 experimental or investigational for the
7 enrollee's particular medical condition; and
8 (B) Is not explicitly listed as an excluded benefit
9 under the enrollee's health benefit plan;
10 (3) The enrollee's treating physician or treating advanced
11 practice registered nurse has certified in writing
12 that:
13 (A) Standard health care services or treatments have
14 not been effective in improving the condition of
15 the enrollee;
16 (B) Standard health care services or treatments are
17 not medically appropriate for the enrollee; or
18 (C) There is no available standard health care
19 service or treatment covered by the health
20 carrier that is more beneficial than the health
21 care service or treatment that is the subject of
22 the adverse action;

1 (4) The enrollee's treating physician or treating advanced
2 practice registered nurse:
3 (A) Has recommended a health care service or
4 treatment that the physician or advanced practice
5 registered nurse certifies, in writing, is likely
6 to be more beneficial to the enrollee, in the
7 physician's or advanced practice registered
8 nurse's opinion, than any available standard
9 health care services or treatments; or
10 (B) Who is a licensed, board certified or board
11 eligible physician qualified to practice in the
12 area of medicine appropriate to treat the
13 enrollee's condition, or who is an advanced
14 practice registered nurse qualified to treat the
15 enrollee's condition, has certified in writing
16 that scientifically valid studies using accepted
17 protocols demonstrate that the health care
18 service or treatment that is the subject of the
19 adverse action is likely to be more beneficial to
20 the enrollee than any available standard health
21 care services or treatments;

(5) The enrollee has exhausted the health carrier's internal appeals process or the enrollee is not required to exhaust the health carrier's internal appeals process pursuant to section 432E-33(b); and

(6) The enrollee has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form and disclosure of conflict of interest information as provided under section 432E-33(a)."

6. By amending subsection (i) to read as follows:

"(i) [~~Upon receipt of a request for appeal pursuant to subsection (h), the commissioner shall review the request for external review submitted pursuant to subsection (a) and, if eligible, shall refer the enrollee for external review. The commissioner's determination of eligibility for expedited external review shall be made in accordance with the terms of the enrollee's health benefit plan and all applicable provisions of this part. If an enrollee is not eligible for external review, the commissioner shall notify the enrollee, the enrollee's appointed representative, and the health carrier of the reasons for ineligibility within three business days.~~]

1 (1) The commissioner may determine that a request is
2 eligible for external review under subsection (g)
3 notwithstanding a health carrier's initial
4 determination that the request is ineligible and
5 require that it be referred for external review; and
6 (2) In making a determination under paragraph (1), the
7 commissioner's decision shall be made in accordance
8 with the terms of the enrollee's health benefit plan
9 and shall be subject to all applicable provisions of
10 this chapter."
11 7. By amending subsection (l) to read as follows:
12 "(l) Within five business days after the date of receipt
13 of notice pursuant to subsection (j), the health carrier or its
14 designated utilization review organization shall provide to the
15 assigned independent review organization all documents and
16 information it considered in issuing the adverse action that is
17 the subject of external review[.] and any documents related to
18 the request for external review that have been received by the
19 health carrier or its designated utilization review
20 organization. Failure by the health carrier or its utilization
21 review organization to provide the documents and information
22 within five business days shall not delay the conduct of the

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1 external review; provided that the assigned independent review
2 organization may terminate the external review and reverse the
3 adverse action that is the subject of the external review. The
4 independent review organization shall notify the enrollee, the
5 enrollee's appointed representative, the health carrier, and the
6 commissioner within three business days of the termination of an
7 external review and reversal of an adverse action pursuant to
8 this subsection."

9 8. By amending subsection (o) to read as follows:

10 "(o) Except as provided in subsection (p), within twenty
11 days after being selected to conduct the external review, a
12 clinical reviewer shall provide an opinion to the assigned
13 independent review organization pursuant to subsection (q)
14 regarding whether the recommended or requested health care
15 service or treatment subject to an appeal pursuant to this
16 section shall be covered.

17 The clinical [~~(~~]reviewer's[~~)~~] opinion shall be in writing
18 and shall include:

19 (1) A description of the enrollee's medical condition;

20 (2) A description of the indicators relevant to
21 determining whether there is sufficient evidence to
22 demonstrate that the recommended or requested health

1 care service or treatment is more likely than not to
2 be more beneficial to the enrollee than any available
3 standard health care services or treatments and
4 whether the adverse risks of the recommended or
5 requested health care service or treatment would not
6 be substantially increased over those of available
7 standard health care services or treatments;
8 (3) A description and analysis of any medical or
9 scientific evidence, as that term is defined in
10 section 432E-1.4, considered in reaching the opinion;
11 (4) A description and analysis of any medical necessity
12 criteria defined in section 432E-1; and
13 (5) Information on whether the reviewer's rationale for
14 the opinion is based on approval of the health care
15 service or treatment by the federal Food and Drug
16 Administration for the condition or medical or
17 scientific evidence or evidence-based standards that
18 demonstrate that the expected benefits of the
19 recommended or requested health care service or
20 treatment is likely to be more beneficial to the
21 enrollee than any available standard health care
22 services or treatments and the adverse risks of the

1 recommended or requested health care service or
2 treatment would not be substantially increased over
3 those of available standard health care services or
4 treatments."
5 9. By amending subsection (r) to read as follows:
6 "(r) Except as provided in subsection (s), within twenty
7 days after the date it receives the opinion of the clinical
8 reviewer pursuant to subsection (o), the assigned independent
9 review organization, in accordance with subsection (t), shall
10 determine whether the health care service at issue in an
11 external review pursuant to this section shall be a covered
12 benefit and shall notify the enrollee, the enrollee's appointed
13 representative, the health carrier, and the commissioner of its
14 determination. The independent review organization shall
15 include in the notice of its decision:
16 (1) A general description of the reason for the request
17 for external review;
18 (2) The written opinion of each clinical reviewer,
19 including the recommendation of each clinical reviewer
20 as to whether the recommended or requested health care
21 service or treatment should be covered and the
22 rationale for the reviewer's recommendation;

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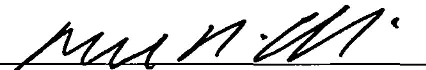
1 (3) The date the independent review organization was
2 assigned by the commissioner to conduct the external
3 [~~{~~]review[~~}~~];
4 (4) The date the external review was conducted;
5 (5) The date the decision was issued;
6 (6) The principal reason or reasons for its decision; and
7 (7) The rationale for its decision.
8 Upon receipt of a notice of a decision reversing the
9 adverse action, the health carrier immediately shall approve
10 coverage of the recommended or requested health care service or
11 treatment that was the subject of the adverse action."
12 SECTION 6. Statutory material to be repealed is bracketed
13 and stricken. New statutory material is underscored.
14 SECTION 7. This Act shall take effect on January 1, 2024.
15
16 INTRODUCED BY: 
17 BY REQUEST

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Report Title:
Insurance; Health Insurance; External Review Procedure; Mammography

Description:
Provides amendments to external review procedures to improve consistency with the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act. Requires health insurers, mutual benefit societies, and health maintenance organizations to cover mandated services for mammography at least as favorably as coverage for other radiological examinations.

JUSTIFICATION SHEET **SB. NO. 1326**

DEPARTMENT:	Commerce and Consumer Affairs
TITLE:	A BILL FOR AN ACT RELATING TO TITLE 24, HAWAII REVISED STATUTES.
PURPOSE:	To more closely conform the external review provisions in chapter 432E, part IV, Hawaii Revised Statutes (Part IV) with the Uniform Health Carrier External Review Model Act (Model Act); codify a base level of coverage for existing mammography coverage mandate.
MEANS:	Amend sections 431:10A-116, 432:1-605(b), 432E-34(d) and (g), 432E-35(b), (c), (d), (e), and (f), and 432E-36(c), (d), (e), (f), (g), (i), (l), (o), and (r), Hawaii Revised Statutes (HRS).
JUSTIFICATION:	Part IV of chapter 432E currently mandates that the Insurance Commissioner (Commissioner) review health carrier decisions that external review requests are not eligible for review under Part IV, and provide notice of a decision within a very short time period (immediately or within three days depending on the situation), while the Model Act provides the Commissioner an authority to review the decisions. This deviation from the Model Act interferes with Insurance Division staff's ability to perform other duties and requires the Insurance Commissioner (Commissioner) to render decisions even where the available record is sparse or when underlying issues are inappropriate for the Commissioner to assess, especially within the context of an external review request, such as contract disputes between health carriers and providers. The burden of the existing deviation from the Model Act is additionally problematic because it potentially imposes no time limit for requesting an appeal, which mandates a definitive response from the Commissioner that a request either is or is not eligible for review within a very short time.

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With respect to mammography, the existing mandates do not describe a baseline for benefits. This would give more clarity on coverage for mammography in the event of changes in federal coverage mandates.

Impact on the public: Individuals may continue to ask the Commissioner to review decisions by health carriers that external review requests are not eligible for external reviews under HRS chapter 432E, part IV (Part IV); however, the Commissioner would not be obligated to render a yes or no decision immediately or within three business days. A base level of coverage for mammography services covered by health plans would be established.

Impact on the department and other agencies: This bill would permit the Commissioner to not render decisions under Part IV in situations where it is inappropriate, such as when the record is sparse or when a Part IV dispute is ancillary to a dispute that the Commissioner should not be adjudicating. It would also relieve Insurance Division staff from neglecting other duties during Part IV requests to review health carrier external review eligibility determinations and provide the Insurance Division with more clarity on coverage for mammography in the event of changes in federal coverage mandates.

GENERAL FUNDS:	None.
OTHER FUNDS:	None.
PPBS PROGRAM DESIGNATION:	CCA-106.
OTHER AFFECTED AGENCIES:	None.
EFFECTIVE DATE:	January 1, 2024.