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# 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,  
2 is 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~~] that is within the lawful  
11          scope of practice of a duly licensed optometrist, the  
12          person entitled to benefits or the person performing  
13          the services shall be entitled to reimbursement  
14          whether the service is performed by a licensed  
15          physician or by a licensed optometrist. Visual or  
16          optometric services shall include eye or visual  
17          examination, or both, or a correction of any visual or



1 muscular anomaly, and the supplying of ophthalmic  
2 materials, lenses, contact lenses, spectacles,  
3 eyeglasses, and appurtenances thereto;

4 (2) Notwithstanding any provision to the contrary, for all  
5 policies, contracts, plans, or agreements issued on or  
6 after May 30, 1974, whenever provision is made for  
7 reimbursement or indemnity for any service related to  
8 surgical or emergency procedures [~~which~~] that is  
9 within the lawful scope of practice of any  
10 practitioner licensed to practice medicine in this  
11 State, reimbursement or indemnification under the  
12 policy, contract, plan, or agreement shall not be  
13 denied when the services are performed by a dentist  
14 acting within the lawful scope of the dentist's  
15 license;

16 (3) Notwithstanding any provision to the contrary,  
17 whenever the policy provides reimbursement or payment  
18 for any service [~~which~~] that is within the lawful  
19 scope of practice of a psychologist licensed in this  
20 State, the person entitled to benefits or performing  
21 the service shall be entitled to reimbursement or



1 payment, whether the service is performed by a  
2 licensed physician or licensed psychologist;  
3 (4) Notwithstanding any provision to the contrary, each  
4 policy, contract, plan, or agreement issued on or  
5 after February 1, 1991, except for policies that only  
6 provide coverage for specified diseases or other  
7 limited benefit coverage, but including policies  
8 issued by companies subject to chapter 431, article  
9 10A, part II, and chapter 432, article 1, shall  
10 provide coverage for screening by low-dose mammography  
11 for occult breast cancer as follows:

- 12 (A) For women forty years of age and older, an annual  
13 mammogram; and
- 14 (B) For a woman of any age with a history of breast  
15 cancer or whose mother or sister has had a  
16 history of breast cancer, a mammogram upon the  
17 recommendation of the woman's physician.

18 The services provided in this paragraph are  
19 subject to any coinsurance provisions that may be in  
20 force in these policies, contracts, plans, or  
21 agreements[-]; provided that the insured's dollar



1 limits, deductibles, and copayments for services shall  
2 be on terms at least as favorable to the insured as  
3 those applicable to other radiological examinations.

4 For the purpose of this paragraph, the term "low-  
5 dose mammography" means the x-ray examination of the  
6 breast using equipment dedicated specifically for  
7 mammography, including but not limited to the x-ray  
8 tube, filter, compression device, screens, films, and  
9 cassettes, with an average radiation exposure delivery  
10 of less than one rad mid-breast, with two views for  
11 each breast. An insurer may provide the services  
12 required by this paragraph through contracts with  
13 providers; provided that the contract is determined to  
14 be a cost-effective means of delivering the services  
15 without sacrifice of quality and meets the approval of  
16 the director of health; and

- 17 (5) (A) (i) Notwithstanding any provision to the  
18 contrary, whenever a policy, contract, plan,  
19 or agreement provides coverage for the  
20 children of the insured, that coverage shall  
21 also extend to the date of birth of any



1 newborn child to be adopted by the insured;  
2 provided that the insured gives written  
3 notice to the insurer of the insured's  
4 intent to adopt the child prior to the  
5 child's date of birth or within thirty days  
6 after the child's birth or within the time  
7 period required for enrollment of a natural  
8 born child under the policy, contract, plan,  
9 or agreement of the insured, whichever  
10 period is longer; provided further that if  
11 the adoption proceedings are not successful,  
12 the insured shall reimburse the insurer for  
13 any expenses paid for the child; and

14 (ii) Where notification has not been received by  
15 the insurer prior to the child's birth or  
16 within the specified period following the  
17 child's birth, insurance coverage shall be  
18 effective from the first day following the  
19 insurer's receipt of legal notification of  
20 the insured's ability to consent for



1 treatment of the infant for whom coverage is  
2 sought; and

3 (B) When the insured is a member of a health  
4 maintenance organization, coverage of an adopted  
5 newborn is effective:

6 (i) From the date of birth of the adopted  
7 newborn when the newborn is treated from  
8 birth pursuant to a provider contract with  
9 the health maintenance organization, and  
10 written notice of enrollment in accord with  
11 the health maintenance organization's usual  
12 enrollment process is provided within thirty  
13 days of the date the insured notifies the  
14 health maintenance organization of the  
15 insured's intent to adopt the infant for  
16 whom coverage is sought; or

17 (ii) From the first day following receipt by the  
18 health maintenance organization of written  
19 notice of the insured's ability to consent  
20 for treatment of the infant for whom  
21 coverage is sought and enrollment of the



1           adopted newborn in accord with the health  
2           maintenance organization's usual enrollment  
3           process if the newborn has been treated from  
4           birth by a provider not contracting or  
5           affiliated with the health maintenance  
6           organization."

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

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

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

17           1. By amending subsection (d) to read:

18           "~~(d) [Upon receipt of a request for appeal pursuant to~~  
19 ~~subsection (c), the commissioner shall review the request for~~  
20 ~~external review submitted by the enrollee pursuant to subsection~~  
21 ~~(a), determine whether an enrollee is eligible for external~~



1 ~~review and, if eligible, shall refer the enrollee to external~~  
2 ~~review. The commissioner's determination of eligibility for~~  
3 ~~external review shall be made in accordance with the terms of~~  
4 ~~the enrollee's health benefit plan and all applicable provisions~~  
5 ~~of this part. If an enrollee is not eligible for external~~  
6 ~~review, the commissioner shall notify the enrollee, the~~  
7 ~~enrollee's appointed representative, and the health carrier~~  
8 ~~within three business days of the reason for ineligibility.]~~

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

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

19       2. By amending subsection (g) to read:

20       "(g) Within five business days after the date of receipt  
21 of notice pursuant to subsection (e), the health carrier or its



1 designated utilization review organization shall provide to the  
2 assigned independent review organization all documents and  
3 information it considered in issuing the adverse action that is  
4 the subject of external review[-] and any documents related to  
5 the request for external review that have been received by the  
6 health carrier or its designated utilization review  
7 organization. Failure by the health carrier or its utilization  
8 review organization to provide the documents and information  
9 within five business days shall not delay the conduct of the  
10 external review; provided that the assigned independent review  
11 organization may terminate the external review and reverse the  
12 adverse action that is the subject of the external review. The  
13 independent review organization shall notify the enrollee, the  
14 enrollee's appointed representative, the health carrier, and the  
15 commissioner within three business days of the termination of an  
16 external review and reversal of an adverse action pursuant to  
17 this subsection."

18 SECTION 4. Section 432E-35, Hawaii Revised Statutes, is  
19 amended by amending subsections (b) through (f) to read as  
20 follows:



1           "(b) Upon receipt of a request for an expedited external  
2 review, the commissioner shall immediately send a copy of the  
3 request to the health carrier. Immediately upon receipt of the  
4 request, the health carrier shall determine whether the request  
5 meets the reviewability requirements set forth in [subsection  
6 ~~(a)-~~] section 432E-34(b). The health carrier shall immediately  
7 notify the enrollee or the enrollee's appointed representative  
8 of its determination of the enrollee's eligibility for expedited  
9 external review.

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

16           (c) ~~[Upon receipt of a request for appeal pursuant to  
17 subsection (b), the commissioner shall review the request for  
18 expedited external review submitted pursuant to subsection (a)  
19 and, if eligible, shall refer the enrollee for external review.  
20 The commissioner's determination of eligibility for expedited  
21 external review shall be made in accordance with the terms of~~



1 ~~the enrollee's health benefit plan and all applicable provisions~~  
2 ~~of this part. If an enrollee is not eligible for expedited~~  
3 ~~external review, the commissioner shall immediately notify the~~  
4 ~~enrollee, the enrollee's appointed representative, and the~~  
5 ~~health carrier of the reasons for ineligibility.]~~

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

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

17 (d) If the commissioner determines that an enrollee is  
18 eligible for expedited external review [~~even though the enrollee~~  
19 ~~has not exhausted the health carrier's internal review process,]~~  
20 pursuant to subsection (c) and the request for expedited  
21 external review is based on an adverse determination as provided



1 under subsection (a)(1), the health carrier shall not be  
2 required to proceed with its internal review process [~~—The~~  
3 ~~health carrier~~] but may elect to proceed with its internal  
4 review process [~~even though the request is determined by the~~  
5 ~~commissioner to be eligible for expedited external review~~];  
6 provided that the internal review process shall not delay or  
7 terminate an expedited external review unless the health carrier  
8 decides to reverse its adverse determination and provide  
9 coverage or payment for the health care service that is the  
10 subject of the adverse determination. Immediately after making  
11 a decision to reverse its adverse determination, the health  
12 carrier shall notify the enrollee, the enrollee's authorized  
13 representative, the independent review organization assigned  
14 pursuant to subsection (e), and the commissioner in writing of  
15 its decision. The assigned independent review organization  
16 shall terminate the expedited external review upon receipt of  
17 notice from the health carrier pursuant to this subsection.

18 (e) Upon receipt of the notice pursuant to subsection (b)  
19 or a determination of the commissioner pursuant to subsection  
20 [~~(d)~~] (c) that the enrollee meets the eligibility requirements  
21 for expedited external review, the commissioner shall



1 immediately randomly assign an independent review organization  
2 to conduct the expedited external review from the list of  
3 approved independent review organizations qualified to conduct  
4 the external review, based on the nature of the health care  
5 service that is the subject of the adverse action and other  
6 factors determined by the commissioner including conflicts of  
7 interest pursuant to section 432E-43, compiled and maintained by  
8 the commissioner to conduct the external review and immediately  
9 notify the health carrier of the name of the assigned  
10 independent review organization.

11 (f) Upon receipt of the notice from the commissioner of  
12 the name of the independent review organization assigned to  
13 conduct the expedited external review, the health carrier or its  
14 designee utilization review organization shall provide or  
15 transmit all documents and information it considered in making  
16 the adverse action that is the subject of the expedited external  
17 review, and any documents related to the request for expedited  
18 external review that have been received by the health carrier or  
19 its designated utilization review organization, to the assigned  
20 independent review organization electronically or by telephone,  
21 facsimile, or any other available expeditious method."



1 SECTION 5. Section 432E-36, Hawaii Revised Statutes, is  
2 amended as follows:

3 1. By amending subsections (c) through (g) to read:

4 "(c) Upon notice of the request for expedited external  
5 review, the health carrier shall immediately determine whether  
6 the request meets the requirements of subsection ~~[(b)-]~~ (g).

7 The health carrier shall immediately notify the commissioner,  
8 the enrollee, and the enrollee's appointed representative of its  
9 eligibility determination.

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

16 ~~(d) [Upon receipt of a request for appeal pursuant to  
17 subsection (c), the commissioner shall review the request for  
18 external review submitted by the enrollee pursuant to subsection  
19 (a), determine whether an enrollee is eligible for external  
20 review and, if eligible, shall refer the enrollee to external  
21 review. The commissioner's determination of eligibility for~~



1 ~~external review shall be made in accordance with the terms of~~  
2 ~~the enrollee's health benefit plan and all applicable provisions~~  
3 ~~of this part. If an enrollee is not eligible for external~~  
4 ~~review, the commissioner shall notify the enrollee, the~~  
5 ~~enrollee's appointed representative, and the health carrier of~~  
6 ~~the reason for ineligibility within three business days.]~~

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

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

17       (e) Upon receipt of the notice pursuant to subsection  
18 ~~[(a)]~~ (c) or a determination of the commissioner pursuant to  
19 subsection (d) that the enrollee meets the eligibility  
20 requirements for expedited external review, the commissioner  
21 shall immediately randomly assign an independent review



1 organization to conduct the expedited external review from the  
2 list of approved independent review organizations qualified to  
3 conduct the external review, based on the nature of the health  
4 care service that is the subject of the adverse action and other  
5 factors determined by the commissioner including conflicts of  
6 interest pursuant to section 432E-43, compiled and maintained by  
7 the commissioner to conduct the external review and immediately  
8 notify the health carrier of the name of the assigned  
9 independent review organization.

10 (f) Upon receipt of the notice from the commissioner of  
11 the name of the independent review organization assigned to  
12 conduct the expedited external review, the health carrier or its  
13 designee utilization review organization shall provide or  
14 transmit all documents and information it considered in making  
15 the adverse action that is the subject of the expedited external  
16 review, and any documents related to the request for expedited  
17 external review that have been received by the health carrier or  
18 its designated utilization review organization, to the assigned  
19 independent review organization electronically or by telephone,  
20 facsimile, or any other available expeditious method.



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

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

14 (2) The recommended or requested health care service or  
15 treatment that is the subject of the adverse action:

16 (A) Would be a covered benefit under the enrollee's  
17 health benefit plan but for the health carrier's  
18 determination that the service or treatment is  
19 experimental or investigational for the  
20 enrollee's particular medical condition; and



1 (B) Is not explicitly listed as an excluded benefit  
2 under the enrollee's health benefit plan;

3 (3) The enrollee's treating physician or treating advanced  
4 practice registered nurse has certified in writing  
5 that:

6 (A) Standard health care services or treatments have  
7 not been effective in improving the condition of  
8 the enrollee;

9 (B) Standard health care services or treatments are  
10 not medically appropriate for the enrollee; or

11 (C) There is no available standard health care  
12 service or treatment covered by the health  
13 carrier that is more beneficial than the health  
14 care service or treatment that is the subject of  
15 the adverse action;

16 (4) The enrollee's treating physician or treating advanced  
17 practice registered nurse:

18 (A) Has recommended a health care service or  
19 treatment that the physician or advanced practice  
20 registered nurse certifies, in writing, is likely  
21 to be more beneficial to the enrollee, in the



1           physician's or advanced practice registered  
2           nurse's opinion, than any available standard  
3           health care services or treatments; or  
4           (B) Who is a licensed, board certified or board  
5           eligible physician qualified to practice in the  
6           area of medicine appropriate to treat the  
7           enrollee's condition, or who is an advanced  
8           practice registered nurse qualified to treat the  
9           enrollee's condition, has certified in writing  
10          that scientifically valid studies using accepted  
11          protocols demonstrate that the health care  
12          service or treatment that is the subject of the  
13          adverse action is likely to be more beneficial to  
14          the enrollee than any available standard health  
15          care services or treatments;  
16          (5) The enrollee has exhausted the health carrier's  
17          internal appeals process or the enrollee is not  
18          required to exhaust the health carrier's internal  
19          appeals process pursuant to section 432E-33(b); and  
20          (6) The enrollee has provided all the information and  
21          forms required by the commissioner that are necessary



1 to process an external review, including the release  
2 form and disclosure of conflict of interest  
3 information as provided under section 432E-33(a)."

4 2. By amending subsection (i) to read:

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

16 (1) The commissioner may determine that a request is  
17 eligible for external review under subsection (g)  
18 notwithstanding a health carrier's initial  
19 determination that the request is ineligible and  
20 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       3. By amending subsection (1) to read:

7       "(1) Within five business days after the date of receipt  
8 of notice pursuant to subsection (j), the health carrier or its  
9 designated utilization review organization shall provide to the  
10 assigned independent review organization all documents and  
11 information it considered in issuing the adverse action that is  
12 the subject of external review[-] and any documents related to  
13 the request for external review that have been received by the  
14 health carrier or its designated utilization review  
15 organization. Failure by the health carrier or its utilization  
16 review organization to provide the documents and information  
17 within five business days shall not delay the conduct of the  
18 external review; provided that the assigned independent review  
19 organization may terminate the external review and reverse the  
20 adverse action that is the subject of the external review. The  
21 independent review organization shall notify the enrollee, the



1 enrollee's appointed representative, the health carrier, and the  
2 commissioner within three business days of the termination of an  
3 external review and reversal of an adverse action pursuant to  
4 this subsection."

5 4. By amending subsection (o) to read:

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

13 The clinical [f]reviewer's[+] opinion shall be in writing  
14 and shall include:

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

16 (2) A description of the indicators relevant to  
17 determining whether there is sufficient evidence to  
18 demonstrate that the recommended or requested health  
19 care service or treatment is more likely than not to  
20 be more beneficial to the enrollee than any available  
21 standard health care services or treatments and



1           whether the adverse risks of the recommended or  
2           requested health care service or treatment would not  
3           be substantially increased over those of available  
4           standard health care services or treatments;

5           (3) A description and analysis of any medical or  
6           scientific evidence, as that term is defined in  
7           section 432E-1.4, considered in reaching the opinion;

8           (4) A description and analysis of any medical necessity  
9           criteria defined in section 432E-1; and

10          (5) Information on whether the reviewer's rationale for  
11          the opinion is based on approval of the health care  
12          service or treatment by the federal Food and Drug  
13          Administration for the condition or medical or  
14          scientific evidence or evidence-based standards that  
15          demonstrate that the expected benefits of the  
16          recommended or requested health care service or  
17          treatment is likely to be more beneficial to the  
18          enrollee than any available standard health care  
19          services or treatments and the adverse risks of the  
20          recommended or requested health care service or  
21          treatment would not be substantially increased over



1           those of available standard health care services or  
2           treatments."

3           5. By amending subsection (r) to read:

4           "(r) Except as provided in subsection (s), within twenty  
5           days after the date it receives the opinion of the clinical  
6           reviewer pursuant to subsection (o), the assigned independent  
7           review organization, in accordance with subsection (t), shall  
8           determine whether the health care service at issue in an  
9           external review pursuant to this section shall be a covered  
10          benefit and shall notify the enrollee, the enrollee's appointed  
11          representative, the health carrier, and the commissioner of its  
12          determination. The independent review organization shall  
13          include in the notice of its decision:

14          (1) A general description of the reason for the request  
15          for external review;

16          (2) The written opinion of each clinical reviewer,  
17          including the recommendation of each clinical reviewer  
18          as to whether the recommended or requested health care  
19          service or treatment should be covered and the  
20          rationale for the reviewer's recommendation;



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 July 1, 2050.



**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. Effective 7/1/2050. (SD1)

*The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.*

