S.B. NO. 3082

JAN 24 2024

A BILL FOR AN ACT

RELATING TO TITLE 24, HAWAII REVISED STATUTES.

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

SECTION 1. Section 431:10A-116, Hawaii Revised Statutes, is amended to read as follows:

"**§431:10A-116 Coverage for specific services.** Every person insured under a policy of accident and health or sickness insurance delivered or issued for delivery in this State shall be entitled to the reimbursements and coverages specified below:

(1) Notwithstanding any provision to the contrary, whenever a policy, contract, plan, or agreement provides for reimbursement for any visual or optometric service[~~, which~~] that is within the lawful scope of practice of a duly licensed optometrist, the person entitled to benefits or the person performing the services shall be entitled to reimbursement whether the service is performed by a licensed physician or by a licensed optometrist. Visual or optometric services shall include eye or visual examination, or both, or a correction of any visual or muscular anomaly, and the supplying of ophthalmic

materials, lenses, contact lenses, spectacles, eyeglasses, and appurtenances thereto;

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

(3) Notwithstanding any provision to the contrary, whenever the policy provides reimbursement or payment for any service [~~, which~~] that is within the lawful scope of practice of a psychologist licensed in this State, the person entitled to benefits or performing the service shall be entitled to reimbursement or payment, whether the service is performed by a licensed physician or licensed psychologist;

(4) Notwithstanding any provision to the contrary, each policy, contract, plan, or agreement issued on or after February 1, 1991, except for policies that only provide coverage for specified diseases or other limited benefit coverage, but including policies issued by companies subject to chapter 431, article 10A, part II, and chapter 432, article 1, shall provide coverage for screening by low-dose mammography for occult breast cancer as follows:

(A) For women forty years of age and older, an annual mammogram; and

(B) For a woman of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer, a mammogram upon the recommendation of the woman's physician.

The services provided in this paragraph are subject to any coinsurance provisions that may be in force in these policies, contracts, plans, or agreements[~~.~~]; provided that the insured's dollar limits, deductibles, and copayments for services shall

be on terms at least as favorable to the insured as those applicable to other radiological examinations.

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

(5) (A) (i) Notwithstanding any provision to the contrary, whenever a policy, contract, plan, or agreement provides coverage for the children of the insured, that coverage shall also extend to the date of birth of any newborn child to be adopted by the insured; provided that the insured gives written

notice to the insurer of the insured's intent to adopt the child prior to the child's date of birth or within thirty days after the child's birth or within the time period required for enrollment of a natural born child under the policy, contract, plan, or agreement of the insured, whichever period is longer; provided further that if the adoption proceedings are not successful, the insured shall reimburse the insurer for any expenses paid for the child; and

(ii) Where notification has not been received by the insurer prior to the child's birth or within the specified period following the child's birth, insurance coverage shall be effective from the first day following the insurer's receipt of legal notification of the insured's ability to consent for treatment of the infant for whom coverage is sought; and

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

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

(ii) From the first day following receipt by the health maintenance organization of written notice of the insured's ability to consent for treatment of the infant for whom coverage is sought and enrollment of the adopted newborn in accord with the health maintenance organization's usual enrollment process if the newborn has been treated from

birth by a provider not contracting or affiliated with the health maintenance 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:

"(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:

"(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 review organization to provide the documents and information within five business days shall not delay the conduct of the external review; provided that the assigned independent review organization may terminate the external review and reverse the adverse action that is the subject of the external review. The independent review organization shall notify the enrollee, the enrollee's appointed representative, the health carrier, and the commissioner within three business days of the termination of an external review and reversal of an adverse action pursuant to this subsection."

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

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

of its determination of the enrollee's eligibility for expedited 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 expedited 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.

(d) If the commissioner determines that an enrollee is eligible for expedited external review [~~even though the enrollee has not exhausted the health carrier's internal review process,~~] pursuant to subsection (c) and the request for expedited external review is based on an adverse determination as provided under subsection (a)(1), the health carrier shall not be required to proceed with its internal review process [~~. The health carrier~~] but may elect to proceed with its internal review process [~~even though the request is determined by the commissioner to be eligible for expedited external review~~]; provided that the internal review process shall not delay or terminate an expedited external review unless the health carrier decides to reverse its adverse determination and provide coverage or payment for the health care service that is the

subject of the adverse determination. Immediately after making a decision to reverse its adverse determination, the health 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, Hawaii Revised Statutes, is amended as follows:

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

"(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.

(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 and shall be subject to all applicable provisions of this chapter.

(e) Upon receipt of the notice pursuant to subsection [~~(a)~~] (c) or a determination of the commissioner pursuant to subsection (d) 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.

(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;

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

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

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

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

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

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

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

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

(A) Has recommended a health care service or treatment that the physician or advanced practice registered nurse certifies, in writing, is likely to be more beneficial to the enrollee, in the physician's or advanced practice registered nurse's opinion, than any available standard health care services or treatments; or

(B) Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the enrollee's condition, or who is an advanced practice registered nurse qualified to treat the enrollee's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment that is the subject of the adverse action is likely to be more beneficial to the enrollee than any available standard health 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)."

2. By amending subsection (i) to read:

"(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) 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 and shall be subject to all applicable provisions of this chapter."

3. By amending subsection (l) to read:

"(l) Within five business days after the date of receipt of notice pursuant to subsection (j), 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 review organization to provide the documents and information within five business days shall not delay the conduct of the

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

4. By amending subsection (o) to read:

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

The clinical [~~,~~]reviewer's[~~,~~] opinion shall be in writing and shall include:

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

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

care service or treatment is more likely than not to be more beneficial to the enrollee than any available standard health care services or treatments and whether the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

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

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

(5) Information on whether the reviewer's rationale for the opinion is based on approval of the health care service or treatment by the federal Food and Drug Administration for the condition or medical or scientific evidence or evidence-based standards that demonstrate that the expected benefits of the recommended or requested health care service or treatment is likely to be more beneficial to the enrollee than any available standard health care services or treatments and the adverse risks of the

recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments."

5. By amending subsection (r) to read:

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

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

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

(3) The date the independent review organization was assigned by the commissioner to conduct the external [~~+~~] review [~~+~~];

(4) The date the external review was conducted;

(5) The date the decision was issued;

(6) The principal reason or reasons for its decision; and

(7) The rationale for its decision.

Upon receipt of a notice of a decision reversing the adverse action, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse action."

SECTION 6. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 7. This Act, upon its approval, shall take effect on January 1, 2025.

INTRODUCED BY: _____

BY REQUEST

S.B. NO. 3082

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.

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

SB. NO. 3082

JUSTIFICATION SHEET

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) through (f), and 432E-36(c) through (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 that the Commissioner has authority to determine that a request is eligible. This deviation from the Model Act interferes with Insurance Division staff's ability to perform other duties and requires the 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.

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 chapter 432E, part IV, HRS (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, 2025.