ACT 123 S.B. NO. 2361

A Bill for an Act Relating to No-fault Insurance.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Chapter 431:10C, Hawaii Revised Statutes, is amended by adding six[1] new sections to be appropriately designated and to read as follows:

"§431:10C-A Immediate rate freeze; rate reduction; relief. (a) No insurer may increase motor vehicle insurance rates between the effective date of this Act and December 31, 1993.

(b) Commencing on January 1, 1993, all authorized insurers transacting motor vehicle insurance in this State shall implement a fifteen per cent rate reduction from the rates on file with the commissioner for all motor vehicle insurance policies in effect on March 1, 1992, and for each new and renewal policy issued thereafter. The reduced rate shall continue to apply to each new and renewal policy for a period of one year.

(c) There shall be no exception to the requirements of this section unless the commissioner, pursuant to an insurer's petition, finds that those requirements will result in imminent danger of insolvency of the insurer. An insurer who contends that a rate required by this section will result in imminent danger of insolvency of the insurer shall designate in its petition the rate it contends is appropriate and shall state with specificity the factors and data upon which it relies. The insurer shall be permitted to use all generally accepted actuarial techniques in filing any petition pursuant to this subsection. The insurer shall have the burden of proof to actuarially justify any rate increase from those provided for in subsections (a) and (b) and shall furnish all information, facts, and data requested by the commissioner reviewing any rate request.

(d) Effective January 1, 1994, all insurers shall include data on the impact of the provisions of this Act on all requested rate adjustments. The commissioner shall not approve any rate adjustments that do not contain a statement of the impact of the provisions of this Act, the method used in calculating such impact, and the data used to determine such impact.

§431:10C-B Limitation on charges. (a) As used in this article, the term "workers' compensation schedules" means the schedules adopted and as may be

amended by the director of labor and industrial relations for workers' compensation cases under chapter 386, establishing fees and frequency of treatment guidelines, and contained in sections 12-13-30, 12-13-35, 12-13-38, 12-13-39, 12-13-45, 12-13-85 through 92, and 12-13-94, Hawaii Administrative Rules. References in the workers' compensation schedules to "the employer", "the director", and "the industrial injury", shall be respectively construed as references to "the insurer", "the commissioner", and "the injury covered by no-fault benefits" for purposes of this article.

(b) Effective January 1, 1993, the charges and frequency of treatment for services specified in section 431:10C-103(10)(A)(i) and (ii), except for emergency services provided within seventy-two hours following a motor vehicle accident resulting in injury, shall not exceed the charges and frequency of treatment permissible under the workers' compensation schedules, except as provided in section 431:10C-C. Charges for independent medical examinations to be conducted by a licensed Hawaii provider, unless the insured consents to an out-of-state provider, shall not exceed the charges permissible under the workers' compensation schedules for consultation for a complex medical problem. The workers' compensation schedules shall not apply to independent medical examinations conducted by out-of-state providers; provided that the charges for the examinations are reasonable. The commissioner may adopt administrative rules relating to fees or frequency of treatment for injuries covered by no-fault benefits. If adopted, these administrative rules shall prevail to the extent that they are inconsistent with the workers' compensation schedules.

(c) Charges for services for which no fee is set by the workers' compensation schedules or other administrative rules adopted by the commissioner shall be limited to eighty per cent of the provider's usual and customary charges for these services. These charges shall be deemed appropriate and reasonable if so determined by a provider unless they are found inappropriate or unreasonable by a peer review organization in accordance with section 431:10C-C.

(d) Services for which no frequency of treatment guidelines are set forth in the workers' compensation schedules or other administrative rules adopted by the commissioner shall be deemed appropriate and reasonable expenses necessarily incurred if so determined by a provider unless they are found inappropriate or unreasonable by a peer review organization in accordance with section 431:10C-C.

(e) The provider of services described in section 431:10C-103(10)(A)(i) and (ii) shall not bill the insured directly for those services but shall bill the insurer for a determination of the amount payable. The provider shall not bill or otherwise attempt to collect from the insured the difference between the provider's full charge and the amount paid by the insurer.

§431:10C-C Permissible charges in excess of the fee schedules and guidelines for frequency of treatment and reasonable utilization of services; peer review process. (a) Charges and treatment in excess of fee schedules or treatment guidelines shall be governed by this section. The fee schedules or treatment guidelines may be exceeded if a provider of treatment or rehabilitative services finds that the nature of the injuries and the process of recovery require a treatment plan resulting in fee schedules or treatment guidelines to be exceeded. If an insurer desires to challenge treatment and rehabilitative services in excess of the fee schedules or treatment guidelines, the insurer may do so by filing, within five working days of a request made pursuant to subsection (d), a challenge with the commissioner for submission to a peer review organization as provided in this section.

(b) For the purposes of this section, "peer review organization" means any

health care review company, approved by the commissioner, that engages in peer review for the purpose of determining that medical and rehabilitative services are appropriate and reasonable. The membership of any peer review organization utilized in connection with this section shall include representation from the profession of the provider whose services are subject to the review. Peer review recommendations or decisions shall contain a statement of the reasons for the recommendations or decisions and the data utilized by the peer review organization.

(c) The commissioner shall contract with one or more peer review organizations established for the purpose of evaluating treatment and rehabilitative services provided to any injured person. The evaluation shall be for the purpose of confirming that such treatment and rehabilitative services are appropriate and reasonable. An insurer's challenge shall be filed with the commissioner for submission to a peer review organization within ten working days of the insurer's receipt of the provider's bill for treatment or rehabilitative services; provided that a challenge may be made at any time for continuing treatment or services. Notice of the challenge shall be given in writing to both the insured and the service provider.

(d) A provider may request prior approval from the insurer for treatment exceeding the workers' compensation schedules or treatment guidelines. The request shall include a treatment plan with a time schedule of measurable objectives and an estimate of the total cost of services. The insurer shall respond to such a request within five working days of mailing of the request, giving authorization or stating in writing the reasons for refusal to the provider and the insured. Any such refusal shall be filed concurrently for submission to the peer review organization. Failure by the insurer to respond within five working days shall constitute approval of the treatment.

(e) A health care provider shall be compensated by the insurer for preparing reports documenting the need for treatments which exceed the schedules in accordance with the fee schedule for special reports.

(f) An insurer, provider, or insured may request a reconsideration by the peer review organization of its initial determination within thirty days of the initial determination. If reconsideration is requested for the services of a physician or other licensed health care professional, then the reviewing individual shall be, or the reviewing panel shall include, an individual in the same specialty as the individual subject to review. Any insured or provider may, in addition to or in lieu of reconsideration, seek an administrative hearing, arbitration, or court review of a denial of no-fault benefits based, in whole or in part, upon a peer review organization determination.

(g) If the insurer challenges a bill for medical treatment or rehabilitative services within thirty days of receipt, the insurer need not pay the provider for the disputed portion of the bill subject to the challenge until a determination has been made by the peer review organization.

(h) If a peer review organization determines that treatment or rehabilitative services were appropriate and reasonable, the insurer shall pay to the provider the outstanding amount plus interest at a rate of twelve per cent per year on any amount withheld by the insurer pending the peer review.

(i) Payment of interest under this section shall not reduce the amount of no-fault benefits available to the insured beyond the actual expense of treatment or rehabilitative services.

(j) If a peer review organization determines that a provider has provided treatment or rehabilitative services that are not appropriate or reasonable or that future provision of such treatment or rehabilitative services will not be appropriate or reasonable, or both, the provider shall not collect payment for the inappropriate or unreasonable treatment or rehabilitative services from either the insurer

or the insured. The peer review organization shall report all such decisions to the regulated industries complaints office of the department of commerce and consumer affairs. In no case shall the failure of a provider to return any payment made by the insurer for treatment or services determined to be inappropriate or unreasonable obligate the insured to reimburse the insurer for the payment.

§431:10C-D No-fault administration revolving fund. (a) There is established a separate revolving fund to be administered by the commissioner and to be designated as the no-fault administration revolving fund.

(b) This fund shall be used to pay the costs of administering the commissioner's obligations under this article. The costs shall include but not be limited to costs of peer review of treatment and rehabilitation services for injuries covered by no-fault insurance, costs related to public education and information, costs related to determination of the medical-rehabilitative threshold, and costs relating to closed claims studies and other studies and evaluations relating to motor vehicle insurance.

(c) Every insurer making a challenge which is submitted to a peer review organization pursuant to section 431:10C-C, shall pay to the commissioner a fair and equitable amount to be determined by the commissioner, plus the cost of the peer review. The commissioner may increase the amount from time to time as warranted by increases in the cost of administering the peer review program. All payments collected by the commissioner shall be deposited in the no-fault administration revolving fund. The commissioner or the peer review organization shall not receive or accept any additional emolument on account of any challenge to a peer review organization. The peer review organization shall submit its charges, which shall not exceed charges permissible under the workers' compensation schedules for consultation for a complex medical problem, along with the peer review organization's recommendation to the commissioner. The commissioner shall pay the peer review organization out of the no-fault administration revolving fund. The commissioner shall transmit copies of the peer review recommendation to the insured, insurer, and provider. The commissioner shall transmit the peer review charges to the insurer, and the insurer shall reimburse the no-fault administration revolving fund for such charges within thirty days.

(d) Each insurer authorized to transact motor vehicle insurance in this State and each self-insurer shall deposit with the commissioner a fair and equitable amount to be determined by the commissioner on March 1 of each year, to be credited to the no-fault administration revolving fund. In addition, each insurer authorized to transact motor vehicle insurance in this State and each self-insurer in this State, shall pay to the commissioner at a time determined by the commissioner, a one-time deposit in an amount to be determined by the commissioner, to be credited to the no-fault administration revolving fund.

(e) Moneys in the no-fault administration revolving fund shall not revert to the general fund.

(f) The commissioner shall report annually to the legislature before the convening of each regular session as to fund administration and expenditures.

§431:10C-E Disclosure of no-fault limits and payments. (a) Effective January 1, 1993, every insurer shall advise every person entitled to no-fault benefits, as defined in section 431:10C-103(10)(A), of the maximum amount of no-fault benefits available under the policy within thirty days of receiving an initial notice, claim, or application for no-fault benefits. The disclosure of no-fault policy limits shall include a description of the nature of no-fault benefits, matters covered by no-fault benefits, and the procedure for submitting no-fault claims.

(b) Every no-fault insurer shall give written notice to every person eligible for no-fault benefits when $5,000 in benefits has been paid and at $5,000 increments thereafter up to the policy limits, including any optional additional coverages.

§431:10C-F Client-patient referrals prohibited. (a) An attorney or a law firm of which the attorney is a member or by which the attorney is employed may not establish a pattern of consistently referring clients to the same health care provider as a result of any accidental harm which is subject to benefits under this article, and a health care provider may not establish a pattern of consistently referring patients to the same attorney or law firm as a result of any accidental harm which is subject to benefits under this article. Any attorney, or any attorney from the law firm of which the attorney is a member or by which the attorney is employed, and that health care provider engaged in such pattern shall be presumed to be in violation of this section.

As used in this subsection, "law firm" means any sole proprietorship, partnership, corporation, or other entity having members or employees who engage in the practice of law in this State.

(b) The regulated industries complaints office, department of commerce and consumer affairs, shall refer any attorney or health care provider in violation of this section to the appropriate professional licensing or regulatory body, for appropriate disciplinary action, including the suspension or revocation of the attorney's or health care provider's license to practice.

(c) The regulated industries complaints office, department of commerce and consumer affairs, may initiate investigations to enforce this section and shall investigate any reports of attorney-health care provider referrals of persons eligible for benefits under this article that may violate this section.

§431:10C-G Notice of cancellation for insurer ceasing to issue no-fault policies. Any insurer authorized to issue no-fault policies, which ceases to engage in the motor vehicle insurance business in this State, shall give written notice to each insured not less than sixty days prior to the effective date of closing its business."

SECTION 2. Section 431:10C-103, Hawaii Revised Statutes, is amended:

1. By amending the definition of "maximum limit" to read:

"(6) Maximum limit means the total no-fault benefits payable per person or, on the person's death, to the person's survivor on account of accidental harm sustained by the person in any one motor vehicle accident shall be [$15,000,] $20,000, regardless of the number of motor vehicles involved or policies [applicable.], to be applied as follows:

(A) $10,000 for benefits described in section 431:10C-103(10)(A)(i) and (ii); and

(B) $10,000 for benefits described in section 431:10C-103(10)(A)(iii) and (iv).

During the course of a pending claim, the no-fault insured or legal representative shall at his or her sole option, be allowed to transfer any part of all of the unused portion of the benefits under (A) to (B) or from (B) to (A); provided that the total benefits payable shall not exceed the maximum limit of $20,000.

(For example, if the insured has $5,000 in unused benefits under (B), that amount may be transferred for use under (A) thereby increasing the limits under (A) to $15,000.) In the event that the amount in (A) is exhausted for any reason, no-fault benefits for medical expenses shall be deemed exhausted for purposes of other contractual insurance medical benefits available to the insured."

2. By amending the definition of "no-fault benefits" to read:

"(10) (A) No-fault benefits, sometimes referred to as personal injury protection benefits, with respect to any accidental harm means:

(i) All appropriate and reasonable expenses necessarily incurred for medical, hospital, surgical, professional, nursing, dental, optometric, ambulance, prosthetic services, products and accommodations furnished, and x-ray. The foregoing expenses may include any nonmedical remedial care and treatment rendered in accordance with the teachings, faith, or belief of any group which depends for healing upon spiritual means through prayer;

(ii) All appropriate and reasonable expenses necessarily incurred for psychiatric, physical, and occupational therapy and rehabilitation;

(iii) Monthly earnings loss measured by an amount equal to the lesser of:

(I) [$900] $1,200 a month; or

(II) The monthly earnings for the period during which the accidental harm results in the inability to engage in available and appropriate gainful activity;

(iv) All appropriate and reasonable expenses necessarily incurred as a result of such accidental harm, including, but not limited to:

(I) Expenses incurred in obtaining services in substitution of those that the injured or deceased person would have performed not for income but for the benefit of the person or the person's family up to $800 a month;

(II) Funeral expenses not to exceed $1,500; and

(III) Attorney's fees and costs to the extent provided in section 431:10C-211(a);

provided that the term, when applied to a no-fault policy issued at no cost under the provisions of section 431:10C-410(3)(A), shall not include benefits under items (i), (ii), and (iii) for any person receiving public assistance benefits.

(B) No-fault benefits shall be subject to:

(i) An aggregate limit of [$15,000] $10,000 for services provided under section 431:10C-103(10)(A)(i) and (ii) and $10,000 for services provided under section 431:10C-103(A)(iii) and (iv) per person or such person's survivor where each applicable policy provides only the basic no-fault coverage; [or]

(ii) An aggregate limit of the expanded limits where the insured has contracted for it under an optional additional coverage[.]; or

(iii) The aggregate limit shall be subject to the application of benefits or transfer thereof as provided in section 431:10C-103(6)."

SECTION 3. Section 431:10C-202, Hawaii Revised Statutes, is amended by amending subsection (f) to read as follows:

"(f) Notwithstanding any provision in this section to the contrary, the plans and rates for any surcharge or credit included by an insurer as part of the proposed rate filing shall be separately identified. Only reasonable surcharges [and credits that] approved by the commissioner [deems reasonable] shall be used; provided that [surcharges and credits] no surcharge for the failure to maintain no-fault insurance shall be approved by the commissioner unless the insured has previously been convicted of driving without insurance within the preceding three years. Credits shall be deemed reasonable if there is no objection by the commissioner [within sixty days of their filing]. Insurers shall furnish the prospective insured with a written explanation, in easily understandable language, clearly describing the reason for the surcharge or credit and how the amount of the surcharge or credit is determined."

SECTION 4. Section 431:10C-301[1] is amended to read as follows:

"§431:10C-301 Required motor vehicle policy coverage. (a) In order to meet the requirements of a no-fault policy as provided in this article, an insurance policy covering a motor vehicle shall provide:

(1) Coverage specified in section 431:10C-304; and

(2) Insurance to pay on behalf of the owner or any operator of the insured motor vehicle using the motor vehicle with the express or implied permission of the named insured, sums which the owner or operator may legally be obligated to pay for injury, death, or damage to property of others, except property owned by, being transported by, or in the charge of the insured, which arise out of the ownership, operation, maintenance, or use of the motor vehicle.

(b) A motor vehicle insurance policy shall include:

(1) Liability coverage of not less than [$35,000] $25,000 for all damages arising out of accidental harm sustained by any one person as a result of any one accident applicable to each person sustaining accidental harm arising out of ownership, maintenance, use, loading, or unloading of the insured vehicle;

(2) Liability coverage of not less than $10,000 for all damages arising out of injury to or destruction of property including motor vehicles and including the loss of use thereof, but not including property owned by, being transported by, or in the charge of the insured, as a result of any one accident arising out of ownership, maintenance, use, loading, or unloading, of the insured vehicle;

(3) With respect to any motor vehicle registered or principally garaged in this State, liability coverage provided therein or supplemental thereto, in limits for bodily injury or death [set forth in section 287-7], under provisions filed with and approved by the commissioner, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, or disease, including death, resulting therefrom; provided, however, that the coverage

required under this paragraph shall not be applicable where any named insured in the policy shall reject the coverage in writing; and

(4) Coverage for loss resulting from bodily injury or death suffered by any person legally entitled to recover damages from owners or operators of underinsured motor vehicles. An insurer may offer the underinsured motorist coverage required by this paragraph in the same manner as uninsured motorist coverage; provided that such offer of both shall:

(A) Be conspicuously displayed so as to be readily noticeable by the insured;

(B) Set forth the premium for the coverage adjacent to the offer in such a manner that the premium is clearly identifiable with the offer and may be easily subtracted from the total premium to determine the premium payment due in the event the insured elects not to purchase the option; and

(C) Provide for written rejection of the coverage by requiring the insured to affix the insured's signature in a location adjacent to or directly below the offer.

(c) The stacking or aggregating of uninsured or underinsured motorist coverage, whichever is applicable, is prohibited. However, an insurer shall offer an option to stack uninsured motorist and underinsured motorist coverage, as applicable, in each no-fault policy whenever any policy is issued, delivered, or renewed.

(d) An insurer shall offer uninsured motorist coverage and underinsured motorist coverage of not less than the amount of the maximum bodily injury liability coverage in the insured's policy when the policy is first issued; provided that written rejection shall only be required when the policy is first issued or first renewed. No further rejections are required. Provided further that for any existing policies an insurer shall offer such coverage at the first renewal after January 1, 1993."

SECTION 5. The commissioner shall monitor the impact of the provisions of this Act and the provisions of H.B. 3974, H.D. 1, S.D. 1, C.D. 1,[2] on the motor vehicle insurance (no-fault) system in Hawaii. In monitoring the impact of these provisions, the commissioner shall be guided by the primary purposes of the Hawaii motor vehicle insurance law as set forth in section 431:10C-102, Hawaii Revised Statutes. The commissioner shall also make determinations, as a result of this monitoring, which shall include but not be limited to:

(1) Whether premium rates can be further reduced or stabilized by further adjusting the minimum no-fault coverage set forth in this Act;

(2) Whether the rate reduction set forth in this Act may be continued and for what period of time, or whether any modification is necessary; and

(3) Whether the medical-rehabilitation limit is sufficient to ensure that ninety per cent of all no-fault claims are screened out.

SECTION 6. **Severability.** If any provision of this Act, or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 7. The provisions of this Act do not affect rights, duties, or

actions that are based upon events or acts which have taken place prior to the effective date of this Act, or the effective date of any provision of this Act, nor to penalties that were incurred or proceedings begun before the effective date of this Act.

SECTION 8. Statutory material to be repealed is bracketed. New statutory material is underscored.[3]

SECTION 9. In codifying this Act in the Hawaii Revised Statutes, the revisor of statutes shall substitute, in section 1, the references to "Act" with the appropriate act number assigned to this Act and the alphabetic section designations with appropriate numeric designations.

SECTION 10. This Act shall take effect upon its approval; provided that:

(1) The provisions in section 1 relating to rate reduction (431:10C-A(b) and (c)); fee schedules (section 431:10C-B); peer review (section 431:10C-C); and disclosure of no-fault payments (section 431:10C-E) shall take effect on January 1, 1993;

(2) The provision in section 3[1] prohibiting stacking of uninsured or underinsured motorist coverage (section 431:10C-301(c) and (d)) shall take effect on January 1, 1993; and

(3) This Act, upon its approval, shall take effect only if H.B. No. 3974[2] in conference draft is passed by the legislature, regular session of 1992, and becomes an Act.

(Approved June 3, 1992.)

Notes

1. So in original.
2. Act 124.
3. Edited pursuant to HRS §23G-16.5.