HOUSE OF REPRESENTATIVES
TWENTY-FIFTH LEGISLATURE, 2010
STATE OF HAWAII

H.B. NO. 2660

A BILL FOR AN ACT

RELATING TO HEALTHCARE CLAIMS.

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

1 SECTION 1. Chapter 431, Hawaii Revised Statutes, is
2 amended by adding a new part to article 10A to be appropriately
3 designated and to read as follows:

4 **"PART . ESTABLISHMENT OF THE HAWAII HEALTHCARE CLAIMS**
5 **UNIFORM REPORTING AND EVALUATION SYSTEM**

6 **§431:10A-A Definitions.** As used in this part, unless the
7 content otherwise requires:

8 "Capitated services" means services rendered by a provider
9 through a contract in which payments are based upon a fixed
10 dollar amount for each member on a monthly basis.

11 "Cell size" means the count of persons that share a set of
12 characteristics contained in a statistical table.

13 "Charge" means the actual dollar amount charged on the
14 claim.

15 "Co-insurance" means the percentage a member pays toward
16 the cost of a covered service.

1 "Commissioner" or "insurance commissioner" means the
2 insurance commissioner of the State of Hawaii as defined in
3 section 431:2-102.
4 "Co-payment" means the fixed dollar amount a member pays to
5 a health care provider at the time a covered service is provided
6 or the full cost of a service when that is less than the fixed
7 dollar amount.
8 "Data set" means a collection of individual data records,
9 whether in electronic or manual files.
10 "Deductible" means the total dollar amount a member pays
11 towards the cost of covered services over an established period
12 of time before the contracted third-party payer makes any
13 payments.
14 "Designee" means an entity with which the insurance
15 commissioner has entered into an arrangement pursuant to chapter
16 103D, in which the entity performs data management, data
17 collection, and administrative functions and under which the
18 entity is strictly prohibited from using or releasing the
19 information and data obtained in that capacity for any purposes
20 other than those specified in the agreement.

1 "Direct personal identifiers" means information relating to
2 an individual patient, member, or enrollee that contains primary
3 or obvious identifiers, including but not limited to:
4 (1) Names;
5 (2) Business names when that name would serve to identify
6 a person;
7 (3) Postal address information other than town or city,
8 state, and five-digit zip code;
9 (4) Specific latitude and longitude or other geographic
10 information that would be used to derive a postal
11 address;
12 (5) Telephone and fax numbers;
13 (6) Electronic mail addresses;
14 (7) Social security numbers;
15 (8) Vehicle identifiers and serial numbers, including but
16 not limited to license plate numbers;
17 (9) Medical record numbers;
18 (10) Health plan beneficiary numbers;
19 (11) Certificate and license numbers;
20 (12) Internet protocol addresses and uniform resource
21 locators that identify a business that would serve to
22 identify a person; and

1 (13) Personal photographic images.
2 "Disclosure" means the release, transfer, provision of
3 access to, or divulging in any other manner of information
4 outside the entity holding the information.
5 "Encrypted identifiers" means a code or other means of
6 record identification to allow patients, members, or enrollees
7 to be tracked across the data set without revealing their
8 identity. Encrypted identifiers are not direct identifiers.
9 "Encryption" means a method by which the true value of data
10 has been disguised to prevent the identification of persons or
11 groups, and which does not provide the means for recovering the
12 true value of the data.
13 "Health benefit plan" means a policy, contract,
14 certificate, or agreement entered into or offered by a health
15 insurer to provide, deliver, arrange for, pay for, or reimburse
16 any of the costs of health care services.
17 "Health care" means care, services, or supplies related to
18 the health of an individual. It includes but is not limited to
19 preventive, diagnostic, therapeutic, rehabilitative,
20 maintenance, or palliative care; counseling, service,
21 assessment, or procedure with respect to the physical or mental
22 condition, or functional status, of an individual or that

1 affects the structure or function of the body; and sale or
2 dispensing of a drug, device, equipment, or other item in
3 accordance with a prescription.

4 "Health care facility" means all persons or institutions,
5 including mobile facilities, whether public or private,
6 proprietary or not for profit, which offer diagnosis, treatment,
7 inpatient, or ambulatory care to two or more unrelated persons,
8 and the buildings in which those services are offered. The term
9 shall not apply to any institution operated by religious groups
10 relying solely on spiritual means through prayer for healing,
11 but shall include but is not limited to:

12 (1) Hospitals, including general hospitals, mental
13 hospitals, chronic disease facilities, birthing
14 centers, maternity hospitals, and psychiatric
15 facilities including any hospital conducted,
16 maintained, or operated by the State or its political
17 subdivisions, or a duly authorized agency thereof;

18 (2) Nursing homes, health maintenance organizations, home
19 health agencies, outpatient diagnostic or therapy
20 programs, kidney disease treatment centers, mental
21 health agencies or centers, diagnostic imaging
22 facilities, independent diagnostic laboratories,

1 cardiac catheterization laboratories, radiation
2 therapy facilities, or any inpatient or ambulatory
3 surgical, diagnostic, or treatment center.
4 "Health care provider" means a person, partnership,
5 corporation, facility, or institution licensed, certified, or
6 authorized by law to provide professional health care services
7 in the State to an individual during that individual's medical
8 care, treatment, or confinement.
9 "Health claims data" means information consisting of or
10 derived directly from member eligibility files, medical claims
11 files, pharmacy claims files, and other related data pursuant to
12 the Hawaii healthcare claims uniform reporting and evaluation
13 system in effect at the time of the data submission.
14 "Healthcare claims data" does not include analysis, reports, or
15 studies containing information from health care claims data sets
16 if those analyses, reports, or studies have already been
17 released in response to another request for information or as
18 part of a general distribution of public information by the
19 insurance commissioner.
20 "Health information" means any information whether oral or
21 recorded in any form or medium that is created or received by a
22 health care provider, health plan, public health authority,

1 employer, life insurer, school or university, or health care
2 clearinghouse and relates to the past, present, or future
3 physical or mental health or condition of an individual, the
4 provision of health care to an individual, or the past, present,
5 or future payment for the provision of health care to an
6 individual.
7 "Health insurance" shall have the same meaning as accident
8 and health or sickness insurance as defined in section
9 431:1-205.
10 "Indirect personal identifiers" means information relating
11 to an individual patient, member, or enrollee that a person with
12 appropriate knowledge of and experience with generally accepted
13 statistical and scientific principles and methods could apply to
14 render the information individually identifiable by using the
15 information alone or in combination with other reasonably
16 available information.
17 "Insurance division" means that division of the department
18 of commerce and consumer affairs that oversees the Hawaii
19 insurance industry.
20 "Mandated reporter" or "reporter" means a health insurer as
21 defined herein with two hundred or more enrolled or covered
22 members in each month during a calendar year, including both

1 Hawaii residents and any non-residents receiving covered
2 services provided by Hawaii health care providers and
3 facilities.
4 "Medical claims file" means a data file composed of service
5 level remittance information for all non-denied adjudicated
6 claims for each billed service including but not limited to
7 member demographics, provider information, care and payment
8 information, and clinical diagnosis and procedure codes, and
9 shall include all claims related to behavioral or mental health.
10 "Member" means the insured subscriber and any spouse or
11 dependent covered by the subscriber's policy.
12 "Member eligibility file" means a data file containing
13 demographic information for each individual member eligible for
14 medical or pharmacy benefits for one or more days of coverage at
15 any time during the reporting month.
16 "Patient" means any person in the data set that is the
17 subject of the activities of the claim performed by the health
18 care provider.
19 "Payer" means a third-party payer or third-party
20 administrator.
21 "Payment" means the actual dollar amount paid for a claim
22 by a health insurer.

1 "Personal identifiers" means information relating to an
2 individual that contains direct or indirect identifiers to which
3 a reasonable basis exists to believe that the information can be
4 used to identify an individual.
5 "Pharmacy benefit management" means an arrangement for the
6 procurement of prescription drugs at a negotiated rate for
7 dispensation within this State to beneficiaries, the
8 administration or management of prescription drug benefits
9 provided by a health plan for the benefit of beneficiaries, or
10 any of the following services provided with regard to the
11 administration of pharmacy benefits: mail service pharmacy;
12 claims processing, retail network management, and payment of
13 claims to pharmacies for prescription drugs dispensed to
14 beneficiaries; clinical formulary development and management
15 services; rebate contracting and administration; certain patient
16 compliance, therapeutic intervention, and generic substitution
17 programs; and disease or chronic care management programs.
18 "Pharmacy benefit manager" means a person or entity that
19 performs pharmacy benefit management. The term includes a
20 person or entity in a contractual or employment relationship
21 with an entity performing pharmacy benefit management for a
22 health plan.

1 "Pharmacy claims file" means a data file containing service
2 level remittance information from all non-denied adjudicated
3 claims for each prescription including but not limited to:
4 member demographics; provider information; charge and payment
5 information; and national drug codes.
6 "Prepaid amount" means the fee for the service equivalent
7 that would have been paid for a specific service if the service
8 had not been capitated.
9 "Principal investigator" means the person in charge of a
10 project that makes use of limited use research health care
11 claims data sets. The principal investigator is the custodian
12 of the data and is responsible for compliance with all
13 restrictions, limitations, and conditions of use associated with
14 the data release.
15 "Public use data set" means a publically available data set
16 containing only the public use data elements specified in this
17 part as unrestricted data elements.
18 "Subscriber" means the individual responsible for payment
19 of premiums or whose employment is the basis for eligibility for
20 membership in a health benefit plan.
21 "Third party administrator" means any person who, on behalf
22 of a health insurer or purchaser of health benefits, receives or

1 collects charges, contributions, or premiums for, or adjusts or
2 settles claims on or for residents of this State or Hawaii
3 health care providers and facilities.
4 "Voluntary reporter" includes any entity other than a
5 mandated reporter, including any health benefit plan offered or
6 administered by or on behalf of the federal government where the
7 plan, with the agreement of the federal government, voluntarily
8 submits data to the insurance commissioner for inclusion in the
9 database on terms as may be appropriate.
10 **§431:10A-B Registration and reporting requirements for**
11 **healthcare claims forms.** (a) On an annual basis on or before
12 March 1 of each year, each health insurer doing business in the
13 State shall register with the insurance commissioner and shall
14 identify whether health care claims are being paid for members
15 who are Hawaii residents and whether health care claims are
16 being paid for non-residents receiving covered services from
17 Hawaii health care providers or facilities. Where applicable,
18 the completed form shall identify the types of files to be
19 submitted pursuant to section 431:10A-C. This form shall be
20 submitted to the insurance commissioner.
21 (b) Any person or entity that provides third party
22 administration services in the State shall register with the

1 insurance commissioner prior to March 1, 2011, and on an annual
2 basis thereafter.
3 (c) Any person or entity that performs pharmacy benefit
4 management in the State shall register with the insurance
5 commissioner prior to March 1, 2011, and on an annual basis
6 thereafter.
7 (d) Any health insurer shall regularly submit medical
8 claims data, pharmacy claims data, provider data, and other
9 information relating to health care provided to Hawaii residents
10 and health care provided by Hawaii health care providers and
11 facilities to both Hawaii residents and non-residents to the
12 insurance commissioner for each health line of business,
13 including but not limited to comprehensive major medical,
14 TPA/ASO, medicare supplemental, medicare part C, and medicare
15 part D.
16 (e) Voluntary reporters may, with the permission of the
17 commissioner, participate in Hawaii health insurance claims
18 uniform reporting system and submit medical claims files,
19 pharmacy claims files, member eligibility files, provider data,
20 and other information relating to health care provided to Hawaii
21 residents and health care provided by Hawaii health care

1 providers to both Hawaii residents and non-residents to the
2 insurance commissioner.
3 **§431:10A-C Required healthcare data files.** (a) Mandated
4 reporters shall submit to the insurance commissioner health care
5 claims data for all members who are Hawaii residents and all
6 non-residents who received covered services provided by Hawaii
7 health care providers or facilities in accordance with the
8 requirements of this section. Each mandated reporter is also
9 responsible for the submission of all health care claims
10 processed by any sub-contractor on its behalf unless the
11 subcontractor is already submitting the identical data as a
12 mandated reporter in its own right. The health care claims data
13 submitted shall include, where applicable, a member eligibility
14 file containing records associated with each of the claims files
15 reported including a medical claims file and a pharmacy claims
16 file. The data submitted shall also include supporting
17 definition files for payer specific provider specialty taxonomy
18 codes and procedure or diagnosis codes.
19 (b) General requirements for data submission shall be as
20 follows:
21 (1) Adjustment records shall be reported with the
22 appropriate positive or negative fields with the

1 medical and pharmacy claims file submissions.
2 Negative values shall contain the negative sign before
3 the value. No sign shall appear before a positive
4 value;
5 (2) All claims related to behavioral or mental health
6 shall be included in the medical claims file;
7 (3) Claims for capitated services shall be reported with
8 all medical and pharmacy claims file submissions;
9 (4) Records for the medical and pharmacy claims file
10 submissions shall be reported at the visit, service,
11 or prescription level. The submission of the medical
12 and pharmacy claims is based upon the paid dates and
13 not upon the dates of service associated with the
14 claims;
15 (5) Unless otherwise specified in this part, code sources
16 shall be issued by the insurance commissioner and
17 shall be utilized in association with the member
18 eligibility file and medical and pharmacy claims file
19 submissions;
20 (6) Reporters shall assign to each of their members a
21 unique identification code that is the member's social
22 security number:

1 (A) If a reporter does not collect the social
2 security numbers for all members, the reporter
3 shall use the social security number of the
4 subscriber and then assign a discrete two-digit
5 suffix for each member under the subscriber's
6 contract;
7 (B) If a reporter does not collect the social
8 security number for a subscriber, a version of
9 the subscriber's certificate or contract number
10 shall be used in its place. The discrete
11 two-digit suffix shall also be used with the
12 certificate or contract number. The certificate
13 or contract number with the two-digit suffix
14 shall be at least eleven but not more than
15 sixty-four characters in length;
16 (C) The social security number of the member or
17 subscriber and the subscriber and member names
18 shall be encrypted prior to submission by the
19 reporter utilizing a standard encryption
20 methodology provided by the insurance
21 commissioner. The unique member identification
22 code assigned by each reporter shall remain with

1 each member or subscriber for the entire period
2 of coverage for that individual; and
3 (D) With the exception of provider, provider
4 specialty, and procedure and diagnosis codes,
5 specific or unique coding systems shall not be
6 permitted as part of the health care claims data
7 set submission;
8 (7) Co-insurance and co-payment are to be reported in two
9 separate fields in the medical and pharmacy claims
10 file submissions;
11 (8) Claims where multiple parties have financial
12 responsibility shall be included with all medical and
13 pharmacy claims file submissions;
14 (9) Denied claims shall be excluded from all medical and
15 pharmacy claims file submissions. When a claim
16 contains both fully processed and paid service lines
17 and partially processed or denied service lines, only
18 the fully processed and paid service lines shall be
19 included as part of the health care claims data set
20 submittal;
21 (10) Records for the member eligibility file submission
22 shall be reported at the individual member level with

1 one record submitted for each claim type. If a member
2 is covered as both a subscriber and a dependent on two
3 different policies during the same month, two records
4 must be submitted. If a member has two contract
5 numbers for two different coverage types, two member
6 eligibility records shall be submitted;
7 (11) Exceptions to this section shall include but are not
8 limited to:
9 (A) All claims related to services provided under
10 stand-alone health care policies shall be
11 excluded if the services are not covered by
12 comprehensive medical insurance policies and are
13 provided on a stand-alone basis for specific
14 disease, accident, injury, hospital indemnity,
15 disability, long-term care, student liability,
16 vision coverage, or durable medical equipment;
17 (B) Claims for pharmacy services containing national
18 drug codes are to be included in the pharmacy
19 claims file but excluded from the medical claims
20 file; and
21 (C) Members without medical or pharmacy coverage for
22 the month reported shall be excluded;

1 (12) Reporters are required to submit a key lookup table
2 when submitting member eligibility files. The key
3 look-up table shall link an insured group or policy
4 number to the name of the group associated with each
5 insured group or policy number, but shall not identify
6 any individual policyholders in connection with
7 non-group policies;
8 (13) Each member eligibility file and each medical and
9 pharmacy claims file submission shall contain a header
10 record and a trailer record. The header record is the
11 first record of each separate file submission and the
12 trailer record is the last. The header and trailer
13 record formats shall be issued by the insurance
14 commissioner;
15 (14) Claims for pharmacy services shall be included in the
16 following files:
17 (A) If the pharmacy claims are covered under the
18 medical benefit then the claim shall be included
19 in the medical claims file and not the pharmacy
20 claims file; and

1 (B) If the claim is covered under the prescription
2 benefit then the claim shall be included in the
3 pharmacy claims file;
4 (15) Any prepaid amounts are to be reported in a separate
5 field in the medical and pharmacy claims file
6 submissions; and
7 (16) Claims related to supplemental health insurance are to
8 be included if the policies are for health care
9 services entirely excluded by the medicare, tricare,
10 or other publicly funded health benefit programs.
11 (c) Detailed field specifications are as follows:
12 (1) All required fields shall be filled where applicable.
13 Non-required text, date, and integer fields shall be
14 set to null when unavailable. Non-applicable decimal
15 fields shall be filled with one zero and shall not
16 include decimal points when unavailable;
17 (2) All text fields are to be left justified. All integer
18 and decimal fields are to be right justified;
19 (3) Positive values are assumed and need not be indicated
20 as such. Negative values shall be indicated with a
21 minus sign and shall appear in the left-most position

1 of all integer and decimal fields. Over-punched
2 signed integers or decimals are not to be used; and
3 (4) Individual data elements, data types, field lengths,
4 field description/code assignments, and mapping
5 locaters for each file shall be detailed according to
6 insurance commissioner instructions.
7 **§431:10A-D Submission requirements.** (a) It is the
8 responsibility of each health insurer to resubmit or amend the
9 health care claims data required by section 431:10A-C whenever
10 modifications occur relative to the data files or contact
11 information.
12 (b) The member eligibility file, medical claims file, and
13 pharmacy claims file shall be submitted to the insurance
14 commissioner as separate files in a format to be decided by the
15 insurance commissioner.
16 (c) Files shall be submitted utilizing media specified by
17 the insurance commissioner.
18 (d) All file submissions on physical media shall be
19 accompanied by a hard copy transmittal sheet containing the
20 following information: identification of the reporter, file
21 name, type of file, data periods, date sent, record counts for
22 the files, and a contact person with telephone number and

1 electronic mail address. The information on the transmittal
2 sheet shall match the information on the header and trailer
3 records.
4 (e) At least sixty days prior to the initial submission of
5 the files or whenever the data element content of the files as
6 described in section 431:10A-C is subsequently altered, each
7 reporter shall submit to the insurance commissioner a data set
8 for comparison to the standards listed in section 431:10A-E.
9 The size, based upon a calendar period of one month, quarter, or
10 year, of the data files submitted shall correspond to the filing
11 period established for each reporter under subsection (i) of
12 this section.
13 (f) Failure to conform to subsection (a), (b), (c), or (d)
14 of this section shall result in the rejection and return of the
15 applicable data files. All rejected and returned files shall be
16 resubmitted in the appropriate, corrected form to the insurance
17 commissioner within ten days.
18 (g) No reporter may replace a complete data file
19 submission more than one year after the end of the month in
20 which the file was submitted unless it can establish exceptional
21 circumstances for the replacement. Any replacements after this
22 period must be approved by the commissioner. Individual

1 adjustment records may be submitted with any monthly data file
2 submission.
3 (h) Reporters shall submit medical and pharmacy claims
4 files for at least a six month period following the termination
5 of coverage date for all members who are Hawaii residents or
6 non-residents receiving covered services provided by Hawaii
7 health care providers or facilities.
8 (i) The reporting period for submission of each specified
9 file listed in section 431:10A-C shall be determined on a
10 separate basis for Hawaii members and non-resident members by
11 the highest total number of Hawaii resident members or
12 non-resident members receiving covered services provided by
13 Hawaii providers or facilities for which claims are being paid
14 for any one month of the calendar year. Data files are to be
15 submitted in accordance with the following schedule:
16

Total Number of Members	**Reporting Period**	**Reporting Schedule**
≥2,000	Monthly	Prior to the end of the month following the month in which claims were paid
500-1,999	Quarterly	Prior to April 30, July 31, October 31, and January 31 for

		each preceding calendar quarter in which claims were paid
200-499	Annually	Prior to April 30 of the following year for the preceding twelve months in which claims were paid
<200	N/A	

If the data files submitted by an individual reporter support or are related to the files submitted by another reporter, the insurance commissioner shall establish a filing period for the parties involved.

§431:10A-E Compliance with data standards. (a) The insurance commissioner shall evaluate each member eligibility file, medical claims file, and pharmacy claims file in accordance with the following standards:

(1) The applicable code for each data element shall be as specified by the insurance commissioner and shall be included within eligible values for the element;

(2) Coding values indicating "data not available", "data unknown", or the equivalent shall not be used for individual data elements unless specified as an eligible value for the element;

1 (3) Member sex, diagnosis and procedure codes, date of
2 birth, and all other date fields shall be consistent
3 within an individual record;
4 (4) Member identifiers shall be consistent across files;
5 and
6 (5) Files submitted shall not contain direct personal
7 identifiers.
8 (b) Upon completion of this evaluation, the insurance
9 commissioner shall promptly notify each reporter whose data
10 submissions do not satisfy the standards for any reporting
11 period. This notification will identify the specific file and
12 the data elements that are determined to be unsatisfactory.
13 (c) Each reporter notified under subsection (b) shall
14 resubmit the required changes within sixty days of receipt of
15 the notification.
16 **§431:10A-F Procedures for the approval and release of**
17 **claims data.** The insurance commissioner shall classify health
18 care claims data sets as unrestricted, restricted, or
19 unavailable. The requirements, procedures, and conditions under
20 which persons other than the insurance commissioner may have
21 access to health care claims data sets and related information

1 received or generated by the insurance commissioner pursuant to
2 this part shall depend upon the following considerations:
3 (1) Data elements that the insurance commissioner
4 designates as "unrestricted" shall be available for
5 general use and public release as part of a public use
6 file:
7 (A) Unrestricted data elements collected or generated
8 by the insurance commissioner shall be made
9 available in public use files and provided to any
10 person upon written request, except where
11 otherwise prohibited by law; and
12 (B) The insurance commissioner shall maintain a
13 public record of all requests for and releases of
14 public use data sets;
15 (2) Data elements designated by the insurance commissioner
16 as "restricted" shall not be available for use outside
17 the insurance division other than by persons
18 designated by the commissioner, except as part of a
19 limited use research health care claims data set
20 approved by the commissioner pursuant to the
21 requirements of this part:

1 (A) Limited use health care claims research data sets
2 shall be those sets which contain restricted data
3 elements, shall not be available to the general
4 public, and shall be released to a requestor only
5 for the purpose of research upon a determination
6 by the commissioner that the following conditions
7 have been met:
8 (i) Any person requesting access to or use of
9 limited use health care claims research data
10 sets has submitted an application, in
11 written and electronic form, to the
12 commissioner including:
13 (aa) The identity of the principal
14 investigator with name, address,
15 telephone number, organizational
16 affiliation, professional
17 qualifications, and the phone number
18 of the principal investigator's
19 contact person, if any;
20 (bb) The identity of the person requesting
21 access, with name, address, telephone
22 number, any entities for whom that

1 person is acting in requesting the
2 data, organizational affiliation,
3 professional qualifications, and name
4 and telephone number of a contact
5 person;
6 (cc) The identity of and qualifications of
7 any other persons who may have access
8 to the data;
9 (dd) A detailed research protocol including
10 a summary of background, purposes, and
11 origin of the research; a statement of
12 the health-related problem or issue to
13 be addressed by the research; the
14 research design and methodology,
15 including either the topics of
16 exploratory research or the specific
17 research hypotheses to be tested; the
18 procedures to maintain the
19 confidentiality of any data or copies
20 of records provided to the principal
21 investigator or other persons; and the
22 intended research completion date;

1 (ee) The particular data set requested,
2 including the time period of the data
3 requested; the specific data elements
4 or fields of information required; a
5 justification of the need for each
6 restricted element or field, as
7 identified in the data release
8 schedule; the minimum needed
9 specificity of the requested data
10 elements, including the manner in
11 which the data may be recoded by the
12 insurance commissioner to be less
13 specific; the selection criteria for
14 the minimum needed data records
15 required; and any particular format or
16 layout of data requested by the
17 principal investigator; and
18 (ff) Any changes to information submitted
19 as part of an application pursuant to
20 these clauses shall require notice to
21 the insurance commissioner by the

1 applicant and shall be subject to the
2 approval of the commissioner;
3 (ii) The person or entity requesting access and
4 the principal investigator shall be subject
5 to the following requirements and
6 limitations and shall, in addition, sign and
7 submit a data use agreement acknowledging
8 and accepting these same provisions as a
9 necessary condition to any data access:
10 (aa) Use of data for any purpose other than
11 as specified in the application and
12 approved by the commissioner shall be
13 prohibited;
14 (bb) Appropriate safeguards to protect the
15 confidentiality of the data and
16 prevent unauthorized use of the data
17 shall be established;
18 (cc) The use, disclosure, sale, or
19 dissemination of the data set or
20 statistical tabulations derived from
21 the data set to any person or
22 organization for any purpose other

1 than as described in the application
2 and as permitted by the data use
3 agreement shall be prohibited without
4 the express written consent of the
5 commissioner;
6 (dd) The use, disclosure, sale, or
7 dissemination of any information
8 contrary to law shall be prohibited;
9 (ee) No person shall disclose the identity
10 of patients, employer groups, or
11 purchaser groups from information
12 contained in the limited use data set;
13 (ff) No person shall disclose any of the
14 information that has been encrypted or
15 removed from the data;
16 (gg) The content of cells that contain
17 counts of persons in statistical
18 tables in which the cell size is more
19 than zero and less than five shall not
20 be disclosed, published or made public
21 in any manner except as "<5";

1 (hh) The publication, dissemination, or
2 disclosure of any information that
3 could be used to identify providers of
4 abortion services shall be prohibited;
5 (ii) Any use or disclosure of the
6 information that is contrary to the
7 data use agreement or this part shall
8 be reported to the insurance
9 commissioner within five days of when
10 the principal investigator becomes
11 aware of the disclosure;
12 (jj) The insurance commissioner and the
13 Hawaii healthcare claims uniform
14 reporting and evaluation system shall
15 be acknowledged as the source and
16 owner of the data in any and all
17 public reports, publications, or
18 presentations generated from the data;
19 (kk) Written materials shall prominently
20 state that the analysis, conclusions,
21 and recommendations drawn from the
22 data are solely those of the requestor

1 or principal investigator and are not
2 necessarily those of the insurance
3 commissioner;
4 (11) The insurance commissioner shall be
5 provided with a copy of any proposed
6 report or publication containing
7 information derived from the data at
8 least fifteen days prior to any
9 publication or release to allow the
10 insurance commissioner to review the
11 proposed report or publication and
12 confirm that the conditions of the
13 agreement have been applied. When
14 multiple reports of a similar nature
15 will be created from the data, the
16 insurance division may, on request,
17 waive the requirement that any
18 subsequent reports or publications be
19 provided to the insurance commissioner
20 prior to release by the requesting
21 party;

1 (mm) Data elements shall not be retained
2 for any period of time beyond that
3 necessary to fulfill the requirements
4 of the data request;
5 (nn) Within thirty days after the scheduled
6 completion date of the project, the
7 requestor shall delete, destroy, or
8 otherwise render the data unreadable,
9 so certifying by submitting a written
10 notice to the insurance commissioner
11 or by reapplying for approval if the
12 end date of the project needs to be
13 extended;
14 (oo) Any draft reports or publications
15 supplied to the insurance commissioner
16 shall be considered confidential and
17 exempt from public review;
18 (pp) Failure to adhere to the data use
19 agreement or the limitations and
20 restrictions detailed in this section
21 shall be cause for immediate recall by
22 the insurance commissioner of the

1 data, revocation of permission to use
2 the data, and grounds for civil or
3 administrative enforcement action by
4 the insurance commissioner under
5 application of state law and rules;
6 (iii) The insurance commissioner shall establish a
7 claims data release advisory committee with
8 a chair person and members appointed
9 annually by the commissioner, to provide
10 non-binding advice and opinions to the
11 commissioner, as and when requested, on the
12 merits of the applications for access to
13 limited use data sets. If the commissioner
14 has requested a review of the application,
15 the claims data release advisory committee
16 shall provide the commissioner with any
17 comment on the merit of the application and
18 the research protocol described therein
19 within thirty days. The committee shall
20 comprise of seven members and shall include
21 at least one member representing health
22 insurers; at least one member representing

1 health care facilities; at least one member
2 representing health care providers; at least
3 one member representing purchasers of health
4 insurance or health benefits; and at least
5 one member representing healthcare
6 researchers;
7 (B) The commissioner may approve the release of
8 limited use data sets only when the commissioner
9 is satisfied that:
10 (i) The application submitted is complete and
11 the requesting individuals or entities and
12 principal investigator have signed a data
13 use agreement as specified;
14 (ii) Procedures to ensure the confidentiality of
15 any patient and any confidential data are
16 documented;
17 (iii) The qualifications of the principal
18 investigator and research staff are
19 legitimate, as evidenced by training and
20 previous research, including prior
21 publications, and an affiliation with a
22 university, private research organization,

medical center, state agency, or other qualified entity; and

(iv) No other state or federal law, rule, or regulation prohibits release of the requested information;

(C) If the commissioner declines to release the requested limited use data sets within sixty days of the receipt of a complete application, the commissioner shall give written notice of the basis for denial of the application and the requestor shall have leave to resubmit or supplement the application to address the commissioner's concerns. Any adverse decision regarding an application may be appealed within thirty days by filing a request for hearing with the commissioner pursuant to chapter 91; and

(3) Data elements that are not designated by the insurance commissioner as either unrestricted or restricted, or are designated as "unavailable", shall not be available for release or use outside the insurance division in any data set or disclosed in publicly released report in any circumstance.

1 **§431:10A-G Prices for data sets; fees for programming and**
2 **report generation; duplication rates.** (a) An annual public use
3 file consisting of unrestricted fields and data elements shall
4 be made available to any person upon request at the cost
5 required for the insurance division to process, package, and
6 ship the data set, including any electronic medium used to store
7 the data.
8 (b) Limited use research health care claims data sets
9 approved by the insurance commissioner shall be made available
10 to the requesting party at the cost charged by the insurance
11 division's designated vendor to program and process the
12 requested data extract, including any consulting services and
13 costs to package and ship the data set on a particular
14 electronic medium.
15 (c) Payments are due in full from the requesting party
16 within thirty days of receipt of insurance division data sets,
17 files, reports, or other released material.
18 **§431:10A-H Healthcare claims fees.** A fee of two cents per
19 claim shall be charged for every claim submitted under this part
20 to be paid to the insurance division or its designee.
21 **§431:10A-I Enforcement.** (a) If any health insurer fails
22 to submit medical claims data to the insurance commissioner on a

1 timely basis, or fails to correct submissions rejected because
2 of excessive errors, the insurance commissioner shall provide
3 written notice to the health insurer. If the health insurer
4 fails, without just cause as determined by the commissioner, to
5 provide the required information within two weeks following
6 receipt of the written notice, the health insurer shall pay a
7 penalty of not less than $1,000 and not more than $10,000 for
8 each week of delay.
9 (b) Violations of data submission requirements,
10 confidentiality requirements, data use limitations, fee
11 provisions, or any other provisions of this part shall be
12 subject to an administrative penalty of not more than $1,000 per
13 inadvertent violation and not more than $10,000 per violation
14 that the commissioner finds was wilful. In addition, any person
15 or entity that fails to comply with the confidentiality
16 requirements of this part or confidentiality rules adopted
17 pursuant to this part and uses, sells, or transfers the data or
18 information for commercial advantage, pecuniary gain, personal
19 gain, or malicious harm shall be subject to an administrative
20 penalty of not more than $50,000 per violation.

1 (c) The powers vested in the commissioner by this section
2 shall be in addition to any other powers to enforce any
3 penalties, fines, or forfeitures authorized by law.
4 **§431:10A-J Healthcare claims special fund.** (a) There is
5 established a Hawaii healthcare claims special fund within the
6 treasury of the State into which shall be deposited:
7 (1) All healthcare claims fees established pursuant to
8 section 431:10A-H;
9 (2) All monetary penalties collected pursuant to section
10 431:10A-I; and
11 (3) Any other proceeds derived from the publication and
12 use of health claims data sets.
13 All interest accrued by the revenues of the fund shall become
14 part of the fund.
15 (b) Moneys in the Hawaii healthcare claims special fund
16 shall be used by the commissioner to operate and improve the
17 Hawaii healthcare claims uniform reporting and evaluation
18 system. Expenditures from the Hawaii healthcare claims special
19 fund shall be made by the commissioner.
20 **§431:10A-K Annual report.** The department of commerce and
21 consumer affairs shall submit a complete and detailed report of
22 its activities and expenditures to the legislature at least

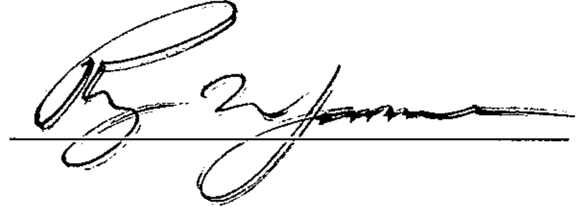
1 twenty days prior to the convening of each regular session of
2 the legislature.
3 **§431:10A-L Rules.** The department of commerce and consumer
4 protection shall adopt, modify, and repeal rules of general
5 application as may be necessary to carry into effect this part.
6 **§431:10A-M Severability.** If any provision of this part or
7 rules adopted for the application of this part are held to be
8 invalid with the federal Health Insurance Portability and
9 Accountability Act of 1996 or for any other reason, the
10 remainder of the law or rule and the application of such
11 provisions to other persons or circumstances shall not be
12 affected."
13 SECTION 2. In codifying the new sections added by
14 section 1 of this Act, the revisor of statutes shall substitute
15 appropriate section numbers for the letters used in designating
16 the new sections in this Act.
17 SECTION 3. This Act does not affect rights and duties that
18 matured, penalties that were incurred, and proceedings that were
19 begun, before its effective date.
20

H.B. NO. 2660

1 SECTION 4. This Act shall take effect on July 1, 2010.

2

INTRODUCED BY:



JAN 25 2010

H.B. NO. 2660

Report Title:
Hawaii Healthcare Claims Uniform Reporting and Evaluation System

Description:
Establishes a system under the department of commerce and consumer protection to collect, analyze and distribute health insurance claims information.

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