

JAN 22 2010

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 a non-profit entity with which the
15 insurance commissioner has entered into an arrangement pursuant
16 to chapter 103D, in which the entity performs data management,
17 data collection, and administrative functions and under which
18 the 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 or its designee.

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 or the commissioner's
9 designee for inclusion in the database on such terms as may be
10 appropriate.

11 **§431:10A-B Registration and reporting requirements for**
12 **healthcare claims forms.** (a) On an annual basis on or before
13 March 1 of each year, each health insurer doing business in the
14 State shall register with the insurance commissioner or the
15 commissioner's designee and shall identify whether health care
16 claims are being paid for members who are Hawaii residents and
17 whether health care claims are being paid for non-residents
18 receiving covered services from Hawaii health care providers or
19 facilities. Where applicable, the completed form shall identify
20 the types of files to be submitted pursuant to section
21 431:10A-C. This form shall be submitted to the insurance
22 commissioner or the commissioner's designee.



1 (b) Any person or entity that provides third party
2 administration services in the State shall register with the
3 insurance commissioner or the commissioner's designee prior to
4 March 1, 2011, and on an annual basis thereafter.

5 (c) Any person or entity that performs pharmacy benefit
6 management in the State shall register with the insurance
7 commissioner or the commissioner's designee prior to March 1,
8 2011, and on an annual basis thereafter.

9 (d) Any health insurer shall regularly submit medical
10 claims data, pharmacy claims data, provider data, and other
11 information relating to health care provided to Hawaii residents
12 and health care provided by Hawaii health care providers and
13 facilities to both Hawaii residents and non-residents to the
14 insurance commissioner or the commissioner's designee for each
15 health line of business including but not limited to
16 comprehensive major medical, TPA/ASO, medicare supplemental,
17 medicare part C, and medicare part D.

18 (e) Voluntary reporters may, with the permission of the
19 commissioner, participate in Hawaii health insurance claims
20 uniform reporting system and submit medical claims files,
21 pharmacy claims files, member eligibility files, provider data,
22 and other information relating to health care provided to Hawaii



1 residents and health care provided by Hawaii health care
2 providers to both Hawaii residents and non-residents to the
3 insurance commissioner or the commissioner's designee.

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

21 (b) General requirements for data submission shall be as
22 follows:



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



1 (6) Reporters shall assign to each of their members a
2 unique identification code that is the member's social
3 security number:

4 (A) If a reporter does not collect the social
5 security numbers for all members, the reporter
6 shall use the social security number of the
7 subscriber and then assign a discrete two-digit
8 suffix for each member under the subscriber's
9 contract;

10 (B) If a reporter does not collect the social
11 security number for a subscriber, a version of
12 the subscriber's certificate or contract number
13 shall be used in its place. The discrete two-
14 digit suffix shall also be used with the
15 certificate or contract number. The certificate
16 or contract number with the two-digit suffix
17 shall be at least eleven but not more than sixty-
18 four characters in length;

19 (C) The social security number of the member or
20 subscriber and the subscriber and member names
21 shall be encrypted prior to submission by the
22 reporter utilizing a standard encryption



1 methodology provided by the insurance
2 commissioner or the commissioner's designee. The
3 unique member identification code assigned by
4 each reporter shall remain with each member or
5 subscriber for the entire period of coverage for
6 that individual; and

7 (D) With the exception of provider, provider
8 specialty, and procedure and diagnosis codes,
9 specific or unique coding systems shall not be
10 permitted as part of the health care claims data
11 set submission;

12 (7) Co-insurance and co-payment are to be reported in two
13 separate fields in the medical and pharmacy claims
14 file submissions;

15 (8) Claims where multiple parties have financial
16 responsibility shall be included with all medical and
17 pharmacy claims file submissions;

18 (9) Denied claims shall be excluded from all medical and
19 pharmacy claims file submissions. When a claim
20 contains both fully processed and paid service lines
21 and partially processed or denied service lines, only
22 the fully processed and paid service lines shall be



- 1 included as part of the health care claims data set
2 submittal;
- 3 (10) Records for the member eligibility file submission
4 shall be reported at the individual member level with
5 one record submitted for each claim type. If a member
6 is covered as both a subscriber and a dependent on two
7 different policies during the same month, two records
8 must be submitted. If a member has two contract
9 numbers for two different coverage types, two member
10 eligibility records shall be submitted;
- 11 (11) Exceptions to this section shall include but are not
12 limited to:
- 13 (A) All claims related to services provided under
14 stand-alone health care policies shall be
15 excluded if the services are not covered by
16 comprehensive medical insurance policies and are
17 provided on a stand-alone basis for specific
18 disease, accident, injury, hospital indemnity,
19 disability, long-term care, student liability,
20 vision coverage, or durable medical equipment;
- 21 (B) Claims for pharmacy services containing national
22 drug codes are to be included in the pharmacy



1 claims file but excluded from the medical claims
2 file; and

3 (C) Members without medical or pharmacy coverage for
4 the month reported shall be excluded;

5 (12) Reporters are required to submit a key lookup table
6 when submitting member eligibility files. The key
7 look-up table shall link an insured group or policy
8 number to the name of the group associated with each
9 insured group or policy number, but shall not identify
10 any individual policyholders in connection with non-
11 group policies;

12 (13) Each member eligibility file and each medical and
13 pharmacy claims file submission shall contain a header
14 record and a trailer record. The header record is the
15 first record of each separate file submission and the
16 trailer record is the last. The header and trailer
17 record formats shall be issued by the insurance
18 commissioner or the commissioner's designee;

19 (14) Claims for pharmacy services shall be included in the
20 following files:

21 (A) If the pharmacy claims are covered under the
22 medical benefit then the claim shall be included



1 in the medical claims file and not the pharmacy
2 claims file; and

3 (B) If the claim is covered under the prescription
4 benefit then the claim shall be included in the
5 pharmacy claims file;

6 (15) Any prepaid amounts are to be reported in a separate
7 field in the medical and pharmacy claims file
8 submissions; and

9 (16) Claims related to supplemental health insurance are to
10 be included if the policies are for health care
11 services entirely excluded by the medicare, tricare,
12 or other publicly funded health benefit programs.

13 (c) Detailed field specifications are as follows:

14 (1) All required fields shall be filled where applicable.
15 Non-required text, date, and integer fields shall be
16 set to null when unavailable. Non-applicable decimal
17 fields shall be filled with one zero and shall not
18 include decimal points when unavailable;

19 (2) All text fields are to be left justified. All integer
20 and decimal fields are to be right justified;

21 (3) Positive values are assumed and need not be indicated
22 as such. Negative values shall be indicated with a

1 minus sign and shall appear in the left-most position
2 of all integer and decimal fields. Over-punched
3 signed integers or decimals are not to be used; and
4 (4) Individual data elements, data types, field lengths,
5 field description/code assignments, and mapping
6 locaters for each file shall be detailed according to
7 instructions from the insurance commissioner or the
8 commissioner's designee.

9 **§431:10A-D Submission requirements.** (a) It is the
10 responsibility of each health insurer to resubmit or amend the
11 health care claims data required by section 431:10A-C whenever
12 modifications occur relative to the data files or contact
13 information.

14 (b) The member eligibility file, medical claims file, and
15 pharmacy claims file shall be submitted to the insurance
16 commissioner or the commissioner's designee as separate files in
17 a format to be decided by the insurance commissioner or the
18 commissioner's designee

19 (c) Files shall be submitted utilizing media specified by
20 the insurance commissioner or the commissioner's designee.

21 (d) All file submissions on physical media shall be
22 accompanied by a hard copy transmittal sheet containing the



1 following information: identification of the reporter, file
2 name, type of file, data periods, date sent, record counts for
3 the files, and a contact person with telephone number and
4 electronic mail address. The information on the transmittal
5 sheet shall match the information on the header and trailer
6 records.

7 (e) At least sixty days prior to the initial submission of
8 the files or whenever the data element content of the files as
9 described in section 431:10A-C is subsequently altered, each
10 reporter shall submit to the insurance commissioner or the
11 commissioner's designee a data set for comparison to the
12 standards listed in section 431:10A-E. The size, based upon a
13 calendar period of one month, quarter, or year, of the data
14 files submitted shall correspond to the filing period
15 established for each reporter under subsection (i) of this
16 section.

17 (f) Failure to conform to subsection (a), (b), (c), or (d)
18 of this section shall result in the rejection and return of the
19 applicable data files. All rejected and returned files shall be
20 resubmitted in the appropriate, corrected form to the insurance
21 commissioner or the commissioner's designee within ten days.



1 (g) No reporter may replace a complete data file
2 submission more than one year after the end of the month in
3 which the file was submitted unless it can establish exceptional
4 circumstances for the replacement. Any replacements after this
5 period must be approved by the commissioner. Individual
6 adjustment records may be submitted with any monthly data file
7 submission.

8 (h) Reporters shall submit medical and pharmacy claims
9 files for at least a six month period following the termination
10 of coverage date for all members who are Hawaii residents or
11 non-residents receiving covered services provided by Hawaii
12 health care providers or facilities.

13 (i) The reporting period for submission of each specified
14 file listed in section 431:10A-C shall be determined on a
15 separate basis for Hawaii members and non-resident members by
16 the highest total number of Hawaii resident members or non-
17 resident members receiving covered services provided by Hawaii
18 providers or facilities for which claims are being paid for any
19 one month of the calendar year. Data files are to be submitted
20 in accordance with the following schedule:

21



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	

1

2 If the data files submitted by an individual reporter support or
3 are related to the files submitted by another reporter, the
4 insurance commissioner or the commissioner's designee shall
5 establish a filing period for the parties involved.

6 **§431:10A-E Compliance with data standards.** (a) The
7 insurance commissioner or the commissioner's designee shall
8 evaluate each member eligibility file, medical claims file, and
9 pharmacy claims file in accordance with the following standards:



- 1 (1) The applicable code for each data element shall be as
2 specified by the insurance commissioner or the
3 commissioner's designee and shall be included within
4 eligible values for the element;
- 5 (2) Coding values indicating "data not available", "data
6 unknown", or the equivalent shall not be used for
7 individual data elements unless specified as an
8 eligible value for the element;
- 9 (3) Member sex, diagnosis and procedure codes, date of
10 birth, and all other date fields shall be consistent
11 within an individual record;
- 12 (4) Member identifiers shall be consistent across files;
13 and
- 14 (5) Files submitted shall not contain direct personal
15 identifies.
- 16 (b) Upon completion of this evaluation, the insurance
17 commissioner or the commissioner's designee will promptly notify
18 each reporter whose data submissions do not satisfy the
19 standards for any reporting period. This notification will
20 identify the specific file and the data elements that are
21 determined to be unsatisfactory.



1 (c) Each reporter notified under subsection (b) shall
2 resubmit the required changes within sixty days of receipt of
3 the notification.

4 **§431:10A-F Procedures for the approval and release of**
5 **claims data.** The insurance commissioner shall classify health
6 care claims data sets as unrestricted, restricted, or
7 unavailable. The requirements, procedures, and conditions under
8 which persons other than the insurance commissioner or the
9 commissioner's designee may have access to health care claims
10 data sets and related information received or generated by the
11 insurance commissioner or the commissioner's designee pursuant
12 to this part shall depend upon the following considerations:

13 (1) Data elements that the insurance commissioner
14 designates as "unrestricted" shall be available for
15 general use and public release as part of a public use
16 file:

17 (A) Unrestricted data elements collected or generated
18 by the insurance division or its designee shall
19 be made available in public use files and
20 provided to any person upon written request,
21 except where otherwise prohibited by law;



1 (B) The insurance division or its designee shall
2 maintain a public record of all requests for and
3 releases of public use data sets;

4 (2) Data elements designated by the insurance division as
5 "restricted" shall not be available for use outside
6 the insurance division other than by their designee
7 except as part of a limited use research health care
8 claims data set approved by the commissioner or the
9 insurance division designee pursuant to the
10 requirements of this part:

11 (A) Limited use health care claims research data sets
12 shall be those sets which contain restricted data
13 elements, shall not be available to the general
14 public, and shall be released to a requestor only
15 for the purpose of research upon a determination
16 by the commissioner or the insurance division's
17 designee that the following conditions have been
18 met:

19 (i) Any person requesting access to or use of
20 limited use health care claims research data
21 sets has submitted an application, in
22 written and electronic form, to the



1 commissioner or the insurance division
2 designee including:

3 (aa) The identity of the principal
4 investigator with name, address,
5 telephone number, organizational
6 affiliation, professional
7 qualifications, and the phone number
8 of the principal investigator's
9 contact person, if any;

10 (bb) The identity of the person requesting
11 access, with name, address, telephone
12 number, any entities for whom that
13 person is acting in requesting the
14 data, organizational affiliation,
15 professional qualifications, and name
16 and telephone number of a contact
17 person;

18 (cc) The identity of and qualifications of
19 any other persons who may have access
20 to the data;

21 (dd) A detailed research protocol including
22 a summary of background, purposes, and



1 origin of the research; a statement of
2 the health-related problem or issue to
3 be addressed by the research; the
4 research design and methodology,
5 including either the topics of
6 exploratory research or the specific
7 research hypotheses to be tested; the
8 procedures to maintain the
9 confidentiality of any data or copies
10 of records provided to the principal
11 investigator or other persons; and the
12 intended research completion date;

13 (ee) The particular data set requested,
14 including the time period of the data
15 requested; the specific data elements
16 or fields of information required; a
17 justification of the need for each
18 restricted element or field, as
19 identified in the data release
20 schedule; the minimum needed
21 specificity of the requested data
22 elements, including the manner in



1 which the data may be recoded by the
2 insurance division or the insurance
3 division's designee to be less
4 specific; the selection criteria for
5 the minimum needed data records
6 required; and any particular format or
7 layout of data requested by the
8 principal investigator;

9 (ff) Any changes to information submitted
10 as part of an application pursuant to
11 these clauses shall require notice to
12 the insurance commissioner or the
13 commissioner's designee by the
14 applicant and shall be subject to the
15 approval of the commissioner or the
16 insurance division's designee:

17 (ii) The person or entity requesting access and
18 the principal investigator shall be subject
19 to the following requirements and
20 limitations and shall, in addition, sign and
21 submit a data use agreement acknowledging



1 and accepting these same provisions as a
2 necessary condition to any data access:

3 (aa) Use of data for any purpose other than
4 as specified in the application and
5 approved by the commissioner or the
6 insurance division's designee shall be
7 prohibited;

8 (bb) Appropriate safeguards to protect the
9 confidentiality of the data and
10 prevent unauthorized use of the data
11 shall be established;

12 (cc) The use, disclosure, sale, or
13 dissemination of the data set or
14 statistical tabulations derived from
15 the data set to any person or
16 organization for any purpose other
17 than as described in the application
18 and as permitted by the data use
19 agreement shall be prohibited without
20 the express written consent of the
21 commissioner;



- 1 (dd) The use, disclosure, sale, or
2 dissemination of any information
3 contrary to law shall be prohibited;
- 4 (ee) No person shall disclose the identity
5 of patients, employer groups, or
6 purchaser groups from information
7 contained in the limited use data set;
- 8 (ff) No person shall disclose any of the
9 information that has been encrypted or
10 removed from the data;
- 11 (gg) The content of cells that contain
12 counts of persons in statistical
13 tables in which the cell size is more
14 than zero and less than five shall not
15 be disclosed, published or made public
16 in any manner except as "<5";
- 17 (hh) The publication, dissemination, or
18 disclosure of any information that
19 could be used to identify providers of
20 abortion services shall be prohibited;
- 21 (ii) Any use or disclosure of the
22 information that is contrary to the



1 data use agreement or any other
2 provisions of this part shall be
3 reported to the insurance commissioner
4 and the commissioner's designee, if
5 any, within five days of when the
6 principal investigator becomes aware
7 of such disclosure;

8 (jj) The insurance commissioner and the
9 Hawaii healthcare claims uniform
10 reporting and evaluation system shall
11 be acknowledged as the source and
12 owner of the data in any and all
13 public reports, publications, or
14 presentations generated from the data;

15 (kk) Written materials shall prominently
16 state that the analysis, conclusions,
17 and recommendations drawn from the
18 data are solely those of the requestor
19 or principal investigator and are not
20 necessarily those of the insurance
21 commissioner;



1 (ll) The insurance commissioner and the
2 commissioner's designee, if any, shall
3 be provided with a copy of any
4 proposed report or publication
5 containing information derived from
6 the data at least fifteen days prior
7 to any publication or release to allow
8 the insurance commissioner or the
9 commissioner's designee to review the
10 proposed report or publication and
11 confirm that the conditions of the
12 agreement have been applied. When
13 multiple reports of a similar nature
14 will be created from the data, the
15 insurance division may, on request,
16 waive the requirement that any
17 subsequent reports or publications be
18 provided to the insurance commissioner
19 or the commissioner's designee prior
20 to release by the requesting party;

21 (mm) Data elements shall not be retained
22 for any period of time beyond that



1 necessary to fulfill the requirements
2 of the data request;

3 (nn) Within thirty days after the scheduled
4 completion date of the project, the
5 requestor shall delete, destroy, or
6 otherwise render the data unreadable,
7 so certifying by submitting a written
8 notice to the insurance commissioner
9 and the commissioner's designee, if
10 any, or by reapplying for approval if
11 the end date of the project needs to
12 be extended;

13 (oo) Any draft reports or publications
14 supplied to the insurance commissioner
15 or the commissioner's designee shall
16 be considered confidential and exempt
17 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 will be cause for immediate recall by
22 the insurance commissioner or the



1 commissioner's designee of the data,
2 revocation of permission to use the
3 data, and grounds for civil or
4 administrative enforcement action by
5 the insurance commissioner under
6 application of state law and rules;

7 (iii) The insurance commissioner shall establish a
8 claims data release advisory committee with
9 a chair person and members appointed
10 annually by the commissioner, to provide
11 non-binding advice and opinions to the
12 commissioner and the insurance division's
13 designee, if any, as and when requested, on
14 the merits of the applications for access to
15 limited use data sets. If the commissioner
16 or the designee has requested a review of
17 the application, the claims data release
18 advisory committee shall provide the
19 commissioner and the designee, if any, with
20 any comment on the merit of the application
21 and the research protocol described therein
22 within thirty days. The committee shall



1 comprise of seven members and shall include
2 at least one member representing health
3 insurers; at least one member representing
4 health care facilities; at least one member
5 representing health care providers; at least
6 one member representing purchasers of health
7 insurance or health benefits; and at least
8 one member representing healthcare
9 researchers;

10 (B) The commissioner or the insurance division's
11 designee may approve the release of limited use
12 data sets only when satisfied that:

13 (i) The application submitted is complete and
14 the requesting individuals or entities and
15 principal investigator have signed a data
16 use agreement as specified;

17 (ii) Procedures to ensure the confidentiality of
18 any patient and any confidential data are
19 documented;

20 (iii) The qualifications of the principal
21 investigator and research staff are
22 legitimate, as evidenced by training and



1 previous research, including prior
2 publications, and an affiliation with a
3 university, private research organization,
4 medical center, state agency, or other
5 qualified entity; and

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

9 (C) If the designee declines to release the requested
10 limited use data sets within sixty days of the
11 receipt of a complete application the designee
12 shall give written notice of the basis for denial
13 of the application and the requestor shall have
14 leave to resubmit or supplement the application
15 to address the designee's concerns. The
16 requestor may resubmit the application to the
17 designee or to the commissioner. Any application
18 resubmitted to the designee resulting in an
19 adverse decision may be appealed within thirty
20 days by filing a request for hearing with the
21 commissioner pursuant to chapter 91;



1 (D) If the commissioner declines to release the
2 requested limited use data sets within sixty days
3 of the receipt of a complete application, the
4 insurance division shall give written notice of
5 the basis for denial of the application and the
6 requestor shall have leave to resubmit or
7 supplement the application to address the
8 commissioner's concerns. Any adverse decision
9 regarding an application may be appealed within
10 thirty days by filing a request for hearing with
11 the commissioner pursuant to chapter 91; and

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

18 **§431:10A-G Prices for data sets; fees for programming and**
19 **report generation; duplication rates.** (a) An annual public use
20 file consisting of unrestricted fields and data elements shall
21 be made available to any person upon request at the cost
22 required for the insurance division or its designee to process,



1 package, and ship the data set, including any electronic medium
2 used to store the data.

3 (b) Limited use research health care claims data sets
4 approved by the insurance commissioner or the commissioner's
5 designee shall be made available to the requesting party at the
6 cost charged by the insurance division's designated vendor to
7 program and process the requested data extract, including any
8 consulting services and costs to package and ship the data set
9 on a particular electronic medium.

10 (c) Payments are due in full from the requesting party
11 within thirty days of receipt of health care claims data sets,
12 files, reports, or other released material.

13 **§431:10A-H Healthcare claims fees.** A fee of two cents per
14 claim shall be charged for every claim submitted under this part
15 to be paid to the insurance division or its designee.

16 **§431:10A-I Enforcement.** (a) If any health insurer fails
17 to submit medical claims data to the insurance commissioner or
18 the commissioner's designee on a timely basis, or fails to
19 correct submissions rejected because of excessive errors, the
20 insurance commissioner or the commissioner's designee shall
21 provide written notice to the health insurer. If the health
22 insurer fails, without just cause as determined by the



1 commissioner, to provide the required information within two
2 weeks following receipt of the written notice, the health
3 insurer shall pay a penalty of not less than \$1,000 and not more
4 than \$10,000 for each week of delay.

5 (b) Violations of data submission requirements,
6 confidentiality requirements, data use limitations, fee
7 provisions, or any other provisions of this part shall be
8 subject to an administrative penalty of not more than \$1,000 per
9 inadvertent violation and not more than \$10,000 per violation
10 that the commissioner finds was wilful. In addition, any person
11 or entity that fails to comply with the confidentiality
12 requirements of this part or confidentiality rules adopted
13 pursuant to this part and uses, sells, or transfers the data or
14 information for commercial advantage, pecuniary gain, personal
15 gain, or malicious harm shall be subject to an administrative
16 penalty of not more than \$50,000 per violation.

17 (c) The powers vested in the commissioner by this section
18 shall be in addition to any other powers to enforce any
19 penalties, fines, or forfeitures authorized by law.

20 §431:10A-J Hawaii healthcare claims special fund. (a)
21 There is established a Hawaii healthcare claims special fund
22 within the treasury of the State into which shall be deposited:



1 (1) All healthcare claims fees established pursuant to
2 431:10A-H.

3 (2) All monetary penalties collected pursuant to section
4 431:10A-I.

5 (3) Any other proceeds derived from the publication and
6 use of health claims data sets.

7 All interest accrued by the revenues of the fund shall become
8 part of the fund.

9 (b) Moneys in the Hawaii healthcare claims special fund
10 shall be used by the commissioner to operate and improve the
11 Hawaii healthcare claims uniform reporting and evaluation
12 system. Expenditures from the Hawaii healthcare claims special
13 fund shall be made by the commissioner.

14 **§431:10A-K Annual report.** The department of commerce and
15 consumer affairs shall submit a complete and detailed report of
16 its activities and expenditures to the legislature at least
17 twenty days prior to the convening of each regular session of
18 the legislature.

19 **§431:10A-L Rules.** The department of commerce and consumer
20 protection shall adopt, modify, and repeal rules of general
21 application as may be necessary to carry into effect this part.



1 **§431:10A-M Severability.** If any provision of this part or
2 the rules adopted for the application of this part are held to
3 be invalid with the federal Health Insurance Portability and
4 Accountability Act of 1996 or for any other reason, the
5 remainder of the law or rule and the application of such
6 provisions to other persons or circumstances shall not be
7 affected."

8 SECTION 2. In codifying the new sections added by
9 section 1 of this Act, the revisor of statutes shall substitute
10 appropriate section numbers for the letters used in designating
11 the new sections in this Act.

12 SECTION 3. This Act does not affect rights and duties that
13 matured, penalties that were incurred, and proceedings that were
14 begun, before its effective date.

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

16

INTRODUCED BY: Amid Y. Jaz



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.

