THE SENATE
TWENTY-FIFTH LEGISLATURE, 2010
STATE OF HAWAII

S.B. NO. 2529 S.D. 1

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.

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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

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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

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

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

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

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

cardiac catheterization laboratories, radiation therapy facilities, or any inpatient or ambulatory surgical, diagnostic, or treatment center.

"Health care provider" means a person, partnership, corporation, facility, or institution licensed, certified, or authorized by law to provide professional health care services in the State to an individual during that individual's medical care, treatment, or confinement.

"Health claims data" means information consisting of or derived directly from member eligibility files, medical claims files, pharmacy claims files, encounters and other related data pursuant to the Hawaii healthcare claims uniform reporting and evaluation system in effect at the time of the data submission. "Healthcare claims data" does not include analysis, reports, or studies containing information from health care claims data sets if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by the insurance commissioner or its designee. "Health claims data" includes claims, encounter data, or substantially similar payment vehicles from insurers and health maintenance organizations.

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"Health information" means any information whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

"Health insurance" shall have the same meaning as accident and health or sickness insurance as defined in section 431:1-205.

"Indirect personal identifiers" means information relating to an individual patient, member, or enrollee that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render the information individually identifiable by using the information alone or in combination with other reasonably available information.

"Insurance division" means that division of the department of commerce and consumer affairs that oversees the Hawaii insurance industry.

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"Mandated reporter" or "reporter" means a health insurer as defined herein with two hundred or more enrolled or covered members in each month during a calendar year, including both Hawaii residents and any non-residents receiving covered services provided by Hawaii health care providers and facilities.

"Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including but not limited to member demographics, provider information, care and payment information, and clinical diagnosis and procedure codes, and shall include all claims related to behavioral or mental health.

"Member" means the insured subscriber and any spouse or dependent covered by the subscriber's policy.

"Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

"Patient" means any person in the data set that is the subject of the activities of the claim performed by the health care provider.

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

"Pharmacy benefit manager" means a person or entity that performs pharmacy benefit management. The term includes a person or entity in a contractual or employment relationship with an entity performing pharmacy benefit management for a health plan.

"Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including but not limited to: member demographics; provider information; charge and payment information; and national drug codes.

"Prepaid amount" means the fee for the service equivalent that would have been paid for a specific service if the service had not been capitated.

"Principal investigator" means the person in charge of a project that makes use of limited use research health care claims data sets. The principal investigator is the custodian of the data and is responsible for compliance with all restrictions, limitations, and conditions of use associated with the data release.

"Public use data set" means a publically available data set containing only the public use data elements specified in this part as unrestricted data elements.

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1 "Subscriber" means the individual responsible for payment
2 of premiums or whose employment is the basis for eligibility for
3 membership in a health benefit plan.
4 "Third party administrator" means any person who, on behalf
5 of a health insurer or purchaser of health benefits, receives or
6 collects charges, contributions, or premiums for, or adjusts or
7 settles claims on or for residents of this State or Hawaii
8 health care providers and facilities.
9 "Voluntary reporter" includes any entity other than a
10 mandated reporter, including any health benefit plan offered or
11 administered by or on behalf of the federal government where the
12 plan, with the agreement of the federal government, voluntarily
13 submits data to the insurance commissioner or the commissioner's
14 designee for inclusion in the database on such terms as may be
15 appropriate.
16 **§431:10A-B Registration and reporting requirements for**
17 **healthcare claims forms.** (a) On an annual basis on or before
18 March 1 of each year, each health insurer doing business in the
19 State shall register with the insurance commissioner or the
20 commissioner's designee and shall identify whether health care
21 claims are being paid for members who are Hawaii residents and
22 whether health care claims are being paid for non-residents

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1 receiving covered services from Hawaii health care providers or
2 facilities. Where applicable, the completed form shall identify
3 the types of files to be submitted pursuant to section
4 431:10A-C. This form shall be submitted to the insurance
5 commissioner or the commissioner's designee.
6 (b) Any person or entity that provides third party
7 administration services in the State shall register with the
8 insurance commissioner or the commissioner's designee prior to
9 March 1, 2011, and on an annual basis thereafter.
10 (c) Any person or entity that performs pharmacy benefit
11 management in the State shall register with the insurance
12 commissioner or the commissioner's designee prior to March 1,
13 2011, and on an annual basis thereafter.
14 (d) Any health insurer shall regularly submit medical
15 claims data, pharmacy claims data, provider data, and other
16 information relating to health care provided to Hawaii residents
17 and health care provided by Hawaii health care providers and
18 facilities to both Hawaii residents and non-residents to the
19 insurance commissioner or the commissioner's designee for each
20 health line of business including but not limited to
21 comprehensive major medical, TPA/ASO, medicare supplemental,
22 medicare part C, and medicare part D.

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

1 submitted shall also include supporting definition files for
2 payer specific provider specialty taxonomy codes and procedure
3 or diagnosis codes.
4 (b) General requirements for data submission shall be as
5 follows:
6 (1) Adjustment records shall be reported with the
7 appropriate positive or negative fields with the
8 medical and pharmacy claims file submissions.
9 Negative values shall contain the negative sign before
10 the value. No sign shall appear before a positive
11 value;
12 (2) All claims related to behavioral or mental health
13 shall be included in the medical claims file;
14 (3) Claims for capitated services shall be reported with
15 all medical and pharmacy claims file submissions;
16 (4) Records for the medical and pharmacy claims file
17 submissions shall be reported at the visit, service,
18 or prescription level. The submission of the medical
19 and pharmacy claims is based upon the paid dates and
20 not upon the dates of service associated with the
21 claims;

1 (5) Unless otherwise specified in this part, code sources
2 shall be issued by the insurance commissioner or the
3 commissioner's designee and shall be utilized in
4 association with the member eligibility file and
5 medical and pharmacy claims file submissions;
6 (6) Reporters shall assign to each of their members a
7 unique identification code that is the member's social
8 security number:
9 (A) If a reporter does not collect the social
10 security numbers for all members, the reporter
11 shall use the social security number of the
12 subscriber and then assign a discrete two-digit
13 suffix for each member under the subscriber's
14 contract;
15 (B) If a reporter does not collect the social
16 security number for a subscriber, a version of
17 the subscriber's certificate or contract number
18 shall be used in its place. The discrete two-
19 digit suffix shall also be used with the
20 certificate or contract number. The certificate
21 or contract number with the two-digit suffix

1 shall be at least eleven but not more than sixty-
2 four characters in length;
3 (C) The social security number of the member or
4 subscriber and the subscriber and member names
5 shall be encrypted prior to submission by the
6 reporter utilizing a standard encryption
7 methodology provided by the insurance
8 commissioner or the commissioner's designee. The
9 unique member identification code assigned by
10 each reporter shall remain with each member or
11 subscriber for the entire period of coverage for
12 that individual; and
13 (D) With the exception of provider, provider
14 specialty, and procedure and diagnosis codes,
15 specific or unique coding systems shall not be
16 permitted as part of the health care claims data
17 set submission;
18 (7) Co-insurance and co-payment are to be reported in two
19 separate fields in the medical and pharmacy claims
20 file submissions;

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1 (8) Claims where multiple parties have financial
2 responsibility shall be included with all medical and
3 pharmacy claims file submissions;
4 (9) Denied claims shall be excluded from all medical and
5 pharmacy claims file submissions. When a claim
6 contains both fully processed and paid service lines
7 and partially processed or denied service lines, only
8 the fully processed and paid service lines shall be
9 included as part of the health care claims data set
10 submittal;
11 (10) Records for the member eligibility file submission
12 shall be reported at the individual member level with
13 one record submitted for each claim type. If a member
14 is covered as both a subscriber and a dependent on two
15 different policies during the same month, two records
16 must be submitted. If a member has two contract
17 numbers for two different coverage types, two member
18 eligibility records shall be submitted;
19 (11) Exceptions to this section shall include but are not
20 limited to:
21 (A) All claims related to services provided under
22 stand-alone health care policies shall be

excluded if the services are not covered by comprehensive medical insurance policies and are provided on a stand-alone basis for specific disease, accident, injury, hospital indemnity, disability, long-term care, student liability, vision coverage, or durable medical equipment;

(B) Claims for pharmacy services containing national drug codes are to be included in the pharmacy claims file but excluded from the medical claims file; and

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

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

(13) Each member eligibility file and each medical and pharmacy claims file submission shall contain a header record and a trailer record. The header record is the

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1 first record of each separate file submission and the
2 trailer record is the last. The header and trailer
3 record formats shall be issued by the insurance
4 commissioner or the commissioner's designee;
5 (14) Claims for pharmacy services shall be included in the
6 following files:
7 (A) If the pharmacy claims are covered under the
8 medical benefit then the claim shall be included
9 in the medical claims file and not the pharmacy
10 claims file; and
11 (B) If the claim is covered under the prescription
12 benefit then the claim shall be included in the
13 pharmacy claims file;
14 (15) Any prepaid amounts are to be reported in a separate
15 field in the medical and pharmacy claims file
16 submissions; and
17 (16) Claims related to supplemental health insurance are to
18 be included if the policies are for health care
19 services entirely excluded by the medicare, tricare,
20 or other publicly funded health benefit programs.
21 (c) Detailed field specifications are as follows:

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

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

(3) Positive values are assumed and need not be indicated as such. Negative values shall be indicated with a minus sign and shall appear in the left-most position of all integer and decimal fields. Over-punched signed integers or decimals are not to be used; and

(4) Individual data elements, data types, field lengths, field description/code assignments, and mapping locaters for each file shall be detailed according to instructions from the insurance commissioner or the commissioner's designee.

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

1 (b) The member eligibility file, medical claims file, and
2 pharmacy claims file shall be submitted to the insurance
3 commissioner or the commissioner's designee as separate files in
4 a format to be decided by the insurance commissioner or the
5 commissioner's designee.
6 (c) Files shall be submitted utilizing media specified by
7 the insurance commissioner or the commissioner's designee.
8 (d) All file submissions on physical media shall be
9 accompanied by a hard copy transmittal sheet containing the
10 following information: identification of the reporter, file
11 name, type of file, data periods, date sent, record counts for
12 the files, and a contact person with telephone number and
13 electronic mail address. The information on the transmittal
14 sheet shall match the information on the header and trailer
15 records.
16 (e) At least sixty days prior to the initial submission of
17 the files or whenever the data element content of the files as
18 described in section 431:10A-C is subsequently altered, each
19 reporter shall submit to the insurance commissioner or the
20 commissioner's designee a data set for comparison to the
21 standards listed in section 431:10A-E. The size, based upon a
22 calendar period of one month, quarter, or year, of the data

files submitted shall correspond to the filing period established for each reporter under subsection (i) of this section.

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

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

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

(i) The reporting period for submission of each specified file listed in section 431:10A-C shall be determined on a

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1 separate basis for Hawaii members and non-resident members by
2 the highest total number of Hawaii resident members or non-
3 resident members receiving covered services provided by Hawaii
4 providers or facilities for which claims are being paid for any
5 one month of the calendar year. Data files are to be submitted
6 in accordance with the following schedule:
7

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	

8
9 If the data files submitted by an individual reporter support or
10 are related to the files submitted by another reporter, the

1 insurance commissioner or the commissioner's designee shall
2 establish a filing period for the parties involved.
3 **§431:10A-E Compliance with data standards.** (a) The
4 insurance commissioner or the commissioner's designee shall
5 evaluate each member eligibility file, medical claims file, and
6 pharmacy claims file in accordance with the following standards:
7 (1) The applicable code for each data element shall be as
8 specified by the insurance commissioner or the
9 commissioner's designee and shall be included within
10 eligible values for the element;
11 (2) Coding values indicating "data not available", "data
12 unknown", or the equivalent shall not be used for
13 individual data elements unless specified as an
14 eligible value for the element;
15 (3) Member sex, diagnosis and procedure codes, date of
16 birth, and all other date fields shall be consistent
17 within an individual record;
18 (4) Member identifiers shall be consistent across files;
19 and
20 (5) Files submitted shall not contain direct personal
21 identifies.

(b) Upon completion of this evaluation, the insurance commissioner or the commissioner's designee will promptly notify each reporter whose data submissions do not satisfy the standards for any reporting period. This notification will identify the specific file and the data elements that are determined to be unsatisfactory.

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

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

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

1 (A) Unrestricted data elements collected or generated
2 by the insurance division or its designee shall
3 be made available in public use files and
4 provided to any person upon written request,
5 except where otherwise prohibited by law;
6 (B) The insurance division or its designee shall
7 maintain a public record of all requests for and
8 releases of public use data sets;
9 (2) Data elements designated by the insurance division as
10 "restricted" shall not be available for use outside
11 the insurance division other than by their designee
12 except as part of a limited use research health care
13 claims data set approved by the commissioner or the
14 insurance division designee pursuant to the
15 requirements of this part:
16 (A) Limited use health care claims research data sets
17 shall be those sets which contain restricted data
18 elements, shall not be available to the general
19 public, and shall be released to a requestor only
20 for the purpose of research upon a determination
21 by the commissioner or the insurance division's

designee that the following conditions have been met:

(i) Any person requesting access to or use of limited use health care claims research data sets has submitted an application, in written and electronic form, to the commissioner or the insurance division designee including:

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

(bb) The identity of the person requesting access, with name, address, telephone number, any entities for whom that person is acting in requesting the data, organizational affiliation, professional qualifications, and name

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

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

1 approval of the commissioner or the
2 insurance division's designee:
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 or the
13 insurance division's designee shall be
14 prohibited;
15 (bb) Appropriate safeguards to protect the
16 confidentiality of the data and
17 prevent unauthorized use of the data
18 shall be established;
19 (cc) The use, disclosure, sale, or
20 dissemination of the data set or
21 statistical tabulations derived from
22 the data set to any person or

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1 organization for any purpose other
2 than as described in the application
3 and as permitted by the data use
4 agreement shall be prohibited without
5 the express written consent of the
6 commissioner;
7 (dd) The use, disclosure, sale, or
8 dissemination of any information
9 contrary to law shall be prohibited;
10 (ee) No person shall disclose the identity
11 of patients, employer groups, or
12 purchaser groups from information
13 contained in the limited use data set;
14 (ff) No person shall disclose any of the
15 information that has been encrypted or
16 removed from the data;
17 (gg) The content of cells that contain
18 counts of persons in statistical
19 tables in which the cell size is more
20 than zero and less than five shall not
21 be disclosed, published or made public
22 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 any other
8 provisions of this part shall be
9 reported to the insurance commissioner
10 and the commissioner's designee, if
11 any, within five days of when the
12 principal investigator becomes aware
13 of such disclosure;
14 (jj) The insurance commissioner and the
15 Hawaii healthcare claims uniform
16 reporting and evaluation system shall
17 be acknowledged as the source and
18 owner of the data in any and all
19 public reports, publications, or
20 presentations generated from the data;
21 (kk) Written materials shall prominently
22 state that the analysis, conclusions,

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

provided to the insurance commissioner or the commissioner's designee prior to release by the requesting party;

(mm) Data elements shall not be retained for any period of time beyond that necessary to fulfill the requirements of the data request;

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

(oo) Any draft reports or publications supplied to the insurance commissioner or the commissioner's designee shall be considered confidential and exempt from public review;

1 (pp) Failure to adhere to the data use
2 agreement or the limitations and
3 restrictions detailed in this section
4 will be cause for immediate recall by
5 the insurance commissioner or the
6 commissioner's designee of the data,
7 revocation of permission to use the
8 data, and grounds for civil or
9 administrative enforcement action by
10 the insurance commissioner under
11 application of state law and rules;
12 (iii) The insurance commissioner shall establish a
13 claims data release advisory committee with
14 a chair person and members appointed
15 annually by the commissioner, to provide
16 non-binding advice and opinions to the
17 commissioner and the insurance division's
18 designee, if any, as and when requested, on
19 the merits of the applications for access to
20 limited use data sets. If the commissioner
21 or the designee has requested a review of
22 the application, the claims data release

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1 advisory committee shall provide the
2 commissioner and the designee, if any, with
3 any comment on the merit of the application
4 and the research protocol described therein
5 within thirty days. The committee shall
6 comprise of seven members and shall include
7 at least one member representing health
8 insurers; at least one member representing
9 health care facilities; at least one member
10 representing health care providers; at least
11 one member representing purchasers of health
12 insurance or health benefits; and at least
13 one member representing healthcare
14 researchers;
15 (B) The commissioner or the insurance division's
16 designee may approve the release of limited use
17 data sets only when satisfied that:
18 (i) The application submitted is complete and
19 the requesting individuals or entities and
20 principal investigator have signed a data
21 use agreement as specified;

1 (ii) Procedures to ensure the confidentiality of
2 any patient and any confidential data are
3 documented;
4 (iii) The qualifications of the principal
5 investigator and research staff are
6 legitimate, as evidenced by training and
7 previous research, including prior
8 publications, and an affiliation with a
9 university, private research organization,
10 medical center, state agency, or other
11 qualified entity; and
12 (iv) No other state or federal law, rule, or
13 regulation prohibits release of the
14 requested information;
15 (C) If the designee declines to release the requested
16 limited use data sets within sixty days of the
17 receipt of a complete application the designee
18 shall give written notice of the basis for denial
19 of the application and the requestor shall have
20 leave to resubmit or supplement the application
21 to address the designee's concerns. The
22 requestor may resubmit the application to the

1 designee or to the commissioner. Any application
2 resubmitted to the designee resulting in an
3 adverse decision may be appealed within thirty
4 days by filing a request for hearing with the
5 commissioner pursuant to chapter 91;
6 (D) If the commissioner declines to release the
7 requested limited use data sets within sixty days
8 of the receipt of a complete application, the
9 insurance division shall give written notice of
10 the basis for denial of the application and the
11 requestor shall have leave to resubmit or
12 supplement the application to address the
13 commissioner's concerns. Any adverse decision
14 regarding an application may be appealed within
15 thirty days by filing a request for hearing with
16 the commissioner pursuant to chapter 91; and
17 (3) Data elements that are not designated by the insurance
18 commissioner as either unrestricted or restricted, or
19 are designated as "unavailable", shall not be
20 available for release or use outside the insurance
21 division or its designee in any data set or disclosed
22 in publicly released report in any circumstance.

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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 or its designee to process,
6 package, and ship the data set, including any electronic medium
7 used to store the data.
8 (b) Limited use research health care claims data sets
9 approved by the insurance commissioner or the commissioner's
10 designee shall be made available to the requesting party at the
11 cost charged by the insurance division's designated vendor to
12 program and process the requested data extract, including any
13 consulting services and costs to package and ship the data set
14 on a particular electronic medium.
15 (c) Payments are due in full from the requesting party
16 within thirty days of receipt of health care claims data sets,
17 files, reports, or other released material.
18 **§431:10A-H Healthcare claims fees.** A fee of two cents per
19 covered life shall be charged for every claim submitted under
20 this part 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 or

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

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

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

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

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

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

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

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

§431:10A-K Annual report. The department of commerce and consumer affairs shall submit a complete and detailed report of its activities and expenditures to the legislature at least

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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 the rules adopted for the application of this part are held to
8 be 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. (a) There is established a healthcare claims
14 uniform reporting and evaluation task force within the
15 department of commerce and consumer affairs for administrative
16 purposes, to consist of eleven members as follows:
17 (1) Six representatives from leading insurers, mutual
18 benefit societies, fraternal benefit societies, and
19 health maintenance organizations servicing Hawaii
20 residents, to be appointed by the insurance
21 commissioner;

1 (2) The insurance commissioner or the commissioner's
2 designee;
3 (3) The director of commerce and consumer affairs or the
4 director's designee;
5 (4) Two physicians licensed and practicing in the State;
6 and
7 (5) A representative from the John A. Burns school of
8 medicine.
9 (b) The members of the healthcare claims uniform reporting
10 and evaluation task force shall elect a chairperson from among
11 their membership.
12 (c) The healthcare claims uniform reporting and evaluation
13 task force shall review the policies and procedures of the
14 healthcare claims uniform reporting and evaluation system and
15 make recommendations to improve it and to make it consistent
16 with national claims reporting and evaluation standards.
17 (d) Members of the healthcare claims uniform reporting and
18 evaluation task force shall serve without compensation and shall
19 not be reimbursed for expenses.
20 (e) The healthcare claims uniform reporting and evaluation
21 task force shall submit a report of its findings and
22 recommendations, including any proposed legislation, to the

1 legislature no later than twenty days prior to the convening of
2 the regular session of 2011.
3 (f) The healthcare claims uniform reporting and evaluation
4 task force shall cease to exist on June 30, 2011.
5 SECTION 3. In codifying the new sections added by section
6 1 of this Act, the revisor of statutes shall substitute
7 appropriate section numbers for the letters used in designating
8 the new sections in this Act.
9 SECTION 4. This Act does not affect rights and duties that
10 matured, penalties that were incurred, and proceedings that were
11 begun, before its effective date.
12 SECTION 5. (a) The specific uniform healthcare claims
13 reporting and evaluation methods detailed in section 1 of this
14 Act shall be repealed upon the same, corresponding, or
15 duplicative standard being adopted, amended, or repealed by
16 rules adopted as part of a national healthcare claims evaluation
17 and reporting system that no less than twenty states
18 participate in. At that time, any provision in part
19 established pursuant to section 1 of this Act that is
20 inconsistent with that national system shall be superseded upon
21 approval by the insurance commissioner.

1 (b) Provisions of this Act not made inconsistent or
2 duplicative by the national system shall remain in effect.
3 SECTION 6. This Act shall take effect upon approval.
4

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; establishes a healthcare claims uniform reporting and evaluation task force to review the policies and procedures of the healthcare claims uniform reporting and evaluation system. (SD1)

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