THE SENATE
TWENTY-FIFTH LEGISLATURE, 2010
STATE OF HAWAII

S.B. NO. 2530

JAN 22 2010

A BILL FOR AN ACT

RELATING TO HEALTHCARE CLAIMS.

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

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

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

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

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

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

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

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

"Commissioner" or "insurance commissioner" means the insurance commissioner of the State of Hawaii as defined in section 431:2-102.

"Co-payment" means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

"Data set" means a collection of individual data records, whether in electronic or manual files.

"Deductible" means the total dollar amount a member pays towards the cost of covered services over an established period of time before the contracted third-party payer makes any payments.

"Designee" means an entity with which the insurance commissioner has entered into an arrangement pursuant to chapter 103D, in which the entity performs data management, data collection, and administrative functions and under which the entity is strictly prohibited from using or releasing the information and data obtained in that capacity for any purposes other than those specified in the agreement.

"Direct personal identifiers" means information relating to an individual patient, member, or enrollee that contains primary or obvious identifiers, including but not limited to:

(1) Names;

(2) Business names when that name would serve to identify a person;

(3) Postal address information other than town or city, state, and five-digit zip code;

(4) Specific latitude and longitude or other geographic information that would be used to derive a postal address;

(5) Telephone and fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Vehicle identifiers and serial numbers, including but not limited to license plate numbers;

(9) Medical record numbers;

(10) Health plan beneficiary numbers;

(11) Certificate and license numbers;

(12) Internet protocol addresses and uniform resource locators that identify a business that would serve to identify a person; and

(13) Personal photographic images.

"Disclosure" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

"Encrypted identifiers" means a code or other means of record identification to allow patients, members, or enrollees to be tracked across the data set without revealing their identity. Encrypted identifiers are not direct identifiers.

"Encryption" means a method by which the true value of data has been disguised to prevent the identification of persons or groups, and which does not provide the means for recovering the true value of the data.

"Health benefit plan" means a policy, contract, certificate, or agreement entered into or offered by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care" means care, services, or supplies related to the health of an individual. It includes but is not limited to preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that

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, 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.

"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.

"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.

"Payer" means a third-party payer or third-party administrator.

"Payment" means the actual dollar amount paid for a claim by a health insurer.

"Personal identifiers" means information relating to an individual that contains direct or indirect identifiers to which a reasonable basis exists to believe that the information can be used to identify an individual.

"Pharmacy benefit management" means an arrangement for the procurement of prescription drugs at a negotiated rate for dispensation within this State to beneficiaries, the administration or management of prescription drug benefits provided by a health plan for the benefit of beneficiaries, or any of the following services provided with regard to the administration of pharmacy benefits: mail service pharmacy; claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries; clinical formulary development and management services; rebate contracting and administration; certain patient compliance, therapeutic intervention, and generic substitution 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.

"Subscriber" means the individual responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health benefit plan.

"Third party administrator" means any person who, on behalf of a health insurer or purchaser of health benefits, receives or

collects charges, contributions, or premiums for, or adjusts or settles claims on or for residents of this State or Hawaii health care providers and facilities.

"Voluntary reporter" includes any entity other than a mandated reporter, including any health benefit plan offered or administered by or on behalf of the federal government where the plan, with the agreement of the federal government, voluntarily submits data to the insurance commissioner for inclusion in the database on terms as may be appropriate.

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

(b) Any person or entity that provides third party administration services in the State shall register with the

insurance commissioner prior to March 1, 2011, and on an annual basis thereafter.

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

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

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

providers to both Hawaii residents and non-residents to the insurance commissioner.

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

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

(1) Adjustment records shall be reported with the appropriate positive or negative fields with the

medical and pharmacy claims file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value;

(2) All claims related to behavioral or mental health shall be included in the medical claims file;

(3) Claims for capitated services shall be reported with all medical and pharmacy claims file submissions;

(4) Records for the medical and pharmacy claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical and pharmacy claims is based upon the paid dates and not upon the dates of service associated with the claims;

(5) Unless otherwise specified in this part, code sources shall be issued by the insurance commissioner and shall be utilized in association with the member eligibility file and medical and pharmacy claims file submissions;

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

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

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

(C) The social security number of the member or subscriber and the subscriber and member names shall be encrypted prior to submission by the reporter utilizing a standard encryption methodology provided by the insurance commissioner. The unique member identification code assigned by each reporter shall remain with

each member or subscriber for the entire period of coverage for that individual; and

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

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

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

(9) Denied claims shall be excluded from all medical and pharmacy claims file submissions. When a claim contains both fully processed and paid service lines and partially processed or denied service lines, only the fully processed and paid service lines shall be included as part of the health care claims data set submittal;

(10) Records for the member eligibility file submission shall be reported at the individual member level with

one record submitted for each claim type. If a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has two contract numbers for two different coverage types, two member eligibility records shall be submitted;

(11) Exceptions to this section shall include but are not limited to:

(A) All claims related to services provided under 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 first record of each separate file submission and the trailer record is the last. The header and trailer record formats shall be issued by the insurance commissioner;

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

(A) If the pharmacy claims are covered under the medical benefit then the claim shall be included in the medical claims file and not the pharmacy claims file; and

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

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

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

(c) Detailed field specifications are as follows:

(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 insurance commissioner instructions.

§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.

(b) The member eligibility file, medical claims file, and pharmacy claims file shall be submitted to the insurance commissioner as separate files in a format to be decided by the insurance commissioner.

(c) Files shall be submitted utilizing media specified by the insurance commissioner.

(d) All file submissions on physical media shall be accompanied by a hard copy transmittal sheet containing the following information: identification of the reporter, file name, type of file, data periods, date sent, record counts for the files, and a contact person with telephone number and

electronic mail address. The information on the transmittal sheet shall match the information on the header and trailer records.

(e) At least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in section 431:10A-C is subsequently altered, each reporter shall submit to the insurance commissioner a data set for comparison to the standards listed in section 431:10A-E. The size, based upon a 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 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 separate basis for Hawaii members and non-resident members by the highest total number of Hawaii resident members or non-resident members receiving covered services provided by Hawaii providers or facilities for which claims are being paid for any one month of the calendar year. Data files are to be submitted in accordance with the following schedule:

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

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

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

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

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

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

(3) Member sex, diagnosis and procedure codes, date of birth, and all other date fields shall be consistent within an individual record;

(4) Member identifiers shall be consistent across files; and

(5) Files submitted shall not contain direct personal identifiers.

(b) Upon completion of this evaluation, the insurance commissioner shall 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 may have access to health care claims data sets and related information

received or generated by the insurance commissioner 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:

(A) Unrestricted data elements collected or generated by the insurance commissioner shall be made available in public use files and provided to any person upon written request, except where otherwise prohibited by law; and

(B) The insurance commissioner shall maintain a public record of all requests for and releases of public use data sets;

(2) Data elements designated by the insurance commissioner as "restricted" shall not be available for use outside the insurance division other than by persons designated by the commissioner, except as part of a limited use research health care claims data set approved by the commissioner pursuant to the requirements of this part:

(A) Limited use health care claims research data sets shall be those sets which contain restricted data elements, shall not be available to the general public, and shall be released to a requestor only for the purpose of research upon a determination by the commissioner 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 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 and telephone number of a contact person;

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

(dd) A detailed research protocol including a summary of background, purposes, and origin of the research; a statement of the health-related problem or issue to be addressed by the research; the research design and methodology, including either the topics of exploratory research or the specific research hypotheses to be tested; the procedures to maintain the confidentiality of any data or copies of records provided to the principal investigator or other persons; and the intended research completion date;

(ee) The particular data set requested, including the time period of the data requested; the specific data elements or fields of information required; a justification of the need for each restricted element or field, as identified in the data release schedule; the minimum needed specificity of the requested data elements, including the manner in which the data may be recoded by the insurance commissioner to be less specific; the selection criteria for the minimum needed data records required; and any particular format or layout of data requested by the principal investigator; and

(ff) Any changes to information submitted as part of an application pursuant to these clauses shall require notice to the insurance commissioner by the

applicant and shall be subject to the approval of the commissioner;

(ii) The person or entity requesting access and the principal investigator shall be subject to the following requirements and limitations and shall, in addition, sign and submit a data use agreement acknowledging and accepting these same provisions as a necessary condition to any data access:

(aa) Use of data for any purpose other than as specified in the application and approved by the commissioner shall be prohibited;

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

(cc) The use, disclosure, sale, or dissemination of the data set or statistical tabulations derived from the data set to any person or organization for any purpose other

than as described in the application and as permitted by the data use agreement shall be prohibited without the express written consent of the commissioner;

(dd) The use, disclosure, sale, or dissemination of any information contrary to law shall be prohibited;

(ee) No person shall disclose the identity of patients, employer groups, or purchaser groups from information contained in the limited use data set;

(ff) No person shall disclose any of the information that has been encrypted or removed from the data;

(gg) The content of cells that contain counts of persons in statistical tables in which the cell size is more than zero and less than five shall not be disclosed, published or made public in any manner except as "<5";

(hh) The publication, dissemination, or disclosure of any information that could be used to identify providers of abortion services shall be prohibited;

(ii) Any use or disclosure of the information that is contrary to the data use agreement or this part shall be reported to the insurance commissioner within five days of when the principal investigator becomes aware of the disclosure;

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

(kk) Written materials shall prominently state that the analysis, conclusions, and recommendations drawn from the data are solely those of the requestor

or principal investigator and are not necessarily those of the insurance commissioner;

(11) The insurance commissioner shall be provided with a copy of any proposed report or publication containing information derived from the data at least fifteen days prior to any publication or release to allow the insurance commissioner to review the proposed report or publication and confirm that the conditions of the agreement have been applied. When multiple reports of a similar nature will be created from the data, the insurance division may, on request, waive the requirement that any subsequent reports or publications be provided to the insurance commissioner 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 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 shall be considered confidential and exempt from public review;

(pp) Failure to adhere to the data use agreement or the limitations and restrictions detailed in this section shall be cause for immediate recall by the insurance commissioner of the

data, revocation of permission to use the data, and grounds for civil or administrative enforcement action by the insurance commissioner under application of state law and rules;

(iii) The insurance commissioner shall establish a claims data release advisory committee with a chair person and members appointed annually by the commissioner, to provide non-binding advice and opinions to the commissioner, as and when requested, on the merits of the applications for access to limited use data sets. If the commissioner has requested a review of the application, the claims data release advisory committee shall provide the commissioner with any comment on the merit of the application and the research protocol described therein within thirty days. The committee shall comprise of seven members and shall include at least one member representing health insurers; at least one member representing

health care facilities; at least one member representing health care providers; at least one member representing purchasers of health insurance or health benefits; and at least one member representing healthcare researchers;

(B) The commissioner may approve the release of limited use data sets only when the commissioner is satisfied that:

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

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

(iii) The qualifications of the principal investigator and research staff are legitimate, as evidenced by training and previous research, including prior publications, and an affiliation with a university, private research organization,

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

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

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

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

§431:10A-G Prices for data sets; fees for programming and report generation; duplication rates. (a) An annual public use file consisting of unrestricted fields and data elements shall be made available to any person upon request at the cost required for the insurance division to process, package, and ship the data set, including any electronic medium used to store the data.

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

(c) Payments are due in full from the requesting party within thirty days of receipt of insurance division data sets, files, reports, or other released material.

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

§431:10A-I Enforcement. (a) If any health insurer fails to submit medical claims data to the insurance commissioner on a

timely basis, or fails to correct submissions rejected because of excessive errors, the insurance commissioner shall provide written notice to the health insurer. If the health insurer fails, without just cause as determined by the commissioner, to provide the required information within two weeks following receipt of the written notice, the health insurer shall pay a penalty of not less than $1,000 and not more than $10,000 for each week of delay.

(b) Violations of data submission requirements, confidentiality requirements, data use limitations, fee provisions, or any other provisions of this part shall be subject to an administrative penalty of not more than $1,000 per inadvertent violation and not more than $10,000 per violation that the commissioner finds was wilful. In addition, any person or entity that fails to comply with the confidentiality requirements of this part or confidentiality rules adopted pursuant to this part and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative 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 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 section 431:10A-H;

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

(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

twenty days prior to the convening of each regular session of the legislature.

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

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

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

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

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

INTRODUCED BY: _____

S.B. NO. 2530

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.