"CHAPTER 432D
HEALTH MAINTENANCE ORGANIZATION ACT

Cross References

Assessments of health insurers, see §431:2-216.
Conformance to federal law, see §431:2-201.5.
Health care provider network adequacy, see chapter 432F.
Peer review, see §663-1.7.
Prescription drug benefits, see chapter 431R.
Prescription drugs; mail order opt out option, see §87A-16.3.

Attorney General Opinions

Section 431:10A-601 applied only to insurers, and not mutual benefit societies or health maintenance organizations. Att. Gen. Op. 97-5.

Case Notes

As this chapter does not cover the field of managed care regulation and because §§432D-2, 432E-1, and article 431:10A can be read together and there is no explicit language or policy reason not to give each statute effect, this chapter does not repeal chapter 432E by implication. 126 H. 326, 271 P.3d 621 (2012).

Properly licensed HMOs, like plaintiff, were authorized pursuant to §432D-1 to "provide or arrange", at their option, for the closed panel health care services required under the managed care plan program; accident and health insurers were authorized under §431:10A-205(b) to arrange for medical services for members using a defined network of providers, i.e., particular "hospitals or persons"; thus, article 431:10A and this chapter authorized both accident and health insurers and HMOs, as risk-bearing entities, to provide the closed panel product required by the managed care plan contracts. 126 H. 326, 271 P.3d 621 (2012).

" **§432D-1 Definitions.** For purposes of this chapter:

"Basic health care services" means the following medical services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory services, and diagnostic and therapeutic radiological services. It does not include mental health services, services for alcohol or drug abuse, dental or vision services, or long-term rehabilitation treatment, except as provided in chapter 431M.

"Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For

purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

"Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, a mutual benefit society, or other entity responsible for the payment of benefits or provision of services under a group contract.

"Commissioner" means the insurance commissioner.

"Copayment" means an amount an enrollee must pay to receive a specific service which is not fully prepaid.

"Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

"Enrollee" means an individual who is covered by a health maintenance organization.

"Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage that is given to the subscriber by the health maintenance organization or by the group contract holder.

"Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.

"Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

"Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

"Group contract holder" means the person to which a group contract has been issued.

"Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments, deductibles, or both.

"Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

"Insolvent" or "insolvency" means that the health maintenance organization has been declared insolvent and placed under an order of supervision, rehabilitation, or liquidation by a court of competent jurisdiction.

"Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

"Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

"Participating provider" means a provider as defined in this section, who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

"Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.

"Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

"Replacement coverage" means the benefits provided by a succeeding carrier.

"Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

"Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency, and for which no alternative arrangements have been made that are acceptable to the commissioner. Uncovered expenditures include but are not limited to out-of-area services, referral services, and hospital services. Uncovered expenditures do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization. [L 1995, c 179, pt of §1; am L 2014, c 186, §15]

Case Notes

Reading this section in pari materia with §432D-8, the Hawaii legislature did not intend to eliminate the enforcement of an implied contract between a participating provider and a health maintenance organization. To hold that only written contracts are valid would render the "implied contract" phrase in this section [definition of "participating provider"] meaningless

because §432-8 would bar the enforcement of such an implied contract. 948 F. Supp. 2d 1131 (2013).

Properly licensed HMOs, like plaintiff, were authorized pursuant to this section to "provide or arrange", at their option, for the closed panel health care services required under the managed care plan program; accident and health insurers were authorized under §431:10A-205(b) to arrange for medical services for members using a defined network of providers, i.e., particular "hospitals or persons"; thus, article 431:10A and chapter 432D authorized both accident and health insurers and HMOs, as risk-bearing entities, to provide the closed panel product required by the managed care plan contracts. 126 H. 326, 271 P.3d 621 (2012).

" **[§432D-1.5] Bona fide trade associations.** (a) At the option of a bona fide trade association, or its designated agent, a health maintenance organization that sells health insurance to the bona fide trade association shall treat the bona fide trade association and its members as a group for the purpose of issuing a group contract; provided that:

(1) The bona fide trade association shall have been formed for purposes other than obtaining insurance;

(2) The health maintenance organization shall be prohibited from restricting, in any manner, the number or types of health plans issued by another insurance entity that the bona fide trade association may offer to its members, including but not limited to such restrictions as clauses that reduce competition between insurers or clauses that require a bona fide trade association to allow an insurer to match the price or terms offered by another insurer; and

(3) Each member of the bona fide trade association shall not be required to be insured under the group policy;

and provided further that this section shall be inapplicable if less than two persons from the bona fide trade association seek to be insured under the group policy.

(b) As used in this section:

"Bona fide trade association" means an association of persons organized to promote common interests and comprised of persons engaged in a business, trade, or profession that:

(1) Has been actively in existence for five years;

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) Does not condition membership in the association on any health status related factor pertaining to an

individual (including an employee of an employer or a dependent of an employee);

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status related factor pertaining to such members (or individuals eligible for coverage through a member);

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(6) Meets such additional requirements as may be imposed under state law. [L 2004, c 118, §§3, 5; am L 2006, c 41, §2]

" **[§432D-2] Establishment of health maintenance organizations.** (a) Any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. No person shall establish or operate a health maintenance organization in this State without obtaining a certificate of authority under this chapter. A foreign corporation may qualify under this chapter, subject to its registration to do business in this State in compliance with all provisions of this chapter and other applicable state laws.

(b) Any health maintenance organization which has not previously received a certificate of authority to operate as a health maintenance organization as of January 1, 1996, shall submit an application for a certificate of authority under subsection (c) within one-hundred-eighty days of January 1, 1996. Each applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied under this chapter, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, official positions, and biographical information on forms acceptable to the commissioner of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association;

(4) A copy of any contract form made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third party administrators, marketing consultants, or persons listed in paragraph (3) and the health maintenance organization;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support, and both a copy of the applicant's most recent certified financial statement and an unaudited current financial statement;

(8) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments, deposits with the State, income and expense statements anticipated from the start of operations until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

(9) A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the commissioner and the commissioner's successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance

organization on a cause of action arising in this State may be served;

(10) A statement or map reasonably describing the geographic area or areas to be served;

(11) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection against insolvency requirements in section 432D-8;

(14) A list of the names, addresses, and license numbers of all providers or groups of providers with which the health maintenance organization has agreements; and

(15) Such other information as the commissioner may require.

(d) If the commissioner finds that the applicant has met the requirements for and is fully entitled thereto under the applicable insurance laws, the commissioner shall issue an appropriate certificate of authority to the applicant. If the commissioner does not so find, the commissioner shall deny the applicant the certificate of authority within a reasonable length of time following filing of the application by the applicant. A certificate of authority shall be denied only after the commissioner complies with the requirements of section 432D-14.

(e) The commissioner may adopt rules under chapter 91 for the implementation and administration of this chapter. [L 1995, c 179, pt of §1]

Revision Note

"January 1, 1996" substituted for "the effective date of this chapter".

Case Notes

As chapter 432D does not cover the field of managed care regulation and because this section, §432E-1, and article 431:10A can be read together and there is no explicit language

or policy reason not to give each statute effect, chapter 432D does not repeal chapter 432E by implication. 126 H. 326, 271 P.3d 621 (2012).

" **[§432D-3] Powers of health maintenance organizations.** (a) The powers of a health maintenance organization include the following:

(1) Purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(2) Participate in transactions between affiliated entities, including loans and the transfer of responsibility under all providers, subscribers, and other contracts between affiliates or between the health maintenance organization and its parent;

(3) Furnishing health care services through providers, provider associations, or agents for providers which are under contract with or employed by the health maintenance organization;

(4) Contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;

(5) Contracting with an insurance company licensed in this State, or with a hospital or medical service corporation authorized to do business in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) Offering other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(7) Joint marketing of products with an insurance company licensed in this State or with a hospital or medical service corporation authorized to do business in this State as long as the company that is offering each product is clearly identified; and

(8) Offering a point of service product consisting of:

(A) In-plan covered health care services obtained from providers who are employed by, or otherwise affiliated with the health maintenance organization and emergency services; and

(B) Out-of-plan covered services consisting of non-emergency, self-referred covered health care services obtained from providers who are not otherwise employed by, not under contract with, and not otherwise affiliated with the health maintenance organization, or services obtained from affiliated specialists without a referral; provided the health maintenance organization shall not expend more than ten per cent of its total health care expenditures for out-of-plan covered services.

(b) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in subsection (a)(1), (2), or (4) which may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove such exercise of power only if in the commissioner's opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove the request within thirty days of the filing of the notice, it shall be deemed approved. The commissioner may adopt rules exempting from the filing requirement of this subsection those activities having a minimal effect. [L 1995, c 179, pt of §1]

" **[§432D-4] Fiduciary responsibilities.** (a) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of an organization shall be responsible for the funds in a fiduciary relationship to the organization.

(b) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees, officers, directors, and partners in an amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the commissioner. [L 1995, c 179, pt of §1]

" **§432D-5 Annual and quarterly reports.** (a) Every health maintenance organization shall file annually, on or before March 1, a report verified by at least two principal officers covering the preceding calendar year. Each health maintenance organization shall file quarterly with the commissioner, on or before the forty-fifth day after each quarter, a copy of its

quarterly report verified by at least two principal officers. These reports shall comply with sections 431:3-301 and 431:3-302. The commissioner may prescribe the forms on which the reports are to be filed. In addition, the health maintenance organization annually shall file with the commissioner the following by the dates specified:

(1) An audit, by an independent certified public accountant or an accounting firm designated by the health maintenance organization of the financial statements, reporting the financial condition and results of operations of the health maintenance organization on or before June 1, or a later date as the commissioner upon request or for cause may specify. The health maintenance organization, on an annual basis and prior to the commencement of the audit, shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit. The commissioner may disapprove the health maintenance organization's designation within fifteen days of receipt of the health maintenance organization's notice, and the health maintenance organization shall be required to designate another independent certified public accountant or accounting firm. The audit required by this paragraph shall be prepared in accordance with the National Association of Insurance Commissioners' accounting practices and procedures manual and rules adopted by the commissioner following the practices and procedures prescribed by the National Association of Insurance Commissioners;

(2) A list of the providers who have executed a contract that complies with section 432D-8(d) on or before March 1; and

(3) A description of the available grievance procedures, the total number of grievances handled through those procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances on or before March 1.

(b) The commissioner may require additional reports as are deemed necessary and appropriate to enable the commissioner to carry out the commissioner's duties under this chapter.

(c) The commissioner may suspend or revoke the certificate of authority of any health maintenance organization who fails to file any of the documents required under subsection (a). In lieu or in addition to the suspension or revocation of the certificate of authority of any health maintenance organization, the commissioner may fine the health maintenance organization

not less than $100 and not more than $500 for each day of delinquency. [L 1995, c 179, pt of §1; am L 1999, c 247, §1; am L 2000, c 74, §4; am L 2003, c 212, §125; am L 2010, c 116, §3]

" **[§432D-6] Information to enrollees or subscribers.** (a) The health maintenance organization shall provide to its subscribers a list of providers and participating providers, upon enrollment and reenrollment.

(b) Every health maintenance organization shall provide to its subscribers notice of any material change in the operation of the organization that will affect them directly within thirty days of the material change.

(c) The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services may be obtained, a description of the internal grievance procedures, and a telephone number for the enrollee to contact the health maintenance organization at no cost to the enrollee.

(d) For the purpose of this section "material change" means any major change in provider or participating provider agreements. [L 1995, c 179, pt of §1]

" **§432D-7 Investments.** All investments permitted under section 432D-3(a)(1) may be considered admitted assets in determination of net worth; provided that these investments are in compliance with article 6 of chapter 431. [L 1995, c 179, pt of §1; am L 2000, c 74, §5; am L 2003, c 212, §126]

" **§432D-8 Protection against insolvency.** (a) Net worth requirements are as follows:

(1) Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization has an initial net worth of $2,000,000 and shall thereafter maintain the minimum net worth required under paragraph (2);

(2) Except as provided in paragraphs (3) and (4), every health maintenance organization shall maintain a minimum net worth equal to the greater of:

(A) $2,000,000;

(B) Two per cent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first $150,000,000 of premium revenues and one per cent of annual premium revenues on the premium revenues in excess of $150,000,000;

(C) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or

(D) An amount equal to the sum of:

(i) Eight per cent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(ii) Four per cent of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner;

(3) The minimum net worth requirement set forth in paragraph (2)(A) shall be phased in as follows:

(A) Seventy-five per cent of the required amount by January 1, 2001; and

(B) One hundred per cent of the required amount by December 31, 2002; and

(4) The following shall apply in determining compliance with the requirements of this subsection:

(A) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated;

(B) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses; and

(C) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(b) Deposit requirements are as follows:

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which

at all times shall have a value of not less than $300,000;

(2) A health maintenance organization that is in operation on January 1, 1996, shall make a deposit equal to $150,000. Within one year after January 1, 1996, a health maintenance organization that is in operation on January 1, 1996, shall make an additional deposit of $150,000 for a total of $300,000;

(3) Deposits shall be an admitted asset of the health maintenance organization in the determination of net worth;

(4) All income from deposits shall be an asset of the health maintenance organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted;

(5) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of article 15 of chapter 431; and

(6) The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the director of finance of this State, or the insurance commissioner, or other official body of the state or jurisdiction of domicile of such health maintenance organization, for the protection of all subscribers and enrollees, wherever located, cash, acceptable securities, or surety, and delivers to the commissioner a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

(c) Every health maintenance organization, when determining liabilities, shall include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to

provide for the expense of adjustment or settlement of claims. Such liabilities shall be computed in accordance with rules adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

(d) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization. In the event that a contract with a participating provider has not been reduced to writing as required by this subsection or that a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

(e) The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements acceptable to the commissioner to assure that benefits are continued as specified above.

(f) An agreement to provide health care services between a provider and a health maintenance organization shall require that a provider shall give the organization at least sixty days' advance notice in the event of termination.

(g) Each health maintenance organization shall prepare for review by the commissioner on or before the forty-fifth day of each quarter, a copy of its quarterly net solvency report verified by at least two principal officers. The commissioner may prescribe the forms on which the reports are to be prepared. Every health maintenance organization shall maintain a copy of its current net solvency report on the premises of its primary place of business. The commissioner may order an examination, subject to article 2 of chapter 431, to determine whether a health maintenance organization is in compliance with this section. Any health maintenance organization that fails or refuses to prepare or produce for review the quarterly net solvency report as required by this subsection shall be liable for a penalty in an amount not less than $100 and not more than $500 per day. [L 1995, c 179, pt of §1; am L 2001, c 185, §2]

Case Notes

Reading §432D-1 in pari materia with this section, the Hawaii legislature did not intend to eliminate the enforcement of an implied contract between a participating provider and a health maintenance organization. To hold that only written contracts are valid would render the "implied contract" phrase in §432D-1 [definition of "participating provider"] meaningless because this section would bar the enforcement of such an implied contract. 948 F. Supp. 2d 1131 (2013).

While the consumer protection function of this section would prevent plaintiff, a participating provider, from seeking payment from consumer subscribers or enrollees in defendant health maintenance organization's health plans, Hawaii law does not prohibit plaintiff from seeking payment from defendant for the violation of an oral or implied contract. 948 F. Supp. 2d 1131 (2013).

" **§432D-9 Uncovered expenditures insolvency deposit.** (a) If, at any time, uncovered expenditures exceed ten per cent of total health care expenditures, a health maintenance organization shall place with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, an uncovered expenditures insolvency deposit consisting of cash or securities that are acceptable to the commissioner. Such deposit shall have, at all times, a fair market value in an amount of one-hundred-twenty per cent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this State, including incurred but not reported

claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section is in addition to the deposit required under section 432D-8 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from the deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or trust account quarterly with the approval of the commissioner.

(c) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(1) A substitute deposit of cash or securities of equal amount and value is made;

(2) The fair market value exceeds the amount of the required deposit; or

(3) The required deposit under subsection (a) is reduced or eliminated.

Deposits, substitutions, or withdrawals may be made only with the prior written approval of the commissioner.

(d) The deposit required under this section is held in trust and may be used only as provided in this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this State for uncovered expenditures in this State. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

(e) The commissioner may prescribe by rule the time, manner, and form for filing claims under subsection (d).

(f) The commissioner may require by rule or order health maintenance organizations to file annual, quarterly, or more frequent reports as the commissioner deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion. [L 1995, c 179, pt of §1; am L 2003, c 212, §127]

" **[§432D-9.5] Reserve credit for reinsurance.** Any health maintenance organization that takes credit for reserves on risks

ceded to a reinsurer shall be subject to provisions of chapter 431 related to credit for reinsurance. [L 2000, c 74, §2]

" **[§432D-10] Enrollment period.** (a) In the event of an insolvency of a health maintenance organization, upon order of the commissioner, all other carriers offered as alternatives to the insolvent health maintenance organization at a group's last regular enrollment period shall offer to those members of the group who enrolled in the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(b) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group's enrollees of the insolvent health maintenance organization, then the commissioner shall equitably allocate the insolvent health maintenance organization's group contracts for such groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group is so allocated shall offer the group the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(c) The commissioner also shall allocate equitably the insolvent health maintenance organization's nongroup enrollees who are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer such nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance

organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes. [L 1995, c 179, pt of §1]

" **[§432D-11] Replacement coverage.** (a) For purposes of this chapter, "discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(b) Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(c) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance. [L 1995, c 179, pt of §1]

" **[§432D-12] Powers of insurers and hospital and medical service corporations.** (a) An insurance company licensed in this State, or a hospital or medical service corporation authorized to do business in this State, either directly or through a subsidiary or affiliate, may organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law to the contrary, any two or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(b) Notwithstanding any contrary provision of laws pertaining to insurance or hospital or medical service corporations, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers. [L 1995, c 179, pt of §1]

" **§432D-13 Examinations.** (a) The commissioner may examine the affairs of any health maintenance organization or of any providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but shall make such examination not fewer than once every five years for health maintenance organizations domiciled in this State.

(b) Every health maintenance organization and provider shall submit its books and records for examination and in every way facilitate the completion of the examination. In the event a health maintenance organization or the provider fails to comply with the directions of the commissioner, the commissioner may examine the affiliates of the health maintenance organization or provider to obtain the information. For the purpose of examinations, the commissioner may administer oaths to, and examine the officers and agents of, the health maintenance organization and the principals of providers concerning their business.

(c) The cost of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner for deposit into the compliance resolution fund.

(d) In lieu of such examination, the commissioner may accept the report of an examination made by the commissioner or director of the department of health of another state. [L 1995, c 179, pt of §1; am L 2004, c 122, §91; am L 2012, c 251, §12]

" **§432D-14 Suspension, revocation, or denial of certificate of authority.** (a) Any certificate of authority issued under this chapter may be suspended or revoked, and any application for a certificate of authority may be denied, if the

commissioner finds that any of the conditions listed below exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under section 432D-2, unless amendments to such submissions have been filed with and approved by the commissioner;

(2) The health maintenance organization does not provide or arrange for basic health care services;

(3) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(4) The health maintenance organization has failed to correct, within the time prescribed by subsection (c), any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

(5) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(6) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(7) The health maintenance organization has otherwise failed substantially to comply with this chapter.

(b) In addition to, or in lieu of, suspension or revocation of a certificate of authority pursuant to this section, the commissioner may levy an administrative fine upon the health maintenance organization in an amount not less than $500 and not more than $50,000 pursuant to section 431:3-221.

(c) The following shall pertain when insufficient net worth is maintained:

(1) Whenever the commissioner finds that the net worth maintained by any health maintenance organization subject to this chapter is less than the minimum net worth required, the commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require the health maintenance organization to:

(A) File with the commissioner a plan for correction of the deficiency acceptable to the commissioner; and

(B) Correct the deficiency within a reasonable time, not to exceed sixty days, unless an extension of

time, not to exceed sixty additional days, is granted by the commissioner. Such a deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation, or liquidation; and

(2) Unless allowed by the commissioner, no health maintenance organization or person acting on its behalf, directly or indirectly, may renew, issue, or deliver any certificate, agreement, or contract of coverage in this State, for which a premium is charged or collected, when the health maintenance organization writing such coverage is impaired, and the fact of such impairment is known to the health maintenance organization or to such person. However, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement, or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed, or converted coverage.

(d) A certificate of authority shall be suspended or revoked or an application for a certificate of authority denied, or an administrative penalty imposed, only after compliance with the requirements of this section.

(1) Suspension or revocation of a certificate of authority, denial of an application, or imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct on which suspension, revocation, denial, or administrative penalty is based. The health maintenance organization or applicant, in writing, may request a hearing pursuant to section 431:2-308; and

(2) If the health maintenance organization or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the director of labor and industrial relations stating:

(A) A specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and

(B) A specific place for the hearing.

(e) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(f) When the certificate of authority of a health maintenance organization is revoked, such organization, immediately following the effective date of the order of revocation, shall proceed to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner, by written order, may permit such further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage. [L 1995, c 179, pt of §1; am L 2016, c 141, §19]

" **[§432D-15] Rehabilitation, liquidation, or conservation of health maintenance organizations.** (a) Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in article 15 of chapter 431, or when in the commissioner's opinion, the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the general public. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(b) For purpose of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by article 15 of chapter 431, for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets. Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services

provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in article 15 of chapter 431. [L 1995, c 179, pt of §1]

" **[§432D-16] Summary orders and supervision.** (a) Whenever the commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this chapter, the commissioner, after notice and hearing, may order the health maintenance organization to take such action as may be reasonably necessary to rectify such condition or violation, including but not limited to one or more of the following:

(1) Reducing the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;
(2) Reducing the volume of new business being accepted;
(3) Reducing expenses by specified methods;
(4) Suspending or limiting the writing of new business for a period of time;
(5) Increasing the health maintenance organization's capital and surplus by contribution; or
(6) Taking such other steps as the commissioner may deem appropriate under the circumstances.

(b) For purposes of this section, the violation by a health maintenance organization of any law of this State to which such health maintenance organization is subject shall be deemed a violation of this chapter.

(c) The commissioner is authorized, by rule, to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in subsection (a).

(d) The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of article 15 of chapter 431. [L 1995, c 179, pt of §1]

" **§432D-17 Fees**. (a) The commissioner shall collect, in advance, the following fees:

(1) Certificate of authority:

(A) Application for a certificate of authority: $900; and

(B) Issuance of certificate of authority: $600; and

(2) For all services subsequent to the issuance of certificate of authority, including extension of the certificate of authority: $600 per year.

(b) No certificate of authority shall contain an expiration date, but all certificates of authority shall be extended by the commissioner from time to time in order to continue to be valid. When the commissioner issues or extends a certificate of authority, the commissioner shall determine the date prior to which the certificate of authority shall be extended and shall so notify the insurer in writing. This date is called the extension date. The extension date shall be any date not less than one year and not more than three years after date of issue or extension of the certificate of authority. If the insurer qualifies, its certificate of authority shall be extended. The commissioner shall provide each holder of a certificate of authority at least thirty days' advance written notice of the applicable extension date. If the fee for the extension of the certificate of authority is not paid before or on the extension date, a penalty shall be imposed in the amount of fifty per cent of the fee. The commissioner shall provide notice in writing of the delinquency of extension and the imposition of the authorized penalty. If the fee and the penalty are not paid within thirty days immediately following the date of the notice of delinquency, the commissioner may revoke the certificate of authority and may not reinstate the certificate of authority until the fee and penalty have been paid.

(c) All fees and penalties collected pursuant to this section and penalties collected pursuant to section 432D-14 shall be deposited to the credit of the compliance resolution fund. [L 1995, c 179, pt of §1; am L 1999, c 247, §2; am L 2012, c 251, §13; am L 2015, c 63, §18]

" **[§432D-18] Penalties and enforcement.** (a) The commissioner, in lieu of suspension or revocation of a certificate of authority, may impose an administrative fine pursuant to section 432D-14(b).

(b) If the commissioner, for any reason, has cause to believe that any violation of this chapter has occurred or is threatened, the commissioner may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their

authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation. Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no order may result from a conference until the requirements of this section are satisfied.

(c) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter. Any person aggrieved by an order of the commissioner under this section may obtain judicial review of the order in the manner provided for by chapter 91.

(d) In the case of any violation of the provisions of this chapter, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (c), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in any court of competent jurisdiction.

(e) Notwithstanding any other provisions of this chapter, if a health maintenance organization fails to comply with the net worth requirement of this chapter, the commissioner may take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees. [L 1995, c 179, pt of §1]

" **§432D-18.5 REPEALED.** L 2009, c 149, §13.

Cross References

Insurance fraud, see §§431:2-401 to 431:2-410.

" **§432D-19 Statutory construction and relationship to other laws.** (a) Except as provided in subsection (d) and otherwise provided in this chapter, the insurance laws and hospital or medical service corporation laws shall not apply to the activities authorized and regulated under this chapter of any health maintenance organization granted a certificate of authority under this chapter. This chapter shall not apply to an insurer or hospital or medical service corporation licensed

and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization granted a certificate of authority under this chapter shall not be deemed to be practicing medicine or osteopathic medicine and shall be exempt from the provision of chapter 453 relating to the practice of medicine or osteopathic medicine.

(d) Article 2, article 2D, part IV of article 3, article 6, part III of article 7, article 9A, article 13, article 14G, and article 15 of chapter 431, and sections 431:3-301, 431:3-302, 431:3-303, 431:3-304, 431:3-305, 431:10-225, and 431:10-226.5, and the powers granted by those provisions to the commissioner shall apply to health maintenance organizations, so long as the application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations. [L 1995, c 179, pt of §1; am L 1998, c 178, §4; am L 2002, c 74, §§4, 6; am L 2003, c 3, §22; am L 2007, c 175, §4; am L 2009, c 11, §54; am L 2011, c 80, §9; am L 2012, c 251, §14; am L 2013, c 56, §2; am L 2014, c 186, §16; am L 2016, c 141, §20]

Note

The repeal and reenactment note at subsection (d) in the main volume took effect on June 30, 2006, pursuant to L 2002, c 74, §6 and L 2003, c 3, §22.

" **[§432D-20] Filings and reports as public documents.** Notwithstanding chapter 92F and any other laws to the contrary, all applications and filings required under this chapter shall be treated as public, except for trade secrets or privileged or confidential quality assurance, commercial, or financial information; provided that any annual financial statement that may be required under section 432D-5 shall be public. [L 1995, c 179, pt of §1]

" **[§432D-21] Confidentiality of medical information.** Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or

from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, upon the express consent of the enrollee or applicant, pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of a claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim. [L 1995, c 179, pt of §1]

Law Journals and Reviews

Driving into the Sunset: A Proposal for Mandatory Reporting to the DMV by Physicians Treating Unsafe Elderly Drivers. 25 UH L. Rev. 59.

" **§432D-22 Acquisition of control of or merger of a health maintenance organization.** No person may make a tender for or a request or invitation for tenders of, enter into an agreement to exchange securities for, or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person, directly or indirectly, or by conversion or by exercise of any right to acquire, would be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the health maintenance organization information required by section 431:11-104 and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner. Approval by the commissioner shall be governed by section 431:11-104(d); provided that if no action is taken by the commissioner within thirty days, the offer, request, invitation, agreement, or acquisition shall be deemed approved. [L 1995, c 179, pt of §1; am L 2000, c 74, §6]

" **§432D-23 Required provisions and benefits.** Notwithstanding any provision of law to the contrary, each policy, contract, plan, or agreement issued in the State after

January 1, 1995, by health maintenance organizations pursuant to this chapter, shall include benefits provided in sections 431:10-212, 431:10A-115, 431:10A-115.5, 431:10A-116, 431:10A-116.2, 431:10A-116.5, 431:10A-116.6, 431:10A-119, 431:10A-120, 431:10A-121, 431:10A-122, 431:10A-125, 431:10A-126, 431:10A-132, 431:10A-133, 431:10A-140, and 431:10A-134, and chapter 431M. [L 1995, c 179, pt of §1; am L 1999, c 77, §8 and c 86, §4; am L 2000, c 243, §4; am L 2009, c 168, §3 and c 169, §8; am L 2010, c 157, §3; am L 2012, c 92, §4; am L 2015, c 197, §3, c 213, §5, and c 235, §5; am L 2016, c 204, §4]

Note

Applicability of 2016 amendment. L 2016, c 204, §§6, 8.

Attorney General Opinions

No reference was made to new section added to article 10A of chapter 431 [§431:10A-601], by §4 of reciprocal beneficiaries act [L 1997, c 383]; thus, §431:10A-601 did not apply to health maintenance organizations. Att. Gen. Op. 97-5.

" **§432D-23.5 Coverage for telehealth.** *[Section effective until December 31, 2016. For section effective January 1, 2017, see below.]* (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider.

(b) No health maintenance organization plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the health maintenance organization, and the provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. There shall be no reimbursement for a telehealth consultation between health care providers unless an existing health care provider-patient relationship exists between the

patient and one of the health care providers involved in the telehealth interaction and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical or other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) For the purposes of this section, "telehealth" means the use of telecommunications services, as defined in section 269-1, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information to parties separated by distance. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter. [L 1998, c 278, §4; am L 2006, c 219, §4; am L 2009, c 20, §5; am L 2014, c 159, §5]

§432D-23.5 Coverage for telehealth. *[Section effective January 1, 2017. For section effective until December 31, 2016, see above.]* (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the health care provider.

(b) No health maintenance organization plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the health maintenance organization, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) All health maintenance organizations shall provide current and prospective insureds with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to enrollment in a policy, contract, plan, or agreement and upon request after enrollment in the policy, contract, plan, or agreement.

(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

(g) For the purposes of this section:

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who

furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter. [L 1998, c 278, §4; am L 2006, c 219, §4; am L 2009, c 20, §5; am L 2014, c 159, §5; am L 2016, c 226, §8]

Note

Applicability of L 2016, c 226 requirement for reimbursement for telehealth services to health benefits plans under chapter 87A. L 2016, c 226, §13.

Cross References

Practice of telehealth, see §453-1.3

" **[§432D-23.6] Federally funded programs; exemption.** Requirements relating to mandated coverages shall not be applicable to any health maintenance organization offering

health insurance under a federally funded program under the Social Security Act, as amended; provided that this exemption shall apply only to that part of the health maintenance organization's business under the federally funded program. [L 1999, c 159, §3]

" **[§432D-24] Coordination of benefits.** (a) Health maintenance organizations are permitted, but not required to adopt provisions for coordination of benefits to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.

(b) If health maintenance organizations adopt provisions for coordination of benefits, the provisions must be consistent with the coordination of benefits provisions that are in general use in the State for coordinating coverage between two or more group health insurance or health care plans. [L 1995, c 179, pt of §1]

" **§432D-25 Disclosure of health care coverage and benefits.** In order to ensure that all individuals understand their health care options and are able to make informed decisions, all health maintenance organizations shall provide current and prospective enrollees with written disclosure of coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage.

The information provided shall be current, understandable, and available prior to enrollment, and upon request after enrollment. A policy or contract provided to an enrollee which describes coverages and benefits shall be in conformance with part I of article 10 of chapter 431. [L 1996, c 274, §3; am L 1999, c 246, §5]

Cross References

Patients' bill of rights and responsibilities act, see chapter 432E.

" **[§432D-26] Genetic information nondiscrimination in health insurance coverage.** (a) No health maintenance organization may:

(1) Use an individual's or a family member's genetic information, or request for genetic services, to deny or limit any coverage or establish eligibility, continuation, enrollment, or premium payments;

(2) Request or require collection or disclosure of an individual's or a family member's genetic information; or

(3) Disclose an individual's or a family member's genetic information without the written consent of the person affected, the person's legal guardian, or a person with power of attorney for health care for the person affected. This consent shall be required for each disclosure and shall include the name of each person or organization to whom the disclosure will be made.

(b) As used in this section:

"Family member" means, with respect to the individual, another individual related by blood to that individual.

"Genetic information" means information about genes, gene products, hereditary susceptibility to disease, or inherited characteristics that may derive from the individual or family member.

"Genetic services" means health services to obtain, assess, or interpret genetic information for diagnosis, therapy, and genetic counseling. [L 1997, c 91, §3]

Law Journals and Reviews

Privacy and Genetics: Protecting Genetic Test Results in Hawai‘i. 25 UH L. Rev. 449.

" **[§432D-26.3] Nondiscrimination on the basis of actual gender identity or perceived gender identity; coverage for services.** (a) No health maintenance organization policy, contract, plan, or agreement shall discriminate with respect to participation and coverage under the policy, contract, plan, or agreement against any person on the basis of actual gender identity or perceived gender identity.

(b) Discrimination under this section includes the following:

(1) Denying, canceling, limiting, or refusing to issue or renew an insurance policy, contract, plan, or agreement on the basis of a person's or the person's family member's actual gender identity or perceived gender identity;

(2) Demanding or requiring a payment or premium that is based on a person's or the person's family member's actual gender identity or perceived gender identity;

(3) Designating a person's or the person's family member's actual gender identity or perceived gender identity as a preexisting condition to deny, cancel, or limit coverage; and

(4) Denying, canceling, or limiting coverage for services on the basis of actual gender identity or perceived gender identity including but not limited to the following:

(A) Health care services related to gender transition; provided that there is coverage under the policy, contract, plan, or agreement for the services when the services are not related to gender transition; and

(B) Health care services that are ordinarily or exclusively available to individuals of one sex.

(c) The medical necessity of any treatment shall be determined pursuant to the insurance policy, contract, plan, or agreement and shall be defined in a manner that is consistent with other covered services.

(d) Any coverage provided shall be subject to copayment, deductible, and coinsurance provisions of a health maintenance organization policy, contract, plan, or agreement that are no less favorable than the copayment, deductible, and coinsurance provisions for substantially all other medical services covered by the policy, contract, plan, or agreement.

(e) As used in this section unless the context requires otherwise:

"Actual gender identity" means a person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.

"Gender transition" means the process of a person changing the person's outward appearance or sex characteristics to accord with the person's actual gender identity.

"Perceived gender identity" means an observer's impression of another person's actual gender identity or the observer's own impression that the person is male, female, a gender different from the gender designed at birth, a transgender person, or neither male nor female.

"Transgender person" means a person who has gender identity disorder or gender dysphoria, has received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth. [L 2016, c 135, §4]

Note

Applicability of section. L 2016, c 135, §§5, 7.

" **§432D-27 Policies relating to domestic abuse cases.** (a) No health maintenance organization shall deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage, on the basis that the applicant or enrollee is, has been, or may be a victim of domestic abuse.

(b) Nothing in this section shall prevent a health maintenance organization from taking any of the actions set forth in subsection (a) on the basis of loss history or medical condition, or for any other reason not otherwise prohibited by this section or any other law, regulation, or rule.

(c) Any form filed or filed after July 15, 1998 or subject to a rule adopted under chapter 91 may exclude coverage for losses caused by intentional or fraudulent acts of any enrollee.

(d) Nothing in this section prohibits a health maintenance organization from investigating a claim and complying with chapter 432D.

(e) As used in this section, "domestic abuse" means:

(1) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;

(2) Sexual assault of one family or household member by another;

(3) Stalking of one family or household member by another family or household member; or

(4) Intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another household member. [L 1998, c 171, §5; am L 2004, c 122, §92]

Revision Note

"July 15, 1998" substituted for "the effective date of this section".

" **[§432D-28] Federal law compliance.** A health maintenance organization shall comply with applicable federal law. The commissioner shall enforce the consumer protections and market reforms relating to insurance as set forth in the federal Patient Protection and Affordable Care Act, Public Law 111-148. [L 2011, c 15, §4]

" **[§432D-29] Prohibition on rescissions of coverage.** (a) Notwithstanding sections 431:10-226.5 and 431:10A-106 to the

contrary, a health maintenance organization shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) The individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud;

(2) The individual makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage; or

(3) The individual fails to timely pay required premiums or contributions toward the cost of coverage; provided that the rescission is in compliance with federal regulations.

As used in this subsection, "a person seeking coverage on behalf of the individual" shall not include an insurance producer or employee or authorized representative of the health carrier.

(b) A health maintenance organization shall provide at least thirty days advance written notice to each plan enrollee or, for individual health insurance coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) regardless of whether, in the case of group health insurance coverage, the rescission applies to the entire group or only to an individual within the group.

(c) This section applies regardless of any applicable contestability period. [L 2014, c 186, §3]