
A BILL FOR AN ACT

RELATING TO TITLE 24, HAWAII REVISED STATUTES.

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

1 SECTION 1. Section 431:10A-116, Hawaii Revised Statutes,
2 is amended to read as follows:

3 "**§431:10A-116 Coverage for specific services.** Every
4 person insured under a policy of accident and health or sickness
5 insurance delivered or issued for delivery in this State shall
6 be entitled to the reimbursements and coverages specified below:

7 (1) Notwithstanding any provision to the contrary,
8 whenever a policy, contract, plan, or agreement
9 provides for reimbursement for any visual or
10 optometric service[~~, which~~] that is within the lawful
11 scope of practice of a duly licensed optometrist, the
12 person entitled to benefits or the person performing
13 the services shall be entitled to reimbursement
14 whether the service is performed by a licensed
15 physician or by a licensed optometrist. Visual or
16 optometric services shall include eye or visual
17 examination, or both, or a correction of any visual or



1 muscular anomaly, and the supplying of ophthalmic
2 materials, lenses, contact lenses, spectacles,
3 eyeglasses, and appurtenances thereto;

4 (2) Notwithstanding any provision to the contrary, for all
5 policies, contracts, plans, or agreements issued on or
6 after May 30, 1974, whenever provision is made for
7 reimbursement or indemnity for any service related to
8 surgical or emergency procedures[~~, which~~] that is
9 within the lawful scope of practice of any
10 practitioner licensed to practice medicine in this
11 State, reimbursement or indemnification under the
12 policy, contract, plan, or agreement shall not be
13 denied when the services are performed by a dentist
14 acting within the lawful scope of the dentist's
15 license;

16 (3) Notwithstanding any provision to the contrary,
17 whenever the policy provides reimbursement or payment
18 for any service[~~, which~~] that is within the lawful
19 scope of practice of a psychologist licensed in this
20 State, the person entitled to benefits or performing
21 the service shall be entitled to reimbursement or



1 payment, whether the service is performed by a
2 licensed physician or licensed psychologist;

3 (4) Notwithstanding any provision to the contrary, each
4 policy, contract, plan, or agreement issued on or
5 after February 1, 1991, except for policies that only
6 provide coverage for specified diseases or other
7 limited benefit coverage, but including policies
8 issued by companies subject to chapter 431, article
9 10A, part II, and chapter 432, article 1, shall
10 provide coverage for screening by low-dose mammography
11 for occult breast cancer as follows:

12 (A) For women forty years of age and older, an annual
13 mammogram; and

14 (B) For a woman of any age with a history of breast
15 cancer or whose mother or sister has had a
16 history of breast cancer, a mammogram upon the
17 recommendation of the woman's physician.

18 The services provided in this paragraph are
19 subject to any coinsurance provisions that may be in
20 force in these policies, contracts, plans, or
21 agreements[-]; provided that the insured's dollar



1 limits, deductibles, and copayments for services shall
2 be on terms at least as favorable to the insured as
3 those applicable to other radiological examinations.

4 For the purpose of this paragraph, the term "low-
5 dose mammography" means the x-ray examination of the
6 breast using equipment dedicated specifically for
7 mammography, including but not limited to the x-ray
8 tube, filter, compression device, screens, films, and
9 cassettes, with an average radiation exposure delivery
10 of less than one rad mid-breast, with two views for
11 each breast. An insurer may provide the services
12 required by this paragraph through contracts with
13 providers; provided that the contract is determined to
14 be a cost-effective means of delivering the services
15 without sacrifice of quality and meets the approval of
16 the director of health; and

17 (5) (A) (i) Notwithstanding any provision to the
18 contrary, whenever a policy, contract, plan,
19 or agreement provides coverage for the
20 children of the insured, that coverage shall
21 also extend to the date of birth of any



1 newborn child to be adopted by the insured;
2 provided that the insured gives written
3 notice to the insurer of the insured's
4 intent to adopt the child prior to the
5 child's date of birth or within thirty days
6 after the child's birth or within the time
7 period required for enrollment of a natural
8 born child under the policy, contract, plan,
9 or agreement of the insured, whichever
10 period is longer; provided further that if
11 the adoption proceedings are not successful,
12 the insured shall reimburse the insurer for
13 any expenses paid for the child; and
14 (ii) Where notification has not been received by
15 the insurer prior to the child's birth or
16 within the specified period following the
17 child's birth, insurance coverage shall be
18 effective from the first day following the
19 insurer's receipt of legal notification of
20 the insured's ability to consent for



1 treatment of the infant for whom coverage is
2 sought; and

3 (B) When the insured is a member of a health
4 maintenance organization, coverage of an adopted
5 newborn is effective:

6 (i) From the date of birth of the adopted
7 newborn when the newborn is treated from
8 birth pursuant to a provider contract with
9 the health maintenance organization, and
10 written notice of enrollment in accord with
11 the health maintenance organization's usual
12 enrollment process is provided within thirty
13 days of the date the insured notifies the
14 health maintenance organization of the
15 insured's intent to adopt the infant for
16 whom coverage is sought; or

17 (ii) From the first day following receipt by the
18 health maintenance organization of written
19 notice of the insured's ability to consent
20 for treatment of the infant for whom
21 coverage is sought and enrollment of the



1 adopted newborn in accord with the health
 2 maintenance organization's usual enrollment
 3 process if the newborn has been treated from
 4 birth by a provider not contracting or
 5 affiliated with the health maintenance
 6 organization."

7 SECTION 2. Section 432:1-605, Hawaii Revised Statutes, is
 8 amended by amending subsection (b) to read as follows:

9 "(b) The services provided in subsection (a) are subject
 10 to any coinsurance provisions that may be in force in these
 11 policies, contracts, plans, or agreements[-]; provided that the
 12 member's dollar limits, deductibles, and copayments for services
 13 shall be on terms at least as favorable to the member as those
 14 applicable to other radiological examinations."

15 SECTION 3. Section 432E-34, Hawaii Revised Statutes, is
 16 amended as follows:

17 1. By amending subsection (d) to read:

18 "~~(d) [Upon receipt of a request for appeal pursuant to~~
 19 ~~subsection (c), the commissioner shall review the request for~~
 20 ~~external review submitted by the enrollee pursuant to subsection~~
 21 ~~(a), determine whether an enrollee is eligible for external~~



1 ~~review and, if eligible, shall refer the enrollee to external~~
2 ~~review. The commissioner's determination of eligibility for~~
3 ~~external review shall be made in accordance with the terms of~~
4 ~~the enrollee's health benefit plan and all applicable provisions~~
5 ~~of this part. If an enrollee is not eligible for external~~
6 ~~review, the commissioner shall notify the enrollee, the~~
7 ~~enrollee's appointed representative, and the health carrier~~
8 ~~within three business days of the reason for ineligibility.]~~

9 (1) The commissioner may determine that a request is
10 eligible for external review under subsection (b)
11 notwithstanding a health carrier's initial
12 determination that the request is ineligible and
13 require that it be referred for external review; and
14 (2) In making a determination under paragraph (1), the
15 commissioner's decision shall be made in accordance
16 with the terms of the enrollee's health benefit plan
17 and shall be subject to all applicable provisions of
18 this part."

19 2. By amending subsection (g) to read:

20 "(g) Within five business days after the date of receipt
21 of notice pursuant to subsection (e), the health carrier or its



1 designated utilization review organization shall provide to the
2 assigned independent review organization all documents and
3 information it considered in issuing the adverse action that is
4 the subject of external review[+] and any documents related to
5 the request for external review that have been received by the
6 health carrier or its designated utilization review
7 organization. Failure by the health carrier or its utilization
8 review organization to provide the documents and information
9 within five business days shall not delay the conduct of the
10 external review; provided that the assigned independent review
11 organization may terminate the external review and reverse the
12 adverse action that is the subject of the external review. The
13 independent review organization shall notify the enrollee, the
14 enrollee's appointed representative, the health carrier, and the
15 commissioner within three business days of the termination of an
16 external review and reversal of an adverse action pursuant to
17 this subsection."

18 SECTION 4. Section 432E-35, Hawaii Revised Statutes, is
19 amended as follows:

20 1. By amending subsections (b) through (f) to read:



1 "(b) Upon receipt of a request for an expedited external
2 review, the commissioner shall immediately send a copy of the
3 request to the health carrier. Immediately upon receipt of the
4 request, the health carrier shall determine whether the request
5 meets the reviewability requirements set forth in [~~subsection~~
6 ~~(a)-.~~] section 432E-34(b). The health carrier shall immediately
7 notify the enrollee or the enrollee's appointed representative
8 of its determination of the enrollee's eligibility for expedited
9 external review.

10 Notice of ineligibility for expedited external review shall
11 include a statement informing the enrollee and the enrollee's
12 appointed representative that a health carrier's initial
13 determination that an external review request that is ineligible
14 for review may be appealed to the commissioner by submission of
15 a request to the commissioner.

16 (c) [~~Upon receipt of a request for appeal pursuant to~~
17 ~~subsection (b), the commissioner shall review the request for~~
18 ~~expedited external review submitted pursuant to subsection (a)~~
19 ~~and, if eligible, shall refer the enrollee for external review.~~
20 ~~The commissioner's determination of eligibility for expedited~~
21 ~~external review shall be made in accordance with the terms of~~



1 ~~the enrollee's health benefit plan and all applicable provisions~~
2 ~~of this part. If an enrollee is not eligible for expedited~~
3 ~~external review, the commissioner shall immediately notify the~~
4 ~~enrollee, the enrollee's appointed representative, and the~~
5 ~~health carrier of the reasons for ineligibility.]~~

6 (1) The commissioner may determine that a request is
7 eligible for expedited external review under section
8 432E-34(b) notwithstanding a health carrier's initial
9 determination that the request is ineligible and
10 require that it be referred for external review; and

11 (2) In making a determination under paragraph (1), the
12 commissioner's decision shall be made in accordance
13 with the terms of the enrollee's health benefit plan
14 and shall be subject to all applicable provisions of
15 this part.

16 (d) If the commissioner determines that an enrollee is
17 eligible for expedited external review [~~even though the enrollee~~
18 ~~has not exhausted the health carrier's internal review process,]~~
19 pursuant to subsection (c) and the request for expedited
20 external review is based on an adverse determination as provided
21 under subsection (a) (1), the health carrier shall not be



1 required to proceed with its internal review process [~~—The~~
2 ~~health carrier]~~ but may elect to proceed with its internal
3 review process [~~even though the request is determined by the~~
4 ~~commissioner to be eligible for expedited external review]~~;
5 provided that the internal review process shall not delay or
6 terminate an expedited external review unless the health carrier
7 decides to reverse its adverse determination and provide
8 coverage or payment for the health care service that is the
9 subject of the adverse determination. Immediately after making
10 a decision to reverse its adverse determination, the health
11 carrier shall notify the enrollee, the enrollee's authorized
12 representative, the independent review organization assigned
13 pursuant to subsection (e), and the commissioner in writing of
14 its decision. The assigned independent review organization
15 shall terminate the expedited external review upon receipt of
16 notice from the health carrier pursuant to this subsection.

17 (e) Upon receipt of the notice pursuant to subsection (b)
18 or a determination of the commissioner pursuant to subsection
19 [~~(d)~~] (c) that the enrollee meets the eligibility requirements
20 for expedited external review, the commissioner shall
21 immediately randomly assign an independent review organization



1 to conduct the expedited external review from the list of
2 approved independent review organizations qualified to conduct
3 the external review, based on the nature of the health care
4 service that is the subject of the adverse action and other
5 factors determined by the commissioner including conflicts of
6 interest pursuant to section 432E-43, compiled and maintained by
7 the commissioner to conduct the external review and immediately
8 notify the health carrier of the name of the assigned
9 independent review organization.

10 (f) Upon receipt of the notice from the commissioner of
11 the name of the independent review organization assigned to
12 conduct the expedited external review, the health carrier or its
13 [designee] designated utilization review organization shall
14 provide or transmit all documents and information it considered
15 in making the adverse action that is the subject of the
16 expedited external review, and any documents related to the
17 request for expedited external review that have been received by
18 the health carrier or its designated utilization review
19 organization, to the assigned independent review organization
20 electronically or by telephone, facsimile, or any other
21 available expeditious method."



1 2. By amending subsection (h) to read:

2 "(h) As expeditiously as the enrollee's medical condition
3 or circumstances requires, but in no event more than seventy-two
4 hours after the date of receipt of the request for an expedited
5 external review that meets the reviewability requirements set
6 forth in [~~subsection (a)7~~] section 432E-34(b), the assigned
7 independent review organization shall:

8 (1) Make a decision to uphold or reverse the adverse
9 action; and

10 (2) Notify the enrollee, the enrollee's appointed
11 representative, the health carrier, and the
12 commissioner of the decision.

13 If the notice provided pursuant to this subsection was not
14 in writing, within forty-eight hours after the date of providing
15 that notice, the assigned independent review organization shall
16 provide written confirmation of the decision to the enrollee,
17 the enrollee's appointed representative, the health carrier, and
18 the commissioner that includes the information provided in
19 section [~~432E-37.~~] 432E-34(j).



1 Upon receipt of the notice of a decision reversing the
2 adverse action, the health carrier shall immediately approve the
3 coverage that was the subject of the adverse action."

4 SECTION 5. Section 432E-36, Hawaii Revised Statutes, is
5 amended as follows:

6 1. By amending subsections (c) through (g) to read:

7 "(c) Upon notice of the request for expedited external
8 review, the health carrier shall immediately determine whether
9 the request meets the requirements of subsection ~~[(b)-]~~ (g).
10 The health carrier shall immediately notify the commissioner,
11 the enrollee, and the enrollee's appointed representative of its
12 eligibility determination.

13 Notice of eligibility for expedited external review
14 pursuant to this subsection shall include a statement informing
15 the enrollee and, if applicable, the enrollee's appointed
16 representative that a health carrier's initial determination
17 that the external review request is ineligible for review may be
18 appealed to the commissioner.

19 ~~(d) [Upon receipt of a request for appeal pursuant to~~
20 ~~subsection (c), the commissioner shall review the request for~~
21 ~~external review submitted by the enrollee pursuant to subsection~~



1 ~~(a), determine whether an enrollee is eligible for external~~
2 ~~review and, if eligible, shall refer the enrollee to external~~
3 ~~review. The commissioner's determination of eligibility for~~
4 ~~external review shall be made in accordance with the terms of~~
5 ~~the enrollee's health benefit plan and all applicable provisions~~
6 ~~of this part. If an enrollee is not eligible for external~~
7 ~~review, the commissioner shall notify the enrollee, the~~
8 ~~enrollee's appointed representative, and the health carrier of~~
9 ~~the reason for ineligibility within three business days.]~~

10 (1) The commissioner may determine that a request is
11 eligible for external review under subsection (g)
12 notwithstanding a health carrier's initial
13 determination that the request is ineligible and
14 require that it be referred for external review; and

15 (2) In making a determination under paragraph (1), the
16 commissioner's decision shall be made in accordance
17 with the terms of the enrollee's health benefit plan
18 and shall be subject to all applicable provisions of
19 this part.

20 (e) Upon receipt of the notice pursuant to subsection
21 ~~[(a)]~~ (c) or a determination of the commissioner pursuant to



1 subsection (d) that the enrollee meets the eligibility
2 requirements for expedited external review, the commissioner
3 shall immediately randomly assign an independent review
4 organization to conduct the expedited external review from the
5 list of approved independent review organizations qualified to
6 conduct the external review, based on the nature of the health
7 care service that is the subject of the adverse action and other
8 factors determined by the commissioner including conflicts of
9 interest pursuant to section 432E-43, compiled and maintained by
10 the commissioner to conduct the external review and immediately
11 notify the health carrier of the name of the assigned
12 independent review organization.

13 (f) Upon receipt of the notice from the commissioner of
14 the name of the independent review organization assigned to
15 conduct the expedited external review, the health carrier or its
16 [~~designee~~] designated utilization review organization shall
17 provide or transmit all documents and information it considered
18 in making the adverse action that is the subject of the
19 expedited external review, and any documents related to the
20 request for expedited external review that have been received by
21 the health carrier or its designated utilization review



1 organization, to the assigned independent review organization
2 electronically or by telephone, facsimile, or any other
3 available expeditious method.

4 (g) Except for a request for an expedited external review
5 made pursuant to subsection (b), within three business days
6 after the date of receipt of the request, the commissioner shall
7 notify the health carrier that the enrollee has requested an
8 [~~expedited~~] external review pursuant to this section. Within
9 five business days following the date of receipt of notice, the
10 health carrier shall determine whether:

11 (1) The individual is or was an enrollee in the health
12 benefit plan at the time the health care service or
13 treatment was recommended or requested or, in the case
14 of a retrospective review, was an enrollee in the
15 health benefit plan at the time the health care
16 service or treatment was provided;

17 (2) The recommended or requested health care service or
18 treatment that is the subject of the adverse action:

19 (A) Would be a covered benefit under the enrollee's
20 health benefit plan but for the health carrier's
21 determination that the service or treatment is



- 1 experimental or investigational for the
2 enrollee's particular medical condition; and
3 (B) Is not explicitly listed as an excluded benefit
4 under the enrollee's health benefit plan;
5 (3) The enrollee's treating physician or treating advanced
6 practice registered nurse has certified in writing
7 that:
8 (A) Standard health care services or treatments have
9 not been effective in improving the condition of
10 the enrollee;
11 (B) Standard health care services or treatments are
12 not medically appropriate for the enrollee; or
13 (C) There is no available standard health care
14 service or treatment covered by the health
15 carrier that is more beneficial than the health
16 care service or treatment that is the subject of
17 the adverse action;
18 (4) The enrollee's treating physician or treating advanced
19 practice registered nurse:
20 (A) Has recommended a health care service or
21 treatment that the physician or advanced practice



1 registered nurse certifies, in writing, is likely
2 to be more beneficial to the enrollee, in the
3 physician's or advanced practice registered
4 nurse's opinion, than any available standard
5 health care services or treatments; or

6 (B) Who is a licensed, board certified or board
7 eligible physician qualified to practice in the
8 area of medicine appropriate to treat the
9 enrollee's condition, or who is an advanced
10 practice registered nurse qualified to treat the
11 enrollee's condition, has certified in writing
12 that scientifically valid studies using accepted
13 protocols demonstrate that the health care
14 service or treatment that is the subject of the
15 adverse action is likely to be more beneficial to
16 the enrollee than any available standard health
17 care services or treatments;

18 (5) The enrollee has exhausted the health carrier's
19 internal appeals process or the enrollee is not
20 required to exhaust the health carrier's internal
21 appeals process pursuant to section 432E-33(b); and



1 (6) The enrollee has provided all the information and
2 forms required by the commissioner that are necessary
3 to process an external review, including the release
4 form and disclosure of conflict of interest
5 information as provided under section 432E-33(a)."

6 2. By amending subsection (i) to read:

7 "~~(i) [Upon receipt of a request for appeal pursuant to~~
8 ~~subsection (h), the commissioner shall review the request for~~
9 ~~external review submitted pursuant to subsection (a) and, if~~
10 ~~eligible, shall refer the enrollee for external review. The~~
11 ~~commissioner's determination of eligibility for expedited~~
12 ~~external review shall be made in accordance with the terms of~~
13 ~~the enrollee's health benefit plan and all applicable provisions~~
14 ~~of this part. If an enrollee is not eligible for external~~
15 ~~review, the commissioner shall notify the enrollee, the~~
16 ~~enrollee's appointed representative, and the health carrier of~~
17 ~~the reasons for ineligibility within three business days.]~~

18 (1) The commissioner may determine that a request is
19 eligible for external review under subsection (g)
20 notwithstanding a health carrier's initial



1 determination that the request is ineligible and
2 require that it be referred for external review; and
3 (2) In making a determination under paragraph (1), the
4 commissioner's decision shall be made in accordance
5 with the terms of the enrollee's health benefit plan
6 and shall be subject to all applicable provisions of
7 this part."

8 3. By amending subsection (1) to read:

9 "(1) Within five business days after the date of receipt
10 of notice pursuant to subsection (j), the health carrier or its
11 designated utilization review organization shall provide to the
12 assigned independent review organization all documents and
13 information it considered in issuing the adverse action that is
14 the subject of external review~~[+]~~ and any documents related to
15 the request for external review that have been received by the
16 health carrier or its designated utilization review
17 organization. Failure by the health carrier or its designated
18 utilization review organization to provide the documents and
19 information within five business days shall not delay the
20 conduct of the external review; provided that the assigned
21 independent review organization may terminate the external



1 review and reverse the adverse action that is the subject of the
2 external review. The independent review organization shall
3 notify the enrollee, the enrollee's appointed representative,
4 the health carrier, and the commissioner within three business
5 days of the termination of an external review and reversal of an
6 adverse action pursuant to this subsection."

7 4. By amending subsection (o) to read:

8 "(o) Except as provided in subsection (p), within twenty
9 days after being selected to conduct the external review, a
10 clinical reviewer shall provide an opinion to the assigned
11 independent review organization pursuant to subsection (q)
12 regarding whether the recommended or requested health care
13 service or treatment subject to an appeal pursuant to this
14 section shall be covered.

15 The clinical [+]reviewer's[+] opinion shall be in writing
16 and shall include:

- 17 (1) A description of the enrollee's medical condition;
18 (2) A description of the indicators relevant to
19 determining whether there is sufficient evidence to
20 demonstrate that the recommended or requested health
21 care service or treatment is more likely than not to



1 be more beneficial to the enrollee than any available
 2 standard health care services or treatments and
 3 whether the adverse risks of the recommended or
 4 requested health care service or treatment would not
 5 be substantially increased over those of available
 6 standard health care services or treatments;

7 (3) A description and analysis of any medical or
 8 scientific evidence, as that term is defined in
 9 section 432E-1.4, considered in reaching the opinion;

10 (4) A description and analysis of any medical necessity
 11 [~~criteria defined in section 432E-1~~]; and

12 (5) Information on whether the reviewer's rationale for
 13 the opinion is based on [~~approval~~]:

14 (A) Approval of the health care service or treatment
 15 by the federal Food and Drug Administration for
 16 the condition; or [~~medical~~]

17 (B) Medical or scientific evidence or evidence-based
 18 standards that demonstrate that the expected
 19 benefits of the recommended or requested health
 20 care service or treatment is likely to be more
 21 beneficial to the enrollee than any available



1 standard health care services or treatments and
2 the adverse risks of the recommended or requested
3 health care service or treatment would not be
4 substantially increased over those of available
5 standard health care services or treatments."

6 5. By amending subsection (r) to read:

7 "(r) Except as provided in subsection (s), within twenty
8 days after the date it receives the opinion of the clinical
9 reviewer pursuant to subsection (o), the assigned independent
10 review organization, in accordance with subsection (t), shall
11 determine whether the health care service at issue in an
12 external review pursuant to this section shall be a covered
13 benefit and shall notify the enrollee, the enrollee's appointed
14 representative, the health carrier, and the commissioner of its
15 determination. The independent review organization shall
16 include in the notice of its decision:

17 (1) A general description of the reason for the request
18 for external review;

19 (2) The written opinion of each clinical reviewer,
20 including the recommendation of each clinical reviewer
21 as to whether the recommended or requested health care



- 1 service or treatment should be covered and the
- 2 rationale for the reviewer's recommendation;
- 3 (3) The date the independent review organization was
- 4 assigned by the commissioner to conduct the external
- 5 [†]review[†];
- 6 (4) The date the external review was conducted;
- 7 (5) The date the decision was issued;
- 8 (6) The principal reason or reasons for its decision; and
- 9 (7) The rationale for its decision.

10 Upon receipt of a notice of a decision reversing the
11 adverse action, the health carrier immediately shall approve
12 coverage of the recommended or requested health care service or
13 treatment that was the subject of the adverse action."

14 SECTION 6. Statutory material to be repealed is bracketed
15 and stricken. New statutory material is underscored.

16 SECTION 7. This Act shall take effect on January 1, 3000.



Report Title:

Insurance; Health Insurance; External Review Procedure;
Mammography

Description:

Requires health insurers, mutual benefit societies, and health maintenance organizations to cover mandated services for mammography at least as favorably as coverage for other radiological examinations. Provides amendments to external review procedures to improve consistency with the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act. Effective 1/1/3000. (HD1)

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

