

HAWAII ADMINISTRATIVE RULES

TITLE 16

DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

CHAPTER 23

MOTOR VEHICLE INSURANCE LAW

Subchapter 1 General Provisions

- §16-23-1 Definitions
- §16-23-2 Repealed
- §16-23-3 Verification of insurance

Subchapter 2 Required Motor Vehicle Insurance Policy Coverage

- §16-23-4 Motor vehicle insurance policy
- §16-23-5 Personal injury protection benefits
- §16-23-6 Entitlement to monthly earnings loss benefits
- §16-23-7 Computation of monthly earnings
- §16-23-8 Computation of monthly earnings loss
- §16-23-9 Liability coverage
- §16-23-10 Determination of tort threshold
- §16-23-10.1 Repealed
- §16-23-10.2 Additional civil liability
- §16-23-10.3 Repealed

Subchapter 3 Optional Additional Insurance

- §16-23-11 Required optional additional coverage
- §16-23-11.1 Naturopathic, acupuncture, and nonmedical remedial care and treatment
- §16-23-11.2 Managed care
- §16-23-11.3 Wage loss
- §16-23-11.4 Repealed
- §16-23-12 Other optional coverages

#### Subchapter 4 Rejection, Cancellation, Non-Renewal

- §16-23-13 Application for motor vehicle insurance policy, rejection of application, JUP placement
- §16-23-14 Repealed
- §16-23-15 Repealed
- §16-23-16 Review of failure to offer JUP placement, cancellation, or refusal to renew

#### Subchapter 5 Licensing of Insurers

- §16-23-17 Repealed
- §16-23-18 Repealed
- §16-23-19 Licensing of health insurers

#### Subchapter 6 Requirements for Self-Insurance

- §16-23-20 Application
- §16-23-21 Agreement
- §16-23-22 Surety bond, deposit of security, or proof of financial ability
- §16-23-23 Amount of cash, securities, or bond
- §16-23-24 Proof of ability to process and pay claims promptly
- §16-23-25 Supplemental bond or excess liability insurance requirement
- §16-23-26 Service of process
- §16-23-27 Issuance of certificate of self-insurance
- §16-23-28 Duty to notify commissioner
- §16-23-29 Drivers' education fund fee
- §16-23-30 Duration of certification
- §16-23-31 Revocation of certificate of self-insurance
- §16-23-32 Termination of self-insurer status and withdrawal of security deposit
- §16-23-33 Reporting requirements

#### Subchapter 7 Repealed

- §16-23-34 to §16-23-55 Repealed

#### Subchapter 8 Driver Education Fund

- §16-23-56 Payment and expenditure

### Subchapter 9 Miscellaneous Provisions

- §16-23-57 Administrative hearing on denial of claim
- §16-23-58 Notice of claim
- §16-23-59 Criminal conduct
- §16-23-60 Motor vehicle insurance policy endorsements

### Subchapter 10 Repealed

- §16-23-61 and §16-23-62 Repealed

### Subchapter 11 Repealed

- §16-23-63 Repealed

### Subchapter 12 Statistical and Reporting Requirements

- §16-23-64 Revision of current statistical plans
- §16-23-65 Quarterly report
- §16-23-66 Annual report
- §16-23-66.5 Repealed

### Subchapter 13 The Joint Underwriting Plan

- §16-23-67 General description
- §16-23-68 Membership in JUP
- §16-23-69 Repealed
- §16-23-70 Allocation of JUP costs
- §16-23-71 Selection of servicing carriers
- §16-23-72 Classifications eligible for JUP
- §16-23-73 Public assistance benefits recipients
- §16-23-74 Application for JUP, placement; reporting disposition
- §16-23-75 Denial of application; appeal
- §16-23-76 Administration by JUP bureau
- §16-23-77 Servicing carriers' duties
- §16-23-78 Allowances to servicing carriers
- §16-23-79 Commissions
- §16-23-80 JUP rates
- §16-23-81 JUP private passenger manual
- §16-23-82 JUP commercial manual
- §16-23-83 Repealed

- §16-23-84 JUP assigned claims; application; and assignment of claims
- §16-23-85 Proration of costs and assigned claims paid
- §16-23-86 JUP membership termination
- §16-23-87 Joint liability for JUP business
- §16-23-88 Auditing of members

Subchapter 14 Repealed

- §16-23-89 Repealed

Subchapter 15 Motor Vehicle Insurance Administration Revolving Fund

- §16-23-90 Peer review costs
- §16-23-91 Allocation of cost of motor vehicle insurance administration

Subchapter 16 Repealed

- §16-23-92 Repealed

Subchapter 17 Fee Schedule and Utilization Guidelines

- §16-23-93 Fee schedules
- §16-23-94 Definitions
- §16-23-95 Treatment plan
- §16-23-96 Health care provider responsibilities
- §16-23-97 Surgery
- §16-23-98 Repealed
- §16-23-99 Concurrent treatment
- §16-23-100 Change in health care or alternative care providers
- §16-23-101 Consultations
- §16-23-102 Licensed physical therapists and registered occupational therapists
- §16-23-103 Rules of decision for allowable fees for medical, surgical, and hospital services and supplies
- §16-23-104 Health care providers
- §16-23-105 Doctors of chiropractic and naturopathy
- §16-23-106 Physician assistants
- §16-23-107 Licensed acupuncturists
- §16-23-108 Biofeedback treatments
- §16-23-109 Massage therapy
- §16-23-110 Anesthesia services
- §16-23-111 Radiology services

- §16-23-112 Repealed
- §16-23-113 Hospital services
- §16-23-114 Drugs, supplies and materials
- §16-23-115 Workers' compensation medical fee schedule
- §16-23-116 Certification by health care providers and alternative care providers

Subchapter 18 Peer Review

- §16-23-117 Time requirements for peer review
- §16-23-117.5 Applicability of peer review
- §16-23-118 Submission to peer review organization
- §16-23-119 Reconsideration
- §16-23-120 Dispute regarding charges

SUBCHAPTER 1

GENERAL PROVISIONS

§16-23-1 Definitions. Unless the context indicates otherwise, as used in this chapter:

"Alternative care provider" means any person providing medical or rehabilitative services as described in section 16-23-11.1 to a claimant covered by a motor vehicle insurance policy.

"Chapter 431", and reference to sections therein, refer to the insurance code contained in the Hawaii Revised Statutes (HRS).

"Commissioner" means the state commissioner of insurance as defined in section 431:2-102, HRS. Pending the appointment of a person to or during any vacancy in that office, it refers to the state director of commerce and consumer affairs.

"County" means the counties of Hawaii, Maui, and Kauai and the City and County of Honolulu.

"Eligible injured person" means:

- (1) The person identified by name as an insured in a motor vehicle insurance policy and any relative, as defined herein, who sustains accidental harm arising out of the operation, maintenance, or use of any motor vehicle;
- (2) A pedestrian or other non-occupant, such as a bicyclist, or any user or operator of a moped as defined in section 249-1, HRS, but not including any operator or passenger of a motorcycle or motor scooter as defined in section 286-2, HRS, who sustains accidental

§16-23-1

harm arising out of the operation, maintenance, or use of, and caused by, any motor vehicle unless expressly provided for in a motor vehicle policy; or

- (3) Any other person who sustains accidental harm arising out of the operation, maintenance, or use of the insured motor vehicle.

"Motor vehicle insurance law" refers to the motor vehicle insurance law, chapter 431:10C, HRS, and sections therein.

"Prepaid health care plan" means a health care plan approved by the department of labor and industrial relations and meeting the requirements of chapter 393 and the rules of the department in effect on January 1, 1998, or thereafter.

"Provider" or "health care provider" means any person providing medical or rehabilitative services as described in section 16-23-5 to a claimant covered by a motor vehicle insurance policy.

"Relative" means a "resident relative" as defined in section 431:10C-302(a)(9)(D)(ii), HRS. [Eff 9/1/74; am 9/1/77; am 9/1/78; am 9/1/79; am and ren §16-23-1, 7/7/80; am and comp 9/1/82; am and comp 9/1/85; am 9/1/87; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am 9/1/91; am and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-103, 431:10C-304)

§16-23-2 Repealed. [R 1/8/99]

§16-23-3 Verification of insurance. (a) The forgery resistant insurance identification card issued by an insurer shall not be issued for a period exceeding the period for which premiums have been paid or earned. This paragraph shall apply only to the first application of a person for a motor vehicle insurance policy and shall not apply to applications for commercial and fleet vehicles.

(b) The forgery resistant insurance identification card issued by an insurer or the certificate of self-insurance issued by the commissioner shall be kept in the insured motor vehicle at all times and shall be exhibited to a law enforcement officer upon demand.

(c) A person who violates subsections (a) and (b) shall be subject to the penalty provisions of section 431:10C-117 and chapter 805, HRS. [Eff 9/1/74; am 9/1/78; am and ren §16-23-3, 7/7/80; am 9/1/80; am and comp 9/1/82; am 9/1/84; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§286-26, 286-108, 286-116, 431:10C-107, 431:10C-113, 431:10C-117, 805-13)

SUBCHAPTER 2

REQUIRED MOTOR VEHICLE INSURANCE  
POLICY COVERAGE

§16-23-4 Motor vehicle insurance policy. (a) In order to be a motor vehicle insurance policy, an insurance policy covering a motor vehicle shall provide:

- (1) Personal injury protection benefits, as described in sections 431:10C-103.5 and 431:10C-103.6, HRS, or first-party benefits, with respect to any accidental harm, covering medical and rehabilitative expenses, payable to the owner, operator, occupant, or user of the insured motor vehicle, or any pedestrian such as a bicyclist or any user or operator of a moped as defined in section 249-1, HRS, but not including any operator or passenger of a motorcycle or motor scooter as defined in section 286-2, HRS, who sustains accidental harm as a result of the operation, maintenance, or use of the insured motor vehicle unless expressly provided for in a motor vehicle policy, among others; and
- (2) Liability coverage, as described in section 431:10C-301, HRS, to pay sums which the owner or operator of the insured motor vehicle may legally be obligated to pay for bodily injury, death, or damage to property of others which arise out of the ownership, operation, maintenance, or use of the motor vehicle.

(b) Subject to section 431:10C-308.5, HRS, a motor vehicle insurance policy may provide that an eligible injured person shall submit to medical or related examination by health care providers selected by, or acceptable to, the insurer when, and as often as, the insurer may reasonably require. Notice of the medical or related examination shall include a list of three health care providers and a request that the advice of the eligible injured person's treating health care provider be sought in choosing the health care provider to perform the medical or related examination. An eligible injured person may be required to submit, at the insurer's expense, to a medical or related examination in a county other than the county in which the eligible injured person resides. [Eff 9/1/74; am 9/1/78; am 9/1/79; am and ren §16-23-4, 7/7/80; am and comp 9/1/82; am 9/1/84; am and comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-301, 431:10C-304)

§16-23-4

§16-23-5 Personal injury protection benefits. (a) An insurer may provide personal injury protection benefits directly or indirectly by contracting with a provider of a prepaid health care plan.

(1) An insurer that contracts with a provider of a prepaid health care plan approved by the department of labor and industrial relations pursuant to chapter 393, HRS, shall be deemed to meet the requirement of substantial comparability under section 431:10C-103.6, HRS.

(2) An insurer that does not contract with a provider under paragraph (a)(1) shall ensure that benefits equal or exceed the coverage provided by the prevalent fee for service (including preferred provider) plan identified by the director of labor and industrial relations, pursuant to chapter 393, HRS.

(b) An insurer may make available, at the option of the named insured, coinsurance arrangements in such amounts and on such terms and rates as approved by the commissioner.

(c) A policy on which a named insured has failed to elect higher limits for personal injury protection or to elect optional additional coverage shall default to the basic minimum required limits of personal injury protection coverage. [Eff 9/1/74; am 9/1/77; am 9/1/78; am and ren §16-23-5, 7/7/80; am 9/1/80; am and comp 9/1/82; am and comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-103, 431:10C-211, 431:10C-302, 1997 SLH, Act 251)

§16-23-6 Entitlement to monthly earnings loss benefits. For accidents arising under policies in effect on or before December 31, 1997, with respect to no-fault monthly earnings loss benefits, a person who loses time from work the person would have performed had the person not been injured suffers earnings loss and is accordingly entitled to earnings loss benefits even if the person's compensation is continued, for example, under a sick leave or other wage continuation plan or as a gratuity. On the other hand, an unemployed person suffers no earnings loss from injury until the time the person would have been employed but for the person's injury, and accordingly would not be entitled to earnings loss benefits until such time. [Eff 9/1/74; am and ren §16-23-6, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-103)



§16-23-7 Computation of monthly earnings. For accidents arising under policies in effect on or before December 31, 1997, for purposes of determining monthly earnings loss, monthly earnings shall be computed in such a manner that the resulting amount represents most fairly, in the light of the pattern of employment or self-employment and the duration of disability, the eligible injured person's compensation or earnings for the period during which the accidental harm results in the person's inability to engage in available and appropriate gainful activity.

In the case of a regularly employed or self-employed person, monthly earnings means one-twelfth of the person's average annual compensation or earnings before state and federal income taxes for the first twelve months immediately preceding the date of injury or death, hereinafter referred to as "pre-accident monthly earnings"; provided, that if a regularly employed person's monthly earnings computed on the basis of the amount of the person's compensation at the time of the accident are higher, then the pre-accident monthly earnings shall be increased accordingly; provided further, that if an eligible injured person or the person's survivors present sufficient credible evidence to show that the person's average annual compensation or earnings for the twelve-month period from and after the date of accident would have been higher than the pre-accident monthly earnings or the person's monthly earnings computed on the basis of the amount of the person's compensation at the time of the accident, then the same shall be increased accordingly.

In the case of an unemployed person, a person not regularly employed or self-employed, or a person who has been working for only a short period of time or is in casual employment, monthly earnings means one-twelfth of the person's anticipated annual compensation paid from the time the person would reasonably have been expected to be regularly employed. Regard may be had to the average annual compensation or earnings of a person of similar training and experience in comparable work. [Eff 9/1/74; am and ren §16-23-7, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-103)

§16-23-8 Computation of monthly earnings loss. (a) For purposes of computing monthly earnings loss for accidents arising under policies in effect on or before December 31, 1997, a month means a calendar month during which the accidental harm results in the inability of the eligible injured person to engage in available and appropriate gainful activity or in the diminution of the eligible injured person's earning capacity.

§16-23-8

(b) If the period during which the loss of earnings is incurred or the initial or terminal portion thereof is shorter than a calendar month, the monthly earnings loss benefits payable for the period or portion shall be the lesser of:

- (1) \$800 per month during the period September 1, 1974 through December 31, 1985, \$900 per month during the period January 1, 1986 through June 2, 1992, and \$1,200 per month from June 3, 1992, and thereafter, plus any optional additional insurance which may be applicable; or
- (2) The ratio of the number of working days in the period or portion thereof to the number of regular days of work in the calendar month of which it is a part, multiplied by the monthly earnings (as defined in section 431:10C-103(7), HRS, prior to January 1, 1998, and in section 16-23-7) applicable to the period during which the accidental harm results in the inability of the eligible injured person to engage in available and appropriate gainful activity.

(c) Monthly earnings loss benefits shall be reduced by any income from substitute work performed by the eligible injured person or by income the eligible injured person would have earned in available appropriate substitute work the eligible injured person was capable of performing but unreasonably failed to undertake.

(d) The total amount of monthly earnings loss benefits an eligible injured person is entitled to receive shall be limited to the amount set out in section 431:10C-103(10)(A)(iii), HRS, prior to January 1, 1998, or the amount of any applicable coverage under section 431:10C-302, HRS, without any deduction of any amount received as compensation for lost earnings under any workers' compensation law; provided that the aggregate of the benefits from both sources shall not exceed eighty per cent of the eligible injured person's monthly earnings. However, if the eligible injured person's employer provides both workers' compensation and no-fault payments, the aggregate of the benefits from both sources shall not exceed the eligible injured person's net monthly earnings (computed by subtracting the total of federal and state income taxes and employee social security contributions from the gross monthly earnings), provided that the workers' compensation payments shall not be less than required by chapter 386, HRS. [Eff 9/1/74; am and ren §16-23-8, 7/7/80; am 9/1/81; am and comp 9/1/82; am and comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am 9/1/91; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-103, 431:10C-305)

§16-23-9 Liability coverage. (a) The liability coverage required to be included in a motor vehicle insurance policy shall provide:

- (1) Liability coverage of not less than \$25,000 during the period September 1, 1974 through December 31, 1985, \$35,000 during the period January 1, 1986 through June 2, 1992, \$25,000 from June 3, 1992, through December 31, 1997, and \$20,000 per person with an aggregate limit of \$40,000 per accident during the period January 1, 1998, and thereafter, for all damages arising out of accidental harm sustained by any one person as a result of any one accident and arising out of ownership, maintenance, use, loading, or unloading, of a motor vehicle; and
  - (2) Liability coverage of not less than \$10,000 for all damages arising out of injury to or destruction of property including motor vehicles and including the loss of use thereof as a result of any one accident arising out of ownership, maintenance, use, loading, or unloading of a motor vehicle.
- (b) A policy on which a named insured has failed to elect or request higher limits or options for bodily injury liability, property damage, stacking, uninsured motorist or underinsured motorist coverages shall default to the following:
- (1) For named insureds who, prior to January 1, 1998, purchased limits of \$25,000 per person bodily injury coverage, the policy shall default to no less than the basic limits bodily injury liability coverage of \$20,000 per person with an aggregate limit of \$40,000;
  - (2) For named insureds who, prior to January 1, 1998, purchased limits of greater than \$25,000 per person bodily injury liability coverage, the policy shall default to no less than the per person bodily injury liability coverage limits purchased prior to January 1, 1998 with an aggregate limit no less than the per person limit;
  - (3) For property damage liability coverage, the coverage shall default to no less than the property damage liability coverage purchased by the named insured prior to January 1, 1998; and
  - (4) For named insureds who prior to January 1, 1998, elected to purchase uninsured and/or underinsured motorist coverages, the policy shall default to include uninsured and/or underinsured motorist coverages as follows:
    - (A) For named insureds who, prior to January 1, 1998, purchased limits of \$25,000 per person coverage, the policy shall default to no less than the basic limits coverage of \$20,000 per person with an aggregate limit of \$40,000, with or without stacking in compliance with section 431:10C-301, HRS; or

- (B) For named insureds who, prior to January 1, 1998, purchased limits of greater than \$25,000 per person coverage, the policy shall default to the per person coverage limits and with an aggregate limit no less than the per person limit purchased prior to January 1, 1998 with or without stacking in compliance with section 431:10C-301, HRS; and
- (C) Stacking of uninsured motorist coverage and underinsured motorist coverage shall be in compliance with section 431:10C-301, HRS.

(c) Alternative care, wage loss, death and funeral benefits shall not be added to a policy unless a named insured has elected to purchase them. [Eff 9/1/74; am and ren §16-23-9, 7/7/80; comp 9/1/82; am and comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-301, 431:10C-302, 1997 SLH, Act 251)

§16-23-10 Determination of tort threshold. (a) The medical-rehabilitative limit established for the purpose of prescribing the tort threshold limit pursuant to section 431:10C-306(b)(2), HRS, is repealed on January 1, 1998 by 1997 SLH, Act 251. It does not preclude the person from receiving no-fault medical-rehabilitative benefits in excess of the amount, subject to the no-fault benefits aggregate limit of \$20,000, for policies effective prior to January 1, 1998.

(b) The medical-rehabilitative limits established for previous years shall continue to remain in full force and effect, and shall be applicable to claims for tort recovery for accidental harm sustained in those respective years. The medical-rehabilitative limit set forth in subsection (b) shall not apply to accidental harm sustained prior to its effective date.

- (c) The medical-rehabilitative limits for previous years are:
  - \$1,500 for accidents before September 1, 1979;
  - \$2,000 for accidents between September 1, 1979 - August 31, 1980;
  - \$2,500 for accidents between September 1, 1980 - August 31, 1981;
  - \$3,000 for accidents between September 1, 1981 - August 31, 1982;
  - \$3,600 for accidents between September 1, 1982 - August 31, 1983;
  - \$4,500 for accidents between September 1, 1983 - August 31, 1984;

\$5,200 for accidents between September 1, 1984 - August 31, 1986;  
\$5,600 for accidents between September 1, 1986 - August 31, 1987;  
\$6,000 for accidents between September 1, 1987 - August 31, 1988;  
\$6,400 for accidents between September 1, 1988 - August 31, 1989;  
\$7,000 for accidents between September 1, 1989 - August 31, 1990;  
\$7,600 for accidents between September 1, 1990 - August 31, 1991;  
\$8,300 for accidents between September 1, 1991 - August 31, 1992;  
\$10,000 for accidents between September 1, 1992 - August 31, 1994;  
\$11,000 for accidents between September 1, 1994 - August 31, 1995;  
\$13,900 for accidents between September 1, 1995 - August 31, 1996;  
\$13,900 for accidents between September 1, 1996 - August 31, 1997; and  
\$13,900 for accidents between September 1, 1997 - December 31, 1997. [Eff 9/1/74; am 9/1/76; am 9/1/77; am 9/1/78; am 9/1/79; am and ren §16-23-10, 7/7/80; am 9/1/80; am 9/1/81; am and comp 9/1/82; am 9/1/83; am 9/1/84; am and comp 9/1/85; am 9/1/86; am 9/1/87; am and comp 9/1/88; am and comp 9/15/89; am and comp 9/1/90; am 9/1/91; am and comp 6/1/93; am 1/30/95; am 8/12/96; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-306)

§16-23-10.1 Repealed. [R 1/8/99]

§16-23-10.2 Additional civil liability. An insurer, whose insured causes death or injury to another person while operating the motor vehicle in violation of section 291-4 or 291-7, HRS, which is not entitled to the reduction provided in section 431:10C-301.5, HRS, shall recover the amount of the covered loss deductible that would have applied from the insured who violated section 291-4

§16-23-10.2

or 291-7, HRS. [Eff and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-306) (Imp: HRS §431:10C-306)

§16-23-10.3 Repealed. [R 1/8/99]

SUBCHAPTER 3

OPTIONAL ADDITIONAL INSURANCE

§16-23-11 Required optional additional coverage. (a) Each insurer shall offer to each policyholder or applicant for a motor vehicle insurance policy the optional coverage as well as the basic motor vehicle insurance coverage, with the applicable premiums therefor, as set forth in Exhibit 1 entitled "Required Optional Additional Coverage," dated July 20, 1998, located at the end of this chapter, which is made a part of this section. Nothing in this subchapter shall limit the use of forms substantially similar to the exhibit.

(b) Every insurer shall fully disclose in writing to each policyholder upon the first renewal after January 1, 1998, or to the applicant, at the issuance or delivery of the policy, the availability of all required and optional coverages and deductibles.

(c) An applicant or policyholder shall in writing decline uninsured motorist coverage and underinsured motorist coverage.

(d) Increased limits for residual bodily injury coverage in the amount of \$300,000 per person with an aggregate limit of \$300,000 per accident and for property damage coverage in the amount of \$50,000 per occurrence shall be available to all motor vehicles required to be insured for those limits by contract or rule of the State of Hawaii or any political subdivision.

(e) Except as provided by section 431:10C-302(a) (9) (D), HRS, the benefits of any optional additional coverages elected by the policyholder are applicable to all eligible insureds. [Eff 9/1/74; am and ren §16-23-11, 7/7/80; am 9/1/81; am and comp 9/1/82; am 9/1/84; am and comp 9/1/85; am 9/1/87; am and comp 9/1/88; am and comp 9/15/89; am and comp 9/1/90; am 9/1/91; am and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-302) (Imp: HRS §431:10C-302)

§16-23-11.1 Naturopathic, acupuncture, and nonmedical remedial care and treatment. (a) Subject to the exceptions allowed under section 431:10C-302, HRS, an insurer shall make available optional coverage for naturopathic, acupuncture, and nonmedical remedial care and treatment rendered in accordance with the teachings, faith or belief of any group which relies upon spiritual means through

prayer for healing. The coverage shall provide for appropriate and reasonable treatment and expenses necessarily incurred as a result of the accidental harm and shall provide an aggregate total among and between the types of providers of thirty visits at no more than \$75 per visit.

(b) An insurer may make available additional coverages for services provided under subsection (a). These coverages shall be for additional blocks of thirty visits at no more than \$75 a visit.

(c) An insurer may make available at appropriately reduced premium rates, and provide at the option of the named insured, deductible, coinsurance or copayment arrangements for this coverage. [Eff and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-302) (Imp: HRS §§431:10C-301, 431:10C-302)

§16-23-11.2 Managed care. (a) An insurer may make available, and provide at the option of the named insured, the benefits described in section 431:10C-103.5(a), HRS, through managed care health care providers or programs including, but not limited to, health maintenance organizations or preferred provider organizations or provider networks; provided that any such program of managed care meets, is substantially comparable to, or exceeds the requirements for prepaid health care plans and the applicable utilization rates of this chapter.

(b) This option may include deductibles, coinsurance or copayment arrangements; provided that any required copayment shall be subject to and apply the utilization requirements applicable under prepaid health care plans.

(c) An insurer may provide managed care options by contracting with prepaid health care plans approved by the department of labor and industrial relations as complying with the requirements of chapter 393, HRS, and if so, such plans shall be deemed to meet the requirement of substantial comparability to prepaid health care plans. An insurer which provides managed care options, by means other than contracting with an approved prepaid health care plan, shall offer benefits which equal or exceed the coverage provided by the prevalent prepaid health managed care plan identified by the department of labor and industrial relations, pursuant to chapter 393, HRS. [Eff and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-302.5) (Imp: HRS §§431:10C-302, 431:10C-302.5)

§16-23-11.3 Wage loss. Subject to the exceptions allowed under section 431:10C-302(a), HRS, an insurer shall make available benefits for monthly earnings loss for injury arising out of a motor vehicle accident as provided by section 431:10C-302(a)(4), HRS. [Eff and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-302) (Imp: HRS §431:10C-302)

§16-23-11.3

§16-23-11.4 Repealed. [R 1/8/99]

§16-23-12 Other optional coverages. An insurer may offer other optional terms, conditions, exclusions, deductible clauses, coverages, and benefits displayed in Exhibit 2 or upon approval by the commissioner. The commissioner shall not approve the same unless they are consistent with the provisions required of a motor vehicle insurance policy, are fair and equitable, and limit the variety of coverage available so as to give buyers of insurance reasonable opportunity to compare the cost of insuring with various insurers. [Eff 9/1/74; am and ren §16-23-12, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-302) (Imp: HRS §431:10C-302)

#### SUBCHAPTER 4

#### REJECTION, CANCELLATION, NON-RENEWAL

§16-23-13 Application for motor vehicle insurance policy, rejection of application, JUP placement. An insurer, including a general agent, subagent, or solicitor, shall within fifteen working days of a request for an appointment service the applicant; provided service shall mean provide an application and rate quote for a motor vehicle insurance policy. Failure to service an applicant within the fifteen working day period shall be deemed a rejection. Upon rejection of an application for motor vehicle insurance policy or optional additional insurance by the affirmative act of the insurer or by a failure to service the applicant within fifteen working days, an insurer, including a general agent, subagent, or solicitor, at a meeting within ten working days of the rejection shall immediately offer to place the requested insurance coverage with the joint underwriting plan. [Eff 9/1/74; am and ren §16-23-13, 7/7/80; am 9/1/81; comp 9/1/82; am 9/1/84; comp 9/1/85; am 9/1/87; comp 9/1/88; comp 9/15/89; am and comp 9/1/90; am

and comp 6/1/93; am 1/30/95; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-106, 431:10C-110)

§16-23-14 Repealed. [R 1/8/99]



§16-23-15 Repealed. [R 1/8/99]

§16-23-16 Review of failure to offer JUP placement, cancellation, or refusal to renew. A person who is not offered a JUP placement after that person's application is rejected, or believes that the person's motor vehicle insurance policy has been canceled or refused renewal without legal justification may file an appeal with the commissioner within ten days after the person has been rejected or received notice of cancellation or refusal to renew. The grievance shall be heard and determined in accordance with chapter 91, HRS, and chapter 16-201. [Eff 9/1/74; am and ren §16-23-16, 7/7/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am 1/30/95; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-110 through 431:10C-114)

## SUBCHAPTER 5

### LICENSING OF INSURERS

§16-23-17 Repealed. [R 6/1/93]

§16-23-18 Repealed. [R 9/1/82]

§16-23-19 Licensing of health insurers. An insurer may be licensed by the commissioner to provide those personal injury protection benefits described in section 431:10C-103.5, HRS, or to provide optional major medical coverages in excess of personal injury protection benefits coverages, or both, if the commissioner finds that the insurer meets the requirements of section 431:10C-119, HRS. In addition, before licensing an insurer to provide the personal injury protection benefits, the commissioner must be satisfied that the insurer has made adequate provision to assure that any person obtaining personal injury protection benefits will simultaneously be obtaining the other coverages required under a motor vehicle insurance policy and will be provided adequate claims processing and payment services.

An insurer licensed hereunder to provide personal injury protection benefits shall also provide those optional major medical coverages which motor vehicle insurers are required to provide under section 431:10C-302, HRS.

A person licensed hereunder to provide personal injury protection benefits or optional major medical coverages shall comply with those provisions in chapter 431:10C, HRS, relating to insurers, such as, but not limited to, those relating to setting of rates and submission of information and reports to the commissioner.

An insurer licensed hereunder shall be assessed its equitable proration of costs and claims paid under the joint underwriting plan (JUP) and the assigned claims program. [Eff 9/1/74; am and ren §16-23-19, 7/7/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-119, 431:10C-214) (Imp: HRS §§431:10C-119, 431:10C-201, 431:10C-202, 431:10C-203, 431:10C-205, 431:10C-209, 431:10C-215, 431:10C-216, 431:10C-302, 431:10C-404, 431:10C-408)

## SUBCHAPTER 6

### REQUIREMENTS FOR SELF-INSURANCE

§16-23-20 Application. A person desiring to qualify as a self-insurer shall apply to the commissioner on a form prescribed by the commissioner. [Eff 9/1/74; am and ren §16-23-20, 7/7/80; comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-119, 431:10C-105)

§16-23-21 Agreement. The applicant shall execute and file with the commissioner an agreement in a form prescribed by the commissioner, that if certified as a self-insurer the applicant will:

- (1) In accordance with and to the extent prescribed in the motor vehicle insurance law as amended from time to time:
  - (A) In case of injury, arising out of a motor vehicle accident, to a person, including, but not limited to, an operator, occupant, or user of the self-insured motor vehicle or any pedestrian who sustains an injury as a result of the operation, maintenance, or use of the vehicle, pay without regard to fault to the health care provider of medical-rehabilitative services an amount equal to the personal injury protection benefits then payable as a result of the injury; and

- (B) Pay on behalf of the applicant or any operator of the insured motor vehicle using the motor vehicle with the express or implied permission of the named insured, sums which the applicant or the operator may legally be obligated to pay for injury or death or damage to property of others which arise out of the ownership, operation, maintenance, use, loading or unloading of the self-insured motor vehicle;
- (2) Permit the commissioner or an authorized representative to inspect and copy records and provide them copies of records pertaining to the self-insurer's financial condition, processing and payment of claims, and any other matters pertinent to the administration and enforcement of the motor vehicle insurance law; and
- (3) Comply with all requirements of the motor vehicle insurance law, rules, and directives of the commissioner, including, but not limited to, those relating to processing and payment of claims and payment of assessments and fees. [Eff 9/1/74; am and ren §16-23-21, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-119, 431:10C-301, 431:10C-304)

§16-23-22 Surety bond, deposit of security, or proof of financial ability.

An applicant for self-insurance shall either:

- (1) File with the commissioner and maintain the bond of a surety company authorized to do business in the State, conditioned for the payment of benefits and amounts as would be payable if the applicant were insured under a motor vehicle insurance policy as prescribed in the motor vehicle insurance law. The bond shall be in the form and penal sum acceptable to the commissioner, but in no event less than \$300,000 and shall provide that the bond may not be canceled or otherwise terminated until two years have elapsed from the last day the applicant was self-insured, unless the commissioner has given prior written consent. It shall be undertaken and may be enforced in the name of "Commissioner of Insurance, State of Hawaii". The surety company may not cancel the bond for the period of the certification; or
- (2) Deposit with the commissioner cash or those securities as may legally be purchased for investment by insurance companies under chapter 431, HRS, and evidence satisfactory to the commissioner

that there are no unsatisfied judgments against the applicant. As used herein, "cash" includes an irrevocable letter of credit issued by a federally insured financial institution whose principal office is located in Hawaii. Prior to issuance of a certificate of self-insurance the securities and cash if appropriate, shall be registered in the name of the "Commissioner of Insurance, State of Hawaii". The deposit shall be held to satisfy claims for personal injury protection benefits and liability coverage as may be payable under a motor vehicle insurance policy as prescribed in the motor vehicle insurance law. The commissioner shall deposit the cash or securities with the director of finance. The applicant shall execute an agreement satisfactory in form to the commissioner with respect to the deposit. The cash or market value of the securities deposited shall be in an amount determined by the commissioner to afford security substantially equivalent to that afforded under a motor vehicle insurance policy, but in no event less than \$300,000 and shall provide that the cash or securities shall not be withdrawn until two years have elapsed from the last day the applicant was self-insured, unless the commissioner has given prior written consent; and

- (3) Furnish the commissioner satisfactory proof of the applicant's solvency and financial ability to timely pay benefits and amounts as would be payable if the applicant were insured under the motor vehicle insurance law. The commissioner shall consider the assets and liabilities and profit and loss record of the applicant, the liquidity of the applicant, the number of vehicles involved, the exposure, and other factors appropriate to determining whether the applicant qualifies as a self-insurer. [Eff 9/1/74; am 9/1/76; am and ren §16-23-22, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-119, 431:10C-214) (Imp: HRS §431:10C-119)

§16-23-23 Amount of cash, securities, or bond. The commissioner shall consider the number of vehicles involved, the exposure, the financial condition of the applicant, and other factors appropriate to determining adequacy of security in fixing the amount of the bond or the amount of cash or securities. [Eff 9/1/74;

am and ren §16-23-23, 7/7/80; comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am and comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-119, 431:10C-214) (Imp: HRS §431:10C-119)

§16-23-24 Proof of ability to process and pay claims promptly. An applicant shall submit proof satisfactory to the commissioner that the applicant has retained an adjuster licensed under chapter 431, HRS, to provide a complete claims service to process and promptly pay claims in accordance with articles 10C and 13 of chapter 431, HRS. During such period that the applicant is self-insured, the applicant shall immediately refer all claims to the adjuster for processing. From time to time, the commissioner may require a self-insurer to show that the self-insurer is continuing to maintain an effective claims service. [Eff 9/1/74; am and ren §16-23-24, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am and comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-119, 431:10C-214) (Imp: HRS §431:10C-119)

§16-23-25 Supplemental bond or excess liability insurance requirement. The commissioner may require any self-insurer to provide a bond or additional bond, cash, and securities or additional securities in a reasonable amount whenever the commissioner finds that the same is necessary or appropriate. The commissioner may also require the self-insurer to provide evidence of excess liability insurance (in excess of the self-insured retention) in a licensed insurer in an amount the commissioner finds appropriate in light of such factors as the exposure, the number of vehicles involved, and the financial condition of the self-insurer. [Eff 9/1/74; am and ren §16-23-25, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-119)

§16-23-26 Service of process. A self-insurer shall appoint an agent, who is a natural person, domiciled in the State of Hawaii to accept service of process and legal documents provided that in the event of a conflict between this chapter and any other statute or rule of civil procedure, the statute or rule of civil procedure shall prevail. [Eff 9/1/74; am and ren §16-23-26, 7/7/80; comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am and comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-119, 431:10C-214) (Imp: HRS §431:10C-119)

§16-23-27 Issuance of certificate of self-insurance. The commissioner shall issue a certificate of self-insurance if:

- (1) The applicant has provided the bond, cash, or securities and proof of qualification as a self-insurer affording security substantially equivalent to that afforded under a motor vehicle insurance policy; and
- (2) The commissioner is satisfied that in case of injury or death or property damage, any claimant would have the same rights against the self-insurer as the claimant would have had if a motor vehicle insurance policy was applicable. [Eff 9/1/74; am 9/1/78; am and ren §16-23-27, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-119, 431:10C-214) (Imp: HRS §431:10C-119)

§16-23-28 Duty to notify commissioner. A self-insurer shall notify the commissioner in writing of any change in status of any motor vehicle which is self-insured, such as transfer, sale, removal from the State, or any additional motor vehicle which the self-insurer desires to self-insure within ten working days after the change is effected. [Eff 9/1/74; am 9/1/78; am and ren §16-23-28, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am and comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-119)

§16-23-29 Drivers' education fund fee. A self-insurer shall comply with the requirements and payments prescribed by subchapter 8. [Eff 9/1/74; am 9/1/78; am and ren §16-23-29, 7/7/80; am 9/1/81; comp 9/1/82; am and comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am 9/1/91; comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-115, 431:10C-214) (Imp: HRS §431:10C-115)

§16-23-30 Duration of certification. A certificate of self-insurance is valid for a period of one year from the date of issuance and may be renewed annually. [Eff 9/1/74; am and ren §16-23-30, 7/7/80; comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-119)

§16-23-31 Revocation of certificate of self-insurance. The commissioner may revoke a certificate of self-insurance for good cause at any time after providing notice and opportunity for a hearing in accordance with chapter 91, HRS, and chapter 16-201. Failure to comply with the motor vehicle insurance law, this chapter, or an order or directive of the commissioner or to pay any lawful fee or assessment is cause for revocation. Upon such revocation, the owner of any theretofore self-insured motor vehicle shall not operate or permit operation of the vehicle in the State until the owner has obtained insurance or has received a new certificate of self-insurance from the commissioner. [Eff 9/1/74; am 9/1/78; am and ren §16-23-31, 7/7/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-119)

§16-23-32 Termination of self-insurer status and withdrawal of security deposit. (a) A person who terminates the person's status as a self-insurer or whose certificate of self-insurance has been revoked, and who obtains a motor vehicle insurance policy of insurance for any formerly self-insured motor vehicle or shows that the person does not own any motor vehicle may apply to the commissioner for return of the person's security deposit or cancellation of the surety bond.

(b) After a lapse of twenty-four months from termination or revocation of self-insurer status and proof satisfactory to the commissioner that all claims have been finally adjudicated and paid, that all allotments and assessments have been paid and that the owner has complied with the applicable provisions of the motor vehicle insurance law, this chapter, orders and directives of the commissioner, and provisions of the self-insurer's agreement, the commissioner may release the securities deposited or permit cancellation of the bond. [Eff 9/1/74; am and ren §16-23-32, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-119)

§16-23-33 Reporting requirements. A self-insurer shall submit the reports prescribed by subchapter 12 of this chapter. [Eff 9/1/74; am and ren §16-23-33, 7/7/80; am and comp 9/1/82; comp 9/1/85; am 9/1/86; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §§431:10C-119, 431:10C-215)

#### SUBCHAPTER 7 REPEALED

§16-23-34 Repealed. [R 9/1/80]

§16-23-33

§16-23-35 Repealed. [R 9/1/80]

§16-23-36 Repealed. [R 9/1/80]

§16-23-37 Repealed. [R 9/1/80]

§16-23-38 Repealed. [R 9/1/80]

§16-23-39 Repealed. [R 9/1/80]

§16-23-40 Repealed. [R 9/1/80]

§16-23-41 Repealed. [R 9/1/80]

§16-23-42 Repealed. [R 9/1/80]

§16-23-43 Repealed. [R 9/1/80]

§16-23-44 Repealed. [R 9/1/80]

§16-23-45 Repealed. [R 9/1/80]

§16-23-46 Repealed. [R 9/1/80]

§16-23-47 Repealed. [R 9/1/80]

§16-23-48 Repealed. [R 9/1/80]



§16-23-49 Repealed. [R 9/1/80]

§16-23-50 Repealed. [R 9/1/80]

§16-23-51 Repealed. [R 9/1/80]

§16-23-52 Repealed. [R 9/1/80]

§16-23-53 Repealed. [R 9/1/80]

§16-23-54 Repealed. [R 9/1/80]

§16-23-55 Repealed. [R 9/1/80]

## SUBCHAPTER 8

### DRIVER EDUCATION FUND

§16-23-56 Payment and expenditure. There is assessed and levied upon each insurer and self-insurer a drivers' education fund underwriters' fee of \$2 per year, on each motor vehicle insured by each insurer or self-insurer. This fee is due and payable in full on a quarterly basis through June 30, 1998, and on an annual basis from July 1, 1998 by means and at a time to be determined by the commissioner. Motor vehicles insured under the joint underwriting plan shall be excluded from the drivers' education fund assessment. The commissioner shall deposit the fees into a special drivers' education fund account to be expended for the operation of the drivers' education program provided for in section 286-128(m), HRS, and the drivers' education program administered by the department of education. [Eff 9/1/74; am 9/1/78; am and ren §16-23-56, 7/7/80; am 9/1/80; am 9/1/81; comp 9/1/82; am 9/1/84; am and comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-115, 431:10C-214) (Imp: HRS §431:10C-115)

SUBCHAPTER 9

MISCELLANEOUS PROVISIONS

§16-23-57 Administrative hearing on denial of claim. If an insurer or self-insurer denies a claim for personal injury protection in whole or in part, it shall mail to the claimant in triplicate a notice of the denial as required by section 431:10C-304(3)(B), HRS. In the case of benefits for services specified in section 431:10C-103.5, HRS, the insurer or self-insurer shall also mail a copy of the denial to the health care provider or alternative health care provider.

If the claimant or health care provider desires a review of any action on the claim for benefits, the claimant or health care provider shall file with the commissioner two copies of the notice of denial of the claim, a request for review and a statement in duplicate giving specific reasons for the request within sixty days after the date of denial of the claim.

The commissioner shall forthwith notify the insurer or self-insurer of the request for review, enclosing a copy of the claimant's or health care provider's statement of reasons therefor.

The review hearing shall be held or conducted in the county in which the claimant or health care provider resides; provided, that the commissioner, upon a showing of good cause, may hold the hearing in another county. The hearing may be held by telephone with the consent of the parties. The commissioner may appoint an impartial referee to hear the matter.

The review shall be heard and determined in accordance with the provisions of chapter 91, HRS, and chapter 16-201. The commissioner shall assess the cost of the hearing upon either or both of the parties.

Nothing in this section precludes determination of any dispute relating to a motor vehicle insurance policy by arbitration and judicial review pursuant to chapter 431:10C, HRS. [Eff 9/1/74; am 9/1/79; am and ren §16-23-57, 7/7/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am 9/1/91; am and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-212, 431:10C-214) (Imp: HRS §§431:10C-212, 431:10C-214)

§16-23-58 Notice of claim. Written notice of claim under a motor vehicle insurance policy and any optional coverage shall be given to the insurer within a reasonable time after the date of the accident on which the claim is based or when the claimant first became aware of the ailment or disability resulting from the accident, subject to the statute of limitations, 431:10C-315, HRS. [Eff 9/1/74; am and ren §16-23-58, 7/7/80; am and comp 9/1/82; comp 9/1/85; am and comp

9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-214)

§16-23-59 Criminal conduct. If a person suffering accidental harm is arrested by or is in the custody of a law enforcement agency of government for the alleged commission of an offense punishable by imprisonment for more than one year in connection with the accidental harm or is charged by a duly constituted governmental authority such as the prosecutor or grand jury with the commission of such an offense, the insurer or self-insurer may withhold payment of personal injury protection benefits accruing from such accidental harm pending final judicial resolution of the criminal charge or reduction of the charge which removes the conduct from the scope of section 431:10C-305(d), HRS. [Eff 9/1/74; am and ren §16-23-59, 7/7/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; am and comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-304)

§16-23-60 Motor vehicle insurance policy endorsements. Any policy issued or renewed on or after January 1, 1998, shall provide the coverage required of a motor vehicle insurance policy in accordance with chapter 431, HRS, and administrative rules as amended from time to time. The endorsement as drafted by the insurer shall be subject to approval by the commissioner. The commissioner may require a certification from the insurer that, to the best of the certifier's knowledge and belief, such form meets the requirements of all applicable Hawaii laws and rules.

Subject to section 431:10C-308.5, HRS, the endorsement may provide that an eligible injured person shall submit to medical or related examination by health care providers selected by, or acceptable to, the insurer when, and as often as, the insurer may reasonably require. Notice of the medical or related examination shall include a list of three health care providers and a request that the advice of the eligible injured person's treating health care provider be sought in choosing the health care provider to perform the medical or related examination. An eligible injured person may be required to submit, at the insurer's expense, to a medical or related examination in a county other than the county in which the eligible injured person resides. [Eff 9/1/74; am and ren §16-23-60, 7/7/80; comp 9/1/82; am 9/1/84; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-214)

SUBCHAPTER 10 REPEALED

§16-23-61 Repealed. [R 9/1/85]

§16-23-62 Repealed. [R 9/1/85]

SUBCHAPTER 11 REPEALED

§16-23-63 Repealed. [R 9/1/86]

SUBCHAPTER 12

STATISTICAL AND REPORTING REQUIREMENTS

§16-23-64 Revision of current statistical plans. Statistical plans currently utilized for the collection and compilation of experience under motor vehicle insurance policies shall be revised and refiled to meet the following additional requirements of this section:

- (1) Compilations made by statistical agents shall be filed with the commissioner within ninety days of the evaluation date of the data contained therein. Accident year experience shall be evaluated as of March 31, and the statistical agent's compilation filed on or before June 30 of each year. In the event that an individual company does not provide proper input data to its designated statistical agent on a timely basis, the statistical agent shall nevertheless file the compilation of such data as has been properly filed on or before June 30 together with a detailed explanation of the incomplete data and the steps being taken to remedy the incompleteness. Every thirty days thereafter, the statistical agent shall file an updated compilation together with a deficiency report, until a complete compilation has been filed;
- (2) Statistical agents shall make available to the commissioner, at request, compilations for any or all individual companies reporting to them;
- (3) Coverage codes shall provide for separate identification of each mandatory option, as specified in section 16-23-11;
- (4) Type of loss codes shall provide for separate identification of each mandatory option as specified in section 16-23-11;

- (5) Provision shall be made to separately identify benefits paid for chiropractic and acupuncture treatments under personal injury protection benefits;
- (6) The definition of excess loss shall be amended to include provision for claims where the amount of personal injury protection benefits incurred equals or exceeds \$10,000, less any applicable offset or deductible;
- (7) Experience under each of the various deductibles, co-payments and managed care options for personal injury protection benefits shall be separately coded and compiled;
- (8) Provision shall be made to separately identify the amount of covered loss deductible offsets to bodily injury liability coverage losses; and
- (9) Experience under each of the various deductibles and optional additional coverage for physical damage shall be separately coded and compiled. [Eff 9/1/74; am and ren §16-23-64, 7/7/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:14-114)

§16-23-65 Quarterly report. (a) Within forty-five days of the end of each quarter, each insurer shall file a quarterly report with the commissioner covering the matters described in this section. Groups of companies shall also file quarterly reports on a combined basis.

(b) A census of vehicles insured as of the end of each calendar quarter shall be provided, indicating the following characteristics:

- (1) Territory;
- (2) Private passenger non-fleet, motorcycle, or commercial;
- (3) Number in paragraph (2) with optional additional coverage for:
  - (A) Limits of personal injury protection benefits;
  - (B) Limits of bodily injury liability benefits;
  - (C) Alternative providers benefits;
  - (D) Wage loss benefits;
  - (E) Death benefits;
  - (F) Funeral benefits;
  - (G) Comprehensive, fire, and theft; and
  - (H) Collision.
- (4) Number in paragraph (2) with personal injury protection benefits subject to:

- (A) Deductibles;
  - (B) Co-payments; or
  - (C) Managed care; and
- (5) Number of insured vehicles charged a rate for basic coverage above the insurer's basic rate for the use classification, mileage, and territory of the vehicle.
- (c) Experience under Hawaii motor vehicle insurance policies shall be provided by accident quarter, developed through the end of the quarter of the report:
- (1) Experience shall be filed separately for private passenger non-fleet, motorcycles, and commercial;
  - (2) Experience shall be filed separately for personal injury protection, alternative providers, wage loss, death, funeral, bodily injury liability, property damage liability, uninsured motorist, underinsured motorist, and for physical damage; and
  - (3) The following data shall be shown for each classification:
    - Car years: written (except earned commercial)
    - Gross premiums: written earned
    - Number of claims: incurred pending as of report date
    - Losses & allocated loss adjustment expense:
      - Paid on closed claims
      - Paid on open claims
      - Reserve for outstanding reported losses
      - Reserve for incurred but not reported losses
- (Number of claims, in the case of personal injury protection, alternative providers, wage loss, death, funeral, uninsured motorist, and underinsured motorist benefits means the number of injured persons receiving benefits. Paid losses should be net of any salvage or subrogation received. Reserve for outstanding reported losses is the amount unpaid as of the report date.)
- (d) Data relating to number of policies canceled or refused renewals due to the following:
- (1) Nonpayment of premium;
  - (2) License suspended or revoked;
  - (3) Policyholder request;
  - (4) Policyholder eligibility;
  - (5) Notices of non-renewal;

- (6) Notices of conditional renewal;
  - (7) Cancellation within sixty days of policy period for paragraphs (1) or (2); and
  - (8) Other conditions which shall be described.
- (e) Data relating to claims for personal injury protection benefits shall be provided as follows:
- (1) Number of claims closed without payment;
  - (2) Number of claims in suit at end of the quarter;
  - (3) Number of claims where suit was instituted during the quarter;
  - (4) Number of claims where accrued benefits were unpaid thirty days after reasonable proof had been received, and the amount of interest penalty paid as a result thereof; and
  - (5) Number of claims denied during the quarter.

This section of the report shall contain an analysis of the reasons for the resistance to or denial of the claims in paragraphs (2), (3), and (5).

(f) Reports shall be filed on diskettes in a format prescribed by the commissioner. [Eff 9/1/74; am and ren §16-23-65, 7/7/80; am 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-215)

§16-23-66 Annual report. By April 1 of each year, each insurer shall file an annual report covering the business of the preceding year. The report shall contain a summary of Hawaii motor vehicle insurance experience in a format prescribed by the commissioner. The experience shall be reported for six major classes of motor vehicle insurance:

- (1) Private Passenger Personal Injury Protection;
- (2) Private Passenger Liability;
- (3) Private Passenger Physical Damage;
- (4) Commercial Personal Injury Protection;
- (5) Commercial Liability; and
- (6) Commercial Physical Damage.

This report shall contain a detailed explanation of the methods used to assign expenses and investment income to Hawaii motor vehicle classifications, and those used to develop reserves for losses and loss adjustment expenses. Groups of companies shall also file an annual report on a combined basis. [Eff 9/1/74; am 9/1/76; am 9/1/77; am and ren §16-23-66, 7/7/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am 9/1/91; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §431:10C-214) (Imp: HRS §431:10C-215)

§16-23-66.5 Repealed. [R 1/1/98]

## SUBCHAPTER 13

### THE JOINT UNDERWRITING PLAN

Historical Note: Subchapter 13 of chapter 16-23 is based substantially upon subchapter 7 of chapter 16-23. [Eff 9/1/74; am 9/1/76; am 9/1/77; am 9/1/78; am 9/1/79; am and ren §16-23-34 to §16-23-55, 7/7/80; R 9/1/80]

§16-23-67 General description. (a) The joint underwriting plan (JUP) is intended to provide motor vehicle insurance and optional additional insurance in a convenient and expeditious manner for those persons, uses, or motor vehicles in certain "high risk" categories with respect to which insurance cannot reasonably be obtained in the market at rates not in excess of JUP rates, or persons who otherwise are in good faith entitled to, but unable to obtain, motor vehicle insurance and optional additional insurance through ordinary methods. Insurers will pool their losses and bona fide expenses under JUP to prevent the imposition of any inordinate burden on any particular insurer.

(b) Another part of the JUP consists of the assignment thereto of claims of victims for whom no policy is applicable, such as the hit-and-run victim who is not covered by a motor vehicle insurance policy. The losses and expenses under the assigned claims program are pro-rated among and shared by all motor vehicle insurers and self-insurers. [Eff 9/1/80; comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am 1/30/95; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-412)

§16-23-68 Membership in JUP. (a) Each insurer shall be a member of the JUP. As a condition of licensure it shall:

- (1) Maintain its membership at a minimum fee of \$1,000 per year or part thereof; and
- (2) Accept appointment as a servicing carrier if the commissioner finds it necessary in the public interest and that the insurer is capable of performing as a servicing carrier.

This section shall not apply to those insurers writing motor vehicle insurance exclusively under section 431:10C-106, HRS.



(b) The commissioner shall notify the insurer of its membership in the JUP at least thirty days before the extension date of the insurer's membership. If the fee is not paid on or before the extension date, the fee shall be increased by a penalty in the amount of fifty per cent of the fee. If the fee and the penalty are not paid within thirty days after the extension date, the commissioner may revoke the insurer's certificate of authority and reissue the certificate of authority when the penalty and the fee have been paid. [Eff 9/1/80; am and comp 9/1/82; am and comp 9/1/85; am 9/1/87; am and comp 9/1/88; comp 9/15/89; am and comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404)

§16-23-69 Repealed. [R 1/8/99]

§16-23-70 Allocation of JUP costs. All costs incurred in the operation of the joint underwriting plan bureau and the operation of the plan, such as administrative, staff, and claims (other than assigned claims) paid, shall be allocated fairly and equitably among the JUP members.

The allocations shall be computed on a "share of the voluntary market" basis.

Allocation of private passenger non-fleet experience will be on the basis of net direct written car years.

Allocation of commercial and all other experience will be on the basis of net direct written premiums.

Member insurers or the statistical agencies designated by them shall report all of the data necessary to comply with the allocation procedures to the commissioner or agent designated by the commissioner. Each insurer shall permit its statistical agent to release such data to the commissioner or agent designated by the commissioner. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404)

§16-23-71 Selection of servicing carriers. The commissioner shall select certain insurers as servicing carriers, who will provide JUP coverage and perform direct insurance operations on behalf of JUP members. In making the selection, the commissioner shall consider:

- (1) Whether the carrier is able to process and maintain a high level of service for all risks submitted through agents;

- (2) Whether it has the facilities to provide JUP policyholders and assigned claimants a high level of service;
- (3) Whether it is able to service private passenger or commercial lines and to process fluctuating work volumes and maintain quality of service through peak periods;
- (4) Whether its claims service is adequate, including an adequately decentralized adjusting staff, a claims examining staff resident in Hawaii, and local authority to settle claims at least up to the statutory basic motor vehicle insurance limits; and
- (5) Whether it is capable of producing accounting and statistical reports and other data as required. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404)

§16-23-72 Classifications eligible for JUP. (a) In addition to the classifications established in section 431:10C-407, HRS, the JUP shall provide motor vehicle insurance policies for the following classes of persons, motor vehicles, and uses:

- (1) Motor vehicles owned by licensed drivers, defined as follows:
  - (A) The applicant or any person who resides in the same household as the applicant and customarily operates the automobile or any other person who regularly and frequently operates the motor vehicle to be insured, who:
    - (i) Within thirty-six months prior to the date of the application has been convicted of operating a motor vehicle without motor vehicle insurance;
    - (ii) Within the eighteen months prior to the date of the application, has been convicted of or forfeited bail for two or more moving traffic violations; or
    - (iii) Has been convicted of any felony involving a motor vehicle;
  - (B) The applicant or any operator of an automobile in the same household who customarily operates the automobile or any other operator who customarily operates the automobile has been involved during the thirty-six month period prior to the date of the application in:
    - (i) Two or more accidents involving bodily injury or death if there is one car in the household or an

average of more than one such accident for all cars in the household, provided that a loss payment has been made or a loss reserve has been established for such accidents;

- (ii) Two or more accidents involving damage to any property, including their own, of \$1,000 or more if there is one car in the household, or an average of more than one such accident for all cars in the household, provided that loss payments or reserves under the comprehensive physical damage coverage shall not be counted; or
- (iii) A combination of two or more such accidents of the type specified in subparagraphs (B)(i) or (ii).

Accidents under subparagraphs (B)(i), (ii), or (iii) shall not be counted unless it can be clearly demonstrated that the applicant or other operator referred to therein was at fault. Accidents occurring under the following circumstances would tend to demonstrate that the applicant or operator was not at fault:

Automobile was lawfully parked (an automobile rolling from a parked position shall not be considered as lawfully parked, but shall be considered as the operation of the last operator); or

Applicant or other operator residing in the same household, was reimbursed by, or on behalf of, a person responsible for the accident or has judgment against that person; or

Automobile for the applicant or other operator resident in the same household was struck in the rear by another vehicle, and the operator has not been convicted of a moving traffic violation in connection with the accident; or

Operator of the other automobile involved in the accident was convicted of a moving traffic violation and the named insured or other operator resident in the same household was not convicted of a moving traffic violation in connection therewith; or

Automobile operated by the applicant or other operator resident in the same household was damaged as a result of contact with a hit-and-run driver, if the accident was reported to proper authority within twenty-four hours; or

Accidents involving contact with animals or fowl; or

Accidents involving physical damage, limited to and caused by flying gravel, missiles, or falling objects; and

(2) All other motor vehicles, not classified under paragraph (1) or section 431:10C-407, HRS, owned by licensed drivers who are unable to obtain motor vehicle insurance policies and optional additional insurance through ordinary methods.

(b) The JUP shall also provide required optional additional insurance for the above classes, with the exception of licensed drivers receiving public assistance benefits and unlicensed permanently disabled individuals who own their motor vehicle and receive public assistance benefits.

(c) The JUP shall provide a named non-owner policy for any applicant. [Eff 9/1/80; am and comp 9/1/82; am and comp 9/1/85; comp 9/1/88; comp 9/15/89; am and comp 9/1/90; am 9/1/91; am and comp 6/1/93; am 1/30/95; am 8/12/96; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §431:10C-407)

§16-23-73 Public assistance benefits recipients. (a) The state department of human services (DHS) shall provide a certificate of eligibility for JUP coverage to eligible licensed drivers and unlicensed permanently disabled individuals unable to operate their motor vehicle, who are receiving public assistance benefits from the department or from the Supplemental Security Income program under the Social Security Administration and who desire basic motor vehicle insurance policy coverage under JUP; provided such licensed drivers and unlicensed permanently disabled individuals unable to operate their motor vehicle are the sole registered owners of motor vehicles to be insured under the JUP. The applicant shall submit the certificate in person or by mail to the servicing carrier of the applicant's choice for a motor vehicle insurance policy. Certificates received by the servicing carrier within thirty days from the date of certification of eligibility by the state department of human services shall be accepted and treated as if it were payment in full for the requested motor vehicle insurance coverages. The servicing carrier shall certify this certificate which will function as a motor vehicle insurance policy and issue the applicant a motor vehicle insurance identification

card. The servicing carrier shall develop the information necessary to validate the eligibility of the applicant. Only basic motor vehicle insurance policy coverages, as defined in sections 16-23-4, 16-23-5, and 16-23-9, shall be bound, and the effective date of coverage shall be the same date as the signature date on the certificate by the applicant; however, the effective date shall not precede the time and date of the certification of eligibility by the state department of human services, the date that the servicing carrier receives the certificate, or the second day after postmark, whichever is later. In the event that the applicant fails to date the certificate, the date that the servicing carrier receives the certificate or the second day after postmark, whichever is earlier, shall be considered the date the applicant signed the certificate. The servicing carrier shall promptly notify the director of human services of public assistance recipients which it insures.

(b) An applicant shall first exhaust all paid coverage under any motor vehicle insurance policy then in force before becoming eligible for JUP coverage.

(c) Upon termination of public assistance benefits, the DHS shall:

(1) Notify the recipient upon termination of public assistance benefits and instruct the recipient that the recipient must immediately notify the servicing carrier of the termination of benefits and obtain timely insurance for the recipient's vehicle;

(2) Give written notice to the recipient that the recipient's JUP basic motor vehicle insurance policy will terminate thirty days from the date of termination of public assistance benefits. This notice of cancellation shall be considered as proper notification under section 431:10C-112, HRS, and section 16-23-15, providing the recipient with thirty days notice of cancellation; and

(3) Notify the servicing carrier of the termination of public assistance benefits and the date the termination was effective. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; am 9/1/86; am and comp 9/1/88; am and comp 9/15/89; comp 9/1/90; am 9/1/91; am and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §431:10C-407)

§16-23-74 Application for JUP, placement; reporting disposition. A person may apply for coverage under the JUP to any motor vehicle insurance general agent, subagent, or solicitor, who shall inform the applicant whether or not the applicant is eligible for JUP coverage.

Any eligible certified public assistance insured (CPAI) shall apply for motor vehicle insurance coverage directly to the servicing carrier of the insured's choice.

If the applicant qualifies for and desires JUP coverage, an agent who represents servicing carriers in the voluntary market shall use these servicing carriers in placing JUP applications, giving preference to the applicant's choice. An agent who does not represent any servicing carrier in the voluntary market may place the JUP insurance with an appropriate servicing carrier, giving preference to the applicant's choice. Each general agent licensed to write motor vehicle insurance shall automatically be licensed and authorized to bind eligible applicants on behalf of the JUP and shall communicate the fact of such binding directly to the affected servicing carrier.

Each general agent shall inform the commissioner in writing of each application for JUP coverage received by it, showing the disposition thereof, -i.e., whether the application was denied (and the reason therefor) or approved, and if approved, the servicing carrier with which the application was placed - within two working days after the date of disposition. The commissioner may inquire into the propriety of any disposition and when indicated by the circumstances may, after affording the applicant, insurer, and any other affected persons an opportunity to be heard, take such action as may be appropriate. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §431:10C-407)

§16-23-75 Denial of application; appeal. If an insurer denies an applicant JUP coverage under section 16-23-72(a)(1) or (a)(2) or section 431:10C-407, HRS, the insurer, by the next working day, shall mail or deliver to the applicant in triplicate a notice of the denial, of the applicant's right to appeal, and of the appeal procedure. If the applicant desires a review of the denial of the application, the applicant shall file with the commissioner two copies of the notice of denial, a request for review, and a statement in duplicate giving the applicant's reasons for the request within seven calendar days after the date of denial of the application.

The commissioner shall forthwith notify the insurer of the request for review, enclosing a copy of the statement of reasons therefor.

The appeal shall be heard and determined in accordance with the provisions of chapter 91, HRS, and chapter 16-201. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am 1/30/95; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §431:10C-402)

§16-23-76 Administration by JUP bureau. If the commissioner determines that the method of assignment of JUP applicants described herein is not operating in an effective and fair manner, the commissioner may have the JUP bureau directly receive, assign, and supervise the servicing of all applications for JUP coverage. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §431:10C-402)

§16-23-77 Servicing carriers' duties. A servicing carrier shall:

- (1) Accomplish confirmation of rating criteria, such as an applicant's or policyholder's driving record;
- (2) Issue insurance policies and endorsements, and certify the eligibility certificates within fifteen working days after receipt of an application for JUP coverage;
- (3) Effectively and efficiently perform all necessary accounting and statistical procedures set forth in the JUP manual;
- (4) Collect the necessary data to disburse commission payments to agents and be able to store the data and transmit it to the Internal Revenue Service annually; and
- (5) Account to the commissioner as required, and take such action as the commissioner may properly require. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404)

§16-23-78 Allowances to servicing carriers. Servicing carriers shall be reimbursed for their servicing expenses on the basis of:

- (1) Non-CPAI:
  - (A) Ten per cent of written premium for operating costs, excluding claims expense, plus;
  - (B) Twelve per cent of earned premium for the reporting period for loss adjustment expenses, both allocated or direct and unallocated or indirect, for liability coverage; and
  - (C) Ten per cent of earned premium for the reporting period for physical damage coverages;
- (2) CPAI:
  - (A) Six per cent of written premium for operating costs, excluding claims expense, plus;

- (B) Twelve per cent of earned premium for the reporting period for loss adjustment expenses, both allocated or direct and unallocated or indirect, for liability coverage. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404)

§16-23-79 Commissions. A servicing carrier shall pay a general agent for business written pursuant to the JUP a commission at the following rate:

- (1) For private passenger non-fleet motor vehicle insurance, a commission of eight per cent of the written premium up to a maximum amount of \$75 per vehicle for all new business and five per cent of the written premium up to a maximum amount of \$35 per vehicle for all renewals;
- (2) For commercial and all other vehicles, five per cent of written premium for all new business and renewals; and
- (3) No commission shall be paid for CPAI business.

All risks transferred from one servicing carrier to another under the JUP or reinstated policies are to be considered renewal business. [Eff 9/1/80; am and comp 9/1/82; am and comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; am 1/30/95; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404)

§16-23-80 JUP rates. The commissioner shall establish rating rules, refinement of classifications, rates, rating plans, territories, and policy forms for use under the JUP after consultation with the JUP board of governors and in accordance with the requirements and standards prescribed in sections 431:10C-409 through 431:10C-412, HRS. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-409 through 431:10C-412)

§16-23-81 JUP private passenger manual. The private passenger manual of the Hawaii joint underwriting plan (HJUP), dated November 1, 1997, and any amendments approved by the commissioner, published by the Automobile Insurance Plans Service Office (Rhode Island), is adopted as the private passenger



automobile manual of the HJUP. Copies of the HJUP private passenger automobile manual are available at the Automobile Insurance Plans Service Office (Rhode Island), and are available for inspection at the insurance division, department of commerce and consumer affairs. [Eff 9/1/80; am 9/1/81; am and comp 9/1/82; am 9/1/83; am 9/1/84; am and comp 9/1/85; am 9/1/86; am 9/1/87; am and comp 9/1/88; am and comp 9/15/89; am and comp 9/1/90; am 9/1/91; am and comp 6/1/93; am 1/30/95; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-409 through 431:10C-412)

§16-23-82 JUP commercial manual. The commercial automobile manual of the Hawaii joint underwriting plan (HJUP), dated November 1, 1997, and any amendments approved by the commissioner, published by the Automobile Insurance Plans Service Office (Rhode Island), is adopted as the commercial automobile manual of the HJUP. Copies of the HJUP commercial automobile manual are available at the Automobile Insurance Plans Service Office (Rhode Island), and are available for inspection at the insurance division, department of commerce and consumer affairs. [Eff 9/1/80; am 9/1/81; am and comp 9/1/82; am 9/1/83; am 9/1/84; am and comp 9/1/85; am 9/1/86; am 9/1/87; am and comp 9/1/88; am and comp 9/15/89; am and comp 9/1/90; am 9/1/91; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-409 through 431:10C-412)

§16-23-83 Repealed. [R 1/8/99]

§16-23-84 JUP assigned claims; application; and assignment of claims. The claimant shall apply to the JUP bureau, which shall promptly assign the claim to an appropriate servicing carrier and notify the claimant thereof. The assignment shall be made so as to minimize inconvenience to the claimant. The claimant and the assignee carrier shall have rights and obligations as set forth in part II of chapter 431:10C, HRS. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; am and comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404, 431:10C-408)

§16-23-85 Proration of costs and assigned claims paid. The commissioner shall annually prorate among and assess all insurers and self-insurers all costs and claims paid under the assigned claims program.

Proration shall be based upon a pro rata distribution for each premium dollar actually or theoretically received. A self-insurer shall be assessed that prorated amount based upon the total premium cost for the coverage and vehicles stated in its certificate of self-insurance, as if the self-insurer had sold such coverage at JUP premium rates. [Eff 9/1/80; comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §431:10C-408)

§16-23-86 JUP membership termination. A member may terminate membership in the JUP upon termination of its licensure to transact motor vehicle insurance business in this State. With respect to all policies in effect on the effective date of a member's termination, the liability of the terminating member shall cease on the anniversary date of each policy during the succeeding year. Termination of membership shall not discharge or otherwise affect liabilities incurred prior to the expiration of these policies and the member shall continue to pay assessments until its proportionate share established by its writings prior to discontinuance of business has been determined. However, if the motor vehicle liability, personal injury protection, or physical damage business of an insurer discontinuing the writing of motor vehicle liability, personal injury protection, or physical damage insurance in this State has been purchased by, transferred to, or reinsured by another insurer, the latter shall pay the assessments of the former until the proportionate share of the former as established by its writings prior to such transfer has been paid.

In the event that an insurer is merged with another insurer or there is a consolidation of insurers, the continuing insurer shall pay the assessments of the insurer merged or consolidated. Groups of insurers under the same ownership and management shall be treated as a single insurer under these provisions. Groups of insurers under either the same ownership or management, but not both, may elect to be treated separately. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404)

§16-23-87 Joint liability for JUP business. In the event of the failure of any member, through insolvency or otherwise, to pay promptly its portion of any loss or expense, after the JUP has made written demand upon it to pay the loss or expense, the commissioner shall take appropriate action. If the loss or expense remains unpaid beyond a reasonable period, all of the other motor vehicle

insurance insurers, upon notification by the commissioner shall promptly pay their respective pro rata shares, based upon the predetermined participation ratios. Members which have made contributions shall have the right to recovery thereafter against the member in default, provided, that the commissioner may enter into an agreement with the member in default, or with its legal representative, upon an amount which shall constitute a full settlement of all of the obligations of the member to the remaining members. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-401 through 431:10C-404)

§16-23-88 Auditing of members. The commissioner may audit the records of any member relating to the JUP and may prescribe policies, and the keeping of records, books of account, documents, and related material that the commissioner deems necessary to carry out JUP functions. This material shall be provided by the members in the form and with the frequency required by the commissioner. [Eff 9/1/80; am and comp 9/1/82; comp 9/1/85; comp 9/1/88; comp 9/15/89; comp 9/1/90; am and comp 6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:10C-214, 431:10C-406) (Imp: HRS §§431:10C-215, 431:10C-401 through 431:10C-404)

#### SUBCHAPTER 14 REPEALED

§16-23-89 Repealed. [R 1/1/98]

#### SUBCHAPTER 15

##### MOTOR VEHICLE INSURANCE ADMINISTRATION REVOLVING FUND

§16-23-90 Peer review costs. Whenever an insurer or self-insurer for a motor vehicle accident occurring on or between January 1, 1993 - December 31, 1997, files a challenge for submission to a peer review organization in accordance with section 431:10C-115.5, HRS, the insurer or self-insurer shall pay to the commissioner the sum of \$200 at the time the challenge is filed. In addition, the insurer or self-insurer shall reimburse the commissioner for expenses relating to review by the peer review organization within thirty days of presentation of an

itemized statement. [Eff 12/28/92; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-202, 431:10C-214) (Imp: HRS §§431:10C-115.5, 431:10C-214)

§16-23-91 Allocation of cost of motor vehicle insurance administration.

(a) Each insurer authorized to transact motor vehicle insurance in this State shall be assessed by the commissioner an amount computed on the basis of the motor vehicle insurance premiums written in this State by the insurer during the previous calendar year. Each self-insurer shall be assessed based upon the total premium cost for the coverage and vehicles stated in its certificate of self-insurance as if the self-insurer had sold the coverage at the premium rates applicable under the Hawaii Joint Underwriting Plan. Annually, on April 1 of each year, the commissioner shall determine the amounts due based on the amount needed for that year to administer the commissioner's obligations under article 10C of chapter 431, HRS. The commissioner shall give written notice to each insurer authorized to write motor vehicle insurance in this State and each self-insurer. The amounts required by this subsection shall be due on September 1 of each year.

(b) The commissioner may pay out of the motor vehicle insurance administration revolving fund moneys to cover the cost of administering article 10C of chapter 431, HRS, as described in section 431:10C-115.5, HRS, and 1997 SLH, Act 251. [Eff 12/28/92; comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§2-202, 431:10C-214) (Imp: HRS §431:10C-115.5)

SUBCHAPTER 16 REPEALED

§16-23-92 Repealed. [R 1/1/98]

SUBCHAPTER 17

FEE SCHEDULE AND UTILIZATION GUIDELINES

§16-23-93 Fee schedules. Subject to the time limitations set forth in section 431:10C-315, HRS, this subchapter shall apply to treatment occurring after May 31, 1993. Charges and treatment rendered for emergency services during the initial seventy-two hours following the motor vehicle accident resulting in injury shall not be subject to this subchapter; provided, however, that charges for

emergency treatment shall not exceed the health care or alternative care provider's usual and customary fee and shall be appropriate, reasonable, and necessarily incurred. Charges for treatment of a primarily palliative nature shall be subject to the requirements of this subchapter in the same manner as any other treatment. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214) (Imp: HRS §431:10C-308.5)

§16-23-94 Definitions. As used in this subchapter:

"Anesthetist" means a registered nurse-anesthetist who performs anesthesia services under the supervision of a licensed physician, preferably an anesthesiologist.

"Claimant" means a person entitled to the benefits described in section 431:10C-103.5, HRS, under a motor vehicle insurance policy.

"Emergency treatment" or "emergency services" means treatment or services which must be performed immediately or within ten working days because the condition is life threatening or could cause serious harm.

"Medical fee schedule" refers to the Medicare Resource Based Relative Value Scale System applicable to Hawaii and Exhibit A at the end of Title 12, Chapter 15, entitled "Workers' Compensation Supplemental Medical Fee Schedule.

"Physician" includes a doctor of medicine, a dentist, a chiropractor, an osteopath, a psychologist, an optometrist, and a podiatrist.

"Specialist" means a physician or surgeon who holds a certificate as a diplomate issued by a specialty board approved by the American Medical Association or the American Dental Association. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-95 Treatment plan. (a) This section shall apply if the injury resulted from an accident occurring on or between January 1, 1993 and December 31, 1997.

(b) When a health care provider of services submits a treatment plan, both the front page of the document submitted and the envelope in which the document is mailed shall be clearly identified as a motor vehicle insurance treatment plan in capital letters and in no less than ten point type. The commissioner may prescribe forms to be used for the treatment plan.

(c) Each treatment plan shall be written in English and shall include at least the following items:

- (1) A current diagnosis of the claimant's condition;

- (2) A description of the treatment to be performed;
- (3) A time schedule for measurable objectives or documented clinical improvement objectives;
- (4) Beginning and termination dates for the treatment and the estimated number of treatments during the treatment period;
- (5) Prognosis or goals at the end of treatment, including, where appropriate, range of motion, functional capacity, and specific goals; and
- (6) The estimated cost of treatment; provided that the charges for treatment shall not exceed the charges permissible under exhibit A to the workers' compensation schedules or, if the treatment is not covered by exhibit A to the workers' compensation schedules, eighty per cent of the provider's usual and customary charges.

(d) A treatment plan which does not address all of the items described in subsection (b) shall be considered invalid and may be rejected by the insurer; provided, however, that such a rejection shall be made, if at all, within five working days after postmark of the treatment plan.

(e) The provider shall be compensated for preparing the initial treatment plan in accordance with the fees permitted under exhibit A to the workers' compensation schedules. The provider shall not be compensated for subsequent treatment plans except in cases where the claimant's diagnosis, condition, or prognosis has changed significantly.

(f) Whenever a treatment plan is submitted, the insurer shall respond within five working days after postmark of the treatment plan, giving authorization or stating in writing the reason for refusal to the health care provider and the claimant. Any such refusal shall be filed concurrently with the commissioner for submission to a peer review organization. Failure by the insurer to respond within five working days after postmark shall constitute approval of the treatment plan.

(g) Nothing in this chapter shall preclude health care or alternative care providers and insurers from informal agreements to accept or negotiate requests for minor variances without using a formal treatment plan as set forth in this section. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214) (Imp: HRS §§431:10C-304, 431:10C-308.5)

§16-23-96 Health care provider responsibilities. (a) The total treatment allowable without prior approval or peer review shall not be performed if the claimant recovers from the injury covered by motor vehicle insurance benefits before exceeding the maximum allowed treatment, whether or not prior approval has been obtained.

(b) The frequency of treatment specified in this chapter and in the medical fee schedule is a guideline to improve health care provider accountability and is not intended to be an authoritative prescription for health care. [Eff and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-97 Surgery. (a) When elective surgery is contemplated for an injury resulting from an accident occurring on or between January 1, 1993 and December 31, 1997, the health care provider who is to perform the surgery shall submit a written request for surgery to the insurer no later than seven calendar days before the date of the proposed surgery. The health care provider shall concurrently provide a copy of the request to the claimant. The written request shall include procedure code, medical documentation justifying the need for surgery, the estimated date of surgery, and the hospital where the surgery is to be performed. When the surgical procedure has a "BR" (by report) fee, the estimated fee shall be submitted with the request. The health care provider's request shall also specify the cost and need for a co-surgeon or assistant and other additional surgical procedures, if any.

(b) Whenever a request for elective surgery is received for an injury resulting from an accident occurring on or between January 1, 1993 and December 1, 1997, the insurer shall respond within seven calendar days after the postmark date of such request, giving authorization or stating in writing the reason for refusal to the health care provider and the claimant. Any such refusal shall be filed concurrently with the commissioner for submission to a peer review organization. Failure by the insurer to respond within seven calendar days shall constitute approval of the request.

(c) Surgery which must be performed immediately or within fourteen calendar days because the condition is life-threatening or could cause serious harm is not considered elective surgery.

(d) When a surgical fee is chargeable, no office or hospital visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the health care provider's first examination.

(e) The fees listed for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "Follow-up Days" in the medical fee schedule. Necessary follow-up care beyond this listed period shall be added on a fee-for-service basis. Where the follow-up period is listed as zero, the listed fee is for the surgical procedure only, and all post-operative care is to be added on a fee-for-service basis.

(f) When additional surgical procedures are carried out within the listed period of follow-up care for a previous surgery, the follow-up periods shall continue concurrently to their normal terminations.

(g) Certain of the listed procedures in the medical fee schedule as provided in section 16-23-115 are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate procedure, not immediately related to other services, the indicated fee is applicable.

(h) When significant time or complexity to patient care results from multiple or bilateral surgical procedures performed at the same operative session, the total fee shall be the fee for the major procedure plus fifty per cent of the fee of the lesser procedure unless otherwise specified in this chapter. When an incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of previous scar) is performed through the same incision, the fee shall be that of the major procedure only.

(i) Where surgical assistance is needed at a major surgery, the separate fee for the assistance shall not exceed fifteen per cent of the fee listed in the medical fee schedule for the surgery, provided that when any major surgery is performed in a hospital where interns or residents are available as surgical assistants, no fee for surgical assistance shall be allowed. A major surgery is defined as any surgical procedure usually or customarily done in an operating room of a hospital. No fee for assistance at a surgical procedure other than a major surgery shall be allowed.

(j) One attending health care provider shall be in charge of the care of the claimant. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each health care provider shall be entitled to the listed fee for services rendered.

(k) Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit.

(l) For those fees not covered by Medicare, bills for services for a claimant who has had major surgery or treatment for major fractures and are later treated by another health care provider for follow-up care shall be limited to the fee schedule during the entire follow-up period as follows:

- (1) The operating surgeon shall submit a fee, reducing it accordingly if aftercare is not rendered;
- (2) The health care provider providing follow-up care shall submit the fee for the aftercare; and
- (3) It shall be the responsibility of the operating surgeon to advise the insurer of the apportionment of the respective fee. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS



§§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-98 Repealed. [R 1/1/98]

§16-23-99 Concurrent treatment. (a) Concurrent treatment by more than one health care or alternative care provider may be allowed if the attending health care provider determines the claimant's injury involves more than one body system, and requires multidiscipline care, or is so severe or complex that services of more than one health care or alternative care provider are required.

(b) If the injury is the result of an accident occurring on or between January 1, 1993 and December 31, 1997, before a claimant receives concurrent care, a treatment plan shall be submitted to the insurer for prior authorization; provided, however, that no request is required for emergency treatment as defined in section 16-23-94. The treatment plan shall include the name, business address, discipline, and specialty of the assisting health care or alternative care provider and the reasons for concurrent treatment shall be submitted to the insurer at least five working days prior to the referral. Each attending health care provider shall also provide a copy of the treatment plan to the claimant. Notwithstanding this section, the attending health care provider shall be compensated for the initial evaluation necessary to prepare a treatment plan for concurrent care so long as the initial evaluation is appropriate and reasonable.

(c) Whenever a request for concurrent treatment is submitted, the insurer shall respond within five working days after postmark of such request, giving authorization or stating in writing the reason for refusal to each attending health care provider and the claimant. Any such refusal shall be filed concurrently with the commissioner. Failure by the insurer to respond within five working days after postmark of the request shall constitute approval of the request. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-100 Change in health care or alternative care providers. The application of the frequency of treatment guidelines set forth in this subchapter shall not be affected when the claimant changes the health care or alternative care provider. If a claimant receives treatments in excess of those specified in the guidelines, regardless of whether the treatments are performed by one health care or alternative care provider or by more than one health care or alternative care provider, the excess treatments may be subject to prior authorization or to peer

§16-23-99

review if the injury resulted from an accident occurring on or between January 1, 1993 and December 31, 1997. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-101 Consultations. (a) If the injury is the result of an accident occurring on or between January 1, 1993 and December 31, 1997, fees for consultation shall be allowed if appropriate and necessary for treatment or rehabilitation of the injury covered by motor vehicle insurance benefits.

(b) If the injury is the result of an accident occurring on or between January 1, 1993 and December 31, 1997, the first consultation for a claimant is not subject to prior authorization or to peer review. For subsequent consultations, the attending health care provider shall submit a written request for consultation to the insurer before arranging the consultation; provided, however, that no request is required if the consultation constitutes emergency treatment as defined in section 16-23-94. The name, business address, discipline, and specialty of the consulting health care or alternative care provider and the reasons for the consultation shall be submitted in writing to the insurer at least five working days prior to referral.

(c) If the injury is the result of an accident occurring on or between January 1, 1993 and December 31, 1997, when a request for consultation is submitted, the insurer shall respond within five working days after postmark of such request, giving authorization or stating in writing the reason for refusal to the attending health care provider and the claimant. Any such refusal shall be filed concurrently with the commissioner for submission to a peer review organization. Failure by the insurer to respond within five working days after postmark of such request shall constitute approval of the request.

(d) If the injury is a result of an accident occurring on or between January 1, 1993 and December 31, 1997, when consultation is required immediately because the condition is life-threatening or could cause serious harm, the attending health care provider shall notify the insurer as soon as possible.

(e) The consultant shall provide a copy of the consultation report to the attending health care provider, the claimant, and the insurer within fourteen calendar days after the examination.

(f) When the consulting health care provider assumes the continuing care of the claimant, this subsequent service will no longer be considered a consultation. If the injury or condition of the claimant necessitates the concurrent services and skill of two or more health care or alternative care providers, concurrent treatment may be provided in accordance with section 16-23-99.

(g) For groups of health care providers or hospitals with satellite clinics, when service is rendered by a member of a group and the claimant is referred to another health care provider in the group for consultation, fees for such consultation may be allowed. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-102 Licensed physical therapists and registered occupational therapists. (a) This section shall apply if the injury resulted from an accident occurring on or between January 1, 1993 and December 31, 1997.

(b) Frequency of treatment provided by a licensed physical therapist or a registered occupational therapist shall not be more than the nature of the injury and the process of recovery require. Treatment requiring a maximum of twenty therapy sessions during the first sixty calendar days of treatment and twelve therapy sessions during each successive thirty calendar days thereafter does not require prior authorization and is not subject to peer review.

(c) Treatment exceeding one hundred twenty calendar days may be subject to prior authorization and to peer review.

(d) A licensed physician, physical therapist, or registered occupational therapist shall be in attendance while a patient is undergoing therapy treatment procedures such as:

- (1) Therapeutic exercises;
- (2) Neuromuscular re-education;
- (3) Functional activities;
- (4) Gait training;
- (5) Manual electrical stimulation;
- (6) Iontophoresis;
- (7) Manual traction;
- (8) Contrast baths;
- (9) Ultrasound;
- (10) Braces;
- (11) Thermal therapy;
- (12) Ultraviolet therapy;
- (13) Pool therapy;
- (14) Hubbard tank;
- (15) Orthotics training (dynamic bracing, splinting, etc.);
- (16) Prosthetic training;
- (17) ADL and diversional activities;
- (18) Mobilization and manipulation;
- (19) Posture training;

§16-23-102

- (20) Therapeutic massage; and
- (21) Therapeutic activities. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-103 Rules of decision for allowable fees for medical, surgical, and hospital services and supplies. (a) When all the required care for a case reasonably falls within the range of qualifications of one health care provider, no other health care provider may claim a fee, except for consultation service or for surgical assistance. For groups of health care providers or hospitals with satellite clinics, when service is rendered by a group member of the same specialty, the group shall submit bills as though one health care provider had cared for the claimant.

(b) Medical, surgical, or hospital care of an unusual type or unlisted fee may occur which represents a type of service over and beyond listed procedures. Appropriate fees may be allowed if the treatment was reasonable, appropriate, and necessary.

(c) Medical conditions or symptoms which are pre-existing and are not aggravated or affected by and do not result from the injury covered by motor vehicle insurance benefits shall not be compensable. Palliative treatment of these unrelated conditions shall be allowed, provided that these conditions directly retard, prevent, or endanger the surgical care or recovery from the injury covered by motor vehicle insurance benefits. In addition, pre-existing conditions which did not require treatment before the motor vehicle accident resulting in accidental harm but which do require treatment as a result of the accident shall be compensable. Pre-existing conditions which required treatment at the time of the accident and which are aggravated or affected so as to require additional treatment shall be compensable to the extent of the additional treatment.

(d) Certain of the procedures listed in medical fee schedules are commonly carried out as an integral part of a total service and do not warrant a separate charge. When such a procedure is carried out as a separate procedure, not immediately related to other services, the indicated fee is applicable.

(e) Minimal dressings, counseling incidental to treatment, etc., are covered by the office visit fee. Necessary drugs, supplies, and materials provided by the health care provider may be charged for separately in accordance with section 16-23-114.

(f) Fees including office visits shall not be paid for more than one visit per day by the same health care provider of service regardless of the number of injuries or conditions treated. [Eff and comp 6/1/93; am and comp 1/1/98; comp

1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-104 Health care providers. (a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of recovery requires. Authorization is not required for the initial fifteen treatments of the injury during the first sixty calendar days, except for chiropractic and acupuncture treatments which are governed by section 431:10C-103.6, HRS, and subsection (d).

(b) A bill for no more than four hours for psychometric, projective, and other psychological testing and the resultant reports shall not be subject to prior authorization or to peer review.

(c) Conservative care extending beyond one hundred twenty calendar days from the date of first treatment may be subject to prior authorization or peer review.

(d)(1) If the injury is the result of an accident on or after January 1, 1998, chiropractic and acupuncture visits shall be limited to the number of and costs for treatments in section 431:10C-103.6, HRS.

(2) A "visit" shall include all examinations or chiropractic manipulative treatments involving one or more regions, spinal, and authorized physiotherapy modalities and procedures or acupuncture treatments provided on the same date.

(3) The Hawaii state chiropractic guidelines are those guidelines in effect on January 25, 1997 (light green cover).

(4) Payments to a chiropractor or an acupuncturist for visits shall conform to paragraph (1) and shall not be reduced or revised by an insurer or its agent(s).

(5) Chiropractic treatments shall not exceed the scope of practice permitted by chapters 431 and 442, HRS.

(e) If the injury is the result of an accident occurring on or after January 1, 1998, for physical medicine and rehabilitation, treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes.

(f) If the injury is the result of an accident occurring on or after January 1, 1998, an insurer or its agent(s) shall not reduce payments to health care providers under this section through the withholding of moneys for the payments

§16-23-104

of taxes. This subsection shall not exempt an insurer or its agent from complying with the Internal Revenue Code. [Eff and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5, 431:10C-B) (Imp: HRS §§431:10C-308.5, 431:10C-B)

§16-23-105 Doctors of chiropractic and naturopathy. (a) This section shall apply if the injury resulted from an accident occurring on or between January 1, 1993 and December 31, 1997.

(b) Frequency and extent of treatment by doctors of chiropractic or naturopathy shall not be more than the nature of the injury and the process of recovery require. A maximum of twenty treatments during the first sixty calendar days following the first treatment are not subject to prior authorization or to peer review. Up to six treatments during the first thirty calendar days thereafter and up to four treatments during the second thirty days thereafter are not subject to prior authorization or peer review.

(c) Chiropractic or naturopathic care extending beyond one hundred twenty calendar days may be subject to prior authorization or peer review.

(d) Taking of x-rays shall be discretionary for sixty days at or following the initial chiropractic or naturopathic treatment and is not subject to prior authorization or peer review during that period.

(e) When the chiropractic adjustment is an ongoing part of a therapeutic regimen, the evaluative process is not part of this regimen, and one evaluation may be permitted each thirty calendar days for sixty calendar days following initial treatment. Additional evaluations may be permitted if new or aggravated symptoms present an indication of need for an additional intermediate or comprehensive evaluation and examination, but these additional evaluations may be subject to prior authorization or peer review.

(f) This section supersedes section 12-13-39, as it applies to injuries covered by no-fault benefits. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: §431:10C-308.5)

§16-23-106 Physician assistants. Attending health care providers may prescribe treatment in their discipline to be carried out by persons certified or licensed to provide the service. Fees for services provided by certified or licensed physician assistants under Hawaii law shall be sixty per cent of the fees authorized

by section 16-23-115. Fees for services provided by assistants not certified or licensed shall be fifty per cent of the fees authorized by section 16-23-115. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-107 Licensed acupuncturists. If the injury is the result of an accident occurring on or between January 1, 1993 and December 31, 1997, frequency of treatment by a licensed acupuncturist shall not be more than the nature of the injury and the process of recovery require. Treatment requiring a maximum of fifteen sessions during the first sixty calendar days of treatment is not subject to prior authorization or peer review. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-108 Biofeedback treatments. If the injury is the result of an accident occurring on or between January 1, 1993 and December 31, 1997, biofeedback treatments shall be compensable if performed by or at the direction of a physician. The frequency and extent of treatment shall not be more than the nature of the injury and the process of recovery require. Treatment requiring a maximum of ten visits is not subject to prior authorization or to peer review. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-B) (Imp: HRS §431:10C-308.5)

§16-23-109 Massage therapy. (a) This section shall apply if the injury resulted from an accident occurring on or between January 1, 1993 and December 31, 1997.

(b) Massage therapy shall be compensable when performed by a licensed massage therapist or in accordance with Hawaii law.

(c) Frequency and extent of treatment shall not be more than the nature of the injury and the process of recovery require. The initial ten treatments do not require prior authorization and are not subject to peer review. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5, 431:10C-A) (Imp: HRS §§431:10C-308.5, 431:10C-A)

§16-23-110 Anesthesia services. (a) A base unit is listed for all procedures in the medical fee schedule in accordance with section 16-23-115.

This includes the base unit of all anesthesia services except the value of the actual time spent administering the anesthesia or in unusual detention with the patient.

(b) As allowed under Medicare, the anesthesia charges are equal to the sum of the base and time units for the service multiplied by a geographical adjusted anesthesia-specific conversion factor.

(c) The total value for anesthesia services includes pre- and post-operative visits, the administration of the anesthetic, and the administration of fluids and blood incident to the anesthesia or surgery.

(d) The time units are computed by dividing the total anesthesia time by fifteen minutes.

(e) Calculated values for anesthesia services shall be used when the anesthesia is administered by an appropriately licensed health care provider and a fee shall be paid only for the individual anesthetic service.

(f) If the general or regional anesthetic is administered by the attending health care provider, the value shall be fifty per cent of the calculated value.

(g) A separate charge may be made for necessary drugs and materials provided by the health care provider or anesthetist in accordance with section 16-23-114.

(h) When unusual detention with the claimant is essential for the safety and welfare of the claimant, the necessary time will be valued on the same basis as indicated for anesthesia time.

(i) No additional fee shall be allowed for local infiltration or digital block anesthesia administered by the operating physician.

(j) When either a hypothermia or a pump oxygenator, or both, are employed in conjunction with an anesthetic, the anesthetic "basic" value will be equal to that of procedure code 00560.

(k) Where anesthesia is administered for dental services, if the above rules are not applicable, a fee equal to that of the procedure code 00122 for inhalation anesthesia and equal to that of procedure code 00102 by an intravenous route will be allowed. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-111 Radiology services. (a) Taking of anterior-posterior (A-P), lateral, and oblique x-rays shall be discretionary for one hundred-twenty days following the initial treatment and may be allowed without authorization. Prior authorization from the insurer shall be obtained for x-rays subsequent to the initial one hundred-twenty days of treatment.

(b) Diagnostic tests and x-rays shall be taken, reported, and marked for identification and orientation in accordance with the accepted standard of



radiologic practice. X-rays shall be taken on machines with a current certification by the department of health.

(c) Where contrast x-ray examinations are performed, fees shall include the usual contrast media. When special trays or materials are provided by the health care provider, rather than by the hospital, an additional charge is warranted.

(d) Injection procedures, including major surgery, for the purpose of performing needed radiological studies, are covered in the section on surgery. The fee shall be paid to the health care provider actually performing the service.

(e) Fees shall include both the technical and professional components. In the absence of any prior agreement between a radiologist and a hospital or other facility furnishing technical radiology services, the professional component shall be thirty-five per cent of the scheduled radiology fee. The technical (-TC) and professional (-26) components may be billed separately using the appropriate modifiers as indicated by Medicare. Billings for x-rays are not reimbursable without a report of the findings.

(f) Radiotherapy includes the use of x-ray and other high energy modalities (betatron, linear accelerator, etc.), radium cobalt, and other radioactive substances. Fees for therapy include follow-up care, and concomitant office visits, but not concomitant surgical, radiological, or laboratory procedures. [Eff and comp 6/1/93; am 1/30/95; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-112 Repealed. [R 1/1/98]

§16-23-113 Hospital services. (a) Subject to the terms of the motor vehicle insurance policy, when hospitalization is required for further treatment of a claimant, that claimant shall have a free choice of a licensed hospital in the county where the injury occurred or in the county where the claimant resides. If the claimant is in critical condition or unable to express a choice, then the attending health care provider may designate the hospital to which the claimant will be taken.

(b) Hospital charges shall be limited to ward rates or the lowest prevailing rate at the hospital where the claimant is confined, except if the nature of the injury requires private care, intensive care, or isolation, as determined by the attending health care provider, in which case the prevailing private rates may be charged.

(c) When a claimant is treated in the emergency facility of a hospital, the allowable hospital charge for the use of the emergency room shall be the established emergency room charge for that particular hospital.

§16-23-111

(d) All hospital charges shall be itemized when a bill is submitted. [Eff and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-114 Drugs, supplies and materials. (a) All charges for prescribed drugs, supplies, or materials for the use of the claimant shall be separately listed and certified by the health care provider, or a duly authorized representative that the charges for the drugs, supplies, or materials were required or prescribed for the injury covered by motor vehicle insurance benefits.

(b) Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific compensable dietary deficiency has been clinically established in the claimant as a result of the injury covered by motor vehicle insurance benefits.

(c) Payment for covered prescription drugs and supplies shall be made at the average wholesale price plus forty per cent of the average wholesale price when sold by a health care provider, hospital, pharmacy, or alternative health care provider of service. Billings for prescriptive drugs shall include the national drug code number listed in the current American Druggist Red Book followed by the average wholesale price listed at time of purchase by the health care provider of service. Approved generics shall be substituted for brand name pharmaceuticals unless the prescribing health care provider certifies no substitution is permitted because the claimant's condition will not tolerate a generic preparation. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-115 Workers' compensation medical fee schedule. (a) Charges for medical services shall not exceed one hundred ten per cent of participating fees prescribed in the Medicare Resource Based Relative Value Scale System applicable to Hawaii (Medicare Fee Schedule) or Exhibit A at the end of Title 12, Chapter 15, entitled "Workers' Compensation Supplemental Medical Fee Schedule" (Exhibit A). The Medicare Fee Schedule and Exhibit A, together herein referred to as the "medical fee schedule," is made a part of this chapter and shall be used to determine the maximum allowable fees using the procedure codes and unit values established by the department of labor and industrial relations pursuant to section 386-21, HRS. Any subsequent amendment by the department of labor and industrial relations to the Medicare fee schedule and Exhibit A, shall be incorporated into this chapter by reference.

(b) If the maximum allowable fees for medical services are listed in both the Medicare Fee Schedule and Exhibit A, charges shall not exceed the maximum allowable fees allowed under Exhibit A.

(c) For the purposes of this section "private patient" means a patient not covered by insurance. If the charges are not listed in the medical fee schedule or in Exhibit A, the health care provider shall charge a fee not to exceed eighty per cent of the health care or alternative care provider's usual and customary fee for the same service rendered to a private patient. Upon request by the insurer, a health care or alternative care provider shall submit a statement itemizing the lowest fee charged for the same health care, services, and supplies furnished to any private patient during a one-year period preceding the date of the particular charge. Requests shall be submitted in writing within twenty calendar days of receipt of a charge allegedly in excess of the allowable amount. The health care or alternative care provider shall reply in writing within ten calendar days of receipt of the request. Failure to comply with the request of the insurer shall be reason for the insurer to deny payment.

(d) Fees listed in the Medicare Fee Schedule shall be subject to the current Medicare Fee Schedule correct coding initiative ("CCI") and follow-up rules. The Health Care Financial Administration Common Procedure Coding System alphabet codes adopted by Medicare shall not be allowed unless specifically adopted by the director of labor. [Eff and comp 6/1/93; am and comp 1/1/98; am and comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

§16-23-116 Certification by health care providers and alternative care providers. Each health care provider shall certify on the bill or charges that the charges are in accordance with this chapter. Any service performed by a alternative care provider shall be similarly certified. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214, 431:10C-308.5) (Imp: HRS §431:10C-308.5)

## SUBCHAPTER 18

### PEER REVIEW

§16-23-117 Time requirements for peer review. A peer review organization shall complete its review of treatment in excess of the applicable utilization schedules and shall report to the commissioner within thirty days after the commissioner submits the case to the peer review organization. [Eff and comp

6/1/93; comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214) (Imp: HRS §431:10C-214)

§16-23-117.5 Applicability of peer review. This subchapter applies to treatment for injuries resulting from accidents occurring on or between January 1, 1993 and December 31, 1997. [Eff and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214) (Imp: HRS §431:10C-214)

§16-23-118 Submission to peer review organization. (a) When an insurer files a challenge with the commissioner for submission to a peer review organization, the insurer shall provide written notice to the claimant and the health care provider. The commissioner may prescribe a form for the notification.

(b) The challenge shall be accompanied by the filing fee specified by section 16-23-90 and shall include the reason for the challenge, any medical or other information necessary to make a determination of whether the challenged treatment is appropriate and reasonable and a list of any medical or other information submitted with the challenge. The challenge shall also include the treatment plan and any other information submitted by the health care provider to the insurer relating to the challenged treatment. The commissioner may prescribe forms to be used for a submission of a challenge to treatment to a peer review organization.

(c) The peer review organization may request additional information if necessary from the insurer, the claimant, or the health care provider. The requested information shall be provided to the peer review organization within five working days of mailing of the request. No other information shall be provided to the peer review organization unless specifically requested.

(d) While a challenge is pending, the claimant shall be entitled to continued health care services requested up until the date of the peer review organization decision. If the peer review organization finds that the treatment is inappropriate or unreasonable, the health care provider shall refund to the insurer all amounts paid for the disapproved treatment.

(e) Only challenges based on whether treatment is appropriate or reasonable shall be filed with the commissioner for submission to a peer review organization. Denial or partial denial of claims based on other grounds, such as coverage questions, shall not be subject to peer review.

(f) In the event an insurer denies a claim on a basis other than the appropriateness and reasonableness of treatment, the health care provider may collect from the claimant the reasonable value of the services rendered. If the claim is later deemed compensable and the claimant has paid the health care

provider, the insurer shall reimburse the claimant for the actual sums paid to the health care provider.

(g) Nothing in these rules shall prohibit a peer review organization from specifying a course of treatment which it would consider appropriate and reasonable. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214) (Imp: HRS §§431:10C-214, 431:10C-308.6)

§16-23-119 Reconsideration. (a) If the peer review organization finds that treatment is appropriate and reasonable, the insurer shall either request reconsideration by the peer review organization that made the original decision or approve payment of the claim.

(b) If the peer review organization finds that treatment is inappropriate or unreasonable, the insurer may deny the claim; in that event, the claimant or the health care provider may request reconsideration by the peer review organization that made the original decision, request an administrative hearing, or seek arbitration or court review of the denial.

(c) Any party seeking reconsideration of a peer review organization's decision shall pay to the commissioner a filing fee of \$100, along with the cost of the reconsideration. The request for reconsideration shall state the basis for reconsideration.

(d) The peer review organization shall complete its reconsideration and report to the commissioner within ten days after the request for reconsideration is submitted to the peer review organization. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214) (Imp: HRS §431:10C-214)

§16-23-120 Dispute regarding charges. (a) In the event of a dispute between the health care provider and the insurer over the amount of a charge or the correct fee and procedure code to be used pursuant to exhibit A to the workers' compensation schedules, the insurer shall pay all charges not in dispute and shall negotiate in good faith with the health care provider on the disputed charges. Such disputes shall not be filed with the commissioner for submission to peer review.

(b) If the health care provider and the insurer cannot resolve the dispute, either party may make a request to the commissioner for a hearing. The request shall include documentation of the efforts of the insurer and the health care provider to reach a negotiated resolution of the dispute. [Eff and comp 6/1/93; am and comp 1/1/98; comp 1/8/99] (Auth: HRS §§431:2-201, 431:10C-214) (Imp: HRS §§431:10C-308.5, 431:10C-214)

§16-23-118

Amendments to and compilation of chapter 16-23, Hawaii Administrative Rules, on the Summary page dated December 18, 1998, were adopted on December 18, 1998, following a public hearing held on the same date, after public notices were given in the Honolulu Star-Bulletin, West Hawaii Today, Hawaii Tribune-Herald, Maui News, and the Garden Island on November 18, 1998.

These amendments and compilation shall take effect ten days after filing with the Office of the Lieutenant Governor.

/s/ Reynaldo D. Gaulty  
REYNALDO D. GRAULTY  
Insurance Commissioner

APPROVED AS TO FORM:      Date 12/22/98

/s/ David A. Webber  
Deputy Attorney General

APPROVED:                      Date 12/22/98

/s/ Kathryn S. Matayoshi  
KATHRYN S. MATAYOSHI, Director  
Commerce and Consumer Affairs

APPROVED:                      Date 12/22/98

/s/ Benjamin J. Cayetano  
BENJAMIN J. CAYETANO  
Governor  
State of Hawaii

December 29, 1998  
Filed  
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

Amendment and Compilation of Chapter 16-23  
Hawaii Administrative Rules

December 18, 1998

SUMMARY

1. §16-23-1 is amended.
2. §16-23-2 is repealed.
3. §§16-23-3 through 16-23-5 are amended.
4. §§16-23-9 and 16-23-10 are amended.
5. §16-23-10.1 is repealed.
6. §16-23-10.2 is amended.
7. §16-23-10.3 is repealed.
8. §§16-23-11 through 16-23-11.3 are amended.
9. §16-23-11.4 is repealed.
10. §§16-23-14 and 16-23-15 are repealed.
11. §16-23-57 is amended.
12. §16-23-60 is amended.
13. §16-23-64 is amended.
14. §16-23-69 is repealed.
15. §§16-23-72 and 16-23-73 are amended.
16. §16-23-75 is amended.
17. §16-23-79 is amended.

THIS MATERIAL CAN BE MADE AVAILABLE FOR INDIVIDUALS WITH SPECIAL NEEDS IN BRAILLE, LARGE PRINT OR AUDIO TAPE. PLEASE  
SUBMIT YOUR REQUEST TO THE INSURANCE DIVISION. ATTENTION TERRENCE ARATANI AT (808) 586-2790.

Amended 1/8/99

18. §16-23-83 is repealed.



19. §16-23-84 is amended.
20. §16-23-96 is amended.
21. §16-23-104 is amended.
22. §16-23-113 is amended.
23. §16-23-115 is amended.
24. Chapter 16-23 is compiled.