HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1710.1

9-11 NET PROGRAM

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§17-1710.1-1 General provisions. (a) This chapter establishes the 9-11 Net program which provides, for a limited period of time, a low-cost alternative medical insurance program for an individual who lost employer-sponsored health insurance coverage as a result of a furlough, layoff, reduction in work hours, or termination from employment due to the economic downturn caused by the terrorist attacks on the United States on September 11, 2001, and who is eligible to participate in the program. The individual's dependent family members may also be covered under this program, provided the affected individual is determined eligible.

(b) This program shall be implemented on the date of adoption of these rules and shall be

terminated effective December 21, 2002, unless otherwise provided by law.

(c) This program, which is unlike the medical assistance programs administered by the department of human services, shall not be subject to the rules of this subtitle, except as specifically set forth in this chapter.

(d) The provisions of chapter 1702 addressing confidentiality shall apply to this program.

(e) The provisions of chapter 1703 addressing administrative appeals shall apply to this program. However, in applying chapter 1703 to this program, the terms "eligibility branch", "eligibility branch administrator", "med-QUEST eligibility office", and "eligibility worker" in chapter 1703 shall be replaced by the term "med-QUEST division staff".

(f) The provisions of chapter 1704 addressing fraud shall apply to this program. However, in applying chapter 1704 to this program, the terms "medical assistance" and "Medicaid" in chapter 1704 shall be replaced by the term "9-11 Net program".

(g) The provisions of subchapters 6 and 7 of chapter 1705 addressing recovery of overpayment to providers and recipient recovery, respectively, shall apply to this program. However, in applying subchapters 6 and 7 to this program, the term "medical assistance" in subchapters 6 and 7 of chapter 1705 shall be replaced by the term "9-11 Net program".

(h) This program shall be administered by the med-QUEST division and contractors identified by the department of human services for the purpose of this program.

(i) For the purposes of this chapter, the med-QUEST division shall mean the med-QUEST division of the department of human services of the State of Hawaii.

(j) For the purposes of this chapter, the Department shall mean the department of human services of the State of Hawaii. [Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

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§17-1710.1-2 Eligibility requirements. To be eligible for this program, the individual must:

(1) Have lost employer-sponsored health insurance coverage as a result of a furlough, layoff, reduction in work hours, or termination from employment due to the economic downturn caused by the terrorist attacks on the United States on or after September 11, 2001;
(2) Not covered by any health insurance;
(3) Agree to pay the premiums for the program coverage;
(4) Have been a resident of Hawaii at the time of the furlough, layoff, reduction in work hours, or termination of employment; and
(5) Be a resident of Hawaii when applying for this program and during the period of coverage under this program.
[Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-3 Application for participation. (a) An application for participation in the program shall be submitted by or on behalf of an applicant for the applicant and, at the applicant's discretion, for the applicant's spouse and dependent's under age nineteen.

(b) The application form designated by the department shall be completed and signed by the applicant and the applicant's present or most recent employer and submitted to the med-QUEST division.

(c) The application shall be processed by the med-QUEST division within forty-five days of the division's receipt of the completed and signed application. [Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-4 Premiums. (a) The monthly premium for coverage under this program shall be sixty-three dollars per covered individual.

(b) The monthly premium shall be paid by or on behalf of the covered individual on or before the twentieth calendar day of a calendar month, or, if the twentieth calendar day falls on a weekend or holiday, on the first State business day thereafter, for coverage for the subsequent calendar month.

(c) Payment of the monthly premium for the first month of coverage shall be submitted with the completed and signed application for participation in the program. If such payment is not submitted by the twentieth calendar day of the month or if the payment is of an insufficient amount, the application shall not be approved until premium payments are received by the med-QUEST division.

(d) If a check for premium payment for a covered individual is not negotiable when processed by the division, a service fee of fifteen dollars, related to that incident, shall be additionally charged for the covered individual.

(e) A covered individual or the responsible parent, spouse, or legal guardian shall be responsible to pay all unpaid premium amounts and service fees, even if the individual is no longer covered by the program.

(f) An individual who is disenrolled due to the individual's premium being in arrears shall be required to satisfy all outstanding premium debts, to the department's satisfaction, prior to being allowed to participate in the 9-11 Net program.
[Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-5 Co-payments. An enrollee shall be responsible for specified dollar amounts, known as co-payments, for certain kinds of services. The following are the dollar amounts of the co-payments and the services related to the co-payments:

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(1) Twenty-five dollars per visit for outpatient hospital emergency room services;
(2) Seven dollars per visit for urgent care services;
(3) Seven dollars per visit for outpatient physician's services;
(4) Two dollars per prescription for prescribed generic or single-source brand drug; and
(5) Five dollars per prescription for multiple-source brand drug. [Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-6 Effective date of coverage. The effective date of a participant's coverage shall be the first day of the calendar month after the participant's application has been approved, provided that the premium payment for the first month of coverage has been received by the twentieth calendar day of the month preceding the effective date of coverage by the med-QUEST division. [Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-7 Termination of coverage. An individual's coverage under this program shall be terminated for any of the following reasons:
(1) Premiums for the following month's coverage are not received by the med-QUEST division by the twentieth calendar day of a calendar month, or if the twentieth day falls on a weekend or a holiday, on the first state business day thereafter;
(2) Death of the covered individual;
(3) The covered individual has or will have other health care coverage;
(4) The covered individual no longer resides in the State;
(5) The covered individual is employed and is eligible for employer-sponsored health

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insurance under the Hawaii Prepaid Health Care Act;

(6) A dependent child attains the age of nineteen;

(7) The individual voluntarily terminates coverage; or

(8) The program is terminated or repealed. [Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-8 Administration of benefits. (a) The department shall contract with a health plan to administer the benefits of the program.

(b) Participants of the program shall be enrolled in the single statewide health plan contracted by the department.

(c) Participants shall adhere to the conditions of enrollment in the health plan.

(d) Participants shall access services through the health plan's provider network. [Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-9 Benefits - general provisions. (a) The benefits for all participants in the program, regardless of age or gender, shall be limited to coverage of the services described in sections 17-1710.1-10, 17-1710.1-11, and this section.

(b) The maximum limits of covered services are applicable to a calendar year.

(c) All covered services shall be provided within the State of Hawaii.

(d) The program shall not include coverage of dental services. [Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-10 Hospital services covered. (a) Within a calendar year, the plan shall provide each

enrollee a maximum coverage of ten days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric care, and substance abuse treatment. The following hospital services shall be made available to each enrollee:

(1) Semi-private room and board and general nursing care for inpatient stays related to medical care, surgery, psychiatric care, and substance abuse treatment;

(2) Intensive care room and board and general nursing care for medical care and surgery;

(3) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the plan medical director for medical care and surgery;

(4) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician;

(5) Other ancillary services associated with hospital care except private duty nursing; and

(6) Ten inpatient physicians visits within a benefit year.

(b) Inpatient hospital care related to maternity, newborn nursery, neonatal intensive care, and inpatient services in a freestanding rehabilitation hospital shall not be covered by this program. [Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-11 Outpatient services covered. (a) Within a calendar year, the plan shall provide each enrollee the coverage of the following outpatient services:

(1) A maximum of twelve outpatient visits including health assessments, family planning services, diagnosis, treatment, consultations, and second opinions. The maximum of twelve outpatient visits shall not pertain to:

(A) Bonafide emergency room visits.

(B) An enrollee's first six mental health visits within a benefit year. After the first six mental health visits, an

enrollee may choose to apply a maximum of six additional mental health visits toward the maximum of twelve physician outpatient visits.

(C) Diagnostic testing, including laboratory and x-ray, directly related to a covered outpatient visit.

(2) Maternity care coverage shall be limited to one routine visit to confirm pregnancy and any visits for the diagnosis and treatment of conditions related to medically indicated or elective termination of pregnancy such as ectopic pregnancy, hydatiform mole, and missed, incomplete, threatened, or elective abortions. These visits shall count toward the twelve maximum outpatient visits, ten maximum inpatient days, or three maximum ambulatory surgeries.

(3) Coverage of medically necessary ambulatory surgical care shall be limited to three procedures per benefit year.

(b) Coverage shall be provided for one health assessment examination, which shall be counted toward the maximum of twelve outpatient physician visits. An annual pap smear for a woman of child bearing age shall be included in the health assessment.

(c) Coverage of immunizations for diphtheria and tentanus shall be provided.

(d) Coverage shall be provided for bonafide emergency room visits including ground ambulance, emergency room services, and physician services in conjunction with the emergency room visits. Bonafide emergency room visits shall be restricted to those requiring services for medical conditions manifesting themselves in acute symptoms of such severity that the absence of medical attention could reasonably be expected to result in placing the enrollee's health in serious jeopardy, or serious impairment of bodily functions, or serious dysfunction of any body organ or part.

(e) Within a calendar year, each enrollee shall be provided a maximum coverage of six mental health visits, limited to one treatment per day.

(1) After exhausting the coverage of six mental health visits, an enrollee may use coverage of up to six of the enrollee's twelve outpatient physician visits per calendar year, as available, for additional mental health visits.

(2) Services for alcohol and substance abuse conditions shall be covered as mental health visits. The following restrictions on alcohol and substance abuse treatment apply.
(A) Outpatient alcohol or substance abuse services shall be considered toward the maximum coverage of six mental health visits and six annual outpatient physician office visits if used for additional mental health visits.
(B) Inpatient alcohol or substance abuse services shall be considered toward an enrollee's maximum coverage of ten hospital days.
(C) All alcohol or substance abuse services shall be provided under an individualized treatment plan approved by the plan.

(f) Coverage of drugs shall be the same as provided under HMSA QUEST-Net contracted formulary.

(g) Coverage shall be provided for family planning services to include family planning services rendered by physician or nurse midwife and family planning drugs, supplies and devices approved by the federal Food and Drug Administration.
[Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)

§17-1710.1-12 Services not covered. The following services shall not be covered:
(1) Custodial or domiciliary care;
(2) Services received in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded;
(3) Personal care items such as shampoos, toothpastes, mouthwashes, denture cleansers, shoes including orthopedic footwear, slippers, clothing, laundry services, baby oils and powders, sanitary napkins, soaps, lip balms, and band-aids;
(4) Non-medical items such as books, telephones, electronic transmitting and paging devices, radios, linens, clothing, televisions sets, computers, air conditioners, air purifiers, fans, household items and furnishings;

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(5) Emergency facility services for non-emergencies;
(6) Out-of-state emergency and non-emergency services;
(7) Experimental and investigational services, procedures, drugs, devices, and treatments;
(8) Organ and tissue transplantation and transplantation services for either a recipient or a donor;
(9) Blood, blood products, and blood storage on an outpatient basis;
(10) Gender reassignment and related medical, surgical, and psychiatric services, drugs, and hormones;
(11) In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures, and drugs to test fertility;
(12) Eyeglasses, contact lenses, low vision aids, orthoptic training, and refractions;
(13) Hearing aids and related supplies and services, including fitting for, purchase of, rental of, and insuring of hearing aids;
(14) Durable medical equipment, prostheses, orthoses, medical supplies, and related services including purchase, rental, repairs, and related services, except as supplied as part of an inpatient hospital stay;
(15) All dental services, including orthodontic services and supplies;
(16) Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment;
(17) Obesity treatment, weight loss programs, food, food supplements, health foods, and prepared formulas;
(18) All services, procedures, equipment, and supplies not specifically listed which are not medically necessary;
(19) Cosmetic surgery or treatment, cosmetic rhinoplasties, reconstructive or plastic surgery to improve appearance and not bodily function, piercing of ears and other body areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniculectomies and other body sculpturing procedures, excision or destruction of

benign skin or subcutaneous lesions without medical justification;

(20) Transportation including air (fixed wing or helicopter) ambulances;

(21) Hospice services;

(22) All home health agency services;

(23) Personal care, chore services, adult day health, private duty nursing, social worker services, case management services, targeted case management services, and home and community based waiver services;

(24) Funeral payment services;

(25) Tuberculosis services when provided without cost to the general public;

(26) Hansen's disease treatment or follow-up;

(27) Treatment of persons confined to a public institution;

(28) Penile and testicular prostheses and related services;

(29) Chiropractic services;

(30) Psychiatric care and treatment for sex and marriage problems; weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy, and consortium;

(31) Routine foot care and treatment of flat feet;

(32) Swimming lessons, summer camp, gym membership, weight control classes;

(33) Outpatient renal dialysis, cardiac and coronary artery surgery involving cardio-pulmonary by-pass, cataract surgery with or without intraoccular lens implants, and refractive keratoplasty;

(34) Physical therapy, occupational therapy, speech therapy, respiratory services, and sleep studies rendered on an outpatient basis;

(35) Medical services provided without charge by any other federal, state, municipal, territorial, or other government agency including the Veterans Administration;

(36) Medical services for an injury or illness caused by another person or third party from whom the enrollee has or may have a right to recover damages;

(37) Medical services that are payable under the terms of any other group or non-group health plan overage;

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(38) Medical services that do not follow standard medical practice or are not medically necessary;
(39) Stand-by services by a stand-by physician and telephone consultation;
(40) Services provided for illness or injury caused by an act of war, whether or not a state of war legally exists, or required during a period of active duty that exceeds thirty days in any branch of the military;
(41) Treatment of sexual dysfunction including medical and surgical procedures, supplies, drugs, and equipment;
(42) All services excluded by the Hawaii Medicaid Program;
(43) All services not provided by providers licensed or certified in the State of Hawaii to perform the service;
(44) Medical services that are payable under terms of worker compensation, automobile medical and no-fault, underinsured or uninsured motorist, or similar contract of insurance;
(45) Physical examination required for continuing employment, such as taxi driver's or truck driver's licensing, or as required by government or private businesses;
(46) Physical examinations, psychological evaluations, and immunizations as a requirement for licenses or for purposes of securing insurance policies or plans;
(47) Allergy testing and treatment;
(48) Treatment of any complication resulting from previous cosmetic, experimental, investigation service, or any other non-covered service;
(49) Rehabilitation services requiring intensive continuous care, inpatient or outpatient, including cardiac, alcohol or drug dependence rehabilitation;
(50) All acne treatment, surgery, drugs for adults; removal or treatment of asymptomatic benign skin lesions or growth; and
(51) Prenatal, postpartum, and delivery services including all laboratory testing in both inpatient and outpatient setting. An exception is one outpatient visit to confirm pregnancy, as identified as a covered service in this chapter.

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[Eff 06/13/02] (Auth: HRS §346-14, SLH 2001 3 SP, Act 6) (Imp: HRS §346-14, SLH 2001 3 SP, Act 6)