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TO THE SENATE COMMITTEE ON COMMERCE, CONSUMER PROTECTION AND AFFORDABLE HOUSING

TWENTY-FOURTH LEGISLATURE
Regular Session of 2008

Thursday, February 21, 2008
9:00 a.m.

TESTIMONY ON SENATE BILL NO. 3015 SD1 – RELATING TO THE PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES ACT.

TO THE HONORABLE RUSSELL S. KOKUBUN, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J. P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department strongly supports this Administration bill.

The purpose of this bill is to help protect consumers of health insurance by establishing prohibited practices for managed care plans. This bill is based partly on the California Knox-Keene Act regulating managed care plans and federal law.

This bill:

- Prohibits disenrollment because of medical condition. This is similar to the provisions of §1358.8 of California's Knox Keene Act and the requirements of the federal law set out in the Employee Retirement Income Security Act (ERISA) (29 USC §1182) and in 42 U.S.C. § 300gg-1(a)(1) the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

- Prohibits withdrawal of authorization for a procedure by the health plan after the provider has provided health care services. This is similar to the provisions of §1371.8 of California's Knox Keene Act;

- Prohibits health insurance contract modifications during the term of the contract, unless such modifications are agreed to. This is similar to §1374.20 of the California statute;

- Prohibits post claims underwriting, i.e., terminating an individual's health plan coverage because the insurer discovers a medical condition that they didn't know about at the time of underwriting. This is similar to the prohibition found in §1398 of the California Knox-Keene Act; and,

- Provides that eligible charges for nonparticipating providers should be the same as for participating providers.

This last provision is not taken from the California or federal law but arises from our own experience of a case where a nonparticipating provider, an assistant surgeon for a bladder cancer surgery, charged $864.00 for his services, the plan allowed a nonparticipating provider eligible charge of $77.04 – and paid 70% of that amount, i.e., $53.93. The patient was billed for the balance – $810.07. It is patently unfair for an insured who has been paying health insurance premiums, often for many years, to end up paying $810 of an $864 doctor's bill and having coverage for only $53.93. In this particular case an external review panel overturned this reimbursement citing Hawaii case law that:

> "In interpreting insurance policies, the insured's *reasonable expectations* must be given effect. Under the doctrine of illusory coverage, insurance contracts should, if possible, be construed so as not to be a delusion to the insured."

Keeping in mind that a participating provider eligible charge is often considerably less than the medical provider's usual and customary charge, this bill would require that the plan use the same eligible charge that it pays participating providers so that at least we can expect a payment somewhere in the ballpark of reasonableness. Otherwise there is no control over what amount the coverage will be and, as we can see from the external review case I've noted, that the amount of insurance coverage can be ridiculously low. Although this particular case was overturned after an external review hearing, unless an appeal is filed, we have no way of knowing how many other

consumers have been victimized by this practice. This bill will give insureds some protection against the insurer setting unreasonably low and arbitrary nonparticipating provider eligible charges.

Other highlights of this bill include that after the health insurance company authorizes a treatment by a health care provider, subsection 2 of the bill would prohibit health insurers from rescinding or modifying the authorization after the provider renders the health care service in good faith and pursuant to the authorization. The reason for this provision is that consumers and providers should be able to rely on insurance companies to verify eligibility and benefits at the time of service and not be allowed to rescind the authorization after services are provided. If a health plan verifies eligibility and either provides a prior authorization or indicates that prior authorization is not required, it is reasonable for the patient and the provider to assume that the service will be paid for once billed and this provision would protect that reasonable expectation.

Another highlight is subsection 4, the post-claims underwriting provision. This provision is taken from the California managed care statute and prohibits a health insurer from waiting until the insured submits a big claim and then reviewing the enrollment application for an excuse to cancel or otherwise modify the policy. Post-claims underwriting has been considered by some courts to be a violation of an insurance company's duty of good faith to the policyholder. Insurance companies have a duty of good faith and fair dealing with the people they insure. This means that these companies have a duty to protect the interests of the people they insure in the same way they protect their own interests. This duty of good faith and fair dealing is required from the insurance company whether or not it appears in any written contract. When the insurance company issues a medical insurance policy, the person insured thinks he or she has medical coverage and relies on that understanding. If the company has a legitimate reason for denying coverage and tells the person at the time of the insurance application, the person can find other coverage. If the insurance company doesn't review applications until claims are filed and then retroactively cancels the policies, the people insured by the company find themselves without insurance and liable for all the

medical expenses that they thought were covered by their medical insurance. This is a very serious injury caused by the insurance company's bad faith failure to review the enrollment application in a timely manner. It is also bad faith for an insurance company to cancel a policy on the basis of excuses that would not have been sufficient to refuse coverage at the time of the insurance application. In other words a misrepresentation on the part of a person applying for coverage must be material, meaning it must be something that if it had been disclosed upon application would have resulted in a denial of coverage.

Another important aspect of this bill is that it helps protect the consumer by allowing action by the Commissioner against insurers by way of complaint or investigation rather than suing in court or having external review as the only mechanism for redress. Often consumers cannot obtain legal representation for either court action or external review appeals. This bill gives the Commissioner greater flexibility in addressing consumer grievances by allowing resolution by administrative action.

We thank this Committee for the opportunity to present testimony on this matter and ask for your favorable consideration.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 20, 2008

The Honorable Russell Kokubun, Chair
The Honorable David Ige, Vice Chair

Senate Committee on Commerce, Consumer Protection and Affordable Housing

Re: SB 3015 SD1 – Relating to the Patients' Bill of Rights and Responsibilities Act

Dear Chair Kokubun, Vice Chair Ige and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 3015 SD1 which would amend the Patients' Bill of Rights and Responsibilities Act by prohibiting certain unfair or deceptive business practices by managed care plans.

The language in this measure is intended to protect consumers against deceptive business practices perpetuated by a health plan. HMSA does not engage in the practices listed in SB 3015 SD1.

That being said, we would like to provide comments on one section and request a small amendment to the measure. On page 3, Line 17 it seems that this line needs to be edited to read:

heard, that an insurer has violated this section, the

In addition, we would respectfully request that instead of SB 3015 SD1 becoming effective upon approval that the effective date be pushed back till January 2009. This will enable all health plans to ensure that current contract language complies with the requirements of this measure.

Thank you for the opportunity to testify on SB 3015 SD1.

Sincerely,

Jennifer Diesman
Director, Government Relations