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TO THE HOUSE COMMITTEES ON
CONSUMER PROTECTION & COMMMERCE
AND
JUDICIARY

TWENTY-FOURTH LEGISLATURE
Regular Session of 2008

Monday, March 31, 2008
2:00 p.m.

TESTIMONY ON SENATE BILL NO. 3015 SD2, HD1 – RELATING TO THE PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES ACT.

TO THE HONORABLE ROBERT N. HERKES AND TOMMY WATERS, CHAIRS, AND MEMBERS OF THE COMMITTEES:

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.

Faith Action for
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March 31, 2008

COMMITTEE ON COMSUMER PROTECTION & COMMERCE
Rep. Robert N. Herkes, Chair

COMMITTEE ON JUDICIARY
Rep. Tommy Waters, Chair

RELATING TO THE PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES ACT
SB 3015, SD2, HD1

DATE: Monday, March 31, 2008
TIME: 2:00 p.m.
PLACE: Conference Room 325

TESTIFIER: Rev. Bob Nakata, President, FACE
Clementina D. Ceria-Ulep, PhD, RN,
Chair, Healthcare Committee, FACE

Chairs Herkes and Waters and members of the Committees on Consumer Protection Commerce and Judiciary:

We are Rev. Bob Nakata President of FACE and Clem Ceria-Ulep, the Chair of the FACE Healthcare Committee and we are in support of legislative protection of healthcare consumers from unfair or deceptive business practices by managed care plans.

F.A.C.E., as a faith-based community grassroots organization, believes that all the citizens of the State of Hawaii should have access to quality education, affordable homes, and ***quality healthcare***. On February 16, 2008, we held our first healthcare summit to address the crisis in the access and delivery of healthcare to Hawaii's people regardless of their socio-economic status. We are hearing from our members that this crisis is having a profound effect on their families, employers and employees. However, as an organization it became apparent that our membership must first understand the history of healthcare in Hawaii, the root causes of our current crisis and the financial implications.

F.A.C.E. represents 28,000 members who are consumers of health insurance. This measure will further add protections by establishing prohibited practices of the managed care plans for our members and other consumers in the State of Hawaii. This measure incorporates accepted practices in California under the Knox-Keene Act and federal law.

Healthcare law and regulations are the most complicated insurance for the consumers. This measure will prohibit certain unfair or deceptive business practices by managed care plans, such as disenrolling a person because of a medical condition. Because of the potential expense for consumers needing to hire an attorney to sue in court in the event of unfair or deceptive acts or practices in managed care plans, especially at a time when the consumer is ill, this measure will allow the Commissioner greater flexibility in addressing grievances by allowing resolution by administrative action.

On behalf of our 28,000 members and other healthcare consumers, please pass this measure without the defective date.

Hawaii Coalition for Health
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Wahiawa, HI 96786

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HOUSE OF REPRESENTATIVES
THE TWENTY-.FOURTH LEGISLATURE
REGULAR SESSION OF 2008

COMMITTEE ON CONSUMER PROTECTION& COMMERCE
Rep. Robert N. Herkes, Chair
Rep. Angus L.K. McKelvey, Vice Chair
Members of the Committee

COMMITTEE ON JUDICIARY
Rep. Tommy Waters, Chair
Rep. Blake K. Oshiro, Vice Chair
Members of the Committee

NOTICE OF HEARING

DATE: Monday, March 31, 2008
TIME: 2:00 pm
PLACE: Conference Room 325
State Capitol
415 South Beretania Street

TESTIMONY IN SUPPORT OF SB 3015 – Relating to the Patients' Bill of Rights and Responsibilities Act, but with amendment of the effective date to January 2009.

March 30, 2008

Dear Honorable Chairs, Vice Chairs, and Members of the Committees:

The Hawaii Coalition For Health (HCFH) appreciates this opportunity to testify in support of SB 3015 SD 2 HD 1.

The HCFH concurs completely with the testimony given by Insurance Commissioner J.P. Schmidt to the Senate Committee on Commerce, Consumer Protection and Affordable Housing on March 14, 2008, and we are proud of the current administration's accomplishments on behalf of consumers and its demonstrated commitment to the protection of consumer rights.

As a consumer advocacy organization chiefly concerned with access to health care services, the HCFH strongly supports SB3015. Not only will passage of this Bill provide needed protections for consumers of health insurance against potential unfair business practices as described in this legislation, but it will further help to protect

consumers by allowing action by the Commissioner against offending insurers, and we note that SB3015 has not been opposed by the industry.

The HCFH is convinced that these further protections are needed due to its first-hand experience with instances in which health insurers have engaged in the types of conduct against which this Bill seeks legislative prohibition, to the great detriment of our patients. SB3015 will provide the Commissioner with the specific powers to act swiftly when there is need.

Thank you for the opportunity to testify.

RAFAEL DEL CASTILLO
ARLEEN JOUXSON-MEYERS for

HAWAII COALITION FOR HEALTH

Submitted by e-mail to: CPCtestimony@Capitol.hawaii.gov.

Richard S. Miller
Professor of Law, Emeritus and former dean
Member, Board of Kokua Council and the Drug Policy Forum of Hawaii

DATE: Monday, March 31, 2008
TIME: 2:00 pm
PLACE: Conference Room 325.

TESTIMONY IN STRONG SUPPORT OF SB 3015 HD1 – Relating to the Patients' Bill of Rights and Responsibilities Act, but with amendment of the effective date to January 2009.

TO: COMMITTEE ON CONSUMER PROTECTION& COMMERCE AND THE COMMITTEE ON JUDICIARY

Chair Herkes, Vice Chair McKelvey, Chair Waters, Vice Chair Oshiro and Distinguished Committee Members:

I am speaking today as a private citizen deeply concerned with the fair, effective, and honest administration of the health insurance laws of this State and with the wellbeing of Hawai'i's patients.

For the reasons so well stated by Insurance Commissioner J.P. Schmidt, I urge you to pass SB 3015, HD1 **but to amend the effective date to January 2009**.

Hawai'i, because of its size and remoteness from the mainland, is subjected to the control and manipulation of extraordinarily wealthy, powerful and influential health insurers, particularly the near monopoly of the market by HMSA, with its enormous reserve and large market share. Over the years, the Hawai'i Coalition for Health (HCFH), a voluntary non-profit organization, has attempted, with its meager budget, to advocate for patients whose rights under their health insurance contract have wrongly been denied or are threatened. HCFH was one of the earliest proponents and supporters of our Patients' Bill of Rights. HCFH has had some important and impressive victories, but has been frustrated in its patient-protective goals because of its limited resources and personnel, And because Hawai'i's physicians are severely constrained by the Antitrust laws from joining together to bring about reform of the antipatient practices of health insurers, which often deny patients with serious life-threatening conditions the benefits of research-proven cutting-edge medicine, the job of protecting these patients from improper insurance practices has devolved upon the Insurance Commissioner.

However, the Insurance Commissioner is narrowly constrained by the language of the insurance code. The commissioner cannot furnish protection to ill patients if the right to that protection is not provided by the laws of health insurance.

SB 3015 is a brilliant bill which extends protection to a number of important, vital patient rights. The passage of this bill could go far to protect patients against improper and

dangerous insurance practices. **Unfortunately, however, the current extended effective date, if adopted, would undermine the entire bill and render it ineffective.**

On behalf of the many fellow citizens suffering from serious illness and disease who can and will benefit significantly from scientifically proven medical advances, I implore you to pass SB 3015 HD1 with an effective date of January, 2009.

I wish I could be present in person to present this, I ran into a conflict with an already planned and paid-for trip to the Big Island. Please accept my appreciation for considering my testimony.

Respectfully,